Obtained via MI FOIA by Judicial Watch, Inc.

From: MDHHS FOIA Records Center
To: Bill Marshall
Subject: MDHHS FOIA Request :: H010401-030421
Date: Wednesday, April 7, 2021 11:18:09 AM

RE: Public Records Request, Reference # H010401-030421

Dear Senior Investigator Marshall,

This notice is issued in response to your request, legally received by the Michigan Department of Health and Human Services (Department) on March 05, 2021, requesting information under the Freedom of Information Act (FOIA), MCL 15.231 *et seq*.

Your request is partially granted and partially denied. Please login to the FOIA Records Center to access the records.

As to the granted portion, the Department has identified and included the responsive information falling within the scope of your request. To the best of the Department's knowledge, information, and belief, these are all the records in the possession of the Department falling within the scope of your request.

As to the denied portion, information of a personal nature, the disclosure of which would constitute a clearly unwarranted invasion of an individual's privacy, are exempt from disclosure under the FOIA per MCL 15.243 §13(1)(a). Information subject to attorney-client privilege are exempt per MCL 15.243 §13(1)(g). Medical records are exempt per MCL 15.243 §13(1)(l). Records of an advisory nature to the extent that they that are preliminary to a final determination of policy or action are exempt per MCL 15.243 §13(1)(m); in this particular instance the public interest in encouraging frank communication between employees of the Department clearly outweighs the public interest in disclosure. Records of a public body's security measures, including security plans, security codes and combinations, passwords, passes, keys, and security procedures are exempt per MCL 15.243 §13(1)(u).

As to the denial, the Department is obligated to inform you that under MCL 15.240 §10 the following remedies are available:

1. Appeal this decision in writing to the Legal Affairs Administration for the Department of Health and Human Services, PO Box 30195, Lansing, MI 48909. The writing must specifically state the word "appeal" and must identify the reason or reasons you believe the partial denial should be reversed. The Department must respond to your appeal within ten days of its receipt. Under unusual circumstances, the time for response to your appeal may be extended by 10 business days.

Obtained via MI FOIA by Judicial Watch, Inc.

2. File an action in the appropriate court within 180 days after the date of the final determination to partially deny the request. If you prevail in such an action, the court is to award reasonable attorney fees, costs, disbursements, and possible damages.

The Department's FOIA policies and procedures are available at Policies and Procedures.

Sincerely,

Bureau of Legal Affairs

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Gordon, Robert (DHHS)
Cc: rmgordon1580@gmail.com
Subject: Acceptance of Resignation
Date: Friday, January 22, 2021 2:41:23 PM

Robert,

This email is to notify you that the governor has accepted your resignation as Director of the Michigan Department of Health and Human Services today, January 22, 2021. If you would like to discuss an executive separation agreement, please contact Assistant Attorney General Jeanmarie Miller, Department of Attorney General, at millerj51@michigan.gov to schedule a meeting. Thank you for your service.

Mark

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email and any associated documents may contain information that is privileged or otherwise exempt from disclosure. It is intended for use only by the person to whom it is addressed. Please contact me before disclosure. If you have received this email in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Gordon, Robert (DHHS)
Cc: gordonrobert@gmail.com
Subject: Acceptance of Resignation
Date: Friday, January 22, 2021 2:52:44 PM

Re-sending with correct personal email address.

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email and any associated documents may contain information that is privileged or otherwise exempt from disclosure. It is intended for use only by the person to whom it is addressed. Please contact me before disclosure. If you have received this email in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

From: Totten, Mark
Sent: Friday, January 22, 2021 2:41 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Cc:
Subject: Acceptance of Resignation

Robert,

This email is to notify you that the governor has accepted your resignation as Director of the Michigan Department of Health and Human Services today, January 22, 2021. If you would like to discuss an executive separation agreement, please contact Assistant Attorney General Jeanmarie Miller, Department of Attorney General, at millerj51@michigan.gov to schedule a meeting. Thank you for your service.

Mark

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue

Obtained via MI FOIA by Judicial Watch, Inc.

Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email and any associated documents may contain information that is privileged or otherwise exempt from disclosure. It is intended for use only by the person to whom it is addressed. Please contact me before disclosure.** **If you have received this email in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

Obtained via MI FOIA by Judicial Watch, Inc.

SEPARATION AGREEMENT & RELEASE
Between the State of Michigan
&
Robert Gordon

This agreement and release is non-precedent setting and is made voluntarily, without any duress or coercion, and constitutes a final and binding agreement resolving all issues pertaining to the employment of Robert Gordon (Employee) with the State of Michigan (Employer).

1. Employee voluntarily resigned his employment effective January 22, 2021.

2. In consideration for releasing all claims against Employer arising out of his employment, Employer will pay Employee the sum of $155,506.05 which represents 9 months of salary and COBRA payments. Employer bears no further responsibility for Employee's COBRA enrollment or payments.

3. In the interest of protecting deliberations among government officials, the parties agree to maintain confidentiality regarding Employee's departure from employment unless required by law to release such information. In response to a Freedom of Information Act request that specifically references Employee, Employer will inform Employee when a determination has been made that all of the conditions have been met for the release of documents. Employer will provide Employee with a description of the FOIA request. If a release subsequently occurs, Employee will be provided access to the released documents at the same time and in the same manner as the requestor of the information. Employer and Employee may choose to comment on any matter as to which a release is required by law. In response to any inquiries from prospective employers, Employer will state that Employee voluntarily resigned.

4. The parties recognize that Employee is presently named as a Defendant, in both his official and individual capacity, in various lawsuits currently pending and arising out of his appointment to and service as the Director of the Michigan Department of Health and Human Services. The parties also recognize that future litigation could be filed related to actions and matters that arose during Employee's employment wherein Employee could be named in his individual capacity. Employee will cooperate with Employer in connection with any such litigation, such as by providing information or executing documents, in a manner that does not unreasonably interfere with Employee's work obligations. With regard to presently known litigation and any future litigation, the parties recognize that Employee may be entitled to or may receive legal representation pursuant to MCL 691.1408, Civil Service Rule 2-19, and other applicable laws, rules, and practices. Employee will

Obtained via MI FOIA by Judicial Watch, Inc.

direct requests for representation (including requests for representation in response to court subpoenas, deposition notices, requests by a government agency for information, or similar requests), to Matthew Rick, Senior Deputy Director, Legal Affairs Administration at rickm@michigan.gov. In response to such requests, Employer will provide legal representation for Employee in matters relating to actions taken by Employee while in the course of his employment and while acting within the scope of his authority. Pursuant to MCL 691.6408, in the event a settlement is reached or judgment is entered against Employee, Employee may seek indemnification for damages awarded based upon actions taken by Employee in the course of his employment and while acting within the scope of his authority. In response to such request, Employer will not unreasonably withhold indemnification.

5. In exchange for this agreement, Employee agrees to fully and finally release all claims against Employer. Employee, for himself, his successors, heirs, assigns, and any other persons who could lawfully make claim on his behalf, do hereby release, forever discharge, and hold harmless Employer, and each of its departments, divisions, institutions, agencies, sections, bureaus, commissions, officers, attorneys, and employees and former employees, and the successors, heirs and assigns of such persons and entities, from any and all rights, actions, grievances, claims, liabilities, duty disability retirement claims, demands, suits, and causes of action, whether in law or equity, of each kind and nature, and description, whether known or unknown, suspected or arising out of his employment with Employer, including, but not limited to, any claim for costs or for attorney fees and any claim related to his employment, including but not limited to, his separation from employment.

WITH FULL KNOWLEDGE AND UNDERSTANDING OF MY RIGHTS, Employee, my successors, heirs, assigns, and any other persons who could lawfully make claim on my behalf specifically releases, forever discharges, and holds harmless Employer and all departments, divisions, institutions, agencies, sections, bureaus, commissions, officers, attorneys, and employees and former employees of Employer and the successors, heirs and assigns of such persons and entities, from any and all federal or state actions, grievances, claims, liabilities, duty disability retirement claims, demands, suits, and causes of action, whether in law or equity, of each kind and nature, and description, whether known or unknown, suspected or arising out of my employment with Employer, including, but not limited to, any claim for costs or for attorney fees and any claim related to my employment, including but not limited to, my separation from employment.

This release includes all claims and grievances for age discrimination, race discrimination, gender discrimination, national origin discrimination, religious discrimination, discriminatory harassment, unlawful retaliation,

Obtained via MI FOIA by Judicial Watch, Inc.

breach of express or implied contract, breach of the duty of fair representation, violation of public policy, workers' compensation, violation of any applicable compensation plan, intentional or negligent infliction of emotional distress, breach of the covenant of good faith and fair dealing, fraud, misrepresentation, conspiracy, unpaid wages, overtime and/or commissions, defamation, retaliation, tortuous conduct, violation of due process, federal or state civil rights claims or any other type of claim including claims arising under Michigan Civil Service Rules and Regulations, tort, or contact, that arises from or related to employment with Employer and/or any wages and benefits available in connection with such employment. Employee further acknowledges that he has not sustained any work-related injury or illness during his employment with Employer.

This release has been executed for the valuable consideration agreed to above between the parties that is incorporated in its entirety herein.

It is expressly understood and agreed that the sole consideration for this Release is the consideration set forth in the Settlement Agreement and incorporated herein; that the consideration herein is contractual and not a mere recital; that all agreements between the parties released herein do not admit liability but expressly deny the same and shall not be construed to be an admission of liability; and that said consideration is paid in compromise and settlement of a disputed claim or claims.

Employee represents and acknowledges that before signing this Release, he has read the same, consisting of four (4) pages; that he fully understands its terms, content, and effect; and that he has had the opportunity to consult with an attorney of his choosing, if so desired, and has relied fully and completely on his judgment and the judgment of counsel, if applicable, in executing this Full and Final Release of All Claims. Employee further acknowledges that under the Older Workers' Benefits Protection Act, he has the right to consult an attorney prior to executing this agreement. Employee also specifically waives any right under the Older Workers' Benefits Protection Act to consider the agreement for the full twenty-one (21) day period. Employee further acknowledges that he has a right to revoke the agreement within seven (7) calendar days of the date of his signature and further agrees that any revocation will be communicated in writing addressed to Mark Totten, Chief Legal Counsel Office of the Governor, State of Michigan, George W. Romney Building 111 S. Capitol Avenue, Lansing, Michigan 48909, tottenm1@michigan.gov via email, hand delivery or

Obtained via MI FOIA by Judicial Watch, Inc.

certified mail delivery. Employee represents and acknowledges that he has executed this Release voluntarily and willingly.

IN WITNESS WHEREOF, I ROBERT GORDON executed this SEPARATION AGREEMENT AND FULL AND FINAL RELEASE OF ALL CLAIMS by my free act and deed on 22 of February, 2021.

Robert Gordon
Employee

Mark Totten
On Behalf of Employer State of Michigan

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Huls, JoAnne
To:	Foster, Tricia; Khaldun, Joneigh (DHHS); LyonCallo, Sarah (DHHS); Gordon, Robert (DHHS); Hertel, Elizabeth (DHHS); Totten, Mark
Cc:	Smith, Tammy
Subject:	Re: Modeling Follow Up
Date:	Thursday, July 9, 2020 9:58:24 AM

Thanks Trish - It makes sense to me to include Brom. Does it also make sense to include McGowan or Gasper?

From: Foster, Tricia <FosterT13@michigan.gov>
Sent: Thursday, July 9, 2020 8:53:55 AM
To: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>
Cc: Smith, Tammy <SmithT89@michigan.gov>
Subject: Modeling Follow Up

Good morning strategy team. Tammy will be coordinating a call with this small leadership group in follow up to the discussions about data/modeling this week and how we communicate and make decisions that impact residents. The purpose will be to talk through, banter, and strategize around what our new baseline should be for the thresholds of low, medium, and high risk in advance of schools, universities and flu season approaching. A certain amount of uptick is expected as mobility increases; but what is the math problem that correlates to acceptable risk today versus in March or is it the same? In addition; to chat through the following and to see where resources are needed to help push quickly given we are 6-8 weeks away…

1. Surveillance
2. Pooling
3. Targeted Testing/Tracing – Outbreak driven
4. New Supply Chain
5. Flu/Vaccines
6. Communications
7. Mask Up
8. Human Resources/Partnerships

One further thought – It seems appropriate for Brom to join if you feel comfortable expanding the group slightly. Please advise. Thank you.

Tricia L. Foster, CPM, ACoM
Chief Operating Officer
State of Michigan
Fostert13@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Huls, JoAnne; Foster, Tricia; Khaldun, Joneigh (DHHS); LyonCallo, Sarah (DHHS); Hertel, Elizabeth (DHHS); Totten, Mark
Cc: Smith, Tammy
Subject: RE: Modeling Follow Up
Date: Thursday, July 9, 2020 10:35:50 AM

We're happy with any adds here. Good convo w Brom this am on masks. Thanks.

From: Huls, JoAnne <HulsJ1@michigan.gov>
Sent: Thursday, July 9, 2020 9:58 AM
To: Foster, Tricia <FosterT13@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>
Cc: Smith, Tammy <SmithT89@michigan.gov>
Subject: Re: Modeling Follow Up

Thanks Trish - It makes sense to me to include Brom. Does it also make sense to include McGowan or Gasper?

From: Foster, Tricia <FosterT13@michigan.gov>
Sent: Thursday, July 9, 2020 8:53:55 AM
To: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>
Cc: Smith, Tammy <SmithT89@michigan.gov>
Subject: Modeling Follow Up

Good morning strategy team. Tammy will be coordinating a call with this small leadership group in follow up to the discussions about data/modeling this week and how we communicate and make decisions that impact residents. The purpose will be to talk through, banter, and strategize around what our new baseline should be for the thresholds of low, medium, and high risk in advance of schools, universities and flu season approaching. A certain amount of uptick is expected as mobility increases; but what is the math problem that correlates to acceptable risk today versus in March or is it the same? In addition; to chat through the following and to see where resources are needed to help push quickly given we are 6-8 weeks away…

1. Surveillance
2. Pooling
3. Targeted Testing/Tracing – Outbreak driven
4. New Supply Chain
5. Flu/Vaccines
6. Communications
7. Mask Up

Obtained via MI FOIA by Judicial Watch, Inc.

8. Human Resources/Partnerships

One further thought – It seems appropriate for Brom to join if you feel comfortable expanding the group slightly. Please advise. Thank you.

Tricia L. Foster, CPM, ACoM
Chief Operating Officer
State of Michigan
Fostert13@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Gordon, Robert (DHHS)
To:	Foster, Tricia; Khaldun, Joneigh (DHHS); LyonCallo, Sarah (DHHS); Hertel, Elizabeth (DHHS); Huls, JoAnne; Totten, Mark
Cc:	Smith, Tammy
Subject:	RE: Modeling Follow Up
Date:	Sunday, July 12, 2020 8:30:03 PM
Attachments:	Google tracing tech recommendation memo v3.docx

Hope everyone has had a good weekend. Attached please find a two-page memo on the pros and cons of the Google/Apple tracing app. The memo recommends that SOM work with a big university on a pilot for back-to-school. Without making any commitments, Dr. LC has mentioned the concept to U of M already; we can also flag the idea to other colleges in the conversations this week. It will take several weeks to get into execution, even for a pilot. Perhaps good for discussion on Tuesday. Thank you.

From: Foster, Tricia <FosterT13@michigan.gov>
Sent: Thursday, July 9, 2020 8:54 AM
To: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>
Cc: Smith, Tammy <SmithT89@michigan.gov>
Subject: Modeling Follow Up

Good morning strategy team. Tammy will be coordinating a call with this small leadership group in follow up to the discussions about data/modeling this week and how we communicate and make decisions that impact residents. The purpose will be to talk through, banter, and strategize around what our new baseline should be for the thresholds of low, medium, and high risk in advance of schools, universities and flu season approaching. A certain amount of uptick is expected as mobility increases; but what is the math problem that correlates to acceptable risk today versus in March or is it the same? In addition; to chat through the following and to see where resources are needed to help push quickly given we are 6-8 weeks away…

1. Surveillance
2. Pooling
3. Targeted Testing/Tracing – Outbreak driven
4. New Supply Chain
5. Flu/Vaccines
6. Communications
7. Mask Up
8. Human Resources/Partnerships

One further thought – It seems appropriate for Brom to join if you feel comfortable expanding the group slightly. Please advise. Thank you.

Tricia L. Foster, CPM, ACoM
Chief Operating Officer

Obtained via MI FOIA by Judicial Watch, Inc.

State of Michigan
Fostert13@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

Memo – Proximity Tracking software

This memo recommends a university-based pilot of Bluetooth-based proximity tracking technology to aid in contact tracing efforts in Michigan.

Introduction and Context

Bluetooth proximity tracking technology does not track the specific geographic movements of individuals. It tracks whether individuals come into close contact such that one might convey COVID to the other. For example, if there are two individuals sitting next to one another for a park bench for a lengthy period of time, the proximity tracking technology understands that their phones have been close to one another, but it does not know the specific geographic location of the park bench. If one of the individuals tests positive and enters that information in the app, the other person on the park bench will be notified that they may have come into close contact with someone who has tested positive for COVID-19. Downloading and using the application is entirely voluntary.

Several other countries (including Western European countries like Germany, Austria, Switzerland, and France, as well as South Korea, Singapore, and Israel) have rolled out proximity tracking apps. Virginia, and North Dakota are pursuing this approach as well, with other big states like us in consideration.

How the Tracking App Would Work

- Individuals download the app onto their phone and turn it on.
- When a person tests positive, they do a case interview as today. The case interviewer gives them a code which they can enter into their phone in order to self-identify as a positive case.
- The system then matches personally deidentified keys with other individuals who were in proximity. The criteria for making a match would be set by DHHS. Based on what we know, we would set a high threshold aiming to minimize false positives: for example, the two phones spent at least 15 minutes exchanging Bluetooth signals with high confidence that the phones were within 6 feet of each other.
- If a second phone matched the phone of the positive case, the user would receive a message from DHHS. Because the technology is so new and we do not yet have confidence about the quality of the match, we would not direct positive persons to quarantine. We would instead include a notification that essentially says, you may have been a close contact of someone positive, you should get a COVID test; here are some test sites; here is a link for more information.

Google and Apple have partnered to enable the Bluetooth use; we would engage a Google-approved partner to provide the app and partner on the technology.

Advantages

Proximity tracking technology cannot supplant traditional contact tracing. However, it could help the state and local health departments in two important ways.

First, it can provide notification to individuals about close contacts that have tested positive if those close contacts are "strangers" or not otherwise known to the positive case. If, for example, an individual attends a social gathering and is in close proximity to several individuals for a lengthy period of time, they may not know those individuals, or be able to contact them. If, however, a substantial portion of the individuals at the social gathering are using a proximity tracing application, once the affected individual enters their positive test in the app, a notification can be sent out to the other individuals instructing them to quarantine, monitor symptoms, or get tested.

Obtained via MI FOIA by Judicial Watch, Inc.

Second, it can compensate for incomplete or otherwise faulty memories. If an individual tests positive and talks to a manual contact tracer, they may not remember all of the individuals with whom they have had close contact. If, however, they have a tracing app downloaded and their close contacts do as well, those individuals can get notified nonetheless.

Disadvantages

Though there are clear benefits to proximity tracking, there are reasons to be wary as well:

First, the technology may not work, and could even backfire. There is no data on efficacy, and many things could go wrong. It may be that not enough people sign up to use the app; or they use it but don't report their positive tests into the app; or the technology causes more false matches than anticipated, and not enough people go and test; or something else goes wrong. A failed implementation could undermine broader confidence in tracing.

Second, proximity tracking programs can be misconstrued as invading privacy, and damage public confidence in traditional tracing. Though these programs do *not* track individuals' actual geographic location, there has been a lot of concern in the media around government tracking individuals' movements. While we are trying to raise public awareness around tracing and increase individuals' willingness to pick up the phone, this could lead to anxiety about privacy that undermines compliance.

Third, implementing this program may consume significant DHHS staff time. The contact tracing team is still very busy trying to increase contact rates for traditional (manual) case investigation and contact tracing, and the ability of the team to absorb additional work needs to be considered.

Fourth, use of the apps may place additional strain on local health departments. Individuals who download the app are likely to have a variety of questions ("What does it mean when I get notified" "What privacy protections are in place" "Are you monitoring my movements?). The state must be careful to not place too much additional strain on local health departments as they prepare for a fall surge.

Proposed Approach

If effective, this technology would identify more close contacts than working solely through traditional methods; as a result, we could encourage more infected individuals to isolate; as a result, we could reduce the spread of COVID. However, there is no certainty that the technology will be effective, and there are costs to its use in terms of staff time and potential impact on public confidence.

Balancing these concerns, this memo recommends a pilot of proximity tracing in connection with a willing large university and local health department partner. If the technology is effective, the pilot will position us to scale more quickly than if we wait and watch other states. The pilot would not fully integrate the technology with our existing TraceForce or data systems, limiting the needed staff time.

A large university would provide a good testing ground for this technology – younger individuals are more likely to use the technology, have broad social circles, and to have many more close contacts given their residential settings. Moreover, given the risks around return to school, an effective implementation at a university would have immediate benefits. A pilot implementation means that the public knows we are not going "all in" with the technology; we are limiting burdens on our staff and LHD staff; and if it does not work, there would be less criticism.

If the pilot efficiently identifies significant numbers of individuals who promptly get tested and test positive, we would refine the program, potentially integrate it with our own systems, and scale it statewide. If it does not achieve these goals, we would shut it down.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Gordon, Robert (DHHS)
Subject: Re: Needs
Date: Thursday, March 19, 2020 2:27:35 PM

Ok. I think we will address most of this tonight. I've got a person/process for each.

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Thursday, March 19, 2020 2:26:50 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>
Subject: Needs

This is a portion of something Jonathan prepared last night. Most of it is just FYI in case useful, but I'll try to catch you on one item.

I think the biggest things we need help with are:

1. **Data integration** – we are struggling today to bring together disparate data sources (inventories from different parts of the state, epidemiological models, EMResource, etc.)
2. **Robust analytics** – our team has done great work to date on a lot of preparedness issues, but we could use help in modelling out the impact of different interventions on disease spread and hospital capacity. (As it happens, I don't think we generally have the advanced data modeling skills internally either, but more importantly, this is an issue of time)

Specific items we could use help with

Overall modeling and data

- Overall model of the progression of the disease at a sub-county level (dynamic model that will adapt as the situation on the ground changes)
- Work with SOM team to refine its data model to better ingest and integrate data from EMResource, MiHIN, other systems to give real-time tracking of the spread of COVID-19, # of available beds, ICU beds, PPE, ventilators, respirators, etc.

Beds

- Full projections at a sub-geographic level of needs for beds, ventilators, respirators, PPE
- Take emergency preparedness plans from hospitals and model overall impact – help SOM develop additional plans in partnership with hospitals to address even larger surge
- Build a financial model to construct additional beds/facilities (how do we finance it)

Supplies

- Develop a system that fully integrates the state's data to understand where all of the PPE (and other key equipment) is in case the state needs to reallocate
- Identify areas in the supply chain that the state is not leveraging today

Personnel

- Projections of specific supply shortages based on potential infection rates / utilization

Obtained via MI FOIA by Judicial Watch, Inc.

Policy solutions to address the shortages, projections of the impact of those solutions, and implementation plans for each

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: "Whitmer, Gretchen"
Subject: RE: New study investigates California"s possible herd immunity to COVID-19
Date: Wednesday, April 8, 2020 3:02:05 PM

Got it. Will discuss this with the team. It is odd that the only person quoted in this article is Victor David Hanson. He is a conservative historian/commentator and someone defending Trump admin on Coronavirus.

-----Original Message-----
From: Whitmer, Gretchen <WhitmerG1@michigan.gov>
Sent: Wednesday, April 8, 2020 2:18 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: New study investigates California's possible herd immunity to COVID-19

The antibody test is going to be crucial

https://gcc01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.ksbw.com%2Farticle%2Fnew-study-investigates-californias-possible-herd-immunity-to-covid-19%2F32073873&data=02%7C01%7CGordonR3%40michigan.gov%7C9a2a2bd11d9d425ebc8208d7dbe93d28%7Cd5fb7087377742ad966a892ef47225d1%7C0%7C0%7C637219667101746171&sdata=VnF0OewlK7WMSBGB9Zpq%2BCpRFuVjC%2FrsETsQG731pQQ%3D&reserved=0

Sent from my iPhone

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Gordon, Robert (DHHS)
To:	Huls, JoAnne; Taverna, Andrea (DHHS-Contractor); Totten, Mark; Hertel, Elizabeth (DHHS); Massey, Kate (DHHS); Pohl, Zack; Khaldun, Joneigh (DHHS); Emerson, Erin (DHHS)
Cc:	Foster, Tricia
Subject:	RE: Nursing Home Testing/Results
Date:	Sunday, April 19, 2020 9:27:46 PM
Attachments:	LTC Strategy Press Release Draft Updated 4.19.2020 (002).docx

Thanks. We had a call discussing these issues earlier tonight. I'm adding Kate Massey and Erin Emerson who are leading the way from Medicaid, as well as some other folks who have been involved.

Two key pieces are:

- Mandatory reporting—through the recent EO we mandated increased reporting to DHHS (including but not limited to positives) for nursing facilities and for other elder care facilities (adult foster cares, homes for the aging, assisted living facilities). This happens through EM Resource. Nursing homes use that platform now and we are pushing ahead with them. We have realized there are added complexities with the other facilities (and how the EO applies to them generally) and are working those issues through tomorrow.
- The strike team is also something we are also implementing, and ready to announce tomorrow.

These items are described in the attached draft release, which I think we can adjust a bit and get out tomorrow.

Happy to discuss further.

Thanks,
Robert

From: Huls, JoAnne <HulsJ1@michigan.gov>
Sent: Sunday, April 19, 2020 9:10 PM
To: Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>
Cc: Foster, Tricia <FosterT13@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: Nursing Home Testing/Results

Hi,

We talked recently (maybe yesterday?) about how we need to get results identified from tests that are from a nursing home. Totten, you suggested that this perhaps get routed in through the team that LInda Scott works with (the one that Megan works with to get local results by noon that we post from Hospitals.)

I'm not familiar enough with DHHS to know if Nursing homes currently report in which of their

Obtained via MI FOIA by Judicial Watch, Inc.

patients test positive (while either in the facility or in the hospital), and if a positive happens, how we put together the “strike team” to go immediately into the nursing homes to test/isolate — but it seems like we should try to pull this piece apart first thing tomorrow morning. If this is happening, great. Can someone tell me exactly what the procedure is? If not .. . .

Elizabeth/Andie - is this you who will take this apart? Just wanted to make sure that we keep this one top of mind.

Thanks
JoAnne

Obtained via MI FOIA by Judicial Watch, Inc.

MDHHS implementing strategies in long-term care facilities to help slow the spread of COViD-19 and protect residents and staff

LANSING, Mich. – To implement and support the goals of Executive Order 2020-50, the Michigan Department of Health and Human Services (MDHHS) is rolling out a comprehensive strategy to combat the impact of COVID-19 in long-term care settings and ensure residents and employees are protected.

The strategy includes the following actions:

1. Mandates enhanced reporting requirements for all long-term care settings.
2. Activates a COVID-19 Infection Prevention Resource and Assessment Team (COVID iPRAT).
3. Establishes MDHHS-designated COVID-19 Regional Hubs.

Beginning April 20, MDHHS will mandate all long-term-care facilities (nursing homes, homes for the aged, adult foster care facilities and assisted living facilities) submit daily reports to MDHHS. Using the EMResource platform, facilities will be required to submit up-to-date information regarding current capacity/bed availability, personal protective equipment inventory and the current number of COVID-19 cases and deaths within their facility.

“We know older Michiganders and those with underlying health conditions are at higher risk for more severe complications from COVID-19,” said Dr. Joneigh Khaldun, chief medical executive and chief deputy for health. “Enhanced and timely reporting of this information will assist the department in identifying areas to prioritize resources, provide technical assistance or other interventions that will help protect these vulnerable individuals.”

MDHHS has established a COVID iPRAT team comprised of staff members from across the Public Health Administration Division of Communicable Diseases. The COVID iPRAT was designed to help prevent COVID-19 infections and contain the spread of COVID-19 in long-term care facilities. The team will work closely with the Medical Services Administration, Michigan Long-Term Care Ombudsman, Michigan Licensing and Regulatory Affairs and local health department partners.

Through the iPRAT, local health departments and long-term care facilities in their jurisdiction will have access to training on the latest MDHHS, Centers for Disease Control and Prevention (CDC), and the Centers for Medicare & Medicaid Services guidance. Additionally, facilities will receive focused review of infection control policies and procedures, standardized trainings and protocols, remote contract tracing assistance and remote facilitation of an Infection Prevention and Control Assessment using CDC’s Tele-ICAR tool.

"The spread of COVID-19 has had a significant impact on residents and employees at Michigan’s long-term care facilities,” said Gov. Gretchen Whitmer. “A strong cross

Obtained via MI FOIA by Judicial Watch, Inc.

department, state and local partnership will help combat the spread of this virus and protect residents and staff of these facilities."

MDHHS has also established a regional hub strategy to assist in reducing the spread of COVID-19 within congregate care settings. COVID-19 Regional Hubs are dedicated to treating COVID-19-affected individuals from congregate care settings who do not require hospital-level care.

COVID-19 Regional Hubs will be designated by MDHHS and announced as they are established. Facilities across the state are being considered for this model based on willingness to serve as a hub facility, capacity to contribute to local need for services, proximity to acute care facilities experiencing high COVID-19-related demand, ability to effectively quarantine COVID-19-affected residents and performance history of the facility. COVID-19 Regional Hubs will be required to complete enhanced reporting to the department on a daily basis.

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Gordon, Robert (DHHS)
To:	Laura Appel
Cc:	Totten, Mark; Foster, Tricia; Groen, Meghan; Massey, Kate (DHHS); Emerson, Erin (DHHS); Hertel, Elizabeth (DHHS)
Subject:	RE: Nursing homes and COVID patients; reissuing executive order
Date:	Tuesday, May 19, 2020 11:31:09 AM

Thanks very much for this perspective. Adding a few colleagues in case they wish to follow up.

From: Laura Appel <lappel@mha.org>
Sent: Tuesday, May 19, 2020 11:04 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Cc: Totten, Mark <TottenM1@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>
Subject: Nursing homes and COVID patients; reissuing executive order

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Director Gordon—
I apologize for this late email regarding the need to reissue an executive order on nursing homes. I certainly understand the dilemma of how to best care for our older and potentially most frail patients/residents, while protecting others in nursing homes.
Keeping people who are recovered as residents in hospitals is not a good solution as it keeps a bed from being available to someone who needs inpatient care, and most likely the hospital is not reimbursed for a patient who no longer needs that level of medical services. Hospitals are frequently audited for appropriateness of service delivery, meaning that reimbursement is clawed back if a hospital continues to bill for a patient who is not eligible for inpatient services.
At the same time, acute care hospitals are generally the best places for isolating people and for achieving infection control.
A solution may be to emphasize the use of "swing beds." Swing beds are beds which certain hospitals (in rural areas/fewer than 100 beds in the hospital) may use as either inpatient or skilled nursing beds. Most Critical Access Hospitals (CAHs) have these beds, as do some of Michigan's larger rural hospitals. This flexibility in the definition of the bed avoids the reimbursement problem. Hospitals with swing beds frequently take transfers from other hospitals for people who need step down care. For example, a person may have a serious surgical procedure at a tertiary care center, then continue to recover closer to home at a hospital like Mackinac Straits in St. Ignace using a swing bed.
Given that so many COVID patients or nursing home residents are in urban areas, a rural solution may seem of little value. However, Michigan has a broad definition of rural county. Tuscola County is adjacent to Genesee and Saginaw Counties and could assist Flint and Saginaw. Montcalm, Allegan and Ionia are all adjacent to Kent County. Eaton and Clinton are both rural and adjacent to Ingham. There are other examples across the state.
Because Michigan has a large number of CAHs, they would also have the potential to take nursing home residents who have not been hospitalized. There are several CAHs in the UP and northern Michigan, but some are also in mid-Michigan, southwest Michigan, and the Thumb.

Obtained via MI FOIA by Judicial Watch, Inc.

In addition to using these hospitals which have the infection control and single room resources, the reimbursement for Medicare patients could assist these rural hospitals because of the COVID-19 uplift in current Medicare reimbursement.

For the direct SE Michigan counties, it may be wise to consider making further adjustments to the care setting at Suburban Showplace to allow for skilled nursing facility patients to reside there for a quarantine or isolation period.

I hope you find this information useful. I can connect department and the Executive Office to more information/expertise about swing beds if that would be helpful.

Laura

Laura Appel | Senior Vice President
Chief Innovation Officer
Michigan Health & Hospital Association
110 W. Michigan Ave | Lansing, MI 48933
517-703-8606 Office | 517-285-2962 Cell
lappel@mha.org

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Hertel, Elizabeth (DHHS); Groen, Meghan; Foster, Tricia
Cc: Gordon, Robert (DHHS); Khaldun, Joneigh (DHHS); Flood, Jennifer
Subject: Re: Participation as COVID-19 Relief Hospital Memo
Date: Wednesday, March 25, 2020 8:58:12 PM

Thanks. Hearing lots of feedback on this. I'm assuming this will go far and wide.

From: Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>
Sent: Wednesday, March 25, 2020 8:55:15 PM
To: Groen, Meghan <GroenM@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Subject: FW: Participation as COVID-19 Relief Hospital Memo

The attached guidance will be going to health care coordinators and out through the MHA as we work to balance patient capacity. The governor did mention this morning that we recognize the need to balance patient loads and we are putting this out as guidance and assistance to help facilitate the safe transfer of patients. It is not our intention to begin moving patients across the state if it is not necessary, and we have reiterated that a number of times. This guidance also underscores that we do not recommend transferring patients that are in critical condition.

From: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Sent: Wednesday, March 25, 2020 8:46 PM
To: Taylor, Kerri (DHHS) <TaylorK10@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>
Cc: White, Ricardo <WhiteR22@michigan.gov>; Ingersoll, Jean (DHHS) <IngersollJ2@michigan.gov>; Scott, Linda (DHHS) <ScottL12@michigan.gov>; Fales, William (DHHS-Contractor) <FalesW@michigan.gov>; William D Fales <William.Fales@med.wmich.edu>; dstrong2@hfhs.org
Subject: RE: Participation as COVID-19 Relief Hospital Memo

Thanks all! Please see final letter attached. Please send pdf. Appreciate you all and have a good night.

From: Taylor, Kerri (DHHS) <TaylorK10@michigan.gov>
Sent: Wednesday, March 25, 2020 8:37 PM
To: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>
Cc: White, Ricardo <WhiteR22@michigan.gov>; Ingersoll, Jean (DHHS) <IngersollJ2@michigan.gov>; Scott, Linda (DHHS) <ScottL12@michigan.gov>; Fales, William (DHHS-Contractor) <FalesW@michigan.gov>; William D Fales <William.Fales@med.wmich.edu>
Subject: RE: Participation as COVID-19 Relief Hospital Memo

Forgot to cc – Linda and Dr. Fales.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Taylor, Kerri (DHHS)
Sent: Wednesday, March 25, 2020 7:57 PM
To: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>
Cc: White, Ricardo <WhiteR22@michigan.gov>; Ingersoll, Jean (DHHS) <IngersollJ2@michigan.gov>
Subject: Participation as COVID-19 Relief Hospital Memo
Importance: High

Memo attached for review approval to send out tonight.

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Huls, JoAnne
To:	Ingersoll, Jean (DHHS); Totten, Mark; Foster, Tricia
Cc:	Gordon, Robert (DHHS); Hertel, Elizabeth (DHHS); Khaldun, Joneigh (DHHS); Gasper, Joe (MSP); McGowan, Emmitt (MSP)
Subject:	Re: Pharmaceutical Update
Date:	Friday, April 3, 2020 8:24:23 PM
Attachments:	image001.jpg

Thanks Jean,

WIll circulate among the EOG team and get some things moving and loop back with you.

Thanks
JoAnne

From: Ingersoll, Jean (DHHS) <IngersollJ2@michigan.gov>
Sent: Friday, April 3, 2020 7:54:36 PM
To: Totten, Mark <TottenM1@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Gasper, Joe (MSP) <GasperJ@michigan.gov>; McGowan, Emmitt (MSP) <McGowanE1@michigan.gov>
Subject: Pharmaceutical Update

Good Evening:
I briefed Elizabeth this evening on our attempts to secure pharmaceuticals and would like to provide you an update.

The SEOC submitted three resource requests this week for pharmaceuticals (one for the TCF cache, one for Henry Ford Health System, and one for sedation meds required for covid). All three requests are currently at the VHA acquisition center awaiting confirmation.

With the assistance of the Michigan Pharmacists Association, we contacted our wholesalers: Cardinal, Amerisource, McKesson, etc.. none of which have the medications that our hospitals require. We had a candid conversation with the Cardinal representative that works with Beaumont and they place multiple orders daily and many of the orders have gone unfilled.

MPA also began calling manufacturers and proved to be unsuccessful – all wholesalers and manufacturers state that they do not have sufficient supply. Today we had a call with ASHP (American Society of Health-System Pharmacists). ASHP remarked that we are doing all that we can do to procure pharmaceuticals and offered to also call manufacturers on our behalf. ASHP's CEO recently sent a letter to Vice President Pence (attached) compelling him to increase the manufacturing of the pharmaceuticals necessary for Covid-19 patient care.

After speaking with Elizabeth, we believe that escalation is necessary and she suggested that I

Obtained via MI FOIA by Judicial Watch, Inc.

attach this draft letter for your review. Jean

Jean Ingersoll, JD
Administrative Deputy Director
Public Health Administration
333 S. Grand Ave., 4th Floor
Lansing, MI 48933
Cell: 517.582.4660
Direct: 517.284.4022
Email: ingersollj2@michigan.gov



Confidentiality Notice: This message, including any attachments, is intended solely for the use of the named recipient(s) and may contain confidential and/or privileged information. Any unauthorized review, use, disclosure or distribution of this communication is expressly prohibited. If you are not the intended recipient, please contact me by email and destroy any and all copies of the original email message.

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Gordon, Robert (DHHS)
To:	Pohl, Zack; Huls, JoAnne; Belden, Eileen; Laidlaw, Emily; Groen, Meghan; Totten, Mark
Cc:	Hertel, Elizabeth (DHHS); Schwarzkopf, Emily (DHHS); Roubal, Lewis (DHHS); Flood, Jennifer; Jen, Kyle (DTMB); Bouknight, Rey (DHHS)
Subject:	RE: Potential addition for unemployment release
Date:	Monday, March 16, 2020 1:49:06 PM
Attachments:	COVID-19 Cash Assistance Draft Press Release final.docx

This is good to go from DHHS

From: Pohl, Zack <PohlZ@michigan.gov>
Sent: Monday, March 16, 2020 9:48 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>; Belden, Eileen <BeldenE@michigan.gov>; Laidlaw, Emily <LaidlawE@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>
Cc: Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Schwarzkopf, Emily (DHHS) <SchwarzkopfE1@michigan.gov>; Roubal, Lewis (DHHS) <RoubalL@michigan.gov>; Flood, Jennifer <FloodJ1@michigan.gov>; Jen, Kyle (DTMB) <JenK1@michigan.gov>; Bouknight, Rey (DHHS) <BouknightR@michigan.gov>
Subject: Re: Potential addition for unemployment release

Robert: please just have Rey circle back with us in a couple hours on this. We are crashing on about 3 other releases at the moment. If he could draft it that would be great. I'd say aim for 3pm release if you can.

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Monday, March 16, 2020 9:32 AM
To: Huls, JoAnne <HulsJ1@michigan.gov>; Pohl, Zack <PohlZ@michigan.gov>; Belden, Eileen <BeldenE@michigan.gov>; Laidlaw, Emily <LaidlawE@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>
Cc: Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Schwarzkopf, Emily (DHHS) <SchwarzkopfE1@michigan.gov>; Roubal, Lewis (DHHS) <RoubalL@michigan.gov>; Flood, Jennifer <FloodJ1@michigan.gov>; Jen, Kyle (DTMB) <JenK1@michigan.gov>; Bouknight, Rey (DHHS) <BouknightR@michigan.gov>
Subject: RE: Potential addition for unemployment release

Yes--we can announce later today and make effective for tomorrow. We still would love to have your voice on the announcement because we really want to get the word out.

Many thanks.

From: Huls, JoAnne <HulsJ1@michigan.gov>
Sent: Monday, March 16, 2020 9:24 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Pohl, Zack <PohlZ@michigan.gov>; Belden, Eileen <BeldenE@michigan.gov>; Laidlaw, Emily <LaidlawE@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>

Obtained via MI FOIA by Judicial Watch, Inc.

Cc: Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Schwarzkopf, Emily (DHHS) <SchwarzkopfE1@michigan.gov>; Roubal, Lewis (DHHS) <RoubalL@michigan.gov>; Flood, Jennifer <FloodJ1@michigan.gov>; Jen, Kyle (DTMB) <JenK1@michigan.gov>
Subject: Re: Potential addition for unemployment release

Director Gordon, Can we wait on this to later today, or does it need to go this morning? We have the ability to make a broader ask of the legislature and want to do it all at once vs piece meal.

I'm fine either way, but think it's worth also making the answer comprehensive.

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Monday, March 16, 2020 9:20:16 AM
To: Pohl, Zack <PohlZ@michigan.gov>; Belden, Eileen <BeldenE@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>; Laidlaw, Emily <LaidlawE@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>
Cc: Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Schwarzkopf, Emily (DHHS) <SchwarzkopfE1@michigan.gov>; Roubal, Lewis (DHHS) <RoubalL@michigan.gov>; Flood, Jennifer <FloodJ1@michigan.gov>; Jen, Kyle (DTMB) <JenK1@michigan.gov>
Subject: Potential addition for unemployment release

Per some convos earlier, this is a policy change that we are looking to make today that we would like for you to publicize. We have discussed with Kyle, and Emily is now getting in touch with Jen about leg notifications. The policy is explained in more detail on slide 8 of the attached but short version is as follows:

"Effective today, MDHHS is making it easier for families to get assistance without coming into DHHS or Michigan Works! offices. In the Family Independence Program (FIP), the Department will temporarily defer the requirement to attend an orientation and engage in employment activities through MDHHS and MichiganWorks!. This will allow individuals to receive assistance more quickly and will avoid requiring them to congregate in state offices and go out in public looking for work."

Robert Gordon
Director, Michigan Department of Health & Human Services
gordonr3@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

FOR IMMEDIATE RELEASE:
March 16, 2020

CONTACT: Bob Wheaton
517-241-2112
wheatonb@michigan.gov

Due to COVID-19, Gov. Whitmer, MDHHS temporarily suspends cash assistance rules that require families to go out in public

LANSING, Mich. – Gov. Gretchen Whitmer and the Michigan Department of Health and Human Services (MDHHS) today announced plans to make it easier for families to receive state assistance benefits without going out to state offices the COVID-19 outbreak.

Under a temporary policy change, families who receive or apply for cash assistance under the Family Independence Program will not be required to attend orientations at Michigan Works! offices or engage in employment activities. The changes will become effective Tuesday, March 17, and last until at least May 31.

“Michigan is doing all it can to mitigate the spread of coronavirus,” Whitmer said. “We are asking residents to make smart choices by not going into group settings unless it’s necessary. Removing these requirements temporarily prevents people from having to visit government offices when they don’t have to.”

MDHHS also has moved to conducting telephone interviews with all public assistance clients and applicants to reduce the need for people to come into offices. MDHHS encourages people who are applying for or receiving benefits to use www.michigan.gov/MIBridges. This is the most efficient way to submit paperwork, review benefit information, report changes, apply for benefits and complete the process for redetermining eligibility for assistance.

About 15,000 low-income Michigan families receive monthly cash assistance through the Family Independence Program. A typical family receives about $350 per month.

The program rules being temporarily suspended require recipients and applicants to congregate in groups by participating in employment readiness activities, thereby increasing the risk of getting or spreading coronavirus. School closings as a result of the coronavirus outbreak also provide a barrier to complying with the requirements because of childcare issues.

“We’re committed to protecting public health and getting families help they need to get through this emergency,” said MDHHS Director Robert Gordon. “This temporary policy change accomplishes both objectives. Vulnerable families will get financial support more quickly and we will reduce the risk of overwhelming our hospitals with additional COVID-19 cases”

Michigan had identified 53 COVID-19 cases as of Sunday.

Obtained via MI FOIA by Judicial Watch, Inc.

Today about 7,500 beneficiaries are subject to job search or readiness activity requirements that this action removes.

# # #

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Gordon, Robert (DHHS)
To:	Stallworth, Tommy; Khaldun, Joneigh (DHHS); Gilchrist, Garlin
Cc:	Laidlaw, Emily; Flood, Jennifer; Huls, JoAnne; Groen, Meghan; Cook, Kara; Myers, Shaquila; Roubal, Lewis (DHHS)
Subject:	RE: RDTF Policy Priorities
Date:	Tuesday, July 28, 2020 1:01:18 PM

Eager to discuss.

We are supportive of legislative changes around #1 and #2, and could add additional items along the lines of #2 that would increase cash assistance for very poor families.

We are working on a request to USDA for a waiver on #3.

Adding Lew Roubal. Thanks.

From: Stallworth, Tommy <StallworthT@michigan.gov>
Sent: Tuesday, July 28, 2020 10:11 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Gilchrist, Garlin <GilchristG1@michigan.gov>
Cc: Laidlaw, Emily <LaidlawE@michigan.gov>; Flood, Jennifer <FloodJ1@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>; Cook, Kara <CookK14@michigan.gov>; Myers, Shaquila <MyersS11@michigan.gov>
Subject: Fwd: RDTF Policy Priorities

The below email is high level feedback from the policy team regarding Racial Disparities Task Force policy priorities for your review. I think that the next step is for Jen and I to convene a strategy session for moving the legislative process. More to follow.

Thomas F. Stallworth III
Senior Advisor; Office of the Governor
George Romney Building
111 South Capitol Ave
PO Box 30013
Lansing Mich. 48909
Cell: 517-256-8937

From: Groen, Meghan <GroenM@michigan.gov>
Sent: Tuesday, July 21, 2020 11:18 PM
To: Stallworth, Tommy
Cc: Kletke, Malcolm; Michienzi, Grace
Subject: Food Assistance Questions

Tommy,

Here are a few high-level bullets on the policy items we discussed. I am including Grace who has covered a lot of food access issues over the COVID period. Happy to go into further detail and talk with DHHS about any of these.

Obtained via MI FOIA by Judicial Watch, Inc.

Hot meals may be able to be done administratively for the elderly, disabled and homeless. It is not something that could be adopted overnight but it is probably worth a conversation with the department to learn more.

Waive the felony drug conviction ban on food assistance benefits *(Legislative)*

1. While federal law prohibits people with felony drug convictions from receiving SNAP, discretion is granted to states to allow access. (MI has a law less stringent than the federal law but does not waive the prohibition entirely).
2. Many states – both red and blue - allow individuals with felony drug convictions to be eligible for SNAP. Louisiana, Mississippi, and Illinois recently adopted this provision to reduce recidivism and access federal job training funds for returning citizens.
3. This is the right time to push this policy. Communities of color have experienced disproportionate health and economic impacts from COVID which perpetuates historic racial disparities and over-representation in the justice system.
4. SNAP is federally-funded and does not have a cap. Thus, enrolling additional Michiganders would bring in more federal dollars at no-cost to the state.
5. Sen. Ananich has introduced legislation that would allow people with criminal drug convictions to access SNAP benefits.
6. DHHS has had to deny approximately 11,000 people because of this barrier to access.

Eliminate lifetime limits on the Family Independence Program (FIP) *(Legislative)*

1. FIP is a temporary cash assistance program for families with minor children and/or pregnant women, and Michigan currently places a lifetime limit on FIP of 48 months.
2. Because FIP is mostly funded through TANF, and TANF has a lifetime limit of 60 months, the legislature can choose to expand the FIP lifetime limit to 60 months.
3. Given the increased financial strain on families, the 48-month limit should be extended to 60 months. This is especially important for those who may have already or come close to exhausting benefits before this increased chance of economic insecurity hit through COVID-19.

Allow hot meals to be purchased with SNAP for the elderly and disabled *(Potentially Administrative)*

1. Prohibitions on hot meals disproportionally impacts older people and those with disabilities who may find it difficult to prepare meals and the homeless have no place to make meals.
2. After disasters like hurricanes and wildfires the USDA routinely waives the prohibition on using SNAP benefits to purchase prepared hot foods like rotisserie chickens at the grocery store.
    1. TN and DC have applied for waivers but COVID is a “national emergency” as opposed to a “natural disaster” and they have not been approved.
3. The Restaurant Meals Program is a federal government initiative that allows qualified elderly, disabled, and homeless SNAP recipients to use benefits at participating restaurants.
    1. AZ has the only statewide program and CA and RI offer the program in some municipalities. FL has a program for the homeless.
    2. Michigan could explore this opportunity.
4. Grocery stores have established relationships with food assistance and have been more successful in adopting hot meals/prepared food (deli sandwiches) than restaurants in areas that have adopted these policies. Restaurants have largely been fast food chains due to funding/cost constraints.

Meghan Groen

Obtained via MI FOIA by Judicial Watch, Inc.

Health and Human Services Policy Advisor
Executive Office of Governor Whitmer
GroenM@michigan.gov
(517) 896-6530

***This email and any associated documents may contain information that is privileged, confidential, and exempt from disclosure. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.*

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Whitmer, Gretchen (MIEOG)
To:	Alison Hirschel
Cc:	Hawks, Orlene (LARA); Horvath, Larry (LARA); Gordon, Robert (DHHS); Khaldun, Joneigh (DHHS); Massey, Kate (DHHS); Travis, Alexis (DHHS); Barrie, Brian (DHHS); Dana Nessel; Evans, Jason (AG); Salli Pung
Subject:	RE: Second request and clarification regarding suspension of long term care facility discharges during the current crisis
Date:	Saturday, March 28, 2020 8:12:13 PM

Hi Alison,

Thanks for sending. Please accept this email as confirmation of receipt and a note to confirm we are reviewing.

Thanks again and have a great rest of your evening!

Best,
Scottie Marie Barton
Director of Constituent Services
Governor Gretchen Whitmer
(517) 335-7858

From: Alison Hirschel <hirschel@meji.org>
Sent: Saturday, March 28, 2020 6:24 PM
To: Whitmer, Gretchen (MIEOG) <Gretchen.Whitmer@michigan.gov>
Cc: Hawks, Orlene (LARA) <HawksO@michigan.gov>; Horvath, Larry (LARA) <horvathl@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Massey, Kate (DHHS) <MasseyK4@michigan.gov>; Travis, Alexis (DHHS) <TravisA1@michigan.gov>; Barrie, Brian (DHHS) <BarrieB@michigan.gov>; Dana Nessel <dananessel@gmail.com>; Evans, Jason (AG) <EvansJ@michigan.gov>; Salli Pung <spung@meji.org>
Subject: Second request and clarification regarding suspension of long term care facility discharges during the current crisis

Dear Governor Whitmer:

Thank you for all you are doing to protect Michigan residents. Ten days ago, Salli Pung, the State Long Term Care Ombudsman, and I requested that you prohibit all routine, facility-initiated evictions ("discharges") from long term care facilities during the present crisis. We are renewing that request today in the attached letter. We also want to clarify that our request pertains only to routine evictions, including those for non-payment or at the end of a Medicare stay, and does include a ban on transfers for necessary health care or resident relocations related to the need to house COVID-19 patients.

Thank you for your consideration of this request and for your continued efforts to respond to this unprecedented crisis.

Sincerely,

Obtained via MI FOIA by Judicial Watch, Inc.

Alison Hirschel
Director, Michigan Elder Justice Initiative
and
Salli Pung
State Long Term Care Ombudsman

--
Alison E. Hirschel
(she/hers)
Managing Attorney, Michigan Elder Justice Initiative
15851 S. US 27, Suite 73
Lansing, MI 48906
Phone: (517) 827-8023
Fax: (517) 574-5301

Please note: We are open for business but working remotely due to the COVID-19 crisis. We will respond promptly to emails, faxes, and phone calls.

This electronic communication may be subject to the attorney-client privilege and may contain confidential information.
If you are not the intended recipient, any distribution, copying or disclosure is strictly prohibited. If you have received this communication in error, please notify the sender immediately and delete this copy from your system. Thank you for your cooperation.

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Gordon, Robert (DHHS)
To:	Totten, Mark; Hertel, Elizabeth (DHHS); Khaldun, Joneigh (DHHS); Huls, JoAnne; Foster, Tricia; LyonCallo, Sarah (DHHS); Taverna, Andrea (DHHS-Contractor); Warsh, Jonathan (DHHS)
Subject:	RE: see attached
Date:	Monday, March 23, 2020 2:43:58 PM
Attachments:	Recommendations for COVID-19 response for a major metropolitan area .pdf

Sorry, sent wrong version, please use this.

From: Gordon, Robert (DHHS)
Sent: Monday, March 23, 2020 2:43 PM
To: Totten, Mark <TottenM1@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>
Subject: FW: see attached

Johns Hopkins team wrote this. Lots on testing. I will try to find a few minutes to read and see what we might be missing.

From: Josh Sharfstein <joshua.sharfstein@jhu.edu>
Sent: Monday, March 23, 2020 11:24 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: see attached

Joshua M. Sharfstein, M.D.
Vice Dean, Public Health Practice and Community Engagement
Director, Bloomberg American Health Initiative

Johns Hopkins Bloomberg School of Public Health
615 N. Wolfe Street, Baltimore, MD 21205
Phone: 443.424.8490
www.jhsph.edu |americanhealth.jhu.edu
The Public Health Crisis Survival Guide | The Opioid Epidemic: What Everyone Needs to Know | The Public Health On Call Podcast

Obtained via MI FOIA by Judicial Watch, Inc.

Recommendations for a Metropolitan COVID-19 response

Executive Summary

This document reflects recommendations for immediate and medium-term response to the COVID-19 pandemic in a metropolitan area. It should be seen as recommendations as of March 21, 2020, and in light of constantly changing circumstances. We recommend:

1. Convening a regional steering group at least twice a week to review the current local, regional, national and global situation and advice, and revise recommendations.
2. Developing a comprehensive internal and external communication plan that includes an assessment of existing communication messages and resources, provides daily status and guidance updates from trusted authorities, and draws on a community advisory group to ensure locally appropriate messages.
3. Instituting a robust testing approach, including specific instructions for those testing positive, contact tracing, utilizing a call center, multiple testing sites offered through a variety of approaches, and training and guidance on testing protocols, community messaging, and tracking. Until robust testing is possible, recommendations should be provided for isolation and quarantine based on signs and symptoms.
4. Establishing a system for automated text-based messages for follow-up of cases and contacts to provide accurate information related to their existing or emerging symptoms. There should be similar outreach for people without access to phones.
5. Developing and implementing a plan to make isolation and quarantine possible for special populations, including individuals who are homeless or living in long-term facilities and group homes, as well as healthcare workers. This is essential to minimize the spread of COVID-19 in the metropolitan area.
6. Implementing a clear and consistent plan for discharge of confirmed COVID-19 patients.
7. Identifying and providing information on existing resources that could assist home-bound individuals who may need assistance accessing food, medicines, or routine medical care.

Obtained via MI FOIA by Judicial Watch, Inc.

Communication

We recommend urgently setting up ongoing and proactive communication channels to inform and advise the public about the outbreak. Accurate and up-to-date information should be provided on an ongoing basis via information sites and from local leaders daily.

First, we recommend a daily data-driven press conference delivered by a trusted source including health officers and county leaders. These briefings should include information about the outbreak, particularly local case and mortality information, local prevention recommendations and mandates focusing on social distancing, and how and when to access testing and care. These messages need to be amplified by local community leaders who are convened and asked to convey these messages in their communities regularly. All available communication channels including television, radio, and social media should amplify these messages.

Additionally, we recommend urgent assessment and updating of existing and, if necessary, creation of new communication materials targeted for public consumption, including cases and contacts, high risk communities such as long term care facilities and group homes, and healthcare providers and hospitals. It is important to develop tailored approaches and materials and engage local advisory groups for community engagement and communication. Materials should be updated frequently, as informed by new evidence and continuous analysis of local data, disseminated through official websites and social media channels and press releases, and amplified by community groups. We recommend developing, employing, and regularly updating channel-specific daily update templates as soon as possible.

This plan will require official communication channels and resources; contacts for key entities; a mechanism to gather, solicit and respond to frequently asked questions from residents; and real-time access to COVID-19 data. This approach and these materials should be reviewed and adapted regularly to meet the needs of the evolving situation. It will be important to use these methods to convey such messages as the need for social distances for extended periods of time.

Increasing testing and messaging about testing to communities

Call Center. We recommend setting up a call center staffed by individuals with clinical training with one highly publicized phone number to triage public calls, make recommendations for testing based on symptoms reported, advise callers about the nearest testing sites, and make appointments at testing sites. The call center would enter patient data into a secure web-based platform accessible to testing sites and integrated with results retrieval, patient tracking and contact tracing and tracking capabilities. Patients would be alerted to results via the system, which would prompt further human and/or automated messaging depending on outbreak stage and capacity (described more fully in the contact tracing section below).

Multiple community testing sites. We recommend rapid access to testing for local populations, especially those at high risk of infection and severe outcomes. For those who cannot drive to testing sites, we recommend community-based testing outside the home at designated community sites to serve high-risk individuals who lack non-public transportation options.

Obtained via MI FOIA by Judicial Watch, Inc.

People who could have coronavirus infection should not be sent for testing via public transportation. High risk and need communities should be identified using existing data. Community advisory groups and local clinics/businesses should be contacted now to facilitate this process. Creative solutions may be needed for testing at home.

In sum, we recommend:

1. Hospitals expand and continue safe (with adequate PPE) screening and testing already being conducted in tents outside hospitals,

2. Partnering with existing health clinics such as urgent care centers to offer testing, and

3. Setting up static, stand-alone drive-through and walkup testing sites staffed by school nurses, clinicians from the state medical corps, or other available health providers.

We recommend, as testing platforms advance, that specimens could be collected by patients themselves to minimize risk to healthcare providers. We further recommend that messaging convey the strong preference to schedule testing through the call center to reduce contact with other patients and keep providers safe. However, if possible, drive-up and walk-in testing should be offered without an appointment to be able to identify as many positive cases as possible.

Requirements. Requirements for this strategy include plans for how to run testing at new sites, provision of sufficient PPE, and training for community sites on testing protocols and public health (isolation/quarantine) messaging, partnerships with private clinics, and a system for tracking results. Possible limitations include shortage of specimen collection supplies.

Scaling up. A question to consider is what to do until sufficient testing is fully available. We recommend that, until testing is widely available, patients who have compatible symptoms but do not meet criteria for testing be directed to self-isolate for 14 days and inform their close contacts that they should self-quarantine for the same period. We recommend that the call center issue a code to these individuals to track isolation compliance and symptom progression, and that based on their inputs they receive an automated text message when testing is available more widely in their area with a link to their closest testing site.

Another potential option, which depends on availability of specimen collection supplies, is collecting and storing samples now for testing as soon as testing is available on a more widespread basis. Even if delayed, results of tests conducted can be used to produce epidemic curves, maps and data summaries that reflect more accurately the course of the outbreak and the characteristics of confirmed cases. The knowledge of having been infected (or not) can help someone know whether they are released from isolation, their contacts are released from quarantine, and whether they might acquire some immunity to the virus following future exposures. It will further provide critical information at the city and state level to understand the risk of lifting social distancing measures in the future. We recommend that alternative specimen types be explored but believe fresh frozen saliva might work.

Contact Tracing

Even in the setting of widespread transmission of the novel coronavirus, there is value in as much contact tracing as is feasible. Traditional contact tracing involves calling all cases

Obtained via MI FOIA by Judicial Watch, Inc.

identified from the national electronic disease surveillance system (NEDSS; CDC) to provide isolation requirements, collect contact information, and to call contacts to inform them of their risk and need for quarantine. This practice should be implemented to the extent possible and monitored to ensure that it is functioning well enough to have an impact.

We recommend creating a system for automated text-based messages for follow-up as soon as possible. The conversations with cases would be followed by two text messages that would be automatically sent to each case. The first message would include isolation guidelines and quarantine measures for their household members and instructions to input status daily into a web-based platform, and instructions for forwarding a second text message that will be sent to close contacts outside the home with quarantine and reporting instructions. If cases have concerns about notifying contacts, instructions would be given for reporting contacts through the on-line system.

Once cases overwhelm calling capacity to notify contacts, we recommend responding only with text messages as above. The system would also generate automatic reminders to enter tracking data.

We are aware of two technology companies with the capabilities to launch such a system within approximately one week.

Isolation and Quarantine Options

Isolation of infected patients and quarantine of their close contacts is the key to reducing transmission and slowing the spread of COVID-19. There must be a strategy to assist people who are in need of isolation and quarantine but do not have the capacity to do so effectively.

Specifically, patients testing positive and people under quarantine without a place to isolate/quarantine because of homelessness, group housing or living with family need a way to avoid putting others at risk and to adhere to discharge and/or quarantine instructions. This group also includes health care workers.

Given reductions in travel, many cities are prioritizing the use of hotels and motels as the first line of alternative housing. With most universities now closed, now-vacant university dorms could be considered. As needs surge, we recommend considering community facilities such as churches and schools that could be staged and managed for this purpose. We recommend convening a high-level group of city and county planners to discuss, prioritize options and work to make them available.

Special Populations

Residents of long-term care facilities, nursing homes and group homes represent a major high-risk group for morbidity and mortality. Given the high risk associated with infection, a special focus to ensure best practices at these facilities is warranted. Compliance with stated guidance could be bolstered or tracked by regular reporting into a web-based system by these facilities of key metrics, such as: policies for sick staff, number of staff calling in sick in the past week, current stocks of key PPE (gowns, masks, gloves), number of hand-washing stations, number fully functioning stations, number of sanitizer dispensers, stock of sanitizer, and daily visitor counts. We recommend that there are automated summaries of these data and flags that

Obtained via MI FOIA by Judicial Watch, Inc.

prompt follow-up by the health department. Even though testing remains limited, testing patients in these facilities who develop compatible signs and symptoms in order to rapidly isolate them and quarantine contacts should be a priority to save lives in this high-risk group.

Discharge of Hospitalized Patients

We recommend that each hospital's plan to discharge confirmed COVID-19 patients from their facility be compiled and reviewed so that the city and counties can harmonize discharge protocols. To facilitate home care when clinically suitable, every hospital should include discharge instructions for home-isolation for the patient and quarantine protocol for household contacts, with follow up similar to what other case and contacts receive. Partnerships with funeral homes will be required to support the safe and humane management of the deceased.

Mitigating Adverse Outcomes due to Social Distancing

Recommendations for social support for individuals who are home-bound to protect themselves or because of isolation and quarantine will be needed. We recommend that the city and county departments of health identify existing resources that could assist home-bound individuals who may need assistance accessing food or medicines or routine medical care. Messages should be provided so that home-bound individuals who need assistance have a single number to call, such as 311 and 211, with phone operators able to link to a specific set of services that address critical needs.

Obtained via MI FOIA by Judicial Watch, Inc.

These recommendations were developed by:

Melissa A. Marx, PhD, MPH is an Assistant Professor at Johns Hopkins Bloomberg School of Public Health (JHSPH) in the International Health Department with nearly 20 years of applied public health experience. Dr. Marx was an Epidemic Intelligence Service officer at the New York City Department of Health and an epidemiologist with the Centers for Disease Control and Prevention. She has responded to SARS, H1N1, Ebola and other outbreaks.

Emily Gurley, PhD, MPH is an Associate Scientist at JHSPH in the Epidemiology Department. Dr. Gurley spent 12 years at the International Center for Diarrheal Diseases Research, Bangladesh where she led the Surveillance and Outbreak Investigation Unit, and served as Director of the Program on Emerging Infections. She led investigations of outbreaks of Nipah virus, cholera, influenza, and anthrax, among others.

Jennifer Nuzzo, DrPH, is an Associate Professor at JHSPH in the Department of Environmental Health and Engineering and is a Senior Scholar at the Johns Hopkins Center for Health Security. Dr. Nuzzo directs the Outbreak Observatory, which conducts, in partnership with front-line public health practitioners, operational research to improve outbreak preparedness and response.

Lauren Sauer, MS, is the director of Operations in the Johns Hopkins Office of Critical Event Preparedness and Response and an Assistant Professor of Emergency Medicine at Johns Hopkins School of Medicine. She also serves as the JHU focal point for their partnership with the WHO Global Outbreak and Alert Response Network. She has worked in the field of disaster and public health emergency research and education for almost two decades working on healthcare system preparedness in disasters and outbreaks.

Rupali J. Limaye, PhD, MPH is an Associate Scientist at JHSPH in the Department of International Health and also serves as the Associate Director for Behavioral Research at the Institute for Vaccine Safety and as the Prevention Core manager for the Center for AIDS Research. She has a background in marketing and communication, and has developed health communication campaigns and materials in more than 20 countries.

William Moss, MD, is a Professor at JHSPH in the Department of Epidemiology, is the Executive Director for the International Vaccine Access Center, and a Deputy Director at the Johns Hopkins Malaria Research Institute. He is a pediatrician with subspecialty training in infectious diseases.

Justin Lessler, PhD, is an Associate Professor at JHSPH in the Department of Epidemiology researching the dynamics and control of infectious disease, with particular focus in the spread of pandemics. He works on the development and application of statistics, dynamic models and novel study designs to better understand and control infectious disease.

Obtained via MI FOIA by Judicial Watch, Inc.

Supporting members include Molly Sauer (content), Diwakar Mohan (input), Alain Labrique (input), and Forrest Jones (support).

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: LLOYD WOOSTER; Whitmer, Gretchen (MIEOG)
Subject: RE: shutdowns
Date: Sunday, January 10, 2021 2:40:00 PM

Thanks for your note. Glad you are wearing a mask and appreciate your perspective, as well as the civil tone. Please know we give these matters the utmost thought and attention. Best wishes.

-----Original Message-----
From: [redacted]
Sent: Sunday, January 10, 2021 2:29 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Whitmer, Gretchen (MIEOG) <Gretchen.Whitmer@michigan.gov>
Subject: shutdowns

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Dear Governor Whitmer & Robert Gordon,

Greetings, hope this finds you both well.

I have questions and comments about restaurants and bars.

First off, I am a long time supporter and challenge some individuals views. However, it is getting harder and harder. One would believe that you both have a hidden agenda for a death wish for the small mom & pop restaurants and bars/grills. I do not believe that these institutions are the worst places for a possibility of a covid19 outbreak.

Have either of you actually been out and about? I am a retiree and recently started a part time position delivering parts for and auto parts store. I deliver to auto repair businesses, body shops & car dealer service garages. NO ONE (employees & in many cases customers) in any of the places I deliver to are masking up or practicing social distancing. Some even seem annoyed that I wear a mask! In our area most people in the Meijer and Walmart are not wearing masks or practicing social distancing. Yet you seem convinced that keeping restaurants shut down is what will help everyone.

Please give some thought to all the places that are struggling and give them a chance to make a living again. Especially for all the establishments that are honestly trying to follow your guidelines.

Thank you for listening.

[redacted]

PS: Please don't insult my intelligence by responding, if you do, with one of your "thanks for contacting us" form letters

Obtained via MI FOIA by Judicial Watch, Inc.

From: Whitmer, Gretchen
To: Gordon, Robert (DHHS)
Subject: Re: Social distancing
Date: Monday, March 30, 2020 7:37:48 AM

I will call you around 8/8:15

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Monday, March 30, 2020 7:34:31 AM
To: Whitmer, Gretchen <WhitmerG1@michigan.gov>
Subject: RE: Social distancing

Hi Governor, thanks for your leadership. There is an item on the agenda for your 9am that I would be grateful to touch base on. Would only take a minute. Best, Robert 517 242 0165

From: Whitmer, Gretchen <WhitmerG1@michigan.gov>
Sent: Friday, March 27, 2020 7:02 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Cc: Totten, Mark <TottenM1@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Subject: Re: Social distancing

Ok, please keep me looped in

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Friday, March 27, 2020 6:54:06 AM
To: Whitmer, Gretchen <WhitmerG1@michigan.gov>
Cc: Totten, Mark <TottenM1@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Subject: Social distancing

Good morning, Governor.

Just wanted to share – I talked with Josh Sharfstein from Johns Hopkins last night about what more we can do in light of the urgent situation in and around Detroit. His advice was that while we are doing the right things on surge, we should not lose sight of potential more active steps on social distancing. Even small gains will help, even if mostly to bring down the peak sooner. Brainstormed ideas with Josh and then with Zeke Emanuel, who made the connection below. (Aware of procurement issue and have thoughts.) Mark will be leading a broader call on these ideas at 9:30.

Best,
Robert

From: Emanuel, Ezekiel J <zemanuel@upenn.edu>

Obtained via MI FOIA by Judicial Watch, Inc.

Sent: Friday, March 27, 2020 6:45 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Sacha Samotin <sacha@applecart.co>
Cc: Gayle Yelon <gayle@applecart.co>; Joe Shafer <joe@applecart.co>; Matthew Kalmans <matt@applecart.co>
Subject: Re: Re:

Hope this connection works magic to enhance physical distancing and repsonsible conduct in Mich

Ezekiel J. Emanuel, M.D., Ph.D.

Vice Provost of Global Initiatives

Chair, Department of Medical Ethics and Health Policy (on Leave 2019-2020)

Levy University Professor

Co-Director, Healthcare Transformation Institute

Perelman School of Medicine and The Wharton School

University of Pennsylvania

Phone: 215-898-7226 or 215-573-8104

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Friday, March 27, 2020 6:35 AM
To: Sacha Samotin <sacha@applecart.co>; Emanuel, Ezekiel J <zemanuel@upenn.edu>
Cc: Gayle Yelon <gayle@applecart.co>; Joe Shafer <joe@applecart.co>; Matthew Kalmans <matt@applecart.co>
Subject: RE: Re:

Hi, I'm up and free next hour or so; have a related call at 930. If you can, please give me a call, 517 242 0165. Or if you prefer conf life I can dial in. Robert

From: Sacha Samotin <sacha@applecart.co>
Sent: Friday, March 27, 2020 6:33 AM
To: Emanuel, Ezekiel J <zemanuel@upenn.edu>

Obtained via MI FOIA by Judicial Watch, Inc.

Cc: Gayle Yelon <gayle@applecart.co>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Joe Shafer <joe@applecart.co>; Matthew Kalmans <matt@applecart.co>
Subject: Re:

Thanks for everything you're doing Zeke, and thanks for everything you're doing Robert.

Let me know when makes sense to chat, I'm available whenever works best for you and we're eager to help however we can.

If there's a specific time that works best we can get a conference call line set up, otherwise feel free to reach me on my cell at any time. 239-272-6052.

Sacha

On Fri, Mar 27, 2020 at 5:40 AM Emanuel, Ezekiel J <zemanuel@upenn.edu> wrote:

> Robert meet Sacha,
>
> Sacha is a former Penn student--the tops-- who runs a company that uses social media and behavioral economic technquies--prompts by people you know-- to get people to vote and do other socially positive things.
>
> He has had some great ideas about how to do that for COVID-19. This might address your PR campaign issues.
>
> In full disclosure, I have an investment in Sacha's company. But that is because it is super effective at what it does.
>
> Ezekiel J. Emanuel, M.D., Ph.D.
>
> Vice Provost of Global Initiatives
>
> Chair, Department of Medical Ethics and Health Policy (on Leave 2019-2020)
>
> Levy University Professor
>
> Co-Director, Healthcare Transformation Institute
>
> Perelman School of Medicine and The Wharton School
>
> University of Pennsylvania

Obtained via MI FOIA by Judicial Watch, Inc.

Phone: 215-898-7226 or 215-573-8104

Obtained via MI FOIA by Judicial Watch, Inc.

From: Whitmer, Gretchen
To: Gordon, Robert (DHHS)
Cc: Totten, Mark; Huls, JoAnne
Subject: Re: Social distancing
Date: Friday, March 27, 2020 7:02:23 AM

Ok, please keep me looped in

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Friday, March 27, 2020 6:54:06 AM
To: Whitmer, Gretchen <WhitmerG1@michigan.gov>
Cc: Totten, Mark <TottenM1@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Subject: Social distancing

Good morning, Governor.

Just wanted to share – I talked with Josh Sharfstein from Johns Hopkins last night about what more we can do in light of the urgent situation in and around Detroit. His advice was that while we are doing the right things on surge, we should not lose sight of potential more active steps on social distancing. Even small gains will help, even if mostly to bring down the peak sooner. Brainstormed ideas with Josh and then with Zeke Emanuel, who made the connection below. (Aware of procurement issue and have thoughts.) Mark will be leading a broader call on these ideas at 9:30.

Best,
Robert

From: Emanuel, Ezekiel J <zemanuel@upenn.edu>
Sent: Friday, March 27, 2020 6:45 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Sacha Samotin <sacha@applecart.co>
Cc: Gayle Yelon <gayle@applecart.co>; Joe Shafer <joe@applecart.co>; Matthew Kalmans <matt@applecart.co>
Subject: Re: Re:

Hope this connection works magic to enhance physical distancing and repsonsible conduct in Mich

Ezekiel J. Emanuel, M.D., Ph.D.

Vice Provost of Global Initiatives

Chair, Department of Medical Ethics and Health Policy (on Leave 2019-2020)

Obtained via MI FOIA by Judicial Watch, Inc.

Levy University Professor

Co-Director, Healthcare Transformation Institute

Perelman School of Medicine and The Wharton School

University of Pennsylvania

Phone: 215-898-7226 or 215-573-8104

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Friday, March 27, 2020 6:35 AM
To: Sacha Samotin <sacha@applecart.co>; Emanuel, Ezekiel J <zemanuel@upenn.edu>
Cc: Gayle Yelon <gayle@applecart.co>; Joe Shafer <joe@applecart.co>; Matthew Kalmans <matt@applecart.co>
Subject: RE: Re:

Hi, I'm up and free next hour or so; have a related call at 930. If you can, please give me a call, 517 242 0165. Or if you prefer conf life I can dial in. Robert

From: Sacha Samotin <sacha@applecart.co>
Sent: Friday, March 27, 2020 6:33 AM
To: Emanuel, Ezekiel J <zemanuel@upenn.edu>
Cc: Gayle Yelon <gayle@applecart.co>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Joe Shafer <joe@applecart.co>; Matthew Kalmans <matt@applecart.co>
Subject: Re:

Thanks for everything you're doing Zeke, and thanks for everything you're doing Robert.

Let me know when makes sense to chat, I'm available whenever works best for you and we're eager to help however we can.

If there's a specific time that works best we can get a conference call line set up, otherwise feel free to reach me on my cell at any time. 239-272-6052.

Sacha

On Fri, Mar 27, 2020 at 5:40 AM Emanuel, Ezekiel J <zemanuel@upenn.edu> wrote:

> Robert meet Sacha,

Obtained via MI FOIA by Judicial Watch, Inc.

Sacha is a former Penn student--the tops-- who runs a company that uses social media and behavioral economic technquies--prompts by people you know-- to get people to vote and do other socially positive things.

He has had some great ideas about how to do that for COVID-19. This might address your PR campaign issues.

In full disclosure, I have an investment in Sacha's company. But that is because it is super effective at what it does.

Ezekiel J. Emanuel, M.D., Ph.D.

Vice Provost of Global Initiatives

Chair, Department of Medical Ethics and Health Policy (on Leave 2019-2020)

Levy University Professor

Co-Director, Healthcare Transformation Institute

Perelman School of Medicine and The Wharton School

University of Pennsylvania

Phone: 215-898-7226 or 215-573-8104

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: "Whitmer, Gretchen"
Subject: RE: Social distancing
Date: Monday, March 30, 2020 7:34:35 AM

Hi Governor, thanks for your leadership. There is an item on the agenda for your 9am that I would be grateful to touch base on. Would only take a minute. Best, Robert 517 242 0165

From: Whitmer, Gretchen <WhitmerG1@michigan.gov>
Sent: Friday, March 27, 2020 7:02 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Cc: Totten, Mark <TottenM1@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Subject: Re: Social distancing

Ok, please keep me looped in

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Friday, March 27, 2020 6:54:06 AM
To: Whitmer, Gretchen <WhitmerG1@michigan.gov>
Cc: Totten, Mark <TottenM1@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Subject: Social distancing

Good morning, Governor.

Just wanted to share – I talked with Josh Sharfstein from Johns Hopkins last night about what more we can do in light of the urgent situation in and around Detroit. His advice was that while we are doing the right things on surge, we should not lose sight of potential more active steps on social distancing. Even small gains will help, even if mostly to bring down the peak sooner. Brainstormed ideas with Josh and then with Zeke Emanuel, who made the connection below. (Aware of procurement issue and have thoughts.) Mark will be leading a broader call on these ideas at 9:30.

Best,
Robert

From: Emanuel, Ezekiel J <zemanuel@upenn.edu>
Sent: Friday, March 27, 2020 6:45 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Sacha Samotin <sacha@applecart.co>
Cc: Gayle Yelon <gayle@applecart.co>; Joe Shafer <joe@applecart.co>; Matthew Kalmans <matt@applecart.co>
Subject: Re: Re:

Hope this connection works magic to enhance physical distancing and repsonsible conduct in

Obtained via MI FOIA by Judicial Watch, Inc.

Mich

Ezekiel J. Emanuel, M.D., Ph.D.

Vice Provost of Global Initiatives

Chair, Department of Medical Ethics and Health Policy (on Leave 2019-2020)

Levy University Professor

Co-Director, Healthcare Transformation Institute

Perelman School of Medicine and The Wharton School

University of Pennsylvania

Phone: 215-898-7226 or 215-573-8104

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Friday, March 27, 2020 6:35 AM
To: Sacha Samotin <sacha@applecart.co>; Emanuel, Ezekiel J <zemanuel@upenn.edu>
Cc: Gayle Yelon <gayle@applecart.co>; Joe Shafer <joe@applecart.co>; Matthew Kalmans <matt@applecart.co>
Subject: RE: Re:

Hi, I'm up and free next hour or so; have a related call at 930. If you can, please give me a call, 517 242 0165. Or if you prefer conf life I can dial in. Robert

From: Sacha Samotin <sacha@applecart.co>
Sent: Friday, March 27, 2020 6:33 AM
To: Emanuel, Ezekiel J <zemanuel@upenn.edu>
Cc: Gayle Yelon <gayle@applecart.co>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Joe Shafer <joe@applecart.co>; Matthew Kalmans <matt@applecart.co>
Subject: Re:

Thanks for everything you're doing Zeke, and thanks for everything you're doing Robert.

Let me know when makes sense to chat, I'm available whenever works best for you and we're eager

Obtained via MI FOIA by Judicial Watch, Inc.

to help however we can.

If there's a specific time that works best we can get a conference call line set up, otherwise feel free to reach me on my cell at any time. 239-272-6052.

Sacha

On Fri, Mar 27, 2020 at 5:40 AM Emanuel, Ezekiel J <zemanuel@upenn.edu> wrote:

> Robert meet Sacha,
>
> Sacha is a former Penn student--the tops-- who runs a company that uses social media and behavioral economic technquies--prompts by people you know-- to get people to vote and do other socially positive things.
>
> He has had some great ideas about how to do that for COVID-19. This might address your PR campaign issues.
>
> In full disclosure, I have an investment in Sacha's company. But that is because it is super effective at what it does.
>
> Ezekiel J. Emanuel, M.D., Ph.D.
>
> Vice Provost of Global Initiatives
>
> Chair, Department of Medical Ethics and Health Policy (on Leave 2019-2020)
>
> Levy University Professor
>
> Co-Director, Healthcare Transformation Institute
>
> Perelman School of Medicine and The Wharton School
>
> University of Pennsylvania
>
> Phone: 215-898-7226 or 215-573-8104

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: "Whitmer, Gretchen"
Subject: RE: Social distancing
Date: Monday, March 30, 2020 7:38:30 AM

Thanks.

From: Whitmer, Gretchen <WhitmerG1@michigan.gov>
Sent: Monday, March 30, 2020 7:38 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: Re: Social distancing

I will call you around 8/8:15

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Monday, March 30, 2020 7:34:31 AM
To: Whitmer, Gretchen <WhitmerG1@michigan.gov>
Subject: RE: Social distancing

Hi Governor, thanks for your leadership. There is an item on the agenda for your 9am that I would be grateful to touch base on. Would only take a minute. Best, Robert 517 242 0165

From: Whitmer, Gretchen <WhitmerG1@michigan.gov>
Sent: Friday, March 27, 2020 7:02 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Cc: Totten, Mark <TottenM1@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Subject: Re: Social distancing

Ok, please keep me looped in

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Friday, March 27, 2020 6:54:06 AM
To: Whitmer, Gretchen <WhitmerG1@michigan.gov>
Cc: Totten, Mark <TottenM1@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Subject: Social distancing

Good morning, Governor.

Just wanted to share – I talked with Josh Sharfstein from Johns Hopkins last night about what more we can do in light of the urgent situation in and around Detroit. His advice was that while we are doing the right things on surge, we should not lose sight of potential more active steps on social distancing. Even small gains will help, even if mostly to bring down the peak sooner. Brainstormed ideas with Josh and then with Zeke Emanuel, who made the connection below. (Aware of

Obtained via MI FOIA by Judicial Watch, Inc.

procurement issue and have thoughts.) Mark will be leading a broader call on these ideas at 9:30.

Best,
Robert

From: Emanuel, Ezekiel J <zemanuel@upenn.edu>
Sent: Friday, March 27, 2020 6:45 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Sacha Samotin <sacha@applecart.co>
Cc: Gayle Yelon <gayle@applecart.co>; Joe Shafer <joe@applecart.co>; Matthew Kalmans <matt@applecart.co>
Subject: Re: Re:

Hope this connection works magic to enhance physical distancing and repsonsible conduct in Mich

Ezekiel J. Emanuel, M.D., Ph.D.

Vice Provost of Global Initiatives

Chair, Department of Medical Ethics and Health Policy (on Leave 2019-2020)

Levy University Professor

Co-Director, Healthcare Transformation Institute

Perelman School of Medicine and The Wharton School

University of Pennsylvania

Phone: 215-898-7226 or 215-573-8104

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Friday, March 27, 2020 6:35 AM
To: Sacha Samotin <sacha@applecart.co>; Emanuel, Ezekiel J <zemanuel@upenn.edu>
Cc: Gayle Yelon <gayle@applecart.co>; Joe Shafer <joe@applecart.co>; Matthew Kalmans <matt@applecart.co>

Obtained via MI FOIA by Judicial Watch, Inc.

Subject: RE: Re:

Hi, I'm up and free next hour or so; have a related call at 930. If you can, please give me a call, 517 242 0165. Or if you prefer conf life I can dial in. Robert

From: Sacha Samotin <sacha@applecart.co>
Sent: Friday, March 27, 2020 6:33 AM
To: Emanuel, Ezekiel J <zemanuel@upenn.edu>
Cc: Gayle Yelon <gayle@applecart.co>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Joe Shafer <joe@applecart.co>; Matthew Kalmans <matt@applecart.co>
Subject: Re:

Thanks for everything you're doing Zeke, and thanks for everything you're doing Robert.

Let me know when makes sense to chat, I'm available whenever works best for you and we're eager to help however we can.

If there's a specific time that works best we can get a conference call line set up, otherwise feel free to reach me on my cell at any time. 239-272-6052.

Sacha

On Fri, Mar 27, 2020 at 5:40 AM Emanuel, Ezekiel J <zemanuel@upenn.edu> wrote:

> Robert meet Sacha,
>
> Sacha is a former Penn student--the tops-- who runs a company that uses social media and behavioral economic technquies--prompts by people you know-- to get people to vote and do other socially positive things.
>
> He has had some great ideas about how to do that for COVID-19. This might address your PR campaign issues.
>
> In full disclosure, I have an investment in Sacha's company. But that is because it is super effective at what it does.
>
> Ezekiel J. Emanuel, M.D., Ph.D.
>
> Vice Provost of Global Initiatives

Obtained via MI FOIA by Judicial Watch, Inc.

Chair, Department of Medical Ethics and Health Policy (on Leave 2019-2020)

Levy University Professor

Co-Director, Healthcare Transformation Institute

Perelman School of Medicine and The Wharton School

University of Pennsylvania

Phone: 215-898-7226 or 215-573-8104

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Gordon, Robert (DHHS); Triplett, Sarah
Subject: Re: Tele Town Halls w/ Governor Whitmer
Date: Sunday, March 22, 2020 1:00:43 PM

Great, no problem.

Sarah — i need the Director for something at these exact times :). Can you work with Dr J to get her on? Thanks

---

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Sunday, March 22, 2020 12:52:57 PM
To: Triplett, Sarah <TriplettS4@michigan.gov>
Cc: Huls, JoAnne <HulsJ1@michigan.gov>
Subject: RE: Tele Town Halls w/ Governor Whitmer

Sarah, I wonder if Dr. J might be more appropriate on these. If not, I am happy to do. Thanks for all you're doing.

From: Triplett, Sarah <TriplettS4@michigan.gov>
Sent: Sunday, March 22, 2020 11:53 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: Tele Town Halls w/ Governor Whitmer

Dear Director Gordon,

Governor Whitmer is participating in two tele townhalls in the coming week to give an update on the administration's response to COVID-19. I'm reaching out to see if you might be interested and willing to join to give an update on the DHHS perspective as well. The calls are as follows:

- Monday, March 23 at 11:30 am for educators (hosted by the MEA, AFT & AFSCME). Expected participants would be 100,000 +.
- Thursday, March 26 at 5:30 pm for nurses (hosted by the Michigan Nurses Association Teamsters & AFSCME).

Appreciate all that you have done and continue to do.

Sincerely,

Sarah

Sarah Gonzales Triplett
Deputy Director of Public Affairs
Office of Governor Gretchen Whitmer
E: tripletts4@michigan.gov
C: 517-256-8727

Obtained via MI FOIA by Judicial Watch, Inc.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Triplett, Sarah
Cc: Huls, JoAnne
Subject: RE: Tele Town Halls w/ Governor Whitmer
Date: Sunday, March 22, 2020 12:48:23 PM

Sarah, I wonder if Dr. J might be more appropriate on these. If not, I am happy to do. Thanks for all you're doing.

From: Triplett, Sarah <TriplettS4@michigan.gov>
Sent: Sunday, March 22, 2020 11:53 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: Tele Town Halls w/ Governor Whitmer

Dear Director Gordon,

Governor Whitmer is participating in two tele townhalls in the coming week to give an update on the administration's response to COVID-19. I'm reaching out to see if you might be interested and willing to join to give an update on the DHHS perspective as well. The calls are as follows:

- Monday, March 23 at 11:30 am for educators (hosted by the MEA, AFT & AFSCME). Expected participants would be 100,000 +.
- Thursday, March 26 at 5:30 pm for nurses (hosted by the Michigan Nurses Association Teamsters & AFSCME).

Appreciate all that you have done and continue to do.

Sincerely,

Sarah

Sarah Gonzales Triplett
Deputy Director of Public Affairs
Office of Governor Gretchen Whitmer
E: tripletts4@michigan.gov
C: 517-256-8727

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Huls, JoAnne
To:	Taverna, Andrea (DHHS-Contractor); Foster, Tricia; Khaldun, Joneigh (DHHS); Hertel, Elizabeth (DHHS); Gordon, Robert (DHHS)
Subject:	Re: Testing & Contact Tracing: Update, Recs, Input Needed
Date:	Wednesday, March 25, 2020 4:48:32 PM

that's who we talked to at Roche and moved out the additional tests originally. We shoudl make the calls with the names we have. I'll find the number.

From: Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>
Sent: Wednesday, March 25, 2020 4:46 PM
To: Foster, Tricia; Khaldun, Joneigh (DHHS); Huls, JoAnne; Hertel, Elizabeth (DHHS); Gordon, Robert (DHHS)
Subject: RE: Testing & Contact Tracing: Update, Recs, Input Needed

Thanks very much!!

Our contacts there are direct sales reps. We're asking ASAP for higher up contacts for the G.

But I think you'll have better success going through SEOC.

JoAnne, whoever you spoke with at Roche is likely best – mind sending over & I'll compile for Mary?

From: Foster, Tricia <FosterT13@michigan.gov>
Sent: Wednesday, March 25, 2020 4:45 PM
To: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>
Subject: RE: Testing & Contact Tracing: Update, Recs, Input Needed

I will ask Major

Tricia L. Foster, CPM, ACoM
Chief Operating Officer
State of Michigan
Fostert13@michigan.gov

From: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Sent: Wednesday, March 25, 2020 4:37 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>
Subject: RE: Testing & Contact Tracing: Update, Recs, Input Needed

Thanks JoAnne. Not sure Tricia if someone in SEOC was contacting Cepheid and Biofire. Biofire just got their EUA approval today -need to contact both of them ASAP.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne <HulsJ1@michigan.gov>
Sent: Wednesday, March 25, 2020 4:34 PM
To: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>
Subject: Re: Testing & Contact Tracing: Update, Recs, Input Needed

Thanks

I see there are some calls at the bottom you are asking the Governor or someone to make. Should we chase the numbers or do you have?

I have only spoken to Roche.
Thanks

From: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Sent: Wednesday, March 25, 2020 9:18:47 AM
To: Huls, JoAnne <HulsJ1@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: FW: Testing & Contact Tracing: Update, Recs, Input Needed

FYI- update on testing strategy.

From: Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>
Sent: Wednesday, March 25, 2020 8:22 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Subject: FW: Testing & Contact Tracing: Update, Recs, Input Needed

Yes – please find attached an updated write up, remaining asks noted at top; details on specific company calls at bottom. Excellent to have delegation pushing this as well.

Asks of Gov's Office

1. Call test kit suppliers to ask them to commit additional kits to MI (details at bottom of note)
2. Call U.S. HHS to push for release of 200K test swabs from Strategic National Stockpile, as requested on 3/19
    a. Congressional delegation engaged on this ask & pushing as well
3. Connect MDHHS with best contact at Dow Chemical – to pursue Dow potentially manufacturing reagents needed to run test kits

Obtained via MI FOIA by Judicial Watch, Inc.

1. Summary
    a. Best estimate data suggests capacity remains about 1,000 tests/day statewide (see second tab in spreadsheet). Data quality/certainty is improving, and I'll be tracking this closely.
    b. Additional hospital labs coming online by end of week; with expected capacity of 500+ tests per day
    c. Biggest issue remains supply chain of test kits, reagents, and swabs.
        i. Strong pipeline of hospitals developing test capability, including a couple high-volume sites; together, this could likely hit the 4 – 5k/day target first discussed
        ii. But we are – and will continue to – ration tests performed at a level below maximal capacity due to limits on supplies (more info below)
        iii. FYI only: I have not spent much effort trying to quantify level of testing truly needed, since it's clear that we'll be well below it for at least next 7 – 10 days
        iv. Similarly, additional community test sites like drive throughs are great – but doesn't make much sense to stand them up without adequate testing supplies to use them – and our testing priorities are narrow enough to limit drive thru utility (pasted at bottom)

2. Testing Supplies: Kits, Reagents, Swabs
    a. Biggest limitation is availability of testing kits, reagents to run the tests, and swabs
        i. State Lab (BOL) has ~6 days of supply on hand. Suppliers will only commit to small amounts at once and are prioritizing NY, CA, and WA.
        ii. Given lack of secure supply chain, severe prioritization of tests makes sense, because running out is not an option.

    b. Recommendations
        i. Kits:
            1. State Lab has orders in with numerous suppliers, and I will speak with DTMB to cross-check that we've been as aggressive in procuring as possible. But fundamentally, we are competing against many states & entities for a very limited resource – and I believe our biggest card to play is elevating the conversation with a high-level political ask.
            2. Ask Governor or high-level state officials to reach out to Roche (a high capacity kit supplier) to seek additional tests for MI. Roche has committed 1,400 tests/week here, but is prioritizing NY, CA, WA. Michigan is not far behind those states, esp. in per capita cases. We could, obviously, research best POC; do pre-call with them; and devise concrete strategy.
            3. Same ask for two additional suppliers, who will have point-of-care tests coming to market on 3/30
            4. See details on companies at bottom
            5. A very aggressive version of this strategy would entail directly calling on the WH for assistance with kit numbers or trying to draw on MI political connections in the R party to reach out

Obtained via MI FOIA by Judicial Watch, Inc.

ii. Swabs:
   1. MI has a request in to SNS for 200K swabs, but has not heard back. This would last us for several weeks at least.
   2. Would strongly recommend we bring political pressure to bear on this as well – maximally, that would be a call from G to US HHS; G's DC Office simultaneously pursuing; and congressional delegation simultaneously pursuing
   3. Congressional delegation briefed on 3/24 and moving quickly to press for release of this material and PPE

iii. Reagents:
   1. Similarly, chemical reagents needed to use the kits are low. MDHHS is competing against many states and has pursued/received additional reagents from state universities.
   2. I believe that pursuing potential private sector producers (or new producers) is the best option to build on existing procurement channels.
   3. Request for connection to Dow Chemical from Gov's Office or MDHHS leadership.

3. Community Testing
   a. FEMA has offered to set up drive-thru/walk-up/community testing sites and supply the personnel – and importantly kits – for them
   b. We're following up on this ASAP; if the details hold, it would be win-win-win

4. Contact Tracing
   a. Wayne, Oakland, and potentially other SE MI local health departments have stopped pursuing full contact tracing, given the overwhelming number of cases. Instead, they focus only on case investigation for health workers and group facilities. Out state health departments continue to trace, to our knowledge.
   b. There is disagreement among subject matter experts about the best strategy here – Johns Hopkins and other public leaders recommend continuing contact tracing even in areas of broad community transmission; the MDHHS epi team doubts that tracing in this scenario is an effective use of resources, even if we pursued options to augment resources (more below)

   c. MDHHS seeking expert feedback, finalizing strategy within 24 hours, and quickly implementing options to augment capacity.

   d. MDHHS will very likely pursue two options to add capacity, whether out state, SE MI, or statewide.

      i. Seek volunteers to aid with tracing: in convos with local health depts about their interest and determining MDHHS capacity to manage such an effort (e.g., baseline training, matching volunteers to depts, etc.)

Obtained via MI FOIA by Judicial Watch, Inc.

1. This makes lots of sense in out state. In Wayne/Oakland/Macomb, the manpower exists – but the Q is whether building this is a good use of resources

ii. Pursue technology – e.g., patient survey, app – to automate some tracing, map cases/suspected cases, and potentially make results public
1. Speaking with Google this AM; ask out to US Digital Service alumni group

MDHHS NEXT STEPS – IN PROGRESS

1. Follow up ASAP on FEMA offer re: community testing
2. Quickly finalize and implement contact tracing strategy

REQUESTED GOV. CALLS TO:

1. Roche
    a. High-capacity test kit supplier
    b. Has committed 1,400 tests per week to MI, but is prioritizing NY, CA, and WA. MI is not far behind these states, especially in per capita cases
    c. ASK: commit more tests to MI

2. Cepheid
    a. As of 3/30, will be delivering new supply of test kits; recently approved by FDA to offer kits
    b. Very many hospitals use this system, so we could increase testing capacity at locations nearest patient care
    c. ASK: commit more tests to MI

3. BioFire
    a. Same as above.
    b. Again, many hospitals use this system, so it would provide important flexibility in supply chain (versus matching more niche test kits with the right lab equipment)

4. U.S. Dept of Health and Human Services
    a. MI put in a request to the Assistant Secretary for Preparedness and Response on 3/19 for 200,000 testing swabs, which would last the state several weeks or even over a month
    b. This would also provide important predictability to our supply chain, rather than requiring constant effort to secure numerous small orders
    c. MDHHS has not yet heard back
    d. ASK: fulfill Michigan's request

COVID TEST PRIORITY CRITERIA

Priority 1 Testing for COVID-19

Obtained via MI FOIA by Judicial Watch, Inc.

Hospitalized patients
- Healthcare facility workers with symptoms

Priority 2 Testing for COVID-19
- Patients in long-term care facilities with symptoms
- Patients over age 65 years with symptoms
- Patients with underlying conditions with symptoms
- First responders with symptoms

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Wednesday, March 25, 2020 6:19 AM
To: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>
Cc: Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Esty, Sarah (DHHS) <EstyS@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>
Subject: RE: Testing & Contact Tracing: Update, Recs, Input Needed

Great the delegation is mobilized and so much of this is in progress. I connected Josh and Andie last night.

Dr. J or Andie, my only further suggestion is quickly revising Andie's summary to make it fully up to date and then getting it over to JoAnne and Tricia this morning.

Thanks.

From: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Sent: Tuesday, March 24, 2020 11:22 PM
To: Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Esty, Sarah (DHHS) <EstyS@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>
Subject: Re: Testing & Contact Tracing: Update, Recs, Input Needed

Thanks for this Andie. Been great working through this with you today.

Per my previous email, already had a call with Governor and federal delegation this evening re ask of SNS and HHS/WH in general on all things supplies- highlighted testing but also ventilators, PPE. They are in full attack mode and ready to submit letters, meeting with FEMA head, etc. on our behalf, Wednesday. Tricia Foster was also on the call, I'd recommend just contacting her directly to move on calling suppliers- time is of the essence.

Jean said she was working in convo with FEMA though SEOC-let's make sure that convo happens Wednesday.

Obtained via MI FOIA by Judicial Watch, Inc.

You may have had more conversations with the Epi team after our call, but I thought I'd asked us to quickly set up additional contact tracing capacity- we can figure out how to pay for it. I can connect you this evening to Josh Sharfstein for his insight. If he can't answer he'll know who to send it to. I'd like to finalize our plan on that in next 24 hours.

Thanks!
Dr J

On Mar 24, 2020, at 10:10 PM, Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov> wrote:

Robert, Joneigh, Elizabeth – (copying Sarah & Jonathan for visibility and any thoughts)

Sharing a summary of testing status, key issues, and recommendations with you. Attached is the testing strategy so far – with key items highlighted.

At the bottom of this note are next steps and one ask. In short, the options are really not great on testing, but we can try to play the cards we have. On tracing, hoping for a connection to Hopkins for more info – but expect the strategy here will require this team's input if possible.

Joneigh & the broader team discussed today, and this benefited from a huge amount of expertise across the MDHHS team.

Apologies in advance for the long note,
A

1. Summary
    a. Best estimate data suggests capacity remains about 1,000 tests/day statewide (see second tab in spreadsheet). Data quality/certainty is improving, and I'll be tracking this closely.
    b. Additional hospital labs coming online by end of week; with expected capacity of 500+ tests per day
    c. Biggest issue remains supply chain of test kits, reagents, and swabs.
        i. Strong pipeline of hospitals developing test capability, including a couple high-volume sites; together, this could likely hit the 4 – 5k/day target first discussed
        ii. But we are – and will continue to – ration tests performed at a level below maximal capacity due to limits on supplies (more info below)
        iii. FYI only: I have not spent much effort trying to quantify level of testing truly needed, since it's clear that we'll be well below it for at least next 7 – 10 days

Obtained via MI FOIA by Judicial Watch, Inc.

iv. Similarly, additional community test sites like drive throughs are great – but doesn't make much sense to stand them up without adequate testing supplies to use them – and our testing priorities are narrow enough to limit drive thru utility (pasted at bottom)

2. Testing Supplies: Kits, Reagents, Swabs
    a. Biggest limitation is availability of testing kits, reagents to run the tests, and swabs
        i. BOL has ~6 days of supply on hand. Suppliers will only commit to small amounts at once and are prioritizing NY, CA, and WA.
        ii. Given lack of secure supply chain, severe prioritization of tests makes sense, because running out is not an option.

    b. Recommendations
        i. Kits:
            1. BOL has orders in with numerous suppliers, and I will speak with DTMB to cross-check that we've been as aggressive in procuring as possible. But fundamentally, we are competing against many states & entities for a very limited resource – and I believe our biggest card to play is elevating the conversation with a high-level political ask.
            2. Ask Governor or high-level state officials to reach out to Roche (a high capacity kit supplier) to seek additional tests for MI. Roche has committed 1,400 tests/week here, but is prioritizing NY, CA, WA. Michigan is not far behind those states, esp. in per capita cases. We could, obviously, research best POC; do pre-call with them; and devise concrete strategy.
            3. Same ask for two additional suppliers, who will have point-of-care tests coming to market on 3/30
            4. A very aggressive version of this strategy would entail directly calling on the WH for assistance with kit numbers or trying to draw on MI political connections in the R party to reach out

        ii. Swabs:
            1. MI has a request in to SNS for 200K swabs, but has not heard back. This would last us for several weeks at least.
            2. Would strongly recommend we bring political pressure to bear on this as well – maximally, that would be a call from G to US HHS; G's DC Office simultaneously pursuing; and congressional delegation simultaneously pursuing

        iii. Reagents:

Obtained via MI FOIA by Judicial Watch, Inc.

1. Similarly, chemical reagents needed to use the kits are low. MDHHS is competing against many states and has pursued/received additional reagents from state universities.
2. Dow Chemical has tentatively reached out about the situation. I believe that pursuing this and other potential private sector producers (or new producers) is the best option to build on existing procurement channels.

3. Community Testing
    a. FEMA has offered to set up drive-thru/walk-up/community testing sites and supply the personnel – and importantly kits – for them
    b. We're following up on this ASAP; if the details hold, it would be win-win-win

4. Contact Tracing
    a. Wayne, Oakland, and potentially other SE MI local health departments have stopped pursuing full contact tracing, given the overwhelming number of cases. Instead, they focus only on case investigation for health workers and group facilities. Out state health departments continue to trace, to our knowledge.
    b. There is disagreement among subject matter experts about the best strategy here – Johns Hopkins and other public leaders recommend continuing contact tracing even in areas of broad community transmission; the MDHHS epi team doubts that tracing in this scenario is an effective use of resources, even if we pursued options to augment resources (more below)
    c. I recommend seeking a conversation with Hopkins about their rationale, then quickly meeting with senior MDHHS leaders and epi team to determine our strategy

    d. Potential options also exist for augmenting tracing resources – in SE MI or elsewhere
        i. Seek volunteers to aid with tracing: in early convos with local health depts about their interest and determining MDHHS capacity to manage such an effort (e.g., baseline training, matching volunteers to depts, etc.)
            1. This makes lots of sense in out state. In Wayne/Oakland/Macomb, the manpower exists – but the Q is whether building this is a good use of resources
        ii. Pursue technology – e.g., patient survey, app – to automate some tracing and potentially even make results public
            1. Still hoping to hear back from JoAnne Huls on Google's offer to us; Qualtrics had another
            2. I think this makes a lot of sense in SE MI

Obtained via MI FOIA by Judicial Watch, Inc.

Next Steps – if Approved

1. Write-up ask to G's office re: calls to kit suppliers
2. Write-up ask to G's office and congressional delegation re: calls to US HHS for SNS swabs
3. Follow up on FEMA offer re: community testing
4. Speak with Hopkins or other recommended experts about contact tracing strategy
    a. ASK: connection to them
5. Meet with senior leadership on contact tracing strategy

Priority 1 Testing for COVID-19

- Hospitalized patients
- Healthcare facility workers with symptoms

Priority 2 Testing for COVID-19

- Patients in long-term care facilities with symptoms
- Patients over age 65 years with symptoms
- Patients with underlying conditions with symptoms
- First responders with symptoms

Andrea Taverna
Senior Advisor
Michigan Department of Health and Human Services
TavernaA1@michigan.gov
Cell: 517-528-3558

<Testing and Tracing Plan 2020.03.24 9 pm.xlsx>

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Huls, JoAnne
To:	Khaldun, Joneigh (DHHS); Foster, Tricia; Hertel, Elizabeth (DHHS); Gordon, Robert (DHHS); Taverna, Andrea (DHHS-Contractor)
Subject:	Re: Testing & Contact Tracing: Update, Recs, Input Needed
Date:	Wednesday, March 25, 2020 4:38:07 PM

Ok. We can do that - just need to know who to call. If there are scheduling requests please pop them up to the top to have someone get scheduled. I'm connecting Andie and Mary now to make that happen.

From: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Sent: Wednesday, March 25, 2020 4:37:14 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>
Subject: RE: Testing & Contact Tracing: Update, Recs, Input Needed

Thanks JoAnne. Not sure Tricia if someone in SEOC was contacting Cepheid and Biofire. Biofire just got their EUA approval today -need to contact both of them ASAP.

From: Huls, JoAnne <HulsJ1@michigan.gov>
Sent: Wednesday, March 25, 2020 4:34 PM
To: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>
Subject: Re: Testing & Contact Tracing: Update, Recs, Input Needed

Thanks

I see there are some calls at the bottom you are asking the Governor or someone to make. Should we chase the numbers or do you have?

I have only spoken to Roche.
Thanks

From: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Sent: Wednesday, March 25, 2020 9:18:47 AM
To: Huls, JoAnne <HulsJ1@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: FW: Testing & Contact Tracing: Update, Recs, Input Needed

FYI- update on testing strategy.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>
Sent: Wednesday, March 25, 2020 8:22 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Subject: FW: Testing & Contact Tracing: Update, Recs, Input Needed

Yes – please find attached an updated write up, remaining asks noted at top; details on specific company calls at bottom. Excellent to have delegation pushing this as well.

Asks of Gov's Office

1. Call test kit suppliers to ask them to commit additional kits to MI (details at bottom of note)
2. Call U.S. HHS to push for release of 200K test swabs from Strategic National Stockpile, as requested on 3/19
    a. Congressional delegation engaged on this ask & pushing as well
3. Connect MDHHS with best contact at Dow Chemical – to pursue Dow potentially manufacturing reagents needed to run test kits

1. Summary
    a. Best estimate data suggests capacity remains about 1,000 tests/day statewide (see second tab in spreadsheet). Data quality/certainty is improving, and I'll be tracking this closely.
    b. Additional hospital labs coming online by end of week; with expected capacity of 500+ tests per day
    c. Biggest issue remains supply chain of test kits, reagents, and swabs.
        i. Strong pipeline of hospitals developing test capability, including a couple high-volume sites; together, this could likely hit the 4 – 5k/day target first discussed
        ii. But we are – and will continue to – ration tests performed at a level below maximal capacity due to limits on supplies (more info below)
        iii. FYI only: I have not spent much effort trying to quantify level of testing truly needed, since it's clear that we'll be well below it for at least next 7 – 10 days
        iv. Similarly, additional community test sites like drive throughs are great – but doesn't make much sense to stand them up without adequate testing supplies to use them – and our testing priorities are narrow enough to limit drive thru utility (pasted at bottom)

2. Testing Supplies: Kits, Reagents, Swabs
    a. Biggest limitation is availability of testing kits, reagents to run the tests, and swabs
        i. State Lab (BOL) has ~6 days of supply on hand. Suppliers will only commit to small amounts at once and are prioritizing NY, CA, and WA.
        ii. Given lack of secure supply chain, severe prioritization of tests makes sense, because running out is not an option.

Obtained via MI FOIA by Judicial Watch, Inc.

b. Recommendations
    i. Kits:
        1. State Lab has orders in with numerous suppliers, and I will speak with DTMB to cross-check that we've been as aggressive in procuring as possible. But fundamentally, we are competing against many states & entities for a very limited resource – and I believe our biggest card to play is elevating the conversation with a high-level political ask.
        2. Ask Governor or high-level state officials to reach out to Roche (a high capacity kit supplier) to seek additional tests for MI. Roche has committed 1,400 tests/week here, but is prioritizing NY, CA, WA. Michigan is not far behind those states, esp. in per capita cases. We could, obviously, research best POC; do pre-call with them; and devise concrete strategy.
        3. Same ask for two additional suppliers, who will have point-of-care tests coming to market on 3/30
        4. See details on companies at bottom
        5. A very aggressive version of this strategy would entail directly calling on the WH for assistance with kit numbers or trying to draw on MI political connections in the R party to reach out

    ii. Swabs:
        1. MI has a request in to SNS for 200K swabs, but has not heard back. This would last us for several weeks at least.
        2. Would strongly recommend we bring political pressure to bear on this as well – maximally, that would be a call from G to US HHS; G's DC Office simultaneously pursuing; and congressional delegation simultaneously pursuing
        3. Congressional delegation briefed on 3/24 and moving quickly to press for release of this material and PPE

    iii. Reagents:
        1. Similarly, chemical reagents needed to use the kits are low. MDHHS is competing against many states and has pursued/received additional reagents from state universities.
        2. I believe that pursuing potential private sector producers (or new producers) is the best option to build on existing procurement channels.
        3. Request for connection to Dow Chemical from Gov's Office or MDHHS leadership.

3. Community Testing
    a. FEMA has offered to set up drive-thru/walk-up/community testing sites and supply the personnel – and importantly kits – for them
    b. We're following up on this ASAP; if the details hold, it would be win-win-win

4. Contact Tracing
    a. Wayne, Oakland, and potentially other SE MI local health departments have stopped

Obtained via MI FOIA by Judicial Watch, Inc.

pursuing full contact tracing, given the overwhelming number of cases. Instead, they focus only on case investigation for health workers and group facilities. Out state health departments continue to trace, to our knowledge.

b. There is disagreement among subject matter experts about the best strategy here – Johns Hopkins and other public leaders recommend continuing contact tracing even in areas of broad community transmission; the MDHHS epi team doubts that tracing in this scenario is an effective use of resources, even if we pursued options to augment resources (more below)

c. MDHHS seeking expert feedback, finalizing strategy within 24 hours, and quickly implementing options to augment capacity.

d. MDHHS will very likely pursue two options to add capacity, whether out state, SE MI, or statewide.

    i. Seek volunteers to aid with tracing: in convos with local health depts about their interest and determining MDHHS capacity to manage such an effort (e.g., baseline training, matching volunteers to depts, etc.)
        1. This makes lots of sense in out state. In Wayne/Oakland/Macomb, the manpower exists – but the Q is whether building this is a good use of resources

    ii. Pursue technology – e.g., patient survey, app – to automate some tracing, map cases/suspected cases, and potentially make results public
        1. Speaking with Google this AM; ask out to US Digital Service alumni group

MDHHS NEXT STEPS – IN PROGRESS

1. Follow up ASAP on FEMA offer re: community testing
2. Quickly finalize and implement contact tracing strategy

REQUESTED GOV. CALLS TO:

1. Roche
    a. High-capacity test kit supplier
    b. Has committed 1,400 tests per week to MI, but is prioritizing NY, CA, and WA. MI is not far behind these states, especially in per capita cases
    c. ASK: commit more tests to MI

2. Cepheid
    a. As of 3/30, will be delivering new supply of test kits; recently approved by FDA to offer kits
    b. Very many hospitals use this system, so we could increase testing capacity at locations nearest patient care
    c. ASK: commit more tests to MI

Obtained via MI FOIA by Judicial Watch, Inc.

3. BioFire
    a. Same as above.
    b. Again, many hospitals use this system, so it would provide important flexibility in supply chain (versus matching more niche test kits with the right lab equipment)

4. U.S. Dept of Health and Human Services
    a. MI put in a request to the Assistant Secretary for Preparedness and Response on 3/19 for 200,000 testing swabs, which would last the state several weeks or even over a month
    b. This would also provide important predictability to our supply chain, rather than requiring constant effort to secure numerous small orders
    c. MDHHS has not yet heard back
    d. ASK: fulfill Michigan's request

COVID TEST PRIORITY CRITERIA

Priority 1 Testing for COVID-19

- Hospitalized patients
- Healthcare facility workers with symptoms

Priority 2 Testing for COVID-19

- Patients in long-term care facilities with symptoms
- Patients over age 65 years with symptoms
- Patients with underlying conditions with symptoms
- First responders with symptoms

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Wednesday, March 25, 2020 6:19 AM
To: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>
Cc: Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Esty, Sarah (DHHS) <EstyS@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>
Subject: RE: Testing & Contact Tracing: Update, Recs, Input Needed

Great the delegation is mobilized and so much of this is in progress. I connected Josh and Andie last night.

Dr. J or Andie, my only further suggestion is quickly revising Andie's summary to make it fully up to date and then getting it over to JoAnne and Tricia this morning.

Thanks.

From: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>

Obtained via MI FOIA by Judicial Watch, Inc.

Sent: Tuesday, March 24, 2020 11:22 PM
To: Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Esty, Sarah (DHHS) <EstyS@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>
Subject: Re: Testing & Contact Tracing: Update, Recs, Input Needed

Thanks for this Andie. Been great working through this with you today.

Per my previous email, already had a call with Governor and federal delegation this evening re ask of SNS and HHS/WH in general on all things supplies- highlighted testing but also ventilators, PPE. They are in full attack mode and ready to submit letters, meeting with FEMA head, etc. on our behalf, Wednesday. Tricia Foster was also on the call, I'd recommend just contacting her directly to move on calling suppliers- time is of the essence.

Jean said she was working in convo with FEMA though SEOC-let's make sure that convo happens Wednesday.

You may have had more conversations with the Epi team after our call, but I thought I'd asked us to quickly set up additional contact tracing capacity- we can figure out how to pay for it. I can connect you this evening to Josh Sharfstein for his insight. If he can't answer he'll know who to send it to. I'd like to finalize our plan on that in next 24 hours.

Thanks!
Dr J

> On Mar 24, 2020, at 10:10 PM, Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov> wrote:
>
> Robert, Joneigh, Elizabeth – (copying Sarah & Jonathan for visibility and any thoughts)
>
> Sharing a summary of testing status, key issues, and recommendations with you. Attached is the testing strategy so far – with key items highlighted.
>
> At the bottom of this note are next steps and one ask. In short, the options are really not great on testing, but we can try to play the cards we have. On tracing, hoping for a connection to Hopkins for more info – but expect the strategy here will require this team's input if possible.
>
> Joneigh & the broader team discussed today, and this benefited from a huge amount of expertise across the MDHHS team.
>
> Apologies in advance for the long note,

Obtained via MI FOIA by Judicial Watch, Inc.

A

1. Summary
    a. Best estimate data suggests capacity remains about 1,000 tests/day statewide (see second tab in spreadsheet). Data quality/certainty is improving, and I'll be tracking this closely.
    b. Additional hospital labs coming online by end of week; with expected capacity of 500+ tests per day
    c. Biggest issue remains supply chain of test kits, reagents, and swabs.
        i. Strong pipeline of hospitals developing test capability, including a couple high-volume sites; together, this could likely hit the 4 – 5k/day target first discussed
        ii. But we are – and will continue to – ration tests performed at a level below maximal capacity due to limits on supplies (more info below)
        iii. FYI only: I have not spent much effort trying to quantify level of testing truly needed, since it's clear that we'll be well below it for at least next 7 – 10 days
        iv. Similarly, additional community test sites like drive throughs are great – but doesn't make much sense to stand them up without adequate testing supplies to use them – and our testing priorities are narrow enough to limit drive thru utility (pasted at bottom)

2. Testing Supplies: Kits, Reagents, Swabs
    a. Biggest limitation is availability of testing kits, reagents to run the tests, and swabs
        i. BOL has ~6 days of supply on hand. Suppliers will only commit to small amounts at once and are prioritizing NY, CA, and WA.
        ii. Given lack of secure supply chain, severe prioritization of tests makes sense, because running out is not an option.

    b. Recommendations
        i. Kits:
            1. BOL has orders in with numerous suppliers, and I will speak with DTMB to cross-check that we've been as aggressive in procuring as possible. But fundamentally, we are competing against many states & entities for a very limited resource – and I believe our biggest card to play is elevating the conversation with a high-level political ask.
            2. Ask Governor or high-level state officials to reach out to Roche (a high capacity kit supplier) to seek additional tests for MI. Roche has committed 1,400 tests/week here, but is prioritizing NY, CA, WA. Michigan is not far behind those states, esp. in per capita cases. We could, obviously,

Obtained via MI FOIA by Judicial Watch, Inc.

research best POC; do pre-call with them; and devise concrete strategy.
3. Same ask for two additional suppliers, who will have point-of-care tests coming to market on 3/30
4. A very aggressive version of this strategy would entail directly calling on the WH for assistance with kit numbers or trying to draw on MI political connections in the R party to reach out

ii. Swabs:
1. MI has a request in to SNS for 200K swabs, but has not heard back. This would last us for several weeks at least.
2. Would strongly recommend we bring political pressure to bear on this as well – maximally, that would be a call from G to US HHS; G's DC Office simultaneously pursuing; and congressional delegation simultaneously pursuing

iii. Reagents:
1. Similarly, chemical reagents needed to use the kits are low. MDHHS is competing against many states and has pursued/received additional reagents from state universities.
2. Dow Chemical has tentatively reached out about the situation. I believe that pursuing this and other potential private sector producers (or new producers) is the best option to build on existing procurement channels.

3. Community Testing
   a. FEMA has offered to set up drive-thru/walk-up/community testing sites and supply the personnel – and importantly kits – for them
   b. We're following up on this ASAP; if the details hold, it would be win-win-win

4. Contact Tracing
   a. Wayne, Oakland, and potentially other SE MI local health departments have stopped pursuing full contact tracing, given the overwhelming number of cases. Instead, they focus only on case investigation for health workers and group facilities. Out state health departments continue to trace, to our knowledge.
   b. There is disagreement among subject matter experts about the best strategy here – Johns Hopkins and other public leaders recommend continuing contact tracing even in areas of broad community transmission; the MDHHS epi team doubts that tracing in this scenario is an effective use of resources, even if we pursued options to augment resources (more below)

Obtained via MI FOIA by Judicial Watch, Inc.

c. I recommend seeking a conversation with Hopkins about their rationale, then quickly meeting with senior MDHHS leaders and epi team to determine our strategy

d. Potential options also exist for augmenting tracing resources – in SE MI or elsewhere
    i. Seek volunteers to aid with tracing: in early convos with local health depts about their interest and determining MDHHS capacity to manage such an effort (e.g., baseline training, matching volunteers to depts, etc.)
        1. This makes lots of sense in out state. In Wayne/Oakland/Macomb, the manpower exists – but the Q is whether building this is a good use of resources
    ii. Pursue technology – e.g., patient survey, app – to automate some tracing and potentially even make results public
        1. Still hoping to hear back from JoAnne Huls on Google's offer to us; Qualtrics had another
        2. I think this makes a lot of sense in SE MI

Next Steps – if Approved

1. Write-up ask to G's office re: calls to kit suppliers
2. Write-up ask to G's office and congressional delegation re: calls to US HHS for SNS swabs
3. Follow up on FEMA offer re: community testing
4. Speak with Hopkins or other recommended experts about contact tracing strategy
    a. ASK: connection to them
5. Meet with senior leadership on contact tracing strategy

Priority 1 Testing for COVID-19

- Hospitalized patients
- Healthcare facility workers with symptoms

Priority 2 Testing for COVID-19

- Patients in long-term care facilities with symptoms
- Patients over age 65 years with symptoms
- Patients with underlying conditions with symptoms
- First responders with symptoms

Andrea Taverna
Senior Advisor
Michigan Department of Health and Human Services
TavernaA1@michigan.gov
Cell: 517-528-3558

Obtained via MI FOIA by Judicial Watch, Inc.

<Testing and Tracing Plan 2020.03.24 9 pm.xlsx>

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Khaldun, Joneigh (DHHS); Foster, Tricia; Hertel, Elizabeth (DHHS); Gordon, Robert (DHHS); Taverna, Andrea (DHHS-Contractor)
Subject: Re: Testing & Contact Tracing: Update, Recs, Input Needed
Date: Wednesday, March 25, 2020 4:33:54 PM

Thanks

I see there are some calls at the bottom you are asking the Governor or someone to make. Should we chase the numbers or do you have?

I have only spoken to Roche.
Thanks

From: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Sent: Wednesday, March 25, 2020 9:18:47 AM
To: Huls, JoAnne <HulsJ1@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: FW: Testing & Contact Tracing: Update, Recs, Input Needed

FYI- update on testing strategy.

From: Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>
Sent: Wednesday, March 25, 2020 8:22 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Subject: FW: Testing & Contact Tracing: Update, Recs, Input Needed

Yes – please find attached an updated write up, remaining asks noted at top; details on specific company calls at bottom. Excellent to have delegation pushing this as well.

Asks of Gov's Office

1. Call test kit suppliers to ask them to commit additional kits to MI (details at bottom of note)
2. Call U.S. HHS to push for release of 200K test swabs from Strategic National Stockpile, as requested on 3/19
    a. Congressional delegation engaged on this ask & pushing as well
3. Connect MDHHS with best contact at Dow Chemical – to pursue Dow potentially manufacturing reagents needed to run test kits

1. Summary
    a. Best estimate data suggests capacity remains about 1,000 tests/day statewide (see second tab in spreadsheet). Data quality/certainty is improving, and I'll be tracking this closely.

Obtained via MI FOIA by Judicial Watch, Inc.

b. Additional hospital labs coming online by end of week; with expected capacity of 500+ tests per day
c. Biggest issue remains supply chain of test kits, reagents, and swabs.
    i. Strong pipeline of hospitals developing test capability, including a couple high-volume sites; together, this could likely hit the 4 – 5k/day target first discussed
    ii. But we are – and will continue to – ration tests performed at a level below maximal capacity due to limits on supplies (more info below)
    iii. FYI only: I have not spent much effort trying to quantify level of testing truly needed, since it's clear that we'll be well below it for at least next 7 – 10 days
    iv. Similarly, additional community test sites like drive throughs are great – but doesn't make much sense to stand them up without adequate testing supplies to use them – and our testing priorities are narrow enough to limit drive thru utility (pasted at bottom)

2. Testing Supplies: Kits, Reagents, Swabs
    a. Biggest limitation is availability of testing kits, reagents to run the tests, and swabs
        i. State Lab (BOL) has ~6 days of supply on hand. Suppliers will only commit to small amounts at once and are prioritizing NY, CA, and WA.
        ii. Given lack of secure supply chain, severe prioritization of tests makes sense, because running out is not an option.

    b. Recommendations
        i. Kits:
            1. State Lab has orders in with numerous suppliers, and I will speak with DTMB to cross-check that we've been as aggressive in procuring as possible. But fundamentally, we are competing against many states & entities for a very limited resource – and I believe our biggest card to play is elevating the conversation with a high-level political ask.
            2. Ask Governor or high-level state officials to reach out to Roche (a high capacity kit supplier) to seek additional tests for MI. Roche has committed 1,400 tests/week here, but is prioritizing NY, CA, WA. Michigan is not far behind those states, esp. in per capita cases. We could, obviously, research best POC; do pre-call with them; and devise concrete strategy.
            3. Same ask for two additional suppliers, who will have point-of-care tests coming to market on 3/30
            4. See details on companies at bottom
            5. A very aggressive version of this strategy would entail directly calling on the WH for assistance with kit numbers or trying to draw on MI political connections in the R party to reach out

        ii. Swabs:
            1. MI has a request in to SNS for 200K swabs, but has not heard back. This would last us for several weeks at least.

Obtained via MI FOIA by Judicial Watch, Inc.

2. Would strongly recommend we bring political pressure to bear on this as well – maximally, that would be a call from G to US HHS; G's DC Office simultaneously pursuing; and congressional delegation simultaneously pursuing
3. Congressional delegation briefed on 3/24 and moving quickly to press for release of this material and PPE

iii. Reagents:

1. Similarly, chemical reagents needed to use the kits are low. MDHHS is competing against many states and has pursued/received additional reagents from state universities.
2. I believe that pursuing potential private sector producers (or new producers) is the best option to build on existing procurement channels.
3. Request for connection to Dow Chemical from Gov's Office or MDHHS leadership.

3. Community Testing
   a. FEMA has offered to set up drive-thru/walk-up/community testing sites and supply the personnel – and importantly kits – for them
   b. We're following up on this ASAP; if the details hold, it would be win-win-win

4. Contact Tracing
   a. Wayne, Oakland, and potentially other SE MI local health departments have stopped pursuing full contact tracing, given the overwhelming number of cases. Instead, they focus only on case investigation for health workers and group facilities. Out state health departments continue to trace, to our knowledge.
   b. There is disagreement among subject matter experts about the best strategy here – Johns Hopkins and other public leaders recommend continuing contact tracing even in areas of broad community transmission; the MDHHS epi team doubts that tracing in this scenario is an effective use of resources, even if we pursued options to augment resources (more below)

   c. MDHHS seeking expert feedback, finalizing strategy within 24 hours, and quickly implementing options to augment capacity.

   d. MDHHS will very likely pursue two options to add capacity, whether out state, SE MI, or statewide.

      i. Seek volunteers to aid with tracing: in convos with local health depts about their interest and determining MDHHS capacity to manage such an effort (e.g., baseline training, matching volunteers to depts, etc.)
         1. This makes lots of sense in out state. In Wayne/Oakland/Macomb, the manpower exists – but the Q is whether building this is a good use of resources

Obtained via MI FOIA by Judicial Watch, Inc.

ii. Pursue technology – e.g., patient survey, app – to automate some tracing, map cases/suspected cases, and potentially make results public
    1. Speaking with Google this AM; ask out to US Digital Service alumni group

MDHHS NEXT STEPS – IN PROGRESS

1. Follow up ASAP on FEMA offer re: community testing
2. Quickly finalize and implement contact tracing strategy

REQUESTED GOV. CALLS TO:

1. Roche
    a. High-capacity test kit supplier
    b. Has committed 1,400 tests per week to MI, but is prioritizing NY, CA, and WA. MI is not far behind these states, especially in per capita cases
    c. ASK: commit more tests to MI

2. Cepheid
    a. As of 3/30, will be delivering new supply of test kits; recently approved by FDA to offer kits
    b. Very many hospitals use this system, so we could increase testing capacity at locations nearest patient care
    c. ASK: commit more tests to MI

3. BioFire
    a. Same as above.
    b. Again, many hospitals use this system, so it would provide important flexibility in supply chain (versus matching more niche test kits with the right lab equipment)

4. U.S. Dept of Health and Human Services
    a. MI put in a request to the Assistant Secretary for Preparedness and Response on 3/19 for 200,000 testing swabs, which would last the state several weeks or even over a month
    b. This would also provide important predictability to our supply chain, rather than requiring constant effort to secure numerous small orders
    c. MDHHS has not yet heard back
    d. ASK: fulfill Michigan's request

COVID TEST PRIORITY CRITERIA

Priority 1 Testing for COVID-19

- Hospitalized patients
- Healthcare facility workers with symptoms

Priority 2 Testing for COVID-19

Obtained via MI FOIA by Judicial Watch, Inc.

Patients in long-term care facilities with symptoms
- Patients over age 65 years with symptoms
- Patients with underlying conditions with symptoms
- First responders with symptoms

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Wednesday, March 25, 2020 6:19 AM
To: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>
Cc: Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Esty, Sarah (DHHS) <EstyS@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>
Subject: RE: Testing & Contact Tracing: Update, Recs, Input Needed

Great the delegation is mobilized and so much of this is in progress. I connected Josh and Andie last night.

Dr. J or Andie, my only further suggestion is quickly revising Andie's summary to make it fully up to date and then getting it over to JoAnne and Tricia this morning.

Thanks.

From: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Sent: Tuesday, March 24, 2020 11:22 PM
To: Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Esty, Sarah (DHHS) <EstyS@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>
Subject: Re: Testing & Contact Tracing: Update, Recs, Input Needed

Thanks for this Andie. Been great working through this with you today.

Per my previous email, already had a call with Governor and federal delegation this evening re ask of SNS and HHS/WH in general on all things supplies- highlighted testing but also ventilators, PPE. They are in full attack mode and ready to submit letters, meeting with FEMA head, etc. on our behalf, Wednesday. Tricia Foster was also on the call, I'd recommend just contacting her directly to move on calling suppliers- time is of the essence.

Jean said she was working in convo with FEMA though SEOC-let's make sure that convo happens Wednesday.

You may have had more conversations with the Epi team after our call, but I thought I'd asked us to quickly set up additional contact tracing capacity- we can figure out how to pay for it. I can connect you this evening to Josh Sharfstein for his insight. If he can't answer he'll know who to send it to. I'd like to finalize our plan on that in next 24 hours.

Obtained via MI FOIA by Judicial Watch, Inc.

Thanks!
Dr J

On Mar 24, 2020, at 10:10 PM, Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov> wrote:

Robert, Joneigh, Elizabeth – (copying Sarah & Jonathan for visibility and any thoughts)

Sharing a summary of testing status, key issues, and recommendations with you. Attached is the testing strategy so far – with key items highlighted.

At the bottom of this note are next steps and one ask. In short, the options are really not great on testing, but we can try to play the cards we have. On tracing, hoping for a connection to Hopkins for more info – but expect the strategy here will require this team's input if possible.

Joneigh & the broader team discussed today, and this benefited from a huge amount of expertise across the MDHHS team.

Apologies in advance for the long note,
A

1. Summary
    a. Best estimate data suggests capacity remains about 1,000 tests/day statewide (see second tab in spreadsheet). Data quality/certainty is improving, and I'll be tracking this closely.
    b. Additional hospital labs coming online by end of week; with expected capacity of 500+ tests per day
    c. Biggest issue remains supply chain of test kits, reagents, and swabs.
        i. Strong pipeline of hospitals developing test capability, including a couple high-volume sites; together, this could likely hit the 4 – 5k/day target first discussed
        ii. But we are – and will continue to – ration tests performed at a level below maximal capacity due to limits on supplies (more info below)
        iii. FYI only: I have not spent much effort trying to quantify level of testing truly needed, since it's clear that we'll be well below it for at least next 7 – 10 days
        iv. Similarly, additional community test sites like drive throughs are great – but doesn't make much sense to stand them up without adequate testing supplies to use them – and our testing priorities are narrow enough to limit drive thru utility

Obtained via MI FOIA by Judicial Watch, Inc.

(pasted at bottom)

2. Testing Supplies: Kits, Reagents, Swabs
    a. Biggest limitation is availability of testing kits, reagents to run the tests, and swabs
        i. BOL has ~6 days of supply on hand. Suppliers will only commit to small amounts at once and are prioritizing NY, CA, and WA.
        ii. Given lack of secure supply chain, severe prioritization of tests makes sense, because running out is not an option.

    b. Recommendations
        i. Kits:
            1. BOL has orders in with numerous suppliers, and I will speak with DTMB to cross-check that we've been as aggressive in procuring as possible. But fundamentally, we are competing against many states & entities for a very limited resource – and I believe our biggest card to play is elevating the conversation with a high-level political ask.
            2. Ask Governor or high-level state officials to reach out to Roche (a high capacity kit supplier) to seek additional tests for MI. Roche has committed 1,400 tests/week here, but is prioritizing NY, CA, WA. Michigan is not far behind those states, esp. in per capita cases. We could, obviously, research best POC; do pre-call with them; and devise concrete strategy.
            3. Same ask for two additional suppliers, who will have point-of-care tests coming to market on 3/30
            4. A very aggressive version of this strategy would entail directly calling on the WH for assistance with kit numbers or trying to draw on MI political connections in the R party to reach out

        ii. Swabs:
            1. MI has a request in to SNS for 200K swabs, but has not heard back. This would last us for several weeks at least.
            2. Would strongly recommend we bring political pressure to bear on this as well – maximally, that would be a call from G to US HHS; G's DC Office simultaneously pursuing; and congressional delegation simultaneously pursuing

        iii. Reagents:
            1. Similarly, chemical reagents needed to use the kits are low. MDHHS is competing against many states and has pursued/received additional reagents from state universities.

Obtained via MI FOIA by Judicial Watch, Inc.

2. Dow Chemical has tentatively reached out about the situation. I believe that pursuing this and other potential private sector producers (or new producers) is the best option to build on existing procurement channels.

3. Community Testing
    a. FEMA has offered to set up drive-thru/walk-up/community testing sites and supply the personnel – and importantly kits – for them
    b. We're following up on this ASAP; if the details hold, it would be win-win-win

4. Contact Tracing
    a. Wayne, Oakland, and potentially other SE MI local health departments have stopped pursuing full contact tracing, given the overwhelming number of cases. Instead, they focus only on case investigation for health workers and group facilities. Out state health departments continue to trace, to our knowledge.
    b. There is disagreement among subject matter experts about the best strategy here – Johns Hopkins and other public leaders recommend continuing contact tracing even in areas of broad community transmission; the MDHHS epi team doubts that tracing in this scenario is an effective use of resources, even if we pursued options to augment resources (more below)
    c. I recommend seeking a conversation with Hopkins about their rationale, then quickly meeting with senior MDHHS leaders and epi team to determine our strategy

    d. Potential options also exist for augmenting tracing resources – in SE MI or elsewhere
        i. Seek volunteers to aid with tracing: in early convos with local health depts about their interest and determining MDHHS capacity to manage such an effort (e.g., baseline training, matching volunteers to depts, etc.)
            1. This makes lots of sense in out state. In Wayne/Oakland/Macomb, the manpower exists – but the Q is whether building this is a good use of resources
        ii. Pursue technology – e.g., patient survey, app – to automate some tracing and potentially even make results public
            1. Still hoping to hear back from JoAnne Huls on Google's offer to us; Qualtrics had another
            2. I think this makes a lot of sense in SE MI

Next Steps – if Approved

1. Write-up ask to G's office re: calls to kit suppliers
2. Write-up ask to G's office and congressional delegation re: calls to US HHS for

Obtained via MI FOIA by Judicial Watch, Inc.

SNS swabs

3. Follow up on FEMA offer re: community testing
4. Speak with Hopkins or other recommended experts about contact tracing strategy
    a. ASK: connection to them
5. Meet with senior leadership on contact tracing strategy

Priority 1 Testing for COVID-19

- Hospitalized patients
- Healthcare facility workers with symptoms

Priority 2 Testing for COVID-19

- Patients in long-term care facilities with symptoms
- Patients over age 65 years with symptoms
- Patients with underlying conditions with symptoms
- First responders with symptoms

Andrea Taverna
Senior Advisor
Michigan Department of Health and Human Services
TavernaA1@michigan.gov
Cell: 517-528-3558

<Testing and Tracing Plan 2020.03.24 9 pm.xlsx>

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Gordon, Robert (DHHS)
Subject: RE: today"s meeting
Date: Sunday, March 29, 2020 6:24:21 AM

Planning on it

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Sunday, March 29, 2020 6:24 AM
To: Totten, Mark <TottenM1@michigan.gov>
Subject: today's meeting

Can you please get Tricia on that call? I want to talk about mask production

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark; Khaldun, Joneigh (DHHS)
Subject: RE: Tomorrow
Date: Saturday, March 21, 2020 8:33:47 AM

From a few hours ago, this is worth reading.

https://www.cnn.com/2020/03/20/health/coronavirus-response-must-adapt-frieden-analysis/index.html

---

From: Totten, Mark <TottenM1@michigan.gov>
Sent: Friday, March 20, 2020 9:44 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Subject: Tomorrow

Robert and Joneigh, I wanted to mention to you that the governor is going to have a few calls tomorrow morning on the health side with people outside state government regarding COVID-19. She wants to keep the calls small - it will be her and a few others from within EOG. I'll be taking notes and if helpful I'm happy to share toplines of what was shared btw 11:30-12p. Just let me know. I have calls from 12-1p, and then our call starts at 1p.

Mark

_____

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

**This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark
Cc: Khaldun, Joneigh (DHHS)
Subject: Re: Tomorrow
Date: Saturday, March 21, 2020 6:47:28 AM

Thanks. If it's easy to hear those toplines that'd be great, but don't worry about it.

Sent from my iPhone

> On Mar 20, 2020, at 9:44 PM, Totten, Mark <TottenM1@michigan.gov> wrote:
>
> Robert and Joneigh, I wanted to mention to you that the governor is going to have a few calls tomorrow morning on the health side with people outside state government regarding COVID-19. She wants to keep the calls small - it will be her and a few others from within EOG. I'll be taking notes and if helpful I'm happy to share toplines of what was shared btw 11:30-12p. Just let me know. I have calls from 12-1p, and then our call starts at 1p.
>
> Mark
>
> _____
> Mark Totten
> Chief Legal Counsel
> Office of the Governor, State of Michigan
> George W. Romney Building
> 111 S. Capitol Avenue
> Lansing, Michigan 48909
> tottenm1@michigan.gov
> (517) 241-0061
>
> **This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Gordon, Robert (DHHS); Groen, Meghan; Rising, Jay
Subject: Re: Tomorrow"s Medicaid call
Date: Monday, March 16, 2020 10:23:01 AM

Ok great.

jh

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Monday, March 16, 2020 10:22:24 AM
To: Huls, JoAnne <HulsJ1@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>; Rising, Jay <RisingJ@michigan.gov>
Subject: RE: Tomorrow's Medicaid call

Shoot, we have announced our employee town hall for 2:30 with all our senior leadership. Looks like what landed on sched is 2:00 on benefits and 3:30 on Medicaid, and that will work.

From: Huls, JoAnne <HulsJ1@michigan.gov>
Sent: Monday, March 16, 2020 10:15 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>; Rising, Jay <RisingJ@michigan.gov>
Subject: RE: Tomorrow's Medicaid call

We are adding a discussion at 2:30 specifically about some of these issues.

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Monday, March 16, 2020 10:14 AM
To: Groen, Meghan <GroenM@michigan.gov>; Rising, Jay <RisingJ@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Subject: RE: Tomorrow's Medicaid call

Please let me know if concerns with including Medicaid folks below on call later today. Thank you.

From: Groen, Meghan <GroenM@michigan.gov>
Sent: Monday, March 16, 2020 8:24 AM
To: Massey, Kate (DHHS) <MasseyK4@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Rising, Jay <RisingJ@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Cc: Emerson, Erin (DHHS) <EmersonE@michigan.gov>
Subject: RE: Tomorrow's Medicaid call

Thanks all. This is very exciting.

- What I am getting at with the paid leave and child care is also to get the money to the

Obtained via MI FOIA by Judicial Watch, Inc.

employee instead of the margins.
- For wrap-around – it's certainly a different situation so maybe it doesn't fit here – but intuitively there could be a space for additional behavioral health supports around emotional stress, wages lost, as well as food security, child care and other social determinant of health.

From: Massey, Kate (DHHS) <MasseyK4@michigan.gov>
Sent: Sunday, March 15, 2020 10:55 PM
To: Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Rising, Jay <RisingJ@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Cc: Emerson, Erin (DHHS) <EmersonE@michigan.gov>
Subject: RE: Tomorrow's Medicaid call

Agree with Jonathan's responses.

With regard to healthy behaviors, from a policy perspective, the implementation could technically still go-live in October but compliance could be addressed through a streamlined redetermination process. Small nuance.

From: Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>
Sent: Sunday, March 15, 2020 9:27 PM
To: Groen, Meghan <GroenM@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Rising, Jay <RisingJ@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Cc: Massey, Kate (DHHS) <MasseyK4@michigan.gov>; Emerson, Erin (DHHS) <EmersonE@michigan.gov>
Subject: RE: Tomorrow's Medicaid call

Thanks for the really thoughtful responses, Meghan. Answers below in red. Kate/Erin – please jump in if I've mischaracterized anything below.

From: Groen, Meghan <GroenM@michigan.gov>
Sent: Sunday, March 15, 2020 9:12 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Rising, Jay <RisingJ@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Cc: Massey, Kate (DHHS) <MasseyK4@michigan.gov>; Emerson, Erin (DHHS) <EmersonE@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>
Subject: Re: Tomorrow's Medicaid call

This is really great. I love it.

I do have couple thoughts:

1. Would those in the expansion population be subject to income eligibility and immigration status?
   Depends on how we filed the waiver. Our ingoing view was no on both, so the only limiting

Obtained via MI FOIA by Judicial Watch, Inc.

factor would be if the individual was receiving testing/treatment related to COVID-19.

2. Assume that people are eligible so there is not delay in treatment (presumptive eligibility population)?
   Yes. We have also talked about expanding the presumptively eligible population (did not include this on this list for you but it's on our broader list). We may also need to expand the list of providers that can certify presumptive eligible status (e.g., nursing homes) given target population for COVID-19
3. Targeted wrap-around supports and care management services for those experiencing financial or health distress specific to enrollees during the COVID-19 emergency – similar to what was in the Flint waiver?
   We actually didn't talk about this in detail because we did not yet have a sense of what services the COVID-19 population would need. But that could certainly be on the table.
4. If we suspend redetermination does it delay health behavior provisions and time limits so people can stay on longer.
   Believe the answer to this is yes – Erin/Kate, please correct me if you disagree.
5. Would there be value in creating a pass-thru for paid sick time and childcare purposes for health care workers for the rate increase, or would it just be a general rate increase they could use at their discretion?
   As we framed it below, it was just going to be a general rate increase that they could use at their discretion. But I could see value in creating a pass-thru for paid sick time and childcare. Our general thought was that if it's getting harder and harder to incent folks to come to work because of fears about public health/safety, a straight increase in wages was going to be the most helpful. But we could certainly discuss this one further.

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Sunday, March 15, 2020 7:52:51 PM
To: Rising, Jay <RisingJ@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>
Cc: Massey, Kate (DHHS) <MasseyK4@michigan.gov>; Emerson, Erin (DHHS) <EmersonE@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>
Subject: Tomorrow's Medicaid call

Below are priorities on Medicaid expansions. Note we haven't gone through operational implications or priced out our share, and so would want to evaluate in conjunction with everything else. If you're open to it, I would suggest using part of the call at 3:30 also to discuss our benefits proposals, which I've reattached as well.

Feel free to distribute further of course.

Best,
Robert

Coverage

- **Expand coverage** – MDHHS could ask for a waiver to expand Medicaid coverage. Our

Obtained via MI FOIA by Judicial Watch, Inc.

recommendation is that the waiver would expand coverage only for individuals who test positive and are receiving treatment for COVID-19 or related complications. This would help individuals seek care, but it would also provide financial benefits for hospitals who might otherwise have to provide large amounts of uncompensated care. We recommend that the coverage extend to legal immigrants who have been in the state for less than five years, who are not currently eligible for Medicaid coverage.

- **Simplify application for new applications for eligibility** (e.g., reduce documentation requirements) – this would only apply to new applications for benefits (the waiver described in the bullet above)
- **Simplify redeterminations** – MDHHS could ask for waiver authority to suspend the need to re-certify eligibility for current Medicaid beneficiaries. This would reduce strain on MDHHS offices and ensure continuity of coverage for Medicaid beneficiaries.

Access to Services

- **Eliminate co-pays** – our recommendation is that the elimination of copays only apply to testing for COVID-19 and treatment for COVID-19 related services.
- **Allow for early refills of prescriptions and promote mail order prescriptions** (this will not require a waiver)
- **Waive face to face requirements** (e.g., assessments with Community Health Workers, certain Substance Use Disorder services, like methadone)

Delivery System Capacity

- **Take advantage of flexibilities for provider enrollment** (e.g., allowing prescriptions for those who are not enrolled in CHAMPS)
- **Helping address hospital overflow by allowing for payments to providers under non-traditional arrangements** (e.g., in hypothetical field hospitals)
- **Increasing the rates for providers who are likely to face significant strain or be most affected by COVID-19** (e.g., nursing facilities, home and community based care, adult foster care, opioid treatment facilities, Non-Emergency Medical Transportation)

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Gordon, Robert (DHHS); Groen, Meghan; Rising, Jay
Subject: RE: Tomorrow"s Medicaid call
Date: Monday, March 16, 2020 10:15:19 AM

We are adding a discussion at 2:30 specifically about some of these issues.

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Monday, March 16, 2020 10:14 AM
To: Groen, Meghan <GroenM@michigan.gov>; Rising, Jay <RisingJ@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Subject: RE: Tomorrow's Medicaid call

Please let me know if concerns with including Medicaid folks below on call later today. Thank you.

From: Groen, Meghan <GroenM@michigan.gov>
Sent: Monday, March 16, 2020 8:24 AM
To: Massey, Kate (DHHS) <MasseyK4@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Rising, Jay <RisingJ@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Cc: Emerson, Erin (DHHS) <EmersonE@michigan.gov>
Subject: RE: Tomorrow's Medicaid call

Thanks all. This is very exciting.

- What I am getting at with the paid leave and child care is also to get the money to the employee instead of the margins.
- For wrap-around – it's certainly a different situation so maybe it doesn't fit here – but intuitively there could be a space for additional behavioral health supports around emotional stress, wages lost, as well as food security, child care and other social determinant of health.

From: Massey, Kate (DHHS) <MasseyK4@michigan.gov>
Sent: Sunday, March 15, 2020 10:55 PM
To: Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Rising, Jay <RisingJ@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Cc: Emerson, Erin (DHHS) <EmersonE@michigan.gov>
Subject: RE: Tomorrow's Medicaid call

Agree with Jonathan's responses.

With regard to healthy behaviors, from a policy perspective, the implementation could technically still go-live in October but compliance could be addressed through a streamlined redetermination process. Small nuance.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>
Sent: Sunday, March 15, 2020 9:27 PM
To: Groen, Meghan <GroenM@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Rising, Jay <RisingJ@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Cc: Massey, Kate (DHHS) <MasseyK4@michigan.gov>; Emerson, Erin (DHHS) <EmersonE@michigan.gov>
Subject: RE: Tomorrow's Medicaid call

Thanks for the really thoughtful responses, Meghan. Answers below in red. Kate/Erin – please jump in if I've mischaracterized anything below.

From: Groen, Meghan <GroenM@michigan.gov>
Sent: Sunday, March 15, 2020 9:12 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Rising, Jay <RisingJ@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Cc: Massey, Kate (DHHS) <MasseyK4@michigan.gov>; Emerson, Erin (DHHS) <EmersonE@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>
Subject: Re: Tomorrow's Medicaid call

This is really great. I love it.

I do have couple thoughts:

1. Would those in the expansion population be subject to income eligibility and immigration status?
   Depends on how we filed the waiver. Our ingoing view was no on both, so the only limiting factor would be if the individual was receiving testing/treatment related to COVID-19.
2. Assume that people are eligible so there is not delay in treatment (presumptive eligibility population)?
   Yes. We have also talked about expanding the presumptively eligible population (did not include this on this list for you but it's on our broader list). We may also need to expand the list of providers that can certify presumptive eligible status (e.g., nursing homes) given target population for COVID-19
3. Targeted wrap-around supports and care management services for those experiencing financial or health distress specific to enrollees during the COVID-19 emergency – similar to what was in the Flint waiver?
   We actually didn't talk about this in detail because we did not yet have a sense of what services the COVID-19 population would need. But that could certainly be on the table.
4. If we suspend redetermination does it delay health behavior provisions and time limits so people can stay on longer.
   Believe the answer to this is yes – Erin/Kate, please correct me if you disagree.
5. Would there be value in creating a pass-thru for paid sick time and childcare purposes for health care workers for the rate increase, or would it just be a general rate increase they could use at their discretion?

Obtained via MI FOIA by Judicial Watch, Inc.

As we framed it below, it was just going to be a general rate increase that they could use at their discretion. But I could see value in creating a pass-thru for paid sick time and childcare. Our general thought was that if it's getting harder and harder to incent folks to come to work because of fears about public health/safety, a straight increase in wages was going to be the most helpful. But we could certainly discuss this one further.

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Sunday, March 15, 2020 7:52:51 PM
To: Rising, Jay <RisingJ@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>
Cc: Massey, Kate (DHHS) <MasseyK4@michigan.gov>; Emerson, Erin (DHHS) <EmersonE@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>
Subject: Tomorrow's Medicaid call

Below are priorities on Medicaid expansions. Note we haven't gone through operational implications or priced out our share, and so would want to evaluate in conjunction with everything else. If you're open to it, I would suggest using part of the call at 3:30 also to discuss our benefits proposals, which I've reattached as well.

Feel free to distribute further of course.

Best,
Robert

Coverage

- **Expand coverage** – MDHHS could ask for a waiver to expand Medicaid coverage. Our recommendation is that the waiver would expand coverage only for individuals who test positive and are receiving treatment for COVID-19 or related complications. This would help individuals seek care, but it would also provide financial benefits for hospitals who might otherwise have to provide large amounts of uncompensated care. We recommend that the coverage extend to legal immigrants who have been in the state for less than five years, who are not currently eligible for Medicaid coverage.
- **Simplify application for new applications for eligibility** (e.g., reduce documentation requirements) – this would only apply to new applications for benefits (the waiver described in the bullet above)
- **Simplify redeterminations** – MDHHS could ask for waiver authority to suspend the need to re-certify eligibility for current Medicaid beneficiaries. This would reduce strain on MDHHS offices and ensure continuity of coverage for Medicaid beneficiaries.

Access to Services

- **Eliminate co-pays** – our recommendation is that the elimination of copays only apply to testing for COVID-19 and treatment for COVID-19 related services.
- **Allow for early refills of prescriptions and promote mail order prescriptions** (this will not require a waiver)

Obtained via MI FOIA by Judicial Watch, Inc.

Waive face to face requirements (e.g., assessments with Community Health Workers, certain Substance Use Disorder services, like methadone)

Delivery System Capacity

- **Take advantage of flexibilities for provider enrollment** (e.g., allowing prescriptions for those who are not enrolled in CHAMPS)
- **Helping address hospital overflow by allowing for payments to providers under non-traditional arrangements** (e.g., in hypothetical field hospitals)
- **Increasing the rates for providers who are likely to face significant strain or be most affected by COVID-19** (e.g., nursing facilities, home and community based care, adult foster care, opioid treatment facilities, Non-Emergency Medical Transportation)

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Groen, Meghan; Rising, Jay; Huls, JoAnne
Subject: RE: Tomorrow"s Medicaid call
Date: Monday, March 16, 2020 10:14:28 AM

Please let me know if concerns with including Medicaid folks below on call later today. Thank you.

From: Groen, Meghan <GroenM@michigan.gov>
Sent: Monday, March 16, 2020 8:24 AM
To: Massey, Kate (DHHS) <MasseyK4@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Rising, Jay <RisingJ@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Cc: Emerson, Erin (DHHS) <EmersonE@michigan.gov>
Subject: RE: Tomorrow's Medicaid call

Thanks all. This is very exciting.

- What I am getting at with the paid leave and child care is also to get the money to the employee instead of the margins.
- For wrap-around – it's certainly a different situation so maybe it doesn't fit here – but intuitively there could be a space for additional behavioral health supports around emotional stress, wages lost, as well as food security, child care and other social determinant of health.

From: Massey, Kate (DHHS) <MasseyK4@michigan.gov>
Sent: Sunday, March 15, 2020 10:55 PM
To: Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Rising, Jay <RisingJ@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Cc: Emerson, Erin (DHHS) <EmersonE@michigan.gov>
Subject: RE: Tomorrow's Medicaid call

Agree with Jonathan's responses.

With regard to healthy behaviors, from a policy perspective, the implementation could technically still go-live in October but compliance could be addressed through a streamlined redetermination process. Small nuance.

From: Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>
Sent: Sunday, March 15, 2020 9:27 PM
To: Groen, Meghan <GroenM@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Rising, Jay <RisingJ@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Cc: Massey, Kate (DHHS) <MasseyK4@michigan.gov>; Emerson, Erin (DHHS) <EmersonE@michigan.gov>
Subject: RE: Tomorrow's Medicaid call

Obtained via MI FOIA by Judicial Watch, Inc.

Thanks for the really thoughtful responses, Meghan. Answers below in red. Kate/Erin – please jump in if I've mischaracterized anything below.

From: Groen, Meghan <GroenM@michigan.gov>
Sent: Sunday, March 15, 2020 9:12 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Rising, Jay <RisingJ@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Cc: Massey, Kate (DHHS) <MasseyK4@michigan.gov>; Emerson, Erin (DHHS) <EmersonE@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>
Subject: Re: Tomorrow's Medicaid call

This is really great. I love it.

I do have couple thoughts:

1. Would those in the expansion population be subject to income eligibility and immigration status?
   Depends on how we filed the waiver. Our ingoing view was no on both, so the only limiting factor would be if the individual was receiving testing/treatment related to COVID-19.
2. Assume that people are eligible so there is not delay in treatment (presumptive eligibility population)?
   Yes. We have also talked about expanding the presumptively eligible population (did not include this on this list for you but it's on our broader list). We may also need to expand the list of providers that can certify presumptive eligible status (e.g., nursing homes) given target population for COVID-19
3. Targeted wrap-around supports and care management services for those experiencing financial or health distress specific to enrollees during the COVID-19 emergency – similar to what was in the Flint waiver?
   We actually didn't talk about this in detail because we did not yet have a sense of what services the COVID-19 population would need. But that could certainly be on the table.
4. If we suspend redetermination does it delay health behavior provisions and time limits so people can stay on longer.
   Believe the answer to this is yes – Erin/Kate, please correct me if you disagree.
5. Would there be value in creating a pass-thru for paid sick time and childcare purposes for health care workers for the rate increase, or would it just be a general rate increase they could use at their discretion?
   As we framed it below, it was just going to be a general rate increase that they could use at their discretion. But I could see value in creating a pass-thru for paid sick time and childcare. Our general thought was that if it's getting harder and harder to incent folks to come to work because of fears about public health/safety, a straight increase in wages was going to be the most helpful. But we could certainly discuss this one further.

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Sunday, March 15, 2020 7:52:51 PM

Obtained via MI FOIA by Judicial Watch, Inc.

To: Rising, Jay <RisingJ@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>
Cc: Massey, Kate (DHHS) <MasseyK4@michigan.gov>; Emerson, Erin (DHHS) <EmersonE@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>
Subject: Tomorrow's Medicaid call

Below are priorities on Medicaid expansions. Note we haven't gone through operational implications or priced out our share, and so would want to evaluate in conjunction with everything else. If you're open to it, I would suggest using part of the call at 3:30 also to discuss our benefits proposals, which I've reattached as well.

Feel free to distribute further of course.

Best,
Robert

Coverage

- **Expand coverage** – MDHHS could ask for a waiver to expand Medicaid coverage. Our recommendation is that the waiver would expand coverage only for individuals who test positive and are receiving treatment for COVID-19 or related complications. This would help individuals seek care, but it would also provide financial benefits for hospitals who might otherwise have to provide large amounts of uncompensated care. We recommend that the coverage extend to legal immigrants who have been in the state for less than five years, who are not currently eligible for Medicaid coverage.
- **Simplify application for new applications for eligibility** (e.g., reduce documentation requirements) – this would only apply to new applications for benefits (the waiver described in the bullet above)
- **Simplify redeterminations** – MDHHS could ask for waiver authority to suspend the need to re-certify eligibility for current Medicaid beneficiaries. This would reduce strain on MDHHS offices and ensure continuity of coverage for Medicaid beneficiaries.

Access to Services

- **Eliminate co-pays** – our recommendation is that the elimination of copays only apply to testing for COVID-19 and treatment for COVID-19 related services.
- **Allow for early refills of prescriptions and promote mail order prescriptions** (this will not require a waiver)
- **Waive face to face requirements** (e.g., assessments with Community Health Workers, certain Substance Use Disorder services, like methadone)

Delivery System Capacity

- **Take advantage of flexibilities for provider enrollment** (e.g., allowing prescriptions for those who are not enrolled in CHAMPS)
- **Helping address hospital overflow by allowing for payments to providers under non-traditional arrangements** (e.g., in hypothetical field hospitals)
- **Increasing the rates for providers who are likely to face significant strain or be most**

Obtained via MI FOIA by Judicial Watch, Inc.

affected by COVID-19 (e.g., nursing facilities, home and community based care, adult foster care, opioid treatment facilities, Non-Emergency Medical Transportation)

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Huls, JoAnne; Groen, Meghan; Rising, Jay
Subject: RE: Tomorrow"s Medicaid call
Date: Monday, March 16, 2020 10:22:31 AM

Shoot, we have announced our employee town hall for 2:30 with all our senior leadership. Looks like what landed on sched is 2:00 on benefits and 3:30 on Medicaid, and that will work.

From: Huls, JoAnne <HulsJ1@michigan.gov>
Sent: Monday, March 16, 2020 10:15 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>; Rising, Jay <RisingJ@michigan.gov>
Subject: RE: Tomorrow's Medicaid call

We are adding a discussion at 2:30 specifically about some of these issues.

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Monday, March 16, 2020 10:14 AM
To: Groen, Meghan <GroenM@michigan.gov>; Rising, Jay <RisingJ@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Subject: RE: Tomorrow's Medicaid call

Please let me know if concerns with including Medicaid folks below on call later today. Thank you.

From: Groen, Meghan <GroenM@michigan.gov>
Sent: Monday, March 16, 2020 8:24 AM
To: Massey, Kate (DHHS) <MasseyK4@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Rising, Jay <RisingJ@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Cc: Emerson, Erin (DHHS) <EmersonE@michigan.gov>
Subject: RE: Tomorrow's Medicaid call

Thanks all. This is very exciting.

- What I am getting at with the paid leave and child care is also to get the money to the employee instead of the margins.
- For wrap-around – it's certainly a different situation so maybe it doesn't fit here – but intuitively there could be a space for additional behavioral health supports around emotional stress, wages lost, as well as food security, child care and other social determinant of health.

From: Massey, Kate (DHHS) <MasseyK4@michigan.gov>
Sent: Sunday, March 15, 2020 10:55 PM
To: Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Rising, Jay <RisingJ@michigan.gov>; Huls,

Obtained via MI FOIA by Judicial Watch, Inc.

JoAnne <HulsJ1@michigan.gov>
Cc: Emerson, Erin (DHHS) <EmersonE@michigan.gov>
Subject: RE: Tomorrow's Medicaid call

Agree with Jonathan's responses.

With regard to healthy behaviors, from a policy perspective, the implementation could technically still go-live in October but compliance could be addressed through a streamlined redetermination process. Small nuance.

From: Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>
Sent: Sunday, March 15, 2020 9:27 PM
To: Groen, Meghan <GroenM@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Rising, Jay <RisingJ@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Cc: Massey, Kate (DHHS) <MasseyK4@michigan.gov>; Emerson, Erin (DHHS) <EmersonE@michigan.gov>
Subject: RE: Tomorrow's Medicaid call

Thanks for the really thoughtful responses, Meghan. Answers below in red. Kate/Erin – please jump in if I've mischaracterized anything below.

From: Groen, Meghan <GroenM@michigan.gov>
Sent: Sunday, March 15, 2020 9:12 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Rising, Jay <RisingJ@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Cc: Massey, Kate (DHHS) <MasseyK4@michigan.gov>; Emerson, Erin (DHHS) <EmersonE@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>
Subject: Re: Tomorrow's Medicaid call

This is really great. I love it.

I do have couple thoughts:

1. Would those in the expansion population be subject to income eligibility and immigration status?
   Depends on how we filed the waiver. Our ingoing view was no on both, so the only limiting factor would be if the individual was receiving testing/treatment related to COVID-19.
2. Assume that people are eligible so there is not delay in treatment (presumptive eligibility population)?
   Yes. We have also talked about expanding the presumptively eligible population (did not include this on this list for you but it's on our broader list). We may also need to expand the list of providers that can certify presumptive eligible status (e.g., nursing homes) given target population for COVID-19
3. Targeted wrap-around supports and care management services for those experiencing financial or health distress specific to enrollees during the COVID-19 emergency – similar to

Obtained via MI FOIA by Judicial Watch, Inc.

what was in the Flint waiver?

We actually didn't talk about this in detail because we did not yet have a sense of what services the COVID-19 population would need. But that could certainly be on the table.

4. If we suspend redetermination does it delay health behavior provisions and time limits so people can stay on longer.

   Believe the answer to this is yes – Erin/Kate, please correct me if you disagree.

5. Would there be value in creating a pass-thru for paid sick time and childcare purposes for health care workers for the rate increase, or would it just be a general rate increase they could use at their discretion?

   As we framed it below, it was just going to be a general rate increase that they could use at their discretion. But I could see value in creating a pass-thru for paid sick time and childcare. Our general thought was that if it's getting harder and harder to incent folks to come to work because of fears about public health/safety, a straight increase in wages was going to be the most helpful. But we could certainly discuss this one further.

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Sunday, March 15, 2020 7:52:51 PM
To: Rising, Jay <RisingJ@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>
Cc: Massey, Kate (DHHS) <MasseyK4@michigan.gov>; Emerson, Erin (DHHS) <EmersonE@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>
Subject: Tomorrow's Medicaid call

Below are priorities on Medicaid expansions. Note we haven't gone through operational implications or priced out our share, and so would want to evaluate in conjunction with everything else. If you're open to it, I would suggest using part of the call at 3:30 also to discuss our benefits proposals, which I've reattached as well.

Feel free to distribute further of course.

Best,
Robert

Coverage

- **Expand coverage** – MDHHS could ask for a waiver to expand Medicaid coverage. Our recommendation is that the waiver would expand coverage only for individuals who test positive and are receiving treatment for COVID-19 or related complications. This would help individuals seek care, but it would also provide financial benefits for hospitals who might otherwise have to provide large amounts of uncompensated care. We recommend that the coverage extend to legal immigrants who have been in the state for less than five years, who are not currently eligible for Medicaid coverage.
- **Simplify application for new applications for eligibility** (e.g., reduce documentation requirements) – this would only apply to new applications for benefits (the waiver described in the bullet above)

Obtained via MI FOIA by Judicial Watch, Inc.

Simplify redeterminations – MDHHS could ask for waiver authority to suspend the need to re-certify eligibility for current Medicaid beneficiaries. This would reduce strain on MDHHS offices and ensure continuity of coverage for Medicaid beneficiaries.

Access to Services

- **Eliminate co-pays** – our recommendation is that the elimination of copays only apply to testing for COVID-19 and treatment for COVID-19 related services.
- **Allow for early refills of prescriptions and promote mail order prescriptions** (this will not require a waiver)
- **Waive face to face requirements** (e.g., assessments with Community Health Workers, certain Substance Use Disorder services, like methadone)

Delivery System Capacity

- **Take advantage of flexibilities for provider enrollment** (e.g., allowing prescriptions for those who are not enrolled in CHAMPS)
- **Helping address hospital overflow by allowing for payments to providers under non-traditional arrangements** (e.g., in hypothetical field hospitals)
- **Increasing the rates for providers who are likely to face significant strain or be most affected by COVID-19** (e.g., nursing facilities, home and community based care, adult foster care, opioid treatment facilities, Non-Emergency Medical Transportation)

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Gordon, Robert (DHHS)
To:	Smith, Dana; Huls, JoAnne; Khaldun, Joneigh (DHHS); Taverna, Andrea (DHHS-Contractor); LyonCallo, Sarah (DHHS); Rivera, Joshua (DHHS); Warsh, Jonathan (DHHS); Myers, Shaquila; Bagley, Nick; Totten, Mark; Foster, Tricia; Gasper, Joe (MSP)
Cc:	Bowden, Andrea (DHHS); White, Ricardo; Barnes, Kate; Durkee, Amaya; Crockett, Tracy; Smith, Tammy; Luebs, Heather (MSP)
Subject:	RE: Tracing Discussion
Date:	Saturday, April 18, 2020 11:03:34 AM
Attachments:	Containment-Tracing Strategy.pptx

Please find attached materials for the 12:15 discussion on Tracing. Thanks.

-----Original Appointment-----
From: Smith, Dana <SmithD131@michigan.gov>
Sent: Friday, April 17, 2020 12:24 PM
To: Smith, Dana; Huls, JoAnne; Gordon, Robert (DHHS); Khaldun, Joneigh (DHHS); Taverna, Andrea (DHHS-Contractor); LyonCallo, Sarah (DHHS); Rivera, Joshua (DHHS); Warsh, Jonathan (DHHS); Myers, Shaquila; Bagley, Nick; Totten, Mark; Foster, Tricia; Gasper, Joe (MSP)
Cc: Bowden, Andrea (DHHS); White, Ricardo; Barnes, Kate; Durkee, Amaya; Crockett, Tracy; Smith, Tammy; Luebs, Heather (MSP)
Subject: Tracing Discussion
When: Saturday, April 18, 2020 12:30 PM-1:15 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Microsoft Teams Meeting

[redacted]
[redacted] United States, Pontiac (Toll)
Conference ID: [redacted]

Local numbers | Reset PIN | Learn more about Teams | Meeting options

---

Obtained via MI FOIA by Judicial Watch, Inc.

From: Whitmer, Gretchen (MIEOG)
To: Alison Hirschel
Cc: Gordon, Robert (DHHS); Hawks, Orlene (LARA); Massey, Kate (DHHS); Salli Pung
Subject: RE: Urgent Request to Consider Very Limited Expansion of Visitation for Long Term Care Facilities and Outdoor Visits
Date: Tuesday, July 28, 2020 4:34:09 PM

Dear Alison and Salli,

Thank you so much for reaching out about this important issue. So sorry for the delayed response. Please know the care of our most vulnerable is a top priority for the Governor and our team.

We are looking forward to recommendations from the Quality of Life Workgroup in the Nursing Home Preparedness Task Force to improve quality of life and support the mental health of nursing home residents while protecting the health and safety of this vulnerable population.

Thank you again for all your work. Please know we truly appreciate it, and we look forward to continuing to work together.

Best,
Scottie Marie Barton
Director of Constituent Services
Governor Gretchen Whitmer
(517) 335-7858

From: Alison Hirschel <hirschel@meji.org>
Sent: Friday, June 26, 2020 2:12 PM
To: Whitmer, Gretchen (MIEOG) <Gretchen.Whitmer@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Hawks, Orlene (LARA) <HawksO@michigan.gov>; Massey, Kate (DHHS) <MasseyK4@michigan.gov>; Salli Pung <spung@meji.org>
Subject: Urgent Request to Consider Very Limited Expansion of Visitation for Long Term Care Facilities and Outdoor Visits

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Dear Governor Whitmer:

We are deeply grateful for your wise and careful leadership during the pandemic. **We write today in the attached letter about an urgent humanitarian concern that must be balanced with public health imperatives: the need for very limited expansion of visitation in long term care facilities for residents with particularly compelling circumstances and for outdoor visitation with residents in appropriate circumstances. In both cases, we support all necessary safeguards to minimize the risk of transmission of COVID-19.**

Obtained via MI FOIA by Judicial Watch, Inc.

Our increasingly urgent pleas on this topic mirror those from around the country from residents, families, advocates, and providers who recognize the profound and deleterious physical and emotional impact on residents of more than three months of isolation. Just this week, CMS released guidance permitting outdoor visitation and clarifying, consistent with your Executive Orders, that "compassionate care" visits can apply to more than end of life situations. And this month, states around the country have begun permitting outdoor visitation with appropriate safeguards.

We implore you to permit some very modest relaxation of the strict and nearly universal ban on contact between residents and their loved ones in the situations described in our attached letter. While other Michiganians, including facility staff, have the opportunity to assume and put others at considerable risk while they resume many aspects of their regular lives, residents and families continue to be denied the human contact they crave and need, especially as many residents approach the end of their lives.

Thank you for your consideration.

Best wishes,
Alison Hirschel
Director and Managing Attorney, Michigan Elder Justice Initiative

and

Salli Pung
State Long Term Care Ombudsman

--
Alison E. Hirschel
(she/hers)
Director and Managing Attorney, Michigan Elder Justice Initiative
15851 S. US 27, Suite 73
Lansing, MI 48906
Phone: (517) 827-8023
Fax: (517) 574-5301

Please note: We are open for business but working remotely due to the COVID-19 crisis. We will respond promptly to emails, faxes, and phone calls.

This electronic communication may be subject to the attorney-client privilege and may contain confidential information.
If you are not the intended recipient, any distribution, copying or disclosure is strictly prohibited. If you have received this communication in error, please notify the sender immediately and delete this copy from your system. Thank you for your cooperation.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Khaldun, Joneigh (DHHS)
Cc: Foster, Tricia; Gordon, Robert (DHHS); Totten, Mark
Subject: Re: Very rough estimates on cases and hospitalizations
Date: Saturday, March 21, 2020 9:33:32 PM

Thanks

We have had a lot of offers of help (free!) to help with tracing if we are interested in exploring ways to do that outside of the traditional systems. Just like with every other focused group we have, partnering with outside state government resources only increases our bandwidth and allows for expanded boots on the ground to tackle this — at our direction. I'll check in with budget on the expanded tracing persons you mentioned. Which line has tracing — persons, places or products? Let's get them working on tracing ASAP. Working with public health folks by county, but increasing the bandwidth ten fold. There's no reason to do this in a small way. Let me know what group has this. you give us the policy direction on what should happen, and the organized groups will implement.

The other states we have been talking to are shooting for tens of thousands of tests a day — so I'm interested to see our numbers. I'm assuming that you and Mark will be talking more about this in the coming days for how we want it to look in the short term (next week — vs. 5 months from now). We will continue to use our product team (which should be a joint and single operation of CHECC and SEOC) to gather everything we can for tests, where to interject more drive thru, how to do at home, all things tests. You tell us where to test, and we'll figure out how to get them there.

This, and the response from Robert, indicates a conversation is best tomorrow. I'm happy to to help arrange if you want to shoot availability to me.

Thanks

From: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Sent: Saturday, March 21, 2020 9:04 PM
To: Huls, JoAnne
Cc: Foster, Tricia; Gordon, Robert (DHHS); Totten, Mark
Subject: Re: Very rough estimates on cases and hospitalizations

Thanks JoAnne. The places and personnel workgroups as we speak are modeling off of this information, Tricia I'm copying you as the point on products.

We've revved up our lab capacity significantly and expect to have at least 10 labs testing in the next week. That will get us to at least 2,000 tests a day(likely more like 3,000) up from 100 last week. Ive asked my team for addresses/maps for all testing sites(some are just popping up on their own but we are trying actively to compile that info in one place) Part of the testing is the supply chain question of nasal swabs- which the SEOC should be actively

Obtained via MI FOIA by Judicial Watch, Inc.

addressing.

Expansive testing, of the people most likely to be positive, will then guide the tracing and give us a better handle on targeted protective measures. There is a draft guidance that Mark has that specifies more on testing and reporting that I'm hoping can also go out as a declaration under Robert's authority, ASAP. I already sent out letter guidance to all healthcare providers re how they should be testing to maximize yield.

The local health departments do the tracing. I submitted in my initial budget request to SBO additional staff for locals to do this- any guidance on where this landed would be helpful.

Thanks
Joneigh

> On Mar 21, 2020, at 8:46 PM, Huls, JoAnne <HulsJ1@michigan.gov> wrote:
>
> Thank you Dr J,
>
> Sobering. I'm assuming we are taking this information and pushing it into the Places, Products and Personnel groups so that they will be able to plan actively for this given the timeline suggested here.
>
> I'd like to make sure that we have clear direction and expectation on next steps. If this group needs to talk again in the morning regarding structure please let me know. I'm happy to facilitate that call if necessary. I know work groups are active, but there still seems to be two lines here that need to get collapsed into one aggressive plan housed in the SEOC.
>
> Your policy of aggressive social distancing is being captured by the Governor's EO in the coming day(s). Other policy guidance on testing and tracing would be helpful. I'm wondering if you have a sense of our current testing scenario, and what we need to move to, and how else we can actively and aggressively do more tracing?
>
> Thanks
> JoAnne

From: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Sent: Saturday, March 21, 2020 7:31:56 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>

Obtained via MI FOIA by Judicial Watch, Inc.

Subject: Very rough estimates on cases and hospitalizations

Hello,

Dr Sarah Lyon Callo drafted some rough estimates, based on what's occurring in Italy and projections for infectivity of the virus that causes COVID-19.

Based on some broad assumptions (worst case but possible scenario), we believe there will be about 6.9 million people in Michigan who become infected across all ages (70% of population), 1 million of those will need hospitalization, and 435,000 of those will require an ICU stay. A subset of the ICU cases will unfortunately die, but I do not have that estimate at this time.

This is estimated to occur over the next 2-4 weeks, and social distancing measures will bring this down regarding the acuity of the patients and the speed with which it spreads. My recommendation is the most aggressive public health action we can take at this time.

Joneigh S. Khaldun, MD, MPH, FACEP
Chief Medical Executive
Chief Deputy Director for Health
Michigan Department of Health and Human Services
Office: 517-284-4730
khaldunj@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Gordon, Robert (DHHS); Khaldun, Joneigh (DHHS); Foster, Tricia; Totten, Mark
Subject: Re: Very rough estimates on cases and hospitalizations
Date: Saturday, March 21, 2020 9:24:19 PM

Ok. I'm happy to arrange a conversation. Some people "think" in spread sheet, others in power point, others with "accountability charts". Whatever works, as long as it gets us to clarity on who is doing what.

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Saturday, March 21, 2020 9:01 PM
To: Huls, JoAnne; Khaldun, Joneigh (DHHS); Foster, Tricia; Totten, Mark
Subject: RE: Very rough estimates on cases and hospitalizations

Thanks for the questions. I will leave Dr. J to reply regarding other policy guidance and testing.

On roles and responsibilities, the three groups and our improved internal protocols have helped, but there could still be greater clarity between SEOC and DHHS and at the name level regarding accountabilities. Attached is a spreadsheet that Jonathan put together and shared with Dr. J, Elizabeth, and me. I think it would be clarifying for a group of us to sit down and complete it. But there may be other good approaches as well.

From: Huls, JoAnne <HulsJ1@michigan.gov>
Sent: Saturday, March 21, 2020 8:46 PM
To: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>
Subject: Re: Very rough estimates on cases and hospitalizations

Thank you Dr J,

Sobering. I'm assuming we are taking this information and pushing it into the Places, Products and Personnel groups so that they will be able to plan actively for this given the timeline suggested here.

I'd like to make sure that we have clear direction and expectation on next steps. If this group needs to talk again in the morning regarding structure please let me know. I'm happy to facilitate that call if necessary. I know work groups are active, but there still seems to be two lines here that need to get collapsed into one aggressive plan housed in the SEOC.

Your policy of aggressive social distancing is being captured by the Governor's EO in the coming day(s). Other policy guidance on testing and tracing would be helpful. I'm wondering if you have a sense of our current testing scenario, and what we need to move to, and how else we can actively and aggressively do more tracing?

Obtained via MI FOIA by Judicial Watch, Inc.

Thanks
JoAnne

From: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Sent: Saturday, March 21, 2020 7:31:56 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>
Subject: Very rough estimates on cases and hospitalizations

Hello,

Dr Sarah Lyon Callo drafted some rough estimates, based on what's occurring in Italy and projections for infectivity of the virus that causes COVID-19.

Based on some broad assumptions (worst case but possible scenario), we believe there will be about 6.9 million people in Michigan who become infected across all ages (70% of population), 1 million of those will need hospitalization, and 435,000 of those will require an ICU stay. A subset of the ICU cases will unfortunately die, but I do not have that estimate at this time.

This is estimated to occur over the next 2-4 weeks, and social distancing measures will bring this down regarding the acuity of the patients and the speed with which it spreads. My recommendation is the most aggressive public health action we can take at this time.

Joneigh S. Khaldun, MD, MPH, FACEP
Chief Medical Executive
Chief Deputy Director for Health
Michigan Department of Health and Human Services
Office: 517-284-4730
khaldunj@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Khaldun, Joneigh (DHHS); Foster, Tricia; Gordon, Robert (DHHS); Totten, Mark
Subject: Re: Very rough estimates on cases and hospitalizations
Date: Saturday, March 21, 2020 8:46:04 PM

Thank you Dr J,

Sobering. I'm assuming we are taking this information and pushing it into the Places, Products and Personnel groups so that they will be able to plan actively for this given the timeline suggested here.

I'd like to make sure that we have clear direction and expectation on next steps. If this group needs to talk again in the morning regarding structure please let me know. I'm happy to facilitate that call if necessary. I know work groups are active, but there still seems to be two lines here that need to get collapsed into one aggressive plan housed in the SEOC.

Your policy of aggressive social distancing is being captured by the Governor's EO in the coming day(s). Other policy guidance on testing and tracing would be helpful. I'm wondering if you have a sense of our current testing scenario, and what we need to move to, and how else we can actively and aggressively do more tracing?

Thanks
JoAnne

From: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Sent: Saturday, March 21, 2020 7:31:56 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>
Subject: Very rough estimates on cases and hospitalizations

Hello,

Dr Sarah Lyon Callo drafted some rough estimates, based on what's occurring in Italy and projections for infectivity of the virus that causes COVID-19.

Based on some broad assumptions (worst case but possible scenario), we believe there will be about 6.9 million people in Michigan who become infected across all ages (70% of population), 1 million of those will need hospitalization, and 435,000 of those will require an ICU stay. A subset of the ICU cases will unfortunately die, but I do not have that estimate at this time.

This is estimated to occur over the next 2-4 weeks, and social distancing measures will bring this down regarding the acuity of the patients and the speed with which it spreads. My recommendation is the most aggressive public health action we can take at this time.

Obtained via MI FOIA by Judicial Watch, Inc.

Joneigh S. Khaldun, MD, MPH, FACEP
Chief Medical Executive
Chief Deputy Director for Health
Michigan Department of Health and Human Services
Office: 517-284-4730
khaldunj@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Huls, JoAnne; Khaldun, Joneigh (DHHS); Foster, Tricia; Totten, Mark
Subject: RE: Very rough estimates on cases and hospitalizations
Date: Saturday, March 21, 2020 8:59:28 PM
Attachments: COVID 19 SOM Roles and Responsibilities v2.xlsx

Thanks for the questions. I will leave Dr. J to reply regarding other policy guidance and testing.

On roles and responsibilities, the three groups and our improved internal protocols have helped, but there could still be greater clarity between SEOC and DHHS and at the name level regarding accountabilities. Attached is a spreadsheet that Jonathan put together and shared with Dr. J, Elizabeth, and me. I think it would be clarifying for a group of us to sit down and complete it. But there may be other good approaches as well.

From: Huls, JoAnne <HulsJ1@michigan.gov>
Sent: Saturday, March 21, 2020 8:46 PM
To: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>
Subject: Re: Very rough estimates on cases and hospitalizations

Thank you Dr J,

Sobering. I'm assuming we are taking this information and pushing it into the Places, Products and Personnel groups so that they will be able to plan actively for this given the timeline suggested here.

I'd like to make sure that we have clear direction and expectation on next steps. If this group needs to talk again in the morning regarding structure please let me know. I'm happy to facilitate that call if necessary. I know work groups are active, but there still seems to be two lines here that need to get collapsed into one aggressive plan housed in the SEOC.

Your policy of aggressive social distancing is being captured by the Governor's EO in the coming day(s). Other policy guidance on testing and tracing would be helpful. I'm wondering if you have a sense of our current testing scenario, and what we need to move to, and how else we can actively and aggressively do more tracing?

Thanks
JoAnne

From: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Sent: Saturday, March 21, 2020 7:31:56 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>

Obtained via MI FOIA by Judicial Watch, Inc.

Subject: Very rough estimates on cases and hospitalizations

Hello,

Dr Sarah Lyon Callo drafted some rough estimates, based on what's occurring in Italy and projections for infectivity of the virus that causes COVID-19.

Based on some broad assumptions (worst case but possible scenario), we believe there will be about 6.9 million people in Michigan who become infected across all ages (70% of population), 1 million of those will need hospitalization, and 435,000 of those will require an ICU stay. A subset of the ICU cases will unfortunately die, but I do not have that estimate at this time.

This is estimated to occur over the next 2-4 weeks, and social distancing measures will bring this down regarding the acuity of the patients and the speed with which it spreads. My recommendation is the most aggressive public health action we can take at this time.

Joneigh S. Khaldun, MD, MPH, FACEP
Chief Medical Executive
Chief Deputy Director for Health
Michigan Department of Health and Human Services
Office: 517-284-4730
khaldunj@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

Category	Activity
Product / Supplies (Tricia Foster)	Inventorying all available products in the state's possession (e.g., PPE) and tracking in real time
	Inventorying all available key products (PPE, ventilators, respirators) at hospitals in the state and understanding where there are shortages TODAY
	Tracking all needs from hospitals, health systems, other providers in a single place
	Predicting future needs for hospitals and other health care entities minus current supply (gap analysis)
	Making recommendations around what to procure from SNS, other manufacturers
	Distributing needed products to health entities across the state
Places / Hospital Capacity / Beds (Elizabeth Hertel)	Inventorying all available beds across the state and potential surge capacity under existing plan
	Tracking all needs from hospitals, health systems, other providers in a single place
	Predicting future needs for hospitals
	Developing policy options to expand overall bed capacity (acute and non-acute)
	Making policy decisions around whether to direct additional surge in the state
	Working with hospitals to coordinate the logistics work of expanding capacity (if necessary)
People / Hospital Workforce issues (Jonathan Warsh)	Inventorying all available medical workforce personnel across the state
	Predicting future healthcare needs
	Developing policy options around preventing healthcare workforce shortages
	Making policy decisions
Testing	Conducting tests
	Evaluating epidemiological trends based on data from state lab and private labs
	Expanding testing capacity throughout the state
Public Health / Social Distancing issues	Evaluating epidemiological trends and providing information on # of cases, deaths in the state
	Presenting policy/legal options on ways to enforce / support social distancing
Volunteers / Donations	Tracking all donations of supplies and potential space in one consolidated space

Obtained via MI FOIA by Judicial Watch, Inc.

	Tracking all individual volunteers (medical)
Communications	Communicating with key public health stakeholders (e.g., local health officials, Tribes)
	Comms approval from DHHS

Obtained via MI FOIA by Judicial Watch, Inc.

Responsible Entity	Responsible person
SEOC	
???	
CHECC or SEOC???	
Products workgroup	Ryan Cross
Products workgroup in consultation with Dr. Khaldun	
SEOC	
CHECC? Or "Places" workgroup	
CHECC (through HCCs)	
Places workgroup	
Places workgroup	
Places workgroup in partnership with Dr. J	
SEOC	
People workgroup	
People workgroup	
People workgroup in partnership with LARA	
???	
State Lab	Dr. Shah
Epidemiology Bureau	Dr. Sarah Lyon-Callo
Epidemiology Bureau	Dr. Sarah Lyon-Callo
Dr. Sarah Lyon-Callo, input from University of Michigan	Dr. Sarah Lyon-Callo
Dr. Khaldun, Mark Totten	Dr. Khaldun, Mark Totten
SEOC???	

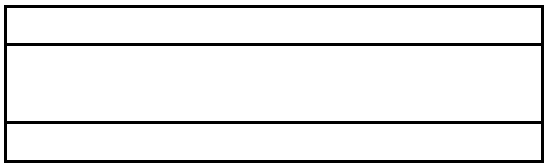
Obtained via MI FOIA by Judicial Watch, Inc.

Victoria Arnold (CHECC)	Victoria Arnold (CHECC)
CHECC	Orlando Todd
JIC / DHHS	Rey Bouknight

Obtained via MI FOIA by Judicial Watch, Inc.

Notes
Do not think that the SEOC is doing this today / has a clear process to do this
This one really needs to be clarified - I think the SEOC sees this as their job today
McKinsey and Co also providing data to support here
Need specific name from SEOC and need to set up an email inbox; also need to find a way to input this data into the Places and People workstreams

Obtained via MI FOIA by Judicial Watch, Inc.



Obtained via MI FOIA by Judicial Watch, Inc.

From:	Totten, Mark
To:	Gordon, Robert (DHHS); Khaldun, Joneigh (DHHS); LyonCallo, Sarah (DHHS); Corbin, Susan (LEO); Anderson, Evan (LEO); Gasper, Joe (MSP); Sweeney, Kevin (MSP); Eubanks, Rachael (TREASURY); Guilfoyle, Jeffrey (TREASURY); Foster, Tricia; Razili Lewis; Mark Burton (MEDC); Huls, JoAnne; Laidlaw, Emily; Flood, Jennifer
Cc:	Crockett, Tracy; Luebs, Heather (MSP); Rockefeller, Cheryl (DHHS); Bowden, Andrea (DHHS); Chrzaszcz, Monica (LEO); Smith, Tammy; Crockett, Tracy
Subject:	Recovery planning
Date:	Friday, October 30, 2020 6:30:38 AM

Hello all,

FEMA is requiring the states who receive FEMA financial support to present a high-level plan for the recovery phase of the COVID-19 emergency, which MSP would present in late November or early December. We are of course still very much within the response stage, and will be for some time, but we need to respond to FEMA's request and of course there's value in even high-level planning for this next phase in the management of this emergency. With this task in mind, Tricia Foster and I have conferred and want to organize a meeting the week of 11/9 to discuss recovery phase planning, and ask the represented departments/organizations to share in advance of that meeting a 1-page summary of key elements for recovery phase actions within the scope of the department's or organization's jurisdiction. This document is high-level and basic; we are not looking for a detailed plan at this point.

So we're working from a shared understanding, here's one explanation of the "recovery phrase" of emergency management that FEMA has provided:

> Disaster recovery is the phase of the emergency management cycle that begins with the stabilization of the incident and ends when the community has recovered from the disaster's impacts. The term incident stabilization refers to the point in time at which the immediate threats to human safety and property resulting from the physical impacts of the primary and secondary hazard agents have been resolved. Thus, the sense of uncertainty and urgency that is the hallmark of the emergency response is beginning to be replaced by thoughts about how to rebuild damaged structures, restore infrastructure services, and return the community to its normal patterns of activity.

Based on my understanding, this phase would begin as we have a widely dispersed vaccine, a sufficiently effective therapeutic, or the disease has changed and no longer poses the same threat it does now. For practical purposes it is likely the first development – a widely dispersed vaccine – that will mark our entry into the recovery phase.

I want to ask Tracy if she can find 1 hour for this group to meet sometime the week of 11/9 to discuss the key elements we identify. (Tracy, you can title the invite: COVID-19 Recovery Planning.) I've structured this group to reflect these three primary aspects of a recovery plan:

1. Public health (DHHS)
2. The economy (LEO/Treasury/MEDC)
3. Emergency response (MSP)

Obtained via MI FOIA by Judicial Watch, Inc.

In addition to the representatives from DHHS/LEO/TREAS/MEDC/MSP, a few of us from EOG will participate and I'll ask Raz from McKinsey to join too. I'll ask the directors for these departments to confirm with Tracy who should attend from your department – whether you and/or a designee; and Raz or others from EOG if you want to add/designate someone just let Tracy know. Each represented department or organization will have 5-7 minutes to present/discuss the key elements they have identified that would need to be included in a recovery phase plan.

Many thanks, Mark

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email and any associated documents may contain information that is privileged or otherwise exempt from disclosure. It is intended for use only by the person to whom it is addressed. Please contact me before disclosure. If you have received this email in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Foster, Tricia; Stibitz, Brom (DTMB); Rogers, Paul (DMVA); Huls, JoAnne; Warsh, Jonathan (DHHS)
Cc: Hertel, Elizabeth (DHHS); Schwarzkopf, Emily (DHHS)
Subject: Residential facilities (part of Places)
Date: Saturday, March 28, 2020 2:19:51 PM
Attachments: Emergency Procurement for Quarantine and Isolation Facilities.pdf

---

The purpose of this email is to help us move forward effectively on providing needed **residential facilities beyond field hospitals/alternative care sites**. Notes were developed in coordination with Elizabeth Hertel and the Places workgroup. Elizabeth and Emily Schwarzkopf on her team will schedule a follow-up conversation.

Uses of added housing:

1. Health professionals—either because they are volunteers away from other regions, or because they want to stay apart from their families to avoid transmitting disease (many already doing)
2. Individuals who are positive or awaiting tests but asymptomatic or do not require hospitalization. Reduces community spread, and may provide care for persons who can't care for themselves. Chicago and New York (attached) are standing up both
    - Currently in group settings like homeless shelters or group homes
    - At home

Facility can serve either purpose but not both.

Needs assessment:

- Health professionals are first priority—but unclear on extent of need—can we develop assessment of anticipated need?
- Isolation wards are second priority—needs unlimited but can we develop hypothesis on target amount needed by area, including most urgent populations (like homeless)

Sources of added housing:

- WSU dorms (state property)—200 beds—purpose toward health professionals
- Hotels: Elizabeth in conversations
- Other sites: Could be added to MING siting reviews—second tier consideration to identify potential added sites, but perhaps that is distraction

Considerations:

- Are locals doing enough here and we can defer to them? Do we need to do an assessment of their efforts and fill gaps as needed?
- Are there efficiencies from statewide approach (eg, Master Service Agreements with chains)
- What protocols for management of isolation wards are needed and who is responsible (NY doc covers this)

Obtained via MI FOIA by Judicial Watch, Inc.

Department of Social Services
Human Resources Administration
Department of Homeless Services

Office of Contracts

Steven Banks
Commissioner

Martha A. Calhoun
General Counsel

Vincent Pullo
Agency Chief Contracting Officer

150 Greenwich Street
New York, NY 10007

929 221 6347

March 24, 2020

Dear Prospective Vendor:

The Department of Homeless Services (DHS) is seeking appropriately qualified vendors to operate quarantine/isolation facilities pursuant to a declared emergency. This emergency procurement has been approved by the Department of Social Services/Department of Homeless Service pursuant to Mayor's Emergency Executive Order 101.

The selected vendor(s) will perform medical and social services at quarantine locations approved by DHS in response to the ongoing Novel Coronavirus pandemic. At this time, DHS will be immediately opening two (2) quarantine/isolation sites; however, DHS anticipates opening additional sites as the crisis gets more severe. Proposers are advised to be ready, willing, and able to provide services on a 24 hours' notice with sites opening as soon as March 30, 2020. Onsite services shall include, but not be limited to the following:

- Providing food, personal care items, and clean laundry to clients who are quarantined at the sites. All items would be delivered to the clients' rooms;
- Providing security guards at access control areas and on each floor of the proposed sites;
- Providing 24-hour medical staff at the sites to monitor the health of clients, including escalation and transfers to hospitals if necessary, assistance with medication for conditions unrelated to Novel Coronavirus (COVID-19), mental health need assessments and references to telehealth services;
- Provide Light Touch Social Services[1] to all clients in quarantine at the site;

[1] Information regarding this will provided after selection

Obtained via MI FOIA by Judicial Watch, Inc.

- Empathically and accurately provide all necessary DOHMH approved information and materials to persons when they check-in to hotel rooms, including, but not limited to:
    - Materials for self-monitoring
    - Recommendation to stay inside the room
    - Tips for dealing with stress while separated from others
    - Information about what services will be provided while on-site
    - Obtain consent to communicate congregate housing/shelter provider regarding check-out date (planned/unplanned check-out or transport to the hospital)
    - Information about daily check-ins and the circumstances under which the provider, hotel staff, or emergency responders will enter the hotel room without consent
    - Procedures for determining date of check-out
- Communicate to clients' congregate housing/shelter providers:
    - Projected check-out date and confirmation of plan for travel arrangements to return to residential/supportive housing.
    - Notification to congregate housing/shelter provider if person was transported to the hospital, and which hospital
- Be available on-site to manage issues as they arise:
    - Liaise with hotel operations staff, as needed
    - Escalate major questions/concerns to DHS, DOHMH, NYCEM
    - Call 911 for emergencies
- Submit an accurate daily roster of persons in hotel rooms to DHS and DOHMH with the following information:
    - Full name
    - Isolation location
    - Name, email and cellphone number for two points of contact from the person's congregate/shelter provider
    - Check-in date
    - Projected or actual check-out date
    - Reason for check-out (as planned; unplanned-against guidance; unplanned-transport to hospital)

Obtained via MI FOIA by Judicial Watch, Inc.

- Providing transportation to and from shelters/congregate setting and hospitals and the quarantine/isolation sites;
- Conducting deep cleansing of individual rooms at turnover.

At this time, proposers who are ready willing and able to supply the services above on or about March 30, 2020 should respond. In addition, proposers who are able to mobilize and operate quarantine/isolation shelters on short notice should apply as well, with a proposal on how it can do so. DHS will engage only with vendors who can be ready to provide services on an emergency basis.

DHS anticipates that each proposed quarantine/isolation facility will be staffed to provide care to clients who are being isolated due to the inability to isolate in shelter/congregate setting. Each vendor will provide staff in accordance with the requirements herein.

All staff assigned to these facilities must work in appropriate protective gear to protect against contracting COVID-19. Please be advised, proposed medical staff would need to provide their own personal protective equipment (PPE). Identified medical staff would not be responsible for COVID-19 testing, only client monitoring and basic care. All necessary equipment and supplies should be included with the submitted line-item budget. The selected vendor(s) will be needed for the period of the next six (6) months from site opening; however, DHS reserves the right to extend the engagement if the need arises.

Please note that the selected applicant must have thorough knowledge of all medical resources available to individuals whom have or are suspected to have been exposed to COVID-19. Proposers must show this experience in their response or indicate whether they will subcontract such services.

As part of this solicitation, proposers submitting responses should briefly address the following:

A. Experience

Proposers should discuss its past experience in providing case management and social services in situations where vulnerable clients are

Obtained via MI FOIA by Judicial Watch, Inc.

in severe distress following a serious medical event. In addition, proposers should describe its ability to interface with healthcare providers and hospitals. Moreover, proposers should discuss their past experience providing shelter or other housing services medically frail and/or vulnerable populations in a congregate-like setting.

B. Proposed Approach

Proposers should describe in detail how it will effectively carry out the scope of services described herein. Include a description on how they will coordinate care, and liaise, on the behalf of clients with hospital emergency departments, and the DHS Office of the Medical Director, and congregate residences.

C. Organizational Capability

Proposers should indicate how it will effectively manage staff in the quarantine/isolation centers and managing budgets without timely City reimbursement. In addition, proposers should indicate how it can fully staff its facilities by on or about March 30, 2020 and/or can operate a shelter immediately upon DHS notice.

D. Payment Structure

The anticipated amount for the entire procurement is $40,392,000 for a period of six (6) months. Proposers should provide a full time and materials budget to operate the sites they are proposing. Any services to be subcontracted should be clearly indicated. The City reserves the right to change such amount. It is anticipated that the payment structure for contracts awarded under this Emergency Declaration will be a line-item budget reimbursement. Price Proposals should include services only; site costs will be discussed after selection and prior to opening of the shelter.

E. Subcontracting

Any services that the proposer elects to subcontract should be indicated in their proposals. Please provide the subcontractor information as well as the description of subcontracted services. Any subcontracted work can commence only with prior approval of DHS in accordance with the City's formal subcontracting process.

Any services that the proposer elects to subcontract should be indicated in their proposals. Please provide the subcontractor information as well as the

Obtained via MI FOIA by Judicial Watch, Inc.

description of subcontracted services. Any subcontracted work can commence only with prior approval of DHS in accordance with the City's formal subcontracting approval process. If any subcontracted services necessities obtaining services from a single source due to exigent circumstances, proposers should identify such sources, the reason the single source has to be utilized, and that discuss how the subcontracted price is consistent past subcontracted costs and/or costs for such services as otherwise available in the market.

F. Proposed Number of Rooms

Proposers are requested to provide services for 1122 rooms at sites to be later determined. Please note that 500 of these units will be utilized for non-DHS clients and as directed by the New York City Department of Mental Health and Hygiene. In addition, up to 150 of the rooms may be utilized for medically frail individuals recently released from Department of Correction facilities. If interested in submitting a proposal for these rooms, please indicate the number of rooms for which you can provide services, and whether you are available to provide services to medically frail individuals recently released from Department of Corrections facilities.

G. Proposal Instructions and Basis of Award

Interested entities should complete the attached application form and indicate the site for which it is proposing. If the proposer is planning to submit for multiple sites, please submit each site as a separate proposal.

This award will be made to responsive and responsible applicant(s) offering the most advantageous offer to the City. DHS will consider the following criteria when evaluating submissions:

Experience	40%
Proposed Approach	20%
Organizational Capability / Ability to mobilize immediately	40%

It is the intent to award contracts to the highest ranked submissions for the site proposals, and then rank the proposals submitted for the remaining site for later consideration. However, DHS reserves the right to skip proposals and limit selections based on criteria such as vendor capacity and the ability to provide an appropriate medical and social services to individuals whom have or are suspected to have been exposed to COVID-19. In addition, The City reserves the right to assign proposers to sites different from the site the vendor has proposed in the best interests of the City. In addition, the City

Obtained via MI FOIA by Judicial Watch, Inc.

reserves the right to change sites and the number of rooms available at the site(s). In addition, the City reserves the right to limit rooms ultimately awarded based on vendor capacity and in the best interests of the City.

Pursuant to Local Law 34 of 2007, amending the City's Campaign Finance Law, the City is required to establish a computerized database containing the names of any "person" that has "business dealings with the city" as such terms are defined in the Local Law. In order for the City to obtain necessary information to establish the required database, vendors responding to this solicitation should complete the Doing Business Data Form (Attachment A) and return it with this proposal. The submission of a Doing Business Data Form that is not accurate and complete may result in appropriate sanctions.

If you are interested in applying to provide the above services, please submit your proposal to accoprocurements@dss.nyc.gov by **March 27, 2020 at 2:00 PM. Note that the City reserves the right to open proposals and score proposals and commence services at an earlier time if (1) proposals have been submitted; (2) the emergency requires immediately staffing at sites; and (3) if the proposal, if scored at that time, has been determined to be technically viable. Please note that proposers who have submitted to the earlier solicitation, must submit a proposal to this solicitation to be considered.**

Please note, your organization's email system may have a maximum size limitation for sending out emails. Please be advised that DSS cannot accept any email in a size greater than 20 MB.

Once you submit your proposal electronically, it is strongly recommended that you send such email with enough time to determine whether the transmission has failed. Also, DSS strongly recommends that you follow up with an email to accoprocurements@dss.nyc.gov to confirm that the email was transmitted successfully.

Sincerely,

Vincent Pullo
Agency Chief Contracting Officer

Mayor's Office of Contract Services

Obtained via MI FOIA by Judicial Watch, Inc.

Doing Business Data Form
Update Form

A Doing Business Data Form must be completed by an entity when an individual who is or was affiliated with that entity requests to be removed from the Doing Business Database, or when an entity wants to update its information. Please either type responses directly into this fillable form, or print answers by hand in black ink. For all submissions, please be sure to fill out the certification box on the last page, and return the completed Data Form (along with the Request for Removal) to the Doing Business Accountability Project, 253 Broadway, 9th floor, New York, NY 10007 or via email to DoingBusiness@mocs.nyc.gov. **This Data Form is separate from that used to collect information from entities receiving, applying for or proposing on an award, agreement or solicitation.**

This Data Form requires information to be provided on principal officers, owners and senior managers. The name, employer and title of each person identified on the Data Form will be included in a public database of people who do business with the City of New York, as will the organizations that own 10% or more of the enitity. No other information reported on this form will be disclosed to the public. **This Data Form is not related to the City's PASSPort registration or VENDEX requirements.**

Please contact the Doing Business Accountability Project at DoingBusiness@mocs.nyc.gov or 212-788-8104 with any questions regarding this Data Form. Thank you for your cooperation.

*If you are completing this form by hand, **please print clearly.***

Entity Information

Entity EIN/TIN _____ Entity Name _____

Filing Status	**(Select One)**
***NEW:** Data Forms submitted now must include the listing of **organizations,** as well as individuals, with 10% or more ownership of the entity. Until such certification of ownership is submitted through a change, new or update form, a no change form will not be accepted.*	☐ Entity has never completed a Doing Business Data Form. Fill out the entire form. ☐ Change from previous Data Form dated _____. *Fill out only those sections that have changed, and indicate the name of the persons who no longer hold positions with the entity.* ☐ No Change from previous Data Form dated _____. *Skip to the bottom of the last page.*

Entity is a Non-Profit ☐ Yes ☐ No

Entity Type ☐ Corporation (any type) ☐ Joint Venture ☐ LLC ☐ Partnership (any type) ☐ Sole Proprietor ☐ Other (specify) _____

Address _____

City _____ State _____ Zip _____

Phone _____ E-mail _____

Provide your e-mail address in order to receive notices regarding this form by e-mail.

Principal Officers

Please fill in the required identification information for each officer listed below. If the entity has no such officer or its equivalent, please check "This position does not exist." If the entity is filing a Change Form and the person listed is replacing someone who was previously disclosed, please check "This person replaced..." and fill in the name of the person being replaced so his/her name can be removed from the *Doing Business Database,* and indicate the date that the change became effective.

Chief Executive Officer (CEO) or equivalent officer ☐ This position does not exist

The highest ranking officer or manager, such as the President, Executive Director, Sole Proprietor or Chairperson of the Board.

First Name _____ MI ___ Last _____ Birth Date (mm/dd/yy) _____

Office Title _____ Employer (if not employed by entity) _____

Home Address _____

☐ This person replaced former CEO _____ on date _____

Chief Financial Officer (CFO) or equivalent officer ☐ This position does not exist

The highest ranking financial officer, such as the Treasurer, Comptroller, Financial Director or VP for Finance.

First Name _____ MI ___ Last _____ Birth Date (mm/dd/yy) _____

Office Title _____ Employer (if not employed by entity) _____

Home Address _____

☐ This person replaced former CFO _____ on date _____

Chief Operating Officer (COO) or equivalent officer ☐ This position does not exist

The highest ranking operational officer, such as the Chief Planning Officer, Director of Operations or VP for Operations.

First Name _____ MI ___ Last _____ Birth Date (mm/dd/yy) _____

Office Title _____ Employer (if not employed by entity) _____

Home Address _____

☐ This person replaced former COO _____ on date _____

Obtained via NYC FOIL by Judicial Watch, Inc.

Principal Owners

Please fill in the required identification information for all individuals or organizations that, through stock shares, partnership agreements or other means, **own or control 10% or more of the entity.** If no individual or organization owners exist, please check the appropriate box to indicate why and skip to the **Senior Managers** section. If the entity is owned by other companies that control 10% or more of the entity, those companies must be listed. If an owner was identified on the previous page, fill in his/her name and write "See above." If the entity is filing a Change Form, list any individuals or organizations that are no longer owners at the bottom of this section. If more space is needed, attach additional pages labeled "Additional Owners."

There are no owners listed because (select one):

☐ The entity is not-for-profit ☐ The entity is an individual ☐ No individual or organization owns 10% or more of the entity

Other (explain) _____

Individual Owners (who own or control 10% or more of the entity)

First Name _____ MI ___ Last _____ Birth Date (mm/dd/yy) _____

Office Title _____ Employer (if not employed by entity) _____

Home Address _____

First Name _____ MI ___ Last _____ Birth Date (mm/dd/yy) _____

Office Title _____ Employer (if not employed by entity) _____

Home Address _____

Organization Owners (that own or control 10% or more of the entity)

Organization Name _____

Organization Name _____

Organization Name _____

Remove the following previously-reported Principal Owners

Name _____ Removal Date _____

Name _____ Removal Date _____

Name _____ Removal Date _____

Senior Managers

Please fill in the required identification information for all senior managers who oversee any of the entity's relevant transactions with the City (e.g., contract managers if this form is for a contract award/proposal, grant managers if for a grant, etc.). Senior managers include anyone who, either by title or duties, has substantial discretion and high-level oversight regarding the solicitation, letting or administration of any transaction with the City. At least one senior manager must be listed, or the Data Form will be considered incomplete. If a senior manager has been identified on a previous page, fill in his/her name and write "See above." If the entity is filing a Change Form, list individuals who are no longer senior managers at the bottom of this section. If more space is needed, attach additional pages labeled "Additional Senior Managers."

Senior Managers

First Name _____ MI ___ Last _____ Birth Date (mm/dd/yy) _____

Office Title _____ Employer (if not employed by entity) _____

Home Address _____

First Name _____ MI ___ Last _____ Birth Date (mm/dd/yy) _____

Office Title _____ Employer (if not employed by entity) _____

Home Address _____

First Name _____ MI ___ Last _____ Birth Date (mm/dd/yy) _____

Office Title _____ Employer (if not employed by entity) _____

Home Address _____

Remove the following previously-reported Senior Managers

Name _____ removal date _____

Name _____ removal date _____

Certification

I certify that the information submitted on these two pages and ____ additional pages is accurate and complete. I understand that willful or fraudulent submission of a materially false statement may result in the entity being found non-responsible and therefore denied future City awards.

Name _____ Title _____

Entity Name _____ Work Phone # _____

Signature _____ Date _____

Please return this form to the Doing Business Accountability Project by email to DoingBusiness@mocs.nyc.gov. **Update**

Obtained via MI FOIA by Judicial Watch, Inc.

Proposal Budget Summary

Line Item	Annual Budget
Total Annual Funding Request	**$ -**
- **Total Direct Costs**	**$ -**
- **Total Salary and Fringe**	**$ -**
Total Salary	$ -
Total Fringe	$ -
- **Total OTPS**	**$ -**
Operations, Support and Equipment	$ -
Utilities	$ -
Professional Services	$ -
Contracted Services	$ -
- **Indirect Costs**	
- **Total Indirect Costs**	**$ -**
- **Program Income**	
- **Total Program Income**	

Obtained via MI FOIA by Judicial Watch, Inc.

Budget Item Descriptions

Total Salary: Indicate the total cost of all employees (full-time, 35 hours or more per week; part-time and seasonal less than 35 hours per week)

Total Fringe: Indicate total cost of fringe associated with your employees. Fringe benefits must include FICA. This may also include unemployment insurance, worker's compensation, disability, pension, life insurance and medical coverage as per your policies.

Operations, Support and Equipment : Includes Supplies that are not lasting or permanent in nature, such as office, program and/or maintenance supplies. Purchase of equipment that is durable or permanent, such as furniture, printers, calculators, computers etc. The rental, lease, repair and maintenance of office/programmatic equipment utilized in the program's operation.
This also includes audit costs, postage, printing and publications, subscriptions, etc. Also include any other operating costs that cannot be classified in any other category.

Utilities: Cost related to utilities such as electricity, water, gas and telecommunications.

Professional Services: Cost associated with independent entities with professional or technical skills, such as accounting or legal services, that support vendor operations.

Contracted Services: Cost associated with independent entities with professional or technical skills retained to perform specific tasks or complete projects related to the program that cannot be accomplished by regular staff. Also, independent, usually nonprofit, entities retained to perform program services.

Indirect Costs: Costs related to overhead incurred by a contractor operating several programs.

Program Income: Anticipated income the program generates. This could be client fees or contributions, earned revenue, In-kind contribution, private match, or grant funds to support the program.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: whitmerg1@michigan.gov; Huls, JoAnne; Foster, Tricia; Totten, Mark; Pohl, Zack; Kolodin, Zach; Flood, Jennifer
Cc: Khaldun, Joneigh (DHHS); Darling, Darice (DHHS)
Subject: Response to orders
Date: Friday, December 4, 2020 6:29:00 AM
Attachments: EMR27069 - Michigan Survey Late November Study (002).pdf

---

Attached are the results of a survey of 2000 Michiganders from November 20 to December 1. The focus was vaccine attitudes and messaging, and you can see the big challenges ahead. We also added a few questions on the pause order (starting at page 55). Responses there are more encouraging.

We can hit the highlights in the meeting later but wanted you to have the whole thing.

Thanks,
Robert

Robert Gordon
Director, Michigan Department of Health & Human Services
gordonr3@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

Michigan Survey

November 2020

edison research

Michigan COVID-19 Survey:

Obtained via MI FOIA by Judicial Watch, Inc.

- 2006 online interviews with residents of Michigan, ages 14 and older
- Interviews conducted 11/20/20 through 12/1/20
- Data weighted to match the sex, age, ethnicity and region of MI residents

edison research

Survey Key finding:

Obtained via MI FOIA by Judicial Watch, Inc.

Mask behaviors

- Over three-quarters of Michigan residents report “always” wearing a mask when necessary. This figure changed very little throughout the weekly research waves conducted from September through early November
- There are clear demographic differences on self-reported mask-wearing behavior, with men more likely than women to be mask resistant, and those age 55+ significantly more likely to “always” wear a mask than those under age 55

edison research

Survey Key findings:

Obtained via MI FOIA by Judicial Watch, Inc.

Vaccine attitudes

- There is significant reluctance toward Covid-19 vaccine adoption, with 66% saying they are likely to get a COVID-19 vaccine, but only 43% “very likely”
- Attitudes toward the Covid-19 vaccine vary widely by demographic group, with more men saying they are “very likely” to get the vaccine (51%) than women (35%)
- Age is a key factor in how likely someone is to get the vaccine, with over 62% of respondents 65+ reporting that they are “very likely” to get the vaccine (higher than younger age groups)
- There are also striking differences in vaccine adoption by race, with white respondent’s almost far more likely to say they are “very likely” (47%) to get the vaccine than are black respondents (25%)

edison research

Survey Key findings:

Obtained via MI FOIA by Judicial Watch, Inc.

“Pause to Save Lives” campaign awareness and influence

- 89% of the sample were aware of the new emergency order that limited indoor gatherings starting on November 18th
- 84% of the sample thought the new order was helpful, with 38% saying “very helpful”
- Those age 45-64, and those who were Black were more likely to say the new order was “very helpful” in reducing the spread of COVID-19; Hispanics were significantly less likely to say the order was “very helpful”
- 48% of the sample said the new order make them less likely to attend indoor gatherings; 41% said it had no effect
- Those age 65+, and those who were Black were more likely to say the new order made them less likely to attend indoor gatherings

edison research

Survey Key findings:

Obtained via MI FOIA by Judicial Watch, Inc.

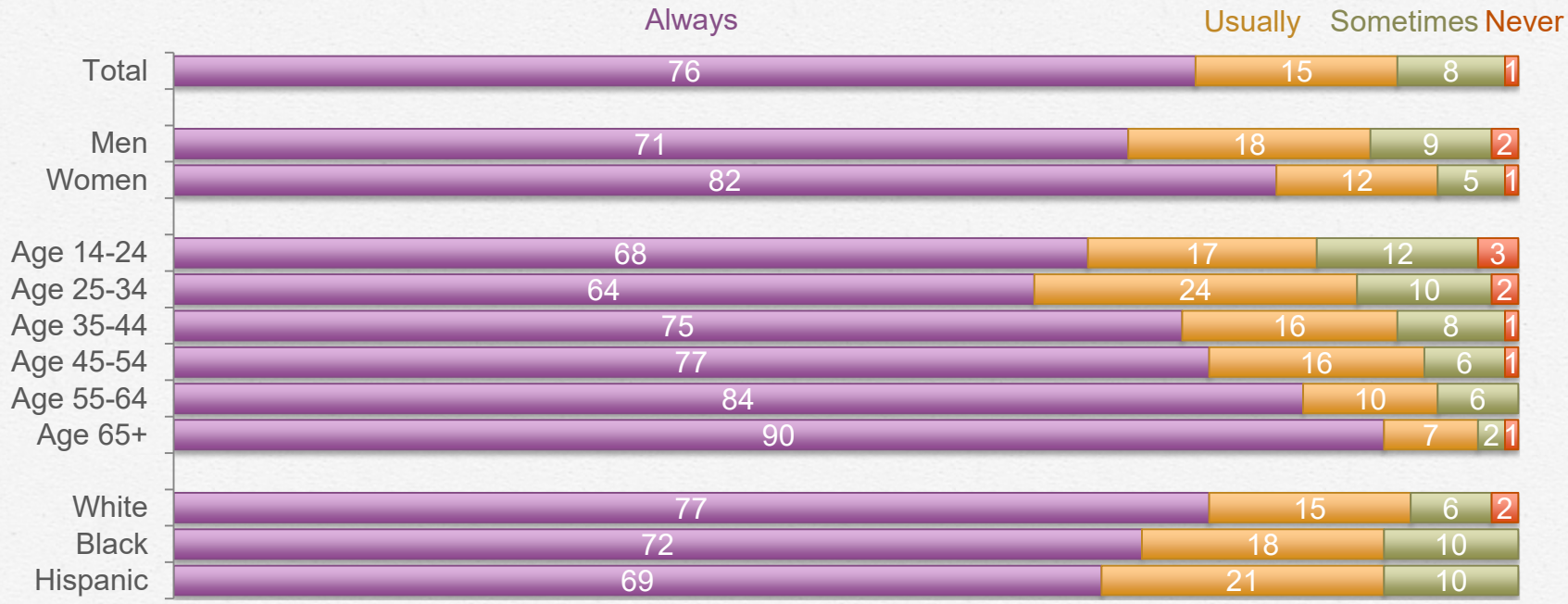
Vaccine campaign preferences

- None of the eight campaign messages received much negative feedback
- “Smallpox, polio, now COVID-19: Vaccines have a long history of hope and healing” received the highest ratings, though only by one point (it was the favorite among older age groups, and the second to least favorite among Hispanics)

edison research

In general, how often do you wear a mask or facial covering in indoor public spaces and in crowded outdoor places?

Obtained via MI FOIA by Judicial Watch, Inc.



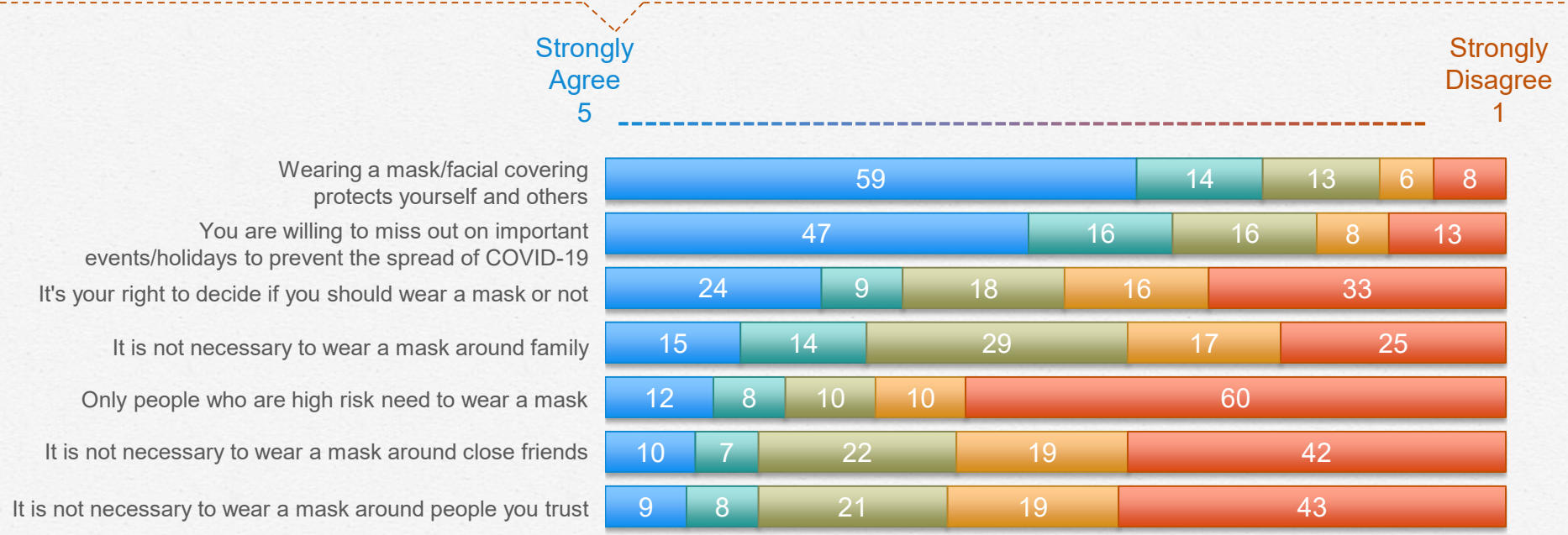
edison research

Survey conducted 11/20/20-12/1/20

Agree/Disagree:

Obtained via MI FOIA by Judicial Watch, Inc.

"How much do you disagree or agree with each of the following statements?

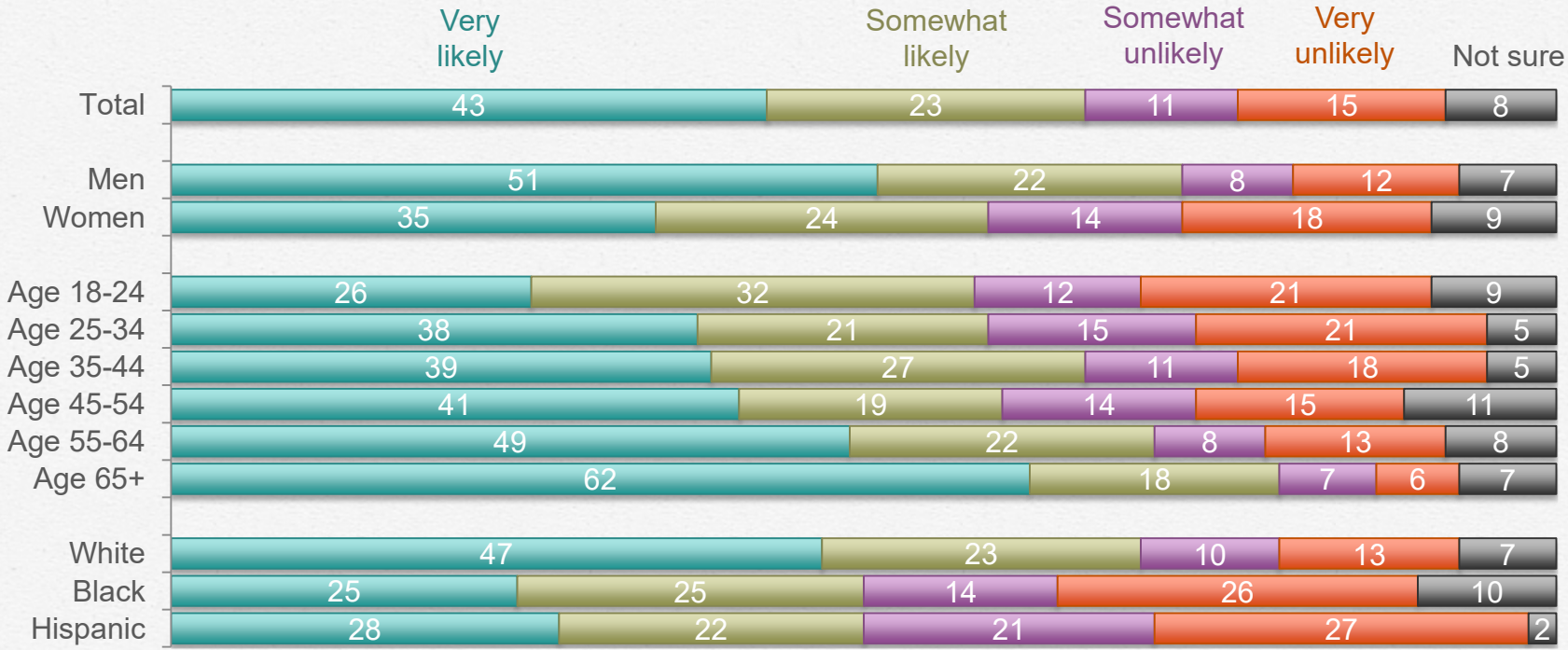


edison research

Survey conducted 11/20/20-12/1/20

If a vaccine for COVID-19 becomes available, how likely would you be to get it?

Obtained via MI FOIA by Judicial Watch, Inc.

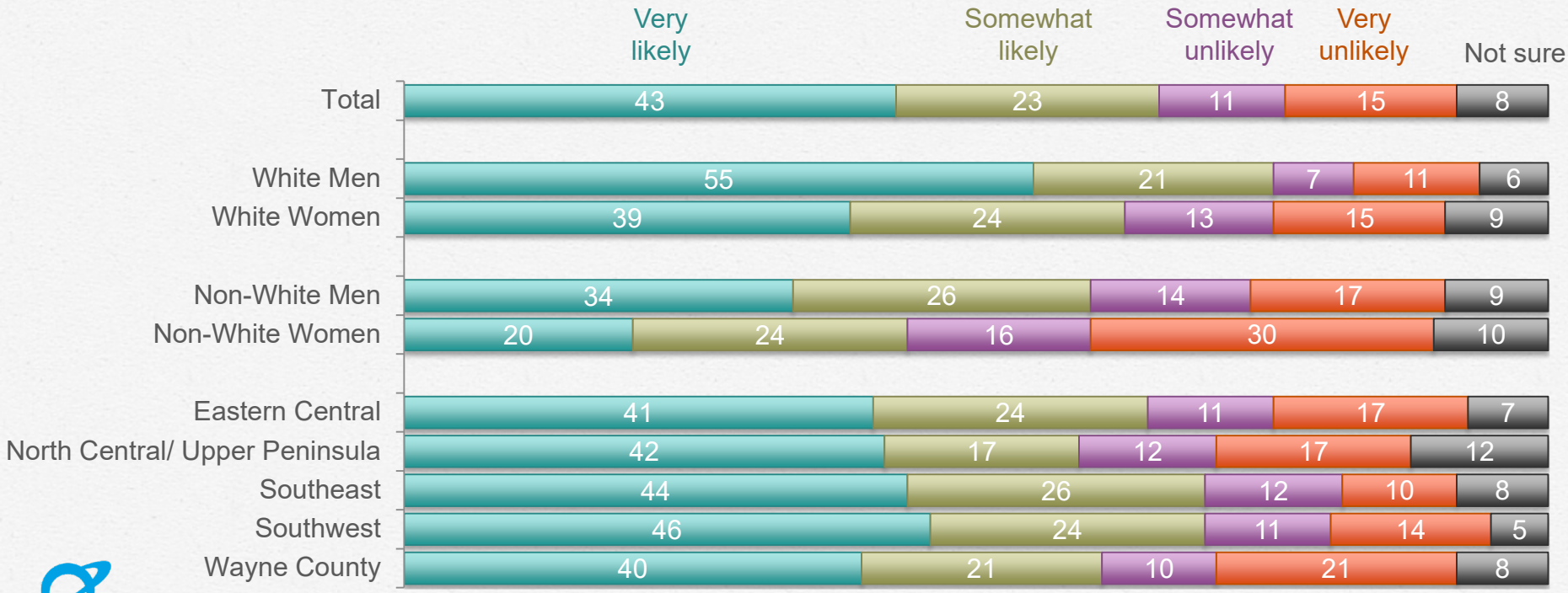


edison research

Survey conducted 11/20/20-12/1/20
Base: Age 18 and older

If a vaccine for COVID-19 becomes available, how likely would you be to get it?

Obtained via MI FOIA by Judicial Watch, Inc.



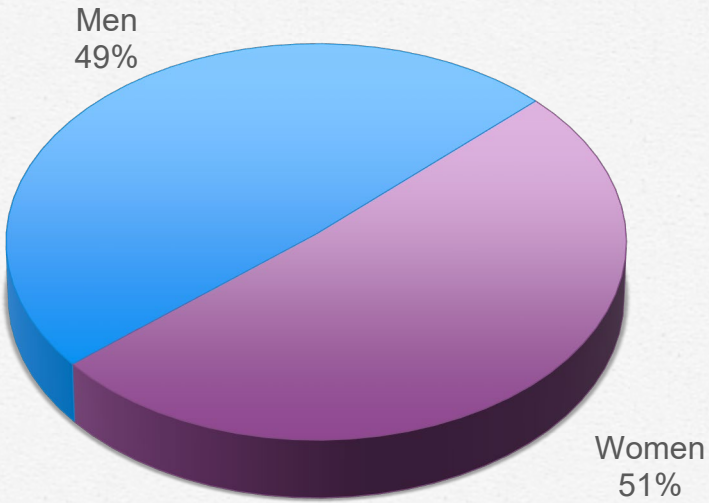
edison research

Survey conducted 11/20/20-12/1/20
Base: Age 18 and older

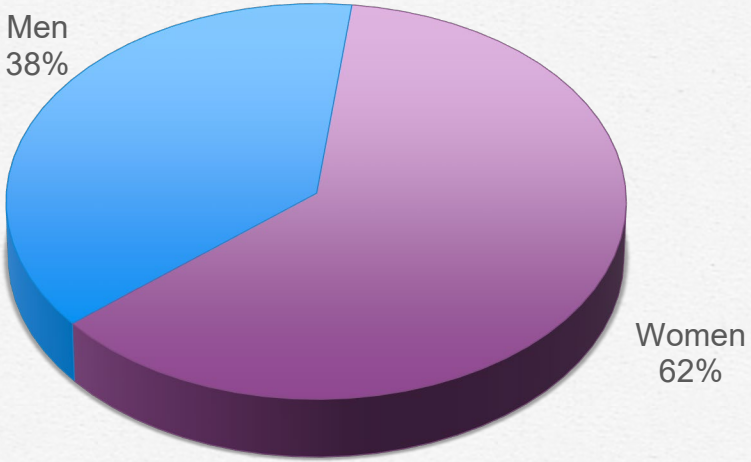
Gender of those who are “somewhat” or “very” unlikely to get vaccine

Obtained via MI FOIA by Judicial Watch, Inc.

Total Sample



Unlikely to Get Vaccine



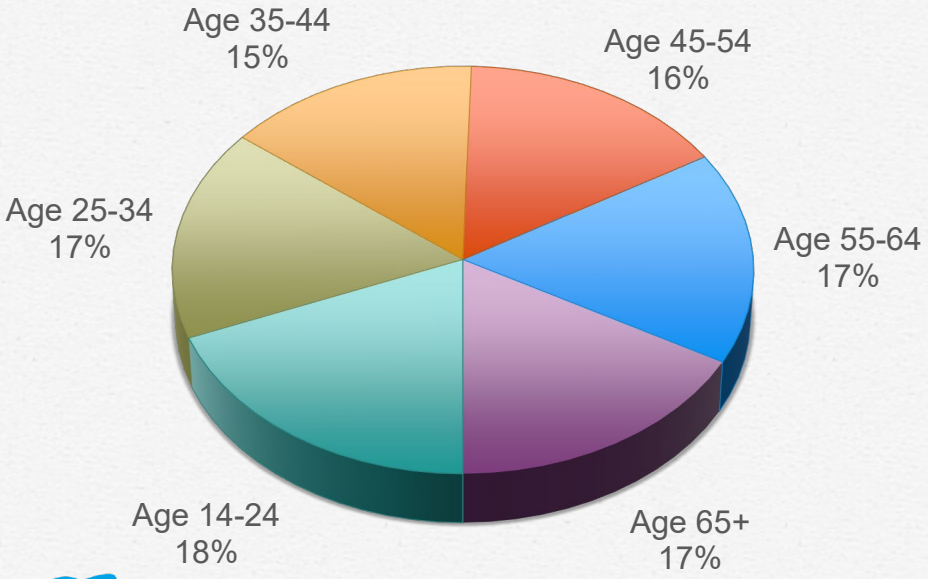
edison research

Survey conducted 11/20/20-12/1/20

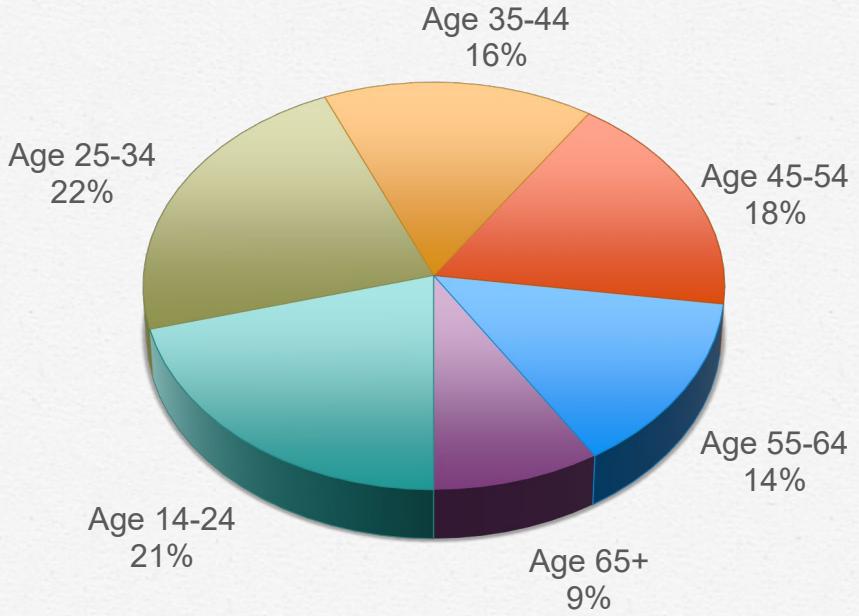
Age of those who are “somewhat” or “very” unlikely to get vaccine

Obtained via MI FOIA by Judicial Watch, Inc.

Total Sample



Unlikely to Get Vaccine



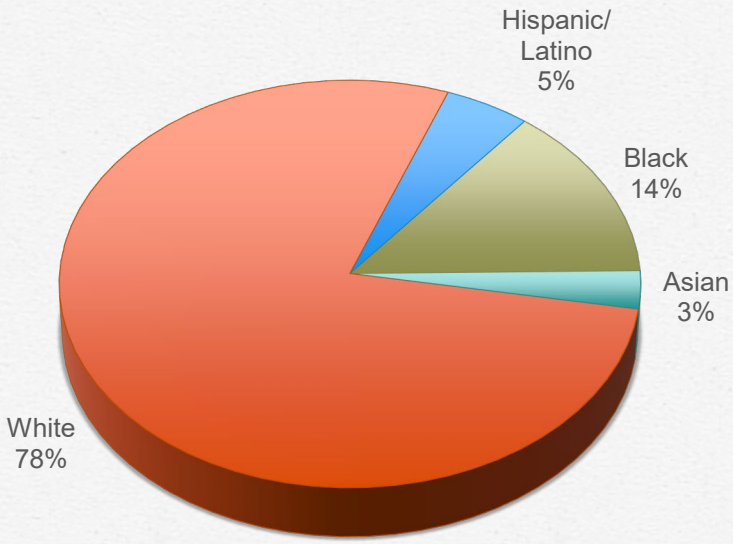
edison research

Survey conducted 11/20/20-12/1/20

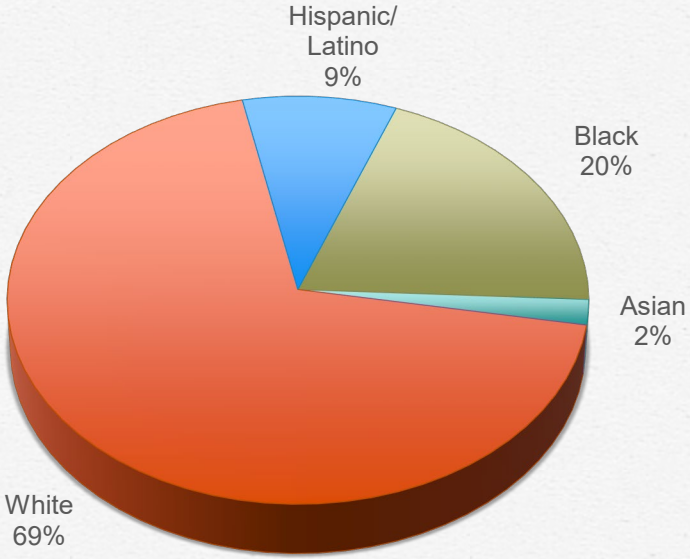
Ethnicity of those who are “somewhat” or “very” unlikely to get vaccine

Obtained via MI FOIA by Judicial Watch, Inc.

Total Sample



Unlikely to Get Vaccine



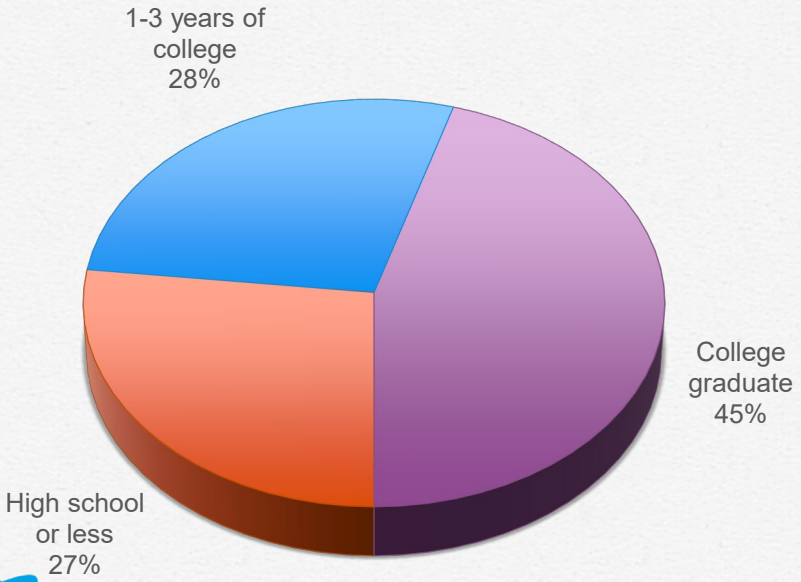
edison research

Survey conducted 11/20/20-12/1/20

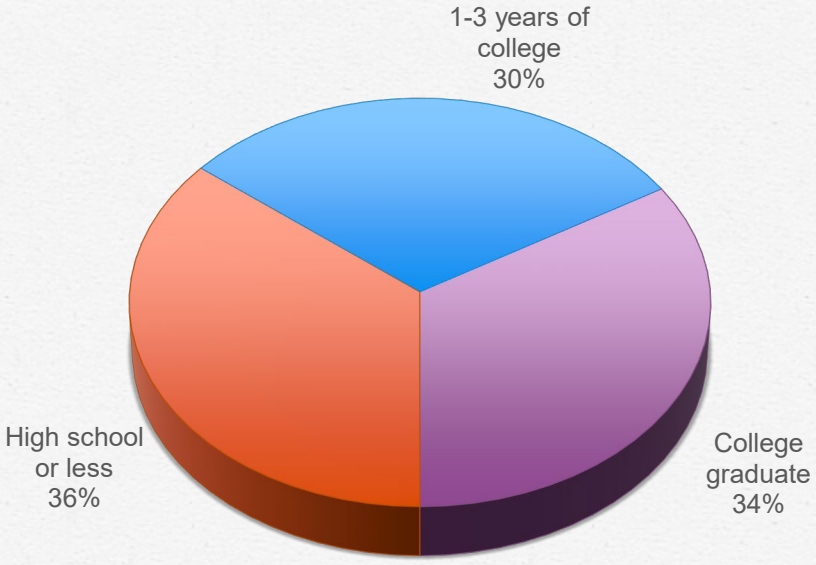
Education of those who are “somewhat” or “very” unlikely to get vaccine

Obtained via MI FOIA by Judicial Watch, Inc.

Total Sample



Unlikely to Get Vaccine



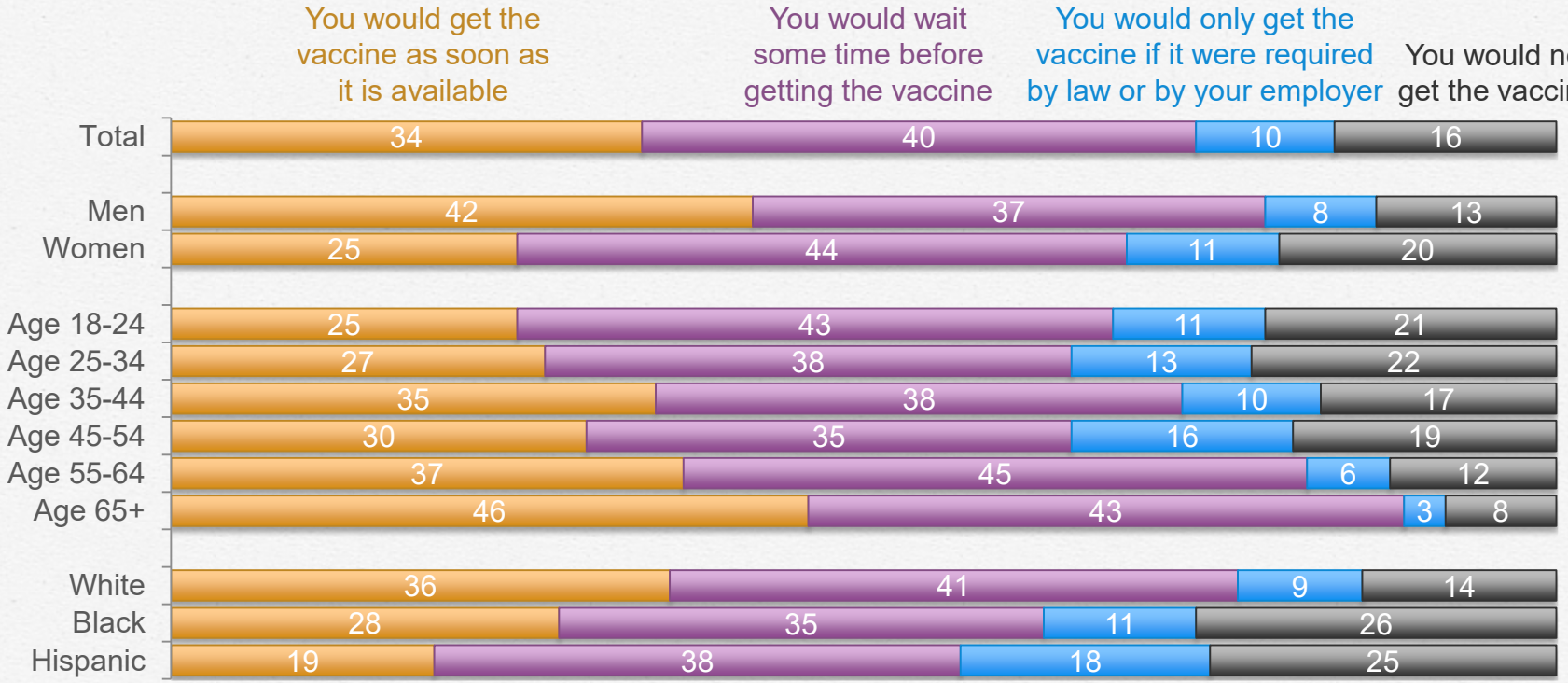
edison research

Survey conducted 11/20/20-12/1/20

Base: Age 18 and older and gave an answer

If a vaccine for COVID-19 becomes available, which of the following best describes when you would receive it?

Obtained via MI FOIA by Judicial Watch, Inc.

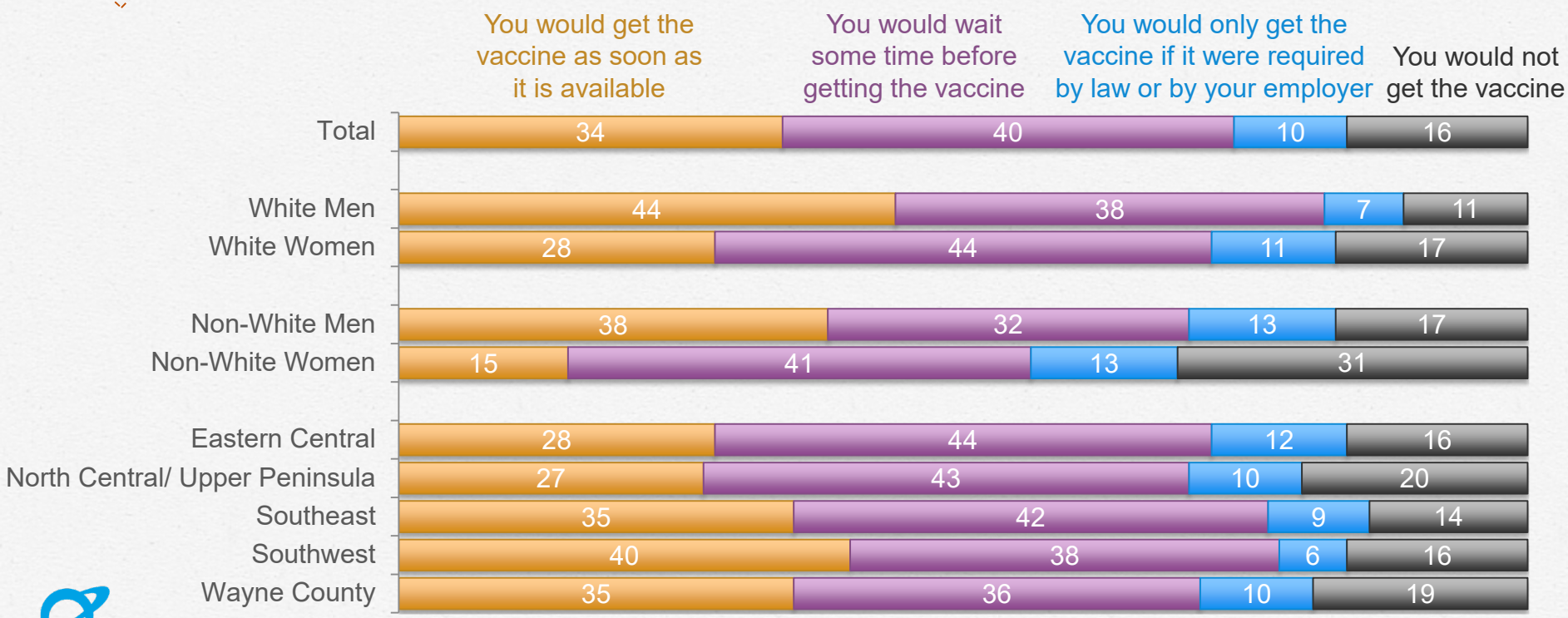


edison research

Survey conducted 11/20/20-12/1/20
Base: Age 18 and older

If a vaccine for COVID-19 becomes available, which of the following best describes when you would receive it?

Obtained via MI FOIA by Judicial Watch, Inc.

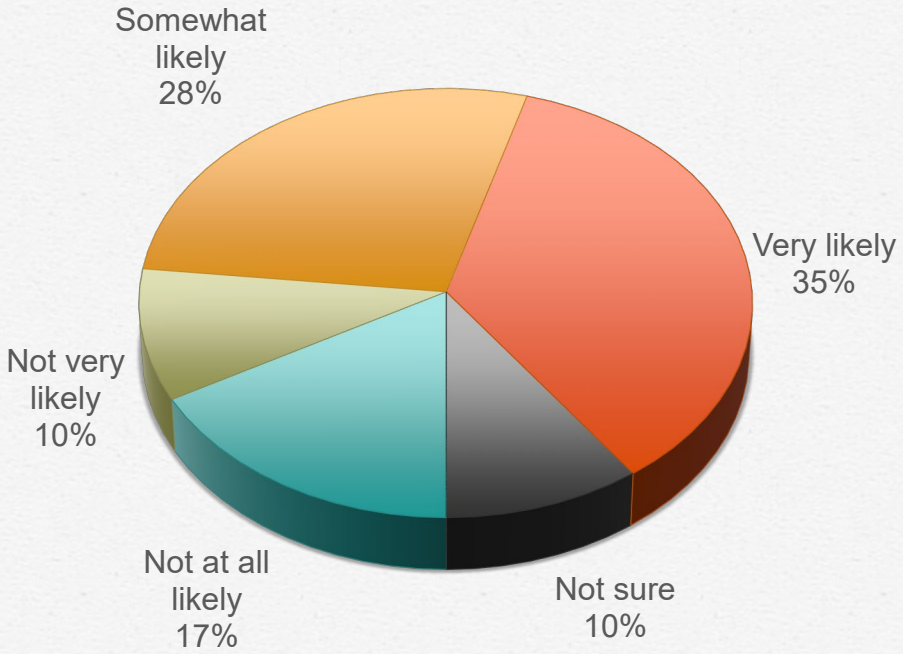


edison research

Survey conducted 11/20/20-12/1/20
Base: Age 18 and older

If a vaccine for COVID-19 becomes available, how likely is it that your children will get the vaccine?

Obtained via MI FOIA by Judicial Watch, Inc.

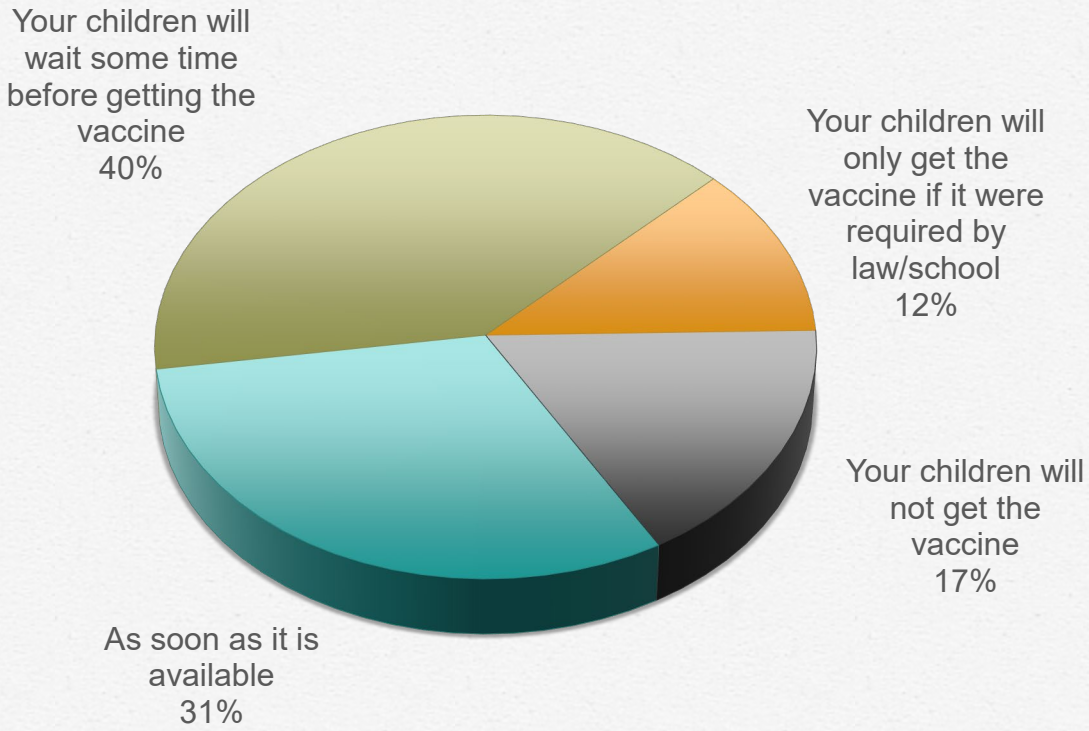


edison research

Survey conducted 11/20/20-12/1/20
Base: Parent or guardian of children under 18; 29%

If a vaccine for COVID-19 becomes available, which of the following best describes when your children will receive it?

Obtained via MI FOIA by Judicial Watch, Inc.

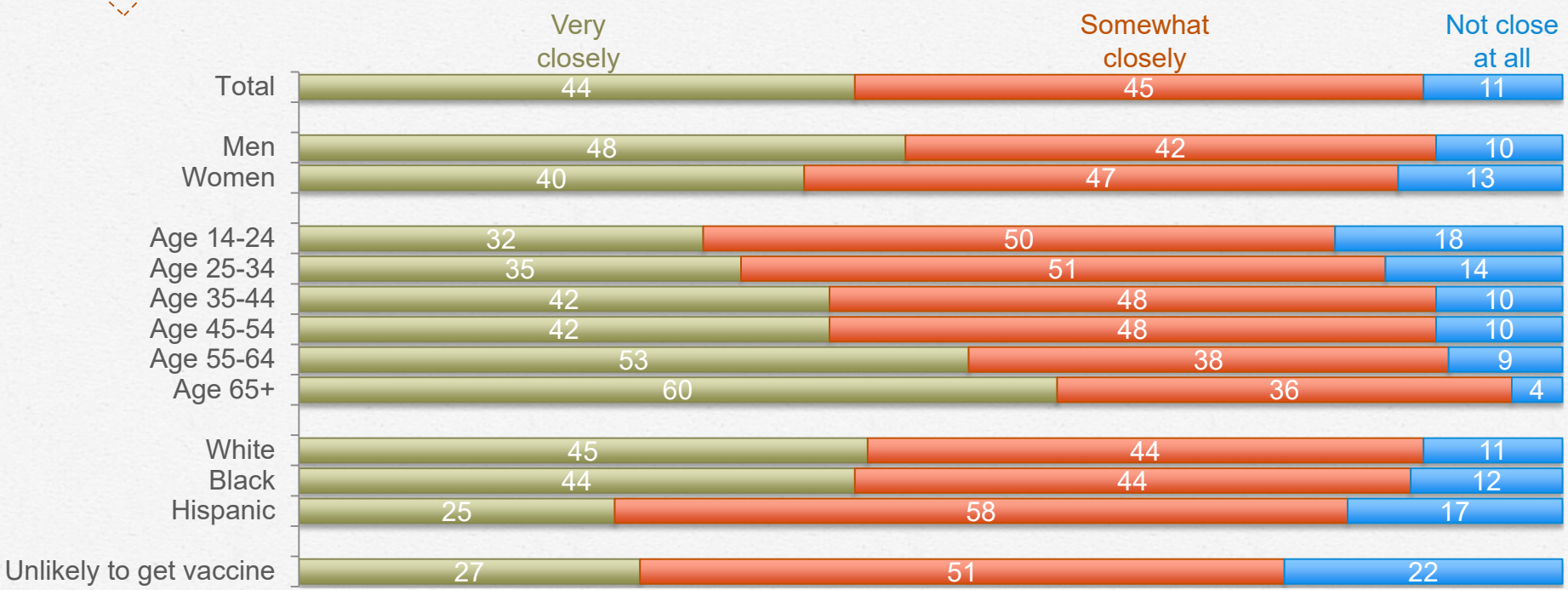


edison research

Survey conducted 11/20/20-12/1/20
Base: Parent or guardian of children under 18; 29%

How closely are you following news about the development of COVID-19 vaccines?

Obtained via MI FOIA by Judicial Watch, Inc.

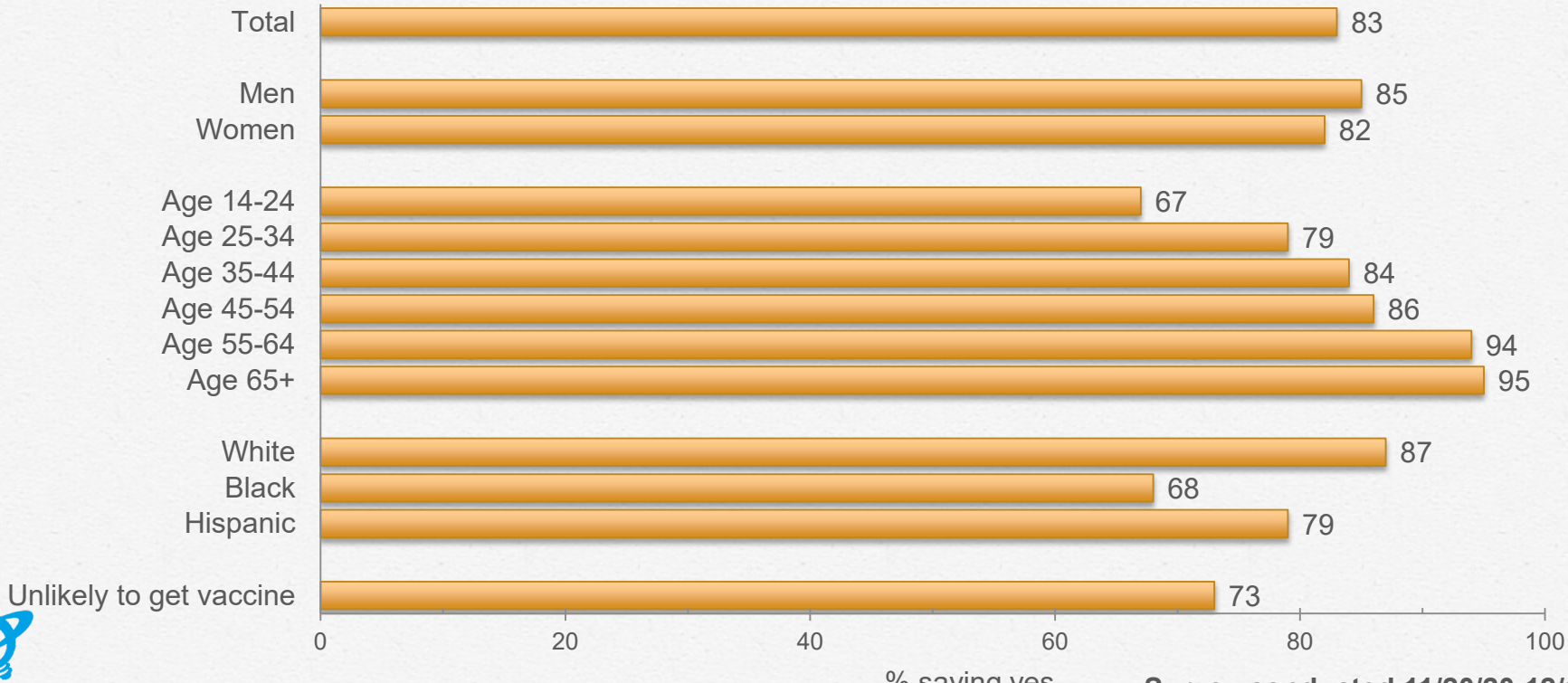


edison research

Survey conducted 11/20/20-12/1/20

Are you aware that preliminary trials for COVID-19 vaccines have been reported to be at least 95% effective?

Obtained via MI FOIA by Judicial Watch, Inc.

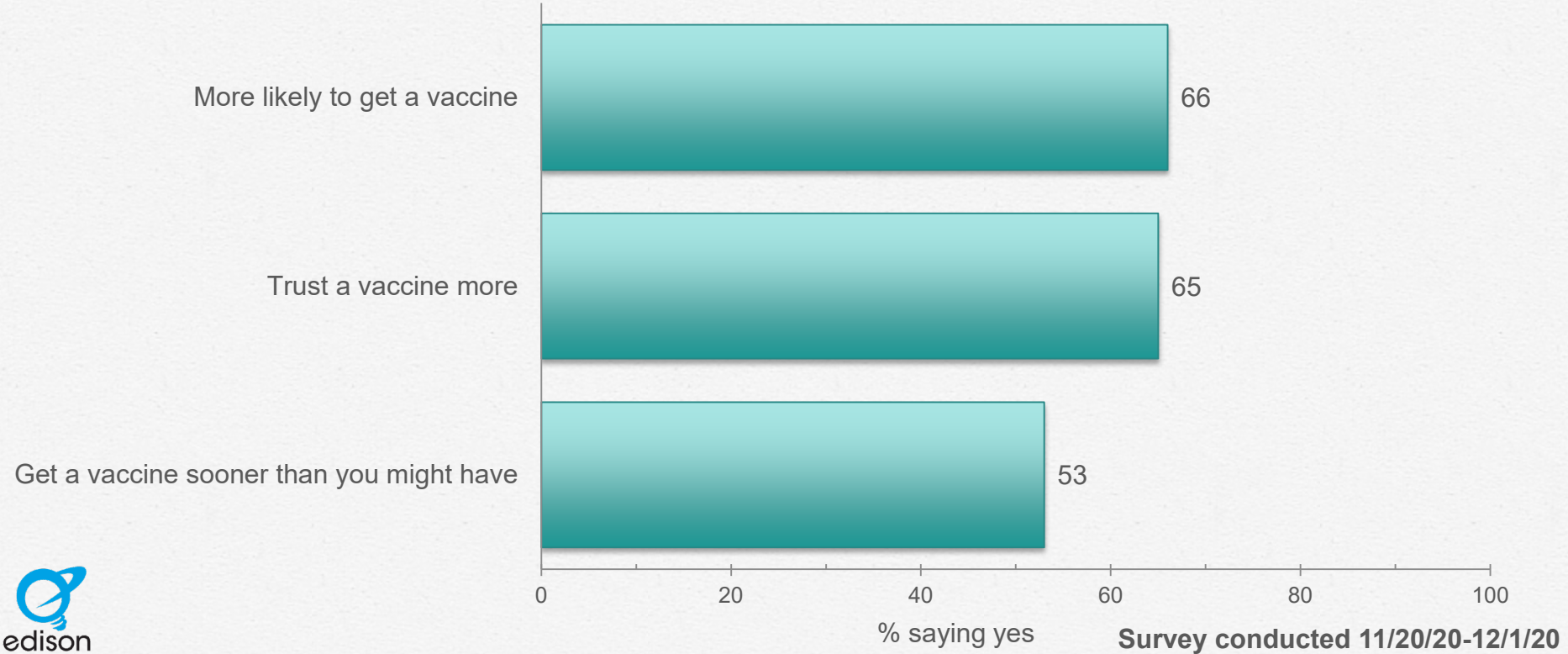


edison research

Survey conducted 11/20/20-12/1/20

Will positive reports about the effectiveness of COVID-19 vaccines make you…?

Obtained via MI FOIA by Judicial Watch, Inc.

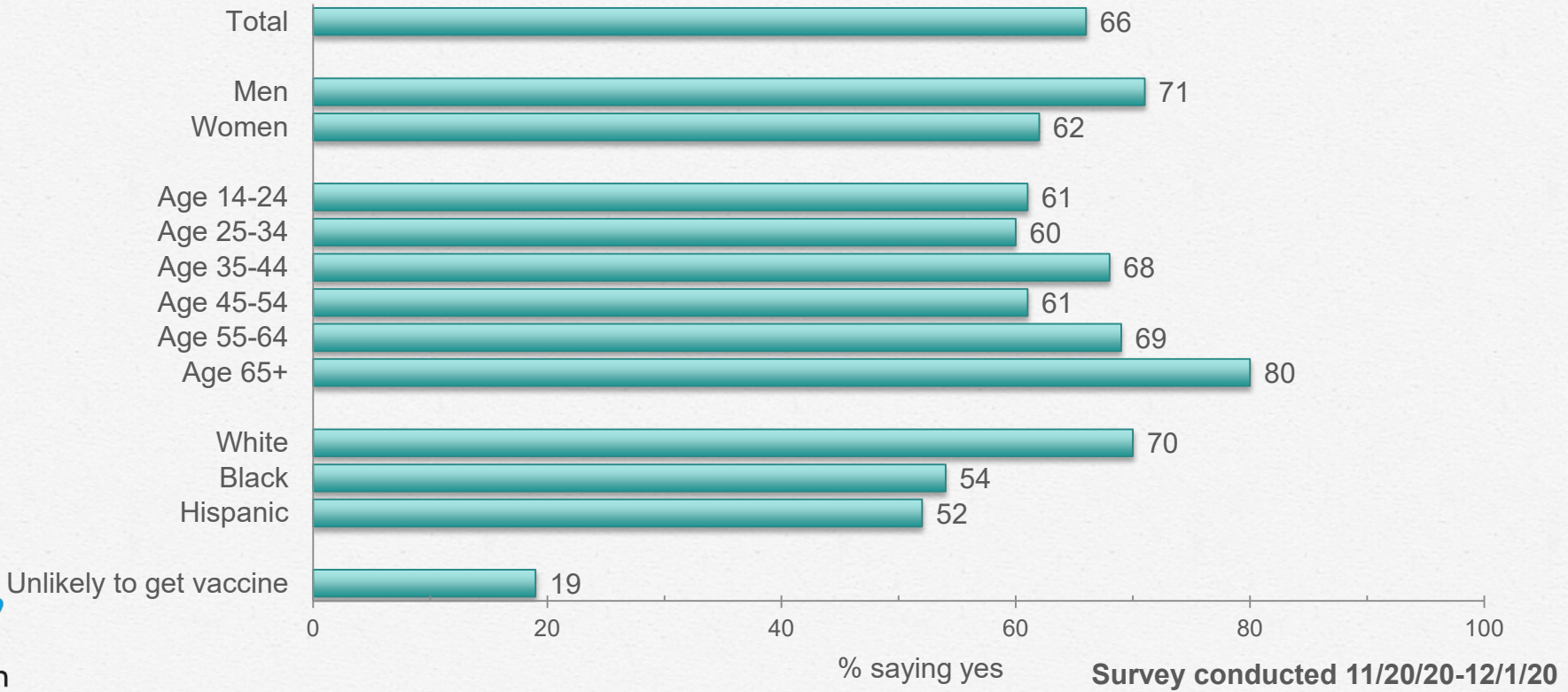


Survey conducted 11/20/20-12/1/20

edison research

Will positive reports about the effectiveness of COVID-19 vaccines make you more likely to get a vaccine?

Obtained via MI FOIA by Judicial Watch, Inc.

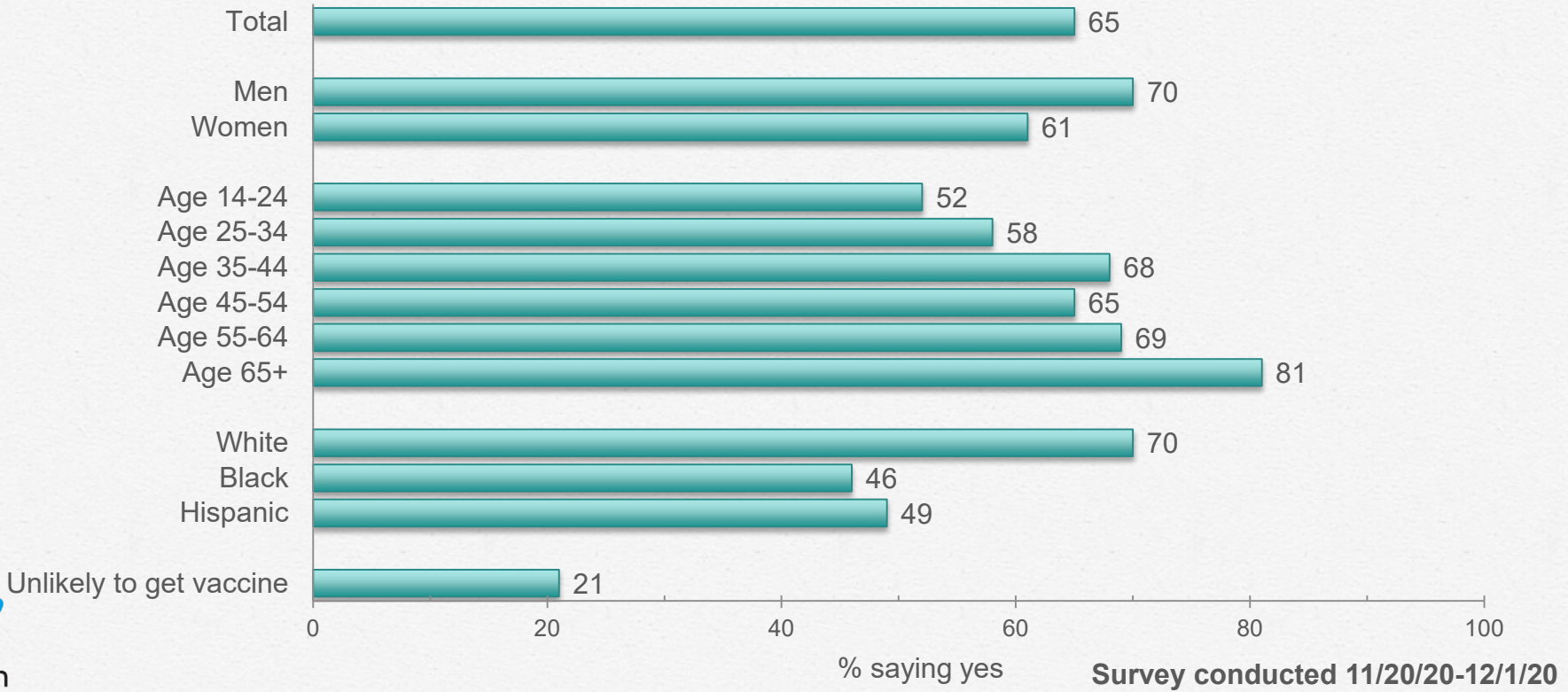


edison research

Survey conducted 11/20/20-12/1/20

Will positive reports about the effectiveness of COVID-19 vaccines make you trust a vaccine more?

Obtained via MI FOIA by Judicial Watch, Inc.

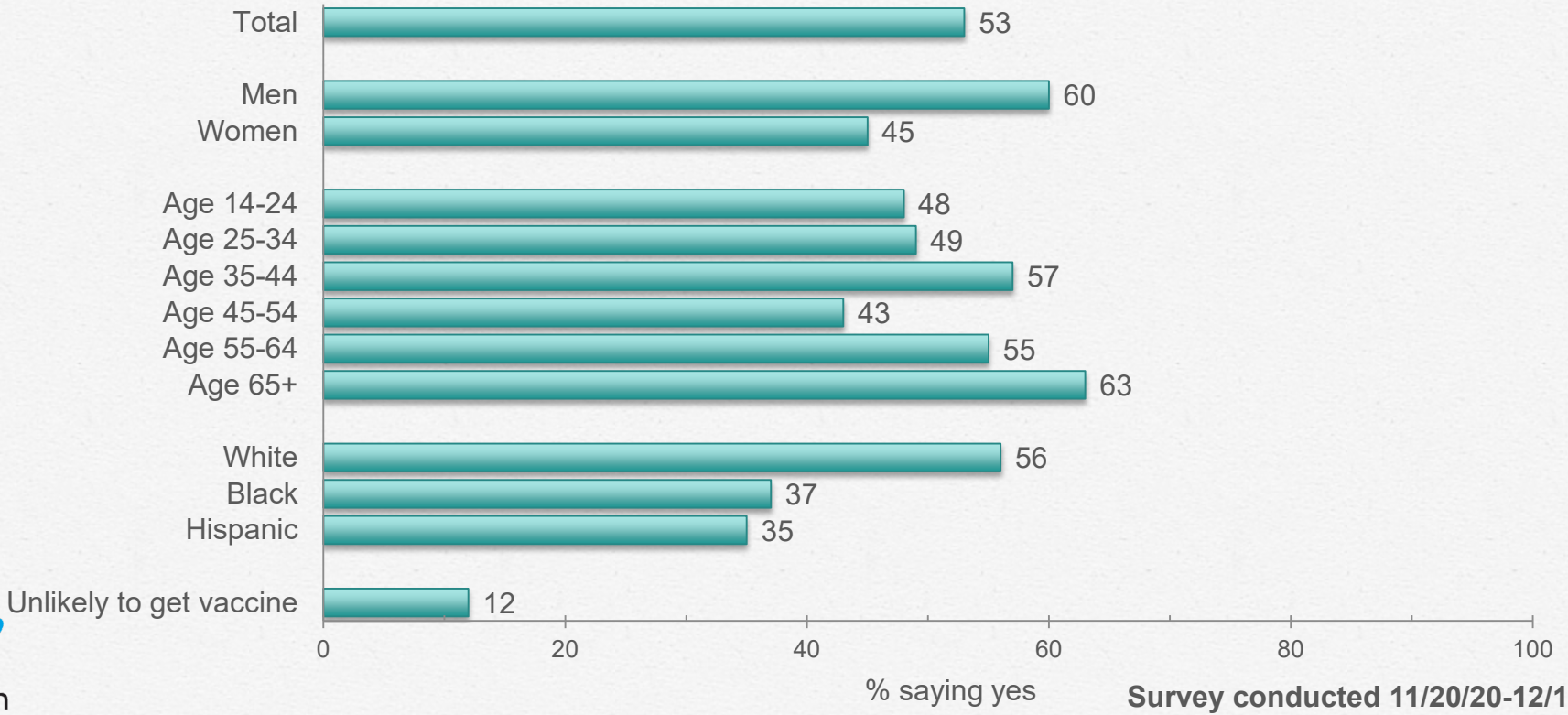


edison research

Survey conducted 11/20/20-12/1/20

Will positive reports about the effectiveness of COVID-19 vaccines make you get a vaccine sooner than you might have?

Obtained via MI FOIA by Judicial Watch, Inc.



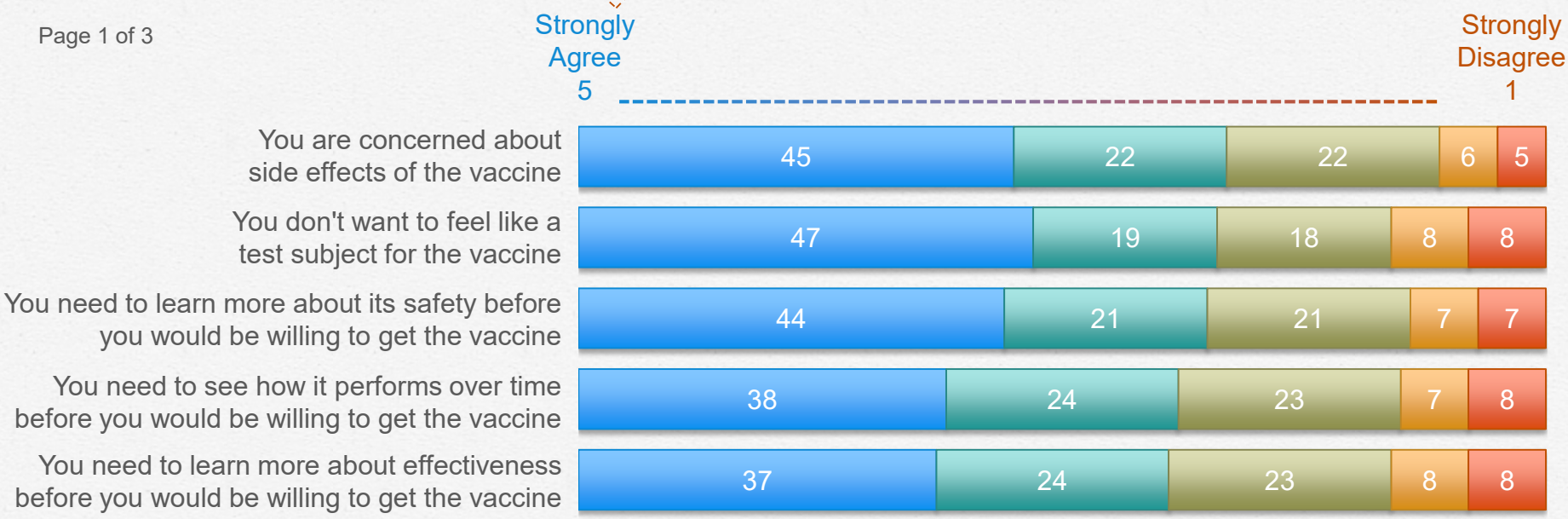
edison research

Survey conducted 11/20/20-12/1/20

Reasons for not getting vaccine as soon as possible:

Obtained via FOIA by Judicial Watch, Inc.

"How much do you disagree or agree with each of the following statements?



edison research

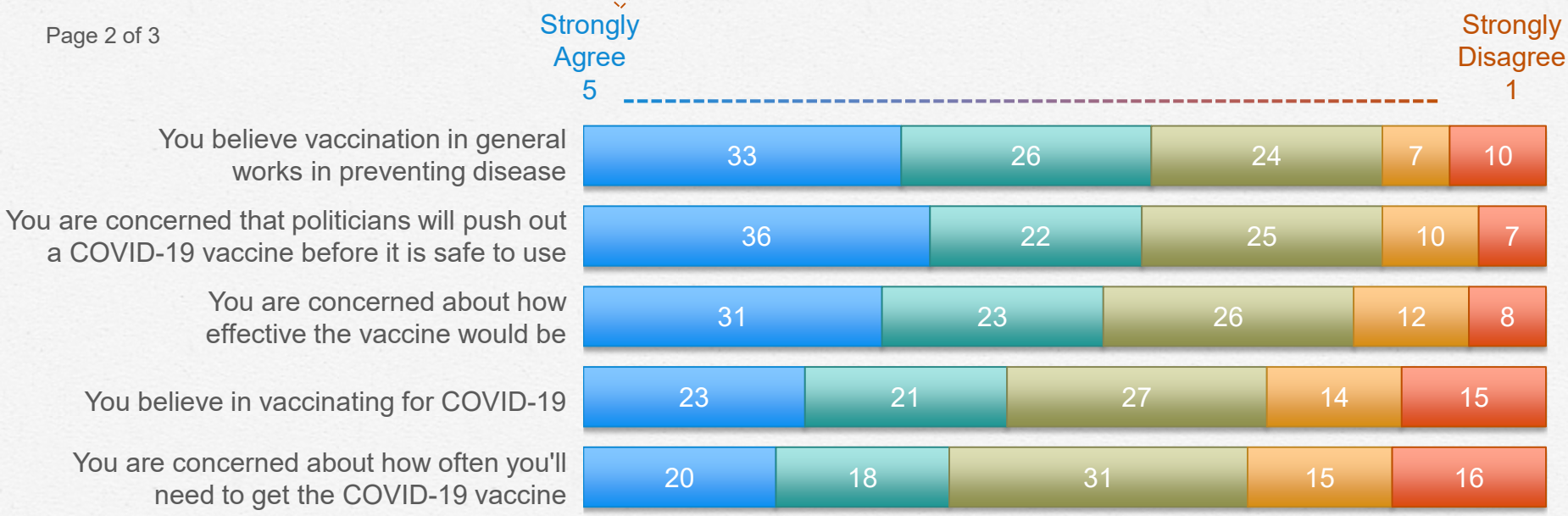
Survey conducted 11/20/20-12/1/20

Base: Age 18 and older and would not get vaccine as soon as possible

Reasons for not getting vaccine as soon as possible:

Obtained via FOIA by Judicial Watch, Inc.

"How much do you disagree or agree with each of the following statements?



edison research

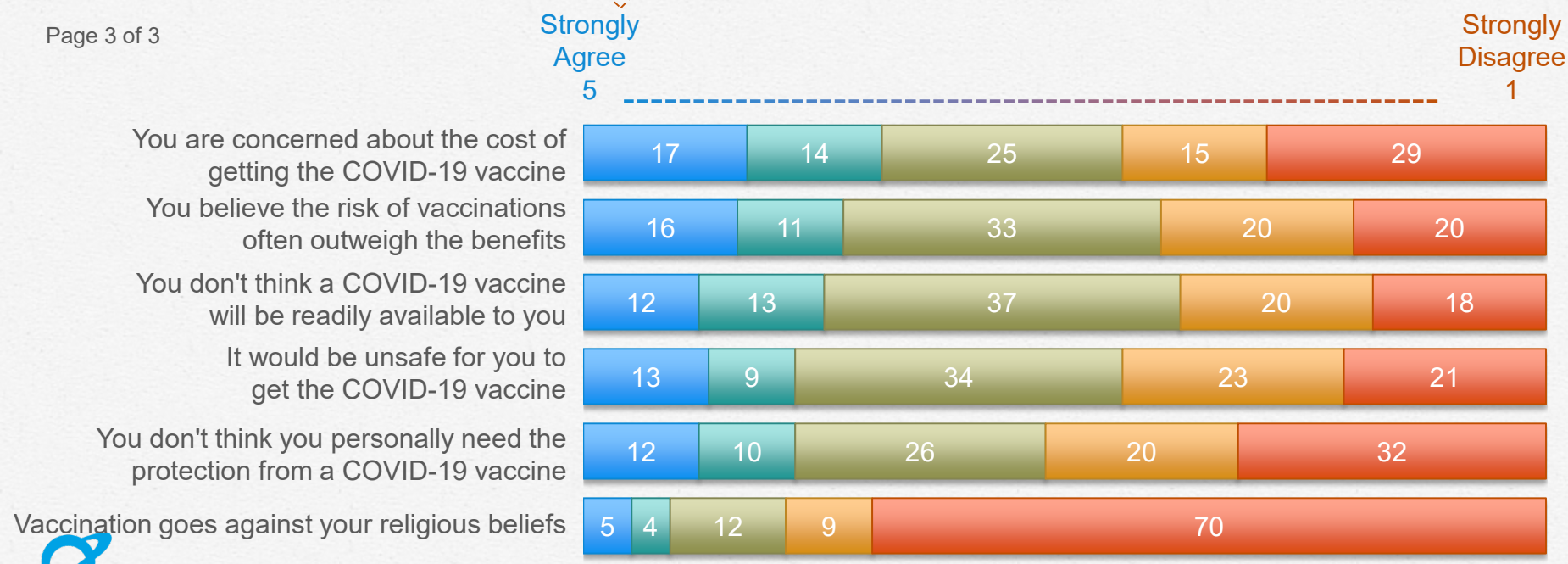
Survey conducted 11/20/20-12/1/20

Base: Age 18 and older and would not get vaccine as soon as possible

Reasons for not getting vaccine as soon as possible:

Obtained via FOIA by Judicial Watch, Inc.

"How much do you disagree or agree with each of the following statements?



edison research

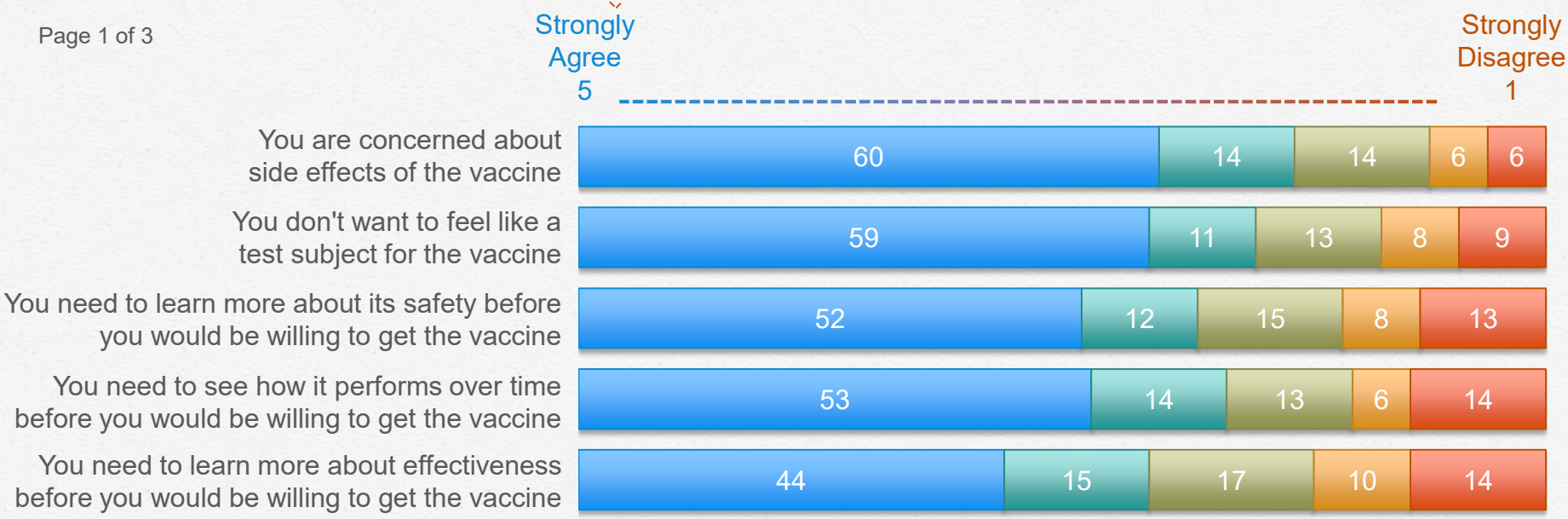
Survey conducted 11/20/20-12/1/20

Base: Age 18 and older and would not get vaccine as soon as possible

Reasons for not getting vaccine as soon as possible: ("Not very" or "Not at all" likely to get vaccine)

Obtained via MI FOIA by Judicial Watch, Inc.

"How much do you disagree or agree with each of the following statements?



edison research

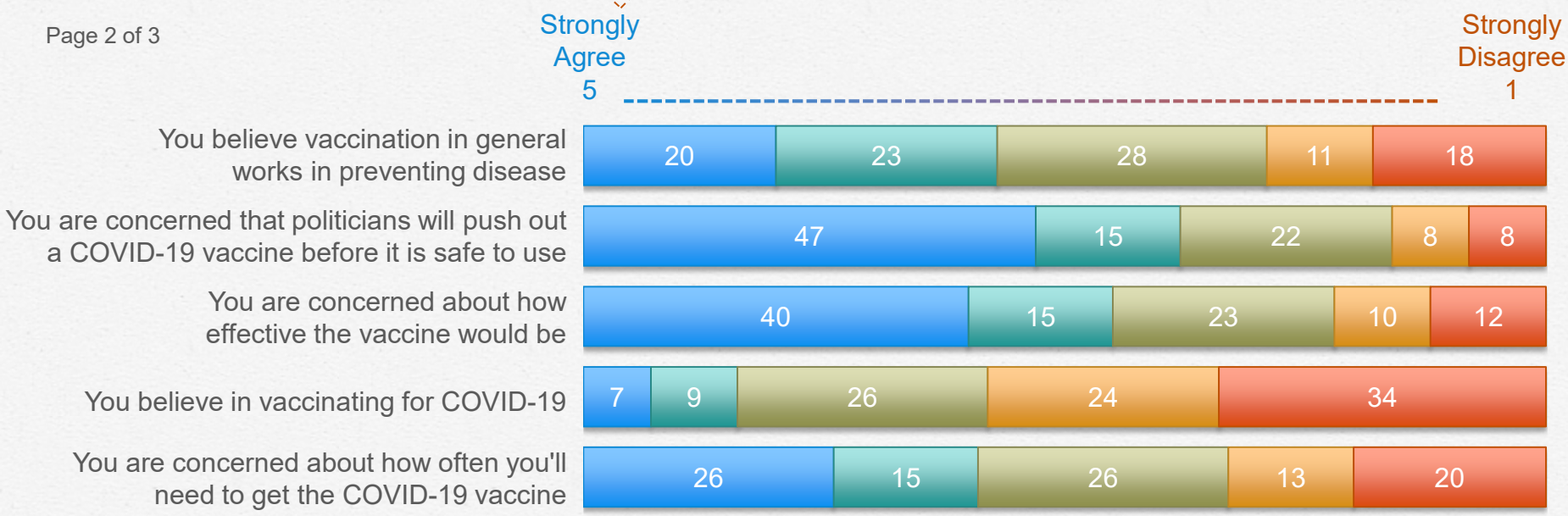
Survey conducted 11/20/20-12/1/20

Base: Age 18 and older and would not get vaccine as soon as possible

Reasons for not getting vaccine as soon as possible: ("Somewhat" or "Very" unlikely to get vaccine)

Obtained via MI FOIA by Judicial Watch, Inc.

"How much do you disagree or agree with each of the following statements?



edison research

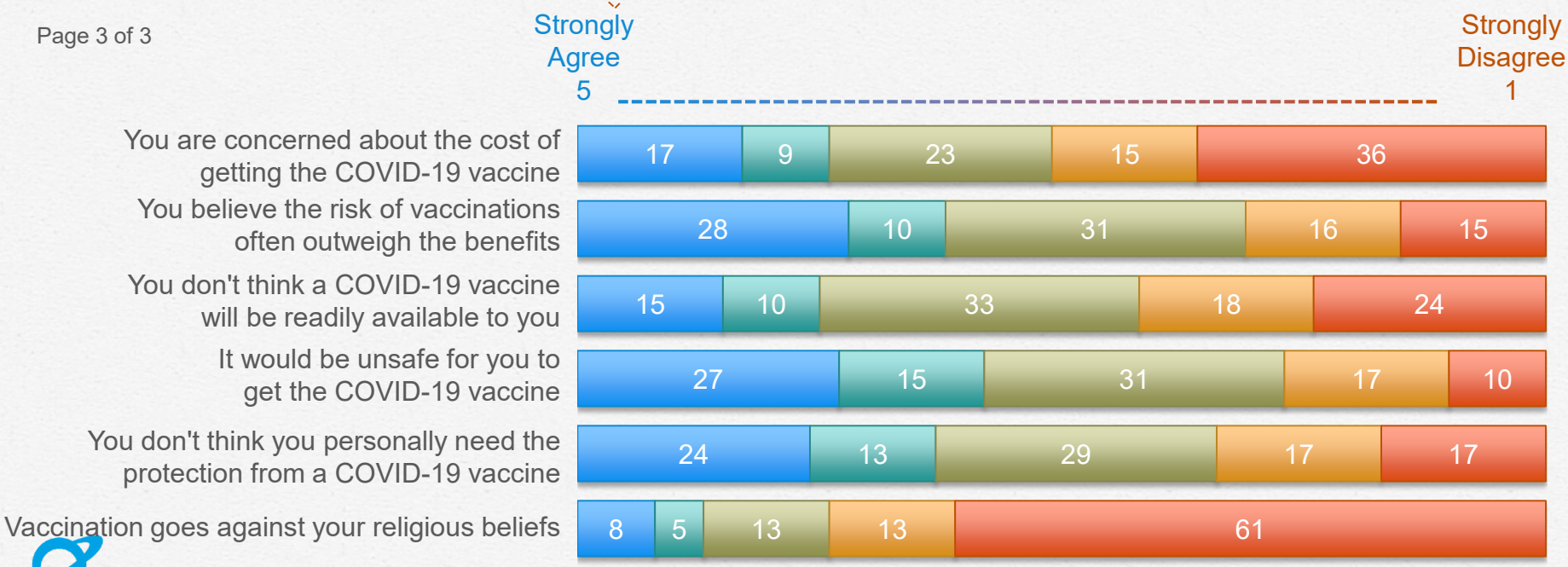
Survey conducted 11/20/20-12/1/20

Base: Age 18 and older and would not get vaccine as soon as possible

Reasons for not getting vaccine as soon as possible: ("Somewhat" or "Very" unlikely to get vaccine)

Obtained via MI FOIA by Judicial Watch, Inc.

"How much do you disagree or agree with each of the following statements?



edison research

Survey conducted 11/20/20-12/1/20

Base: Age 18 and older and would not get vaccine as soon as possible

Obtained via MI FOIA by Judicial Watch, Inc.

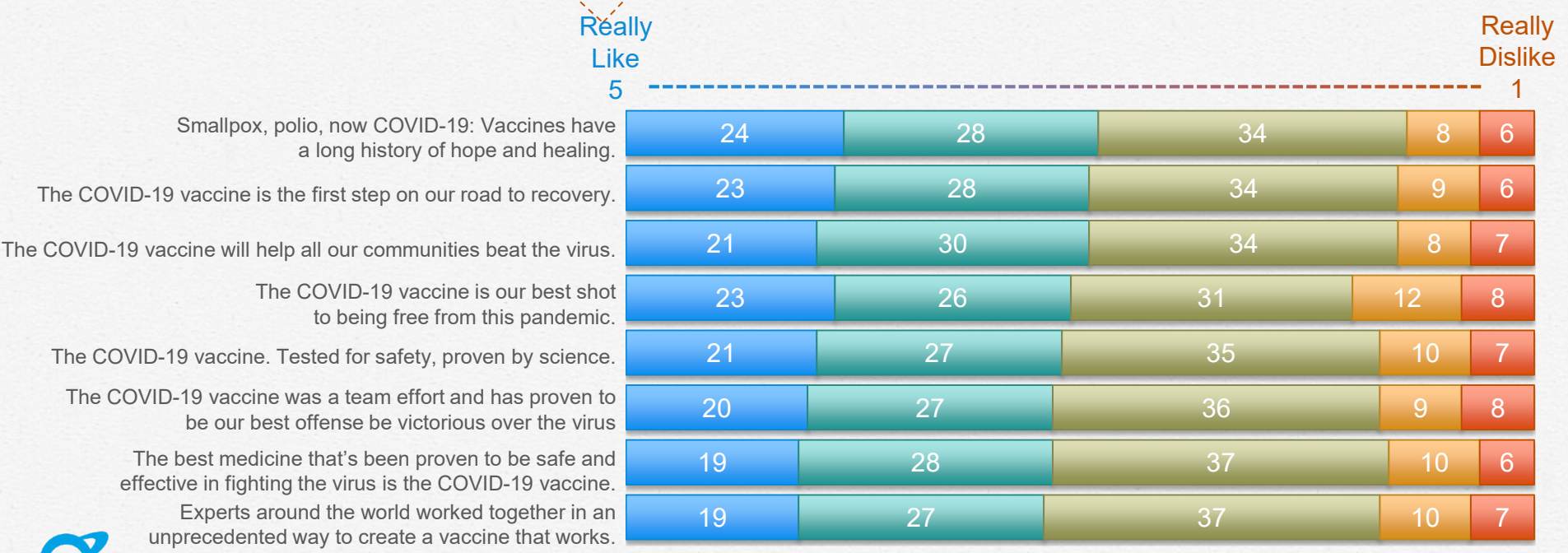
Message Rating



Message Preference:

Obtained via MI FOIA by Judicial Watch, Inc.

"How much do you like or dislike the message you just read?"



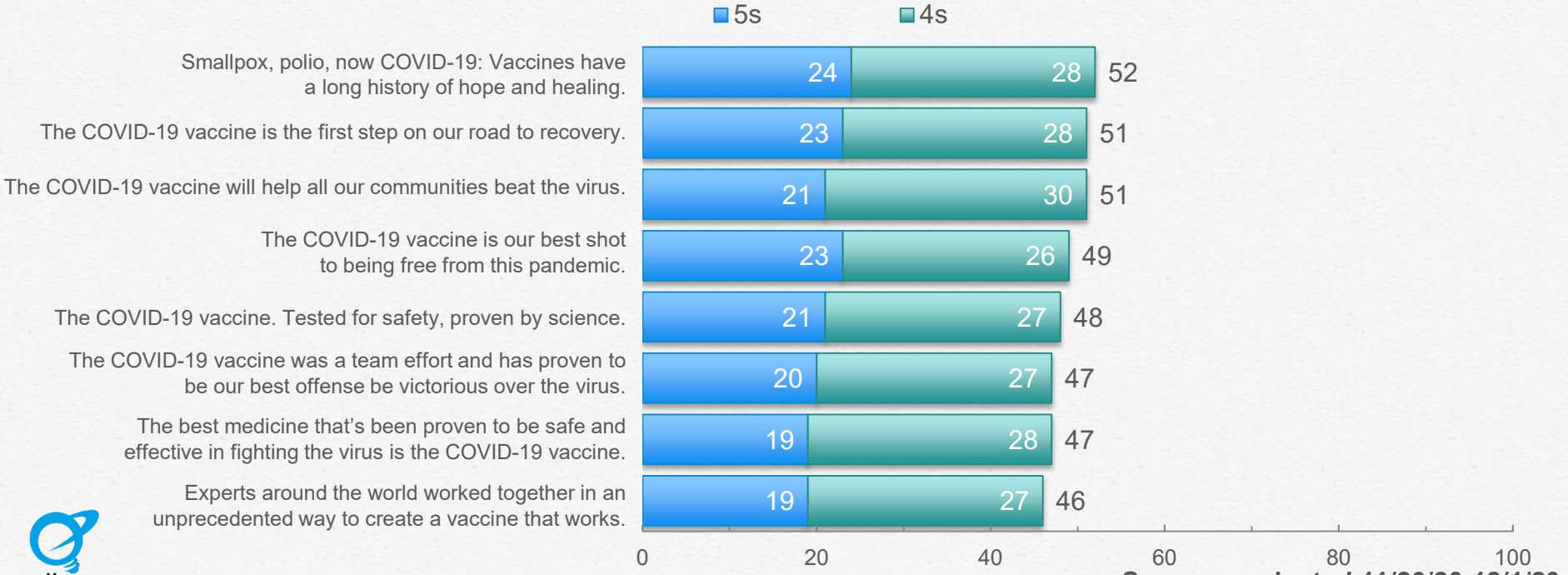
edison research

Survey conducted 11/20/20-12/1/20

Message Preference:

Obtained via MI FOIA by Judicial Watch, Inc.

% Liking message ('4' or '5' on a 5-point scale)



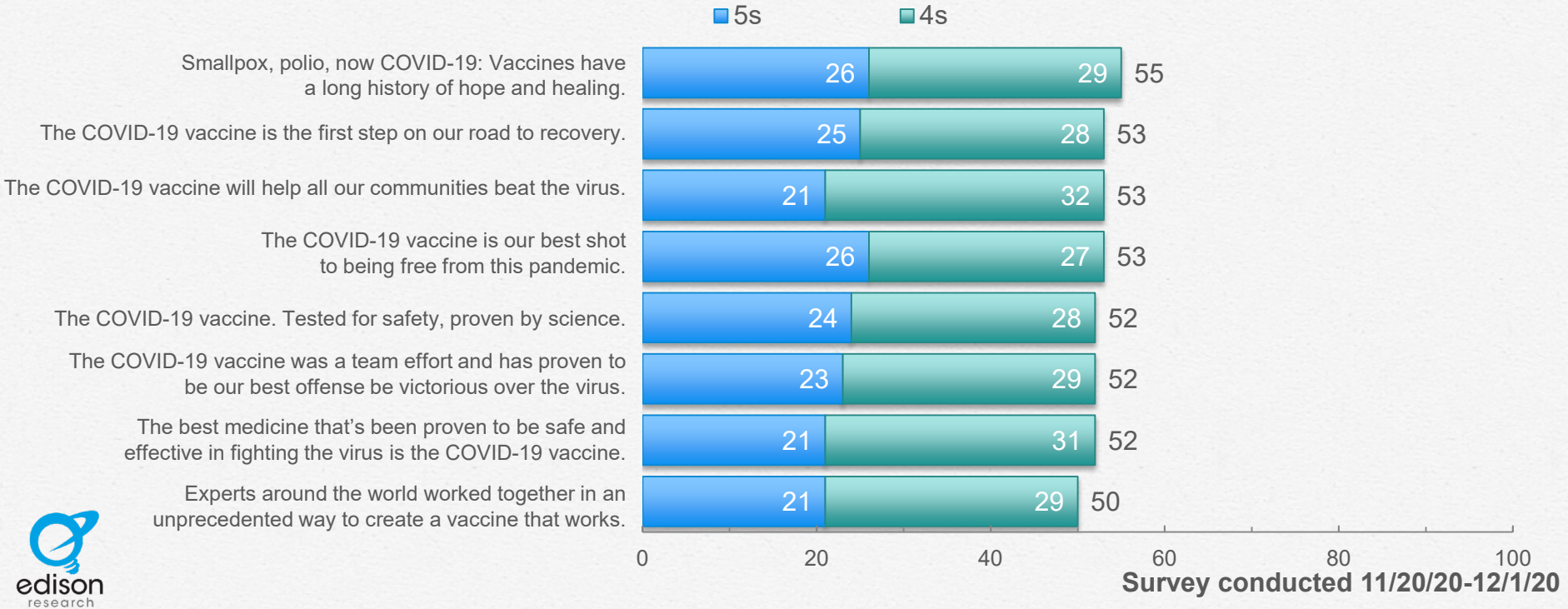
Survey conducted 11/20/20-12/1/20

edison research

Message Preference: (Men)

Obtained via MI FOIA by Judicial Watch, Inc.

% Liking message ('4' or '5' on a 5-point scale)



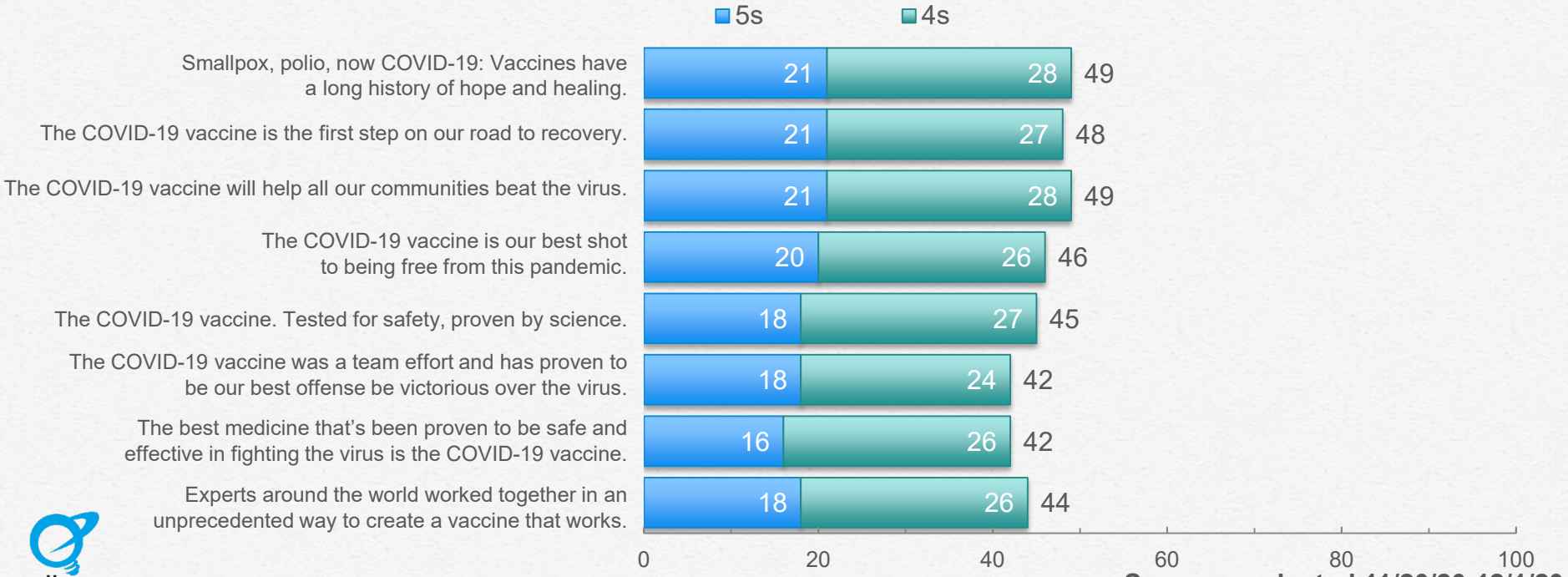
Survey conducted 11/20/20-12/1/20

edison research

Message Preference: (Women)

Obtained via MR FOIA by Judicial Watch, Inc.

% Liking message ('4' or '5' on a 5-point scale)



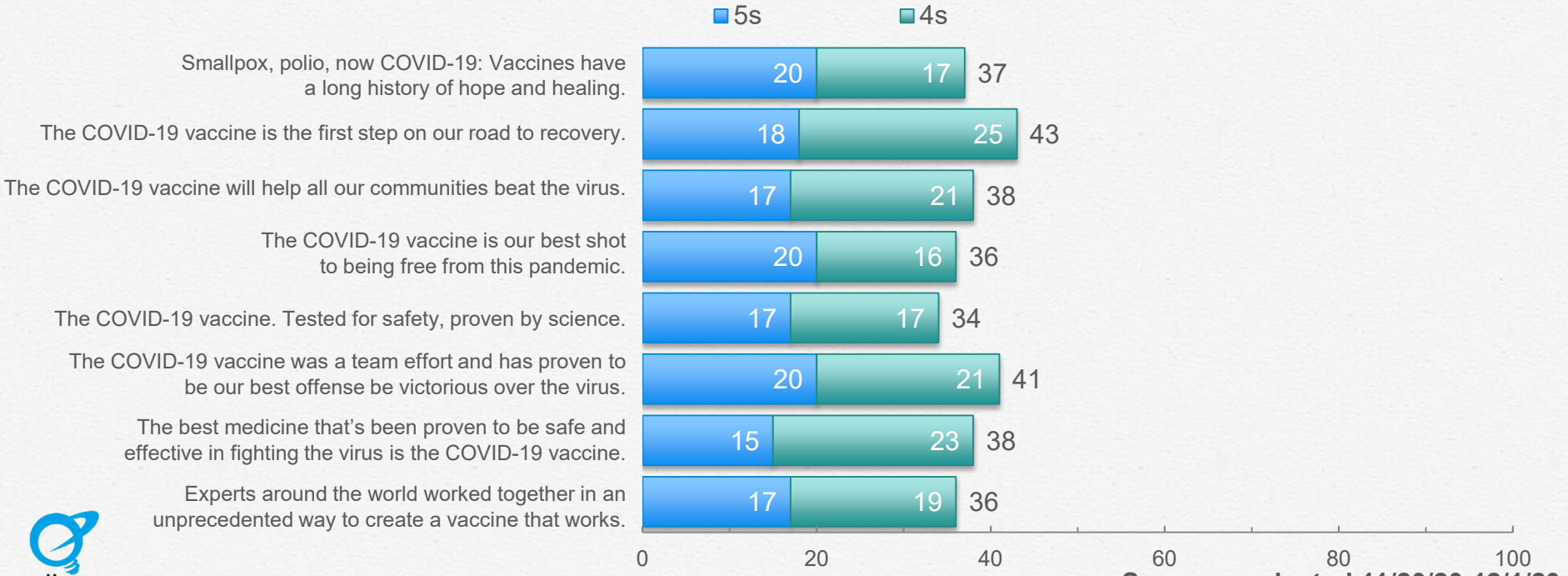
Survey conducted 11/20/20-12/1/20

edison research

Message Preference: (Age 14-24)

Obtained via MI FOIA by Judicial Watch, Inc.

% Liking message ('4' or '5' on a 5-point scale)



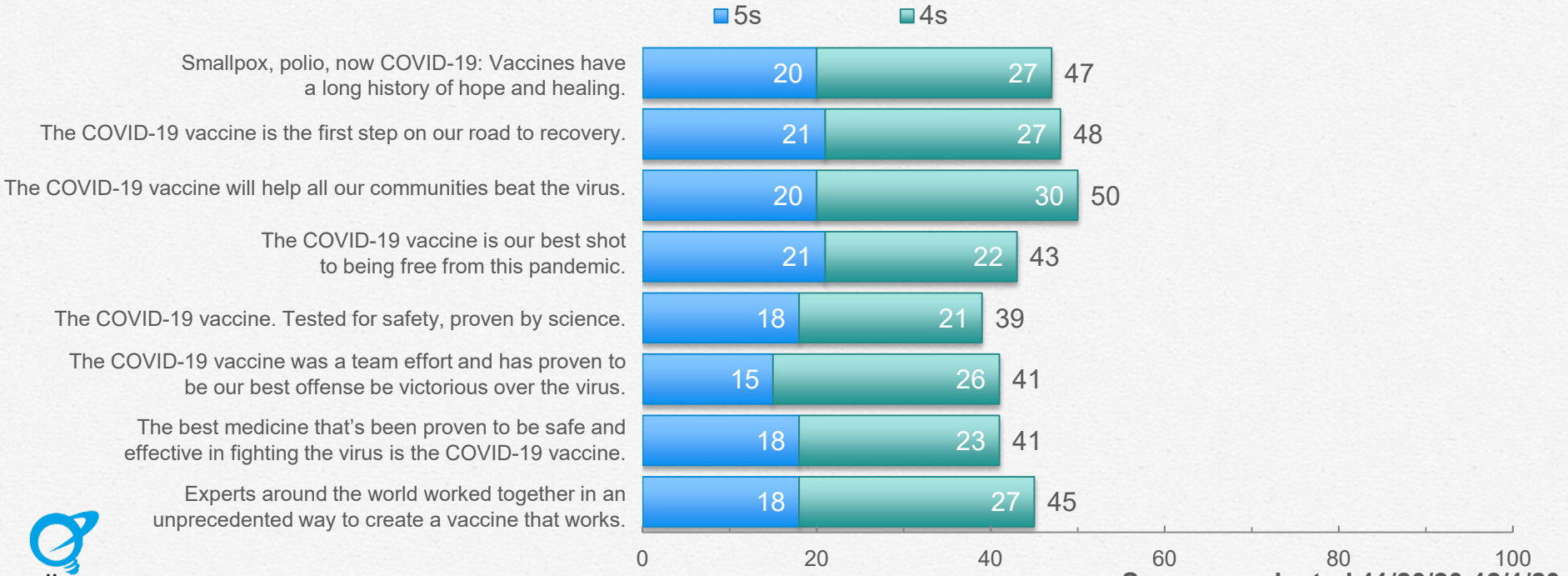
Survey conducted 11/20/20-12/1/20

edison research

Message Preference: (Age 25-34)

Obtained via FOIA by Judicial Watch, Inc.

% Liking message ('4' or '5' on a 5-point scale)

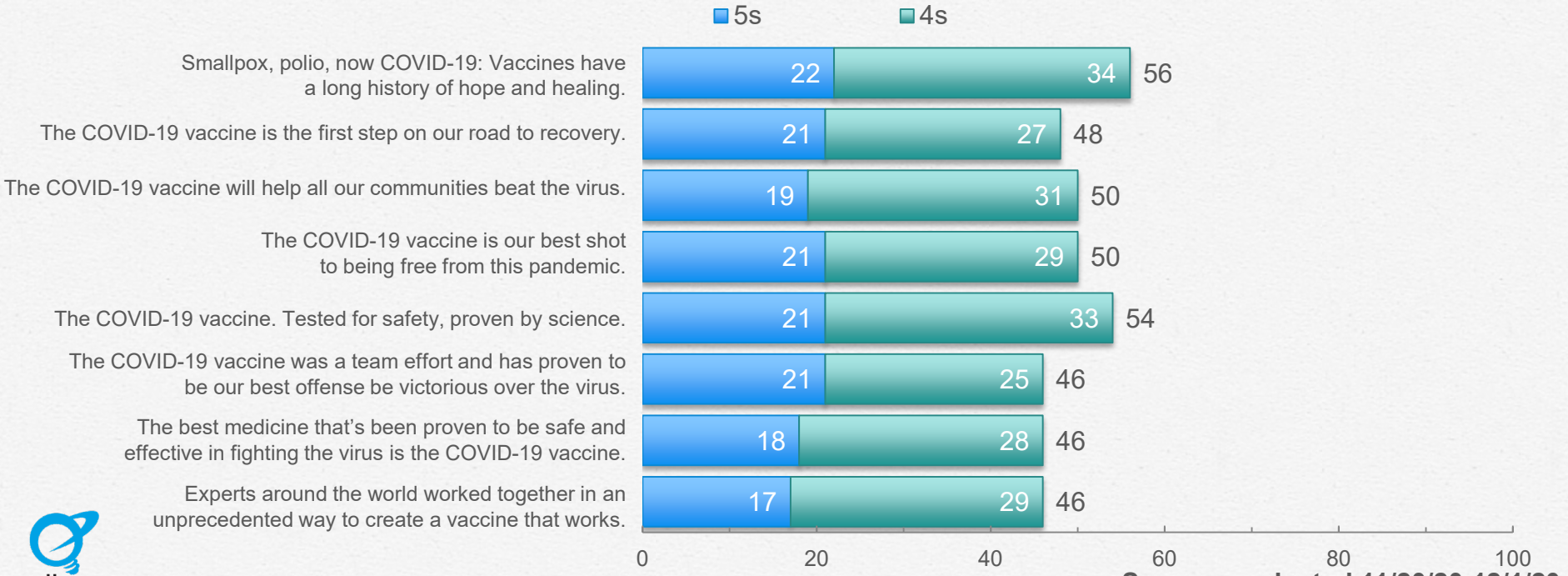


edison research

Message Preference: (Age 35-44)

Obtained via FOIA by Judicial Watch, Inc.

% Liking message ('4' or '5' on a 5-point scale)

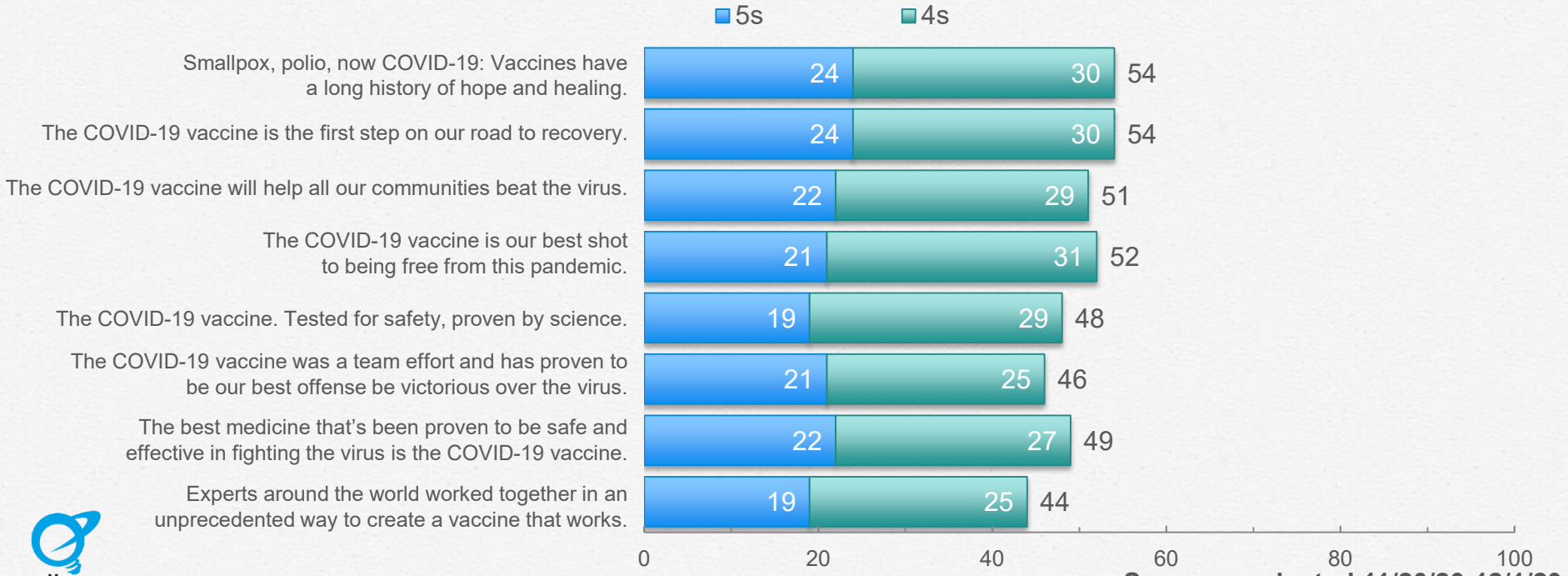


edison research

Message Preference: (Age 45-54)

Obtained via FOIA by Judicial Watch, Inc.

% Liking message ('4' or '5' on a 5-point scale)



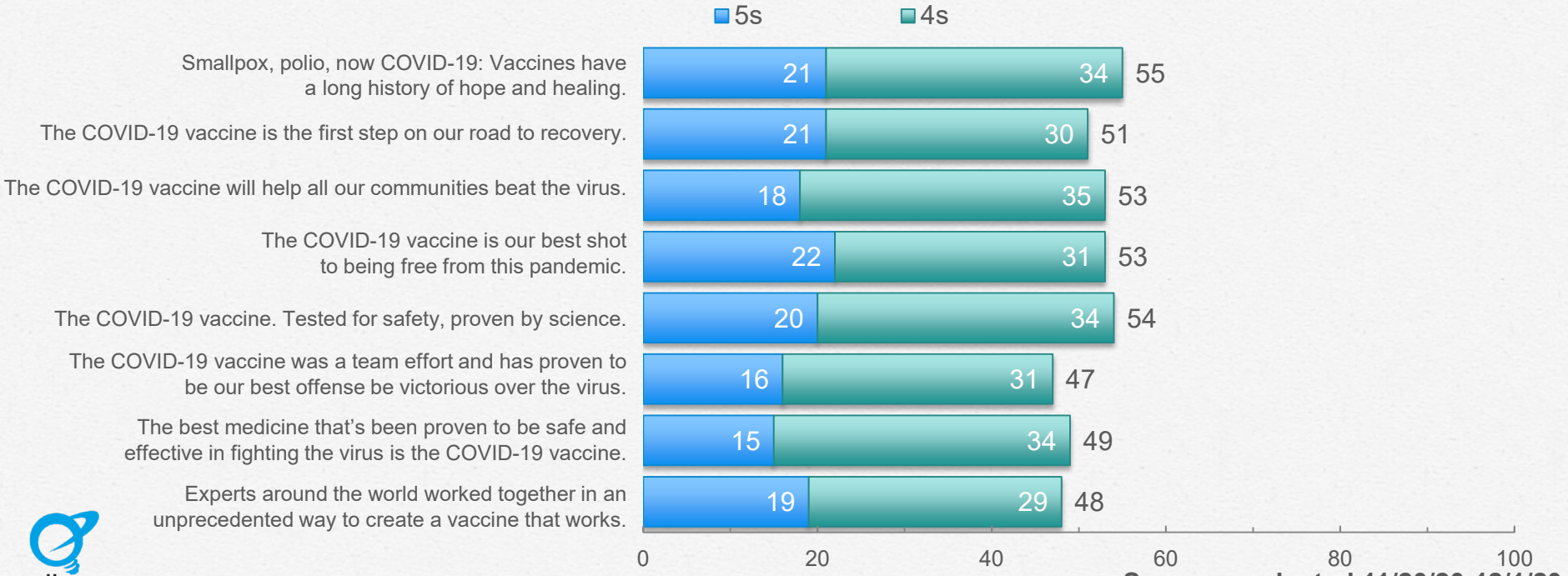
Survey conducted 11/20/20-12/1/20

edison research

Message Preference: (Age 55-64)

Obtained via FOIA by Judicial Watch, Inc.

% Liking message ('4' or '5' on a 5-point scale)

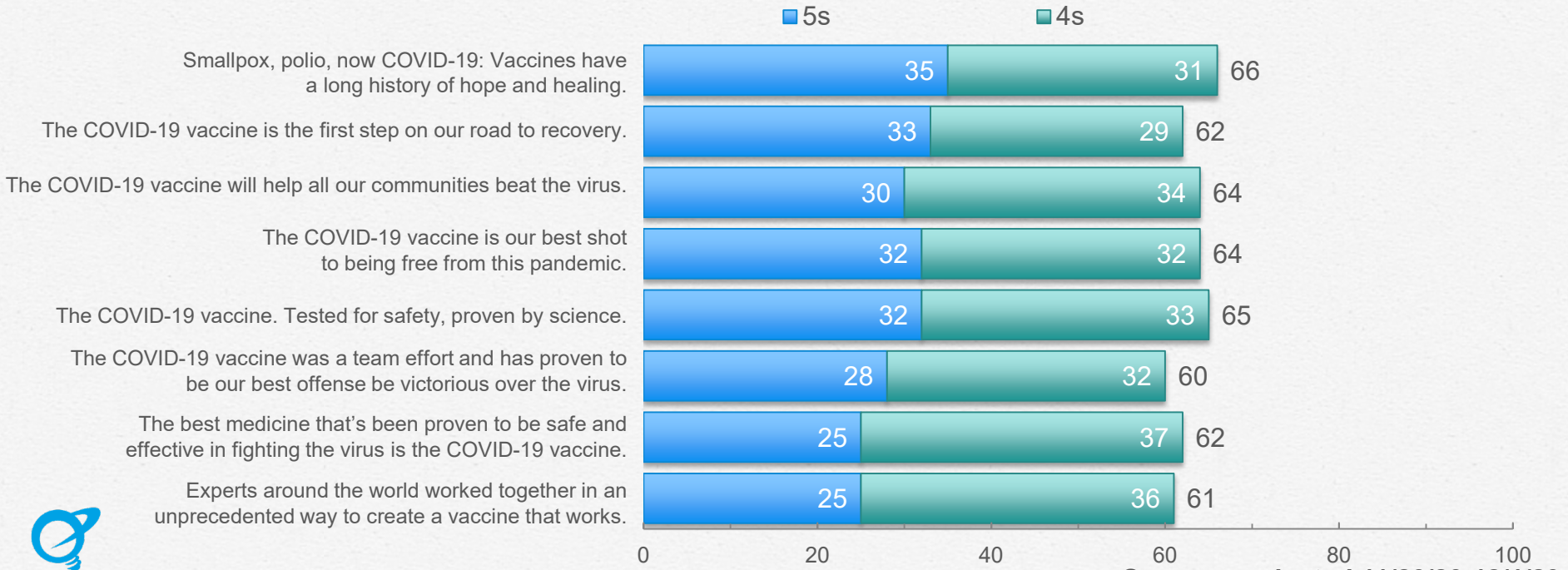


edison research

Message Preference: (Age 65+)

Obtained via FOIA by Judicial Watch, Inc.

% Liking message ('4' or '5' on a 5-point scale)



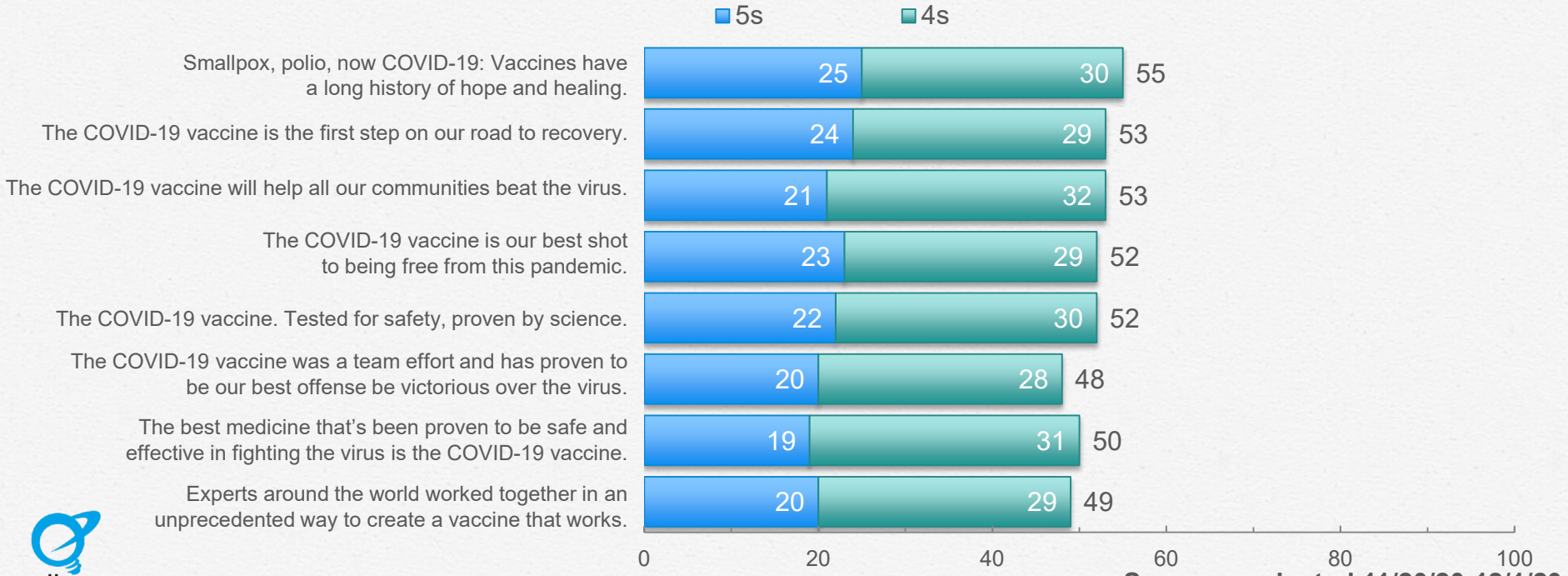
Survey conducted 11/20/20-12/1/20

edison research

Message Preference: (White)

Obtained via MI FOIA by Judicial Watch, Inc.

% Liking message ('4' or '5' on a 5-point scale)



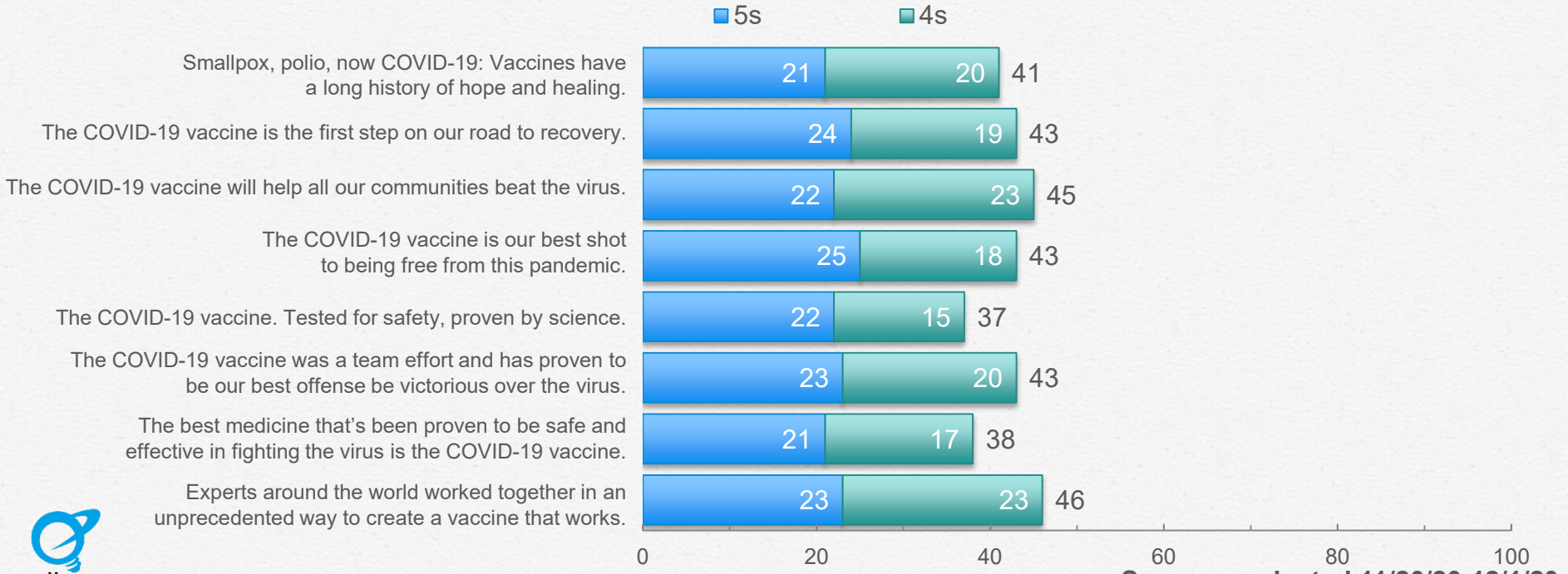
Survey conducted 11/20/20-12/1/20

edison research

Message Preference: (Black)

Obtained via MI FOIA by Judicial Watch, Inc.

% Liking message ('4' or '5' on a 5-point scale)



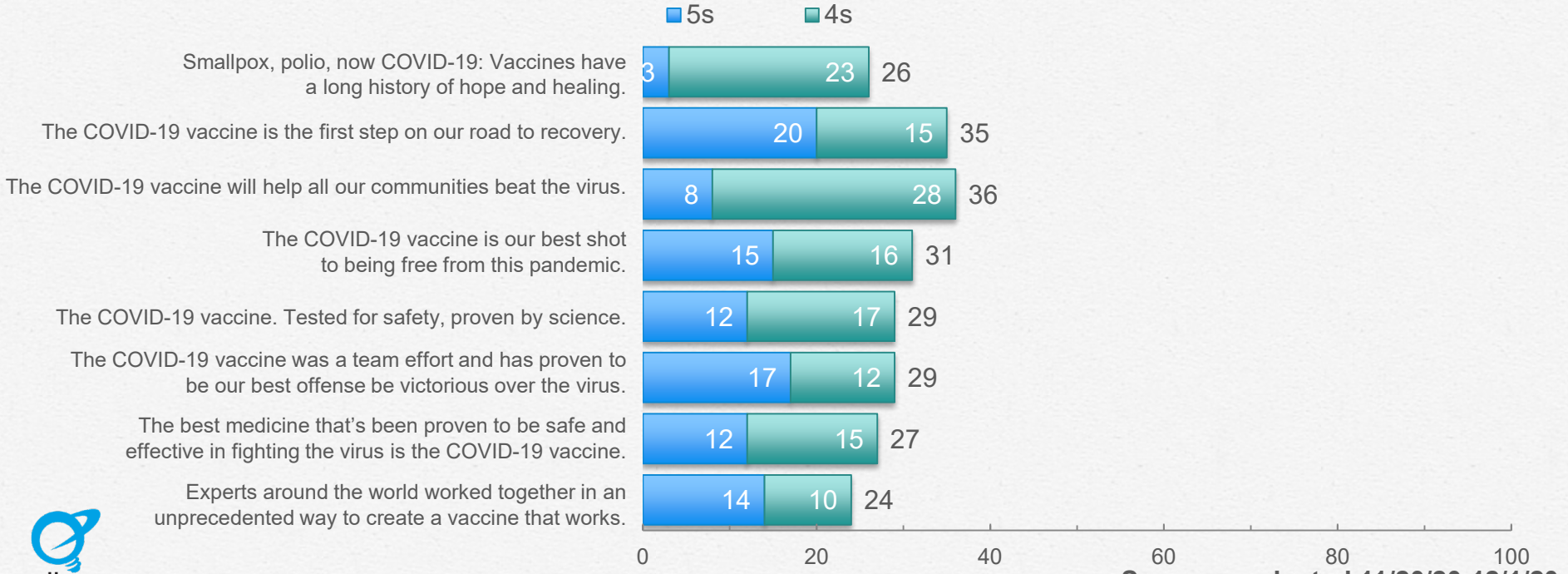
Survey conducted 11/20/20-12/1/20

edison research

Message Preference: (Hispanic)

Obtained via MuckFOIA by Judicial Watch, Inc.

% Liking message ('4' or '5' on a 5-point scale)



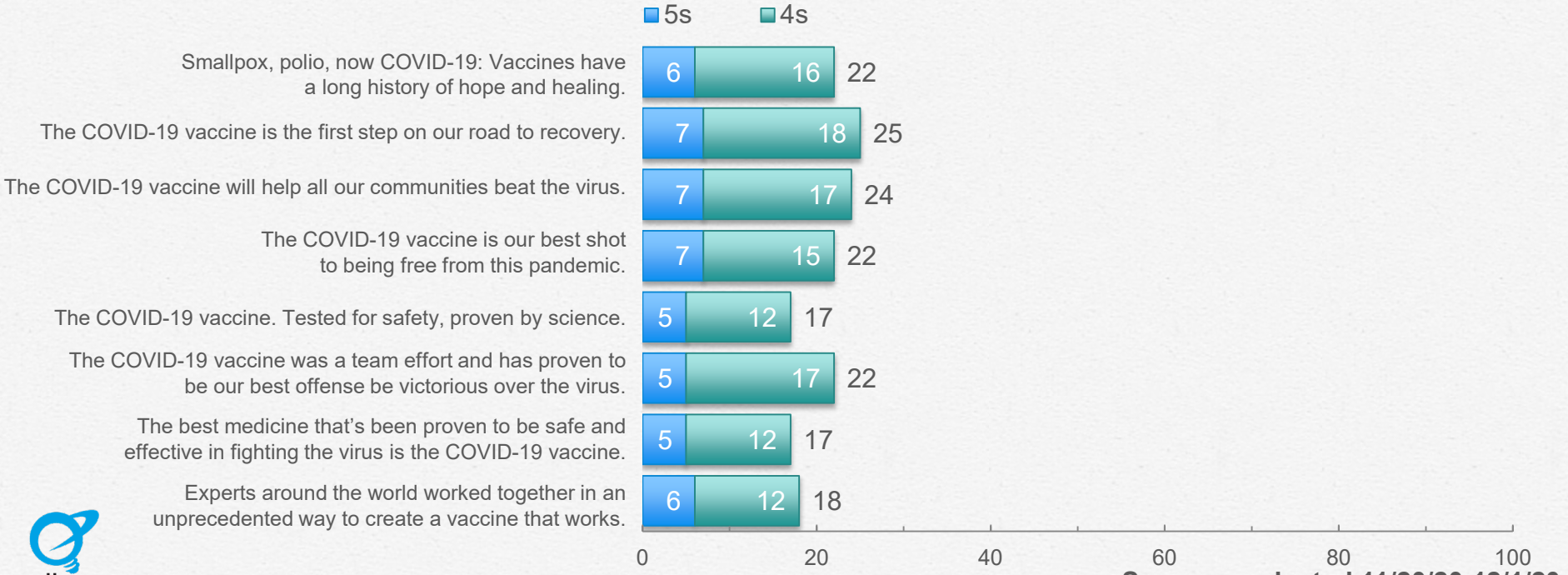
Survey conducted 11/20/20-12/1/20

edison research

Message Preference:
("Not very" or "Not at all" likely to get vaccine)

Obtained via MI FOIA by Judicial Watch, Inc.

% Liking message ('4' or '5' on a 5-point scale)

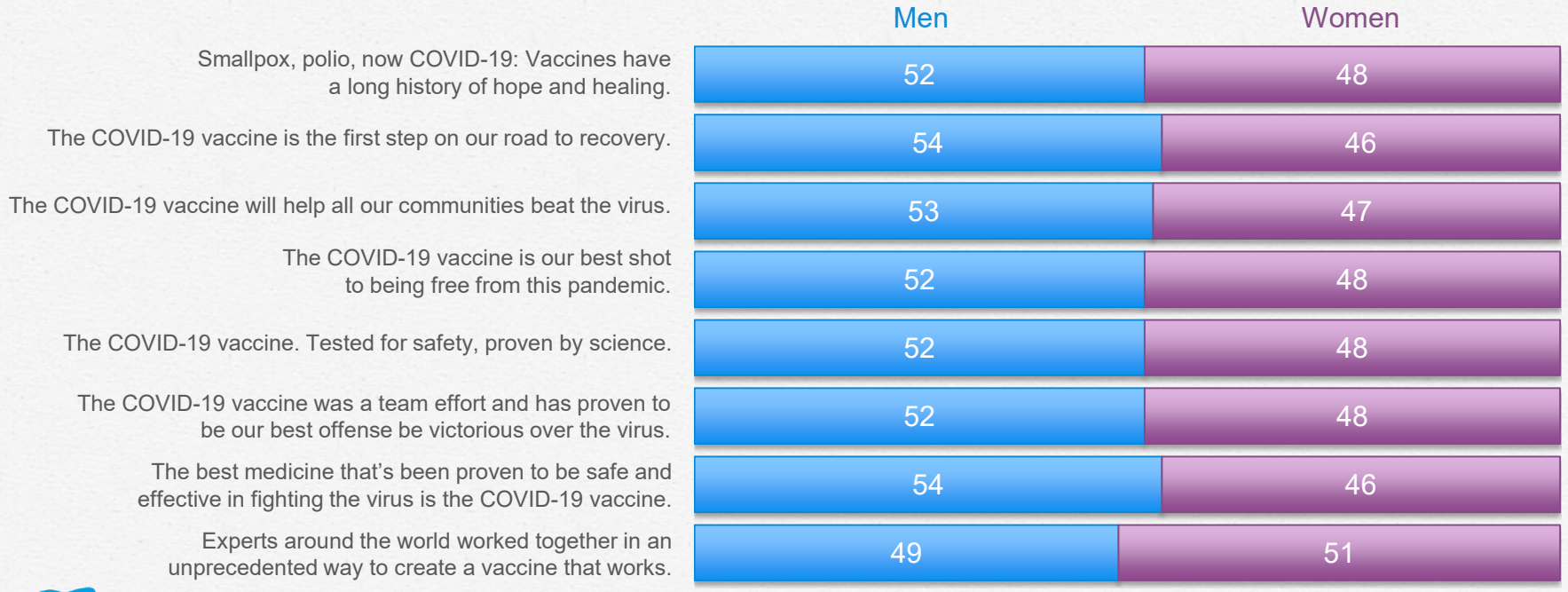


Survey conducted 11/20/20-12/1/20

edison research

Sex of those who like each message:

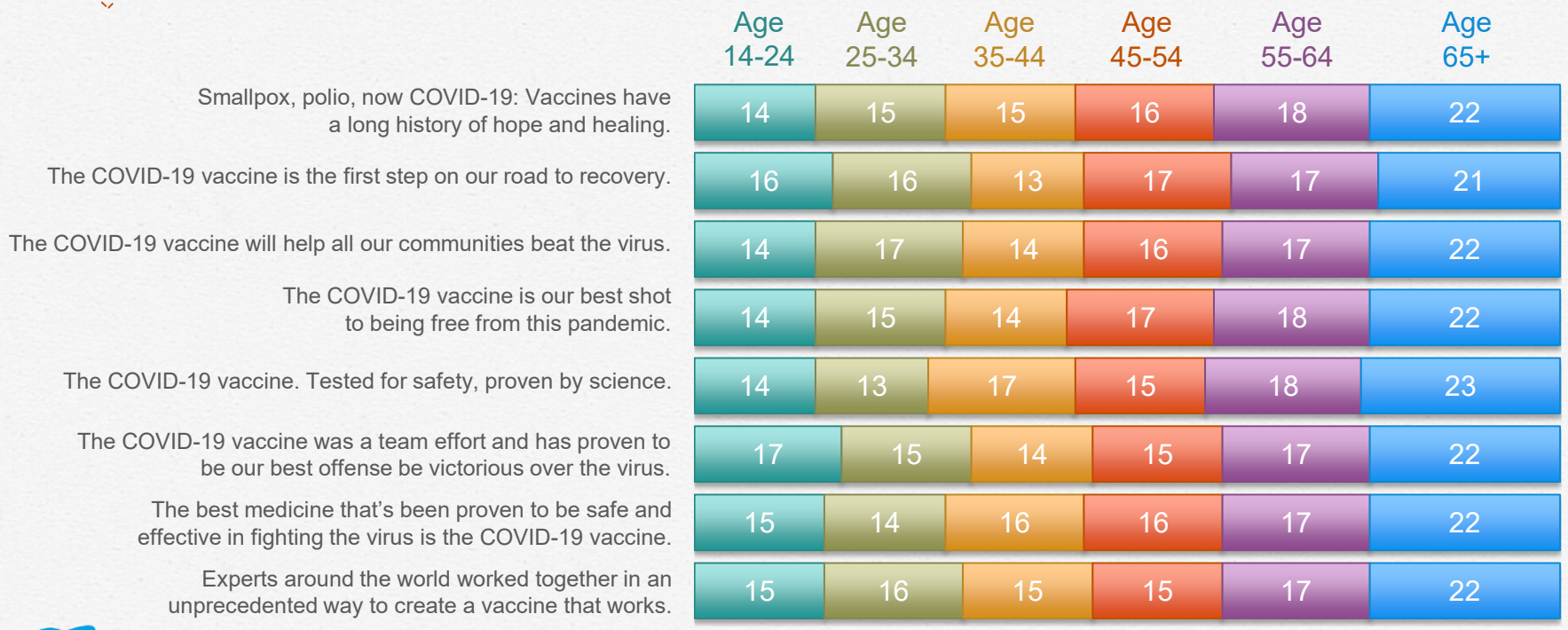
Obtained via MI FOIA by Judicial Watch, Inc.



edison research

Age of those who like each message:

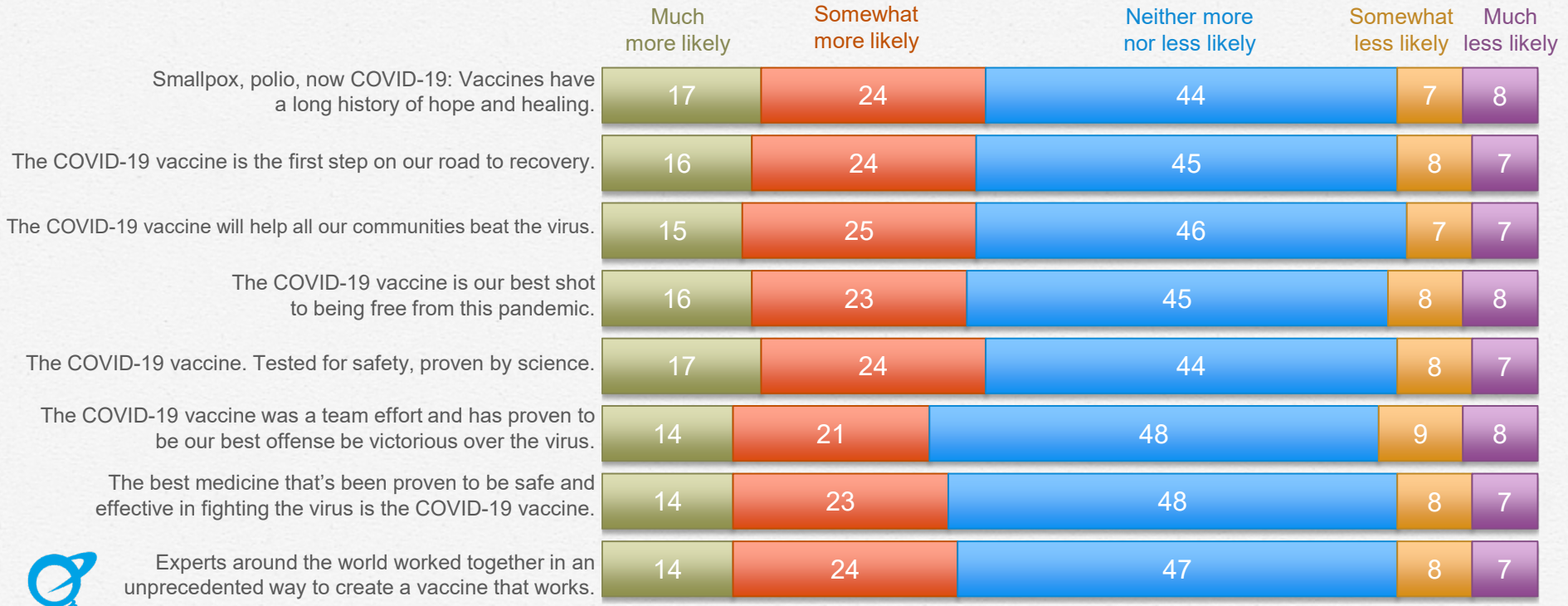
Obtained via MI FOIA by Judicial Watch, Inc.



edison research

Does the message you just read make you more or less likely to receive a COVID-19 vaccine?

Obtained via MI FOIA by Judicial Watch, Inc.

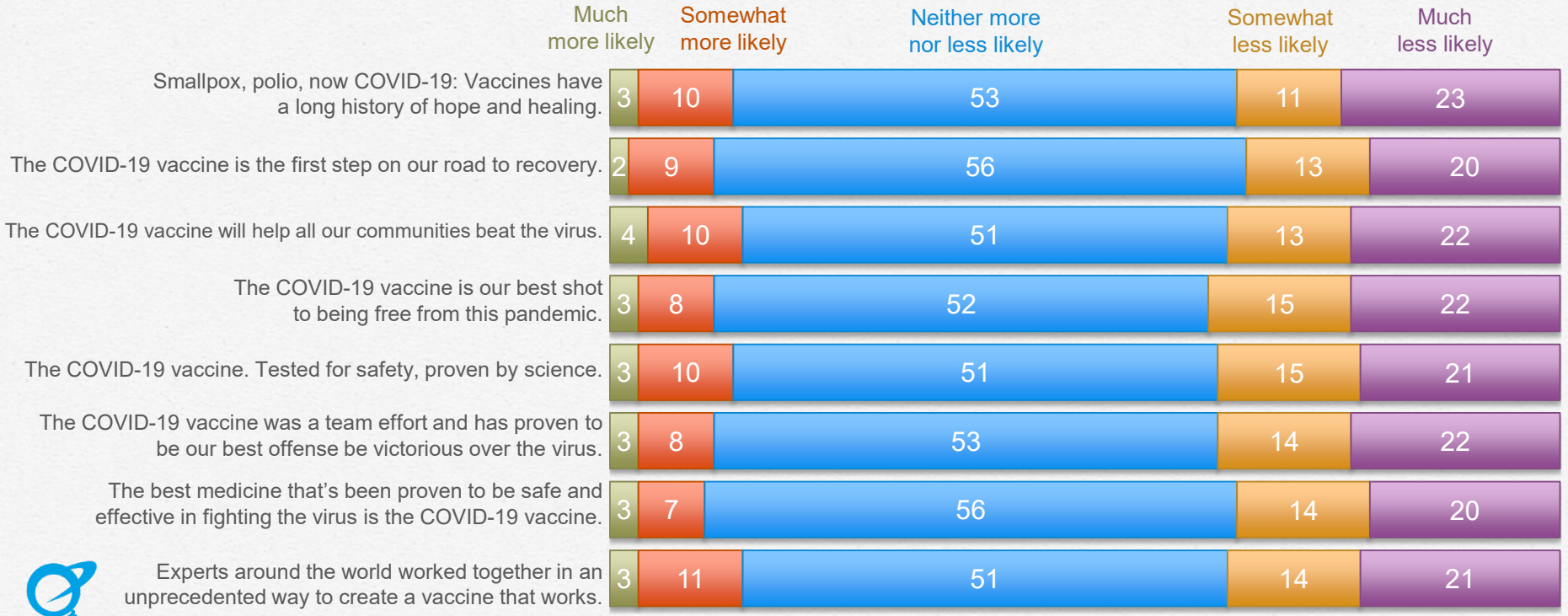


edison research

Survey conducted 11/20/20-12/1/20

Does the message you just read make you more or less likely to receive a COVID-19 vaccine? (“Not very” or “Not at all” likely to get vaccine)

Obtained via MI FOIA by Judicial Watch, Inc.

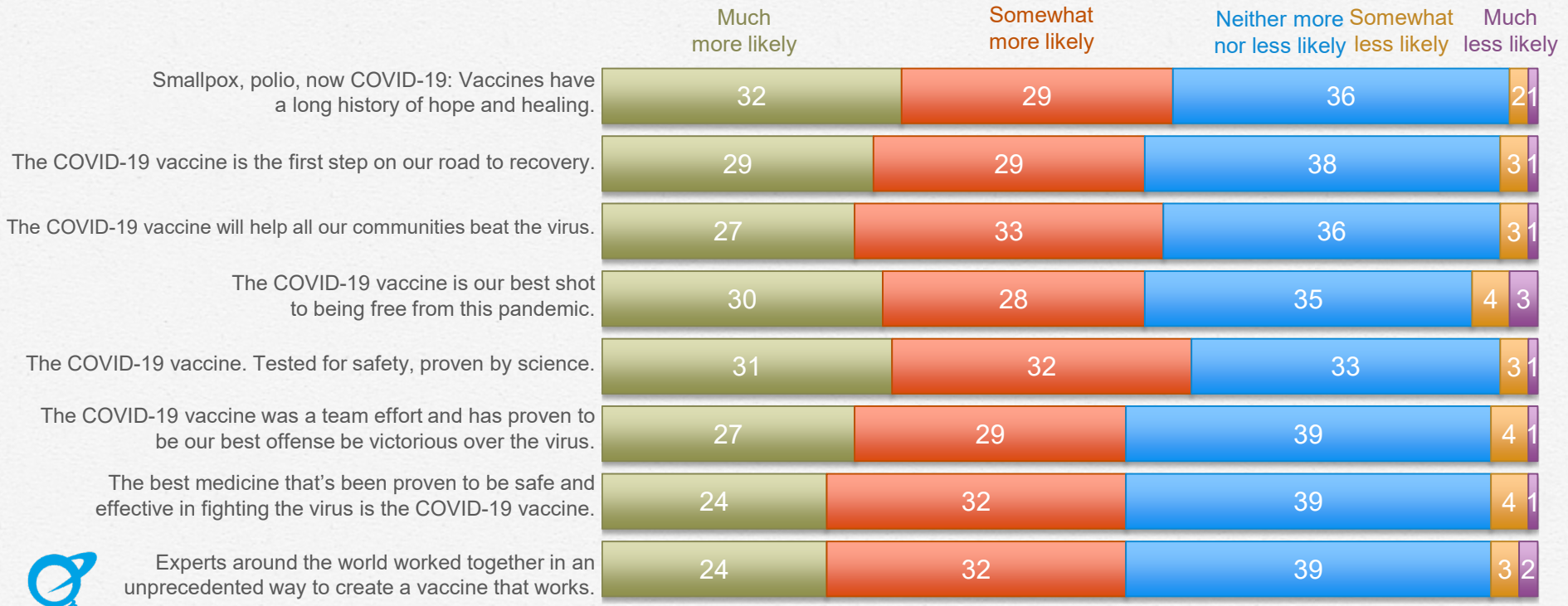


edison research

Survey conducted 11/20/20-12/1/20

Does the message you just read make you more or less likely to receive a COVID-19 vaccine? (“Very” likely to get vaccine)

Obtained via MI FOIA by Judicial Watch, Inc.

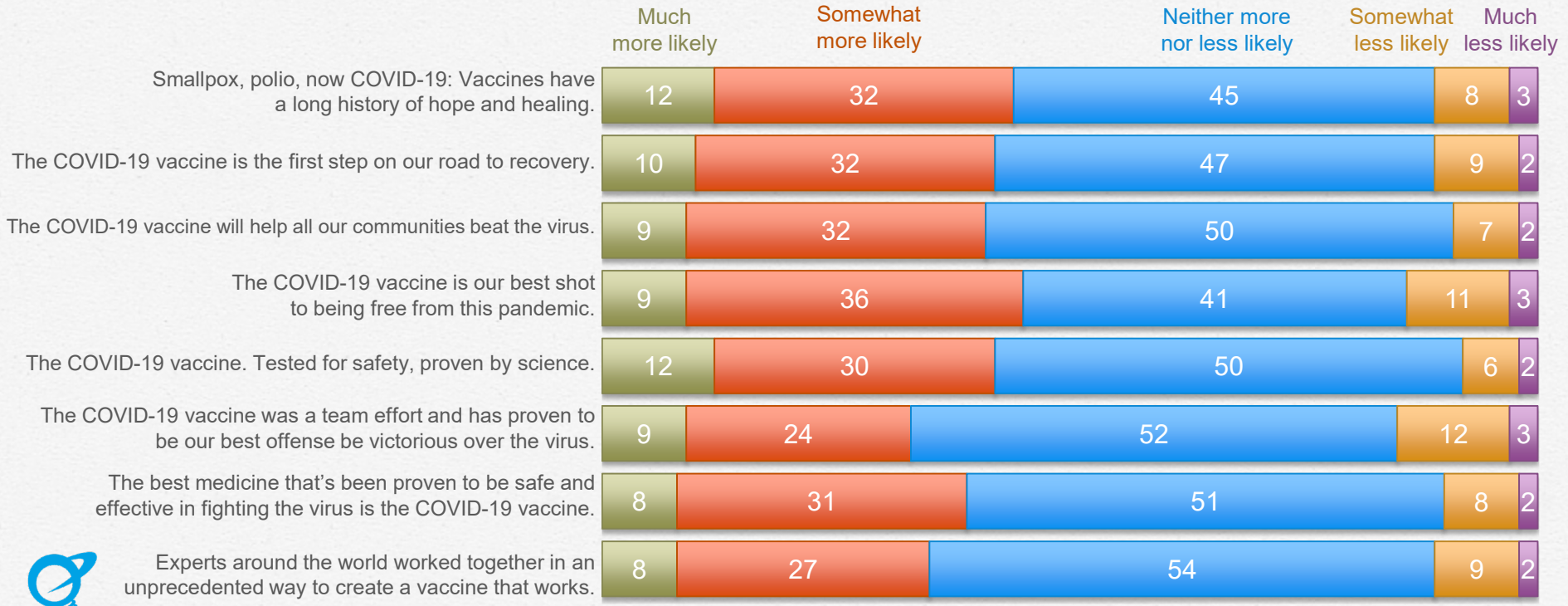


edison research

Survey conducted 11/20/20-12/1/20

Does the message you just read make you more or less likely to receive a COVID-19 vaccine? (“Somewhat” likely to get vaccine)

Obtained via MI FOIA by Judicial Watch, Inc.

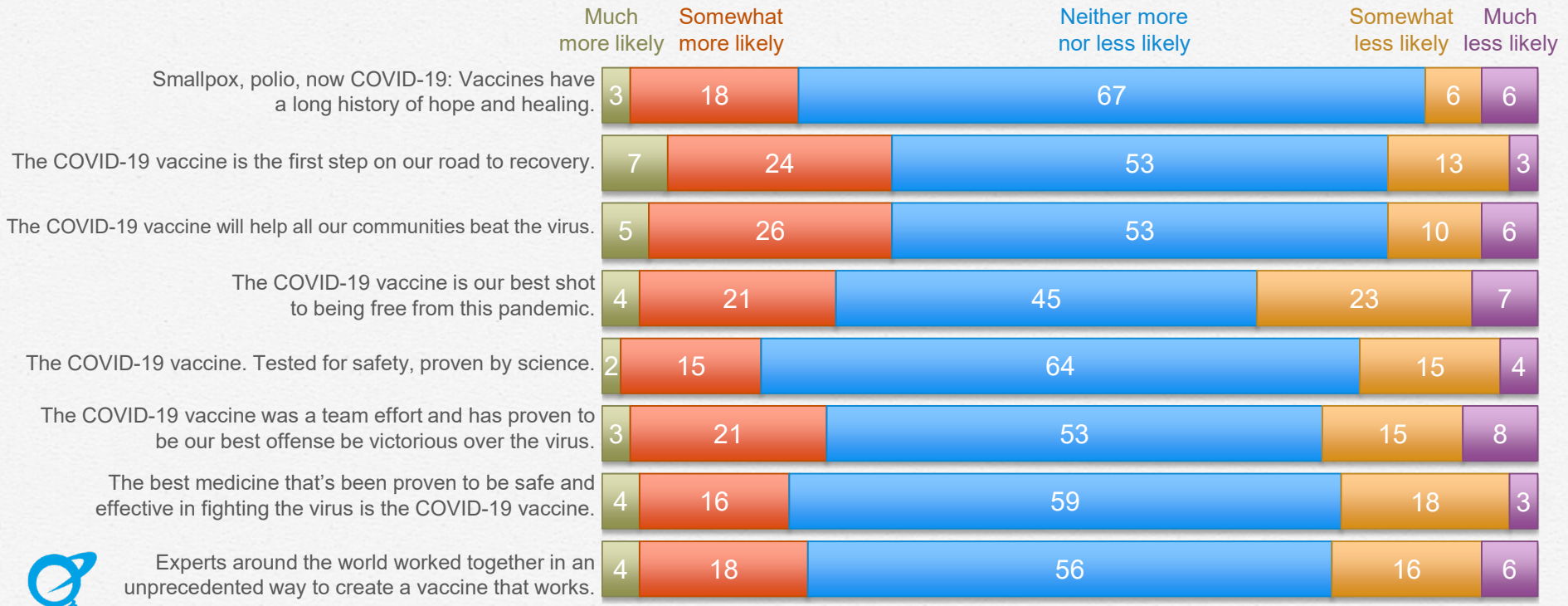


edison research

Survey conducted 11/20/20-12/1/20

Does the message you just read make you more or less likely to receive a COVID-19 vaccine? (“Not very” likely to get vaccine)

Obtained via MI FOIA by Judicial Watch, Inc.

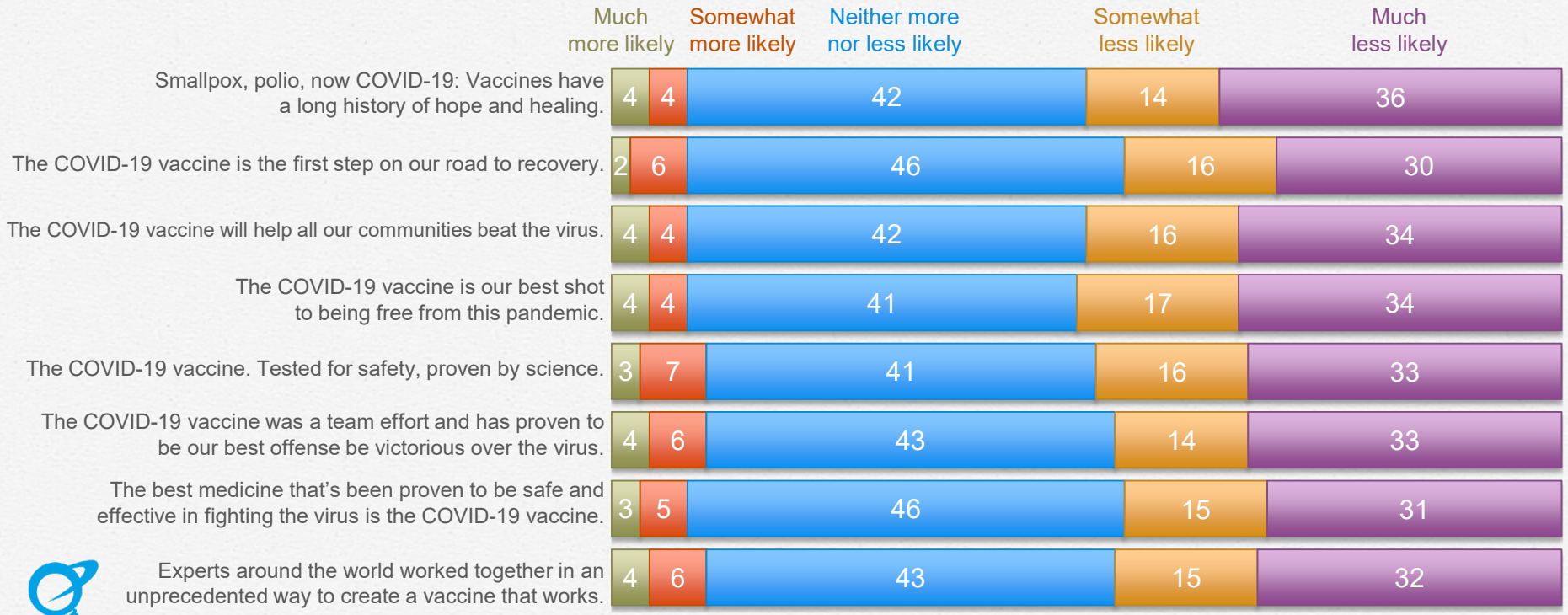


edison research

Survey conducted 11/20/20-12/1/20

Does the message you just read make you more or less likely to receive a COVID-19 vaccine? (“Not at all” likely to get vaccine)

Obtained via MI FOIA by Judicial Watch, Inc.

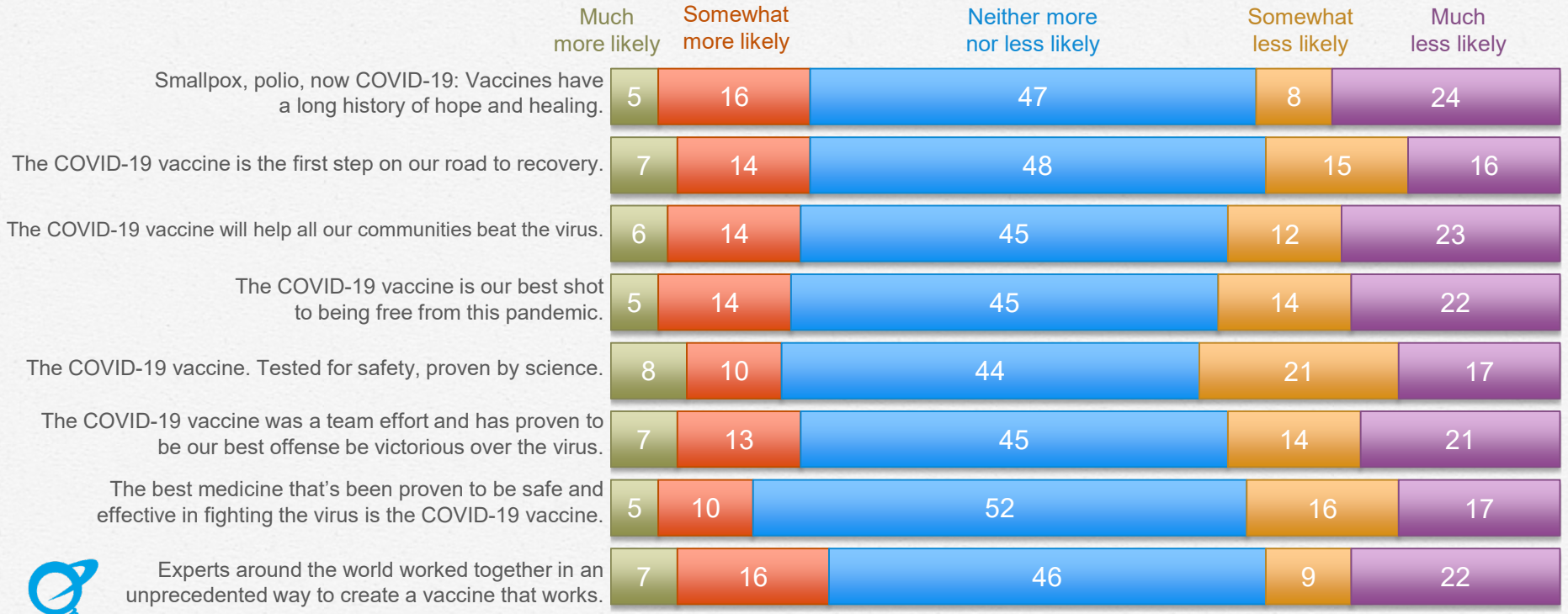


edison research

Survey conducted 11/20/20-12/1/20

Does the message you just read make you more or less likely to receive a COVID-19 vaccine? (“Sometimes” or “Never” wear a mask)

Obtained via MI FOIA by Judicial Watch, Inc.



edison research

Survey conducted 11/20/20-12/1/20

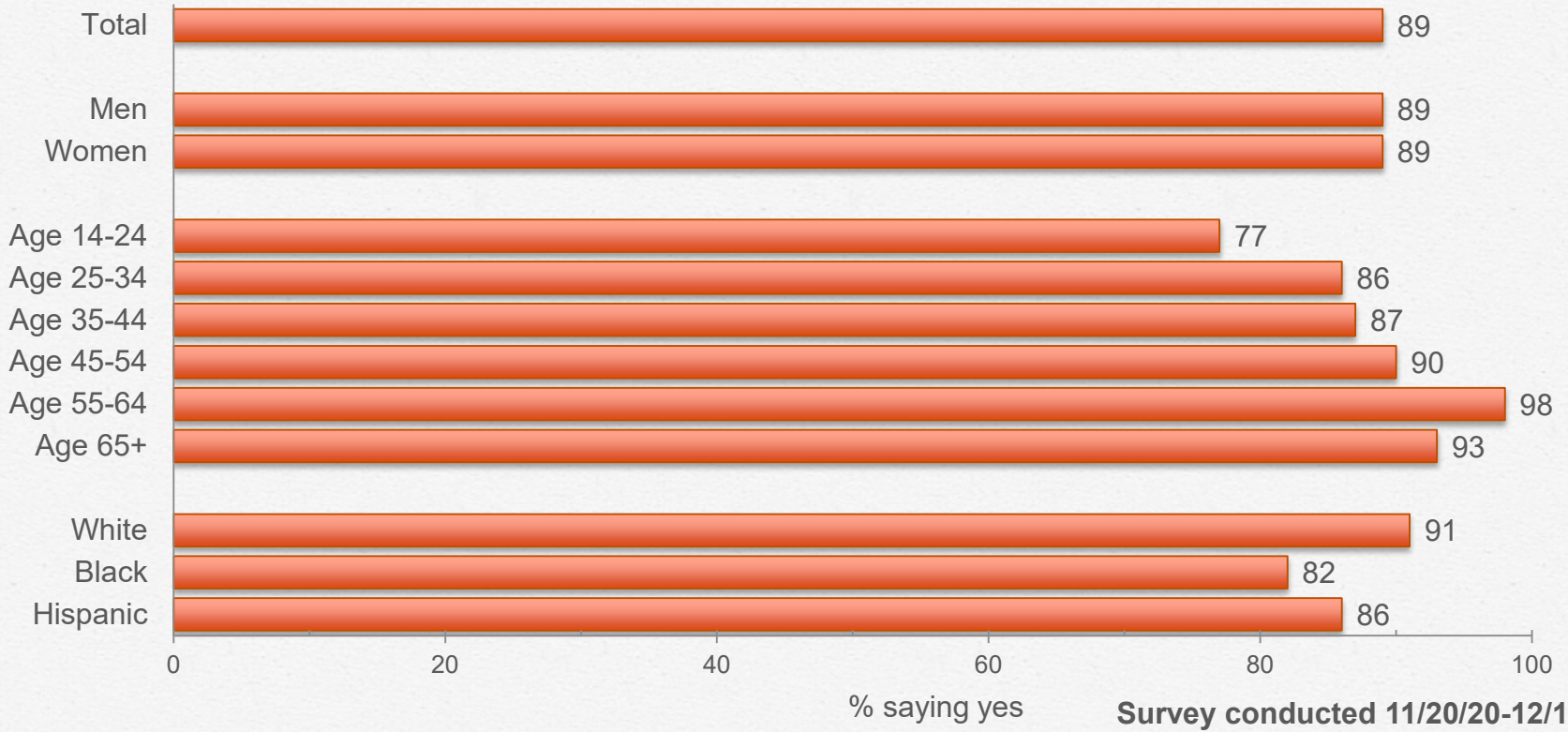
Obtained via MI FOIA by Judicial Watch, Inc.

Pause to Save Lives



Are you aware of the new, three-week emergency order beginning November 18th that limits indoor gatherings where COVID-19 is more likely to spread?

Obtained via MI FOIA by Judicial Watch, Inc.

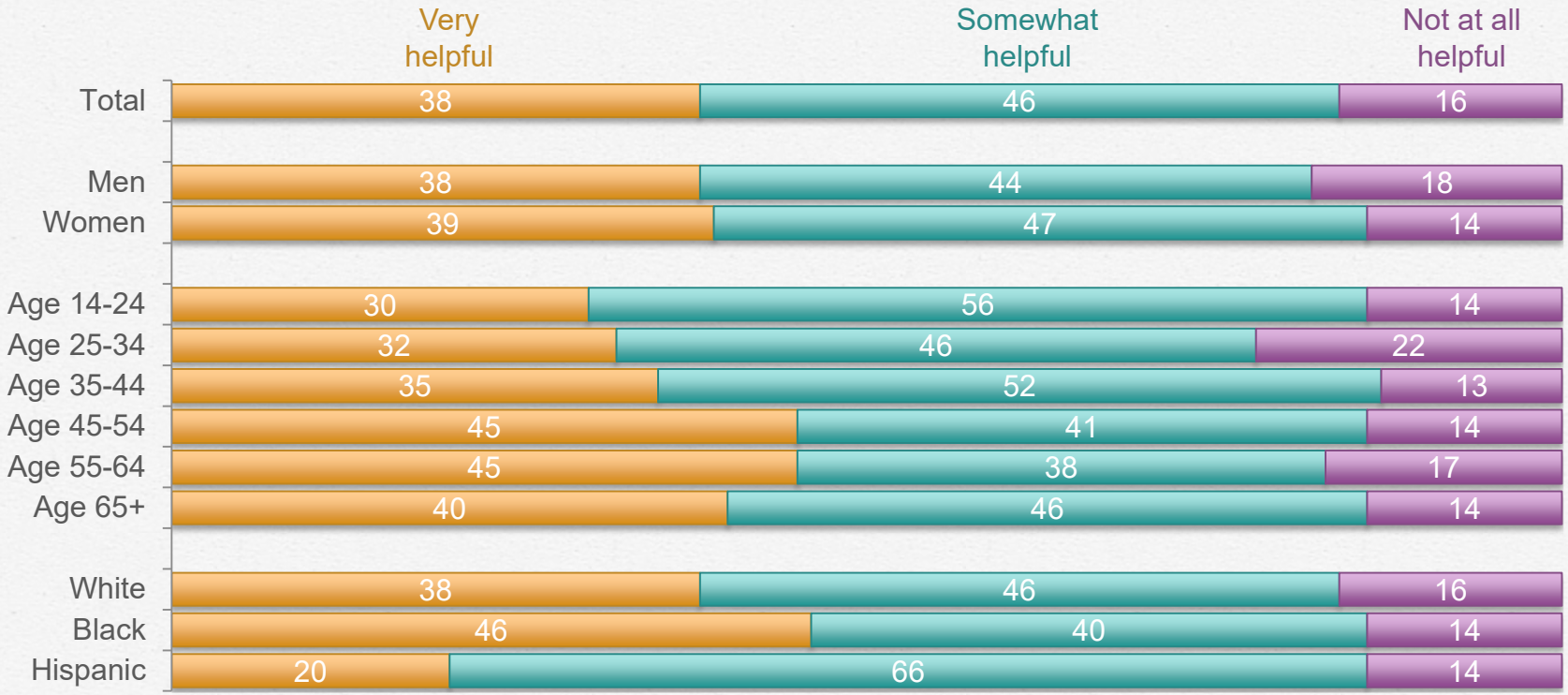


Survey conducted 11/20/20-12/1/20

edison research

Based on what you know about the order, in your opinion, how helpful is this new order in reducing the spread of COVID-19

Obtained via MI FOIA by Judicial Watch, Inc.

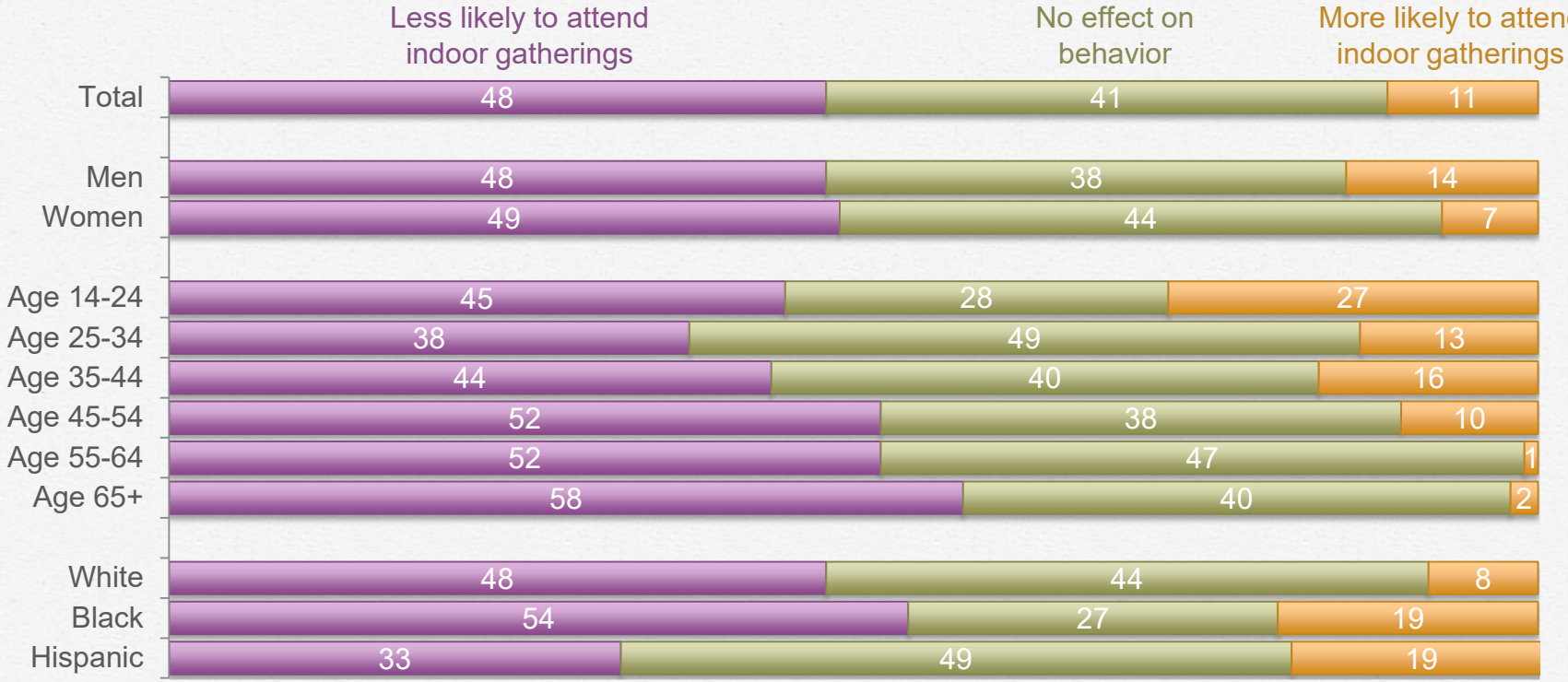


edison research

Survey conducted 11/20/20-12/1/20

Does hearing that the state's health department issue an order limiting indoor gatherings make you…?

Obtained via MI FOIA by Judicial Watch, Inc.

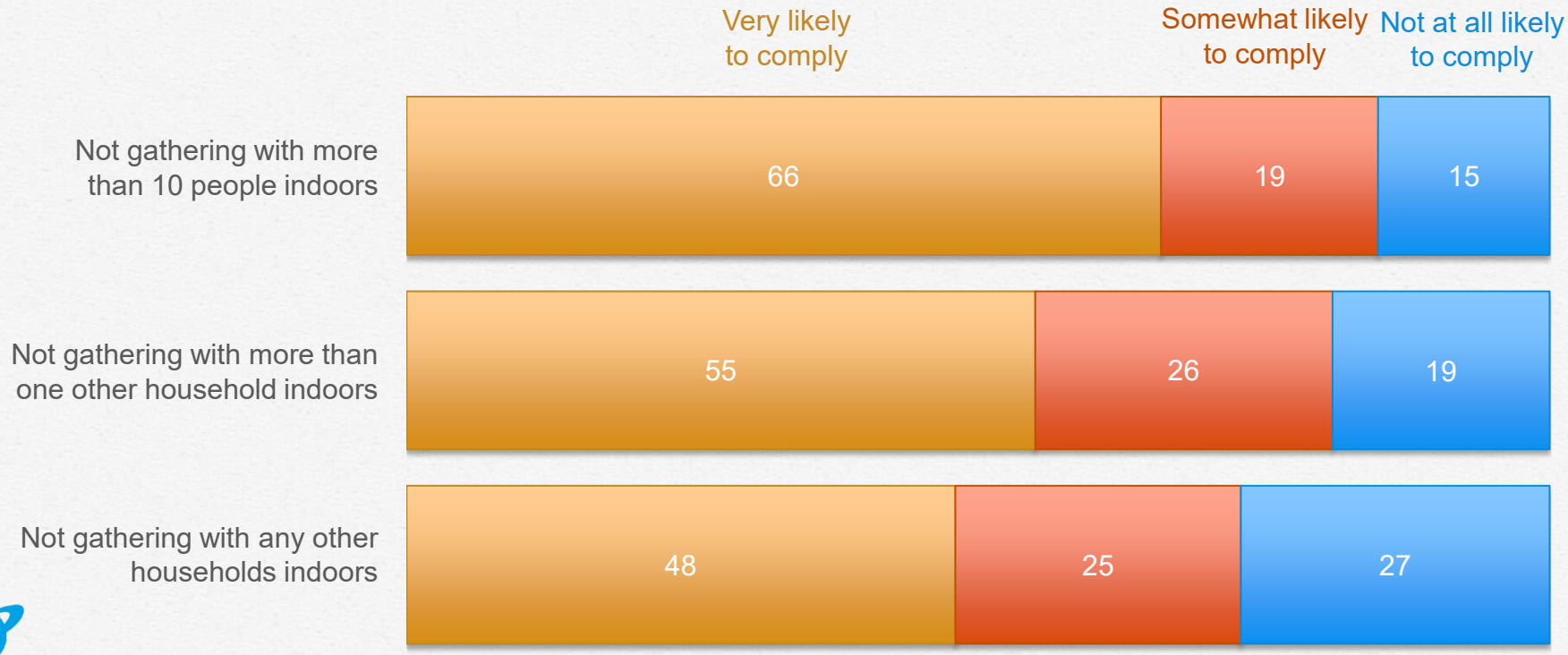


edison research

Survey conducted 11/20/20-12/1/20

How likely would you be to comply with…?

Obtained via FOIA by Judicial Watch, Inc.

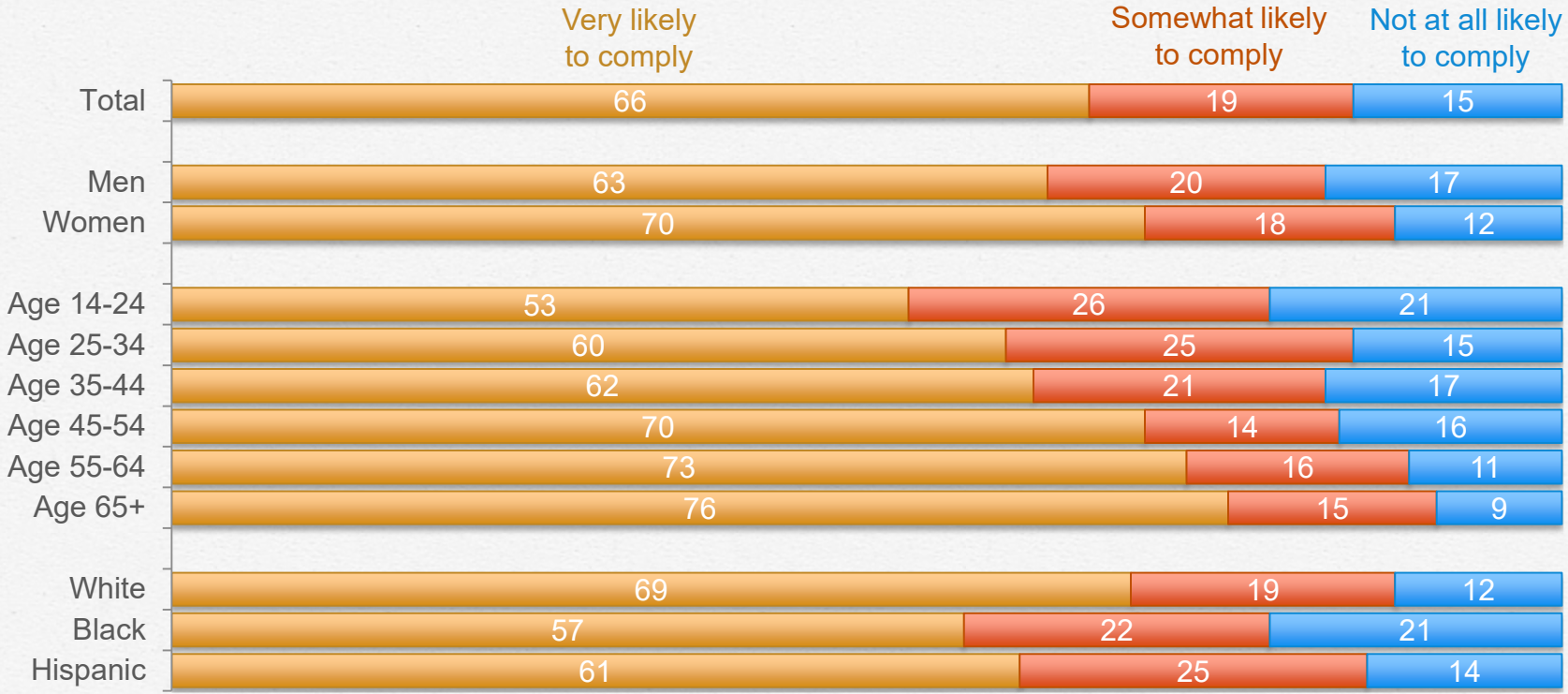


edison research

Survey conducted 11/20/20-12/1/20

How likely would you be to comply with not gathering with more than 10 people indoors?

Obtained via MI FOIA by Judicial Watch, Inc.

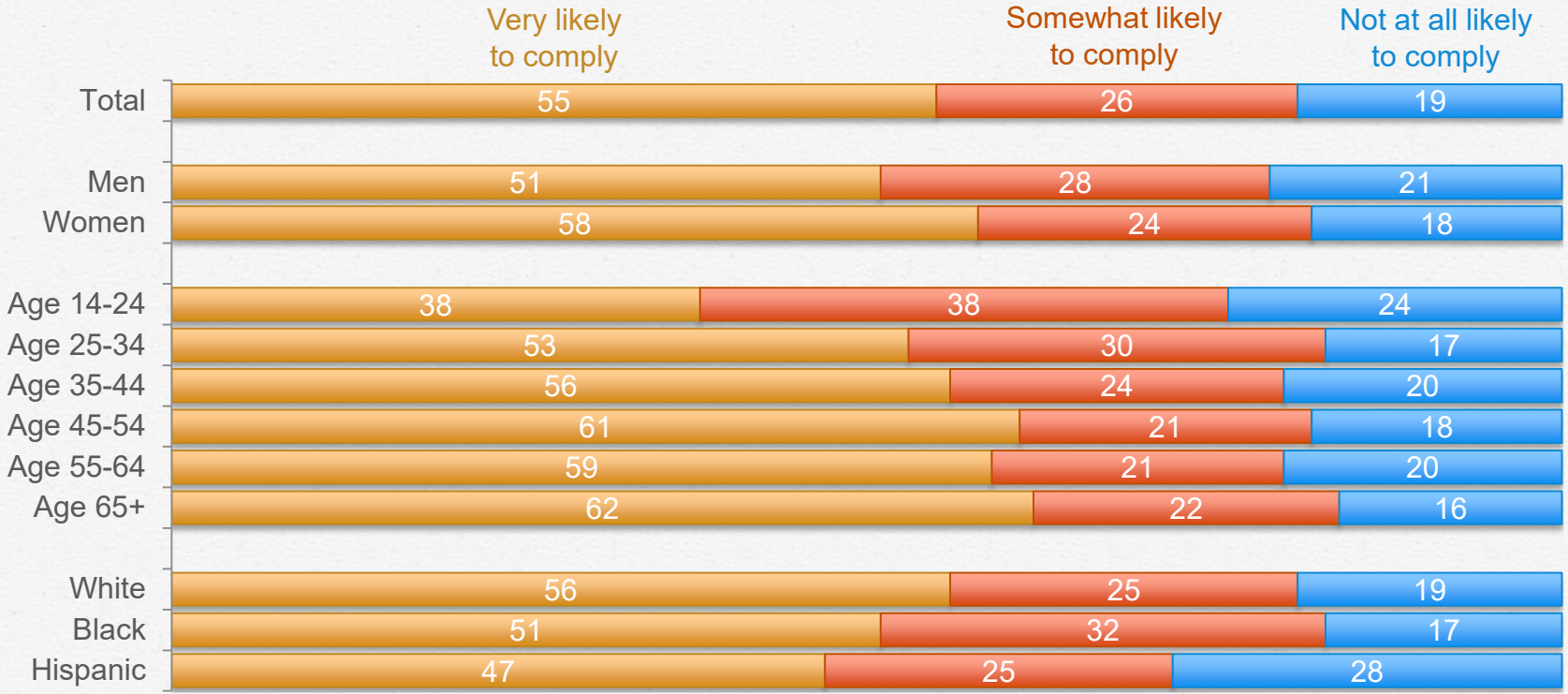


edison research

Survey conducted 11/20/20-12/1/20

How likely would you be to comply with not gathering with more than one other household indoors?

Obtained via MI FOIA by Judicial Watch, Inc.

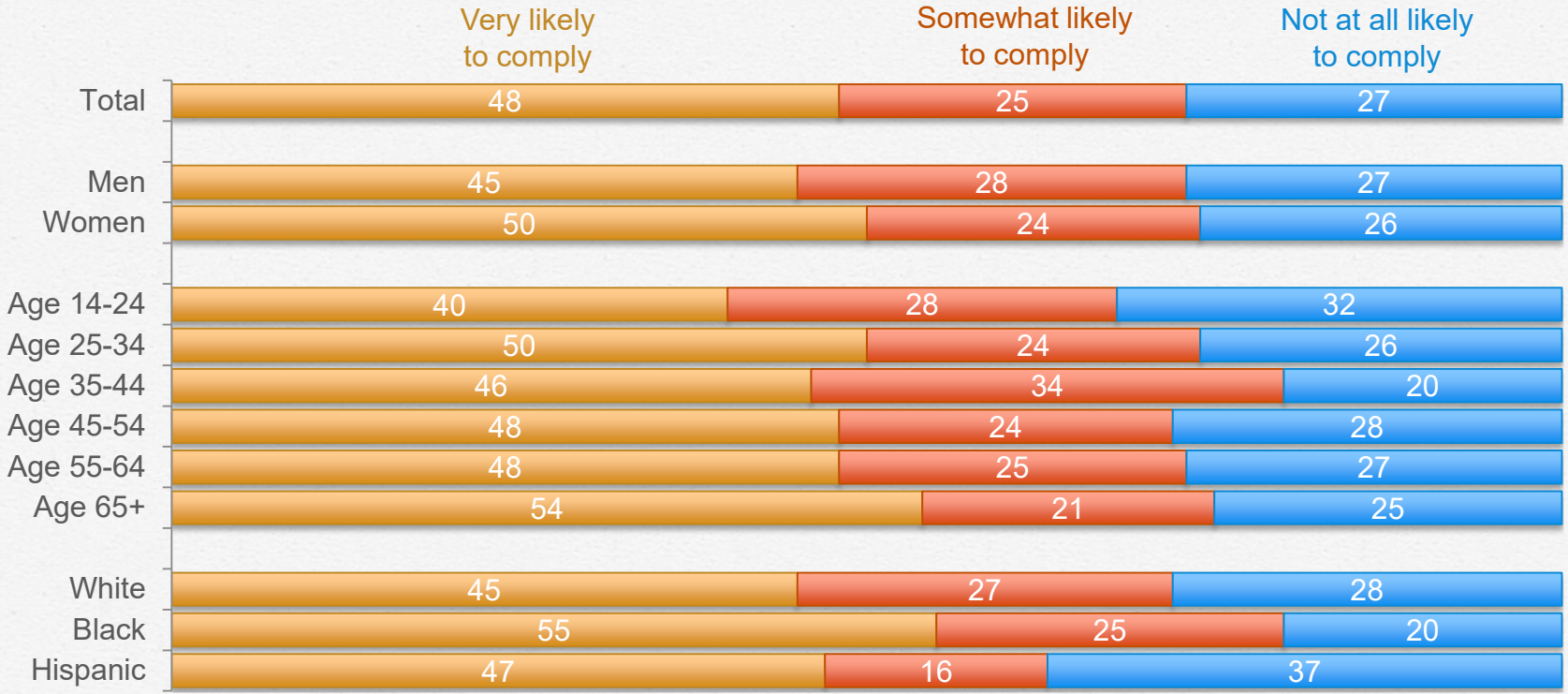


edison research

Survey conducted 11/20/20-12/1/20

How likely would you be to comply with not gathering with any other households indoors?

Obtained via MI FOIA by Judicial Watch, Inc.



edison research

Survey conducted 11/20/20-12/1/20

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: "Whitmer, Gretchen"
Cc: Totten, Mark; Huls, JoAnne
Subject: Social distancing
Date: Friday, March 27, 2020 6:54:07 AM

Good morning, Governor.

Just wanted to share – I talked with Josh Sharfstein from Johns Hopkins last night about what more we can do in light of the urgent situation in and around Detroit. His advice was that while we are doing the right things on surge, we should not lose sight of potential more active steps on social distancing. Even small gains will help, even if mostly to bring down the peak sooner. Brainstormed ideas with Josh and then with Zeke Emanuel, who made the connection below. (Aware of procurement issue and have thoughts.) Mark will be leading a broader call on these ideas at 9:30.

Best,
Robert

From: Emanuel, Ezekiel J <zemanuel@upenn.edu>
Sent: Friday, March 27, 2020 6:45 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Sacha Samotin <sacha@applecart.co>
Cc: Gayle Yelon <gayle@applecart.co>; Joe Shafer <joe@applecart.co>; Matthew Kalmans <matt@applecart.co>
Subject: Re: Re:

Hope this connection works magic to enhance physical distancing and repsonsible conduct in Mich

Ezekiel J. Emanuel, M.D., Ph.D.

Vice Provost of Global Initiatives

Chair, Department of Medical Ethics and Health Policy (on Leave 2019-2020)

Levy University Professor

Co-Director, Healthcare Transformation Institute

Perelman School of Medicine and The Wharton School

University of Pennsylvania

Obtained via MI FOIA by Judicial Watch, Inc.

Phone: 215-898-7226 or 215-573-8104

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Friday, March 27, 2020 6:35 AM
To: Sacha Samotin <sacha@applecart.co>; Emanuel, Ezekiel J <zemanuel@upenn.edu>
Cc: Gayle Yelon <gayle@applecart.co>; Joe Shafer <joe@applecart.co>; Matthew Kalmans <matt@applecart.co>
Subject: RE: Re:

Hi, I'm up and free next hour or so; have a related call at 930. If you can, please give me a call, 517 242 0165. Or if you prefer conf life I can dial in. Robert

From: Sacha Samotin <sacha@applecart.co>
Sent: Friday, March 27, 2020 6:33 AM
To: Emanuel, Ezekiel J <zemanuel@upenn.edu>
Cc: Gayle Yelon <gayle@applecart.co>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Joe Shafer <joe@applecart.co>; Matthew Kalmans <matt@applecart.co>
Subject: Re:

Thanks for everything you're doing Zeke, and thanks for everything you're doing Robert.

Let me know when makes sense to chat, I'm available whenever works best for you and we're eager to help however we can.

If there's a specific time that works best we can get a conference call line set up, otherwise feel free to reach me on my cell at any time. 239-272-6052.

Sacha

On Fri, Mar 27, 2020 at 5:40 AM Emanuel, Ezekiel J <zemanuel@upenn.edu> wrote:

> Robert meet Sacha,
>
> Sacha is a former Penn student--the tops-- who runs a company that uses social media and behavioral economic technquies--prompts by people you know-- to get people to vote and do other socially positive things.
>
> He has had some great ideas about how to do that for COVID-19. This might address your PR campaign issues.

Obtained via MI FOIA by Judicial Watch, Inc.

In full disclosure, I have an investment in Sacha's company. But that is because it is super effective at what it does.

Ezekiel J. Emanuel, M.D., Ph.D.

Vice Provost of Global Initiatives

Chair, Department of Medical Ethics and Health Policy (on Leave 2019-2020)

Levy University Professor

Co-Director, Healthcare Transformation Institute

Perelman School of Medicine and The Wharton School

University of Pennsylvania

Phone: 215-898-7226 or 215-573-8104

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Readinger, Patricia
Cc: Huls, JoAnne
Subject: Stabenow staff convo?
Date: Saturday, March 21, 2020 7:19:52 AM

Hi Patty,

FNS is giving a key part of the new COVID bill a miserly reading that denies added SNAP benefits to a huge chunk of families. CBPP staff (and I personally) think the generous reading is better, or at worst it's ambiguous, and the generous reading is appropriate given the crisis we are in. Could you connect me or someone on my team with someone in Stabenow's office today to get their understanding?

If Stabenow believes the Admin is getting it wrong, I wonder if Gov could help unlock this. I have done my best behind the scenes, gotten nice notes and no action.

Robert

From: Stacy Dean <dean@cbpp.org>
Sent: Friday, March 20, 2020 7:55 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: Re: USDA FNS - Letter from Deputy Under Secretary Brandon Lipps

I would like to see the Gov. engage. But in all fairness, why don't you have a lawyer read a quick write of why we believe that they can do emergency allotments up to the maximum allotment for that household size, i.e. the limitation is on the emergency allotment not the combination of the regular allotment plus the emergency allotment. See below.

Nationally, about 40% of households are at the maximum allotment. I'm just astonished that they would take such a bizarre read and deny this group emergency food. 70% of households with only kids under 6 receive the max allotment.

You can also reach out to Jacqlyn Schneider on Stabenow's staff if it's helpful. I htink they are trying to wrap up the stimulus package tonight and the Senate is leading. So, she could be busy.

Section 2302 Provides for Additional Full Allotments During the COVID-19 Crisis

Some confusion reportedly has arisen concerning section 2302 of the recently signed Families First Coronavirus Response Act. Specifically, some at USDA reportedly read it as limiting additional allot-ments of food assistance to the

Obtained via MI FOIA by Judicial Watch, Inc.

difference between what a household would have received without benefit of the Families First Act and the maximum allotment regular SNAP allows for a household of its size. Under this reading, millions of households (notably the poorest households) would receive no additional food assistance at all. Because this interpretation finds no support in the language or purpose of section 2302, USDA should reconsider.

Section 2302(a)(1) requires USDA "provide, at the request of a State agency … that provides suffici-ent data (as determined by the Secretary through guidance) supporting such request, for emergency allot-ments to households". Nothing in section 2302 or elsewhere in the new law interrupts or overrides the existing authority in the Food and Nutrition Act to issue regular monthly allotments. Therefore, these "emergency allotments" are in addition to, rather than replacements for, the households would receive under regular SNAP. Indeed, other parts of the Families First Act, including section 2301 and section 2302(b), modify the way regular SNAP operates during the crisis. That demonstrates that Congress intended that regular SNAP allotments would continue independently of those under section 2302(a). Congress could have provided for replacing regular SNAP allotments with emergency allotments set at the maximum benefit level, but it did not do so.

Once it is established that section 2302's "emergency allotments" are independent from regular SNAP's monthly allotments, the question arises how much should those emergency allotments be. Section 2302(a)(1) goes on to say that they shall be the amount needed "to address temporary food needs not greater than the applicable maximum monthly allotment for the household size". Thus, an emergency allotment is subject to two constraints, and two constraints only: (1) it must not be more than households require to meet their emergency food needs, and (2) it must not be more than the level the Food and Nutrition Act sets as the maximum allotment for each household size (a figure based on the cost of the Thrifty Food Plan as estimated by USDA). Neither of these constraints has anything whatsoever to do with the amount of a household's regular allotment.

USDA's intention to further limit the amount of emergency allotments under section 2302(a) of the Families First Act apparently derives from language in section 5(h)(3)(A) of the Food and Nutrition Act of 2008. That section provides that

The Secretary shall provide, by regulation, for emergency allotments to eligible households to replace food destroyed in a disaster. The regulations shall provide for

Obtained via MI FOIA by Judicial Watch, Inc.

replacement of the value of food actually lost up to a limit approved by the Secretary not greater than the applicable maximum monthly allotment for the household size.

This is inapplicable for several reasons. First, section 5(h)(3)(A) provides for one kind of emergency allotments; section 2302(a) provides for another. The emergency allotments under section 5(h)(3)(A) are to replace destroyed food; those under section 2302(a) are to address temporary food needs. Similarly, section 5(h)(3)(A) responds to disasters; the President has made no disaster declaration concerning COVID-19 disease, nor does the Families First Act require him to do so for section 2302 to be effective. Nothing about the current crisis tends to destroy food. These are two different kinds of emergencies, and Congress has responded with two different kinds of emergency allotments.

Second, nothing in section 2302 or the rest of the Families First Act references section 5(h)(3)(A) or changes its applicability in any way. Congress was not reluctant to insert cross-references where it thought they would be helpful: several appear in section 2302(a) and many more are found in other parts of the Nutrition Waivers division of the Families First Act. The fact that Congress did not make any reference to section 5(h)(3)(A) at all, much less state that it constrains the amount of emergency allot-ments issued under section 2302(a), strongly suggests that Congress did not intend for those limits to apply. Whether Congress considered and rejected such limits or never considered them is unclear, but in either case USDA has no authority to apply them in lieu of section 2302(a)'s mandate.

Third, reading the limitations of section 5(h)(3)(A) as applying to emergency allotments under the Families First Act will often create a conflict with section 2302(a). If a very low-income household receives a regular SNAP allotment equal to the maximum for its household size, USDA's reading would forbid State agencies from providing them with any emergency allotment. Denying these households emergency allotments would violate section 2302(a)(1)'s requirement that USDA "shall provide … for emergency allotments to households participating in [SNAP] to address temporary food needs". Such a household would have emergency food needs yet receive no assistance in addressing those needs. In resolving such a conflict, the explicit language of section 2302(a)(1) would prevail against an inference that is unclear at best. Even if section 5(h)(3)(A) did explicitly apply to these emergency allotments, standard principles of statutory interpretation would resolve the conflict in favor of the requirement to address households' temporary food needs. As the more specific statute, section 2302(a)(1) would govern. In addition, because section 2302(a)(1) is the later-enacted statute, it could

Obtained via MI FOIA by Judicial Watch, Inc.

not be overridden by a previously-enacted statute like section 5(h)(3)(A).

Finally, reading section 2302(a)(1) to provide no emergency allotment to households currently receiving the maximum regular allotment, and to provide only small emergency allotments to households receiving regular allotments near the maximum, is contrary to the purposes of both the Families First Act and to the Food and Nutrition Act. The Families First Act seeks both to stimulate the economy and to alleviate food insecurity resulting from the current crisis. Imposing the cap from section 5(h)(3)(A) on section 2302 emergency allotments would substantially reduce economic stimulus and would leave some of the most vulnerable households – those likely to have minimal food reserves on hand – little or no assistance in meeting emergency food needs. The Food and Nutrition Act, in turn, seeks "to safeguard

the health and well-being of the Nation's population by raising levels of nutrition among low-income households". Its structure seeks overwhelmingly to target the most assistance on the lowest-income and most vulnerable households. Denying those households emergency allotments would reverse this longstanding principle and give the largest emergency allotments to the least-needy households. Here again, even if the statutory language could plausibly support imposing section 5(h)(3)(A)'s limits on section 2302 emergency allotments, the clear purposes of both statutes would militate strongly to the contrary

---

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Friday, March 20, 2020 5:07 PM
To: Stacy Dean <dean@cbpp.org>
Subject: RE: USDA FNS - Letter from Deputy Under Secretary Brandon Lipps

Let me know if this is something you'd raise to Gov to speak to publicly.

From: Stacy Dean <dean@cbpp.org>
Sent: Friday, March 20, 2020 1:21 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: Re: USDA FNS - Letter from Deputy Under Secretary Brandon Lipps

I'm on the call with FNS. They are kind of operating like this is a disruption rather than an emergency. I'm kind of stunned how tone deaf it is.

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>

Obtained via MI FOIA by Judicial Watch, Inc.

Sent: Friday, March 20, 2020 1:11 PM
To: Stacy Dean <dean@cbpp.org>
Subject: FW: USDA FNS - Letter from Deputy Under Secretary Brandon Lipps

This uses the word “usual” twice.

I did write to her.

From: English, Tim - FNS <tim.english@usda.gov>
Sent: Friday, March 20, 2020 1:07 PM
To: grace.hou@illinois.gov; kbox@isdh.in.gov; ewhetstone@isdh.in.gov; gerd.clabaugh@idoh.iowa.gov; michael.naig@iowaagriculture.gov; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Jan.Malcolm@state.mn.us; amy.acton@odh.ohio.gov; Andrea.Palm@dhs.wisconsin.gov
Cc: stephanie.bess@illinois.gov; LChavez2@isdh.in.gov; Kimberly.stanek@idph.iowa.gov; maury.wills@iowaagriculture.gov; Herring, Christina (DHHS) <HerringC@michigan.gov>; kate.franken@state.mn.us; Sean.Keller@odh.ohio.gov; lisa.murphy@dhs.wiscosnsin.gov; Solis, Patricia - FNS <patricia.solis@usda.gov>; Fletcher, Vista - FNS <vista.fletcher@usda.gov>
Subject: USDA FNS - Letter from Deputy Under Secretary Brandon Lipps

Please find attached a letter from FNCS Deputy Under Secretary Brandon Lipps regarding the Pandemic response.

Tim English
Regional Administrator
Midwest Region
Food and Nutrition Service
United States Department of Agriculture
Tim.English@USDA.gov
Office: 312-353-6664
Cell: 312-208-0837

This electronic message contains information generated by the USDA solely for the intended recipients. Any unauthorized interception of this message or the use or disclosure of the information it contains may violate the law and subject the violator to civil or criminal penalties. If you believe you have received this message in error, please notify the sender and delete the email immediately.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: "Whitmer, Gretchen"; Totten, Mark; Khaldun, Joneigh (DHHS)
Subject: State comparisons
Date: Thursday, April 23, 2020 9:04:55 AM
Attachments: image001.png

It may be worth scrolling down this NYT webpage to the by-state curves on deaths. Nothing to celebrate, and death reporting is bad, but you can see that our curve is now flatter than NJ, with more deaths, and than CT and MA, with smaller total numbers but similar rates. A week ago we were 3rd or 4th in per capita deaths and now we are 6th. Could change today, but notable.

From: Gordon, Robert (DHHS)
Sent: Thursday, April 23, 2020 8:24 AM
To: Whitmer, Gretchen <WhitmerG1@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Subject: importance of masks

Doesn't get to specific issues now being discussed, but this is a good article on potential power of masks

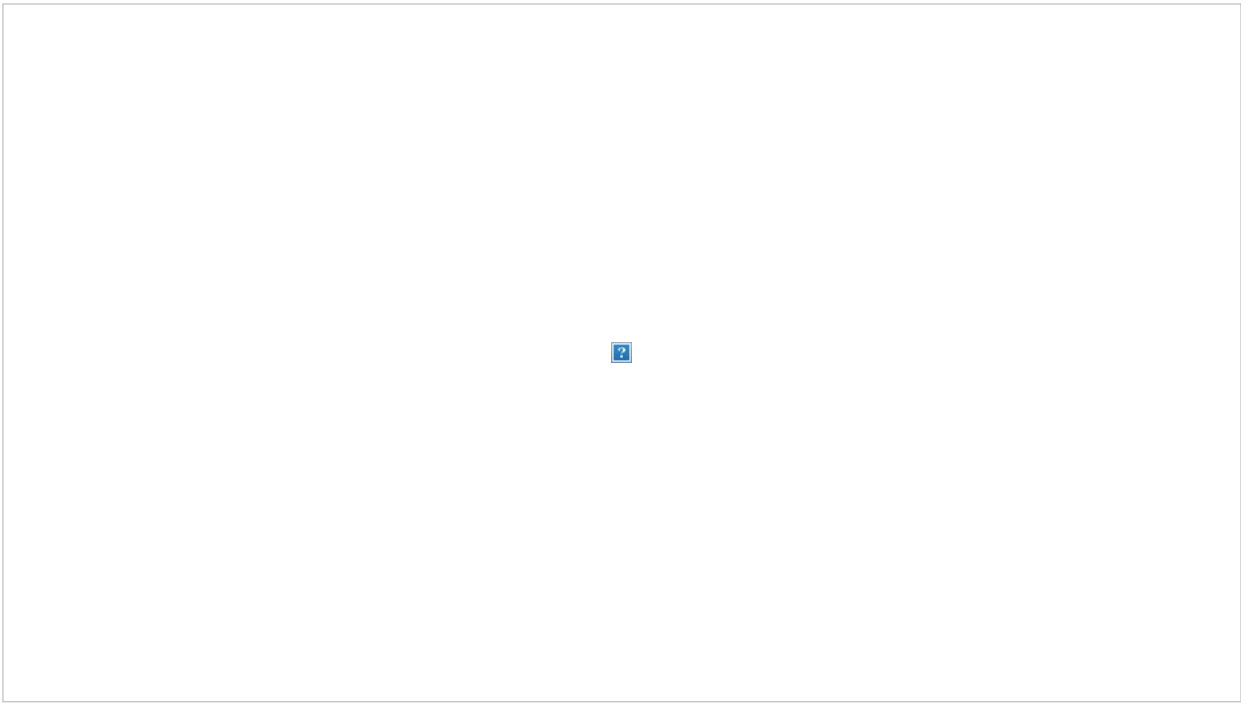
https://www.theatlantic.com/health/archive/2020/04/dont-wear-mask-yourself/610336/

Excerpts

To better understand what level of mask-wearing we need in the population to get this pandemic under control, we assembled a transdisciplinary team of 19 experts and looked at a range of mathematical models and other research to learn what would happen if most people wore a mask in public. We wrote and submitted an academic paper as well as a layperson's summary. Every infectious disease has a reproduction rate, called R. When it's 1.0, that means the average infected person infects one other person. The 1918 pandemic flu had an R of 1.8—so one infected person infected, on average, almost two others. COVID-19's rate, in the absence of measures such as social distancing and masks, is at least 2.4. A disease dies out if its R falls under 1.0. The lower the number, the faster it dies out.

The effectiveness of mask-wearing depends on three things: the basic reproduction number, R_0, of the virus in a community; masks' efficacy at blocking transmission; and the percentage of people wearing masks. The blue area of the graph below indicates an R_0 below 1.0, the magic number needed to make the disease die out.

Models show that if 80 percent of people wear masks that are 60 percent effective, easily achievable with cloth, we can get to an effective R_0 of less than one. That's enough to halt the spread of the disease. Many countries already have more than 80 percent of their population wearing masks in public, including Hong Kong, where most stores deny entry to unmasked customers, and the more than 30 countries that legally require masks in public spaces, such as Israel, Singapore, and the Czech Republic. Mask use in combination with physical distancing is even more powerful.



While cloth masks are sufficient for protecting others, people who are immunocompromised or those who have a few left over from fire season or hobbies may be considering wearing N95s, to better protect themselves. One note of caution: Many

Obtained via MI FOIA by Judicial Watch, Inc.

nonmedical N95s have exhalation valves (to make them less stuffy to wear) that let out unfiltered air, and thus won't stop the wearer from infecting others—so they shouldn't be worn around other people unless the valve is covered over with tape or cloth.

The community use of masks for source control is a "public good": something we all contribute to that eventually benefits everyone—but only if almost everyone contributes, which can be a challenge to persuade people to do. It's like emission filters in our car exhausts and chimneys: They need to be installed in all cars, factories, and houses to guarantee clean air for everyone. Usually, laws, regulations, mandates, or strong cultural norms ensure maximal participation. And once that happens, the result can be amazing.

For example, in Hong Kong, only four confirmed deaths due to COVID-19 have been recorded since the beginning of the pandemic, despite high density, mass transportation, and proximity to Wuhan. Hong Kong's health authorities credit their citizens' near-universal mask-wearing as a key factor (surveys show almost 100 percent voluntary compliance). Similarly, Taiwan ramped up mask production early on and distributed masks to the population, mandating their use in public transit and recommending their use in other public places—a recommendation that has been widely complied with. The country continues to function fully, and their schools have been open since the end of February, while their death total remains very low, at only six. In the Czech Republic, masks were not used during the initial outbreak, but after a grassroots campaign led to a government mandate on March 18, masks in public became ubiquitous. The results took a while to be reflected in the official statistics: The first five days of April still saw an average of 257 new cases and nine deaths per day, but the most recent five days of data show an average of 120 new cases and five deaths per day. Of course, we can't know for sure to what degree these success stories are because of masks, but we do know that in every region that has adopted widespread mask-wearing, case and death rates have been reduced within a few weeks.

Robert Gordon
Director
Michigan Department of Health & Human Services
gordonr3@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Pohl, Zack; Belden, Eileen; Totten, Mark; Huls, JoAnne
Subject: Suggestions for today"s remarks
Date: Wednesday, January 13, 2021 5:57:00 AM

Sharing below some suggested language for Gov's remarks today. Think consistent with yesterday convos. Key themes are that we do not want the restaurant announcement to cause people to lower their guard now, and we need to continue to look at the data. These two ideas work together.

Mark/JoAnne, realize some issues to iron out on policy specifics re restaurants. Hope last graph is clear enough. Let me know plan for bringing to closure. Thank you.

***

We are planning to reopen restaurants on February 1. That is possible because of the hard work we have done in the last two months to control COVID better than any of our Midwestern neighbors, better than all but a few states in the country. And it is safer because with each passing day, we have more Michiganders who are getting protection from the virus from vaccines.

But to stay on this track, we can't let down our guard. When I say that we are planning to reopen restaurants on February 1, that doesn't mean it's okay to start eating in with friends at your house today. It is not smart or safe to do that. We need to do everything in our power to keep our cases and hospitalizations where they are. I ask all Michiganders to continue doing their part by masking and distancing and avoiding indoor gatherings. If the numbers shoot back up, particularly with the alarming new variant from the the United Kingdom, we'll have to reassess what it means for our hospitals, seniors, and restaurants. Nobody wants that.

We are following the science. Because indoor dining involves taking off your mask, it brings a risk of getting or sharing COVID. In order to limit that risk, reopening will come with capacity limits and a curfew. Something else we have learned since the pandemic began is that ventilation is especially important. An indoor space with a good HVAC system moving out air is much safer than one with stale air where COVID just hangs. We'll be working with restaurants on all these things in the coming days.

Robert Gordon
Director, Michigan Department of Health & Human Services
gordonr3@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Ajegba, Paul (MDOT); Clark, Liesl (EGLE); Donofrio, Jeff (LEO); Eichinger, Dan (DNR); Estlund Olson, Liza (OSE); Eubanks, Rachael (TREASURY); Foster, Tricia (DTMB); Fox, Anita (DIFS); Gasper, Joe (MSP); Gordon, Robert (DHHS); Hawks, Orlene (LARA); Kolb, Chris (DTMB); McDowell, Gary (MDARD); Rogers, Paul (DMVA); Washington, Heidi E. (MDOC); Talberg, Sally (LARA); Rice, Michael (MDE); Engelman, Mary (MDCR); Winters, Jan (MCSC)
Subject: TODAY - Briefing at SEOC on COVID-19 at 2p
Date: Wednesday, March 11, 2020 9:59:11 AM

Directors,

At 4p today the governor will announce a series of recommended community mitigation strategies to prevent the spread of COVID-19 in Michigan. These recommendations will apply to various sectors across the state and will reflect a deliberate, proactive strategy to attempt to prevent a spike of cases in the state.

At 2p, Dr. Khaldun, the state's chief medical executive, and I will brief the state emergency management coordinators (SEMCs) and the members of the four COVID-19 task forces on these recommendations at the State Emergency Operations Center (MSP Headquarters, 7150 Harris Drive, Dimondale, MI 48821). You are welcome to join that briefing in person or by phone ([redacted], pin – [redacted]. At 2:30p, the task forces will break out into separate rooms to discuss implementation of these recommendations and prepare for questions that will arise.

Please and share only on an as-needed basis.

Mark Totten

_____

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark
Subject: today"s meeting
Date: Sunday, March 29, 2020 6:23:31 AM

Can you please get Tricia on that call? I want to talk about mask production

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Gordon, Robert (DHHS); Khaldun, Joneigh (DHHS)
Subject: Tomorrow
Date: Friday, March 20, 2020 9:44:29 PM

Robert and Joneigh, I wanted to mention to you that the governor is going to have a few calls tomorrow morning on the health side with people outside state government regarding COVID-19. She wants to keep the calls small - it will be her and a few others from within EOG. I'll be taking notes and if helpful I'm happy to share toplines of what was shared btw 11:30-12p. Just let me know. I have calls from 12-1p, and then our call starts at 1p.

Mark

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

**This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Huls, JoAnne
Subject: Universal Basic Income/Dan Gilbert Michigan push
Date: Wednesday, April 15, 2020 8:56:20 PM

I got a call tonight from someone I know--one of Marian Wright Edelman's sons--who has helped raise $40 million to make $1,000 payments to 40,000 Americans on SNAP, through a nice program called Propel. There are 90,000 Propel participants in Detroit. They are looking for someone, like the Governor, to raise money in Michigan. The pitch is that if we raised another $15 million, they'd match another $15 million, and there would be $30 million in payments for 30,000 Detroiters. I'm sure they'd be delighted with a small fraction of that You can see below he's working with Andrew Yang and just reached out to Dan Gilbert's office. The announcement is Tuesday.

Strikes me as a wonderful thing to do for 30,000 people, with benefits for many others in Detroit as well. As you know I've been interested in making cash payments like this but have seen no way to afford it. But I also get the challenges, the tiny time period, and the enormous number. I am sure they are talking to Mayor Duggan.

Happy to discuss if useful. Thanks.

From: Jonah Edelman <JEdelman@stand.org>
Sent: Wednesday, April 15, 2020 8:19 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: FW: Project 100 Overview / Matching Fund Opportunity for Detroit

fyi

From: Jake Cohen <jake@detroitventurepartners.com>
Sent: Wednesday, April 15, 2020 5:12 PM
To: Jonah Edelman <JEdelman@stand.org>
Cc: Andrew Yang <andrewyang@gmail.com>; Joyce Keller <joycekeller@gilbertfamilyfoundation.org>
Subject: Re: Project 100 Overview / Matching Fund Opportunity for Detroit

Jonah and Andrew, thank you for bringing this opportunity to us. We are certainly doing all we can to

I'm adding Joyce Keller from the Gilbert Family Foundation. I know that she is working around the clock right now to help our community get through these tough times. She has many initiatives, and I'm not certain she has room for more, but I'm happy to connect you.

Jake

Obtained via MI FOIA by Judicial Watch, Inc.

Jacob Cohen
Partner

Detroit Venture Partners
313-373-7752 (office)
734-673-9489 (mobile)

Madison Theater Building
1555 Broadway St
Detroit, MI, 48226

On Wed, Apr 15 2020 at 7:38 PM, Jonah Edelman <JEdelman@stand.org> wrote:

> Jake,
>
> Following up on your conversation with Andrew Yang, here is background on Project 100. As noted below, given how incredibly hard hit Detroit has been, we are able and willing to match local gifts made prior to our Tuesday launch up to a total of $15 million (I can't guarantee that match beyond Tuesday because of the interest the launch will generate). If Detroit donors drew down the whole $15 million in national matching money, that would enable direct payments non-profit GiveDirectly to efficiently provide $30 million in $1000 direct payments to help 30,000 Detroit Fresh EBT user/SNAP recipient families in dire economic circumstances to stay afloat during this terrible time.
>
> Please call me at 503-997-5355 if you have questions after reviewing the information below.
>
> Many thanks,
> Jonah Edelman
>
> **PROJECT 100**
> Next Tuesday, pathbreaking software company Propel, whose Fresh EBT app helps more than two million verified SNAP recipients each month, innovative direct payments non-profit Give Directly, and leading education non-profit Stand for Children will launch **Project 100.**
>
> **Project 100's** goal is to provide $1,000 digital cash transfers within the next 100 days to 100,000 SNAP recipient families in cities hard hit by the COVID-19 pandemic.
>
> Given how deeply impacted Detroit has been, we are open to matching every dollar contributed specifically to provide direct cash payments to Detroit area SNAP recipient families up to $15 million.
>
> Note: there are 90,000 Fresh EBT app user / SNAP recipient families in the Detroit area, making it readily possible to effectively and efficiently target $30 million in direct cash payments to 30,000 families with demonstrated need who can access to Give Directly's digital payments platform.

Obtained via MI FOIA by Judicial Watch, Inc.

Project 100 is the most ambitious COVID-19 response direct payments initiative to date, by far, and the largest private cash assistance campaign in U.S. history.

A pilot effort covered in Washington Post, Vox, Fast Company and supported by Ariana Grande, Google and many others laid the groundwork for **Project 100.** In the last two weeks, GiveDirectly used Hyperwallet to provide $1,000 digital cash transfers to more than 1,500 Fresh EBT user families who completed an app survey about the pandemic's impact.

Here are three actual responses from families who received payments:

"GiveDirectly just provided a way for my family to stay afloat during this crisis we are able to get much needed household items, pay an over due bill, have money for gas in case we need to transport."

"I brought my children laptops so they can do remote learning... I also was able to go food shopping … feeding three children is a lot of food and this took such a weight off of me so I'm extremely grateful."

"I plan on using the funds from give directly by paying my rent and other bills while my kids are out of school. I bought some groceries and diapers and wipes for my youngest child. So all this helped me out tremendously."

Here are two powerful video testimonials from recipients of those timely cash payments: Video Testimonial 1 Video Testimonial 2

Project 100 has already surpassed $40 million in funding thanks to generous support from Stacy Schusterman, Blue Meridian Partners, James Walton, Rihanna, Google.org, Flourish, The Late Show with Stephen Colbert, and many others. Our goal is to secure at least $80M in commitments before the April 21st public launch.

Jonah Edelman | Chief Executive Officer | **Stand for Children** | M 503-997-5355 | jedelman@stand.org | www.stand.org

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Gordon, Robert (DHHS)
Subject: Re: BioFire has EUA
Date: Wednesday, March 25, 2020 4:31:44 PM

WHat am I supposed to be doing here?

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Wednesday, March 25, 2020 4:04:31 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>
Subject: FW: BioFire has EUA

From: Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>
Sent: Wednesday, March 25, 2020 3:56 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Subject: Fwd: BioFire has EUA

Any word back on Gov calls to companies?

One of the key ones just got formal FDA approval.

Sent from my iPhone

Begin forwarded message:

> **From:** "Soehnlen, Marty (DHHS)" <SoehnlenM@michigan.gov>
> **Date:** March 25, 2020 at 3:47:09 PM EDT
> **To:** "Taverna, Andrea (DHHS-Contractor)" <TavernaA1@michigan.gov>
> **Subject: Fwd: BioFire has EUA**
>
> This is one of the companies we really want lots of materials to hand out to hospitals. Their EUA is formally approved.
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> > **From:** "Mosher, Laura B. (DHHS)" <mosherl@michigan.gov>
> > **Date:** March 25, 2020 at 3:44:58 PM EDT
> > **To:** "Robeson, Bruce A. (DHHS)" <robesonb@michigan.gov>, "Riner, Diana (DHHS)" <RinerD@michigan.gov>, "Soehnlen, Marty (DHHS)" <SoehnlenM@michigan.gov>
> > **Cc:** "Rodeman, Kevin M (DHHS)" <rodemank@michigan.gov>, "Day, Julie (DHHS)" <DayJ3@michigan.gov>

Obtained via MI FOIA by Judicial Watch, Inc.

Subject: BioFire has EUA

BioFire now has an EUA for their FilmArray SARS-CoV2

BioMérieux Rapid Coronavirus Test Gets FDA Emergency Use Authorization
Mar 24, 2020
|
staff reporter
Save for later
NEW YORK –BioMérieux said on Tuesday that an assay developed by its subsidiary BioFire Defense to rapidly detect COVID-19, the disease caused by SARS-CoV-2 virus, was granted Emergency Use Authorization by the US Food and Drug Administration.
The BioFire COVID-19 test detects SARS-CoV-2 from nasopharyngeal swabs in transport media in approximately 45 minutes. The test can be run on the BioFire FilmArray system as well as the higher-throughput FilmArray Torch, as previously reported. These platforms require minimal skill and training to operate. They are closed and fully-automated systems that integrate sample preparation, amplification, and detection.
BioMérieux has also received authorization to sell the BioFire COVID-19 test External Control Kit. This positive control material may be used for quality control and laboratory verification of the test, the firm said in a statement.
The BioFire COVID-19 test was developed by leveraging an existing contract between BioFire Defense and the US Department of Defense. It is the second of three tests to be launched by BioMérieux for COVID-19 detection, and the firm said it will also pursue EUA for the two others.
It has already launched a test in France, called SARS-CoV-2 R-Gene, for open real-time PCR platforms, and it is working to expand its FilmArray Respiratory Panel 2 test to include SARS-CoV-2 detection. The new panel will be called FilmArray RP2.1 and will also detect 21 other pathogens that cause respiratory infections.
In addition to the COVID-19 test and respiratory panel, the FilmArray system runs a broad menu of other syndromic multiplex-PCR tests for infectious disease, including pneumonia, bloodstream infections, gastrointestinal infections, meningitis, and encephalitis. BioMérieux said in a recent earnings report that it has placed 10,400 FilmArray instruments to date.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Crockett, Tracy; Foster, Tricia; Huls, JoAnne; Flood, Jennifer; Laidlaw, Emily; Lange, Michelle; Sherry, Dana; Readinger, Patricia; Khaldun, Joneigh (DHHS); LyonCallo, Sarah (DHHS); Ingersoll, Jean (DHHS); Gordon, Robert (DHHS); Corbin, Susan (LEO); Anderson, Evan (LEO); Eubanks, Rachael (TREASURY); Guilfoyle, Jeffrey (TREASURY); Mark Burton (MEDC); Gasper, Joe (MSP); Sweeney, Kevin (MSP); Razili Lewis; Smith Jonathan (LEO); Erin McGovern; Brandon Carrus
Cc: Smith, Dana; Smith, Tammy; Gregory, Robin (DHHS); Lounds, Elizabeth (DHHS); Bowden, Andrea (DHHS); Burton, Diane (LEO); Kabia, Kara (TREASURY); Amiee Evans (MEDC); Luebs, Heather (MSP); Schnepp, Matt (MSP)
Subject: RE: CALL: COVID-19 Recovery Planning
Date: Friday, November 13, 2020 7:31:01 AM

I am going to cancel this meeting today because I think we can achieve our goal without it. (Tracy, please go ahead and cancel it on the calendar.)

Thank you LEO, MDHHS, and MSP for submitting your recovery planning documents. I've combined them into a single document that I will share with MSP and which MSP can draw on as it crafts our recovery plan document to submit to FEMA later this month or early next month. We may need one or more agency-specific conversations during the drafting process, but we can schedule those calls as needed. And of course we will all have chance to review the final document to submit to FEMA before submission.

Thanks, Mark

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email and any associated documents may contain information that is privileged or otherwise exempt from disclosure. It is intended for use only by the person to whom it is addressed. Please contact me before disclosure. If you have received this email in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

-----Original Appointment-----
From: Crockett, Tracy <CrockettT1@michigan.gov>
Sent: Friday, October 30, 2020 3:42 PM
To: Crockett, Tracy; Totten, Mark; Foster, Tricia; Huls, JoAnne; Flood, Jennifer; Laidlaw, Emily; Lange, Michelle; Sherry, Dana; Readinger, Patricia; Khaldun, Joneigh (DHHS); LyonCallo, Sarah (DHHS); Ingersoll, Jean (DHHS); Gordon, Robert (DHHS); Corbin, Susan (LEO); Anderson, Evan (LEO); Eubanks, Rachael (TREASURY); Guilfoyle, Jeffrey (TREASURY); Mark Burton (MEDC); Gasper, Joe (MSP); Sweeney, Kevin (MSP); Razili Lewis; Smith Jonathan (LEO); Erin McGovern; Brandon Carrus
Cc: Smith, Dana; Smith, Tammy; Gregory, Robin (DHHS); Lounds, Elizabeth (DHHS); Bowden, Andrea (DHHS); Burton, Diane (LEO); Kabia, Kara (TREASURY); Amiee Evans (MEDC); Luebs, Heather (MSP);

Obtained via MI FOIA by Judicial Watch, Inc.

Schnepp, Matt (MSP)
Subject: CALL: COVID-19 Recovery Planning
When: Friday, November 13, 2020 10:30 AM-11:30 AM (UTC-05:00) Eastern Time (US & Canada).
Where: Microsoft Teams Meeting

Microsoft Teams meeting

Join on your computer or mobile app
[redacted]

Or call in (audio only)
[redacted] United States, Pontiac
Phone Conference ID: [redacted]
Find a local number | Reset PIN

Learn More | Meeting options

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Hawks, Orlene (LARA); Huls, JoAnne
Cc: Gordon, Robert (DHHS); Foster, Tricia; Gaedeke, Kimberly (LARA); Khaldun, Joneigh (DHHS)
Subject: RE: Care Facilities, non-nursing home
Date: Tuesday, April 21, 2020 7:38:53 AM

+ Joneigh for awareness

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

From: Hawks, Orlene (LARA) <HawksO@michigan.gov>
Sent: Monday, April 20, 2020 11:52 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Gaedeke, Kimberly (LARA) <GaedekeK@michigan.gov>
Subject: Re: Care Facilities, non-nursing home

JoAnne,

Below is a highlight of our collaboration with DHHS along with LARA's continued efforts like DHHS in focusing on our vulnerable senior population:

- BCHS/LARA continue to participate in weekly if not two to three times a week calls with MSA/DHHS for the LTC Workgroup discussion between the two departments. This allows for coordination of efforts, discussion of any emerging issues amongst long term care providers, and open dialogue of issues in general related to long term care and nursing homes. Additionally, both departments participate on provider calls to discuss issues.

- Discussions of "strike teams" has turned into "iPRAT" in that the resources will be focused on virtual meetings with long term care providers first before going on site, "iPRAT" efforts will be coordinated by DHHS and LARA will be available to help and support as needed. LARA will continue to conduct its on-site visits which are unannounced and let DHHS know if there are public health concerns where further resources and/or education may be needed to assist a

Obtained via MI FOIA by Judicial Watch, Inc.

provider.

BCHS priorities include the following as it relates to long term care facilities:

- Nursing homes, county medical care facilities, and hospital long term care units ("nursing homes"): Onsite investigations are being done for allegations of immediate harm to the health, safety and welfare of residents (including lack of staffing) as well as infection control breaches. Allegations of improper discharges or transfers as well as other lower tiered allegations are being performed via phone calls and other electronic methods. Investigations are being done under state licensing and / or federal certification authority (Centers for Medicare and Medicaid Services).

- Hospitals (including inpatient psychiatric hospitals): Onsite investigations are being done for allegations of immediate harm to the health, safety and welfare of patients as well as infection control breaches. Investigations are being done under state licensing and / or federal certification authority (Centers for Medicare and Medicaid Services).

- Dialysis centers: Onsite investigations are being done for allegations of immediate harm to the health, safety and welfare of patients as well as infection control breaches. Investigations are being done under federal certification authority (Centers for Medicare and Medicaid Services).

- Adult foster care homes: Onsite investigations are being done for allegations of immediate harm to the health, safety and welfare of residents. All other lower tiered investigations are being performed via phone calls and other electronic methods. Investigations are being done under state licensing authority.

- Homes for the aged: Onsite investigations are being done for allegations of immediate harm to the health, safety and welfare of residents. All other lower tiered investigations are being performed via phone calls and other electronic methods. Investigations are being done under state licensing authority.

- All other provider types are being monitored and onsite or other methods of investigations are initiated if there is an allegation of immediate harm to the health, safety and welfare of patients or residents. Provider types include hospice agencies and residences, home health agencies, substance use disorder programs, rural health clinics, portable X-ray providers, outpatient therapy and speech pathology providers, and comprehensive outpatient rehabilitation facilities. Investigations are done under both state licensing and / or federal certification authority (Centers for Medicare and Medicaid Services).

- Like nursing homes, adult foster care homes and homes for the aged providers are allowed under EO-50 to cohort residents. Many non-nursing home providers are identifying facilities to cohort residents that are COVID-19 positive or showing

Obtained via MI FOIA by Judicial Watch, Inc.

symptoms of COVID-19. It is unclear if adult foster care home and homes for the aged residents can cohort with like nursing home residents. Providers are waiting additional guidance from MDHHS as all these providers are categorized in EO-50 as long term care facilities. However the non-nursing home hubs are not eligible for the enhanced reimbursement to our understanding unless they are taking nursing home residents. The alternative care sites like TCF and the Suburban locations currently allow only patients to be transferred to these locations from a hospital under limited circumstances, and not directly from a nursing home, adult foster care home or homes for the aged. Providers are seeking clarification from MDHHS on these above matters related to EO-50.

- BCHS/LARA notifies MDHHS Medicaid, adult protective services and the epidemiologist office of any known outbreaks reported to our office from local health departments, significant infection control breaches, or enforcement action that may result in the closure and transfer of residents. BCHS/LARA met today with Nicole Hudson at MDHHS to discuss coordination and responsibilities related to the proposed "strike teams"/"iPRAT" and its possible phased roll out. Currently BCHS/LARA will support the "strike teams" to any of the above-referenced concerns as well as be available to answer any licensing or certification questions a provider may have.

- BCHS/LARA does not receive reports from MDHHS on positive cases within a licensed provider. BCHS/LARA is notified by either the provider directly of a case or cases, by the local health department if there appears to be an outbreak, or by media reports. Almost all nursing home providers have already set up dedicated isolation units and have implemented infection control practices. BCHS/LARA will contact a provider if notified by a local health department, fire department, or EMS if there are local concerns to determine the number of possible COVID-19 cases and infection control practices. If during these conversations with local authorities or the provider, BCHS/LARA may then initiate an unannounced onsite inspection if necessary.

This is a highlight and certainly can provide additional information or details. I'm willing to have a phone conversation as well if that'll be more helpful. I've added Kim to this conversation as she's been the lead on the calls with DHHS.

Orlene

On Apr 20, 2020, at 9:26 PM, Huls, JoAnne <HulsJ1@michigan.gov> wrote:

Directors,

Obtained via MI FOIA by Judicial Watch, Inc.

We have had separate conversations about our most vulnerable populations, and I know your teams are working diligently on pathways to protect people during this time - especially those in congregate care settings. I'm hoping that you can help educate me on connection between your two teams relating to these spaces. This email is to capture some of my thoughts, and to see if you already have a plan, or perhaps we need to knit two plans together.

Director Hawks, I was encouraged by your email that LARA has made 73 visits to nursing homes since March 29th focused on infection control and staffing. Are there similar visits the department is making to Homes for the Aged and Adult Foster Care, particularly the larger care facilities? I know these are "different" but they are similarly vulnerable populations.

Director Gordon, the launch of regional hubs for skilled nursing homes today is a great step forward to control infection in nursing homes and make sure residents and employees are protected. Are there similar efforts underway to protect other vulnerable populations in congregate care like Homes for the Aged and Adult Foster Care? Are there additional partnerships we need to engage in or should we utilize some of our state resources like TCF and Suburban to help protect these vulnerable populations? I have heard that you are looking at this as an option for the operations team — but maybe it makes sense to do regional hubs too? Curious what your thinking is on this.

How does information flow between the departments when:

1. LARA identifies an infection control issue at a visit?
    a. Is there assistance from public health or another bureau in DHHS that helps?
    b. How does the "strike team" fit into these efforts?
2. DHHS gets a report that there is a COVID positive resident.
    a. What happens next?
    b. Does the LARA licensing team assist to make sure proper infection control and quarantines are in place?

Can you share with me the information flow, and action that follows, and what the plan will be (as a shared workgroup) for

- Skilled Nursing Facilities
- Homes for the Aged
- Adult Foster Care

Perhaps this is all happening, which is great! I'm happy to have a phone conversation too — whatever is easiest .

Many thanks
JoAnne

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Gordon, Robert (DHHS); Foster, Tricia
Subject: RE: Cases & Fatalities
Date: Wednesday, September 16, 2020 6:35:01 AM

Thanks for sharing, Robert. I've given it a review and will look for the presentation next Monday evening.

Mark

_____

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email and any associated documents may contain information that is privileged or otherwise exempt from disclosure. It is intended for use only by the person to whom it is addressed. Please contact me before disclosure. If you have received this email in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Monday, September 14, 2020 5:12 PM
To: Totten, Mark <TottenM1@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>
Subject: Cases & Fatalities

We have had some conversations around the relationship between cases and fatalities, as well as the role of policy in variation across states. Yesterday Dr. Parekh did the analysis attached and below. The presentation tonight was jammed so it will be in next week's deck, but I wanted to share this now. Welcome feedback if there's further analysis you'd like.

Column F is the key on the first tab.

Thanks,
Robert

From: Parekh, Vikas <viparekh@med.umich.edu>
Sent: Sunday, September 13, 2020 4:09 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Megan Leitch <Megan_Leitch@mckinsey.com>
Cc: Pardo, Jennifer <jlbrenn@med.umich.edu>; Garifullin, Max <mgariful@med.umich.edu>

Obtained via MI FOIA by Judicial Watch, Inc.

Subject: For consideration

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Three tabs in the spreadsheet.

Tab 1 is the analysis of what if scenarios in Michigan and what deaths would be in each scenario
Tab 2 is quick compilation of interventions in Michigan, Wisconsin, Illinois and timing
Tab 3 is MI, WI, IL case rates/population over time

Major takeaways of course are that in Tab 1 more cases equal more deaths. If we had case rates like our neighbors we'd have had hundreds of more deaths this summer.

In Tab 2 – hard to know what to make of the difference in reopening timelines – see below.

Tab 3- When I cross against case trajectories I can say it seems mask mandates/tightening of mask mandates in Michigan and Wisconsin seemed to result in a change in case trajectory (Michigan flattened, Wisconsin went down).
Wisconsin rose in May with an odd dip in June before rising again, Michigan started rising in June and Illinois a bit later in late June/early July. Maybe opening restaurants/bars later is correlated with the lag although hard to say. It is clear that Illinois and Wisconsin opened up before getting as low as Michigan in cases/population and that may explain a fair amount of the differences in trajectory. Illinois really didn't make any interventions most of the summer until it hit some regional triggers that went into effect late August/early September.

Vikas

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Foster, Tricia; Huls, JoAnne; LyonCallo, Sarah (DHHS); Gordon, Robert (DHHS); Groen, Meghan; Taverna, Andrea (DHHS-Contractor); Hertel, Elizabeth (DHHS); Khaldun, Joneigh (DHHS)
Subject: RE: Comments and recommendations re: Containment teams
Date: Tuesday, April 21, 2020 4:58:58 AM

[Taking off a few people so just EOG/DHHS; adding Dr. J]

I've highlighted the portions of Laura's email below that most grabbed my attention. In particular, her email raises the question of whether we should be expanding testing criteria when (at least some) hospitals cannot test persons with mild symptoms, let alone asymptomatic CIW. Perhaps the answer is that our commercial labs do not have the same problem, and hospitals will often not get as far down the hierarchy of testing priorities because of the nature of their work. Also could be less about hospitals vs. other testing sites, as one region vs. next.

_____

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

**This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.

-----Original Message-----
From: Laura Appel <lappel@mha.org>
Sent: Monday, April 20, 2020 10:27 PM
To: Foster, Tricia <FosterT13@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Vanderstelt, Meghan <sifuente@msu.edu>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>; Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Pohl, Zack <PohlZ@michigan.gov>; Flood, Jennifer <FloodJ1@michigan.gov>
Subject: Comments and recommendations re: Containment teams

▪ Consolidate current data on testing capacity and testing supplies – focus on "why is testing below current total capacity? What are bottlenecks?"

Today the MHA sent a survey to hospitals requesting details on COVID-19 testing supplies including swabs, specimen collecting kids, reagents, viral transport medium, etc.

Obtained via MI FOIA by Judicial Watch, Inc.

This survey did not go to commercial labs and does not include the drive-thru testing the city of Detroit is doing. There maybe another survey tool going to these entities.
I am not certain how Warde, the lab owned by Trinity and other hospital systems, fits into this survey. I assume they will answer the hospital survey, but Warde does not have access to EMResource.

Even without the survey, several of those on the Containment Team were part of a phone call last week with hospital lab directors and are well aware of the problems. With the exception of Michigan Medicine, there were universal reports of shortages of all of the supplies listed above. No hospital reported an ability to expand testing to the mildly symptomatic because there were not enough supplies on hand to safely add more capacity. All supplies were needed to test inpatients, hospital employees and first responders. There is uncertainty about additional supplies coming to hospitals, so testing capacity is essentially rationed by most hospitals.

Michigan Medicine did report it was ready to be in the field and testing in the community. How much testing and how it was organized was not discussed extensively on the phone call.

Communicating expanded testing criteria should be done in areas which have the resources to do the additional testing. Last week, areas of the state with limited supplies were turning away people who fit the newest criteria because the supply of sampling materials is not adequate. Encouraging testing in places without the means to take samples does not create positive results.

Changes to EMResource are expected, and were reported in today's daily brief the MHA sends to all hospital members. However, several times new fields have been entered into EMResource without notice and without assistance to those who complete the data entry on a daily basis. It will be most effective if the new fields go live after the hospitals are notified and given guidance on how to fill in their answers.

Note that the larger hospital systems are organized regionally or even statewide. My understanding is that EMResource only takes information hospital by hospital. Some supplies are not ordered or stored by hospital, but are warehoused for the regional areas of the systems. Anticipating this potential challenge will help maximize accuracy in data collection.

Again—EMResource is a hospital-focused tool. Testing is now in the hands of many entities which are not hospitals. EMResource will not give a full picture of testing capacity and supplies. The past month of results from Warde (15,000 results) were to be handed off to the state last Friday in a data base format. Warde is reportedly doing 1,000 tests per day. It is not clear if these tests are now being included in the state's daily count or if the batch of 15,000 has been incorporated into the totals.

- Build preliminary dashboard/Performance Tracking/Information systems

I recommend Jim Lee from MHA be part of the dashboard work and added to the Performance Tracking and Information systems sub groups.

Obtained via MI FOIA by Judicial Watch, Inc.

▪ Prioritization and Evaluation of alternative testing products and methodologies Brittany Bogan is managing this area for MHA and should be added to to this sub-group.
MHA staff can engage other hospital representatives as needed .

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Gordon, Robert (DHHS)
To:	Foster, Tricia; Totten, Mark; Huls, JoAnne; LyonCallo, Sarah (DHHS); Groen, Meghan; Taverna, Andrea (DHHS-Contractor); Hertel, Elizabeth (DHHS); Khaldun, Joneigh (DHHS)
Subject:	RE: Comments and recommendations re: Containment teams
Date:	Tuesday, April 21, 2020 7:22:15 AM
Attachments:	MDHHS Essential Workers Test Criteri.pdf

Per attached memo the expansion in test criteria includes priority ranking. So if you have enough supplies (like Detroit drive-thrus) you can get to lower-priority groups like asymptomatic essential workers, but if you don't have enough supplies like hospitals, then you don't have to. Others at DHHS could correct me, but we have had ready-to-go unused capacity in the drive-thrus, such that encouraging essential workers and symptomatic to go to them is a way to ramp our testing numbers relatively quickly. I get that Laura's point that this creates a messaging challenge at the hospitals where they lack that ready-to-go capacity. Team will know better than me what it takes to build out through the hospitals; if it's simply the supplies, then it's a good fit for the call mentioned below.

From: Foster, Tricia <FosterT13@michigan.gov>
Sent: Tuesday, April 21, 2020 7:10 AM
To: Totten, Mark <TottenM1@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>; Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Subject: RE: Comments and recommendations re: Containment teams

It is a concern for sure, but always might be. I think we can also use this in our push with the federal government for getting us more supplies. Patty is working on that call with the Admiral for as early as tomorrow. We will need to show we are capable and poised and can ramp up X% to match our protocol modification for who can get tested; if we had the right resources.

Tricia L. Foster, CPM, ACoM
Chief Operating Officer
State of Michigan
Fostert13@michigan.gov

From: Totten, Mark <TottenM1@michigan.gov>
Sent: Tuesday, April 21, 2020 4:59 AM
To: Foster, Tricia <FosterT13@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>; Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Subject: RE: Comments and recommendations re: Containment teams

[Taking off a few people so just EOG/DHHS; adding Dr. J]

Obtained via MI FOIA by Judicial Watch, Inc.

I've highlighted the portions of Laura's email below that most grabbed my attention. In particular, her email raises the question of whether we should be expanding testing criteria when (at least some) hospitals cannot test persons with mild symptoms, let alone asymptomatic CIW. Perhaps the answer is that our commercial labs do not have the same problem, and hospitals will often not get as far down the hierarchy of testing priorities because of the nature of their work. Also could be less about hospitals vs. other testing sites, as one region vs. next.

_____

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

**This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.

-----Original Message-----
From: Laura Appel <lappel@mha.org>
Sent: Monday, April 20, 2020 10:27 PM
To: Foster, Tricia <FosterT13@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Vanderstelt, Meghan <sifuente@msu.edu>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>; Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Pohl, Zack <PohlZ@michigan.gov>; Flood, Jennifer <FloodJ1@michigan.gov>
Subject: Comments and recommendations re: Containment teams

▪ Consolidate current data on testing capacity and testing supplies – focus on "why is testing below current total capacity? What are bottlenecks?"

Today the MHA sent a survey to hospitals requesting details on COVID-19 testing supplies including swabs, specimen collecting kids, reagents, viral transport medium, etc.

This survey did not go to commercial labs and does not include the drive-thru testing the city of Detroit is doing. There maybe another survey tool going to these entities.
I am not certain how Warde, the lab owned by Trinity and other hospital systems, fits into this survey. I assume they will answer the hospital survey, but Warde does not have access to EMResource.

Obtained via MI FOIA by Judicial Watch, Inc.

Even without the survey, several of those on the Containment Team were part of a phone call last week with hospital lab directors and are well aware of the problems. With the exception of Michigan Medicine, there were universal reports of shortages of all of the supplies listed above. No hospital reported an ability to expand testing to the mildly symptomatic because there were not enough supplies on hand to safely add more capacity. All supplies were needed to test inpatients, hospital employees and first responders. There is uncertainty about additional supplies coming to hospitals, so testing capacity is essentially rationed by most hospitals.

Michigan Medicine did report it was ready to be in the field and testing in the community. How much testing and how it was organized was not discussed extensively on the phone call.

Communicating expanded testing criteria should be done in areas which have the resources to do the additional testing. Last week, areas of the state with limited supplies were turning away people who fit the newest criteria because the supply of sampling materials is not adequate. Encouraging testing in places without the means to take samples does not create positive results.

Changes to EMResource are expected, and were reported in today's daily brief the MHA sends to all hospital members. However, several times new fields have been entered into EMResource without notice and without assistance to those who complete the data entry on a daily basis. It will be most effective if the new fields go live after the hospitals are notified and given guidance on how to fill in their answers.

Note that the larger hospital systems are organized regionally or even statewide. My understanding is that EMResource only takes information hospital by hospital. Some supplies are not ordered or stored by hospital, but are warehoused for the regional areas of the systems. Anticipating this potential challenge will help maximize accuracy in data collection.

Again—EMResource is a hospital-focused tool. Testing is now in the hands of many entities which are not hospitals. EMResource will not give a full picture of testing capacity and supplies. The past month of results from Warde (15,000 results) were to be handed off to the state last Friday in a data base format. Warde is reportedly doing 1,000 tests per day. It is not clear if these tests are now being included in the state's daily count or if the batch of 15,000 has been incorporated into the totals.

▪ Build preliminary dashboard/Performance Tracking/Information systems

I recommend Jim Lee from MHA be part of the dashboard work and added to the Performance Tracking and Information systems sub groups.

▪ Prioritization and Evaluation of alternative testing products and methodologies Brittany Bogan is managing this area for MHA and should be added to to this sub-group.

MHA staff can engage other hospital representatives as needed .

Obtained via MI FOIA by Judicial Watch, Inc.

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ROBERT GORDON
DIRECTOR

MEMORANDUM

Date: April 20, 2020

To: Health Care Providers, Healthcare Facilities, Infection Prevention and Control n Specialists, and Laboratory Administrators

From: Joneigh Khaldun, MD, MPH, FACEP
Chief Medical Executive and Chief Deputy for Health
Michigan Department of Health and Human Services (MDHHS)

Executive Summary

- MDHHS is expanding COVID-19 testing prioritization criteria to include all health care workers and first responders (even if they do not have symptoms) as part of the Priority Three group for testing
- MDHHS has added a Priority Four group that includes critical infrastructure workers (i.e., any worker still leaving the home for in-person work), whether they have symptoms or not.
- Health care providers should still prioritize test capacity for higher-risk patients, but if additional specimen collection and testing capacity is still available after serving these patients, providers should also test exposed critical infrastructure workers.
- The full current testing prioritization criteria are reproduced at the end of this memorandum.

Introduction

As the COVID-19 situation in the State of Michigan evolves, MDHHS continues to adapt resource and capacity planning to support the varied needs of our partners in healthcare and local public health organizations. MDHHS recently ordered that all health professionals should conduct testing for the Novel Coronavirus in accordance with the COVID-19 prioritization criteria published by MDHHS. This letter informs you of changes to those criteria.

1. Expansion of COVID-19 Testing Prioritization Criteria to Include All Critical Infrastructure Workers with Potential Exposure, Whether Symptomatic or Asymptomatic

Given the continued expansion of COVID-19 testing capacity in Michigan, MDHHS is expanding the COVID-19 testing prioritization criteria to broaden the populations eligible for testing to include individuals with mild symptoms in certain circumstances. **Specifically, health care providers should test any healthcare facility worker or first responder (even if they do not have symptoms). Critical infrastructure workers (i.e., any worker still leaving the home for in-person work) with potential COVID-19 exposure, whether symptomatic or asymptomatic, should be tested as well, so long as adequate specimen collection and test processing capacity remains after serving all known patients in higher-priority testing categories**.

Obtained via FOIA by Judicial Watch, Inc.

The U.S. Centers for Disease Control and Prevention (CDC) have issued clinical guidance to help prioritize COVID-19 testing resources that, unfortunately, remain too scare nationwide. These guidelines (https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html) group patients into Priority One, Priority Two, and Priority Three categories, reflecting risk of severe illness and other considerations like integrity of the healthcare system.

Providers must continue to follow MDHHS prioritization criteria and must prioritize test capacity for populations from Priority One, Priority Two, and Priority Three patients; these priorities are reproduced at the end of this memorandum. If capacity remains after serving patients from those priority populations, providers should test all critical infrastructure workers with potential COVID-19 exposure, whether symptomatic or asymptomatic. This population is not prioritized by the CDC guidelines.

MDHHS recognizes that population health needs, patient characteristics, and testing capacity vary significantly across the state, and this system seeks to broaden eligibility for testing to fully take advantage of available test capacity in the state, while still ensuring that the highest-risk patients can access testing resources. It is also important to note that Michigan is seeing alarming racial disparities in COVID-19 cases and deaths, with African Americans consisting of 14% of the state's population, but 33% of cases and 40% of deaths. Clinicians should be mindful of this disparity and have heightened awareness when considering testing and treatment strategies in this patient population.

Health care providers should assess available testing resources on a periodic basis (e.g., weekly) and determine if resources are sufficient to serve asymptomatic critical infrastructure workers, alongside other priority populations.

Please note that testing asymptomatic critical infrastructure workers does not change precautions that should be taken to decrease COVID-19 spread, including quarantine of exposed individuals, and that a negative test result reflects infection status at a point in time. An individual may receive a negative test result soon after exposure but later develop an infection.

As a reminder, per the March 24, 2020 MDHHS Emergency Order, all CLIA-certified laboratories in Michigan are required to comply with prioritization criteria as promulgated by MDHHS. This includes Public Health, commercial, and healthcare facility laboratories. We believe that these clarifications and this expansion of prioritization criteria will help to improve access to COVID-19 testing.

This expanded prioritization criteria will take effect at 8:00 AM on April 21, 2020.

2. Full COVID-19 Testing Prioritization Criteria Currently in Effect

As a reminder, the current MDHHS COVID-19 testing prioritization criteria are as follows:

Priority One

- Hospitalized Patients
- Healthcare facility workers with symptoms;
    - Note: MDHHS interprets this to include all workers within a healthcare facility, not just providers of direct healthcare services.

Obtained via FOIA by Judicial Watch, Inc.

Priority Two

- Patients in long-term care facilities with symptoms
    - Note: MDHHS interprets this to include any resident with symptoms in congregate living arrangements, not only long-term care facilities.
- Patients over age 65 years with symptoms
- Patients with underlying conditions with symptoms
- First responders with symptoms

Priority Three

- Critical infrastructure workers with symptoms
- Individuals who do not meet any of the above categories with symptoms
- (Newly added) Asymptomatic health care workers and first responders
- Individuals with mild symptoms in communities experiencing high COVID-19 hospitalizations
    - Note: MDHHS interprets the full state of Michigan to be a community with high COVID-19 hospitalizations

Newly Added Priority

- Critical infrastructure workers, including asymptomatic workers
    - Note: these individuals may be tested only if specimen collection and testing capacity remains after serving all patient groups above

MDHHS is making these changes as part of its efforts to increase testing access to as many Michiganders as feasible while ensuring that statewide testing capacity is sustained. We will continue to monitor test availability and adjust this protocol, as necessary.

For the latest information on Michigan's response to COVID-19, please visit www.michigan.gov/coronavirus. You may also email our Community Health Emergency Coordination Center at: checcdeptcoor@michigan.gov.

Thank you for all you do to serve the residents of Michigan at this difficult time.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Gordon, Robert (DHHS); Foster, Tricia; Totten, Mark; Khaldun, Joneigh (DHHS); Rising, Jay
Cc: Pohl, Zack
Subject: Re: Connecting you
Date: Tuesday, March 31, 2020 12:46:30 PM

Thanks for sharing.

You said this morning that there was something we could do to help move the process along. Do you want to let me know what that is, and we'll do that?

Thanks

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Tuesday, March 31, 2020 12:09:12 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Rising, Jay <RisingJ@michigan.gov>
Cc: Pohl, Zack <PohlZ@michigan.gov>
Subject: FW: Connecting you

As part of the philanthropically funded comms work, there is some new testing on the effectiveness of different messages. The grimmest message works much better than the others:

> *You can have COVID-19 and not even know it. By leaving home, one person with COVID-19 could infect 40 others—and those 40 people could go on to infect 2,000 more. Do your part. Stay home, stay safe and slow the spread.*

This one was suggested by some behavioral science people who said it was now being used in Italy.
From: Alex Koeberle <akoeberle@civisanalytics.com>
Sent: Tuesday, March 31, 2020 11:20 AM
To: Chris Dick <cdick@civisanalytics.com>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Bouknight, Rey (DHHS) <BouknightR@michigan.gov>; Skylar with Civis <smills@civisanalytics.com>; David Shor <dshor@civisanalytics.com>; Lawson, Harper <Harper.Lawson@gmmb.com>; Siegel, Traci <Traci.Siegel@gmmb.com>; Pohl, Zack <PohlZ@michigan.gov>
Subject: Re: Connecting you

Hey all,

Here is the initial memo of results!

Cheers,
Alex

On Mon, Mar 30, 2020 at 10:18 AM Chris Dick <cdick@civisanalytics.com> wrote:

Obtained via MI FOIA by Judicial Watch, Inc.

Robert,

I will check in with the team this morning to see if we can still fit this one in today.

Best,

chris

On Mon, Mar 30, 2020 at 7:47 AM Gordon, Robert (DHHS) <GordonR3@michigan.gov> wrote:

> One more idea I'd like to learn about—a way of reframing help already on offer. If not too late for today, would love to get it in. If too late, next round. Thanks.
> "Staying inside is tough on all of us, but by stopping the spread of Coronavirus, you save lives. If you need help paying the bills right now, you can get it. Visit Michigan.gov/bridges."
>
> **From:** Alex Koeberle <akoeberle@civisanalytics.com>
> **Sent:** Sunday, March 29, 2020 11:02 PM
> **To:** Bouknight, Rey (DHHS) <BouknightR@michigan.gov>
> **Cc:** Skylar with Civis <smills@civisanalytics.com>; David Shor <dshor@civisanalytics.com>; Chris Dick <cdick@civisanalytics.com>; Lawson, Harper <Harper.Lawson@gmmb.com>; Siegel, Traci <Traci.Siegel@gmmb.com>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Pohl, Zack <PohlZ@michigan.gov>
> **Subject:** Re: Connecting you
>
> Thanks Rey! We are running with this tonight and I look forward to talking through next steps tomorrow.
>
> Cheers,
>
> Alex
>
> On Sun, Mar 29, 2020 at 10:51 PM Bouknight, Rey (DHHS) <BouknightR@michigan.gov> wrote:
>
>> Hi Civis,
>>
>> As promised, here are KPIs and messages for testing. We'd like the first round to include the five messages highlighted with results provided Tuesday. Perhaps we can discuss next steps for testing the remaining messages during tomorrow's call. Please let us know if you have any questions. Thank you.
>>
>> Best,
>> Rey
>>
>> **KPIs**

Obtained via MI FOIA by Judicial Watch, Inc.

- Increase willingness to stay home
- Reduce frequency of leaving the house
- Reduce number of in-person interactions with others
- More willing to follow recommended hygienic precautions (i.e. washing hands)
- More willing to isolate yourself from others if sick

Messages For First Round:

Time to Treat

People are dying. Hospitals are overflowing. And there is no vaccine yet to stop COVID-19.

We need time to treat the people that are sick and develop drugs that work. The only way to do that is for *all* of us to help stop the spread by staying home and limiting our contact with others.

Risk to others

You can have COVID-19 and not even know it. By leaving home, one person with COVID-19 could infect 40 others—and those 40 people could go on to infect 2,000 more. Do your part. Stay home, stay safe and slow the spread.

Discrimination

Race. Gender. Age. It doesn't matter—because COVID-19 doesn't discriminate. It's infecting all us all – no matter who we are or where we live. Right now, the best way to protect the community and stay safe is to stay home.

It's you

Doctors and nurses are risking their lives to treat those with it. Scientists are trying to figure out how to beat it – around the clock. Their most important partner in this fight? It's you. You can personally stop coronavirus from spreading to thousands more. Stay home. Stay safe.

Likelihood

The more often you leave your home, the more likely it is that you will catch COVID-19, infect others, and spread the virus. That's why the Governor has urged us to stay at home. The steps being taken to limit contact have worked in other countries, and they will work here in Michigan, too.

Potential Messages For Testing Later:

Grandma

Our communities are only as strong as the most vulnerable among us. You may think you are young or healthy, and that even if you get the virus it won't be so bad. But the truth is: you can you can spread it to your family and the people you love. Do it for

Obtained via MI FOIA by Judicial Watch, Inc.

Grandma. Do it for our community. Stay home to protect others.

It's in your hands
Staying inside is tough on all of us. But by staying home and stopping the spread of coronavirus in our community, you are saving lives. You got this. Stay home. Stay safe.

It won't last forever
It won't last forever, but right now you need to stay home to stay safe. COVID-19 is spreading fast. The only way to slow it down and treat the people who have it, is for all of us to stay home, stay off the streets and stay physically distant.

Our job, too
EMTs, doctors and nurses are putting their lives on the line to treat our communities. They are doing their job. Now we need to do ours. The only way to stop the coronavirus is stop the spread. Stay home. Stay physically distant. And we'll beat it together.

Spreading fast
COVID-19 is spreading fast. More than 5,000 people in Michigan have already been diagnosed, with more than 20 people a day dying from the disease. And those numbers will continue to rise unless we take the right steps to stop it. Staying home is our best chance to save lives.

Doctors
Doctors in Michigan around the world are urging all of us to stay inside; no community is immune. The health of our community depends on all of us staying home. Listen to the doc…stay home, stay safe.

Never anything like it
There's never been anything like COVID-19. It's shut down our businesses. Our hospitals are overflowing. And it's changed our lives. COVID-19 spreads fast and there is no vaccine.
The one thing that will help get us back to normal is stopping the spread by staying home and staying safe. That's how we beat COVID-19.

Areas for possible testing beyond the sample messages:

- Use of "Coronavirus" versus "COVID-19"
- General knowledge that over 5,000 people in Michigan have already tested positive for the disease, and that as many as 20 or a day more dying.
- Knowledge of state COVID-19 Helpline
- Cash incentives vs. penalties

Obtained via MI FOIA by Judicial Watch, Inc.

- Knowledge of phrases such as “flatten the curve”
- People of any age or race can catch and die from the disease
- The Governor has issued an order telling people to stay at home, unless they are going for food or medical care.
- There is no cure yet for the disease
- Specific messengers
- What is your biggest concern or fear about the Coronavirus, also known as COVID-19?
    - Catching the virus
    - Dying from the virus
    - A family member getting sick
    - Not having enough food or groceries to eat
    - Not being able to get medical care
    - The high cost of medical care if I get sick.
    - Losing you job or income.
    - Being evicted
    - Being forced to stay at home for many more months.

Rey Bouknight II, MPH
Director, Office of External Affairs & Communications
Michigan Department of Health and Human Services
Email: bouknightr@michigan.gov
Office: (517) 284-4771
Cell: (517) 285-3862

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Sunday, March 29, 2020 8:25 PM
To: Siegel, Traci <Traci.Siegel@gmmb.com>; Bouknight, Rey (DHHS) <BouknightR@michigan.gov>; Skylar with Civis <smills@civisanalytics.com>
Cc: Alex Koeberle <akoeberle@civisanalytics.com>; Chris Dick <cdick@civisanalytics.com>; David Shor <dshor@civisanalytics.com>; Lawson, Harper <Harper.Lawson@gmmb.com>
Subject: RE: Connecting you

All, excited about our work together! 12:30 PT works for me.

Civis folks, am I right that if we get you messaging/KPIs tonight we can get results Tuesday? Can I ask at what time? There are some policy changes under consideration that it could affect.

Many thanks.

From: Siegel, Traci <Traci.Siegel@gmmb.com>
Sent: Sunday, March 29, 2020 8:21 PM

Obtained via MI FOIA by Judicial Watch, Inc.

To: Bouknight, Rey (DHHS) <BouknightR@michigan.gov>; Skylar with Civis <smills@civisanalytics.com>
Cc: Alex Koeberle <akoeberle@civisanalytics.com>; Chris Dick <cdick@civisanalytics.com>; David Shor <dshor@civisanalytics.com>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Lawson, Harper <Harper.Lawson@gmmb.com>
Subject: Re: Connecting you

Hi Rey – for daily calls, how about we aim for 9:30a PT?

From: "Bouknight, Rey (DHHS)" <BouknightR@michigan.gov>
Date: Sunday, March 29, 2020 at 5:00 PM
To: Traci Siegel <Traci.Siegel@gmmb.com>, Skylar with Civis <smills@civisanalytics.com>
Cc: Alex Koeberle <akoeberle@civisanalytics.com>, Chris Dick <cdick@civisanalytics.com>, David Shor <dshor@civisanalytics.com>, Robert Gordon <GordonR3@michigan.gov>, Harper Lawson <Harper.Lawson@gmmb.com>
Subject: RE: Connecting you

Thanks, Traci.

Time options for MDHHS include: 7am PT, 9:30am PT and 11:30 PT

Skylar et al., just want to let you know that we're on track to provide messaging and KPIs tonight. This will be provided soon with the idea of testing tomorrow as discussed. Please let us know what your availability is tomorrow. It's my understanding that the call isn't intended necessarily to influence the timing of this first round of testing.

Best,
Rey

Rey Bouknight II, MPH
Director, Office of External Affairs & Communications
Michigan Department of Health and Human Services
Email: bouknightr@michigan.gov
Office: (517) 284-4771
Cell: (517) 285-3862

From: Siegel, Traci <Traci.Siegel@gmmb.com>
Sent: Sunday, March 29, 2020 7:00 PM
To: Bouknight, Rey (DHHS) <BouknightR@michigan.gov>
Cc: Skylar with Civis <smills@civisanalytics.com>; Alex Koeberle <akoeberle@civisanalytics.com>; Chris Dick <cdick@civisanalytics.com>; David Shor <dshor@civisanalytics.com>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Lawson,

Obtained via MI FOIA by Judicial Watch, Inc.

Harper <Harper.Lawson@gmmb.com>
Subject: Re: Connecting you

Perfect! We'll have some thoughts on messages back to you shortly. In the meantime, is there a time that this group is available to speak by phone in the morning? I'm in SF, but happy to start as early as 7a PT, and can move anything currently on the schedule other than one 12-1p PT/3-4p ET call.

From: "Bouknight, Rey (DHHS)" <BouknightR@michigan.gov>
Date: Sunday, March 29, 2020 at 3:54 PM
To: Traci Siegel <Traci.Siegel@gmmb.com>
Cc: Skylar with Civis <smills@civisanalytics.com>, Alex Koeberle <akoeberle@civisanalytics.com>, Chris Dick <cdick@civisanalytics.com>, David Shor <dshor@civisanalytics.com>, Robert Gordon <GordonR3@michigan.gov>, Harper Lawson <Harper.Lawson@gmmb.com>
Subject: Re: Connecting you

Thanks, Traci. I like where this is going. We've been so close to the response and moving so quickly that we haven't tested basic messages which we've assumed individuals know, but some (many?) may not. Definitely open to this.

Best,
Rey

Rey Bouknight II, MPH
Communications Director
Office of Communications
Michigan Department of Health and Human Services
Email: bouknightr@michigan.gov
Office: (517) 284-4771
Cell: (517) 285-3862

> On Mar 29, 2020, at 6:00 PM, Siegel, Traci <Traci.Siegel@gmmb.com> wrote:
>
> Hi everyone –
>
> We are working on some suggestions on additional messages to test that we will send along shortly, and also hoping that this effort will allow us to get a baseline sense of public knowledge and opinion on few questions (see thoughts examples below). Is there an instrument you're planning to use tomorrow that you can share for feedback?
>
> Areas for possible testing beyond the sample messages:

Obtained via MI FOIA by Judicial Watch, Inc.

- Use of “Coronavirus” versus “COVID-19”
- General knowledge that over 5,000 people in Michigan have already tested positive for the disease, and that as many as 20 or a day more dying.
- People of any age or race can catch and die from the disease
- The Governor has issued an order telling people to stay at home, unless they are going for food or medical care.
- There is no cure yet for the disease
- What is your biggest concern or fear about the Coronavirus, also known as COVID-19?
    - Catching the virus
    - Dying from the virus
    - A family member getting sick
    - Not having enough food or groceries to eat
    - Not being able to get medical care
    - The high cost of medical care if I get sick.
    - Losing you job or income.
    - Being evicted
    - Being forced to stay at home for many more months.

Thoughts?

Traci

From: Skylar with Civis <smills@civisanalytics.com>
Date: Sunday, March 29, 2020 at 12:17 PM
To: Alex Koeberle <akoeberle@civisanalytics.com>, Chris Dick <cdick@civisanalytics.com>, David Shor <dshor@civisanalytics.com>, Robert Gordon <GordonR3@michigan.gov>
Cc: "Bouknight, Rey (DHHS)" <BouknightR@michigan.gov>, Traci Siegel <Traci.Siegel@gmmb.com>
Subject: Re: Connecting you

Adding the Civis team.

Traci and Ray, I can connect on contracting. David, Alex and Chris are ready to work with you on the messages and KPI’s

On Sun, Mar 29, 2020 at 1:14 PM Gordon, Robert (DHHS) <GordonR3@michigan.gov> wrote:

> Per our conversations. Thanks for what you are doing.
>
> Sent from my iPhone

--

Obtained via MI FOIA by Judicial Watch, Inc.

Skylar Mills
Civis | Analytics
Business Development Manager, Public Sector
Check out how the City of Boston uses Civis

t. 435.619.2345 | smills@civisanalytics.com

This email is intended only for the named addressee. It may contain information that is confidential/private, legally privileged, or copyright-protected, and you should handle it accordingly. If you are not the intended recipient, you do not have legal rights to retain, copy, or distribute this email or its contents, and should promptly delete the email and all electronic copies in your system; do not retain copies in any media. If you have received this email in error, please notify the sender promptly. Thank you.

--
Alex Koeberle
Civis | Analytics
Senior Applied Data Scientist
Pronouns: (he/him)

t. 949-838-5202 | akoeberle@civisanalytics.com

--
Chris Dick
Civis | Analytics
Managing Director, Public Sector

cdick@civisanalytics.com

--
Alex Koeberle
Civis | Analytics
Senior Applied Data Scientist
Pronouns: (he/him)

t. 949-838-5202 | akoeberle@civisanalytics.com

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: LyonCallo, Sarah (DHHS); Belden, Eileen; Pohl, Zack
Cc: Khaldun, Joneigh (DHHS); Darling, Darice (DHHS); Totten, Mark
Subject: RE: COVID slides for today
Date: Thursday, November 12, 2020 9:40:00 AM
Attachments: 111220 potential slides rg.pptx

Revised caption on last slide.

From: LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>
Sent: Thursday, November 12, 2020 9:27 AM
To: Belden, Eileen <BeldenE@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Pohl, Zack <PohlZ@michigan.gov>
Cc: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Darling, Darice (DHHS) <DarlingD1@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>
Subject: RE: COVID slides for today

Update is in this deck.

From: Belden, Eileen <BeldenE@michigan.gov>
Sent: Thursday, November 12, 2020 9:26 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Pohl, Zack <PohlZ@michigan.gov>
Cc: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Darling, Darice (DHHS) <DarlingD1@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>
Subject: RE: COVID slides for today

Thank you, Director Gordon! We are planning to use slides 4 and 7, but it looks like we are waiting on an updated map for slide 4. Can your team please send this when you have a chance?

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Thursday, November 12, 2020 8:24 AM
To: Pohl, Zack <PohlZ@michigan.gov>; Belden, Eileen <BeldenE@michigan.gov>
Cc: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Darling, Darice (DHHS) <DarlingD1@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>
Subject: COVID slides for today

Zack and Eileen,
Per convo last night, here are some slides that either the Governor or Dr. J could voiceover today. Dr. LC developed them with our input. We can have McKinsey make them look nicer once there's agreement on content.
I'm happy to be in a convo about potential edits, but swamped so fine missing as well.
Thanks,
Robert

Obtained via MI FOIA by Judicial Watch, Inc.

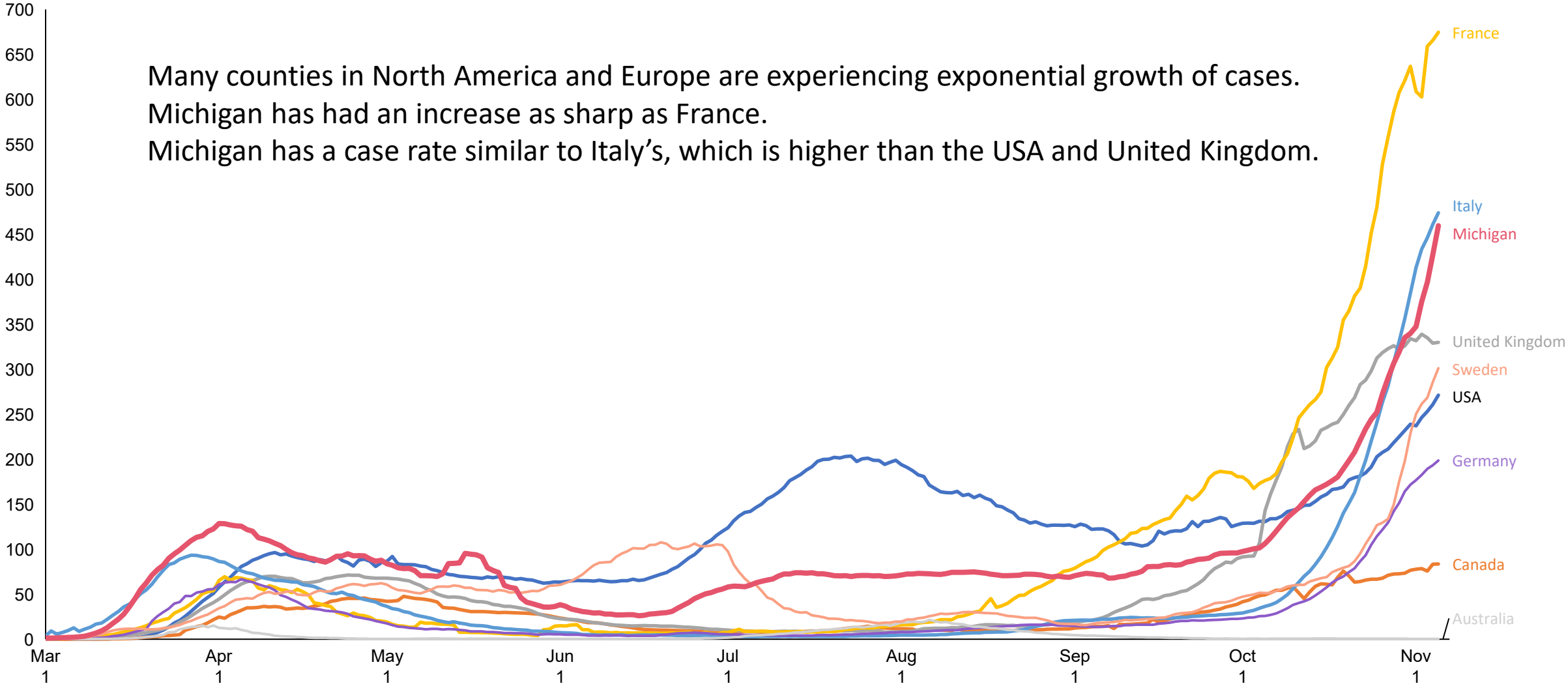
Obtained via MI FOIA by Judicial Watch, Inc.

Potential slides for 11/12

Obtained via MI FOIA by Judicial Watch, Inc.

Average daily new cases per million people by country

7-day rolling average COVID-19 cases per million people



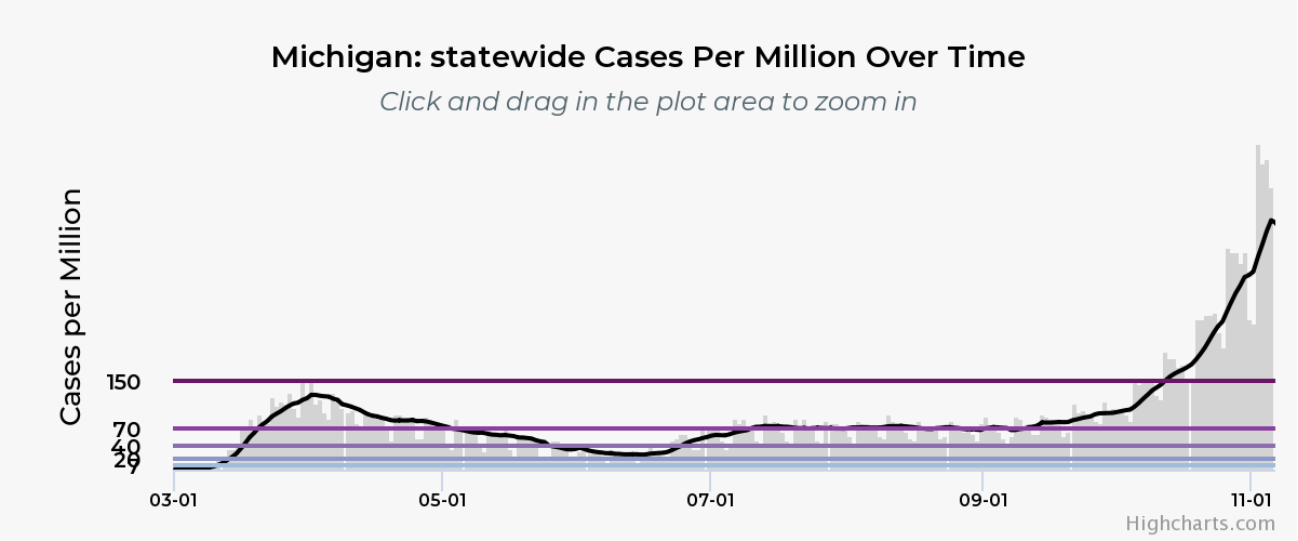
Source: ourworldindata.org/coronavirus; European CDC

Obtained via MI FOIA by Judicial Watch, Inc.

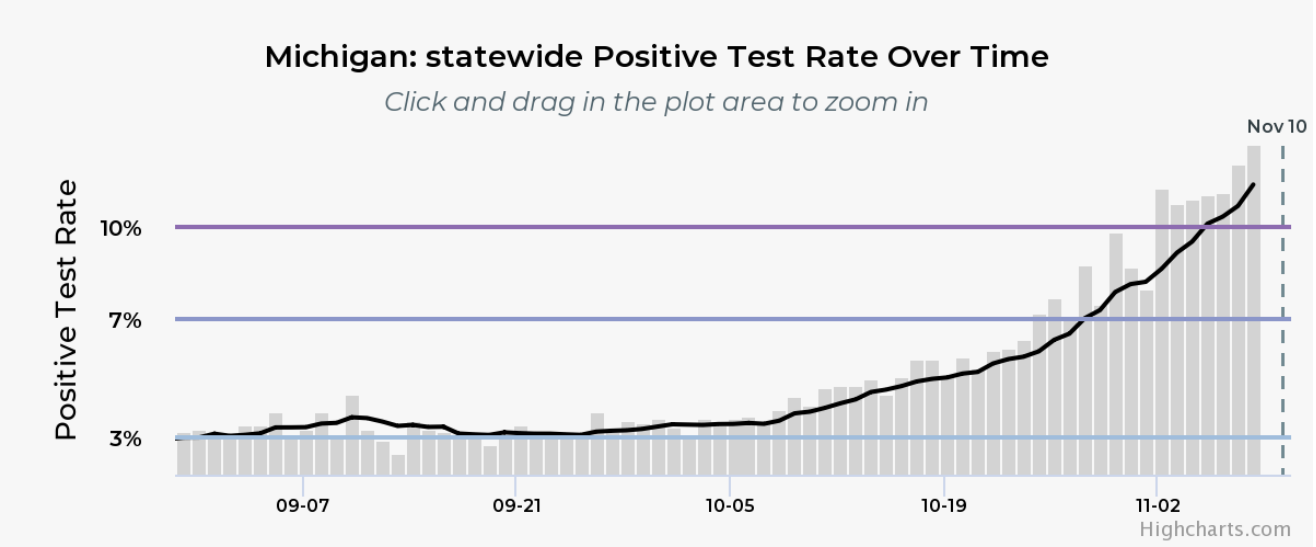
Exponential growth in cases

Cases are now 16 times higher than in June

- Early November highest rates in epidemic
  - 416 cases per million people on Nov 4th
- June 26th: lowest rate in epidemic
  - 26 cases per million people



- Percent of tests are positive over 10%
  - Case numbers will continue to increase

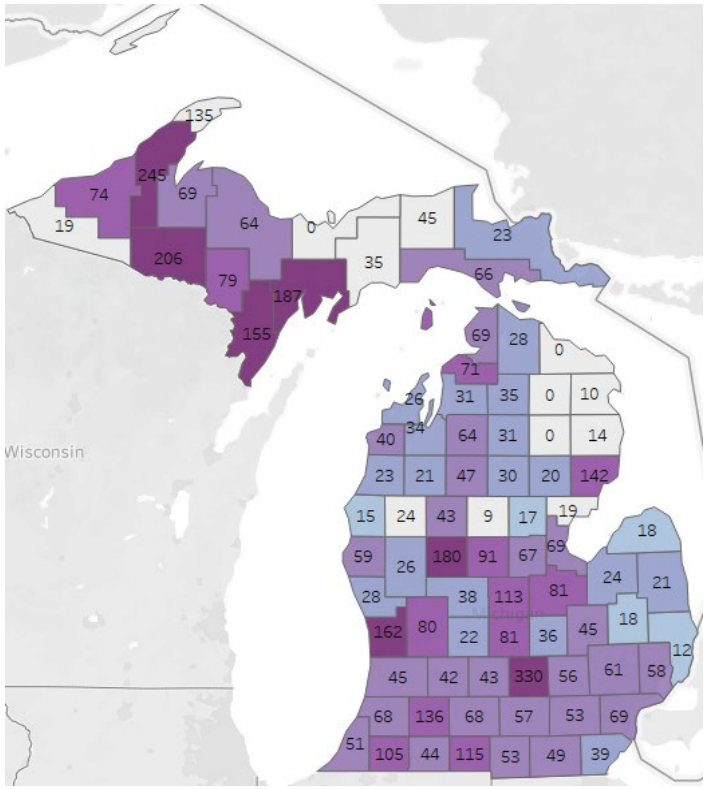


Obtained via MI FOIA by Judicial Watch, Inc.

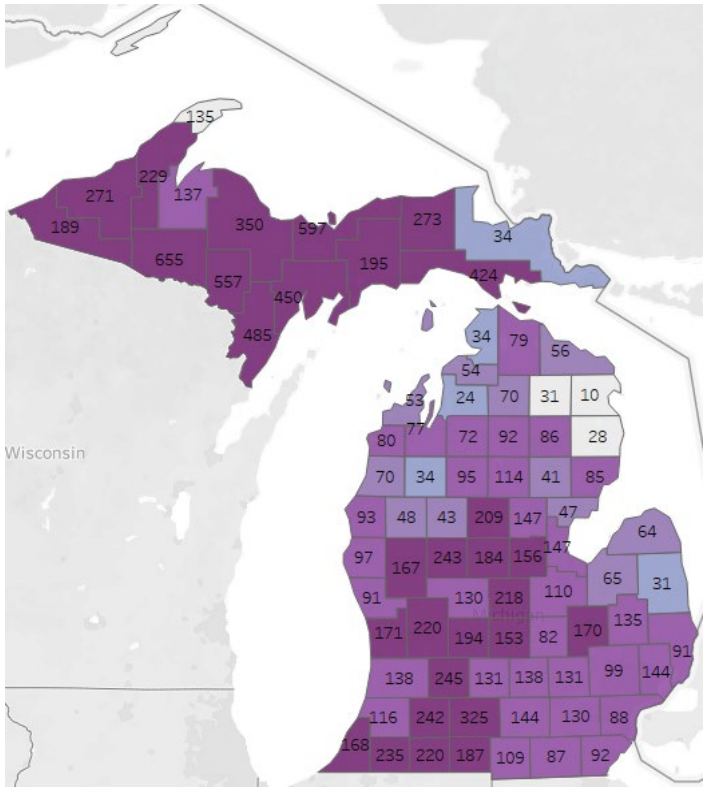
Average daily new confirmed and probable cases per million residents

- **Insufficient sample size;** county has fewer than 3 new cases during the week
- **Fewer than 7** average daily new cases per million
- **7-20** average daily new cases per million
- **20-40** average daily new cases per million
- **40-70** average daily new cases per million
- **70-150** average daily new cases per million
- **150** average daily new cases per million

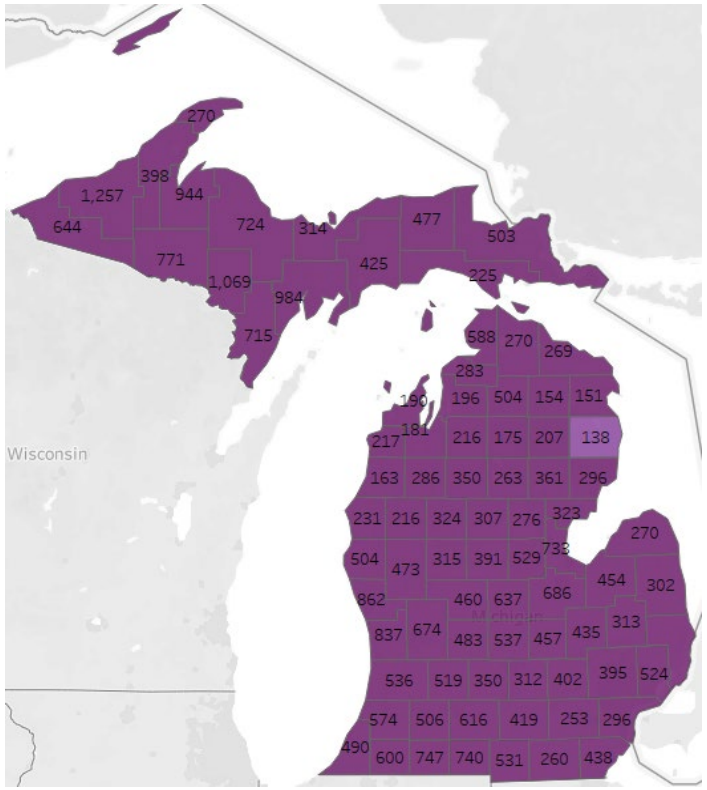
9/6-9/12



10/4-10/10



11/1 -11/7



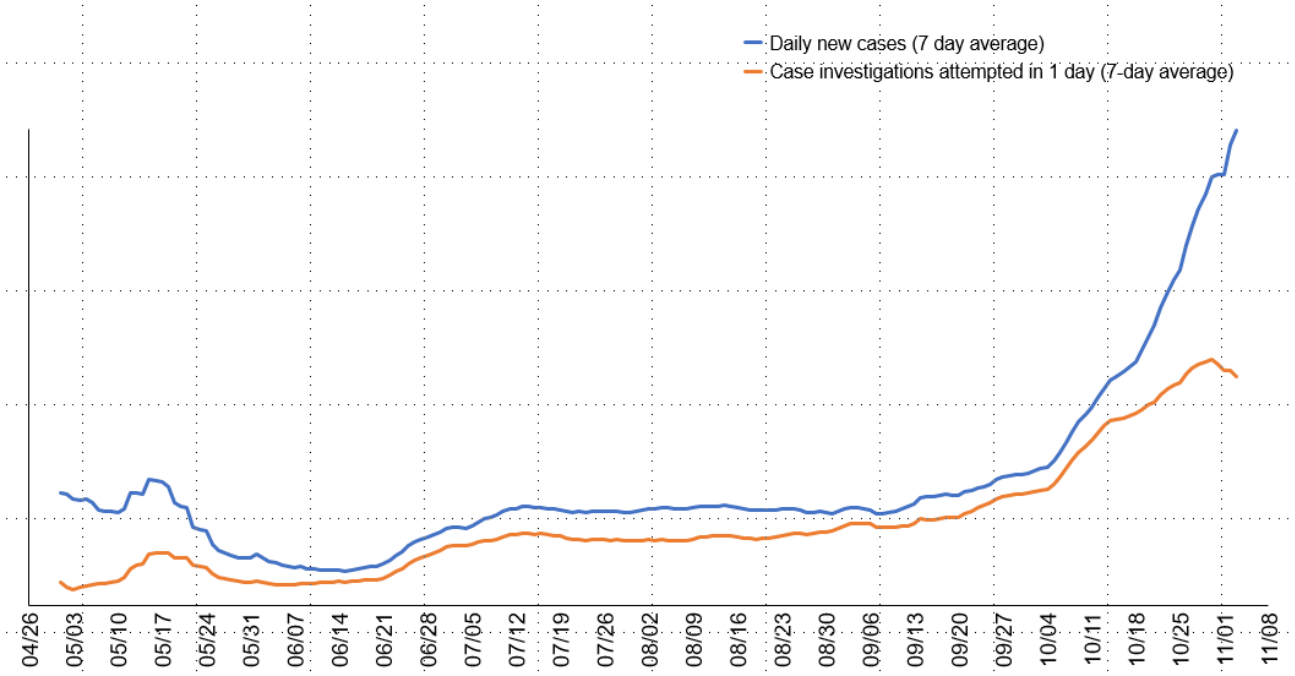
Note: Cases information sourced from MDHHS and reflects date of onset of symptoms (refers to confirmed and probable cases)
Note: Data as of 11/11/2020
Source: MDHHS – Michigan Disease Surveillance System

Obtained via MI FOIA by Judicial Watch, Inc.

Case investigations falling behind

The number of cases is now higher than the capacity of health departments

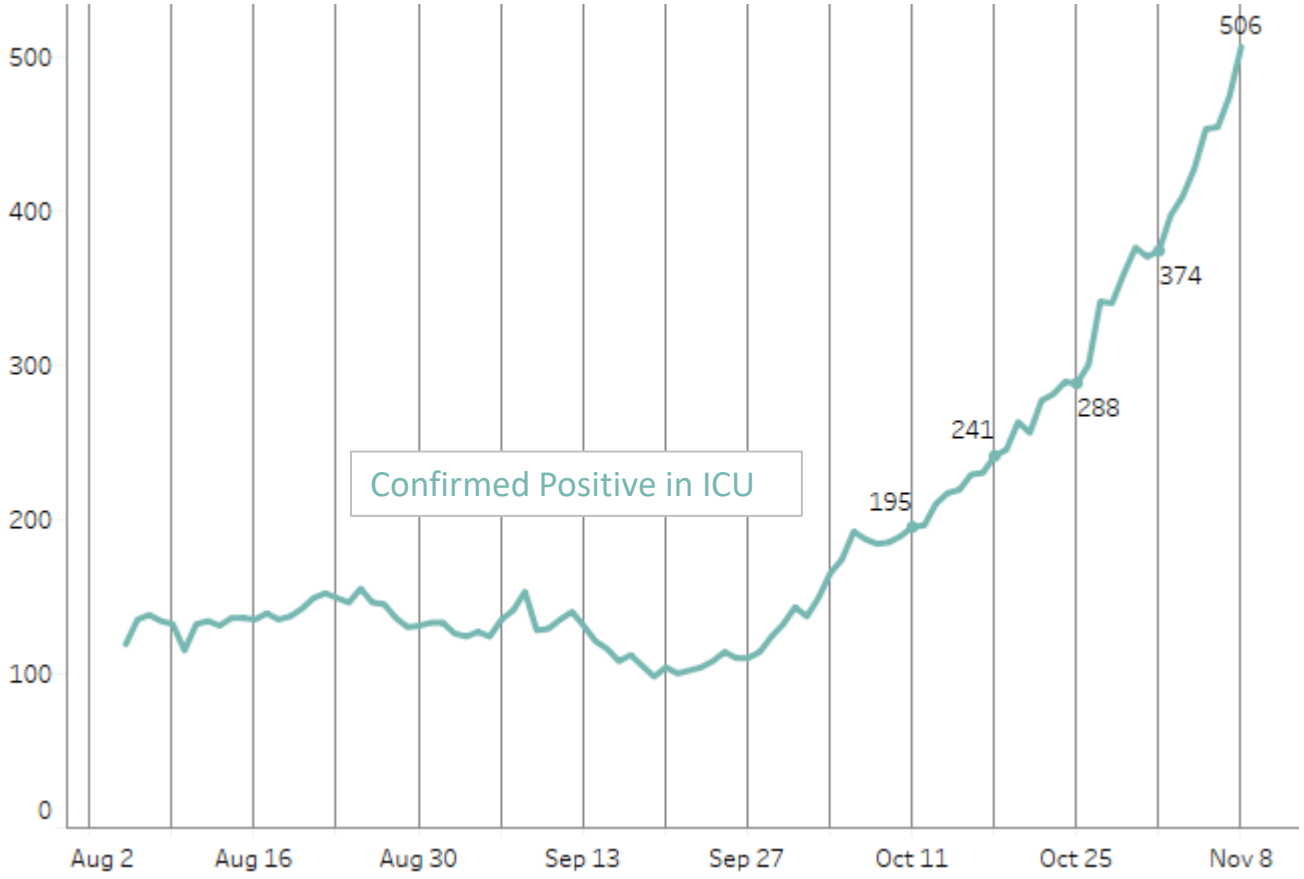
Not all close contacts will be reached.



Obtained via MI FOIA by Judicial Watch, Inc.

Increase in COVID Patients in Intensive Care

Hospitalization Trends 8/1/2020 – 11/8/2020
Confirmed Positive in ICUs



Statewide 20% of Adult ICU beds occupied with COVID

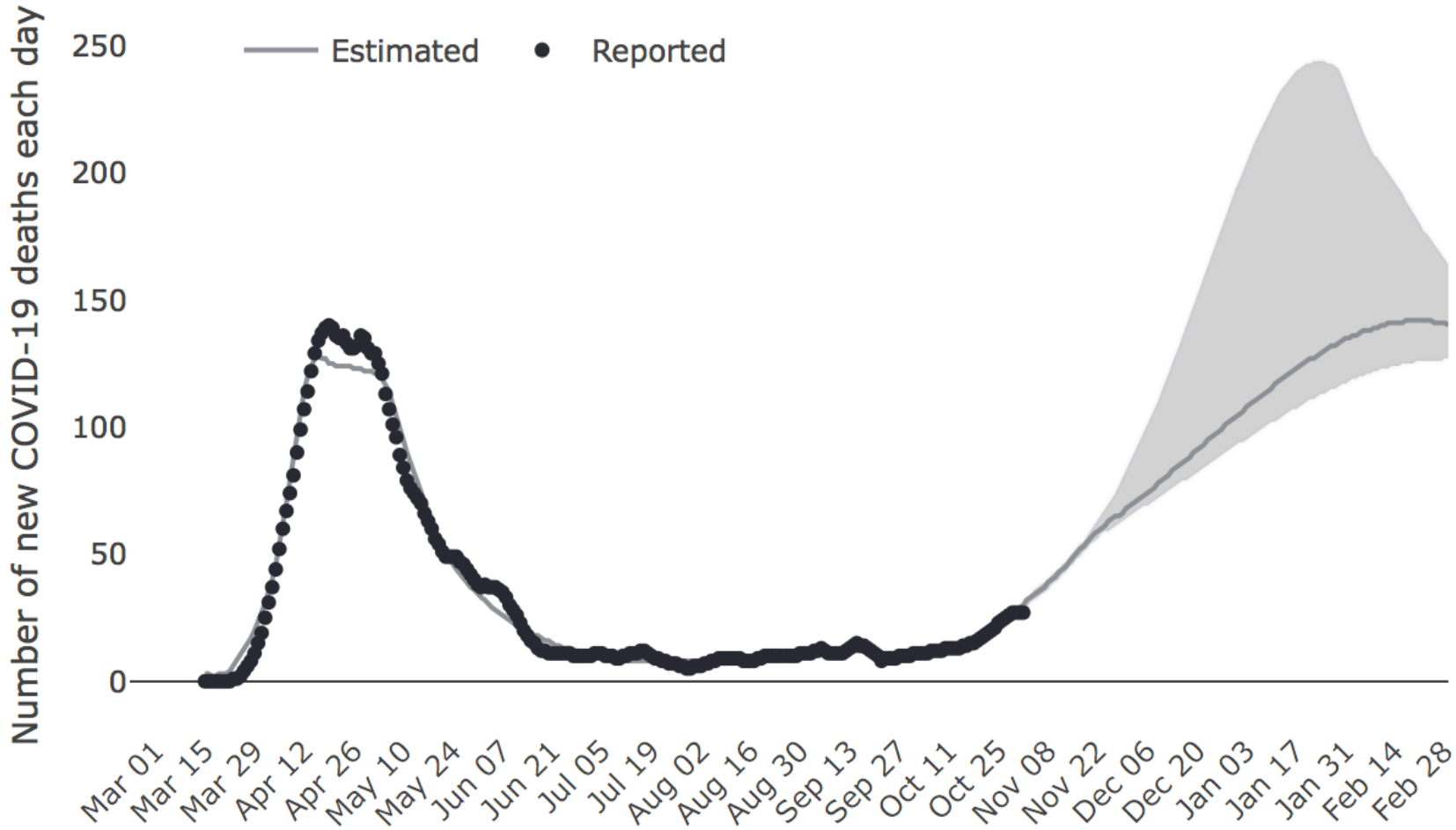
Hospitalizations in ICUs are also increasing at an accelerating rate.

Number of COVID patients in the ICU is 35% higher than last week.

Number of COVID patients in the hospital is 42% higher than last week.

Obtained via MI FOIA by Judicial Watch, Inc.

Longer-term forecasts also project increases in deaths through winter in MI



- Deaths are projected to exceed 100 per day and may exceed 200 per day if no changes in social distancing or public health measures

Source: COVID-SIM

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Khaldun, Joneigh (DHHS); Gordon, Robert (DHHS); Warsh, Jonathan (DHHS); LyonCallo, Sarah (DHHS); Foster, Tricia; Totten, Mark; Hertel, Elizabeth (DHHS)
Subject: Re: COVID-19
Date: Thursday, March 26, 2020 10:10:12 PM

Thanks dr j

Do we have any further updates from either uofm modeling? I've seen two different ones from them. Are they giving resource numbers too?

Thanks

jh

From: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Sent: Thursday, March 26, 2020 10:06:25 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>
Subject: COVID-19

Not sure if folks have seen this model- predicts Michigan will see peak resource use and deaths April 8.

https://gcc01.safelinks.protection.outlook.com/?url=http%3A%2F%2Fcovid19.healthdata.org%2F&data=02%7C01%7CHulsJ1%40michigan.gov%7C73fac1f31ea6419 6a1ac08d7d1f37448%7Cd5fb7087377742ad966a892ef47225d1%7C0%7C0%7C637208715859402266&sdata=jb8JuFhjOFfiuRj3UnD7YdAfJPxtMJ7EfDI%2BEjPTxBAM%3D&reserved=0

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Huls, JoAnne
To:	Khaldun, Joneigh (DHHS); Foster, Tricia; Gordon, Robert (DHHS); Hertel, Elizabeth (DHHS); Warsh, Jonathan (DHHS); McGowan, Emmitt (MSP)
Subject:	Re: COVID-19 Model
Date:	Tuesday, March 24, 2020 3:22:37 PM

Thanks Dr J,

Does this modeling include the potential impact that the stay Home stay safe actions?

Thanks

From: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Sent: Tuesday, March 24, 2020 3:18:48 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>; McGowan, Emmitt (MSP) <McGowanE1@michigan.gov>
Subject: COVID-19 Model

Hello All,

See the link below for the current model from the University of Michigan team we spoke to this weekend.

https://epimath.github.io/covid-19-modeling/

Joneigh S. Khaldun, MD, MPH, FACEP
Chief Medical Executive
Chief Deputy Director for Health
Michigan Department of Health and Human Services
Office: 517-284-4730
khaldunj@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Khaldun, Joneigh (DHHS); Huls, JoAnne; Foster, Tricia; Hertel, Elizabeth (DHHS); Warsh, Jonathan (DHHS); McGowan, Emmitt (MSP)
Subject: RE: COVID-19 Model
Date: Tuesday, March 24, 2020 3:30:38 PM

Please forgive what may be a stupid question, but the model predicts 1,800 cases by March 30 and we just announced 1,791 cases as of today. Are those apples and oranges? Or are things markedly worse than the model as shown here?

From: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Sent: Tuesday, March 24, 2020 3:29 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>; McGowan, Emmitt (MSP) <McGowanE1@michigan.gov>
Subject: RE: COVID-19 Model

It does, but only in the sense that if we do the social distancing well we will be at the lower end of the grey scales. The current model is only based on the positive tests we've gathered thus far. The empty scenario tabs are being built out that should be able to speak more to best and worst case scenarios.

From: Huls, JoAnne <HulsJ1@michigan.gov>
Sent: Tuesday, March 24, 2020 3:23 PM
To: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>; McGowan, Emmitt (MSP) <McGowanE1@michigan.gov>
Subject: Re: COVID-19 Model

Thanks Dr J,

Does this modeling include the potential impact that the stay Home stay safe actions?

Thanks

From: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Sent: Tuesday, March 24, 2020 3:18:48 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>; McGowan, Emmitt (MSP) <McGowanE1@michigan.gov>
Subject: COVID-19 Model

Obtained via MI FOIA by Judicial Watch, Inc.

Hello All,

See the link below for the current model from the University of Michigan team we spoke to this weekend.

https://epimath.github.io/covid-19-modeling/

Joneigh S. Khaldun, MD, MPH, FACEP
Chief Medical Executive
Chief Deputy Director for Health
Michigan Department of Health and Human Services
Office: 517-284-4730
khaldunj@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Foster, Tricia; Warsh, Jonathan (DHHS); Jen, Kyle (DTMB); Totten, Mark; Khaldun, Joneigh (DHHS); Hertel, Elizabeth (DHHS); Esty, Sarah (DHHS)
Cc: Huls, JoAnne
Subject: RE: Covid-19 Work Groups
Date: Friday, March 20, 2020 1:06:00 PM

Thanks. Just to put names on all this

With Dr. J's and my leadership within DHHS

Places will be managed by Elizabeth

People will be managed by Jonathan

Protocols will be managed by Dr. J with support from Sarah Esty

Jonathan will gather the reports out to you

Glad to see McKinsey is already in place to support building out data and analytics

Thanks,
Robert

From: Foster, Tricia <FosterT13@michigan.gov>
Sent: Friday, March 20, 2020 12:39 PM
To: Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>; Jen, Kyle (DTMB) <JenK1@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Cc: Huls, JoAnne <HulsJ1@michigan.gov>
Subject: Covid-19 Work Groups

Thank you for your time last evening. Attached is a draft and preliminary outline of those conversations and our work groups. If you haven't already, please, establish your first meeting. We are working on a sharepoint site for all, but until then, please report out on your progress each evening by 8pm to JoAnne and myself. Brief update on accomplishments, action, needs, and next steps. If you think you need additional team mates, please ask.

Appreciate your help. Any questions, buzz me. I am currently available at 2am….a little levity.

Tricia L. Foster, CPM, ACoM
Chief Operating Officer
State of Michigan
Fostert13@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: LyonCallo, Sarah (DHHS); Huls, JoAnne; Khaldun, Joneigh (DHHS); Warsh, Jonathan (DHHS); Foster, Tricia; Totten, Mark; Hertel, Elizabeth (DHHS)
Subject: RE: COVID-19
Date: Friday, March 27, 2020 6:14:43 AM

Two days ago, we said to assume that reality will be much worse than the median case in the model, and we acted on that assumption. Unless Dr. J or Dr. SLC corrects the below, I would continue to urge that.

Our case count doubled in three days, from March 23 (1328) to March 26 (2856). The median model case according to the notes below is that the number of cases will be 4000 on April 2. The attachment says 5020 cases on April 3. This suggests that we are going from doubling in three days to less than doubling in a week. I am not an expert but that does not seem right to me.

I have not done the math on deaths and hospitalizations but would expect it to track analysis above unless we are told otherwise.

From: LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>
Sent: Thursday, March 26, 2020 10:46 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>
Subject: RE: COVID-19

The Umich model updates for estimates on number of cases, hospital beds, and each day. https://epimath.github.io/covid-19-modeling/#current-forecasts

- The current median across all model simulations for Michigan gives a forecast of:
  - April 2, 2020 (1 week): roughly 4000 cumulative laboratory-confirmed cases – upper bound 13,267
  - April 16, 2020 (3 weeks): roughly 15700 cumulative laboratory-confirmed cases – upper bound 109560
- The current median across model simulations projects:
  - April 2, 2020 (1 week): roughly 400 hospitalized patients (beds needed) with roughly 80 in ICU
  - April 16, 2020 (3 weeks): roughly 1500 hospitalized patients (beds needed) with roughly 300 in ICU – upper bounds are 16300 beds and 2776 ICU
  - April 16 2020 (3 weeks): roughly 165 on vents (1726 upper bound) and 242 on O2 (3791 upper bound).

also contains a social distancing scenarios tab where you can try different scenarios (levels and dates on/off) and see what happens to the trends. Their model gives later peaks than the Murray group. Provided McKinsey spreadsheet to Umich so they can provide information back for McKinsey modelling inputs.

the site Dr. J found is interesting too – Chris Murray came out of WHO and Harvard, now works as consultant for Gates – he used to a lot of QALY/DALY work and global burden of disease estimates.

From: Huls, JoAnne <HulsJ1@michigan.gov>
Sent: Thursday, March 26, 2020 10:10 PM
To: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>
Subject: Re: COVID-19

Thanks dr j

Do we have any further updates from either uofm modeling? I've seen two different ones from them. Are they giving resource numbers too?

Thanks

jh

From: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Sent: Thursday, March 26, 2020 10:06:25 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>
Subject: COVID-19

Not sure if folks have seen this model- predicts Michigan will see peak resource use and deaths April 8.

https://gcc01.safelinks.protection.outlook.com/?url=http%3A%2F%2Fcovid19.healthdata.org%2F&data=02%7C01%7CHulsJ1%40michigan.gov%7C73fac1f31ea64196a1ac08d7d1f37448%7Cd5fb7087377742ad966a892ef47225d1%7C0%7C0%7C637208715859402266&sdata=jb8luFhjOFfuRi3UnD7YdAfJPxtMJ7EfDl%2BEjPTxBAM%3D&reserved=0

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Laura Appel; Khaldun, Joneigh (DHHS); Totten, Mark; Hertel, Elizabeth (DHHS)
Subject: RE: Daily Beaumont Health Data for 4.7.20
Date: Tuesday, April 7, 2020 8:54:17 PM

This is so helpful. So you can see the COVID admissions to Beaumont tapering off. Hard to know what this means without seeing their available beds. Is there somewhere one looks that up?

From: Laura Appel <lappel@mha.org>
Sent: Tuesday, April 7, 2020 8:44 PM
To: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>
Subject: Daily Beaumont Health Data for 4.7.20

You can see from John's information attached below that all large Southeast MIchigan health systems reported COVID-19 patient data today. There are missing data fields, which we are working to resolve.
On my call with Dr. Lyon Callo this evening I asked that she remove stand alone behavioral health hospitals and Karmanos from the denominator in the description of the completeness of Michigan reporting. Dr. Lyon Callo could find few hospitals that had not reported today, other than those types.
There was a much lower rate of reporting (60%) on the weekend.
Laura

Laura Appel

> Please find attached the Beaumont Health Data for 4.7.20
>
> My best,
>
> John

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: LyonCallo, Sarah (DHHS); Khaldun, Joneigh (DHHS); Totten, Mark
Subject: RE: Dashboard
Date: Wednesday, May 13, 2020 8:29:52 AM
Attachments: image001.jpg

Thanks. Will connect you. I will likely miss am meeting due to ltc hearing.

From: LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>
Sent: Wednesday, May 13, 2020 7:59 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>
Subject: RE: Dashboard

This would be really helpful – I think that we would include Marisa/Emily as well.

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Wednesday, May 13, 2020 7:55 AM
To: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>
Subject: FW: Dashboard

Let me know if thoughts; happy to connect Dr LC or others. Seems like opportunity to listen and learn so long as clear we are not committing to replacing our own experts' judgment.

From: Thomas R. Frieden <trfrieden@resolvetosavelives.org>
Sent: Wednesday, May 13, 2020 7:43 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: Dashboard

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Robert,

We're thinking about optimal (and/or minimal) information that should be available, clearly and simply, from each state.

This is quite relevant to the Safe Start you just released. We are working toward something that can be simple and useful. Is there someone on your team we could work with on this? Would you be interested in piloting/thinking together through it?

Thanks.

Tom

Obtained via MI FOIA by Judicial Watch, Inc.

From: "Gordon, Robert (DHHS)" <GordonR3@michigan.gov>
Date: Sunday, May 10, 2020 at 9:06 AM
To: Tom Frieden <trfrieden@resolvetosavelives.org>
Cc: "Warsh, Jonathan (DHHS)" <WarshJ1@michigan.gov>, "LyonCallo, Sarah (DHHS)" <lyoncallos@michigan.gov>
Subject: RE: Draft Contact Tracing Playbook live

Thanks again for this. Would be great if you can connect with the right people on your team our leads on this work: our chief of staff, Jonathan Warsh, and our state epidemiologist, Dr. Sarah LyonCallo.

Best,
Robert

On Sat, May 9, 2020 at 9:21 PM Thomas R. Frieden <trfrieden@resolvetosavelives.org> wrote:

> Correct link:
>
> https://contacttracingplaybook.resolvetosavelives.org
>
> ---
>
> **From:** Tom Frieden <trfrieden@resolvetosavelives.org>
> **Date:** Saturday, May 9, 2020 at 3:59 PM
> **To:** Robert Gordon <gordonrobert@gmail.com>
> **Subject:** Draft Contact Tracing Playbook live
>
> Robert,
>
> Hope you're well.
>
> Hope this is helpful. If there is someone within the contact tracing work who wants to interact with our team more directly, please send the contact information.
>
> Rapid progress here – see link below. All feedback welcome!
>
> All the best,
>
> Tom
>
> ---
>
> **From:** Lindsay Steele <lsteele@resolvetosavelives.org>
> **Date:** Saturday, May 9, 2020 at 1:09 PM

Obtained via MI FOIA by Judicial Watch, Inc.

Hi all,
I'm pleased to share that the draft US COVID-19 Contact Tracing Playbook is live:
https://covidplaybook.resolvetosavelives.org/
This draft version incorporates feedback we received from health departments and others over the past week. We will continue to add implementation tools to support health departments in implementing the steps in the checklists. Despite missing many of the tools, there is value in sharing this site now with health departments and others working in this area.

I welcome thoughts on this. Also, the Playbook is a "living" document, so you may share any comments or edits with me at any point.

Best,
Lindsay

Lindsay Steele, MSc
Senior Program Officer, Nutrition Policy, Resolve to Save Lives
Cell: +1-917-828-2260
lsteele@resolvetosavelives.org

resolve_email01 (002)



–
RESOLVE TO SAVE LIVES
An Initiative of Vital Strategies

STAYCONNECTED
resolvetosavelives.org | Facebook | Twitter

#KnowCOVID: Wash hands, cough into elbow, stay home if sick.
Learn more about how to protect yourself and others at VitalStrategies.org/COVID

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Whitmer, Gretchen (MIEOG)
To:	Dessa Cosma; Totten, Mark; Laidlaw, Emily; Gordon, Robert (DHHS); Engelman, Mary (MDCR); Gilchrist, Garlin (MIEOG)
Subject:	RE: Emergency response for People with Disabilities
Date:	Wednesday, May 6, 2020 9:13:35 PM

Dear Ms. Cosma,

Thank you so much for your email. Please accept this email as a confirmation of receipt and know we are giving your comments close review.

Thank you again.

Best,
Scottie Marie Barton
Director of Constituent Services
Governor Gretchen Whitmer
(517) 335-7858

From: Dessa Cosma <dessa@detroitdisabilitypower.org>
Sent: Wednesday, May 6, 2020 5:25 PM
To: Whitmer, Gretchen (MIEOG) <Gretchen.Whitmer@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Laidlaw, Emily <LaidlawE@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Engelman, Mary (MDCR) <EngelmanM@michigan.gov>; Gilchrist, Garlin (MIEOG) <Garlin.Gilchrist@michigan.gov>
Subject: Emergency response for People with Disabilities

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Governor Whitmer, Lt. Governor Gilchrist, Director Gordon, Interim Director Engelman, Mr. Totten, and Ms. Laidlaw,

Thank you for the executive order last Wednesday ensuring equitable access to health care resources during the COVID-19 pandemic and affirming the civil rights of people with disabilities during a state of emergency. I know that I am not alone in the relief I felt as a disabled person.

Additionally, Detroit Disability Power and dozens of other organizations are still committed to ensuring that there is data collected about COVID-19 patients' disability status- and we hope you can help us with that too. We know that people with disabilities are more susceptible to infection for a variety of reasons and that data capture specific to our community could help in stopping the spread and providing appropriate treatment.

Finally, we never received notification, nor did our local community partners, that an EO was being worked on or would be announced last week. In the chance that the office is in

Obtained via MI FOIA by Judicial Watch, Inc.

need of a stakeholder list, we've attached the contact information of several disability organizations that are local to southeast Michigan. Most are grassroots organizations run by people of color. We think it would be beneficial to include them in future outreach about disability focused policies and events, like the Disability Town Hall that the governor recently attended. At that event, we couldn't help notice that all of the guest speakers were white and did not appear to be people with disabilities themselves. Engaging with the disability organizations provided could help to ensure greater diversity and representation going forward.

We sincerely hope to partner with you to make Michigan work for everyone. Therefore, it would be very helpful to know who at the Governor's office is the primary policy advisor focusing on disability issues, all the while knowing they cut across issue areas. Please advise so we can be in touch.

Again, thank you for the EO and for prioritizing public health and people with disabilities. It meant a lot to our organization, our partners, and the disability community.

Sincerely and respectfully,

Dessa Cosma
Detroit Disability Power, Executive Director
www.DetroitDisabilityPower.org

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Gordon, Robert (DHHS); Totten, Mark; Pohl, Zack
Subject: Re: EO Graphic
Date: Wednesday, April 1, 2020 9:38:38 AM

If we flip the protection of worker piece to the top i think that makes sense — we want to emphasize both points - you're protected for our job as well as your health.

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Wednesday, April 1, 2020 9:36:57 AM
To: Huls, JoAnne <HulsJ1@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Pohl, Zack <PohlZ@michigan.gov>
Subject: FW: EO Graphic

From: Bouknight, Rey (DHHS) <BouknightR@michigan.gov>
Sent: Wednesday, April 1, 2020 9:33 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: FW: EO Graphic

A version that is simpler is being worked on. Based on the below, a team member worked to put this together. Let us know if you're looking for a different direction.

Rey

Rey Bouknight II, MPH
Director, Office of External Affairs & Communications
Michigan Department of Health and Human Services
Email: bouknightr@michigan.gov
Office: (517) 284-4771
Cell: (517) 285-3862

From: Bagley, Nick <BagleyN@michigan.gov>
Sent: Tuesday, March 31, 2020 3:58 PM
To: Bouknight, Rey (DHHS) <BouknightR@michigan.gov>
Subject: bullet points

The order says that people should stay home, even if they're otherwise allowed to leave the home for work, if:

- They have been diagnosed with COVID-19 or who have symptoms of COVID-19.
    - For 3 days after symptoms have dissipated, and
    - For 7 days after they were tested or developed symptoms.

Obtained via MI FOIA by Judicial Watch, Inc.

- They live with someone who's been diagnosed with COVID-19 or has symptoms.
    - For 3 days after symptoms have dissipated, and
    - For 7 days after they were tested or developed symptoms.
- We're not sure about masks yet.
- Crucially, employers can't retaliate against workers for taking time away from work under these circumstances.

Nicholas Bagley
Special Counsel
Office of the Governor, State of Michigan

BagleyN@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Gordon, Robert (DHHS)
To:	Shaefer Luke; Groen, Meghan
Cc:	Laidlaw, Emily; Kolodin, Zach; Flood, Jennifer; Totten, Mark; Bagley, Nick; Roubal, Lewis (DHHS); Singel, Wenona; Hanley, Farah (DHHS)
Subject:	RE: EO request
Date:	Saturday, March 28, 2020 8:38:49 AM
Attachments:	image001.png

Right, on the FIP piece, it's going to be like a million things we are doing that have modest costs. If it hasn't happened already, Farah can notify SBO and if need be I can talk to Kyle, but wouldn't anticipate a problem.

The new COVID-19 Family Support Program requires some more policy analysis from us and then a discussion with you, SBO, and Gov. We can make that happen in the next couple days. Drafting the rest of the EO doesn't need to wait for that decision.

From: Shaefer Luke <lshaefer@umich.edu>
Sent: Saturday, March 28, 2020 8:37 AM
To: Groen, Meghan <GroenM@michigan.gov>
Cc: Laidlaw, Emily <LaidlawE@michigan.gov>; Kolodin, Zach <KolodinZ@michigan.gov>; Flood, Jennifer <FloodJ1@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Bagley, Nick <BagleyN@michigan.gov>; Roubal, Lewis (DHHS) <RoubalL@michigan.gov>; Singel, Wenona <SingelW@michigan.gov>
Subject: Re: EO request

Hi Meghan-

We haven't run a fiscal impact through SBO on those two measures. I believe that suspending redeterminations will have a small impact because the caseload is small, but that's just my analysis.

With the COVID-19 Family Support Program, I believe the discussion between MDHHS and the Governor has been to build a program that costs between $10 and $15 million per month that would only be operational for a short time. This isn't an official estimate, but we have built the program parameters to fit this cost. It could be revised to fit other specifications.

There isn't a final decision yet to implement this program, but it is ready to go and fills a clear gap between programs. We included it for consideration here with the goal of only coming to you all once with requests.

I assume SBO and additional analysis would take place, and there would be final executive decision making before the program is implemented.

Luke

H. Luke Shaefer, Ph.D.
Hermann and Amalie Kohn Professor of Social Justice and Social Policy
Director of Poverty Solutions

Obtained via MI FOIA by Judicial Watch, Inc.

University of Michigan
poverty.umich.edu
lshaefer@umich.edu | 734.615.3894

On Mar 28, 2020, at 7:55 AM, Groen, Meghan <GroenM@michigan.gov> wrote:

These all look solid from a policy perspective. Have we run a fiscal impact through SBO for suspending redetermination and short term family support?

From: Laidlaw, Emily <LaidlawE@michigan.gov>
Sent: Saturday, March 28, 2020 7:45 AM
To: Kolodin, Zach <KolodinZ@michigan.gov>; Shaefer Luke <lshaefer@umich.edu>; Flood, Jennifer <FloodJ1@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Bagley, Nick <BagleyN@michigan.gov>; Roubal, Lewis (DHHS) <RoubalL@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>; Singel, Wenona <SingelW@michigan.gov>
Subject: Re: EO request

Catching up- good ideas. Zach and Wenona- let's check the attendance piece with the other order for schools to make sure we aren't causing confusion. Concept works well with our direction, just flagging clarity.

Was there an attachment in original email? If so, could you please send?

From: Kolodin, Zach <KolodinZ@michigan.gov>
Sent: Friday, March 27, 2020 10:51:29 PM
To: Shaefer Luke <lshaefer@umich.edu>; Flood, Jennifer <FloodJ1@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Bagley, Nick <BagleyN@michigan.gov>; Roubal, Lewis (DHHS) <RoubalL@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>; Laidlaw, Emily <LaidlawE@michigan.gov>; Singel, Wenona <SingelW@michigan.gov>
Subject: RE: EO request

I'll ask Wenona from our office to start working on this.

Best,
Zach

Obtained via MI FOIA by Judicial Watch, Inc.

Zachary Kolodin
Deputy Legal Counsel – Public Policy Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
Cell: 517-242-0449
kolodinz@michigan.gov
he/him/his

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

From: Shaefer Luke <lshaefer@umich.edu>
Sent: Friday, March 27, 2020 6:01 PM
To: Flood, Jennifer <FloodJ1@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Kolodin, Zach <KolodinZ@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Bagley, Nick <BagleyN@michigan.gov>; Roubal, Lewis (DHHS) <RoubalL@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>; Laidlaw, Emily <LaidlawE@michigan.gov>
Subject: Re: EO request

That's exactly correct. We need #1 so we can do #2-4 immediately. I would prefer to reserve the right to make other changes immediately too in an effort to be responsive to changing needs, but if #1 needs to be limited to #2-4, that would be manageable. There are a few changes we'd like to implement to our energy assistance program that I also hope will be covered by #1 and are not listed here.

These requests are related to the MDHHS ESA proposals that were discussed in the past few weeks. I believe this request was broadly discussed with Meghan and others, but these are now the specific requests we have.

Happy to talk about the substance in more detail as needed. My cell phone is 773.206.9110.

Luke

H. Luke Shaefer, Ph.D.
Hermann and Amalie Kohn Professor of Social Justice and Social Policy
Director of Poverty Solutions

University of Michigan
poverty.umich.edu

Obtained via MI FOIA by Judicial Watch, Inc.

lshaefer@umich.edu | 734.615.3894

<image001.png>

On Mar 27, 2020, at 5:51 PM, Flood, Jennifer <FloodJ1@michigan.gov> wrote:

Is the purpose of #1 to allow you to do #2-4 right away? If that's the case (and it's not something broader) I think politics are manageable.

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Friday, March 27, 2020 5:44 PM
To: Kolodin, Zach <KolodinZ@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Bagley, Nick <BagleyN@michigan.gov>
Cc: Roubal, Lewis (DHHS) <RoubalL@michigan.gov>; Shaefer Luke <lshaefer@umich.edu>; Groen, Meghan <GroenM@michigan.gov>; Laidlaw, Emily <LaidlawE@michigan.gov>; Flood, Jennifer <FloodJ1@michigan.gov>
Subject: RE: EO request

Fair enough!

On substance, Luke can reach out to Meghan who can talk with Emily. Think we've discussed before and wouldn't expect objections.

Also flagged for Jen Flood earlier today. There is some sensitivity which I recall we'd been okay with a couple weeks ago, but recognize need to update.

Knowing that lawyers' time is scarce, if you all think it makes sense to have a shared policy/politics convo before you start drafting, we're happy to do that. Could we schedule tomorrow?

From: Kolodin, Zach <KolodinZ@michigan.gov>
Sent: Friday, March 27, 2020 5:41 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Bagley, Nick <BagleyN@michigan.gov>
Cc: Roubal, Lewis (DHHS) <RoubalL@michigan.gov>; Shaefer Luke <lshaefer@umich.edu>
Subject: RE: EO request

Robert,

Obtained via MI FOIA by Judicial Watch, Inc.

Can you provide the policy background here? Has this been discussed with our policy team or a member of the executive team? Appreciate the high priority but want to understand where this is in our process.

Best,
Zach

Zachary Kolodin
Deputy Legal Counsel – Public Policy Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
Cell: 517-242-0449
kolodinz@michigan.gov
he/him/his

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Friday, March 27, 2020 5:38 PM
To: Totten, Mark <TottenM1@michigan.gov>; Bagley, Nick <BagleyN@michigan.gov>; Kolodin, Zach <KolodinZ@michigan.gov>
Cc: Roubal, Lewis (DHHS) <RoubalL@michigan.gov>; Shaefer Luke <lshaefer@umich.edu>
Subject: EO request

Mark, Zach, Nick,
We'd love to get this EO approved as soon as possible, realizing you have a lot going on. Lew Roubal is the Department's lead here and Luke Shaefer from U of M Poverty Solutions has played a key part as well.
Thanks,
Robert

From: Shaefer Luke <lshaefer@umich.edu>
Sent: Friday, March 27, 2020 2:47 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Cc: Roubal, Lewis (DHHS) <RoubalL@michigan.gov>; Rick, Matthew (DHHS) <RickM@michigan.gov>

Obtained via MI FOIA by Judicial Watch, Inc.

Subject: Draft ESA request for Executive Order action

Robert-

We are requesting that the Governor consider four specific actions in an EO:

(1) waive the requirement in state law to provide 30-day's notice to the Michigan Legislature before implementation of policy changes to programs administered by MDHHS under the authority of the Social Welfare Act

(2) Allow MDHHS to delay redeterminations of eligibility for benefits from the Family Independence Program (FIP) and other economic security programs

(3) Suspend school attendance requirements for the Family Independence Program while Michigan public schools are closed

(4) confirm MDHHS's authority to reinstitute and update a previously utilized program that provides a "lump sum, non-recurring benefit"to low-income families with children, called Short-Term Family Support (STFS), to be re-named the COVID-19 Family Support Program [we will make a final decision on this policy over the weekend, but we will want an EO with the three items above regardless]

Details are in the attached document.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Kolodin, Zach; Totten, Mark; Bagley, Nick
Cc: Roubal, Lewis (DHHS); Shaefer Luke; Groen, Meghan; Laidlaw, Emily; Flood, Jennifer
Subject: RE: EO request
Date: Friday, March 27, 2020 5:44:21 PM

Fair enough!

On substance, Luke can reach out to Meghan who can talk with Emily. Think we've discussed before and wouldn't expect objections.

Also flagged for Jen Flood earlier today. There is some sensitivity which I recall we'd been okay with a couple weeks ago, but recognize need to update.

Knowing that lawyers' time is scarce, if you all think it makes sense to have a shared policy/politics convo before you start drafting, we're happy to do that. Could we schedule tomorrow?

From: Kolodin, Zach <KolodinZ@michigan.gov>
Sent: Friday, March 27, 2020 5:41 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Bagley, Nick <BagleyN@michigan.gov>
Cc: Roubal, Lewis (DHHS) <RoubalL@michigan.gov>; Shaefer Luke <lshaefer@umich.edu>
Subject: RE: EO request

Robert,

Can you provide the policy background here? Has this been discussed with our policy team or a member of the executive team? Appreciate the high priority but want to understand where this is in our process.

Best,
Zach

_____

Zachary Kolodin
Deputy Legal Counsel – Public Policy Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
Cell: 517-242-0449
kolodinz@michigan.gov
he/him/his

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or**

Obtained via MI FOIA by Judicial Watch, Inc.

discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Friday, March 27, 2020 5:38 PM
To: Totten, Mark <TottenM1@michigan.gov>; Bagley, Nick <BagleyN@michigan.gov>; Kolodin, Zach <KolodinZ@michigan.gov>
Cc: Roubal, Lewis (DHHS) <RoubalL@michigan.gov>; Shaefer Luke <lshaefer@umich.edu>
Subject: EO request

Mark, Zach, Nick,
We'd love to get this EO approved as soon as possible, realizing you have a lot going on. Lew Roubal is the Department's lead here and Luke Shaefer from U of M Poverty Solutions has played a key part as well.
Thanks,
Robert

From: Shaefer Luke <lshaefer@umich.edu>
Sent: Friday, March 27, 2020 2:47 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Cc: Roubal, Lewis (DHHS) <RoubalL@michigan.gov>; Rick, Matthew (DHHS) <RickM@michigan.gov>
Subject: Draft ESA request for Executive Order action

Robert-

We are requesting that the Governor consider four specific actions in an EO:

(1) waive the requirement in state law to provide 30-day's notice to the Michigan Legislature before implementation of policy changes to programs administered by MDHHS under the authority of the Social Welfare Act

(2) Allow MDHHS to delay redeterminations of eligibility for benefits from the Family Independence Program (FIP) and other economic security programs

(3) Suspend school attendance requirements for the Family Independence Program while Michigan public schools are closed

(4) confirm MDHHS's authority to reinstitute and update a previously utilized program that provides a "lump sum, non-recurring benefit" to low-income families with children, called Short-Term Family Support (STFS), to be re-named the COVID-19 Family Support Program [we will make a final decision on this policy over the weekend, but we will want an EO with the three items above regardless]

Details are in the attached document.

Obtained via MI FOIA by Judicial Watch, Inc.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Esty, Sarah (DHHS); Kolodin, Zach; Totten, Mark; Flood, Jennifer; Laidlaw, Emily; Triplett, Sarah; Groen, Meghan
Subject: RE: Final docs for Mi Safe Start
Date: Thursday, October 29, 2020 2:43:00 PM
Attachments: SlideDeck_PressBriefing_1029Order Final (002).pptx

---

Slightly changed

From: Esty, Sarah (DHHS) <EstyS@michigan.gov>
Sent: Thursday, October 29, 2020 2:42 PM
To: Kolodin, Zach <KolodinZ@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Flood, Jennifer <FloodJ1@michigan.gov>; Laidlaw, Emily <LaidlawE@michigan.gov>; Triplett, Sarah <TriplettS4@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: RE: Final docs for Mi Safe Start

Press release, and ppt Dr. J and Robert will give at 3:15.

From: Esty, Sarah (DHHS)
Sent: Thursday, October 29, 2020 2:20 PM
To: Kolodin, Zach <KolodinZ@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Flood, Jennifer <FloodJ1@michigan.gov>; Laidlaw, Emily <LaidlawE@michigan.gov>; Triplett, Sarah <TriplettS4@michigan.gov>; Meghan Groen (GroenM@michigan.gov) <GroenM@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: Final docs for Mi Safe Start

Final docs, including word version of order if you need for future comparisons.

Press release coming around as soon as all the website links are up so we can embed.

Obtained via MI FOIA by Judicial Watch, Inc.

MDHHS PRESS BRIEFING

COVID-19 UPDATE

October 29, 2020



Obtained via MI FOIA by Judicial Watch, Inc.

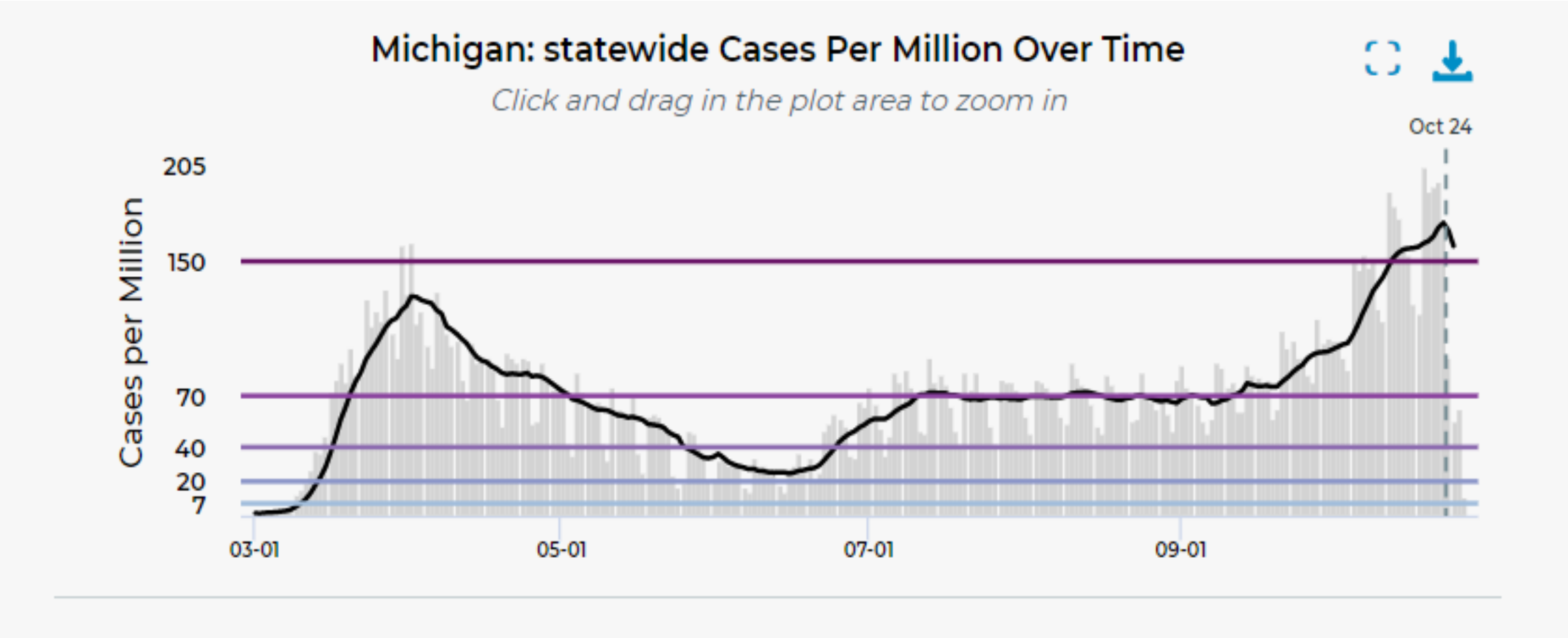
DR. JONEIGH KHALDUN

Chief Medical Executive &
Chief Deputy Director for Health

Michigan Department of Health and Human Services

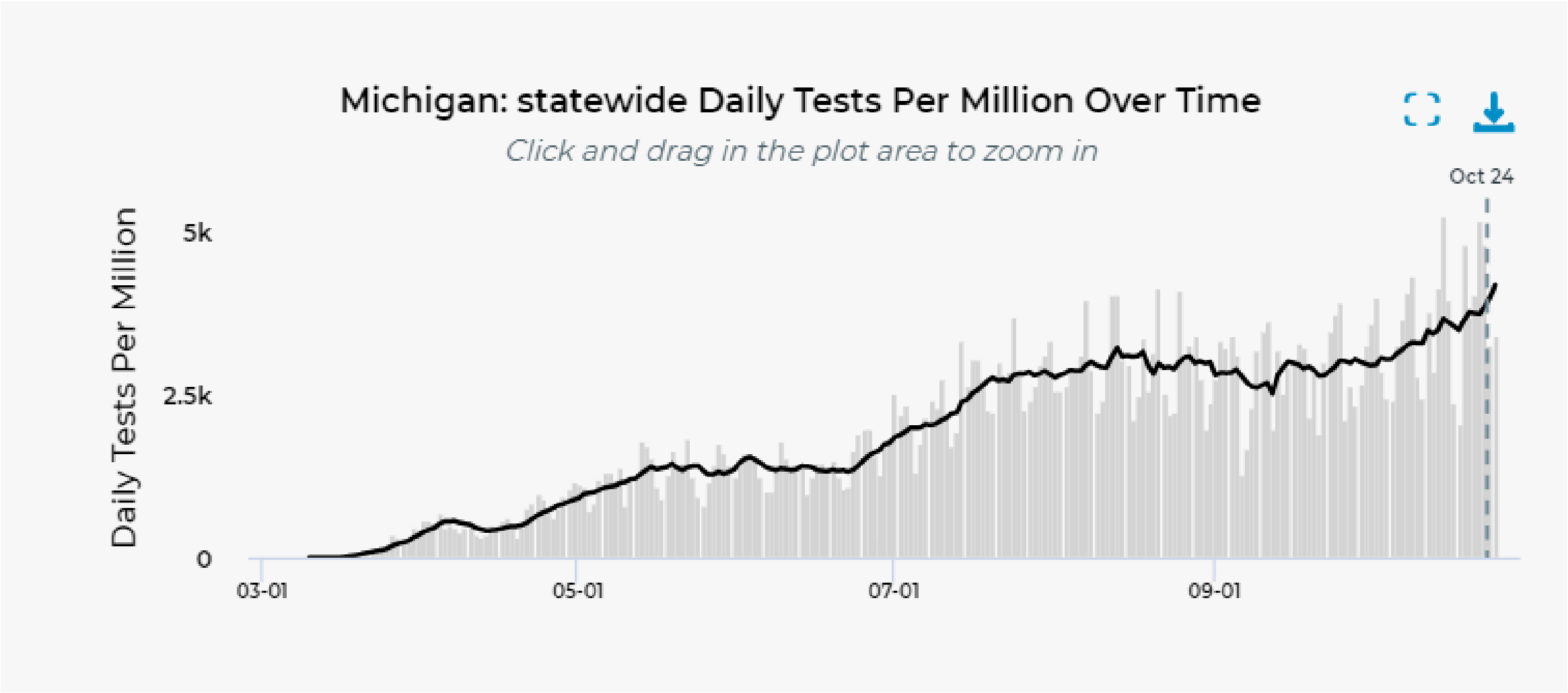
Obtained via MI FOIA by Judicial Watch, Inc.

CASES INCREASING



Obtained via MI FOIA by Judicial Watch, Inc.

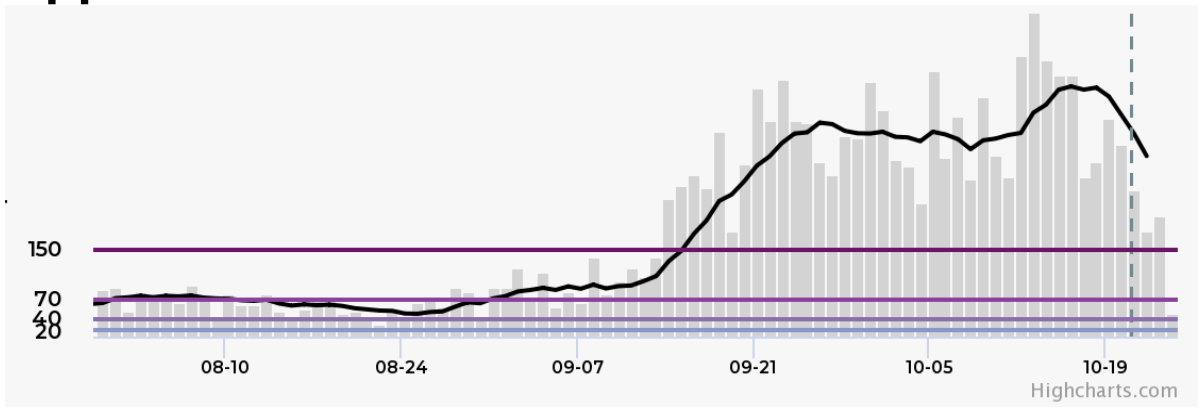
INCREASED TESTING



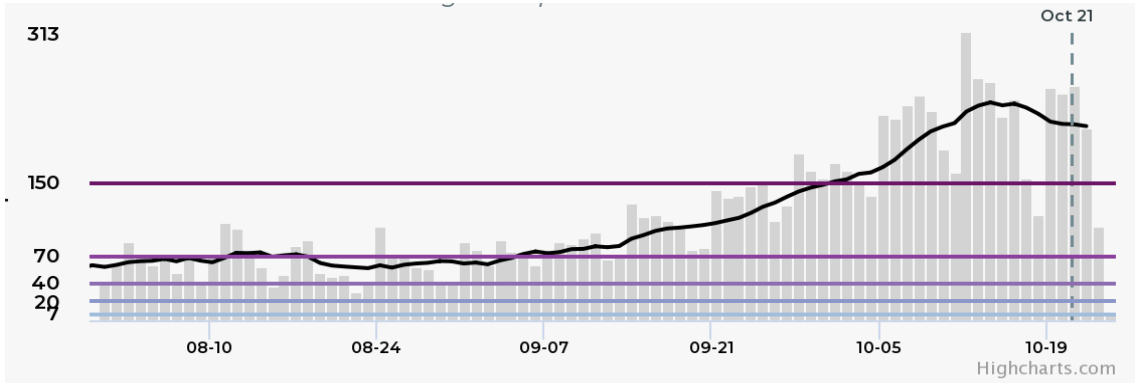
Obtained via MI FOIA by Judicial Watch, Inc.

CASES INCREASING REGIONALLY

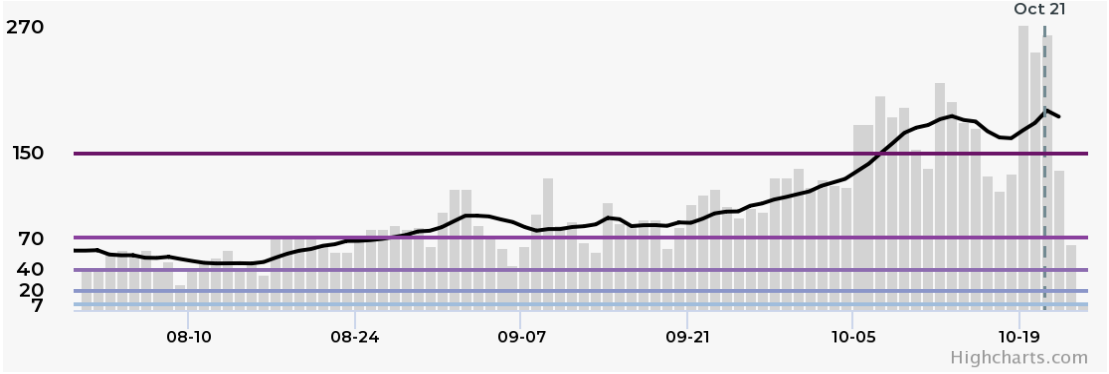
Upper Peninsula



Kalamazoo



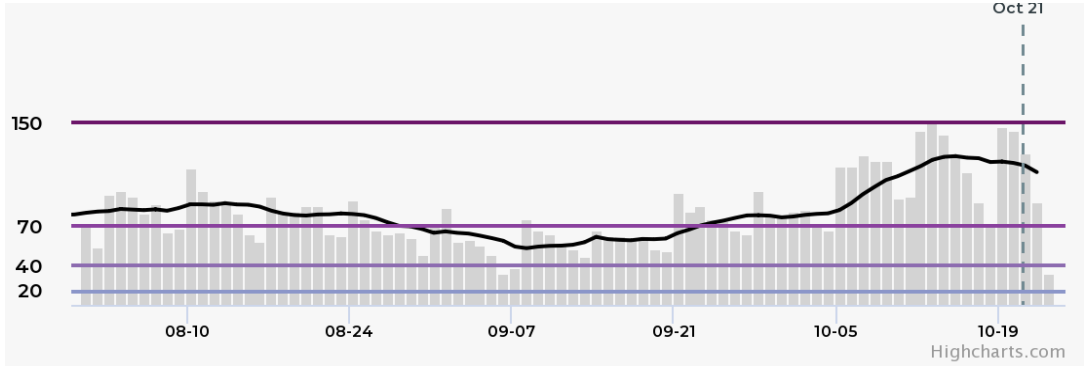
Grand Rapids



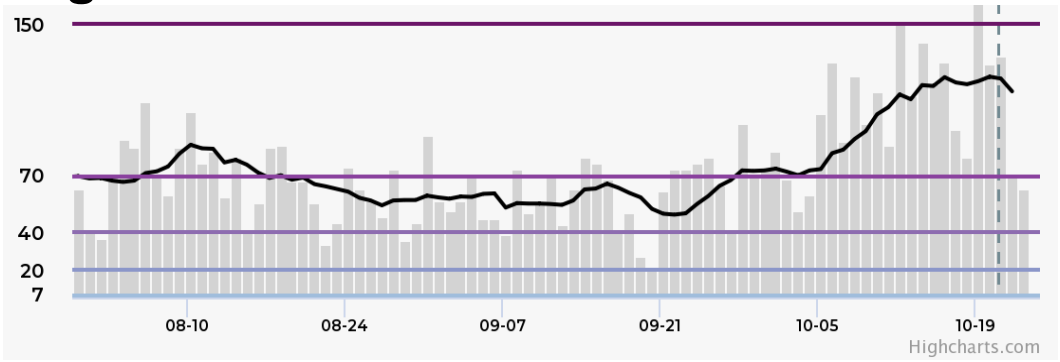
Source: MI Start Map; MDOC excluded

Obtained via MI FOIA by Michael Wells, LLC

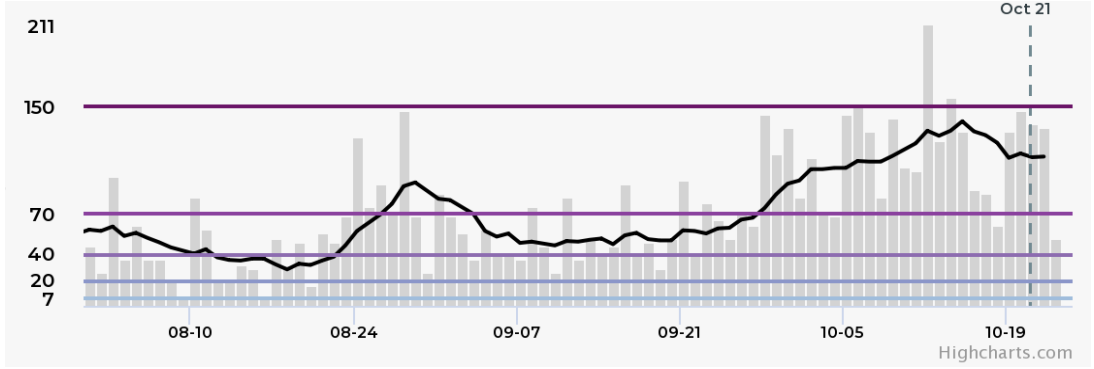
Detroit



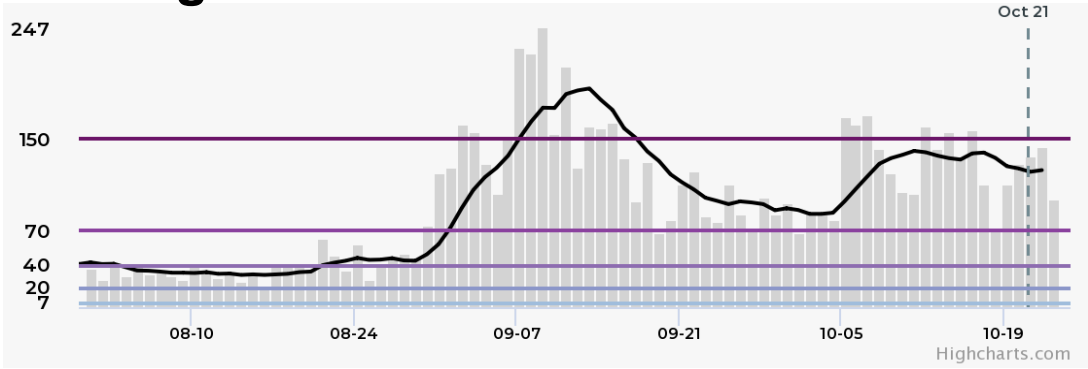
Saginaw



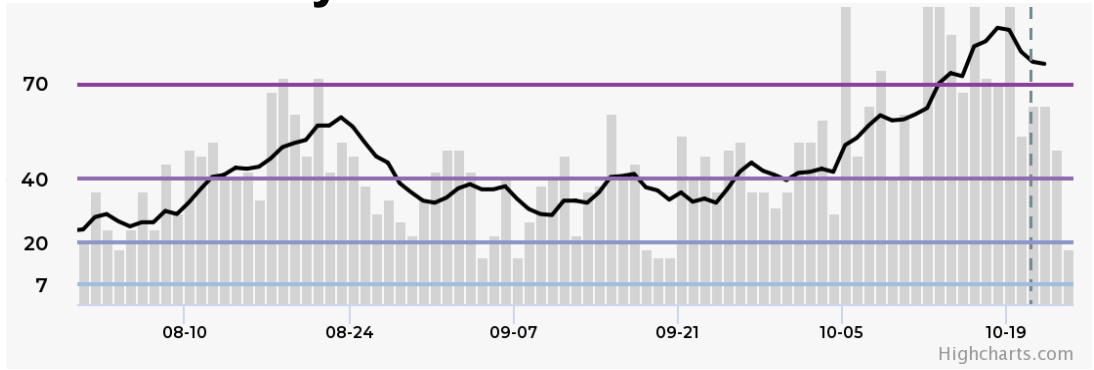
Jackson



Lansing



Traverse City



Source: MI Start Map; MDOC excluded

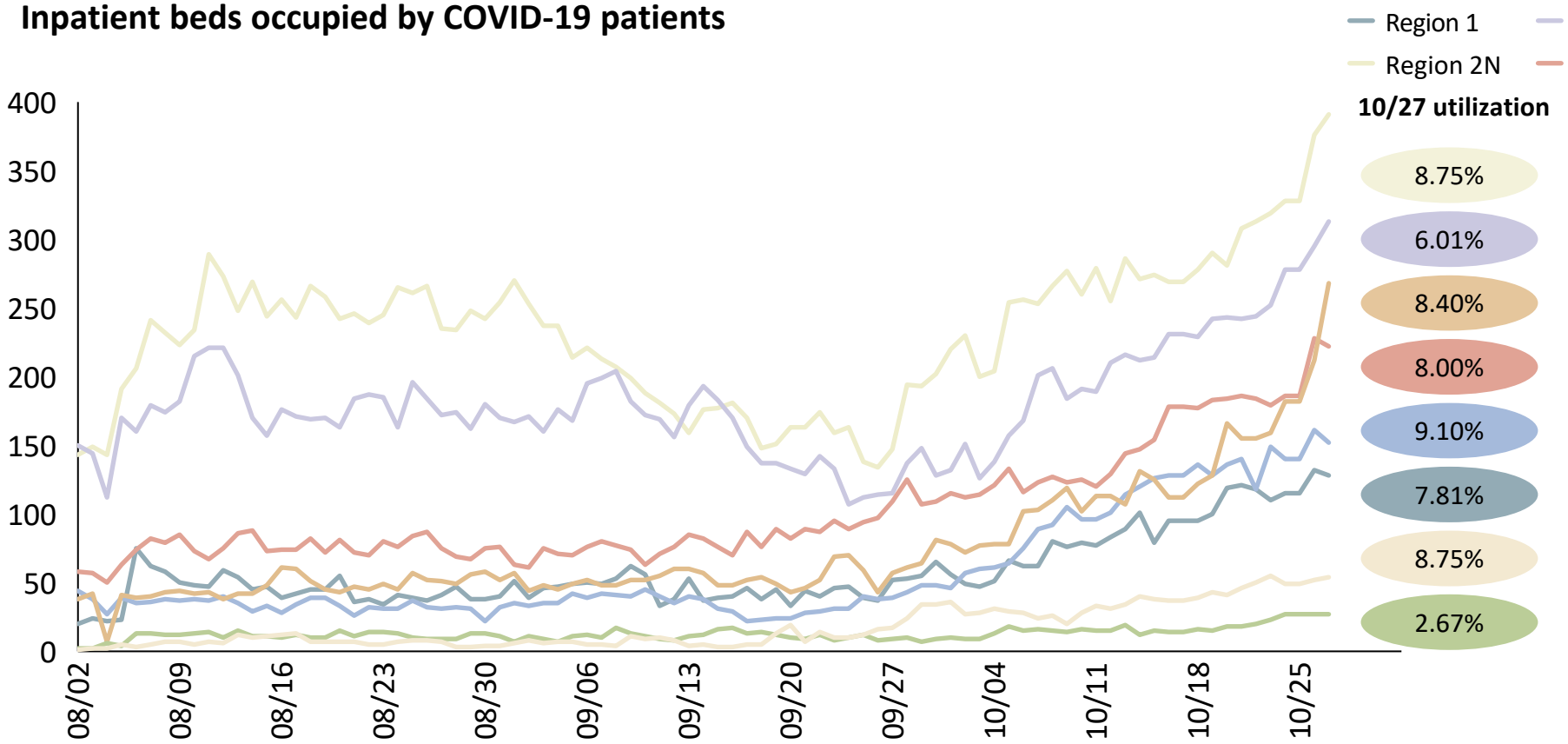
Obtained via MI FOIA by Judicial Watch, Inc.

HOSPITALIZATIONS INCREASING

Hospitalizations continue to increase in every region of the state

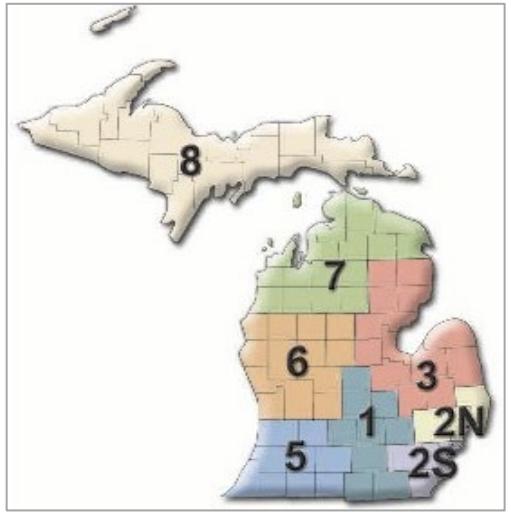
5%-10% of inpatient beds are being used to treat COVID-19 patients in all regions except Traverse City (Region 7)

Inpatient beds occupied by COVID-19 patients



10/27 utilization

Region 1	8.75%
Region 2S	6.01%
Region 5	8.40%
Region 7	8.00%
Region 2N	9.10%
Region 3	7.81%
Region 6	8.75%
Region 8	2.67%



Source: EM Resource data

Obtained via MI FOIA by Judicial Watch, Inc.



DR. JONEIGH KHALDUN

Chief Medical Executive &
Chief Deputy Director for Health

Michigan Department of Health and Human Services



Obtained via MI FOIA by Judicial Watch, Inc.

ROBERT GORDON

Director

Michigan Department of Health and Human Services

Obtained via MI FOIA by Judicial Watch, Inc.

ORDER UPDATES

- No more than 50 people at indoor gatherings without fixed seating.
- No more than 6 people at seated tables at bars, restaurants, and indoor non-residential gatherings.
- Restaurants and bars must collect phone numbers from customers to support contact tracing.
- The entire state is now in phase 4, including the Traverse City region.
- Schedule of fines and enforcement mechanism established.

Obtained via FOIA by Judicial Watch, Inc.

COVID-19

MDHHS EPIDEMIC ORDER OCT. 29

MDHHS has issued orders under a law first enacted by the Michigan Legislature after the Spanish Flu of 1918 specifically to deal with epidemics. Note that the Supreme Court struck down a different, broader law.

Under MDHHS's epidemic order:



1 **Masks** must be worn over nose and mouth in gatherings of two or more people, including stores, offices, schools and events. Businesses cannot admit people without masks, with few exceptions.



2 **Capacity** limits apply to indoor and outdoor gatherings, including business, social and recreational settings. **They're stricter inside.**



3 **Restaurants and bars** must limit capacity for gatherings, **may only seat six people per table**, may only serve alcohol to parties who are seated, and must keep tables six feet apart.



4 **Organized sports** require masks (except for swimming) and have gathering limits.



5 **Employees** who can work from home must do so.



6 **Contact tracing:** Many businesses, **including bars and restaurants**, must collect phone numbers from their customers so they can be contacted in case they are exposed to someone who is ill.

All regions are in Phase 4 of reopening. The same rules now apply to all of Michigan.

Obtained via FOIA by Judicial Watch, Inc.

COVID-19

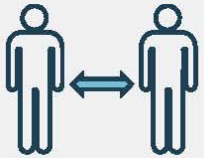
SOCIAL GATHERING GUIDANCE OCT. 29

When socializing with friends or family:

- **Get together outside whenever possible.** Risks are up to 20 times higher inside.
- **If you do get together inside, include no more than two households and never more than 10 people.**
- **If you feel sick, don't go.**
- **Follow these rules whenever you can:**



Wear a mask – only take it off when you eat or drink, then put it back on.



Stay six feet apart.



Limit time together indoors – more time = more risk.



Keep voices down – shouting or cheering can increase COVID-19 in the air by up to 30 times.



Wash hands regularly and do not share utensils.

After a gathering, monitor yourself for symptoms of COVID-19. If anyone in the group feels sick, get tested.

Obtained via MI FOIA by Judicial Watch, Inc.

QUESTIONS?

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Readinger, Patricia; Rising, Jay; Jen, Kyle (DTMB)
Cc: Huls, JoAnne; Kolb, Chris (DTMB)
Subject: RE: FMAP
Date: Wednesday, March 11, 2020 3:03:28 PM

Patty,
Yes, the ask is that we advocate with our delegation and other Govs to change the federal match percentage. Right now, Michigan puts in $1 GF and gets something like $1.75 from the feds. If you increase that match to $2 or higher, it frees up state dollars to spend on other things—more health, education, roads, whatever. This is the core state fiscal relief that Dems always advocate for in a recession, but they're not pushing it now. Below is a further note I just got from someone else living in the middle of this. I think the Gov loudly advocating for FMAP is very warranted and would also be something other Dem Govs quickly rally around.

FURTHER NOTE FROM DC COLLEAGUE:

Very important for Gov to convey importance of this to Michigan delegation and the Dem. Congressional Leadership as quickly as possible. They do not understand that this is important -- and should be done NOW.

Confidentially, last night I was at a reception given by the Council on Michigan Foundations. Res. Dingell and Kildee were there and spoke. Both are focused on immediate coronavirus threats and are not thinking much at this point either about the role Medicaid needs to play or about the importance of an FMAP bump now. Dems on the Hill generally do not understand the magnitude of the threat to the economy and the likelihood that within weeks, the economy will start to slow markedly, unemployment will begin to rise, and lots more people will start turning to Medicaid. Any education you can do will be very important.

From: Readinger, Patricia <ReadingerP@michigan.gov>
Sent: Wednesday, March 11, 2020 2:39 PM
To: Rising, Jay <RisingJ@michigan.gov>; Jen, Kyle (DTMB) <JenK1@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>; Kolb, Chris (DTMB) <KolbC1@michigan.gov>
Subject: RE: FMAP

I don't pretend to be a HC expert, but in sum, is the ask to change the formula/increase the multiplier during this potential economic downturn so the feds contribute more Medicaid dollars? The delegation wants to be helpful on anything we need. Robert, if you can get me some more background this afternoon, impact to MI, I will push from my end.

FYI, attached is the U.S. Senate Dems menu of policy ideas to help workers, local economies, and communities manage COVID-19 outbreaks. This is not an exhaustive list, and it is in addition to the many other ideas and needs in the health policy space. This next supp here is very targeted to "economic stimulus" items, which the House will consider this week. I am also hearing more COVID-

Obtained via MI FOIA by Judicial Watch, Inc.

19 supplementals are still expected as the crisis continues.

On a whole other pathway, might it also be worthy of a letter to HHS Secretary Azar, assuming he might have some authority to act on FMAP?

From: Rising, Jay <RisingJ@michigan.gov>
Sent: Wednesday, March 11, 2020 2:28 PM
To: Jen, Kyle (DTMB) <JenK1@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>; Readinger, Patricia <ReadingerP@michigan.gov>; Kolb, Chris (DTMB) <KolbC1@michigan.gov>
Subject: Re: FMAP

I second Kyle's opinion. We need to pivot quickly to what we need to do to address the problems that may be a consequence of the public health initiatives. That's what I thought were the task force's main objective.

J

Sent from my iPad

> On Mar 11, 2020, at 2:17 PM, Jen, Kyle (DTMB) <JenK1@michigan.gov> wrote:
>
> SBO agrees wholeheartedly. Single most important stabilizer for the state if/when the economy dips.
>
> ---
>
> **From:** Gordon, Robert (DHHS) <GordonR3@michigan.gov>
> **Sent:** Wednesday, March 11, 2020 2:15:23 PM
> **To:** Huls, JoAnne <HulsJ1@michigan.gov>; Rising, Jay <RisingJ@michigan.gov>; Readinger, Patricia <ReadingerP@michigan.gov>; Kolb, Chris (DTMB) <KolbC1@michigan.gov>; Jen, Kyle (DTMB) <JenK1@michigan.gov>
> **Subject:** FMAP
>
> Old senior colleague from DC called me to express his exasperation that congressional Ds are pushing all kinds of things but not FMAP. Said he had talked to Pelosi and she is not there and they are pushing other things that don't directly help states. I said of course we would want FMAP, and more than many other things. He suggested we jump in and push.
>
> If useful to learn more here I would naturally call Bob Greenstein and Ellen Nissenbaum. Will only do if you'd like. Thanks.
>
> Sent from my iPhone

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Khaldun, Joneigh (DHHS); Gordon, Robert (DHHS)
Cc: LyonCallo, Sarah (DHHS); Belden, Eileen; Pohl, Zack
Subject: RE: For Gov remarks
Date: Tuesday, October 20, 2020 8:08:33 AM

I shared this thread with Zach and Eileen, who will be in touch with you all. Added them to this thread.

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email and any associated documents may contain information that is privileged or otherwise exempt from disclosure. It is intended for use only by the person to whom it is addressed. Please contact me before disclosure. If you have received this email in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

From: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Sent: Tuesday, October 20, 2020 8:07 AM
To: Totten, Mark <TottenM1@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Cc: LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>
Subject: RE: For Gov remarks

Thanks. I am speaking tomorrow in the presser as well- we should coordinate my and the Governor's remarks.

From: Totten, Mark <TottenM1@michigan.gov>
Sent: Tuesday, October 20, 2020 8:00 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Cc: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>
Subject: RE: For Gov remarks

Got it – thanks.

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan

Obtained via MI FOIA by Judicial Watch, Inc.

George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email and any associated documents may contain information that is privileged or otherwise exempt from disclosure. It is intended for use only by the person to whom it is addressed. Please contact me before disclosure. If you have received this email in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Tuesday, October 20, 2020 7:58 AM
To: Totten, Mark <TottenM1@michigan.gov>
Cc: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>
Subject: For Gov remarks

Mark,
Per our convo

- Significant number of outbreaks in churches as of last week are listed below. Dr. LC may now have more.
- Basic message for churches is: outdoors if possible; if it has to be inside, socially distance (<50% capacity, 6 feet), wear masks, not the time to sing or touch
- Outbreaks from small indoor gatherings, even two families. Hence: be outdoors whenever you can. If you have to be inside, minimize size of groups, in and out of home. Wear a mask if you are with people from outside your family, even in your house. Eating a meal with another family is source of risk; if you're going to do it, try to socially distance, minimize the time.

We'll look to have more later or tomorrow am.
Thanks,
Robert

From: LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>
Sent: Thursday, October 15, 2020 6:16 PM
To: Foster, Tricia <FosterT13@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: RE: Can you forward the list of faith location

A few others. The formats differ by regions

Region 8

- Luce (157% increase) – Curtis Baptist Church (2 cases), Curtis Clinic (2 cases), Curtis School (3 cases)

Region 5

Obtained via MI FOIA by Judicial Watch, Inc.

Region 5 Outbreaks (cases reported in the past two weeks, 9/30-10/13)

Status	Type of Outbreak	County	Facility/Name	Number Cases
Ongoing	Worksite/Church	Calhoun	Victory Life Church	3
New	Mass Gathering	Barry	Nashville Baptist	1
New	Mass Gathering	Kalamazoo	Radiant Church	45
New	Mass Gathering	Barry	Peace Church	12
Ongoing	Mass Gathering	Calhoun	Wedding [redacted]	3
Ongoing	Mass Gathering	Cass	Moose Lodge	1
Ongoing	Mass Gathering	Calhoun	Wedding [redacted]	7
Ongoing	Mass Gathering	Cass	First Pentacostal Church	3
Ongoing	Mass Gathering	Calhoun	[redacted]	2

Region 3 – Oscoda amish communities

Region 2N

- New outbreaks since 10/6
    - Churches/Faith Organizations
        - Apostolic Church – Port Huron, MI
            - 20 cases, all St Clair County residents
                - Exposures likely occurred at church service on 9/27 and a prayer study on 9/30
            - OUTBREAK ID APOSTOLIC CHURCH PORT HURON, & APOSTOLIC CHURCH PORT HURON SECOND
    - Large Gatherings/Events
        - Wedding in Bowling Green, KY
            - 4 cases, all Oakland residents
            - Outbreak ID 9.26 WEDDING CHARLESTON BOWLING GREEN KENTUCKY

From: LyonCallo, Sarah (DHHS)
Sent: Thursday, October 15, 2020 6:08 PM
To: Foster, Tricia <FosterT13@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: RE: Can you forward the list of faith location

Do you want other regions as well?

Region 6:

- Churches
    - *New* Bethal Church in Kent County
        - 6 cases
        - Outbreak ID: COVID19BETHEL10-20
    - *New* New Community Church in Kent County
        - 3 cases
        - No outbreak ID yet

Obtained via MI FOIA by Judicial Watch, Inc.

New Potter's House Church in Isabella County
- 4 cases
- Outbreak ID: POTTERS HOUSE 10/2020

- *Ongoing* Mel Trotter Ministries in Kent County
  - 3 cases
  - No outbreak ID yet
- *Ongoing* Family Life Church of God Belding in Ionia County
  - 6 cases
  - Outbreak ID: FAMILY LIFE CHURCH OF GOD BELDING C19 9-2020
- *Ongoing* Maranatha Baptist Church in Isabella County
  - 3 cases
  - Outbreak ID: MARANATHA 10/2020
- *Ongoing* City Church Rockford in Kent County
  - 50 cases
  - Outbreak ID: COVID19_CITYCHURCHROCKFORD-092020

Region one

- Clinton (26% increase – 25 more cases than previous 2 week period)
  - *New* Hope Bible Baptist Church in Maple Rapids (7 cases total, 1 Clinton, 6 Gratiot). Referral Date range 9/28 – 10/5. Outbreak ID COVIDHOPEBIBLEBAPTISTCHURCHMR2020
  - *New* [redacted] on 9/26-9/27 (12 cases total, 6 in Clinton). Referral Date Range 9/29 - 10/5. Outbreak ID COVIDOSENTOSKIFUNERAL09/2020
- Jackson (33% increase – 68 more cases than previous 2 week period)
  - *New* Bethel Church 3 cases. Referral date range 10/5 – 10/7. Outbreak ID BethelChurchCovid
  - 1 case in Jackson county jail reported 10/10/20

- Lenawee (34% increase – 33 more cases than previous 2 week period)
  - *New* Christian Mission workplace. 2 employee cases. Referral date range 10/9-10/10. Outbreak ID CHRISTIAN MISSION 10-2020
  - *New* Solid Rock Church. 3 cases. Referral date range 10/3-10/5. Outbreak ID SRCHURCH 10-2020

From: Foster, Tricia <FosterT13@michigan.gov>
Sent: Thursday, October 15, 2020 6:04 PM
To: LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: Can you forward the list of faith location

Outbreaks you showcased at 5 pm please? Working on this topic with the team right now. Ty

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Gordon, Robert (DHHS)
Cc: Khaldun, Joneigh (DHHS); LyonCallo, Sarah (DHHS)
Subject: RE: For Gov remarks
Date: Tuesday, October 20, 2020 7:59:51 AM

Got it – thanks.

_____

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email and any associated documents may contain information that is privileged or otherwise exempt from disclosure. It is intended for use only by the person to whom it is addressed. Please contact me before disclosure. If you have received this email in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Tuesday, October 20, 2020 7:58 AM
To: Totten, Mark <TottenM1@michigan.gov>
Cc: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>
Subject: For Gov remarks

Mark,
Per our convo

- Significant number of outbreaks in churches as of last week are listed below. Dr. LC may now have more.
- Basic message for churches is: outdoors if possible; if it has to be inside, socially distance (<50% capacity, 6 feet), wear masks, not the time to sing or touch
- Outbreaks from small indoor gatherings, even two families. Hence: be outdoors whenever you can. If you have to be inside, minimize size of groups, in and out of home. Wear a mask if you are with people from outside your family, even in your house. Eating a meal with another family is source of risk; if you're going to do it, try to socially distance, minimize the time.

We'll look to have more later or tomorrow am.
Thanks,
Robert

From: LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>
Sent: Thursday, October 15, 2020 6:16 PM

Obtained via MI FOIA by Judicial Watch, Inc.

To: Foster, Tricia <FosterT13@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: RE: Can you forward the list of faith location

A few others. The formats differ by regions

Region 8

- Luce (157% increase) – Curtis Baptist Church (2 cases), Curtis Clinic (2 cases), Curtis School (3 cases)

Region 5

Region 5 Outbreaks (cases reported in the past two weeks, 9/30-10/13)

Status	Type of Outbreak	County	Facility/Name	Number Cases
Ongoing	Worksite/Church	Calhoun	Victory Life Church	3
New	Mass Gathering	Barry	Nashville Baptist	1
New	Mass Gathering	Kalamazoo	Radiant Church	45
New	Mass Gathering	Barry	Peace Church	12
Ongoing	Mass Gathering	Calhoun	Wedding [redacted] - [redacted]	[redacted]
[redacted]	[redacted]	[redacted]	Moose Lodge	1
Ongoing	Mass Gathering	Calhoun	Wedding ([redacted] [redacted])	7
Ongoing	Mass Gathering	Cass	First Pentacostal Church	3
Ongoing	Mass Gathering	Calhoun	[redacted] Party	2

Region 3 – Oscoda amish communities

Region 2N

- New outbreaks since 10/6
    - Churches/Faith Organizations
        - Apostolic Church – Port Huron, MI
            - 20 cases, all St Clair County residents
                - Exposures likely occurred at church service on 9/27 and a prayer study on 9/30
            - OUTBREAK ID APOSTOLIC CHURCH PORT HURON, & APOSTOLIC CHURCH PORT HURON SECOND
    - Large Gatherings/Events
        - Wedding in Bowling Green, KY
            - 4 cases, all Oakland residents
            - Outbreak ID 9.26 WEDDING CHARLESTON BOWLING GREEN KENTUCKY

From: LyonCallo, Sarah (DHHS)
Sent: Thursday, October 15, 2020 6:08 PM
To: Foster, Tricia <FosterT13@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: RE: Can you forward the list of faith location

Obtained via MI FOIA by Judicial Watch, Inc.

Do you want other regions as well?

Region 6:

- Churches
  - *New* Bethal Church in Kent County
    - 6 cases
    - Outbreak ID: COVID19BETHEL10-20
  - *New* New Community Church in Kent County
    - 3 cases
    - No outbreak ID yet
  - *New* Potter's House Church in Isabella County
    - 4 cases
    - Outbreak ID: POTTERS HOUSE 10/2020
  - *Ongoing* Mel Trotter Ministries in Kent County
    - 3 cases
    - No outbreak ID yet
  - *Ongoing* Family Life Church of God Belding in Ionia County
    - 6 cases
    - Outbreak ID: FAMILY LIFE CHURCH OF GOD BELDING C19 9-2020
  - *Ongoing* Maranatha Baptist Church in Isabella County
    - 3 cases
    - Outbreak ID: MARANATHA 10/2020
  - *Ongoing* City Church Rockford in Kent County
    - 50 cases
    - Outbreak ID: COVID19_CITYCHURCHROCKFORD-092020

Region one

- Clinton (26% increase – 25 more cases than previous 2 week period)
  - *New* Hope Bible Baptist Church in Maple Rapids (7 cases total, 1 Clinton, 6 Gratiot). Referral Date range 9/28 – 10/5. Outbreak ID COVIDHOPEBIBLEBAPTISTCHURCHMR2020
  - *New* [redacted] Funeral on 9/26-9/27 (12 cases total, 6 in Clinton). Referral Date Range 9/29 - 10/5. Outbreak ID COVIDOSENTOSKIFUNERAL09/2020
- Jackson (33% increase – 68 more cases than previous 2 week period)
  - *New* Bethel Church 3 cases. Referral date range 10/5 – 10/7. Outbreak ID BethelChurchCovid
  - 1 case in Jackson county jail reported 10/10/20

- Lenawee (34% increase – 33 more cases than previous 2 week period)
  - *New* Christian Mission workplace. 2 employee cases. Referral date range 10/9-10/10. Outbreak ID CHRISTIAN MISSION 10-2020
  - *New* Solid Rock Church. 3 cases. Referral date range 10/3-10/5. Outbreak ID SRCHURCH 10-2020

Obtained via MI FOIA by Judicial Watch, Inc.

From: Foster, Tricia <FosterT13@michigan.gov>
Sent: Thursday, October 15, 2020 6:04 PM
To: LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: Can you forward the list of faith location

Outbreaks you showcased at 5 pm please? Working on this topic with the team right now. Ty

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Gordon, Robert (DHHS); Foster, Tricia; Pohl, Zack
Cc: Chang, Jooyeun (DHHS); Darling, Darice (DHHS)
Subject: RE: FOR IMMEDIATE RELEASE: MDHHS shares gains in reforming state's child welfare system to improve child safety, keep families together; Department's new leadership and team praised by federal judge for 'being devoted to moving this case forward in a ...
Date: Tuesday, November 10, 2020 12:22:38 PM

That's great.

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email and any associated documents may contain information that is privileged or otherwise exempt from disclosure. It is intended for use only by the person to whom it is addressed. Please contact me before disclosure. If you have received this email in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Tuesday, November 10, 2020 12:12 PM
To: Foster, Tricia <FosterT13@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Pohl, Zack <PohlZ@michigan.gov>
Cc: Chang, Jooyeun (DHHS) <ChangJ4@michigan.gov>; Darling, Darice (DHHS) <DarlingD1@michigan.gov>
Subject: Fwd: FOR IMMEDIATE RELEASE: MDHHS shares gains in reforming state's child welfare system to improve child safety, keep families together; Department's new leadership and team praised by federal judge for 'being devoted to moving this case forward in a ...

Federal judge had warm words today in 12-year old lawsuit. She said she is hoping to retire soon and would love to wrap this up before then.

From: Michigan Department of Health and Human Services <MDHHS@govsubscriptions.michigan.gov>
Sent: Tuesday, November 10, 2020 12:04 PM
To: Gordon, Robert (DHHS)
Subject: FOR IMMEDIATE RELEASE: MDHHS shares gains in reforming state's child welfare system to improve child safety, keep families together; Department's new leadership and team praised by federal judge for 'being devoted to moving this case forward in a way t...

MDHHS banner with logo no names

Press Release

Obtained via MI FOIA by Judicial Watch, Inc.

FOR IMMEDIATE RELEASE: Nov. 10, 2020

CONTACT: Bob Wheaton, 517-241-2112, wheatonb@michigan.gov

MDHHS shares gains in reforming state's child welfare system to improve child safety, keep families together

Department's new leadership and team praised by federal judge for being 'devoted to moving this case forward in a way that no prior team has'

LANSING, Mich. – With new leadership in place, Michigan is making needed improvements to its child welfare system to keep children safer and families together. Michigan Department of Health and Human Services (MDHHS) officials today shared successes during the early stages of their reform efforts and promised even more significant progress as new plans are put into place.

MDHHS was in federal court virtually via Zoom to report on child welfare system improvements during the last six months of 2019 and listen to a report from court-appointed monitors. That monitoring period coincided with the beginning of JooYeun Chang's tenure as executive director of the department's Children's Services Agency.

"We are making good progress," said MDHHS Director Robert Gordon. "The improvements we shared today are modest but real. Our focus during the brief period covered by today's report was to develop strategies to set the stage for more rapid improvements in the months to come – particularly in the area of child safety. That progress is already occurring. We look forward to demonstrating greater improvements in outcomes for children and families during the months ahead."

Chang took over as head of the Children's Services Agency in May 2019. Speaking to Judge Nancy G. Edmunds of the U.S. District Court for the Eastern District of Michigan, she highlighted progress MDHHS is making in three areas that demonstrates its commitment to improve critical child safety outcomes. She said MDHHS has:

- Eliminated a previous backlog of 1,300 Children's Protective Services investigations when Chang came to MDHHS. The department has taken swift action by sending additional staff to county field offices, improving policy to eliminate redundancies and outdated requirements, and problem-solving weekly with county offices that were behind. As a result, backlogs were eliminated within four months.
- Taken steps to reduce maltreatment of children in foster care. Among other things, the department has created a new unit that follows up on concerns that children in care are being abused or neglected.
- Provided increased support to relative caregivers so they can keep children safe. MDHHS – which believes children are better off when they are placed with appropriate family members – now provides financial support to relative foster families even if they are not licensed.

"We know there is much more work to do," Chang said. "We will persist in our efforts to transform our system until we are able to meet a child's safety needs before family problems become a crisis and we will dedicate the best evidence-informed programs to support the remaining children who need the temporary protection that foster care provides."

Michigan's child welfare system is under federal court oversight as a result of a lawsuit filed by the advocacy group Children's Rights in 2006. In June 2019 – five months after Gov. Gretchen Whitmer took office – Judge Edmunds approved a new agreement that streamlined the

Obtained via MI FOIA by Judicial Watch, Inc.

monitoring compliance process so MDHHS could devote more resources to getting results.

Tuesday she noted issues remain to be addressed, but she said she's been impressed by the department's new leadership based on what she's heard from court monitor Kevin Ryan.

"My information from Mr. Ryan is that this team that you have assembled is passionate, hardworking and really devoted to moving this case forward in a way that no prior team has," Judge Edmunds told Gordon. "And that's good news for the children and everyone in the state of Michigan."

In addition to working to meet the court's requirements, Chang said MDHHS in the last year has focused on transforming the child welfare system. She said that has included:

- Improving the process for handling reports of suspected child abuse and neglect to the state's toll-free hotline – 855-444-3911. That means decisions about whether complaints should be investigated are more consistent.
- Investing in early intervention and prevention so that families can be assisted before children are at risk of imminent harm or need to be removed from their families. MDHHS partnered with Chapin Hall at the University of Chicago to analyze data to determine which families are most at risk so the department can intervene.
- Ensuring that children are placed in family-like settings whenever possible and increased monitoring of child-caring institutions where some children in foster care are placed so they are safe from harm.

Gordon and Chang also informed the court how MDHHS has responded to a pair of crises during 2020 – the death of a child at a child-caring institution in Kalamazoo and the COVID-19 pandemic.

A 16-year-old died May 1 after he was wrongfully restrained at Lakeside for Children. Since then, MDHHS has moved to revoke Lakeside's license, eliminate the use of dangerous restraints in child-caring facilities and support family-based settings for children in care rather than large institutional facilities.

During the pandemic, MDHHS initiated a rapid review and reunification process, resulting in 432 children in care being safely reunified with their parents. While families spent more time at home due to COVID-19, MDHHS successfully contacted more than 8,000 families beginning in April who had recent CPS cases and more than 5,300 families beginning in August to provide support and resources.

MDHHS also shared with the court significant progress the Children's Services Agency has made in improving its use of technology.

Since the last court hearing, MDHHS has developed and implemented a plan for a new information technology system that will improve the ability to track and analyze data related to cases. The department is close to awarding a contract to build the first part of the new system, which will be constructed in modules as MDHHS phases out the Michigan Statewide Automated Child Welfare Information System (MISACWIS) that has been plagued by problems. The first module is expected to be finished by the end of 2021, with the entire project being completed within three to five years.

To view the latest federal court monitor report and other information, go to www.michigan.gov/ChildWelfareAgreement.

# # #

- Federal Court Monitor Child Welfare Press Release 2020.pdf

Obtained via MI FOIA by Judicial Watch, Inc.

Become a foster parent through Michigan Department of Health & Human Services foster care program.

Questions? Contact Us

SUBSCRIBER SERVICES:
Manage Subscriptions | Unsubscribe All | Subscriber Help

STAY CONNECTED:

This email was sent to gordonr3@michigan.gov using GovDelivery Communications Cloud on behalf of: Michigan Dept of Health & Human Services · 235 S. Grand Ave W. · Lansing, MI 48909 · 1-855-275-6424

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Totten, Mark
To:	Foster, Tricia (DTMB); Winters, Jan (MCSC); Estlund Olson, Liza (OSE); Grossi, Christina (AG); Khaldun, Joneigh (DHHS); McGowan, Emmitt (MSP)
Cc:	Gnodtke, John (MCSC); Keenan, Kelly (AG); Huls, JoAnne; Gordon, Robert (DHHS); Gasper, Joe (MSP); Crockett, Tracy
Subject:	RE: FOR RESPONSE TODAY- COVID-19 Task Force on State Ops, Wed 3/4 2:30-4pm
Date:	Monday, March 2, 2020 3:32:16 PM

One clarification: the Emergency Management Coordinator (EMC) for each department listed below under "Participants" will also be asked to participate on this Task Force. If I asked you to designate 1-2 people, I would ask that you indicate either you will participate, or designate a deputy to participate, in addition to your EMC. Thanks, Mark

Thanks, Mark

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

From: Totten, Mark
Sent: Monday, March 2, 2020 3:12 PM
To: Foster, Tricia (DTMB) <FosterT12@michigan.gov>; Winters, Jan (MCSC) <WintersJ@michigan.gov>; Estlund Olson, Liza (OSE) <EstlundOlsonL@michigan.gov>; Grossi, Christina (AG) <GrossiC@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; McGowan, Emmitt (MSP) <McGowanE1@michigan.gov>
Cc: Gnodtke, John (MCSC) <GnodtkeJ@michigan.gov>; Keenan, Kelly (AG) <KeenanK@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Gasper, Joe (MSP) <GasperJ@michigan.gov>; Crockett, Tracy <CrockettT1@michigan.gov>
Subject: FOR RESPONSE TODAY- COVID-19 Task Force on State Ops, Wed 3/4 2:30-4pm

As I mentioned earlier today (see below), the governor is forming a **COVID-19 Task Force on State Operations**. The first meeting will take place this Wednesday 3/4 from 2:30-4p at the State Emergency Operations Center (SEOC). Please find the relevant details below. In addition, I want to ask the people identified below to respond separately to me ***today*** and identify who from your department or agency will participate on the task force, as we will likely announce the task force by

Obtained via MI FOIA by Judicial Watch, Inc.

press release tomorrow morning. Directors and agency heads do not have to designate themselves as participants, but I would ask that you have at least one deputy-level designee if you are not participating.

- **Scope:** All aspects of state operations, including but not limited to international travel of state workers; cleaning of state facilities; availability of hygienic products; other practices and protections within state facilities; interactions with the public; and work-from-home policies and supporting technologies.

- **Participants:**
  1. Department of Technology, Management, and Budget [***Dir. Foster*** – *please designate 1-2 people total*]
  2. Michigan Civil Service Commission [***Dir. Winters*** – *please designate 1-2 people total*]
  3. Office of the State Employer [***Dir. Estlund-Olson*** – *please designate 1-2 people total*]
  4. Department of Attorney General [***COO Grossi*** – *please designate 1-2 people total*]
  5. Executive Office of the Governor
  6. MDHHS – Health [***Dr. Khaldun*** – *please let me know who will participate*]
  7. MSP/EMHSD [***Captain McGowan*** – *please let me know who will participate*]

- **Time/location of initial meeting:** Wednesday, March 4, 2:30-4pm at the State Emergency Operations Center, located at the Michigan State Police Headquarters, 7150 Harris Drive, Dimondale, MI 48821. Please enter at the main entrance, center of the building, and check-in at the security desk. You will be taken to the SEOC meeting room from there. *You should arrive at least 10 minutes early to allow for check-in.*

I will be in touch with any further details about the meeting as needed. Thanks, Mark

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

From: Totten, Mark

Obtained via MI FOIA by Judicial Watch, Inc.

Sent: Monday, March 2, 2020 9:00 AM
To: Totten, Mark <TottenM1@michigan.gov>
Subject: NEXT STEPS - COVID-19 preparations

Dear directors and agency heads,

As you know, the state is preparing for the likely spread of the coronavirus (COVID-19). Governor Whitmer is moving swiftly to address this threat and ensure Michigan is prepared. This last Friday, the governor activated the State Emergency Operations Center (SEOC) at Level 3 (monitoring and assessment). This decision to manage the response through the state's emergency management system will ensure a unified effort that integrates state, local, and federal government, as well as key partners in the private sector. The Michigan State Police – Emergency Management and Homeland Security Division (MSP-EMHSD) coordinates this system; the Michigan Department of Health and Human Services (MDHHS) will serve as lead department; many other departments and agencies will play important roles; and at all times the governor will oversee the response.

As part of this effort, the governor has directed the formation of four task forces, which will each convene at SEOC for an initial meeting this week:

1. The COVID-19 Task Force on State Operations (covering all aspects of state ops, including employment and facilities);
2. The COVID-19 Task Force on Health Care (covering the provision of medical services);
3. The COVID-19 Task Force on Education (covering K-12 and universities/colleges); and
4. The COVID-19 Task Force on Economy/Workforce (covering general economic impact, workforce, supply chain, business continuity, and related issues)

Scheduling information will go out this morning. Participants on each task force will include: relevant state departments and agencies; the executive office of the governor; MDHHS-Health; MSP-EMHSD; and the Department of Attorney General. Although the initial meeting this week will include state participants, partners in the private sector are critical and will be integrated into this effort. In addition to these four bodies, we may form others as needed. In addition, we are also preparing guidance to share with several external stakeholders this week.

Please make every effort to support these preparations. These meetings will be scheduled this week and will require flexibility. Also, please ensure that you or a deputy have a direct connection to your department's or agency's emergency management coordinator (EMC), each of whom plays an important role in the emergency management system, which the governor has activated.

Thank you for your help. I especially want to thank Dr. Joneigh Khaldun, the state's Chief Medical Executive (MDHHS), and her team, as well as Captain Emmitt McGowan, Deputy State Director of Emergency Management and Homeland Security (MSP), and his team, for the important work they have already begun.

Mark Totten

Obtained via MI FOIA by Judicial Watch, Inc.

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Huls, JoAnne; Foster, Tricia
Subject: RE: Good to talk
Date: Wednesday, April 1, 2020 7:43:19 PM
Attachments: Service Proposal - Masks.03252020.pptx
image001.png

This is from my awesome assistant. It's a week old. Make it 10 million now.

From: Huls, JoAnne <HulsJ1@michigan.gov>
Sent: Wednesday, April 1, 2020 7:36 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>
Subject: Re: Good to talk

We have 20M in the cue.

But we have a ton of demand.

They also have to show up. Ordered is one thin — showing up is a different.

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Wednesday, April 1, 2020 7:33:11 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>
Subject: FW: Good to talk

Jared was chasing 5m masks today! I think if we got this it'd be a whole different ballgame.

From: Ambrosier, Jared (DTMB) <AmbrosierJ@michigan.gov>
Sent: Wednesday, April 1, 2020 5:42 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: RE: Good to talk

We are waiting on confirmation. We placed the order with our supplier, just need the seller to confirm.

Jared Ambrosier
Director, Enterprise Sourcing
Central Procurement Services – Enterprise Sourcing
State of Michigan
517-243-6238
ambrosierj@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

Think Procurement is doing a great job? **Nominate our staff for an Employee Recognition Award!**

Current bids: michigan.gov/sigmavss
Info for vendors: michigan.gov/miprocurement

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Wednesday, April 1, 2020 5:33 PM
To: Ambrosier, Jared (DTMB) <AmbrosierJ@michigan.gov>
Subject: RE: Good to talk

Did you hear back on the 5m masks?

From: Gordon, Robert (DHHS)
Sent: Wednesday, April 1, 2020 10:56 AM
To: Ambrosier, Jared (DTMB) <AmbrosierJ@michigan.gov>
Subject: Good to talk

Let me know if it comes through our not. Thanks.

Obtained via MI FOIA by Judicial Watch, Inc.



Service Proposal: Cloth Masks

March 2020

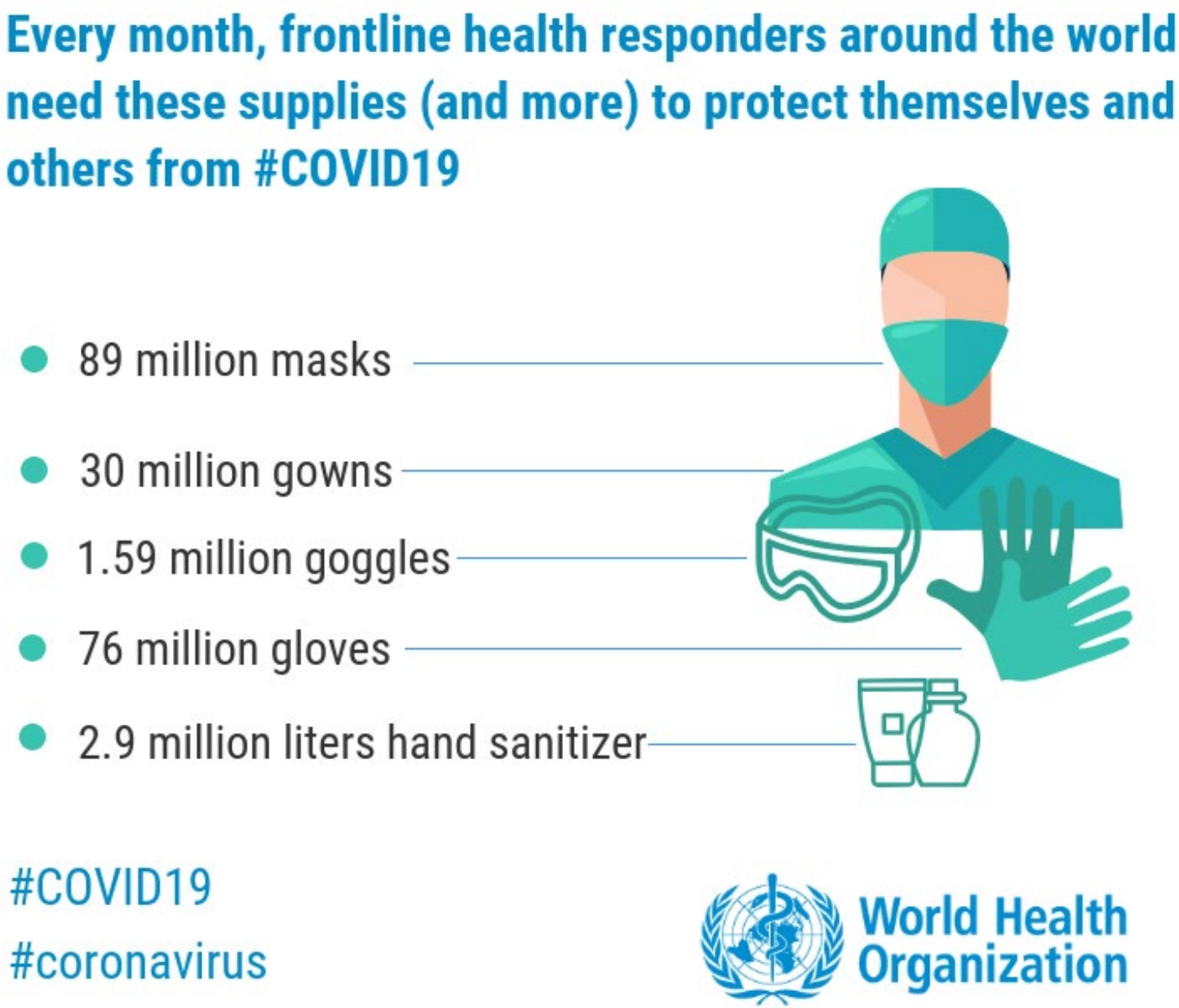
Need

[The WHO](#) issued a warning about upcoming PPE shortages on March 3.

[The Atlantic](#) wrote about a shortage even earlier, on January 30.

[One US hospital](#) reported using five months' worth of supplies in six days.

Obtained via MI FOIA by Judicial Watch, Inc.



MDHHS

Obtained via MI FOIA by Judicial Watch, Inc.

Background



There is a national shortage of surgical masks and other PPE in the United States.

In response, the CDC has issued guidelines allowing for the use of homemade masks in certain circumstances and in combination with other PPE.

Obtained via MI FOIA by Judicial Watch, Inc.

Proposal

In order to fill a growing demand for PPE, the Governor should call on seamstresses, tailors, upholstery companies, quilters, etc. to make and donate masks for healthcare providers and patients. This will create a sense of community and purpose during isolation.



Obtained via MI FOIA by Judicial Watch, Inc.

Cloth Mask Use

Can be used when treating COVID-19 patients in combination with other PPE, such as wearing an N95 mask under a cloth mask, or with a face shield.

Emergency Rooms & doctor's offices can issue cloth masks to patients NOT suspected of having COVID-19. This would free up N95 masks for use with COVID-19 patients.

Can be used by providers and direct care workers in nursing homes and other facilities.



Obtained via MI FOIA by Judicial Watch, Inc.

Method

Materials

- Cloth:
  - Finely Woven Cotton
  - Flannel (for lining)

- Ties:
  - Elastic cord (selling out)
  - Bias tape
  - Shoelaces
  - Hair elastics

Note: Some styles have insert pocket for filter.

Styles







Obtained via MI FOIA by Judicial Watch, Inc.

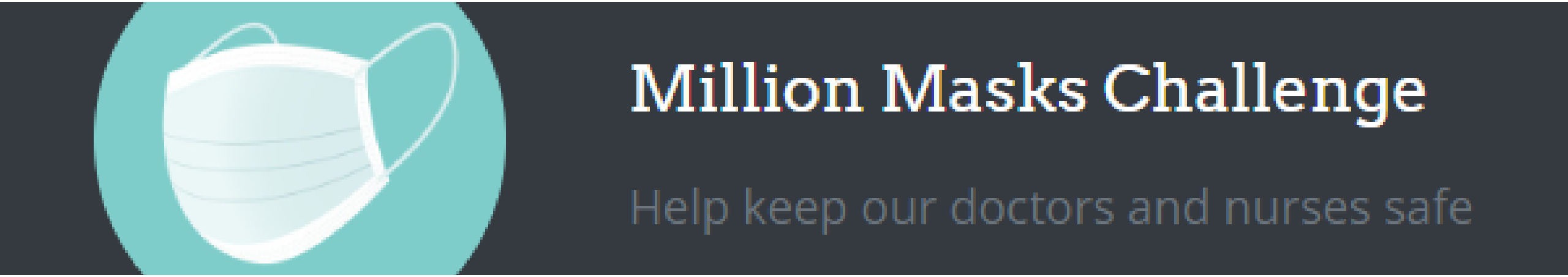
Donation Procedures

- Some hospitals and health departments are accepting donations directly.
- Businesses, including JoAnn fabrics, are accepting drop-off donations.
- Cities and towns, including Lansing, are setting up drop-off locations.



Obtained via MI FOIA by Judicial Watch, Inc.

#1MillionMasks Challenge



Website

Information available regarding organizations requesting donations, tutorials, and other resources available: MillionMaskChallenge

Twitter

#1millionmasks can be used to share goal, information, and resources.

Facebook

Facebook groups, including Mask Makers Collective, is connecting crafters to share tips, tricks, and expertise, as well as share information on organizations that have requested donations.

Obtained via MI FOIA by Judicial Watch, Inc.

Additional Information

The first call:

Deaconess in Indiana

In the news

- Detroit Free Press
- Chicago Tribune
- CNN

Resources:

- WeNeedMasks.org
- JoAnn Fabrics – mask kits & instructions
- #1MillionMasks Challenge website, Twitter, & Facebook groups (Mask Makers Collective)

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Hertel, Elizabeth (DHHS)
Cc: Gordon, Robert (DHHS)
Subject: Re: hawthorne employee
Date: Monday, April 6, 2020 10:15:48 AM

Received

From: Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>
Sent: Monday, April 6, 2020 9:59:06 AM
To: Huls, JoAnne <HulsJ1@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: FW: hawthorne employee

Not sure if possible, but it might be nice for someone from EOG to reach out.

From: Mellos, George (DHHS) <mellosg@michigan.gov>
Sent: Monday, April 6, 2020 9:56 AM
To: Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>
Subject: RE: hawthorne employee

Good morning, Elizabeth.

The employee at HC we discussed is [redacted]. We go back decades and this is very sad. To clarify, [redacted] took ill weeks ago, improved, and then took a turn for the worst and died. [redacted] is not at work. [redacted] has been advised to get tested though hasn't to this point as far as we know. [redacted]

[redacted]

George E. Mellos, MD
Senior Executive Psychiatrist Director
Senior Deputy Director State Hospitals Administration
Michigan Department of Health and Human Services

248-207-3826 State of Michigan Mobile
517-335-4076 Telephone Lewis Cass Building Office
517-335-4077 Fax Lewis Cass Building Office

Obtained via MI FOIA by Judicial Watch, Inc.

From: Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>
Sent: Monday, April 06, 2020 7:55 AM
To: Mellos, George (DHHS) <mellosg@michigan.gov>
Subject: hawthorne employee

When we spoke last week, you mentioned that an employee at hawthorne had tested positive for covid-19, and this person's spouse had also contracted the virus and died. Could you send that person's contact info to me?

Elizabeth Hertel
Chief Administrative Officer
Michigan Department of Health and Human Services
C 517.599.5389

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Ingram, Twanetta (DHHS); Gov. Gretchen Whitmer; Whitmer, Gretchen (MIEOG); Khaldun, Joneigh (DHHS)
Subject: RE: Help w/COVID-19
Date: Wednesday, March 18, 2020 10:09:50 PM

Thank you Twanetta! Appreciate all you are doing in Pontiac and looking for further ways for great Michiganders (and DHHS staff!) to serve. Robert

---

From: Ingram, Twanetta (DHHS) <IngramT@michigan.gov>
Sent: Wednesday, March 18, 2020 9:56 PM
To: Gov. Gretchen Whitmer <GovGretchenWhitmer@govsubscriptions.michigan.gov>; Whitmer, Gretchen (MIEOG) <Gretchen.Whitmer@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Subject: Help w/COVID-19

Greetings,

Although I am a state employee I would like to extend myself to help (volunteer) any way that I can to assist the citizens of our great state. I would like to do more to help outside of my assigned duties. I am willing to assist without pay in whatever capacity is needed, answering phone lines , delivering food etc.

Please contact me via email at ingramt@michigan.gov or my cell at [redacted].

Sincerely,

Twanetta Ingram

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Hertel, Elizabeth (DHHS); Foster, Tricia
Cc: Gordon, Robert (DHHS); Groen, Meghan
Subject: Re: Hospital Laboratory Testing
Date: Saturday, March 28, 2020 3:32:55 PM

Mclaren jsbgoing to have high speed testing by the end of the week too

jh

From: Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>
Sent: Saturday, March 28, 2020 2:51:12 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>
Subject: FW: Hospital Laboratory Testing

Just to give a view on testing capacity currently.

From: Fales, William (DHHS-Contractor) <FalesW@michigan.gov>
Sent: Saturday, March 28, 2020 11:15 AM
To: Shah, Sandip (DHHS) <shahs@michigan.gov>; Soehnlen, Marty (DHHS) <SoehnlenM@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Scott, Linda (DHHS) <ScottL12@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Ingersoll, Jean (DHHS) <IngersollJ2@michigan.gov>
Subject: Hospital Laboratory Testing

Good Morning,

A number of laboratory testing items have come up that I feel are im portant enough to share with this group.

Spectrum Lab Online: Earlier this week Spectrum lab went online reporting capacity for 450/day.

Cumulative Reporting in EMResource for hospital Testing: Last week we implemented a daily EMResource event in which the now 5 hospital labs doing testing report 1) current per day testing capability, 2) # samples tested the previous day, 3) # positive tests from previous day, and 4) cumulative number of samples tested, and 5) cumulative number positive. Below is a summary of all of 5 hospital labs results from this morning.

Hospital Lab	Last Updated	Daily Capability	# Tested Yesterday	# (%) Positive Yesterday	Cumulative # Tested	Cumulative # (%) Positive
Beaumont	3/28	400	381	181 (47.5%)	3834	1529 (39.8%)

Obtained via MI FOIA by Judicial Watch, Inc.

Henry Ford	3/28	800	637	225 (35.3%)	2296	793 (34.5%)
Sparrow	3/27	92	92	2 (2.1%)	934	29 (3.1%)
Spectrum*	3/28	450	192	9 (4.6%)	1630	103 (6.3%)
UM	3/26	282	150	27 (18%)	634	103 (16.2%)
Total		2,024	1,452		8488	2,527
*Report inadequate numbers of testing kits						

I think this interesting and not overly surprising, aligning very much with healthcare system stress. To Drs Shah and Soehnlen, is there any reason we should have to worry that Sparrow and Spectrum might be having high false negative rates causing their positive rate to be lower? Since this info is currently accessible to the HCC's but not in aggregate form, can we make this available to the HCC MDs. I think it will be helpful. I'm also wondering if our State Lab could begin providing this same info and we could enter it into the system as a 6th lab. The info could be sent to the CHECC each morning. Thanks for considering this.

Need for Reagents; We have consistently heard from MHA and directly from a number of hospitals and regional medical directors that many hospitals have the instruments needed for the various new high throughput tests but lack the reagents and cartridges. They report being advised by their supplier that they have been directed by the feds to preferentially ship reagents to hardest impacted states, presumably not MI. For example, Bronson hospital in Kzoo has the instruments needed but are still awaiting cartridges. They are willing to serve a sa priority testing lab for Region 5 but are stuck with no reagents/cartridges. Is there a way Michigan can press the feds (HHS/FDA) or go directly to the suppliers and request we begin receiving reagents. It might be good for us to target at least one hospital in the non SE MI regions to have priority access to reagents if they agree to support their regions. We already have sites in R1 and R6 along with R2N/S. A priority should be getting capacity for in region hospital testing of priority specimens for R3, R5 (Bronson), R7 (Munson?),R8 (UP Health?).

Lab Mutual Aid to Help with Any state Lab Backlog: Based on the numbers above it appears that several labs have capacity to do more testing. Roughly we used about 71% of our total daily hospital capacity. The concept of the MI COVID-19 Lab Network developed a couple of weeks ago called for hospital labs sharing their excess capacity with the state as they could. BOL colleagues is this still something that would be beneficial. If so, maybe a call with the BOL and the hospital labs to discuss how that might be operationalized would be helpful. I think our goal should be to make sure we are fully exploiting the capacity of both BOL and hospital labs.

Any thoughts from the team on these items would be much appreciated....Bill

Obtained via MI FOIA by Judicial Watch, Inc.

Hospitals Lacking Reagents

William Fales, MD

William Fales, MD, FACEP

State Medical Director

Division of EMS and Trauma

Bureau of EMS, Trauma, and Preparedness

Michigan Department of Health and Human Services

Cell: 269-998-2167

Obtained via MI FOIA by Judicial Watch, Inc.

Fax: 269-337-6475

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Gordon, Robert (DHHS)
To:	Groen, Meghan; Emerson, Erin (DHHS); Totten, Mark
Cc:	Massey, Kate (DHHS); Kolodin, Zach; Khaldun, Joneigh (DHHS); LyonCallo, Sarah (DHHS)
Subject:	RE: IMPORTANT: Note on EO 2020-50
Date:	Sunday, June 28, 2020 11:32:32 AM
Attachments:	20200614 State Nursing Home Comparison vF.xlsx

From McK 2 weeks ago.

From: Groen, Meghan <GroenM@michigan.gov>
Sent: Sunday, June 28, 2020 11:18 AM
To: Emerson, Erin (DHHS) <EmersonE@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Massey, Kate (DHHS) <MasseyK4@michigan.gov>; Kolodin, Zach <KolodinZ@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>
Subject: RE: IMPORTANT: Note on EO 2020-50

Relevant CMS Guidance we just referred to:

Note: Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present. Also, if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor, or returning to long-stay original room)

From: Emerson, Erin (DHHS) <EmersonE@michigan.gov>
Sent: Sunday, June 28, 2020 11:13 AM
To: Totten, Mark <TottenM1@michigan.gov>
Cc: Groen, Meghan <GroenM@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Massey, Kate (DHHS) <MasseyK4@michigan.gov>; Kolodin, Zach <KolodinZ@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>
Subject: FW: IMPORTANT: Note on EO 2020-50
Importance: High

Per our discussion.

From: Massey, Kate (DHHS) <MasseyK4@michigan.gov>
Sent: Friday, April 17, 2020 5:39 PM
To: Melissa Samuel <MelissaSamuel@Hcam.org>; Dave Herbel (david@leadingagemi.org) <david@leadingagemi.org>; Renee Beniak <renee@mcmcfc.org>
Cc: Barrie, Brian (DHHS) <BarrieB@michigan.gov>; Gallagher, Elizabeth A. (DHHS) <gallaghere@michigan.gov>; Emerson, Erin (DHHS) <EmersonE@michigan.gov>; Commey, Katherine (DHHS-Contractor) <CommeyK@michigan.gov>
Subject: IMPORTANT: Note on EO 2020-50
Importance: High

Obtained via MI FOIA by Judicial Watch, Inc.

Melissa, Dave, and Renee,

A message regarding EO 2020-50 will be released this weekend but we wanted you to be aware in advance:

> *On Wednesday, April 15, 2020, Governor Gretchen Whitmer signed Executive Order 2020-50, to protect residents and employees of long-term care facilities, and to establish procedures to minimize the spread of COVID-19. MDHHS plans to guidance to long-term care facilities in implementing the requirements of the order. This guidance will share best practices, specify transfer protocols and reporting protocols, and respond to several FAQs. Until such guidance is issued, MDHHS encourages long-term care facilities to begin preparation for implementation, but to postpone movement of COVID-19-affected residents, except as required for medical reasons.*

Please share this with your members as we push this out through our traditional communications channels.

Thanks,

Kate

Obtained via MI FOIA by Judicial Watch, Inc.

	State	Nursing Home COVID Deaths/1K Residents	Total Nursing Home COVID Deaths	Nursing Home % of Total State COVID Deaths
1	OK	59	443	120%
2	WV	14	91	103%
3	ND	8	49	66%
4	PA	53	3,120	50%
5	MS	43	438	49%
6	RI	50	408	49%
7	KY	13	226	45%
8	AL	21	335	43%
9	MA	121	2,955	39%
10	CT	115	1,523	36%
11	VT	9	20	36%
12	DE	44	153	36%
13	SD	2	27	36%
14	IN	30	867	36%
15	NJ	178	4,466	35%
16	OH	19	871	34%
17	**MI**	**62**	**1,947**	**32%**
18	VA	25	481	31%
19	LA	48	920	31%
20	IL	35	1,961	30%
21	IA	11	196	30%
22	MD	55	878	30%
23	CA	19	1,466	29%
24	SC	10	176	29%
25	NC	13	322	29%
26	MO	8	253	29%
27	NH	23	87	27%
28	NE	5	59	27%
29	AR	5	48	27%
30	MN	12	345	26%
31	WA	33	304	25%
32	CO	32	391	24%
33	FL	12	679	23%
34	WI	11	146	21%
35	GA	19	505	21%
36	KS	4	50	21%
37	ME	5	20	20%
38	WY	2	3	17%
39	TX	6	321	16%

Obtained via MI FOIA by Judicial Watch, Inc.

40	TN	4	76	16%
41	NY	44	3,525	12%
42	MT	2	2	11%
43	AZ	23	129	11%
44	DC	44	52	10%
45	OR	3	16	9%
46	UT	3	11	8%
47	NM	16	34	8%
48	ID	1	6	7%
49	NV	7	30	6%
50	HI	0	1	6%
51	AK	0	-	0%

Obtained via MI FOIA by Judicial Watch, Inc.

Note
MI Deaths from EMResource, excluding deaths listed in regional hubs; used data from phone survey process for several facilities with EMResource discrepancies

Metric
Nursing Home Deaths/1K Residents
Nursing Home Deaths
# of Residents
Total Deaths

Obtained via MI FOIA by Judicial Watch, Inc.

Obtained via MI FOIA by Judicial Watch, Inc.

Source	MI Source	Other note
https://data.cms.gov/stories/s/bk	Calculated from EMResource SOM Deaths and CMS	# of Residents
https://data.cms.gov/stories/s/bk	June 14 EMResource SOM Report	
Calculated from CMS Deaths and D	Calculated from CMS Deaths and Deaths Ratio	(source for Hawaii: ht
https://data.cms.gov/stories/s/bk	https://data.cms.gov/stories/s/bkwz-xpvg	

Obtained via MI FOIA by Judicial Watch, Inc.

Obtained via MI FOIA by Judicial Watch, Inc.

tps://www.kff.org/other/state-indicator/number-of-nursing-facility-residents/?currentTimeframe=0&sortMo

Obtained via MI FOIA by Judicial Watch, Inc.

Obtained via MI FOIA by Judicial Watch, Inc.

del=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Groen, Meghan; Emerson, Erin (DHHS); Totten, Mark
Cc: Massey, Kate (DHHS); Kolodin, Zach; Khaldun, Joneigh (DHHS); LyonCallo, Sarah (DHHS)
Subject: RE: IMPORTANT: Note on EO 2020-50
Date: Sunday, June 28, 2020 11:24:32 AM
Attachments: Committee Quotes.docx

Attached has hearing quote. Here's the further discussion in the media I was remembering:

> The early order also said a nursing home with a census below 80% had to create a unit dedicated to the care of COVID-19-affected residents. Facilities "must accept the return" of a resident who had been hospitalized if it can meet the medical needs of the resident, the order said.
>
> The idea was to take pressure off hospitals while caring for individuals in an appropriate setting.
>
> Samuel of the Health Care Association of Michigan said her organization had "significant concerns" with the initial executive order and expressed them immediately to Whitmer's administration, which later made changes and issued additional guidance.
>
> "In essence, it was really never implemented as originally issued," Samuel said
>
> Later guidance and orders gave facilities "flexibility" to decide whether to take an individual with COVID-19 based on whether they had the staff, equipment and isolated space necessary to care for the individual, she said.

From: Groen, Meghan <GroenM@michigan.gov>
Sent: Sunday, June 28, 2020 11:18 AM
To: Emerson, Erin (DHHS) <EmersonE@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Massey, Kate (DHHS) <MasseyK4@michigan.gov>; Kolodin, Zach <KolodinZ@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>
Subject: RE: IMPORTANT: Note on EO 2020-50

Relevant CMS Guidance we just referred to:

Note: Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present. Also, if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor, or returning to long-stay original room)

Obtained via MI FOIA by Judicial Watch, Inc.

From: Emerson, Erin (DHHS) <EmersonE@michigan.gov>
Sent: Sunday, June 28, 2020 11:13 AM
To: Totten, Mark <TottenM1@michigan.gov>
Cc: Groen, Meghan <GroenM@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Massey, Kate (DHHS) <MasseyK4@michigan.gov>; Kolodin, Zach <KolodinZ@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>
Subject: FW: IMPORTANT: Note on EO 2020-50
Importance: High

Per our discussion.

From: Massey, Kate (DHHS) <MasseyK4@michigan.gov>
Sent: Friday, April 17, 2020 5:39 PM
To: Melissa Samuel <MelissaSamuel@Hcam.org>; Dave Herbel (david@leadingagemi.org) <david@leadingagemi.org>; Renee Beniak <renee@mcmcfc.org>
Cc: Barrie, Brian (DHHS) <BarrieB@michigan.gov>; Gallagher, Elizabeth A. (DHHS) <gallaghere@michigan.gov>; Emerson, Erin (DHHS) <EmersonE@michigan.gov>; Commey, Katherine (DHHS-Contractor) <CommeyK@michigan.gov>
Subject: IMPORTANT: Note on EO 2020-50
Importance: High

Melissa, Dave, and Renee,

A message regarding EO 2020-50 will be released this weekend but we wanted you to be aware in advance:

> *On Wednesday, April 15, 2020, Governor Gretchen Whitmer signed Executive Order 2020-50, to protect residents and employees of long-term care facilities, and to establish procedures to minimize the spread of COVID-19. MDHHS plans to guidance to long-term care facilities in implementing the requirements of the order. This guidance will share best practices, specify transfer protocols and reporting protocols, and respond to several FAQs. Until such guidance is issued, MDHHS encourages long-term care facilities to begin preparation for implementation, but to postpone movement of COVID-19-affected residents, except as required for medical reasons.*

Please share this with your members as we push this out through our traditional communications channels.

Thanks,

Kate

Obtained via MI FOIA by Judicial Watch, Inc.

Deanna, Leading Age: **We appreciate the goals of the Governor's to safeguard frail seniors, and the willingness of both the DHHS and LARA to work with providers to address these issues, we have worked them quite often?**

McBroom: Can you elaborate some of the interactions your organization had with the departments in setting up the Executive Order? How soon in advance were you called, did you share a lot of information? Was it just courtesy calls, what sort of interactions did you have?

Deanna: Um, I was not personally involved in all those conversations but my understanding is as early as March 17th, we were engaged in conversations with Director Massey, identifying the needs of what we thought the supports to nursing facilities were, as they were beginning to serve COVID infected residents, which was PPE, streamline some hiring practices, and support nursing home wages. And pretty much I think the conversations became more frequent after April 1st after the first media reports came out, with high counts in SE Michigan facilities. Around April 4, we had our first discussions with the department on establishing dedicated COVID facilities……Around April 11th, w were in conversations about possible sites, the associations were asked about possible sites for regional hubs and on the 15th, obviously the executive order was issued, but my understanding was that we did have quite a few conversations with Director Massey and had a lot of e-mail conversations as well.

Sen. McBroom: I understand that you dealt with Director Massey and the interaction was exactly what?

Um, well I was on some of the conference calls with Director Massey but I was not in the middle of all the conversations between our CEO and Director Massey but I thought that they were numerous. I do believe there were discussions about…[what are] for the need of designated places to safely serve COVID positive residents and what some of the parameters around that however, I was not engaged with all those conversations myself.

Melissa Samuel, HCAM: This was a reasonable approach more than a month ago, particularly in SE Michigan

HCAM shared its concerns with both the MDHHS and the administration in a marked up version of the EO and corresponding memorandum offer further explanation. Multiple ensuing conversations between the department and the administration and HCAM resulted in both verbal and written clarification related to many of the major concerns expressed by HCAM with the EO. Facilities continued to follow CMS and CDC guidance on the establishment of COVID units

Up until recently, the lack of adequate and timely testing has forced providers to rely on symptoms based approach we now know this type of screening is ineffective of controlling the virus and CDC data shows that asymptomatic seniors and staff can unknowingly spread the virus. Testing is the answer to protecting from the spread of COVID 19. We must make nursing facilities the top priority. To this end, we have been working with the department to develop a strategy to operationalize ongoing testing of nursing facility staff and residents. Widespread testing will save lives, we have seen this in Detroit.

Can you share with us what HCAM's interactions were with the department and the beginning of this a prior to issuance of executive order 20-50?

I would agree with Deanna, certainly as COVID started to present in Michigan, particularly in SE Michigan we began the conversations with the department. In regards to the executive order, we were

Obtained via MI FOIA by Judicial Watch, Inc.

again, because of what was happening in SE Michigan having additional conversations around the development of the Hubs. As far as the remaining provisions in the executive order, we did not have conversations on those provisions, it was primarily focused on the development and strategy of the Hubs.

Richie Faran, HCAM: **Senator, if I call also add as well, we also read the language in the EO as a mandate the minute it came out, but very shortly after we had conversations with Director Massey and the administration about our concerns on that, we were told to hold off on implementing, pass that along to our members, which we did, to our knowledge there has not been a mandate for these facilities to establish these units and to our knowledge there has not been a mandate to accept a hospital discharge if it does not have the PPE resources. The CMS and CDC guidance from the get go was the facility cares for these people if they have the staff, PPE, physical plan capability for them. If not, they don't and even with the issuance of the EO, understand completely we read that language the same way we were told to kind of stand down on that language, the way its been operating from the get go is following that CDC and CMS guidelines**

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Jansen, Allen (DHHS); Daniel Cherrin
Cc: Willie Brooks; Gilchrist, Garlin (MIEOG); Groen, Meghan; Eric Doeh; Bowden, Andrea (DHHS); Aikins, Sherida (DHHS)
Subject: RE: In Wayne County, Consumers Are Dying
Date: Friday, April 17, 2020 3:47:58 PM

All, I appreciate the incredibly difficult position you are in, and the suffering that you are confronting. I am sorry not to have been in touch more directly. Like Allen, and like all of you, I have been working the longest days of my life to do everything in my power to support an effective response. This said, there is of course more we must do, and I'm happy to talk personally with you about those steps next week. Best regards, Robert

---

From: Jansen, Allen (DHHS) <JansenA2@michigan.gov>
Sent: Friday, April 17, 2020 3:39 PM
To: Daniel Cherrin <dcherrin@northcoaststrategies.com>
Cc: Willie Brooks <wbrooks@dwihn.org>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Gilchrist, Garlin (MIEOG) <Garlin.Gilchrist@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>; Eric Doeh <edoeh1@dwihn.org>; Bowden, Andrea (DHHS) <BowdenA1@michigan.gov>; Aikins, Sherida (DHHS) <AikinsS@michigan.gov>
Subject: RE: In Wayne County, Consumers Are Dying

Thanks Daniel, Director Gordon and I were able to speak and we would like to talk directly with you, your members and Mr. Brooks again as soon as possible. Please invite other members if desired. I've included both Andrea and Sherida to assist with our schedules. This is an important conversation so we will move what is moveable to make this happen as soon as possible.
Thanks to all for your advocacy.
Allen

From: Daniel Cherrin <dcherrin@northcoaststrategies.com>
Sent: Friday, April 17, 2020 1:44 PM
To: Jansen, Allen (DHHS) <JansenA2@michigan.gov>
Cc: Willie Brooks <wbrooks@dwihn.org>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Gilchrist, Garlin (MIEOG) <Garlin.Gilchrist@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>; Eric Doeh <edoeh1@dwihn.org>
Subject: In Wayne County, Consumers Are Dying

Hi, Allen. I wanted to touch base with you to see if you had a chance to talk to Director Gordon about the urgency in Wayne County and discuss ways to bring immediate relief to your front line mental health providers in the state's hardest-hit county (Wayne County)

We had a very successful call this morning with Senator Stabenow and US Rep. Lawrence. One of the things we asked them for was to provide greater oversight as to how federal dollars are being distributed to the mental health providers on the front lines.

You can let the Director know that they have been briefed on the situation in Wayne County and let me share some more news which I just learned on the call.

Obtained via MI FOIA by Judicial Watch, Inc.

Consumers in residential settings are dying. We hear of people dying in nursing homes or getting sick in prisons, but the same is true in group homes. In fact, one provider reported 8 consumer deaths due to COVID-19 -- That was just one provider. I can share with you additional statistics, which the Senator encouraged us to share with the media to help bring light to the lack of resources to support the delivery of mental health and SUD services.

In addition, the staff of this specific group home are refusing to come to work because they do not want to be exposed to consumers with COVID-19 or to those returning from the hospital. Many of them are still without PPEs. We can also share stories with you about children living in dangerous environments.

We appreciate the support of Willie and the DWIHN - We have been in regular communication. Now we need the MDHHS to step in and provide the resources. If the Director is not available, then I would like to have our providers brief the Lt. Governor whom I am also including in this email.

I look forward to your immediate response and not waiting for another weekend to pass by.

ON BEHALF OF THE MI BEHAVIORAL HEALTH AND WELLNESS COLLABORATIVE,
DANIEL CHERRIN

Collaborative Members:

Goodwill Industries of Greater Detroit|Neighborhood Service Organization|Arab American Chaldean Council| Services To Enhance Potential Northeast Integrated Health|Lincoln Behavioral Services|Development Centers, Inc.|Black Family Development|Community Care Services|Starfish Family Services|The Children's Center|All Well-Being Service|The Guidance Center |Southwest Solutions|Hegira Health, Inc.|Wayne Center

(313) 300-0932 | **DCHERRIN@NORTHCOASTSTRATEGIES.COM**

NorthCoastStrategies.com | **@dancherrin**

Please take a moment to write a review on Google.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Kolodin, Zach; Totten, Mark; Hicks, Jayshona; Brown, Tiffany
Cc: Bouknight, Rey (DHHS); Esty, Sarah (DHHS)
Subject: Re: Introduction/Assistance
Date: Saturday, October 17, 2020 11:58:20 AM

I have a call with him and Bob Stevenson at 4. Bob said it would take time for his exec board to weigh in. I aim to keep us on track for action next week. Seems we could use endorsements independent of these formal bodies. Thanks.

From: Kolodin, Zach <KolodinZ@michigan.gov>
Sent: Saturday, October 17, 2020 10:45:03 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Hicks, Jayshona <HicksJ10@michigan.gov>; Brown, Tiffany <BrownT56@michigan.gov>
Cc: Bouknight, Rey (DHHS) <BouknightR@michigan.gov>; Esty, Sarah (DHHS) <EstyS@michigan.gov>
Subject: RE: Introduction/Assistance

+ Jayshona, Mel,

For your awareness, Colonel Gasper introduced Director Gordon to Matt Saxton. Feel free to provide any additional background.

_____
Zachary Kolodin
Deputy Legal Counsel – Public Policy Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
Cell: 517-242-0449
kolodinz@michigan.gov
he/him/his

**This email and any associated documents may contain information that is privileged or otherwise exempt from disclosure. It is intended for use only by the person to whom it is addressed. Please contact me before disclosure. If you have received this email in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.

-----Original Message-----
From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Saturday, October 17, 2020 6:53 AM
To: Totten, Mark <TottenM1@michigan.gov>; Kolodin, Zach <KolodinZ@michigan.gov>
Cc: Bouknight, Rey (DHHS) <BouknightR@michigan.gov>; Esty, Sarah (DHHS) <EstyS@michigan.gov>
Subject: FW: Introduction/Assistance

FYI. Let me know if I should loop one of you into this. Happy also to follow your lead on other contacts. Thanks.

-----Original Message-----
From: Gordon, Robert (DHHS)
Sent: Saturday, October 17, 2020 6:50 AM
To: Gasper, Joe (MSP) <GasperJ@michigan.gov>
Cc: Matt Saxton <msaxton@msheriff.org>; mkevenson@michiganpolicechiefs.org
Subject: RE: Introduction/Assistance

Thanks a lot, Colonel Gasper, and good morning, Mr. Saxton and Mr. Stevenson,

I appreciate the chance to be in touch with you.

By way of background, last week MDHHS issued an order on masking, social distancing, and capacity limits that is similar to key Executive Orders that are no longer enforceable. The MDHHS order was issued under a statute (MCL 333.2253) enacted by the Michigan Legislature after the Spanish flu in order to control epidemics, specifically by limiting gatherings. That statute that was not before the Supreme Court, and it is narrower than the law the Court struck down.

With COVID-19 cases surging, there is great urgency to encourage masking and social distancing. These are the best tools available to slow the rise in cases, hospitalizations, and deaths. While some people will act because they believe it is important, for others, a credible threat of sanction is likely to be critical.

I know that this is a subject with many complexities and would be eager to talk with you about the approach we have been developing with MSP. I can be available for a conversation at a good time for you, including Monday morning until 10:30. My cell is 517-242-0165.

Here is the order: https://gcc01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.michigan.gov%2Fcoronavirus%2F0%2C9753%2C7-406-98178_98455-541962--%2C00.html&data=04%7C01%7CGordonR3%40michigan.gov%7C96ee158d49454f0929f0f8d872ab3b4d%7Cd5b7f8737774f2a8966a892ef47225d1%7C0%7C0%7C637385427004837474%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=Kh10%2BxNr5MH5H3F13ubR1RKOBI%2FHyOQVs4qKEc8XxGc%3D&reserved=0

Best,

Robert Gordon
Director
Michigan Department of Health & Human Services gordonr3@michigan.gov

-----Original Message-----
From: Gasper, Joe (MSP) <GasperJ@michigan.gov>
Sent: Saturday, October 17, 2020 5:37 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Cc: Matt Saxton <msaxton@msheriff.org>; mkevenson@michiganpolicechiefs.org
Subject: Introduction/Assistance

Director Gordon

By way of a virtual introduction I would like to introduce you to Executive Director Matt Saxton of the Michigan Sheriffs' Association and Executive Director Bob Stevenson of the Michigan Association of Chiefs of Police.

Bob and Matt, Director Robert Gordon leads the Michigan Department of Health and Human Services.

MDDHS and MSP are attempting to establish a process to appropriately enforce the current mask order recently issued by Director Gordon. We would like each of you at the table as we continue to work through the details. We are on an aggressive timeline as there is interest in publishing a press release or holding a press conference next week Tuesday or Wednesday.

I'll step back here and let Director Gordon continue the dialogue to include scheduling a call. Thank you.

Jg

Sent from my iPad

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Whitmer, Gretchen
To:	Laura Appel
Cc:	Foster, Tricia; Gordon, Robert (DHHS); Khaldun, Joneigh (DHHS); Swanson, Robert (DHHS); Ebersole, Kerry (LEO); Brian Peters; Chris Mitchell; Ruthanne Sudderth
Subject:	Re: Letter from the Michigan Health & Hospital Association regarding the COVID-19 vaccine
Date:	Thursday, January 7, 2021 6:53:02 PM

Laura,
I have received your letter and have asked Trish Foster my Chief Operating Officer to respond.
GW

From: Laura Appel <lappel@mha.org>
Sent: Thursday, January 7, 2021 10:00:49 AM
To: Whitmer, Gretchen <WhitmerG1@michigan.gov>
Cc: Foster, Tricia <FosterT13@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Swanson, Robert (DHHS) <swansonr@michigan.gov>; Ebersole, Kerry (LEO) <EbersoleK1@michigan.gov>; Brian Peters <bpeters@mha.org>; Chris Mitchell <cmitchell@mha.org>; Ruthanne Sudderth <rsudderth@mha.org>
Subject: Letter from the Michigan Health & Hospital Association regarding the COVID-19 vaccine

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Governor Whitmer—
The MHA shares your dedication to maximizing vaccination rate of Michigan residents against COVID-19. Please see the attached letter which outlines our association's perspective on opportunities to further improve Michigan's ability to dispense the new vaccines with greater speed and fewer hurdles.
I've copied your leadership team, and MHA leaders on this email in an effort to share this information broadly as quickly as possible. We can continue to improve on what is already a successful effort. Moving forward will be much more challenging. Please consider us a primary partner in meeting those challenges.
Laura

Laura Appel | Senior Vice President
Michigan Health & Hospital Association
Office: (517) 703-8606 | Cell: (517) 285-2962
lappel@mha.org | www.mha.org

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Gordon, Robert (DHHS); Jen, Kyle (DTMB)
Subject: Fwd: Guidance on the Flexibilities of TANF During COVID-19
Date: Tuesday, March 24, 2020 10:28:58 AM
Attachments: TANF COVID-19 PI - ACF-PI-2020-01 FINAL.pdf

From: Hunt, Gregorio (HHS/IEA) <Gregorio.Hunt@hhs.gov>
Sent: Tuesday, March 24, 2020 9:55:36 AM
To: Johnston, Darcie (HHS/IEA) <Darcie.Johnston@hhs.gov>
Cc: Trueman, Laura (HHS/IEA) <Laura.Trueman@hhs.gov>; Rigas, Laura (HHS/IEA) <Laura.Rigas@hhs.gov>; Stevens, Lee (OS/IEA) <Lee.Stevens@hhs.gov>
Subject: Guidance on the Flexibilities of TANF During COVID-19

Dear Governors:

Today, the Administration for Children and Families (ACF) within the Department of Health and Human Services released program instruction (PI) in reference to how the Temporary Assistance for Needy Families (TANF) program can support people affected by the Coronavirus (COVID-19) pandemic.

Given the latest news on the virus, ACF anticipates an increased need in many states for basic assistance and other financial benefits. ACF's top priority is the public health and safety of all those operating our program and receiving its services. For that reason, ACF is releasing this PI as an initial step to recognize current program flexibilities that can aid states and tribes in supporting their communities at this time.

If you have any questions or experience any challenges accessing the attachment, please contact me.

Best,
Darcie

Darcie Johnston, Director
Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

Obtained via MI FOIA by Judicial Watch, Inc.

Temporary Assistance for Needy Families Program Instruction

U.S. Department of Health and Human Services
Administration for Children and Families
Office of Family Assistance
Washington, DC 20201

No. TANF-ACF-PI-2020-01 Date: March 24, 2020

TO: State and territorial agencies (hereafter, states) and tribal agencies administering the Temporary Assistance for Needy Families (TANF) Program.

SUBJECT: Questions and answers about TANF and the Coronavirus Disease 2019 (COVID-19) pandemic

REFERENCES: Title IV-A of the Social Security Act and implementing regulations in 45 CFR Parts 260-265 and 286, and TANF-ACF-PI-2007-08 (Using Federal TANF and State Maintenance-of-Effort (MOE) Funds for Families in Areas Covered by a Federal or State Disaster Declaration).

PURPOSE: To summarize the flexibilities in the TANF program to respond to the COVID-19 pandemic.

BACKGROUND:

As a consequence of the Coronavirus Disease 2019 (COVID-19) pandemic, the United States is experiencing a nationwide emergency, implicating both public health and the economy. Secretary Azar declared a nationwide public health emergency on January 31, 2020, and President Trump declared a national emergency on March 13, 2020.

We have heard from several grantees expressing concerns about the implications of the COVID-19 pandemic for the TANF program and are fielding many questions about how TANF can help support people affected by it. Our top priority is the public health and safety of all those operating our program and receiving its services. Given the latest news on the disease, we anticipate an increased need in many states for basic assistance and other financial benefits. With that in mind, this program instruction includes questions and answers about how state and tribal grantees might use TANF to help those in need. It also addresses TANF's administrative flexibilities for both states and tribes.

QUESTONS AND ANSWERS:

1. **Question**: How can states and tribes use TANF to help anyone affected by the COVID-19 emergency?

   Answer: TANF can be used to assist needy families with children (or expecting a child) who are experiencing financial difficulties due to the COVID-19 emergency. States and tribes set the criteria for "needy," and can set different income levels for different services. A state or tribe could assist needy families in which parents are unable to work due to contracting the disease,

Obtained via MI FOIA by Judicial Watch, Inc.

exposure to someone with the disease, because their children's school or child care provider has closed, or because their own work place has closed.

2. **Question**: What can TANF help with in the immediate crisis?

   Answer: TANF is a very flexible program that can fund a wide range of services and benefits. Because many affected families could have multiple needs, states and tribes may consider expanding their services and broadening their eligibility criteria. One particularly useful option in an emergency or time of crisis is a non-recurrent, short-term benefit (NRST). A NRST: (1) is designed to deal with a specific crisis situation or episode of need; (2) is not intended to meet recurrent or ongoing needs; and (3) will not extend beyond four months. 45 CFR §§ 260.31(b); 286.10(b). A state or tribe has the flexibility to set a higher income standard for an NRST than for regular TANF cash assistance. For example, a state or tribe could provide benefits to impacted families with incomes up to 200 percent of poverty. An NRST payment could help a family that is without income due to COVID-19 meet basic needs.

   NRSTs are outside TANF's definition of "assistance" and therefore do not trigger TANF requirements associated with "assistance," such as the 60-month time limit for states, work requirements, child support assignment, and detailed data reporting. As a result, NRSTs may be less administratively burdensome for grantees. Examples of NRST benefits that might be helpful with the impact of COVID-19 include: short-term benefits to make up for lost wages; short-term rental or mortgage assistance; utility and energy assistance; housing search and placement services; clothing allowances; family support services to deal with stressful events; financial and credit counseling; certain legal services (see https://www.acf.hhs.gov/ofa/resource/q-a-use-of-funds questions 19 and 20); and administrative costs associated with any of these activities. These benefits could come in the form of cash, vouchers, or direct services.

   We remind states that they cannot use federal TANF funds for medical expenditures.

3. **Question**: Does a grantee need to request approval or submit a plan amendment before making program changes to respond to COVID-19?

   Answer: The rules for states and tribes with respect to TANF plan amendments are modestly different. A state has 30 days to submit a plan amendment and, thus, a state does not need to request approval or submit a plan amendment before making program changes, but it should seek guidance from ACF on whether a particular action is allowable under program requirements if the state has any questions. Under 45 CFR § 286.165(b), a tribe should submit an amendment at least 30 days prior to approval; however, we want tribes to make choices that protect the health and safety of their TANF beneficiaries. In the event that a tribe proceeds with implementing activities that require a plan amendment, tribes must seek preliminary approval from ACF. Tribes may do so by sending an e-mail to their regional point of contact. ACF will provide preliminary approval in a reply e-mail, if appropriate. We ask that tribes do not ask for a change in work participation rates through this process, but rather address any difficulties meeting the work participation rate through the process outlined in question 7. ACF will grant retroactive approval of the plan amendment for any changes that received preliminary approval.

Obtained via MI FOIA by Judicial Watch, Inc.

4. **Question**: Are there additional funds in TANF to help with this?

   Answer: At present, there are no additional federal TANF funds available for states to address COVID-19 needs. That means any support states and tribes provide using federal TANF funds must come from their existing allocations and unobligated funds, and must meet the requirements and restrictions that apply to the use of TANF funds. In fact, many grantees have significant unobligated TANF dollars saved as "rainy day" funds to use in situations such as the current emergency.

5. **Question**: Are there ways that states and tribes can alter benefits or ease requirements on TANF applicants or recipients during the emergency?

   Answer: Yes, grantees could use current TANF flexibility in a range of ways, including:

   - Streamlining the application process to expedite eligibility and payment determinations, and offering online or telephonic applications to minimize face-to-face contact;
   - Granting good cause exemptions from work requirements for TANF participants who cannot go to work or training activities because, for example, they are ill, caring for a child whose school or day care is closed due to the pandemic, or because the work or training site is closed;
   - Providing online approaches for participants to engage in work activities virtually, such as online trainings, job search and work readiness to keep them engaged without needing to go to a training site. We view this as a promising alternative that states should consider, so that participants are able to continue advancing their goals through the duration of this emergency;
   - Increasing cash benefit levels for TANF cash assistance recipients who have reduced income or increased needs related to the COVID-19 pandemic;
   - Providing case management by phone or other virtual/electronic communication platforms; and
   - Exercising flexibility within the Income and Eligibility Verification System (IEVS) requirement for states as set forth in TANF-ACF-PI-2007-08.

   Ultimately, grantees are responsible for ensuring that they are providing benefits only to families eligible for those benefits, but we understand that it may not be possible to verify or collect documentation in the same time period that they normally would.

6. **Question**: What should a state or tribe do if participants cannot meet work requirements because of the COVID-19 pandemic?

   Answer: States and tribes should make sound choices that consider the health and safety of TANF recipients and the public during the pandemic. They should establish and exercise good cause exemption criteria that take the current health situation into account and consider the advice of the Centers for Disease Control and Prevention (CDC), their relevant state, tribal, and local health officials. The CDC has information on mitigation strategies, including when it is important to adopt social distancing and to cancel gatherings; we encourage states and tribes to review these resources, e.g., https://www.cdc.gov/coronavirus/2019-ncov/index.html.

Obtained via MI FOIA by Judicial Watch, Inc.

7. **Question**: Will states and tribes still be held accountable for the work participation rates during the emergency?

   Answer: We are facing a national public health and economic emergency of unprecedented proportions. We want grantees to keep their focus on addressing the crisis and protecting the health and safety of the people they serve and the public at large. To help states and tribes do this, we have looked closely at our authority to grant reasonable cause exceptions to grantees that face a penalty for failing the FY 2020 work participation rates due to the COVID-19 emergency. A reasonable cause exception means the grantee would not face a financial penalty. While ACF has no authority to waive the work participation rate requirement itself, it does have authority to grant relief from the resulting penalty in the face of natural disasters and other calamities. ACF will exercise this authority to the maximum extent possible. For more information, grantees should refer to 45 CFR §§ 262.5 and 286.225 for the regulations on reasonable cause applicable to states and tribes, respectively.

8. **Question**: What should a state or tribe do if it is currently operating under a corrective compliance plan (CCP) for its work participation rate and thinks the pandemic will affect its ability to meet that CCP?

   Answer: As with a new failure of the work participation requirement, a state or tribe that does not achieve full compliance with its CCP may request that we reduce the penalty if its failure to comply with the CCP was due to a natural disaster or regional recession. As we noted in the answer above, ACF will exercise this authority in this area to the maximum extent possible.

9. **Question**: Will states or tribes be able to expand what counts for work participation during the COVID-19 pandemic? For example, will ACF allow more excused hours to count than under current regulations?

   Answer: Rather than revise what counts toward the work participation rate, which is specified in statute and regulation for states and in TANF plans for tribes, we will address issues of work participation rate failures, due in whole or in part to the COVID-19 pandemic, through the penalty relief process. Where there is a demonstrable connection between the grantee's failure to meet the work participation rate and the COVID-19 emergency, we expect to exercise our authority to grant penalty relief. Grantees are again encouraged to make sound choices that consider the health and safety of recipients and the public during the pandemic. No one's health and safety should be put at risk because a state or tribe fears it will incur a financial penalty for not meeting its work participation rate.

INQUIRIES: Please direct inquiries to the TANF Program Manager in your region.

-s-

Clarence H. Carter
Director
Office of Family Assistance

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Taverna, Andrea (DHHS-Contractor); Gordon, Robert (DHHS)
Cc: Foster, Tricia
Subject: Fwd: HHS Announces Funding to Provide $186 Million for COVID-19 Response
Date: Monday, April 6, 2020 12:36:43 PM
Attachments: image002.png
Final Press Release HHS Announcement for CDC funding.docx

From: Stevens, Lee (OS/IEA) <Lee.Stevens@hhs.gov>
Sent: Monday, April 6, 2020 11:43:38 AM
To: Johnston, Darcie (HHS/IEA) <Darcie.Johnston@hhs.gov>; Stevens, Lee (OS/IEA) <Lee.Stevens@hhs.gov>
Subject: HHS Announces Funding to Provide $186 Million for COVID-19 Response

Dear Governor and State Health Officials,

We wanted to make you aware of this important release today from the CDC. See attached and below:

News Release

U.S. Department of Health and Human Services

202-690-6343
media@hhs.gov
www.hhs.gov/news
Twitter @SpoxHHS

FOR IMMEDIATE RELEASE
April 6, 2020

HHS Announces Upcoming Funding Action to Provide $186 Million for COVID-19 Response

The Department of Health and Human Services (HHS) is announcing upcoming action by the Centers for Disease Control and Prevention (CDC) to provide $186,000,000 in funding for additional resources to state and local jurisdictions in support of our nation's response to the 2019 novel coronavirus (COVID-19).

Obtained via MI FOIA by Judicial Watch, Inc.

"Testing and surveillance is a vital piece of our efforts to beat the coronavirus, and this new funding will expand our ability to track and prevent the virus's spread across the country," said HHS Secretary Alex Azar. "State and local public health departments are on the frontlines of our fight against the pandemic, and these new resources will help them build the testing and surveillance capabilities needed to beat the new threat we face."

"Increasing the capacity of our nation's public health infrastructure is critical to stopping the spread of COVID-19 in communities across this country," said CDC Director Robert R. Redfield, M.D. "These funds will augment core public health capabilities including surveillance and predictive analytics, laboratory capacity, qualified frontline deployers, and the ability to rapidly respond to emerging disease clusters in communities that currently have limited person to person spread of the virus."

Using supplemental funding, CDC will:

- Supplement an existing cooperative agreement to a number of states and local jurisdictions identified as having the highest number of reported COVID-19 cases ("hot zones") and jurisdictions with accelerating or rapidly accelerating COVID-19 cases. This award will support a range of activities such as lab equipment, supplies, staffing, shipping, infection control, surge staffing, monitoring of individuals, and data management.

- Supplement an existing cooperative agreement to state jurisdictions through the Emerging Infections Program (EIP) to enhance surveillance capabilities. Activities include investigating and assessing the burden and severity of COVID-19, evaluating and determining risk factors and outcomes, and planning and implementing prevention strategies. These activities will build on existing programs developed for influenza and other respiratory pathogens. Funds will also be used to assess and evaluate exposed/infected healthcare personnel through clinical interviews to better identify risk factors and protective factors for COVID-19 infection.

CDC will use existing networks to reach out to state and local jurisdictions to access this initial funding.

To view the list of CDC funding actions to jurisdictions, click here.

For more information about COVID-19, please visit CDC's website:
https://www.cdc.gov/coronavirus/2019-ncov/index.html

###

Follow @SecAzar on Twitter, like HHS on Facebook, and sign up for HHS Email Updates

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

Obtained via MI FOIA by Judicial Watch, Inc.

Obtained via MI FOIA by Judicial Watch, Inc.

News Release

U.S. Department of Health and Human Services

202-690-6343
media@hhs.gov
www.hhs.gov/news
Twitter @SpoxHHS

FOR IMMEDIATE RELEASE
April 6, 2020

HHS Announces Upcoming Funding Action to Provide $186 Million for COVID-19 Response

The Department of Health and Human Services (HHS) is announcing upcoming action by the Centers for Disease Control and Prevention (CDC) to provide $186,000,000 in funding for additional resources to state and local jurisdictions in support of our nation's response to the 2019 novel coronavirus (COVID-19).

"Testing and surveillance is a vital piece of our efforts to beat the coronavirus, and this new funding will expand our ability to track and prevent the virus's spread across the country," said HHS Secretary Alex Azar. "State and local public health departments are on the frontlines of our fight against the pandemic, and these new resources will help them build the testing and surveillance capabilities needed to beat the new threat we face."

"Increasing the capacity of our nation's public health infrastructure is critical to stopping the spread of COVID-19 in communities across this country," said CDC Director Robert R. Redfield, M.D. "These funds will augment core public health capabilities including surveillance and predictive analytics, laboratory capacity, qualified frontline deployers, and the ability to rapidly respond to emerging disease clusters in communities that currently have limited person to person spread of the virus."

Using supplemental funding, CDC will:

- Supplement an existing cooperative agreement to a number of states and local jurisdictions identified as having the highest number of reported COVID-19 cases ("hot zones") and jurisdictions with accelerating or rapidly accelerating COVID-19 cases. This award will support a range of activities such as lab equipment, supplies, staffing, shipping, infection control, surge staffing, monitoring of individuals, and data management.

Obtained via MI FOIA by Judicial Watch, Inc.

- Supplement an existing cooperative agreement to state jurisdictions through the Emerging Infections Program (EIP) to enhance surveillance capabilities. Activities include investigating and assessing the burden and severity of COVID-19, evaluating and determining risk factors and outcomes, and planning and implementing prevention strategies. These activities will build on existing programs developed for influenza and other respiratory pathogens. Funds will also be used to assess and evaluate exposed/infected healthcare personnel through clinical interviews to better identify risk factors and protective factors for COVID-19 infection.

CDC will use existing networks to reach out to state and local jurisdictions to access this initial funding.

To view the list of CDC funding actions to jurisdictions, click here.

For more information about COVID-19, please visit CDC's website:
https://www.cdc.gov/coronavirus/2019-ncov/index.html

###

Follow @SecAzar on Twitter, like HHS on Facebook, and sign up for HHS Email Updates

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Huls, JoAnne
To:	Khaldun, Joneigh (DHHS); Gordon, Robert (DHHS); Hawks, Orlene (LARA)
Cc:	Readinger, Patricia; Brousseau, Jessica; Foster, Tricia
Subject:	Fwd: HHS COVID-19 Guidance - Governor Whitmer.pdf
Date:	Tuesday, March 24, 2020 7:32:32 PM
Attachments:	HHS COVID-19 Guidance - Whitmer.pdf

Please review the attached letter and give guidance to Jessica on what our reply should be.

Thanks

From: Hunt, Gregorio (HHS/IEA) <Gregorio.Hunt@hhs.gov>
Sent: Tuesday, March 24, 2020 6:01:22 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>
Cc: Johnston, Darcie (HHS/IEA) <Darcie.Johnston@hhs.gov>
Subject: HHS COVID-19 Guidance - Governor Whitmer.pdf

Dear Governor Whitmer,

Attached please find a letter from Secretary Azar regarding your healthcare workforce. Thank you for your attention to this important matter.

Best,
Darcie

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

Obtained via MI FOIA by Judicial Watch, Inc.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 2 4 2020

The Honorable Gretchen Whitmer
Governor
State of Michigan
Lansing, MI 48901

Dear Governor Whitmer:

To carry out a whole-America response to the COVID-19 pandemic, I write to ask for your assistance to extend the capacity of the health care workforce to address the pandemic. Specifically, I ask that you take immediate action to:

(1) Allow health professionals licensed or certified in other states to practice their professions in your state, either in person or through telemedicine;
(2) Waive certain statutory and regulatory standards not necessary for the applicable standards of care to establish a patient-provider relationship, diagnose, and deliver treatment recommendations utilizing telehealth technologies;
(3) Relax scope of practice requirements for health care professionals, including allowing professionals to practice in all settings of care;
(4) Allow physicians to supervise a greater number of other health professionals and to do so using remote or telephonic means;
(5) Allow for rapid certification/licensure and recertification/relicensure of certain health care professionals;
(6) Develop a list of your state liability protections for in-state and out-of-state health professionals, including volunteers, during this national emergency, work with your state insurance commissioner to modify or temporarily rescind any provision in any medical malpractice policy issued in your state that may prevent insurance coverage of a health care professional's work responding to the COVID-19 emergency in another state, and work with insurers to have them waive such limitations in their policies;
(7) To the extent deemed appropriate by state health authorities, modify laws or regulations to allow medical students to conduct triage, diagnose, and treat patients under the supervision of licensed medical staff; and,
(8) Modify any laws or regulations that require a signature for deliveries of pharmaceuticals to allow signature-less deliveries, which can help prevent contact between recipients and delivery personnel.

Responsive health professionals will be vital to swiftly containing and eradicating COVID-19 cases in America, as well as treating our citizens during this critical time of need. Doctors and nurses serving on the front lines of this outbreak are at risk of infection and some may be unable to treat patients due to quarantine. They need backup. Your help is needed to ensure health professionals maximize their scopes of practice and are able to travel across state lines or provide telemedicine to communities where they are needed most.

Obtained via MI FOIA by Judicial Watch, Inc.

Non-federal health care professionals carry out health care activities under licensing laws specific to the states in which they provide care. During emergencies, many states have statutory and regulatory mechanisms which allow health care professionals licensed in one state to provide aid in another state without being licensed in that state. These may include mutual aid compacts (multi-state emergency management laws that provide for license reciprocity when the Governor has declared an emergency or public health emergency) and emergency powers that Governors may utilize to modify or temporarily suspend state licensing requirements to allow out-of-state professionals to practice in their states. I ask your assistance to immediately activate these and other health care professional licensure exceptions to the fullest extent appropriate, and to waive any state licensure or certification fees, in order to extend the capacity of health care professionals to fully assist in responding to the COVID-19 emergency. I encourage states to work with their state licensing boards to establish enforcement moratoria for scope of practice and licensure issues to ensure that health care professionals can quickly respond to the COVID-19 emergency without fear of penalty or license revocation. States without existing statutory mechanisms may want to consider working with their legislatures to enact such mechanisms.

Many states also have statutory authority during emergencies to allow for rapid certification and recertification of certain health care professionals. I ask that you use these authorities to the fullest extent possible, and to waive any fees to allow for rapid relicensure or recertification of certain retired health care professionals (especially physicians, nurse practitioners, other registered nurses, and physician assistants), to allow them to reenter the workforce quickly to provide care during the COVID-19 emergency.

States may also be able to modify scope of practice requirements through the Governor's emergency powers or in accordance with the state emergency management laws to temporarily suspend certain scope of practice requirements, including any requirements for written supervision or collaboration agreements in order to avoid significant delays in the provision of services. Alternatively, states may be able to waive geographic restrictions on physicians supervising nurse practitioners (NP) or physician assistants (PA) (i.e., temporarily waive any requirements that the supervising physician be physically co-located with or within a certain geographic distance to the NP or PA who he or she is supervising). This could permit supervising physicians from any state to supervise remote telemedicine services by electronic or telephonic means. To maximize the potential for telemedicine services to expand capacity, states may want to consider waiving certain statutory and regulatory standards not necessary for the applicable standards of care to establish a patient-provider relationship, diagnose, prescribe, and deliver treatment recommendations utilizing telehealth technologies. In addition, states may be able to temporarily expand the number of non-physician health care professionals that a physician may supervise to permit greater use of these non-physician health care professionals to respond to the COVID-19 emergency.

States should also eliminate restrictions on the settings of care where certain types of health care professionals can see patients. Due to recommendations to socially distance, the setting of care will move from clinics to the home or other alternative locations. States should eliminate any restrictions on the types of nurse practitioners, other registered nurses, physicians, and other caregivers that may furnish care in the home or other setting, including restrictions for these providers to be aligned with a home health agency. Finally, states should consider expanding allowable activities for certain health care professionals (such as EMTs and paramedics) to allow those professionals to provide additional health care services during this emergency.

Obtained via MI FOIA by Judicial Watch, Inc.

For health care professionals to feel comfortable serving in expanded capacities on the frontlines of the COVID-19 emergency, it is imperative that they feel shielded from medical tort liability. To prevent medical tort liability from deterring volunteer physicians, Congress passed two volunteer liability reform laws: the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (HIPAA), and the Volunteer Protection Act of 1997, Pub. L. No. 105-19, 111 Stat. 218 (VPA). HIPAA protects physicians who volunteer in free clinics, provided the clinic sponsors the physician by submitting an application to the government. Under the VPA, volunteer health care professionals of a nonprofit organization or governmental entity are not liable for economic damages caused by providing medical care within the scope of their volunteer responsibilities (although this exemption does not extend to non-economic damages). The VPA only protects volunteer health professionals practicing with a license in that state, unless state authorities allow for licensure exceptions. The VPA preempts state laws that are inconsistent with the VPA, unless those state laws provide additional liability protection for volunteers.

In addition, the Public Readiness and Emergency Preparedness (PREP) Act provides broad immunity to health care professionals who administer or use countermeasures covered by declarations issued by the Secretary. Under my COVID-19 - Medical Countermeasures PREP Act declaration (effective February 4, 2020), this protection can apply to health care professionals using countermeasures such as diagnostic or other devices (e.g., COVID-19 testing and respiratory therapy), antiviral medications, other drug therapies, biologics, or vaccines used to treat, diagnose, cure, prevent, or mitigate COVID-19, or the transmission of SARS-CoV-2 or a virus mutating therefrom, as well as devices used to administer such products.

All 50 states and the District of Columbia have enacted laws protecting health professionals under specified circumstances. States should issue guidance summarizing the statutory scope of protections offered under their laws and the process necessary to attach those protections to a health professional's service. Given variation in the scope of these state laws, it is particularly important for states to issue guidance publicly, outlining the available liability protections during the COVID-19 emergency. Further, as noted above, I ask you to analyze whether your state insurance commissioner can modify or temporarily rescind any provision in any medical malpractice policy issued in your state that may prevent coverage of a health care professional's work responding to the COVID-19 emergency in another state and work with insurers to have them waive such limitations in their policies.

I do not want state variations in liability protections to confuse or deter health professionals in this COVID-19 emergency. I ask that your office quickly develop a list of the relevant state liability protections and waivers for health professionals during a national or state emergency and provide public guidance for any steps that out-of-state professionals need to take to provide medical care in your state. I also ask that you take quick action to expand the flexibilities offered in this time of emergency by waiving restrictions such as state licensure, scope of practice, certification, and recertification requirements. In that regard, I thank the National Governors Association for their useful site tracking state declarations and other COVID-19 responses at https://www.nga.org/coronavirus/#states.

Obtained via MI FOIA by Judicial Watch, Inc.

We are all in this together. The U.S. government and the Department of Health and Human Services are committed to working with you and your state to contain and eradicate COVID-19.

Sincerely,

Alex M. Azar II

Enclosure

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Huls, JoAnne
To:	Khaldun, Joneigh (DHHS); Gordon, Robert (DHHS); Foster, Tricia; Gasper, Joe (MSP); Totten, Mark; Rogers, Paul (DMVA)
Subject:	Fwd: HHS COVID-19 Update, 3-27, 2020
Date:	Friday, March 27, 2020 7:39:58 PM
Attachments:	COVID Testing Resources-27 March 2020.pdf Swab factsheet 27 March 2020.pdf Factsheet - CARES Act.docx COVID Testing Resources-27 March 2020.pdf Swab factsheet 27 March 2020.pdf Factsheet - CARES Act.docx

---

jh

From: Stevens, Lee (OS/IEA) <Lee.Stevens@hhs.gov>
Sent: Friday, March 27, 2020 7:32:53 PM
To: Johnston, Darcie (HHS/IEA) <Darcie.Johnston@hhs.gov>; Stevens, Lee (OS/IEA) <Lee.Stevens@hhs.gov>
Subject: HHS COVID-19 Update, 3-27, 2020

Dear Colleagues:

Today, the big news is that Congress passed and the President signed the CARES Act, a $2 trillion relief package that provides much needed economic relief for American families and businesses who are hurting through no fault of their own (CARES Act Fact Sheet attached). This legislation will provide assistance to America's heroic healthcare workers who are on the frontlines of this outbreak, including $100 billion which will go to healthcare providers, $27 billion which will go to bolstering life-saving capabilities, including developing vaccines and the development, purchase, and distribution of critical supplies and $45 billion which will go to the Federal Emergency Management Agency Disaster Relief Fund, more than doubling the amount available to support the President's Emergency and Disaster Declarations to empower State, local, and tribal leaders to effectively respond.

See below for other updates on today's releases:

New Swab Options & New Methods Help Expedite Testing: Initially, nasopharyngeal swab were the only recommended swabs to be used for diagnostic testing of COVID-19. Subsequently, FDA identified a number of other swabs that were available to collect samples. Now, FDA has newly released information that recommends for symptomatic patients, nasal swabs could be used that access just the front of the nose rather than the depth of the nasal cavity. This would provide COVID-19 testing that is more comfortable for patients, allows self-collection of samples at collection sites, and that can be performed with a simpler and more readily available swab. A 2-page fact sheet on the new information that explains what new swabs can be used is attached. In addition, a 13-page document on "COVID-19 Technologies" has also been updated and is attached.

Expanding Face Masks for General Use and Conserving N95 for Health Care Workers: FDA issued an immediately in effect guidance on an Enforcement Policy for Face Masks and Respirators During the COVID-19 Public Health Emergency. The FDA believes the policy set forth in this guidance may

Obtained via MI FOIA by Judicial Watch, Inc.

help address urgent public health concerns by helping to expand the availability of general use face masks for the general public and particulate filtering face piece respirators (including N95 respirators) for health care professionals.

Repurposing Ventilators: FDA has issued guidance allowing ventilators from outpatient surgical centers and clinics to be modified by changing a vent. This policy will assist states with being able to identify a whole new range of ventilators that could be easily converted, add to their supply, and focused at the point of the need in their states. Anesthesiologists Patient Safety Foundation (APSF)/American Society of Anesthesiologists (ASA) has issued guidance on purposing anesthesia machines as ICU ventilators.

Maintaining Essential Health Services During an Outbreak: The WHO released Operational Guidance for Maintaining Essential Health Services During an Outbreak. This document provides guidance on a set of targeted immediate actions that countries should consider at national, regional, and local level to reorganize and maintain access to high-quality essential health services for all.

Public-Private Partnership to Develop a New Screening Tool: In partnership with the White House Coronavirus Task Force, the Department of Health and Human Services, and the Centers for Disease Control and Prevention (CDC), Apple released an app and website that guides Americans through a series of questions about their health and exposure to determine if they should seek care for COVID-19 symptoms. The screening tool provides CDC recommendations on next steps including guidance on social distancing and self-isolating, how to closely monitor symptoms, recommendations on testing, and when to contact a medical provider.

Extending the Supply of and Providing Consumer Information on Hand Sanitizer: FDA issued guidance for the temporary manufacture of ethanol products by firms that manufacture alcohol for incorporation into alcohol-based hand sanitizer products. The FDA posted questions and answers related to consumer use of hand sanitizer during the COVID-19 public health emergency. The FDA wants to make consumers aware of the steps the agency is taking to increase the supply of hand sanitizer during this public health emergency. The questions also discuss hand washing, expiration dates and other frequently asked questions by consumers on hand sanitizer.

Avoid All Non-Essential International Travel: CDC issued a travel warning today for all individuals to avoid all non-essential international travel in an effort to curb the ongoing transmission of COVID-19.

CMS Continuing to Provide State Flexibilities: CMS has now approved 34 Section 1135 Medicaid waivers in states. CMS also approved 8 state requests to invoke emergency flexibilities in their programs that care for the elderly and people w/ disabilities in their homes & communities.

Providing Telehealth Resources for Long-Term Care and Nursing Home Facilities: CMS has broadened access to Medicare telehealth services so that beneficiaries can receive a wider range of services from their doctors without having to travel to a healthcare facility. This toolkit will aid and provide information to facilities utilizing the new telehealth flexibilities.

HRSA Gives Flexibilities to Grantees: HRSA has adopted all 13 administrative flexibilities outlined as

Obtained via MI FOIA by Judicial Watch, Inc.

available by OMB and has released an FAQ on these flexibilities for grantees.

- **Symptom Based Screening May Not Be Sufficient for Skilled Nursing Facilities:** CDC released their Morbidity and Mortality Weekly Report on COVID-19 infections in skilled nursing facility residents in Washington. About 30% of residents tested positive on March 13, and among these positive residents about half were asymptomatic. At the 7-day follow-up assessment, many asymptomatic residents were recategorized as pre-symptomatic, but about one-quarter remained asymptomatic, suggesting that symptom-based screening in skilled nursing facilities could fail to identify half of residents with SARS-CoV-2 infection.
-

Flexibility Regarding Nutrition Labeling: The FDA issued guidance on a Temporary Policy Regarding Nutrition Labeling of Certain Packaged Food During the COVID-19 Public Health Emergency. The FDA is issuing this guidance to provide restaurants and food manufacturers with flexibility regarding nutrition labeling so that they can sell certain packaged foods during the COVID-19 pandemic. For example, restaurants may have purchased ingredients that they can no longer use to prepare restaurant food and instead wish to sell to their customers.

Expansion of Diagnostics to Test for COVID-19: During the COVID-19 pandemic, the FDA has worked with more than 220 test developers who have said they will be submitting emergency use authorizations (EUA) requests to FDA for tests that detect the virus. To date, 17 emergency use authorizations have been issued for diagnostic tests, including the AvellinoCoV2 test, which is a real-time RT-PCR test intended for the qualitative detection of nucleic acid from SARS-CoV-2 in nasopharyngeal and oropharyngeal swab specimens collected from individuals suspected of COVID-19 by their healthcare provider. Additionally, FDA has been notified that more than 100 laboratories have begun testing under the policies set forth in our COVID-19 Policy for Diagnostic Tests for Coronavirus Disease-2019 during the Public Health Emergency Guidance. The FDA also continues to keep its COVID-19 Diagnostics FAQ up to date.

Laura Trueman

***A Note About This Email**: On Tuesday, I started sending out a daily email bundling the many items coming out across the HHS enterprise having to do with COVID-19. Even so, it is not exhaustive, but close. I have gotten lots of people wanting to be added and have added others from my own lists. If you started getting this and don't want it, just let me know. I will do this as long as volume and need for information dictates.*

***For Administration-wide updates to have eyes on what other Departments besides HHS are doing on COVID-19:** Email White House Office of Public Liaison, which sends out a nightly recap OPL@who.eop.gov and asked to be added to their list.*

Laura C. Trueman
Director, Office of Intergovernmental and External Affairs
U.S. Department of Health and Human Services
Washington D.C. 20201
Laura.Trueman@hhs.gov, 202-690-6060 (main office)

COVID-19: Background & Additional Information

Obtained via MI FOIA by Judicial Watch, Inc.

The President's Coronavirus Guidelines for America

For background and the most up-to-date information, please visit the Centers for Disease Control and Prevention Coronavirus Disease 2019 website: HERE

U.S. Department of Health and Human Services:

- Twitter (here)
- Facebook (here)

Centers for Disease Control and Prevention:

- Twitter (here)
- Facebook (here)

What you should know:

- Workplace, School, and Home Guidance
- People at Risk for Serious Illness from COVID-19
- How COVID-19 Spreads
- Symptoms
- Steps to Prevent Illness
- Frequently Asked Questions
- What to Do If You Are Sick with COVID-19
- Stigma Related to COVID-19
- Facts about COVID-19
- Information for People at Higher Risk and Special Populations
- Communication Resources

Situation Updates:

- Situation Summary
- Cases in the U.S.
- Global Locations with COVID-19
- Risk Assessment
- CDC in Action: Preparing Communities

Information for Businesses:

- Interim Guidance for Businesses and Employers
- Information for Communities, Schools, and Businesses
- Environmental Cleaning and Disinfection Recommendations – Community Facilities
- SBA: COVID-19 Resources
- DOL: Guidance for Preparing Workplaces for Coronavirus
- DOL: OHSA Resources for Workers and Employers on COVID-19

Obtained via MI FOIA by Judicial Watch, Inc.

- WHO: Get Your Workplace Ready for COVID-19
- CISA: Risk Management for COVID-19
- EPA: Disinfectants for Use Against COVID-19

Information for Travel and Transportation:

- Information for Travel
- Guidance for Ships
- Guidance for Airlines and Airline Crew
- State: Travel Advisories
- State: Traveler's Checklist
- State: Smart Traveler Enrollment Program
- DOT: FAQs from FTA Grantees Regarding COVID-19

Information for Healthcare Providers, First Responders, and Research Facilities:

- Information for Healthcare Professionals
- Resources for State, Local, Territorial and Tribal Health Departments
- Resources for Healthcare Facilities
- Infection Prevention and Control Recommendations for Patients with COVID-19 or Persons Under Investigation in Healthcare Settings
- Information for Laboratories
- Resources for First Responders
- Guidance for Public Health Professionals Managing People with COVID-19 in Home Care and Isolation Who Have Pets or Other Animals
- FAQs and Considerations for Patient Triage, Placement and Hospital Discharge
- Guidance for Homeless Shelters
- Guidance for Hemodialysis Facilities
- CMS: Information on COVID-19 and Current Emergencies
- CMS: Guidance for Hospice Agencies
- CMS: Emergency Medical Treatment and Labor Act Requirements and Implications Related to COVID-19
- CMS: FAQs for State Survey Agency and Accrediting Organizations
- EPA: Disinfectants for Use Against COVID-19

Information for Law Enforcement:

- What Law Enforcement Personnel Need to Know
- Bureau of Prisons COVID-19 Resources

Information for Families and Households:

- Information on COVID-19 for Pregnant Women and Children

Obtained via MI FOIA by Judicial Watch, Inc.

Interim Guidance for Household Readiness

- Environmental Cleaning and Disinfection Recommendations for U.S. Households
- Guidance for Preventing the Spread of COVID-19 in Homes and Residential Communities
- FAQ: COVID-19 and Children
- EPA: Disinfectants for Use Against COVID-19

Information for Schools and Childcare Providers:

- Interim Guidance for Administrators of U.S. Childcare Programs and K-12 Schools
- Resources for Institutes of Higher Education
- Environmental Cleaning and Disinfection Recommendations – Community Facilities
- USDA: USDA Makes It Easier, Safer to Feed Children in California Amid Coronavirus Outbreak
- DOEd: Resources for Schools and School Personnel
- EPA: Disinfectants for Use Against COVID-19

Information for Community Events and Gatherings:

- Interim Guidance for Mass Gatherings and Large Community Events
- Interim Guidance for Community- and Faith-Based Organizations
- EPA: Disinfectants for Use Against COVID-19

Agency Resources and Information:

- U.S. Department of Health and Human Services
- Centers for Medicare and Medicaid
- U.S. Food & Drug Administration
- U.S. Department of Agriculture
- U.S. Department of Defense
- U.S. Department of Education
- U.S. Department of Energy
- U.S. Department of Homeland Security
- U.S. Department of Labor
- U.S. Department of State
- U.S. Department of Veterans Affairs
- U.S. Environmental Protection Agency
- U.S. Small Business Administration

Obtained via MI FOIA by Judicial Watch, Inc.

March 26, 2020

COVID-19 Diagnostic Technologies

FDA EUA-Approved Diagnostic Product Pairings
FDA Recommended Specimen Collection Materials
FDA EUA-Approved Diagnostic Product Procurement Information

Obtained via MI FOIA by Judicial Watch, Inc.

FDA EUA-Approved Diagnostic Product Pairings

Diagnostic Platform	Diagnostic Test	Extraction Method
Cepheid GeneXpert® Systems	Cepheid Xpert Xpress SARS-CoV-2 test	Not needed (Point of Care test)
DiaSorin Liaison MDX instrument	DiaSorin Molecular LLC Simplexa COVID-19 Direct	Not needed (direct input of collection specimen into diagnostic test)
GenMark ePlex Sample-to-Answer System	GenMark Diagnostics, Inc - ePlex SARS-CoV-2 Test	Proprietary GenMark Kit
Abbott m2000 RealtimeSystem	Abbott Molecular - Abbott Real Time SARS-CoV-2 assay	Proprietary Abbott m2000sp compliant extraction process
Hologic Panther Fusion System	Hologic, Inc - Panther Fusion SARS-CoV-2	Proprietary Panther Fusion Extraction Reagents-S
Roche cobas 6800/8800 Systems	Roche Molecular Systems, Inc - cobas SARS-CoV-2	Proprietary Roche Kit
Bio-Rad CFX Connection Real-Time PCR Detection System	Primerdesign Ltd - COVID-19 genesig Real-Time PCR assay	GXT DNA/RNA Extraction Kit (GenoXtract®, Bruker-HAIN, Lifescience GmbH)
Roche LightCycler 480 II	Primerdesign Ltd - COVID-19 genesig Real-Time PCR assay	GXT DNA/RNA Extraction Kit (GenoXtract®, Bruker-HAIN, Lifescience GmbH)
Roche LightCycler 480	Quidel Corp-Lyra SARS-CoV-2 Assay	bioMérieux NucliSENS easyMAG
Roche LightCycler 480	Quidel Corp-Lyra SARS-CoV-2 Assay	Roche MagNA Pure
Applied Biosystems QuantStudio7 Flex	Laboratory Corporation of America - COVID-19 RT-PCR Test	Roche MagNA Pure 96 Kit
Applied Biosystems 7500	Primerdesign Ltd - COVID-19 genesig Real-Time PCR assay	GXT DNA/RNA Extraction Kit (GenoXtract®, Bruker-HAIN, Lifescience GmbH)
Applied Biosystems 7500	Thermo Fisher Scientific - TaqPath COVID-19 Combo Kit	Thermo Fisher MagMAX™ Viral/Pathogen Nucleic Acid Isolation Kit
Applied Biosystems 7500	Quest Diagnostics Infectious Disease, Inc.- Quest SARS-CoV-2 rRT-PCR	Roche MagNA Pure 96 DNA and Viral NA Small Volume Kit
Applied Biosystems 7500	Quidel Corp- Lyra SARS-CoV-2 Assay	bioMérieux NucliSENS easyMAG

Obtained via MI FOIA by Judicial Watch, Inc.

FDA EUA-Approved Diagnostic Product Pairings

Diagnostic Platform	Diagnostic Test	Extraction Method
Applied Biosystems 7500	Quidel Corp- Lyra SARS-CoV-2 Assay	Roche MagNA Pure
Applied Biosystems 7500	Wadsworth Center, NYSDOH - SARS-CoV-2 Real-time Reverse Transcriptase (RT)-PCR Diagnostic Panel	bioMérieux NucliSENS easyMAG
Applied Biosystems 7500	Wadsworth Center, NYSDOH - SARS-CoV-2 Real-time Reverse Transcriptase (RT)-PCR Diagnostic Panel	QIAGEN EZ1 Advanced XL Kit
Applied Biosystems 7500	CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel	bioMérieux NucliSENS easyMAG
Applied Biosystems 7500	CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel	QIAamp DSP Viral RNA Mini Kit
Applied Biosystems 7500	CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel	QIAamp Viral RNA Mini Kit
Applied Biosystems 7500	CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel	QIAGEN EZ1 DSP Virus Kit
Applied Biosystems 7500	CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel	QIAGEN EZ1 Virus Mini Kit 2.0
Applied Biosystems 7500	CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel	Roche MagNA Pure Total Nucleic Acid Kit
Applied Biosystems 7500	CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel	Roche MagNA Pure Nucleic Acid Isolation Kit
Applied Biosystems 7500	CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel	Roche MagNA Pure 96 DNA and Viral NA Small Volume Kit
Applied Biosystems 7500	PerkinElmer® New Coronavirus Nucleic Acid Detection Kit	The PerkinElmer® Nucleic Acid Extraction Kits
Qiagen Rotator-Gene Q	Quidel Corp- Lyra SARS-CoV-2 Assay	bioMérieux NucliSENS easyMAG
Qiagen Rotator-Gene Q	Quidel Corp- Lyra SARS-CoV-2 Assay	Roche MagNA Pure
BioFire ® FilmArray Systems	BioFire® Covid-19 Test	Not needed (Point of care test)
Accula® System	Accula® SARS-CoV-2 test	Not needed (Point of care test)

Obtained via MI FOIA by Judicial Watch, Inc.

FDA Recommended Specimen Collection Materials

Cat #	Vendor	Name	Type	Platform
305C	Copan	NP swab - UTM/MTM	Swab Kit	N/A
307C	Copan	NP swab - UTM/MTM	Swab Kit	N/A
360C	Copan	NP swab - UTM/MTM	Swab Kit	N/A
519CS01 (flocked OP swab)	Copan	NP swab - UTM/MTM	Swab Kit	N/A
UT-367	Puritan	NP swab - UTM/MTM	Swab Kit	N/A
UT-317	Puritan	NP swab - UTM/MTM	Swab Kit	N/A
UT-302 (flocked OP swab)	Puritan	NP swab - UTM/MTM	Swab Kit	N/A
UT-366 (polyester swab)	Puritan	NP swab - UTM/MTM	Swab Kit	N/A
330CHL	Hardy/Healthlink	NP swab - UTM/MTM	Swab Kit	N/A
220526	BD	NP swab - UTM/MTM	Swab Kit	N/A
220258 (flocked OP swab)	BD	NP swab - UTM/MTM	Swab Kit	N/A
220529	BD	NP swab - UTM/MTM	Swab Kit	N/A
220531	BD	NP swab - UTM/MTM	Swab Kit	N/A
330C.DHI	DHI/Quidel	NP swab - UTM/MTM	Swab Kit	N/A
503CS01.DHI	DHI/Quidel	NP swab - UTM/MTM	Swab Kit	N/A

Obtained via MI FOIA by Judicial Watch, Inc.

FDA Recommended Specimen Collection Materials

Cat #	Vendor	Name	Type	Platform
23001718	Fisher Healthcare	NP swab - UTM/MTM	Swab Kit	N/A
23600952	Fisher Healthcare	NP swab - UTM/MTM	Swab Kit	N/A
23600956	Fisher Healthcare	NP swab - UTM/MTM	Swab Kit	N/A
23600950	Fisher Healthcare	NP swab - UTM/MTM	Swab Kit	N/A
23600957 (flocked OP swab)	Fisher Healthcare	NP swab - UTM/MTM	Swab Kit	N/A
LH-1-02	PrimeStore MTM	NP swab - UTM/MTM	Swab Kit	N/A
481C	Copan	NP swab - Liquid Amies Media	Swab Kit	N/A
482C	Copan	NP swab - Liquid Amies Media	Swab Kit	N/A
480C (flocked OP swab)	Copan	NP swab - Liquid Amies Media	Swab Kit	N/A
480CFA (flocked OP swab)	Copan	NP swab - Liquid Amies Media	Swab Kit	N/A
LA-117	Puritan	NP swab - Liquid Amies Media	Swab Kit	N/A
LA-116-H	Puritan	NP swab - Liquid Amies Media	Swab Kit	N/A
220246	BD	NP swab - Liquid Amies Media	Swab Kit	N/A
220532	BD	NP swab - Liquid Amies Media	Swab Kit	N/A
220245 (flocked OP swab)	BD	NP swab - Liquid Amies Media	Swab Kit	N/A

Obtained via MI FOIA by Judicial Watch, Inc.

FDA Recommended Specimen Collection Materials

Cat #	Vendor	Name	Type	Platform
R723481	ThermoFisher	NP swab - Liquid Amies Media	Swab Kit	N/A
R723482	ThermoFisher	NP swab - Liquid Amies Media	Swab Kit	N/A
R723480 (flocked OP swab)	ThermoFisher	NP swab - Liquid Amies Media	Swab Kit	N/A
481C	Hardy/Healthlink	NP swab - Liquid Amies Media	Swab Kit	N/A
482C	Hardy/Healthlink	NP swab - Liquid Amies Media	Swab Kit	N/A
480C (flocked OP swab)	Hardy/Healthlink	NP swab - Liquid Amies Media	Swab Kit	N/A
480CFA (flocked OP swab)	Hardy/Healthlink	NP swab - Liquid Amies Media	Swab Kit	N/A
89136-656	VWR	NP swab - Liquid Amies Media	Swab Kit	N/A
89136-658	VWR	NP swab - Liquid Amies Media	Swab Kit	N/A
89136-654 (flocked OP swab)	VWR	NP swab - Liquid Amies Media	Swab Kit	N/A
76181-494 (flocked OP swab)	VWR	NP swab - Liquid Amies Media	Swab Kit	N/A
23600901	Fisher Healthcare	NP swab - Liquid Amies Media	Swab Kit	N/A
23600902	Fisher Healthcare	NP swab - Liquid Amies Media	Swab Kit	N/A
23600900 (flocked OP swab)	Fisher Healthcare	NP swab - Liquid Amies Media	Swab Kit	N/A
23600905 (flocked OP swab)	Fisher Healthcare	NP swab - Liquid Amies Media	Swab Kit	N/A

Obtained via MI FOIA by Judicial Watch, Inc.

FDA Recommended Specimen Collection Materials

Cat #	Vendor	Name	Type	Platform
25-3316-H	Puritan	Nasopharyngeal (NP), Hydra Flocked	Swab	N/A
25-3316-U	Puritan	Nasopharyngeal (NP), Ultra Flocked	Swab	N/A
25-3317-H	Puritan	Nasopharyngeal (NP), Hydra Flocked	Swab	N/A
25-3317-U	Puritan	Nasopharyngeal (NP), Ultra Flocked	Swab	N/A
25-3318-H	Puritan	Nasopharyngeal (NP), Hydra Flocked	Swab	N/A
25-3318-U	Puritan	Nasopharyngeal (NP), Ultra Flocked	Swab	N/A
25-3319-H	Puritan	Nasopharyngeal (NP), Hydra Flocked	Swab	N/A
25-3319-U	Puritan	Nasopharyngeal (NP), Ultra Flocked	Swab	N/A
25-3320-H	Puritan	Nasopharyngeal (NP), Hydra Flocked	Swab	N/A
25-3320-U	Puritan	Nasopharyngeal (NP), Ultra Flocked	Swab	N/A
25-3320-H EMB 80	Puritan	Nasopharyngeal (NP), Hydra Flocked	Swab	N/A
25-3320-U EMB 80	Puritan	Nasopharyngeal (NP), Ultra Flocked	Swab	N/A
25-3320-H EMB 100	Puritan	Nasopharyngeal (NP), Hydra Flocked	Swab	N/A
25-3320-U EMB 100	Puritan	Nasopharyngeal (NP), Ultra Flocked	Swab	N/A
25-1406 1PF 50f	Puritan	Nasopharyngeal (NP), Foam	Swab	N/A

Obtained via MI FOIA by Judicial Watch, Inc.

FDA Recommended Specimen Collection Materials

Cat #	Vendor	Name	Type	Platform
25-800 1PD 50	Puritan	Nasopharyngeal (NP), Polyester	Swab	N/A
25-800 1PD ALUM 50	Puritan	Nasopharyngeal (NP), Polyester	Swab	N/A
503CS01	Copan	Nasopharyngeal (NP), Flocked	Swab	N/A
518CS01	Copan	Nasopharyngeal (NP), Flocked	Swab	N/A
501CS01	Copan	Nasopharyngeal (NP), Flocked	Swab	N/A
502CS01	Copan	Nasopharyngeal (NP), Flocked	Swab	N/A
220252	BD	Nasopharyngeal (NP), Flocked	Swab	N/A
220251	BD	Nasopharyngeal (NP), Flocked	Swab	N/A
23600952	DHI/Quidel	Nasopharyngeal (NP), Flocked	Swab	N/A
23600956	DHI/Quidel	Nasopharyngeal (NP), Flocked	Swab	N/A
23600950	DHI/Quidel	Nasopharyngeal (NP), Flocked	Swab	N/A
25-1506 1PF SOLID	Puritan	Oropharyngeal (OP), Foam	Swab	N/A
25-1506 1PF 100	Puritan	Oropharyngeal (OP), Foam	Swab	N/A
25-3206-H	Puritan	Oropharyngeal (OP), Hydra Flocked	Swab	N/A
25-3206-U	Puritan	Oropharyngeal (OP), Ultra Flocked	Swab	N/A

Obtained via MI FOIA by Judicial Watch, Inc.

FDA Recommended Specimen Collection Materials

Cat #	Vendor	Name	Type	Platform
25-3706-H	Puritan	Oropharyngeal (OP), Hydra Flocked	Swab	N/A
25-806 1PD	Puritan	Oropharyngeal (OP), Polyester	Swab	N/A
25-806 1PD BT	Puritan	Oropharyngeal (OP), Polyester	Swab	N/A
502CS01	Copan	Oropharyngeal (OP), Flocked	Swab	N/A
519CS01	Copan	Oropharyngeal (OP), Flocked	Swab	N/A
164KS01	Copan	Oropharyngeal (OP), Polyester	Swab	N/A
175KS01	Copan	Oropharyngeal (OP), Polyester	Swab	N/A
220250	BD	Oropharyngeal (OP), Flocked	Swab	N/A
23600950	Fisher Healthcare	Oropharyngeal (OP), Flocked	Swab	N/A
23600957	Fisher Healthcare	Oropharyngeal (OP), Flocked	Swab	N/A
1490650	Fisher Healthcare	Oropharyngeal (OP), Polyester	Swab	N/A
25-1506 1PF SOLID	Puritan	Mid-Turbinate (MT), Foam	Swab	N/A
25-1506 1PF 100	Puritan	Mid-Turbinate (MT), Foam	Swab	N/A
25-3206-H	Puritan	Mid-Turbinate (MT), Hydra Flocked	Swab	N/A
25-3206-H	Puritan	Anterior Nares, Hydra Flocked	Swab	N/A

Obtained via MI FOIA by Judicial Watch, Inc.

FDA Recommended Specimen Collection Materials

Cat #	Vendor	Name	Type	Platform
25-3206-U	Puritan	Anterior Nares, Ultra Flocked	Swab	N/A
25-3706-H	Puritan	Anterior Nares, Hydra Flocked	Swab	N/A
25-1506 1PF 100	Puritan	Anterior Nares, Foam	Swab	N/A
25-1506 1PF solid	Puritan	Anterior Nares, Foam	Swab	N/A
25-1506 1PF BT	Puritan	Anterior Nares, Foam	Swab	N/A
25-1506 1PF TT MC	Puritan	Anterior Nares, Foam	Swab	N/A
25-1506 2PF BT	Puritan	Anterior Nares, Foam	Swab	N/A
25-1406 1PF BT*	Puritan	Anterior Nares, Foam	Swab	N/A
25-1406 1PF 50*	Puritan	Anterior Nares, Foam	Swab	N/A
20103	Quidel	Anterior Nares, Foam	Swab	N/A
502CS01	Copan	Anterior Nares, Flocked	Swab	N/A
519CS01	Copan	Anterior Nares, Flocked	Swab	N/A
23600950	Fisher Healthcare	Anterior Nares, Flocked	Swab	N/A
23600957	Fisher Healthcare	Anterior Nares, Flocked	Swab	N/A
220144	BD	Anterior Nares, Foam	Swab	N/A
220145	BD	Anterior Nares, Foam	Swab	N/A
220250	BD	Anterior Nares, Flocked	Swab	N/A

Obtained via MI FOIA by Judicial Watch, Inc.

FDA Recommended Specimen Collection Materials

Cat #	Vendor	Name	Type	Platform
UT-300	Puritan	UTM/MTM (no swab)	Media and Vials	N/A
LA-100	Puritan	Liquid Amies Media (no swab)	Media and Vials	N/A
LH-1-03	PrimeStore MTM	UTM/MTM (no swab)	Media and Vials	N/A
R064430	ThermoFisher	Scientific Saline Collection Tubes (no swab)	Collection Tubes	N/A
R064432	ThermoFisher	Scientific Saline Collection Tubes (no swab)	Collection Tubes	N/A
R064434	ThermoFisher	Scientific Saline Collection Tubes (no swab)	Collection Tubes	N/A
R064436	ThermoFisher	Scientific Saline Collection Tubes (no swab)	Collection Tubes	N/A
R064438	ThermoFisher	Scientific Saline Collection Tubes (no swab)	Collection Tubes	N/A
D185	Hardy/Healthlink	Scientific Saline Collection Tubes (no swab)	Collection Tubes	N/A
K248	Hardy/Healthlink	Scientific Saline Collection Tubes (no swab)	Collection Tubes	N/A
R45	Hardy/Healthlink	Scientific Saline Collection Tubes (no swab)	Collection Tubes	N/A
R55	Hardy/Healthlink	Scientific Saline Collection Tubes (no swab)	Collection Tubes	N/A
T-0625	Edge Biologicals	Scientific Saline Collection Tubes (no swab)	Collection Tubes	N/A
T-0110f	Edge Biologicals	Scientific Saline Collection Tubes (no swab)	Collection Tubes	N/A

Obtained via MI FOIA by Judicial Watch, Inc.

FDA EUA-Approved Diagnostic Product Procurement Information

Cat #	Vendor	Name	Type	Platform
09N77-095; 09N77-085; 09N77-010	Abbott Molecular	Abbott Real Time SARS-CoV-2 assay	Test	Abbott m2000 System
423745 (6 pack tests). 423744 (30pack test). 423748 (6pack (+) control)	BioFire	BioFire® Covid-19 Test	Test	BioFire ® FilmArray 2.0
2019-nCoVEUA-01	CDC	CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel	Test	Applied Biosystems 7500 Fast Dx Real-Time PCR Instrument
EXPRSARS-COV-2-10	Cepheid	Xpert ® Express SARS-CoV-2 Test	Test	GeneXpert DX or GeneXpert Infinity Systems
MOL4151	DiaSorin Molecular LLC	Simplexa COVID-19 Direct	Test	Liaison MDX instrument
EA008212	GenMark Diagnostics, Inc	ePlex SARS-CoV-2 Test	Test	ePlex Sample-to-Answer System
PRD-04303; PRD-04332; PRD-06404; PRD-04331; PRD-04334; PRD-06391; PRD-04335; PRD-04304	Hologic, Inc	Panther Fusion SARS-CoV-2	Test	Panther Fusion System
139900	Laboratory Corporation of America	COVID-19 RT-PCR Test	Test	Applied Biosystems QuantStudio7 Flex
COV4100	Mesa BioTech	Accula® SARS-CoV-2 test	Test	Accula® System
TBD	PerkinElmer	PerkinElmer® New Coronavirus Nucleic Acid Detection Kit	Test	Applied Biosystems 7500 Real Time PCR System
Z-Parth-COVID-19-CE	Primerdesign Ltd	COVID-19 genesig Real-Time PCR assay	Test	Applied Biosystems 7500 Real-Time PCR System; Bio-Rad CFX Connection Real-Time PCR Detection System; Roche LightCycler 480 II
61904	Qiagen	QIAGEN QIAamp® DSP Viral RNA Mini Kit	Extraction Kit	QIAGEN QIAcube
1020953	Qiagen	QIAamp® Viral RNA Mini Kit	Extraction Kit	QIAGEN QIAcube

Obtained via MI FOIA by Judicial Watch, Inc.

FDA EUA-Approved Diagnostic Product Procurement Information

Cat #	Vendor	Name	Type	Platform
62724; Supplied Separately: Buffer AVL Cat# 19073; EZ1 Advanced XL DSP Virus Card Cat# 9018703	Qiagen	QIAGEN EZ1 DSP Virus Kit	Extraction Kit	QIAGEN EZ1 Advanced XL
955134; Supplied Separately: Buffer AVL Cat# 19073; EZ1 Advanced XL Virus Card v2.0 Cat#9018708	Qiagen	QIAGEN EZ1 Virus Mini Kit v2.0	Extraction Kit	QIAGEN EZ1 Advanced XL
39433	Quest Diagnostics Infectious Disease, Inc.	Quest SARS-CoV-2 rRT-PCR	Test	Applied Biosystems 7500 Real Time PCR System
M120	Quidel Corp	Lyra SARS-CoV-2 Assay	Test	Applied Biosystems 7500 Fast DX instruments
5323738001	Roche	Roche MagNA Pure Total Nucleic Acid Kit	Extraction Kit	Roche MagNA Pure LC
3730964001	Roche	Roche MagNA Pure Nucleic Acid Isolation Kit I	Extraction Kit	Roche MagNA Pure Compact
6543588001	Roche	Roche MagNA Pure 96 DNA and Viral NA Small Volume Kit	Extraction Kit	Roche MagNA Pure 96
09175431190; 09175440190; 07002238190	Roche Molecular Systems, Inc	cobas SARS-CoV-2	Test	cobas 6800/8800 Systems
A47813; A47814	Thermo Fisher Scientific	TaqPath COVID-19 Combo Kit	Test	Applied Biosystems 7500 Fast Dx Real-Time PCR Instrument
LVD SOF-151.1	Wadsworth Center, NYSDOH	New York SARS-CoV-2 Real-time Reverse Transcriptase (RT)-PCR Diagnostic Panel	Test	Applied Biosystems 7500 Fast Dx Real-Time PCR Instrument

Obtained via MI FOIA by Judicial Watch, Inc.

March 26, 2020

COVID-19 Diagnostic Technologies

FDA EUA-Approved Diagnostic Product Pairings
FDA Recommended Specimen Collection Materials
FDA EUA-Approved Diagnostic Product Procurement Information

Obtained via MI FOIA by Judicial Watch, Inc.

FDA EUA-Approved Diagnostic Product Pairings

Diagnostic Platform	Diagnostic Test	Extraction Method
Cepheid GeneXpert® Systems	Cepheid Xpert Xpress SARS-CoV-2 test	Not needed (Point of Care test)
DiaSorin Liaison MDX instrument	DiaSorin Molecular LLC Simplexa COVID-19 Direct	Not needed (direct input of collection specimen into diagnostic test)
GenMark ePlex Sample-to-Answer System	GenMark Diagnostics, Inc - ePlex SARS-CoV-2 Test	Proprietary GenMark Kit
Abbott m2000 RealtimeSystem	Abbott Molecular - Abbott Real Time SARS-CoV-2 assay	Proprietary Abbott m2000sp compliant extraction process
Hologic Panther Fusion System	Hologic, Inc - Panther Fusion SARS-CoV-2	Proprietary Panther Fusion Extraction Reagents-S
Roche cobas 6800/8800 Systems	Roche Molecular Systems, Inc - cobas SARS-CoV-2	Proprietary Roche Kit
Bio-Rad CFX Connection Real-Time PCR Detection System	Primerdesign Ltd - COVID-19 genesig Real-Time PCR assay	GXT DNA/RNA Extraction Kit (GenoXtract®, Bruker-HAIN, Lifescience GmbH)
Roche LightCycler 480 II	Primerdesign Ltd - COVID-19 genesig Real-Time PCR assay	GXT DNA/RNA Extraction Kit (GenoXtract®, Bruker-HAIN, Lifescience GmbH)
Roche LightCycler 480	Quidel Corp-Lyra SARS-CoV-2 Assay	bioMérieux NucliSENS easyMAG
Roche LightCycler 480	Quidel Corp-Lyra SARS-CoV-2 Assay	Roche MagNA Pure
Applied Biosystems QuantStudio7 Flex	Laboratory Corporation of America - COVID-19 RT-PCR Test	Roche MagNA Pure 96 Kit
Applied Biosystems 7500	Primerdesign Ltd - COVID-19 genesig Real-Time PCR assay	GXT DNA/RNA Extraction Kit (GenoXtract®, Bruker-HAIN, Lifescience GmbH)
Applied Biosystems 7500	Thermo Fisher Scientific - TaqPath COVID-19 Combo Kit	Thermo Fisher MagMAX™ Viral/Pathogen Nucleic Acid Isolation Kit
Applied Biosystems 7500	Quest Diagnostics Infectious Disease, Inc.- Quest SARS-CoV-2 rRT-PCR	Roche MagNA Pure 96 DNA and Viral NA Small Volume Kit
Applied Biosystems 7500	Quidel Corp- Lyra SARS-CoV-2 Assay	bioMérieux NucliSENS easyMAG

Obtained via MI FOIA by Judicial Watch, Inc.

FDA EUA-Approved Diagnostic Product Pairings

Diagnostic Platform	Diagnostic Test	Extraction Method
Applied Biosystems 7500	Quidel Corp- Lyra SARS-CoV-2 Assay	Roche MagNA Pure
Applied Biosystems 7500	Wadsworth Center, NYSDOH - SARS-CoV-2 Real-time Reverse Transcriptase (RT)-PCR Diagnostic Panel	bioMérieux NucliSENS easyMAG
Applied Biosystems 7500	Wadsworth Center, NYSDOH - SARS-CoV-2 Real-time Reverse Transcriptase (RT)-PCR Diagnostic Panel	QIAGEN EZ1 Advanced XL Kit
Applied Biosystems 7500	CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel	bioMérieux NucliSENS easyMAG
Applied Biosystems 7500	CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel	QIAamp DSP Viral RNA Mini Kit
Applied Biosystems 7500	CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel	QIAamp Viral RNA Mini Kit
Applied Biosystems 7500	CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel	QIAGEN EZ1 DSP Virus Kit
Applied Biosystems 7500	CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel	QIAGEN EZ1 Virus Mini Kit 2.0
Applied Biosystems 7500	CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel	Roche MagNA Pure Total Nucleic Acid Kit
Applied Biosystems 7500	CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel	Roche MagNA Pure Nucleic Acid Isolation Kit
Applied Biosystems 7500	CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel	Roche MagNA Pure 96 DNA and Viral NA Small Volume Kit
Applied Biosystems 7500	PerkinElmer® New Coronavirus Nucleic Acid Detection Kit	The PerkinElmer® Nucleic Acid Extraction Kits
Qiagen Rotator-Gene Q	Quidel Corp- Lyra SARS-CoV-2 Assay	bioMérieux NucliSENS easyMAG
Qiagen Rotator-Gene Q	Quidel Corp- Lyra SARS-CoV-2 Assay	Roche MagNA Pure
BioFire ® FilmArray Systems	BioFire® Covid-19 Test	Not needed (Point of care test)
Accula® System	Accula® SARS-CoV-2 test	Not needed (Point of care test)

Obtained via MI FOIA by Judicial Watch, Inc.

FDA Recommended Specimen Collection Materials

Cat #	Vendor	Name	Type	Platform
305C	Copan	NP swab - UTM/MTM	Swab Kit	N/A
307C	Copan	NP swab - UTM/MTM	Swab Kit	N/A
360C	Copan	NP swab - UTM/MTM	Swab Kit	N/A
519CS01 (flocked OP swab)	Copan	NP swab - UTM/MTM	Swab Kit	N/A
UT-367	Puritan	NP swab - UTM/MTM	Swab Kit	N/A
UT-317	Puritan	NP swab - UTM/MTM	Swab Kit	N/A
UT-302 (flocked OP swab)	Puritan	NP swab - UTM/MTM	Swab Kit	N/A
UT-366 (polyester swab)	Puritan	NP swab - UTM/MTM	Swab Kit	N/A
330CHL	Hardy/Healthlink	NP swab - UTM/MTM	Swab Kit	N/A
220526	BD	NP swab - UTM/MTM	Swab Kit	N/A
220258 (flocked OP swab)	BD	NP swab - UTM/MTM	Swab Kit	N/A
220529	BD	NP swab - UTM/MTM	Swab Kit	N/A
220531	BD	NP swab - UTM/MTM	Swab Kit	N/A
330C.DHI	DHI/Quidel	NP swab - UTM/MTM	Swab Kit	N/A
503CS01.DHI	DHI/Quidel	NP swab - UTM/MTM	Swab Kit	N/A

Obtained via MI FOIA by Judicial Watch, Inc.

FDA Recommended Specimen Collection Materials

Cat #	Vendor	Name	Type	Platform
23001718	Fisher Healthcare	NP swab - UTM/MTM	Swab Kit	N/A
23600952	Fisher Healthcare	NP swab - UTM/MTM	Swab Kit	N/A
23600956	Fisher Healthcare	NP swab - UTM/MTM	Swab Kit	N/A
23600950	Fisher Healthcare	NP swab - UTM/MTM	Swab Kit	N/A
23600957 (flocked OP swab)	Fisher Healthcare	NP swab - UTM/MTM	Swab Kit	N/A
LH-1-02	PrimeStore MTM	NP swab - UTM/MTM	Swab Kit	N/A
481C	Copan	NP swab - Liquid Amies Media	Swab Kit	N/A
482C	Copan	NP swab - Liquid Amies Media	Swab Kit	N/A
480C (flocked OP swab)	Copan	NP swab - Liquid Amies Media	Swab Kit	N/A
480CFA (flocked OP swab)	Copan	NP swab - Liquid Amies Media	Swab Kit	N/A
LA-117	Puritan	NP swab - Liquid Amies Media	Swab Kit	N/A
LA-116-H	Puritan	NP swab - Liquid Amies Media	Swab Kit	N/A
220246	BD	NP swab - Liquid Amies Media	Swab Kit	N/A
220532	BD	NP swab - Liquid Amies Media	Swab Kit	N/A
220245 (flocked OP swab)	BD	NP swab - Liquid Amies Media	Swab Kit	N/A

Obtained via MI FOIA by Judicial Watch, Inc.

FDA Recommended Specimen Collection Materials

Cat #	Vendor	Name	Type	Platform
R723481	ThermoFisher	NP swab - Liquid Amies Media	Swab Kit	N/A
R723482	ThermoFisher	NP swab - Liquid Amies Media	Swab Kit	N/A
R723480 (flocked OP swab)	ThermoFisher	NP swab - Liquid Amies Media	Swab Kit	N/A
481C	Hardy/Healthlink	NP swab - Liquid Amies Media	Swab Kit	N/A
482C	Hardy/Healthlink	NP swab - Liquid Amies Media	Swab Kit	N/A
480C (flocked OP swab)	Hardy/Healthlink	NP swab - Liquid Amies Media	Swab Kit	N/A
480CFA (flocked OP swab)	Hardy/Healthlink	NP swab - Liquid Amies Media	Swab Kit	N/A
89136-656	VWR	NP swab - Liquid Amies Media	Swab Kit	N/A
89136-658	VWR	NP swab - Liquid Amies Media	Swab Kit	N/A
89136-654 (flocked OP swab)	VWR	NP swab - Liquid Amies Media	Swab Kit	N/A
76181-494 (flocked OP swab)	VWR	NP swab - Liquid Amies Media	Swab Kit	N/A
23600901	Fisher Healthcare	NP swab - Liquid Amies Media	Swab Kit	N/A
23600902	Fisher Healthcare	NP swab - Liquid Amies Media	Swab Kit	N/A
23600900 (flocked OP swab)	Fisher Healthcare	NP swab - Liquid Amies Media	Swab Kit	N/A
23600905 (flocked OP swab)	Fisher Healthcare	NP swab - Liquid Amies Media	Swab Kit	N/A

Obtained via MI FOIA by Judicial Watch, Inc.

FDA Recommended Specimen Collection Materials

Cat #	Vendor	Name	Type	Platform
25-3316-H	Puritan	Nasopharyngeal (NP), Hydra Flocked	Swab	N/A
25-3316-U	Puritan	Nasopharyngeal (NP), Ultra Flocked	Swab	N/A
25-3317-H	Puritan	Nasopharyngeal (NP), Hydra Flocked	Swab	N/A
25-3317-U	Puritan	Nasopharyngeal (NP), Ultra Flocked	Swab	N/A
25-3318-H	Puritan	Nasopharyngeal (NP), Hydra Flocked	Swab	N/A
25-3318-U	Puritan	Nasopharyngeal (NP), Ultra Flocked	Swab	N/A
25-3319-H	Puritan	Nasopharyngeal (NP), Hydra Flocked	Swab	N/A
25-3319-U	Puritan	Nasopharyngeal (NP), Ultra Flocked	Swab	N/A
25-3320-H	Puritan	Nasopharyngeal (NP), Hydra Flocked	Swab	N/A
25-3320-U	Puritan	Nasopharyngeal (NP), Ultra Flocked	Swab	N/A
25-3320-H EMB 80	Puritan	Nasopharyngeal (NP), Hydra Flocked	Swab	N/A
25-3320-U EMB 80	Puritan	Nasopharyngeal (NP), Ultra Flocked	Swab	N/A
25-3320-H EMB 100	Puritan	Nasopharyngeal (NP), Hydra Flocked	Swab	N/A
25-3320-U EMB 100	Puritan	Nasopharyngeal (NP), Ultra Flocked	Swab	N/A
25-1406 1PF 50f	Puritan	Nasopharyngeal (NP), Foam	Swab	N/A

Obtained via MI FOIA by Judicial Watch, Inc.

FDA Recommended Specimen Collection Materials

Cat #	Vendor	Name	Type	Platform
25-800 1PD 50	Puritan	Nasopharyngeal (NP), Polyester	Swab	N/A
25-800 1PD ALUM 50	Puritan	Nasopharyngeal (NP), Polyester	Swab	N/A
503CS01	Copan	Nasopharyngeal (NP), Flocked	Swab	N/A
518CS01	Copan	Nasopharyngeal (NP), Flocked	Swab	N/A
501CS01	Copan	Nasopharyngeal (NP), Flocked	Swab	N/A
502CS01	Copan	Nasopharyngeal (NP), Flocked	Swab	N/A
220252	BD	Nasopharyngeal (NP), Flocked	Swab	N/A
220251	BD	Nasopharyngeal (NP), Flocked	Swab	N/A
23600952	DHI/Quidel	Nasopharyngeal (NP), Flocked	Swab	N/A
23600956	DHI/Quidel	Nasopharyngeal (NP), Flocked	Swab	N/A
23600950	DHI/Quidel	Nasopharyngeal (NP), Flocked	Swab	N/A
25-1506 1PF SOLID	Puritan	Oropharyngeal (OP), Foam	Swab	N/A
25-1506 1PF 100	Puritan	Oropharyngeal (OP), Foam	Swab	N/A
25-3206-H	Puritan	Oropharyngeal (OP), Hydra Flocked	Swab	N/A
25-3206-U	Puritan	Oropharyngeal (OP), Ultra Flocked	Swab	N/A

Obtained via MI FOIA by Judicial Watch, Inc.

FDA Recommended Specimen Collection Materials

Cat #	Vendor	Name	Type	Platform
25-3706-H	Puritan	Oropharyngeal (OP), Hydra Flocked	Swab	N/A
25-806 1PD	Puritan	Oropharyngeal (OP), Polyester	Swab	N/A
25-806 1PD BT	Puritan	Oropharyngeal (OP), Polyester	Swab	N/A
502CS01	Copan	Oropharyngeal (OP), Flocked	Swab	N/A
519CS01	Copan	Oropharyngeal (OP), Flocked	Swab	N/A
164KS01	Copan	Oropharyngeal (OP), Polyester	Swab	N/A
175KS01	Copan	Oropharyngeal (OP), Polyester	Swab	N/A
220250	BD	Oropharyngeal (OP), Flocked	Swab	N/A
23600950	Fisher Healthcare	Oropharyngeal (OP), Flocked	Swab	N/A
23600957	Fisher Healthcare	Oropharyngeal (OP), Flocked	Swab	N/A
1490650	Fisher Healthcare	Oropharyngeal (OP), Polyester	Swab	N/A
25-1506 1PF SOLID	Puritan	Mid-Turbinate (MT), Foam	Swab	N/A
25-1506 1PF 100	Puritan	Mid-Turbinate (MT), Foam	Swab	N/A
25-3206-H	Puritan	Mid-Turbinate (MT), Hydra Flocked	Swab	N/A
25-3206-H	Puritan	Anterior Nares, Hydra Flocked	Swab	N/A

Obtained via MI FOIA by Judicial Watch, Inc.

FDA Recommended Specimen Collection Materials

Cat #	Vendor	Name	Type	Platform
25-3206-U	Puritan	Anterior Nares, Ultra Flocked	Swab	N/A
25-3706-H	Puritan	Anterior Nares, Hydra Flocked	Swab	N/A
25-1506 1PF 100	Puritan	Anterior Nares, Foam	Swab	N/A
25-1506 1PF solid	Puritan	Anterior Nares, Foam	Swab	N/A
25-1506 1PF BT	Puritan	Anterior Nares, Foam	Swab	N/A
25-1506 1PF TT MC	Puritan	Anterior Nares, Foam	Swab	N/A
25-1506 2PF BT	Puritan	Anterior Nares, Foam	Swab	N/A
25-1406 1PF BT*	Puritan	Anterior Nares, Foam	Swab	N/A
25-1406 1PF 50*	Puritan	Anterior Nares, Foam	Swab	N/A
20103	Quidel	Anterior Nares, Foam	Swab	N/A
502CS01	Copan	Anterior Nares, Flocked	Swab	N/A
519CS01	Copan	Anterior Nares, Flocked	Swab	N/A
23600950	Fisher Healthcare	Anterior Nares, Flocked	Swab	N/A
23600957	Fisher Healthcare	Anterior Nares, Flocked	Swab	N/A
220144	BD	Anterior Nares, Foam	Swab	N/A
220145	BD	Anterior Nares, Foam	Swab	N/A
220250	BD	Anterior Nares, Flocked	Swab	N/A

Obtained via MI FOIA by Judicial Watch, Inc.

FDA Recommended Specimen Collection Materials

Cat #	Vendor	Name	Type	Platform
UT-300	Puritan	UTM/MTM (no swab)	Media and Vials	N/A
LA-100	Puritan	Liquid Amies Media (no swab)	Media and Vials	N/A
LH-1-03	PrimeStore MTM	UTM/MTM (no swab)	Media and Vials	N/A
R064430	ThermoFisher	Scientific Saline Collection Tubes (no swab)	Collection Tubes	N/A
R064432	ThermoFisher	Scientific Saline Collection Tubes (no swab)	Collection Tubes	N/A
R064434	ThermoFisher	Scientific Saline Collection Tubes (no swab)	Collection Tubes	N/A
R064436	ThermoFisher	Scientific Saline Collection Tubes (no swab)	Collection Tubes	N/A
R064438	ThermoFisher	Scientific Saline Collection Tubes (no swab)	Collection Tubes	N/A
D185	Hardy/Healthlink	Scientific Saline Collection Tubes (no swab)	Collection Tubes	N/A
K248	Hardy/Healthlink	Scientific Saline Collection Tubes (no swab)	Collection Tubes	N/A
R45	Hardy/Healthlink	Scientific Saline Collection Tubes (no swab)	Collection Tubes	N/A
R55	Hardy/Healthlink	Scientific Saline Collection Tubes (no swab)	Collection Tubes	N/A
T-0625	Edge Biologicals	Scientific Saline Collection Tubes (no swab)	Collection Tubes	N/A
T-0110f	Edge Biologicals	Scientific Saline Collection Tubes (no swab)	Collection Tubes	N/A

Obtained via MI FOIA by Judicial Watch, Inc.

FDA EUA-Approved Diagnostic Product Procurement Information

Cat #	Vendor	Name	Type	Platform
09N77-095; 09N77-085; 09N77-010	Abbott Molecular	Abbott Real Time SARS-CoV-2 assay	Test	Abbott m2000 System
423745 (6 pack tests). 423744 (30pack test). 423748 (6pack (+) control)	BioFire	BioFire® Covid-19 Test	Test	BioFire ® FilmArray 2.0
2019-nCoVEUA-01	CDC	CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel	Test	Applied Biosystems 7500 Fast Dx Real-Time PCR Instrument
EXPRSARS-COV-2-10	Cepheid	Xpert ® Express SARS-CoV-2 Test	Test	GeneXpert DX or GeneXpert Infinity Systems
MOL4151	DiaSorin Molecular LLC	Simplexa COVID-19 Direct	Test	Liaison MDX instrument
EA008212	GenMark Diagnostics, Inc	ePlex SARS-CoV-2 Test	Test	ePlex Sample-to-Answer System
PRD-04303; PRD-04332; PRD-06404; PRD-04331; PRD-04334; PRD-06391; PRD-04335; PRD-04304	Hologic, Inc	Panther Fusion SARS-CoV-2	Test	Panther Fusion System
139900	Laboratory Corporation of America	COVID-19 RT-PCR Test	Test	Applied Biosystems QuantStudio7 Flex
COV4100	Mesa BioTech	Accula® SARS-CoV-2 test	Test	Accula® System
TBD	PerkinElmer	PerkinElmer® New Coronavirus Nucleic Acid Detection Kit	Test	Applied Biosystems 7500 Real Time PCR System
Z-Parth-COVID-19-CE	Primerdesign Ltd	COVID-19 genesig Real-Time PCR assay	Test	Applied Biosystems 7500 Real-Time PCR System; Bio-Rad CFX Connection Real-Time PCR Detection System; Roche LightCycler 480 II
61904	Qiagen	QIAGEN QIAamp® DSP Viral RNA Mini Kit	Extraction Kit	QIAGEN QIAcube
1020953	Qiagen	QIAamp® Viral RNA Mini Kit	Extraction Kit	QIAGEN QIAcube

Obtained via MI FOIA by Judicial Watch, Inc.

FDA EUA-Approved Diagnostic Product Procurement Information

Cat #	Vendor	Name	Type	Platform
62724; Supplied Separately: Buffer AVL Cat# 19073; EZ1 Advanced XL DSP Virus Card Cat# 9018703	Qiagen	QIAGEN EZ1 DSP Virus Kit	Extraction Kit	QIAGEN EZ1 Advanced XL
955134; Supplied Separately: Buffer AVL Cat# 19073; EZ1 Advanced XL Virus Card v2.0 Cat#9018708	Qiagen	QIAGEN EZ1 Virus Mini Kit v2.0	Extraction Kit	QIAGEN EZ1 Advanced XL
39433	Quest Diagnostics Infectious Disease, Inc.	Quest SARS-CoV-2 rRT-PCR	Test	Applied Biosystems 7500 Real Time PCR System
M120	Quidel Corp	Lyra SARS-CoV-2 Assay	Test	Applied Biosystems 7500 Fast DX instruments
5323738001	Roche	Roche MagNA Pure Total Nucleic Acid Kit	Extraction Kit	Roche MagNA Pure LC
3730964001	Roche	Roche MagNA Pure Nucleic Acid Isolation Kit I	Extraction Kit	Roche MagNA Pure Compact
6543588001	Roche	Roche MagNA Pure 96 DNA and Viral NA Small Volume Kit	Extraction Kit	Roche MagNA Pure 96
09175431190; 09175440190; 07002238190	Roche Molecular Systems, Inc	cobas SARS-CoV-2	Test	cobas 6800/8800 Systems
A47813; A47814	Thermo Fisher Scientific	TaqPath COVID-19 Combo Kit	Test	Applied Biosystems 7500 Fast Dx Real-Time PCR Instrument
LVD SOF-151.1	Wadsworth Center, NYSDOH	New York SARS-CoV-2 Real-time Reverse Transcriptase (RT)-PCR Diagnostic Panel	Test	Applied Biosystems 7500 Fast Dx Real-Time PCR Instrument

Obtained via MI FOIA by Judicial Watch, Inc.

URGENT UPDATE DIAGNOSTIC TESTING

Information for Healthcare Providers, Healthcare Systems, and Laboratories Following Updated FDA Recommendations for SARS-CoV-2 Diagnostic Testing

As part of our COVID-19 response efforts, the US government continues to prioritize efforts to expedite patient testing. Experts continue to work tirelessly during this dynamic and evolving situation. This includes adapting to supply chain pressures and continuing to evaluate options for sample collection as well as working with stakeholders on efforts to facilitate greater access to these critical medical products.

On March 23, 2020, additional types of swabs were added to the FDA's recommendations for SARS-CoV-2 diagnostic processes. These recommendations provide additional options for sampling that, based on industry data, are more readily available and may also lessen exposure risks by facilitating self-collection in an appropriate clinical setting, such as "drive-thru" testing sites.

The self-collected nasal swab was recently determined to be equivalent to a nasopharyngeal swab in detecting coronavirus through a study performed by the United Health Group. As a result of these data, the FDA is recommending a self-collected nasal swab (using a round foam swab) or self-collected mid-turbinate swabs (using a flocked tapered swab) for use when a nasopharyngeal (NP) swab is not performed. Based on available data, the FDA recommends that, for symptomatic patients, nasal swabs could be used that access just the front of the nose rather than the depth of the nasal cavity. This would provide COVID-19 testing that is more comfortable for patients, allows self-collection of samples at collection sites, and that can be performed with a simpler and more readily available swab.

The use of a nasal swab versus a nasopharyngeal swab includes the following benefits:

- Increases the total volume of available sample collection materials, since the recommendations are broadened to include flocked and foam swabs, which are available in large quantities
- Collection of nasal swab samples is less technically complex, so can reduce the risk of the spread of infection to healthcare providers, by (1) reducing the duration of the procedure, and (2) allowing the patient to perform self-collection under supervision
- Helps lessen the impact of PPE utilization, given that the patient can perform self-collection under supervision (versus the health care provider performing the collection)

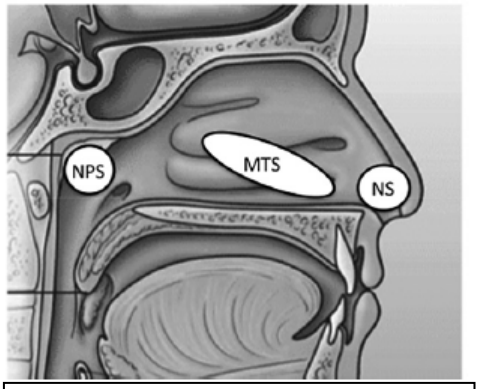
In practice, supervised nasal swab self-collection will occur at at a drive-thru testing site or a healthcare clinic.

Home self-collection is **NOT** recommended.

Background

The FDA identifies preferred preferences for diagnostic sample collections for swab-based SARS-CoV-2. The nasopharyngeal sample is the FDA-preferred sample. In the event that this specimen is not available, the FDA identifies the following alternatives as acceptable:

- oropharyngeal sample collected by a healthcare professional (HCP);
- mid-turbinate sample by onsite self-collection or HCP (using a flocked tapered swab); or
- *anterior nares sample by onsite self-collection or HCP (using a round foam swab).*
- For patients with productive cough, a sputum sample is an acceptable lower respiratory sample.



Sampling Locations: NPS, Nasopharyngeal swab; MTS, midturbinate swab; NS, nasal swab. (From Frazee et al., 2018)

LAST UPDATED 03.26.2020

Obtained via MI FOIA by Judicial Watch, Inc.

Learn More

HHS continues to support efforts to expand testing while basing our recommendations on scientific data.

For updates and information on serological testing Healthcare professionals, laboratories, and diagnostic test developers can review the FDA's Frequently Asked Questions on Diagnostic Testing for SARS-CoV-2: https://www.fda.gov/medical-devices/emergency-situations-medical-devices/faqs-diagnostic-testing-sars-cov-2

The U.S. Department of Health and Human Services has created a resource for stakeholders, COVID-19 testing Diagnostics, to serve as a reference that can be used to facilitate purchasing of Diagnostic materials that have received an Emergency Use Authorization from the FDA.

Coronavirus COVID-19 Diagnostic Tests Hotline

For test developers and labs who have questions about the EUA process or spot shortages of testing supplies.

Contact our toll-free line 24 hours a day: 1-888-INFO-FDA, choose option *.

Additional References

1. Frazee, B. W., et al. (2018). "Accuracy and Discomfort of Different Types of Intranasal Specimen Collection Methods for Molecular Influenza Testing in Emergency Department Patients." Ann Emerg Med 71(4): 509-517 e501.
2. Heikkinen T, Salmi AA, Ruuskanen O. Comparative study of nasopharyngeal aspirate and nasal swab specimens for detection of influenza. BMJ. 2001;322:138.
3. Heikkinen T, Marttila J, Salmi AA, et al. Nasal swab versus nasopharyngeal aspirate for isolation of respiratory viruses. J Clin Microbiol. 2002;40:4337-4339.
4. Sung RY, Chan PK, Choi KC, et al. Comparative study of nasopharyngeal aspirate and nasal swab specimens for diagnosis of acute viral respiratory infection. J Clin Microbiol. 2008;46:3073-3076.
5. Spencer S, Gaglani M, Naleway A, et al. Consistency of influenza A virus detection test results across respiratory specimen collection methods using real-time reverse transcription-PCR. J Clin Microbiol. 2013;51:3880-3882.
6. https://www.fda.gov/medical-devices/emergency-situations-medical-devices/faqs-diagnostic-testing-sars-cov-2#troubleobtainingviraltransport

Obtained via MI FOIA by Judicial Watch, Inc.

URGENT UPDATE DIAGNOSTIC TESTING

Information for Healthcare Providers, Healthcare Systems, and Laboratories Following Updated FDA Recommendations for SARS-CoV-2 Diagnostic Testing

As part of our COVID-19 response efforts, the US government continues to prioritize efforts to expedite patient testing. Experts continue to work tirelessly during this dynamic and evolving situation. This includes adapting to supply chain pressures and continuing to evaluate options for sample collection as well as working with stakeholders on efforts to facilitate greater access to these critical medical products.

On March 23, 2020, additional types of swabs were added to the FDA's recommendations for SARS-CoV-2 diagnostic processes. These recommendations provide additional options for sampling that, based on industry data, are more readily available and may also lessen exposure risks by facilitating self-collection in an appropriate clinical setting, such as "drive-thru" testing sites.

The self-collected nasal swab was recently determined to be equivalent to a nasopharyngeal swab in detecting coronavirus through a study performed by the United Health Group. As a result of these data, the FDA is recommending a self-collected nasal swab (using a round foam swab) or self-collected mid-turbinate swabs (using a flocked tapered swab) for use when a nasopharyngeal (NP) swab is not performed. Based on available data, the FDA recommends that, for symptomatic patients, nasal swabs could be used that access just the front of the nose rather than the depth of the nasal cavity. This would provide COVID-19 testing that is more comfortable for patients, allows self-collection of samples at collection sites, and that can be performed with a simpler and more readily available swab.

The use of a nasal swab versus a nasopharyngeal swab includes the following benefits:

- Increases the total volume of available sample collection materials, since the recommendations are broadened to include flocked and foam swabs, which are available in large quantities
- Collection of nasal swab samples is less technically complex, so can reduce the risk of the spread of infection to healthcare providers, by (1) reducing the duration of the procedure, and (2) allowing the patient to perform self-collection under supervision
- Helps lessen the impact of PPE utilization, given that the patient can perform self-collection under supervision (versus the health care provider performing the collection)

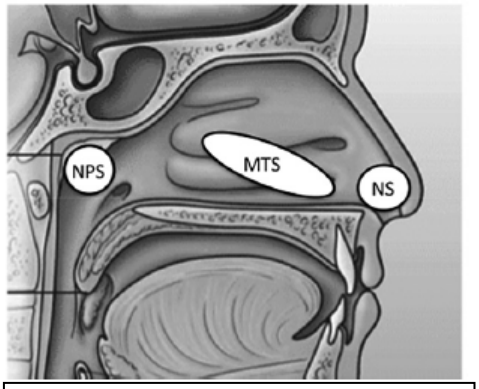
In practice, supervised nasal swab self-collection will occur at at a drive-thru testing site or a healthcare clinic.

Home self-collection is **NOT** recommended.

Background

The FDA identifies preferred preferences for diagnostic sample collections for swab-based SARS-CoV-2. The nasopharyngeal sample is the FDA-preferred sample. In the event that this specimen is not available, the FDA identifies the following alternatives as acceptable:

- oropharyngeal sample collected by a healthcare professional (HCP);
- mid-turbinate sample by onsite self-collection or HCP (using a flocked tapered swab); or
- *anterior nares sample by onsite self-collection or HCP (using a round foam swab).*
- For patients with productive cough, a sputum sample is an acceptable lower respiratory sample.



Sampling Locations: NPS, Nasopharyngeal swab; MTS, midturbinate swab; NS, nasal swab. (From Frazee et al., 2018)

LAST UPDATED 03.26.2020

Obtained via MI FOIA by Judicial Watch, Inc.

Learn More

HHS continues to support efforts to expand testing while basing our recommendations on scientific data.

For updates and information on serological testing Healthcare professionals, laboratories, and diagnostic test developers can review the FDA's Frequently Asked Questions on Diagnostic Testing for SARS-CoV-2: https://www.fda.gov/medical-devices/emergency-situations-medical-devices/faqs-diagnostic-testing-sars-cov-2

The U.S. Department of Health and Human Services has created a resource for stakeholders, COVID-19 testing Diagnostics, to serve as a reference that can be used to facilitate purchasing of Diagnostic materials that have received an Emergency Use Authorization from the FDA.

Coronavirus COVID-19 Diagnostic Tests Hotline

For test developers and labs who have questions about the EUA process or spot shortages of testing supplies.

Contact our toll-free line 24 hours a day: 1-888-INFO-FDA, choose option *.

Additional References

1. Frazee, B. W., et al. (2018). "Accuracy and Discomfort of Different Types of Intranasal Specimen Collection Methods for Molecular Influenza Testing in Emergency Department Patients." Ann Emerg Med 71(4): 509-517 e501.
2. Heikkinen T, Salmi AA, Ruuskanen O. Comparative study of nasopharyngeal aspirate and nasal swab specimens for detection of influenza. BMJ. 2001;322:138.
3. Heikkinen T, Marttila J, Salmi AA, et al. Nasal swab versus nasopharyngeal aspirate for isolation of respiratory viruses. J Clin Microbiol. 2002;40:4337-4339.
4. Sung RY, Chan PK, Choi KC, et al. Comparative study of nasopharyngeal aspirate and nasal swab specimens for diagnosis of acute viral respiratory infection. J Clin Microbiol. 2008;46:3073-3076.
5. Spencer S, Gaglani M, Naleway A, et al. Consistency of influenza A virus detection test results across respiratory specimen collection methods using real-time reverse transcription-PCR. J Clin Microbiol. 2013;51:3880-3882.
6. https://www.fda.gov/medical-devices/emergency-situations-medical-devices/faqs-diagnostic-testing-sars-cov-2#troubleobtainingviraltransport

Obtained via MI FOIA by Judicial Watch, Inc.

PRESIDENT DONALD J. TRUMP IS PROVIDING ECONOMIC RELIEF TO AMERICAN WORKERS, FAMILIES, AND BUSINESSES IMPACTED BY THE CORONAVIRUS

"The legislation developed in the Senate is the first step to restoring confidence and stability to America's economy." – President Donald J. Trump

SECURING EMERGENCY RELIEF: President Donald J. Trump is signing bipartisan legislation to provide relief to American families and workers during the coronavirus outbreak.

- The President worked with Congress to secure bipartisan legislation that will provide emergency relief to families and small businesses that have been impacted by the coronavirus.
    - This unprecedented relief package totals more than $2 trillion.
- The CARES Act provides much needed economic relief for American families and businesses who are hurting through no fault of their own.
- This legislation will provide assistance to America's heroic healthcare workers who are on the frontlines of this outbreak.
    - $100 billion will go to healthcare providers, including hospitals on the front lines of the COVID-19 pandemic.
    - $27 billion will go to bolstering life-saving capabilities, including developing vaccines and the development, purchase, and distribution of critical supplies.
    - $45 billion will go to the Federal Emergency Management Agency Disaster Relief Fund, more than doubling the amount available to support the President's Emergency and Disaster Declarations to empower State, local, and tribal leaders to effectively respond.

SUPPORTING FAMILIES: This legislative package brings security to American families by providing them with economic assistance during this time of crisis.

- This legislation provides tax free payments—treated as a refundable tax credit—to Americans, giving families the immediate financial support they need.
    - Couples earning up to $150,000 will receive $2,400, plus an additional $500 for each child.
    - Individuals earning up to $75,000 will receive $1,200, plus an additional $500 for each child.
    - These payments will phase out for those earning over $75,000, $112,500 for head of household filers, and $150,000 for married couples filing joint tax returns.
- The legislation provides much needed assistance to Americans out of work.
    - The CARES Act allows States to temporarily increase unemployment benefits and receive Federal reimbursement for the additional amount.
    - Encourages States to waive the typical one week waiting period and provides an additional 13 weeks of benefits
    - Creates a new program to assist the self-employed and independent contractors who are unemployed due to the pandemic.
- The legislation provides relief for homeowners and renters, ensuring that Americans' homes are not threatened by the coronavirus.
    - Enables payment forbearance for federally backed mortgages, requires a foreclosure and eviction moratorium for homeowners with such mortgages, and imposes an eviction moratorium for renters in federally supported housing.
- Suspends penalties for withdrawing up to $100,000 from retirement accounts.
- Allows a high-deductible health plan with a health savings account to cover telehealth services prior to a patient reaching the deductible.

Obtained via MI FOIA by Judicial Watch, Inc.

- The legislation provides $3.5 billion in emergency funding to our child care providers to stay open, keep payroll, and prioritize the child care needs of healthcare, emergency, and sanitation workers all across our country.

BOLSTERING THE ECONOMY: This legislation will strengthen our economy by providing needed financial assistance to America's small businesses and workers.

- Small businesses that have been hurt by coronavirus will receive the help they need to survive and prosper.
- This legislation provides small businesses and nonprofits comprised of 500 or fewer employees with almost $350 billion in partially forgivable loans.
    - The maximum loan amount for 7(a) business loans will be temporarily increased.
    - This legislation also provides $17 billion to forgive 6 months of payments on any existing Small Business Administration non-disaster loans.
- The CARES Act provides critical payroll tax relief for small businesses.
- The legislation expands the emergency disaster loan program by funding $10 billion in advances on loan applications to rapidly help small businesses cover expenses including sick leave, payroll, and rent.
- Businesses adversely affected by the coronavirus are eligible for a tax credit of $5,000 for wages paid to each employee.
- The CARES Act includes $500 billion for the Treasury and Federal Reserve to provide liquidity and purchase business, municipal, and State debt.
    - If needed, the Federal Reserve can leverage funds of more than $4 trillion in financial support during this time of disaster.

Obtained via MI FOIA by Judicial Watch, Inc.

PRESIDENT DONALD J. TRUMP IS PROVIDING ECONOMIC RELIEF TO AMERICAN WORKERS, FAMILIES, AND BUSINESSES IMPACTED BY THE CORONAVIRUS

"The legislation developed in the Senate is the first step to restoring confidence and stability to America's economy." – President Donald J. Trump

SECURING EMERGENCY RELIEF: President Donald J. Trump is signing bipartisan legislation to provide relief to American families and workers during the coronavirus outbreak.

- The President worked with Congress to secure bipartisan legislation that will provide emergency relief to families and small businesses that have been impacted by the coronavirus.
    - This unprecedented relief package totals more than $2 trillion.
- The CARES Act provides much needed economic relief for American families and businesses who are hurting through no fault of their own.
- This legislation will provide assistance to America's heroic healthcare workers who are on the frontlines of this outbreak.
    - $100 billion will go to healthcare providers, including hospitals on the front lines of the COVID-19 pandemic.
    - $27 billion will go to bolstering life-saving capabilities, including developing vaccines and the development, purchase, and distribution of critical supplies.
    - $45 billion will go to the Federal Emergency Management Agency Disaster Relief Fund, more than doubling the amount available to support the President's Emergency and Disaster Declarations to empower State, local, and tribal leaders to effectively respond.

SUPPORTING FAMILIES: This legislative package brings security to American families by providing them with economic assistance during this time of crisis.

- This legislation provides tax free payments—treated as a refundable tax credit—to Americans, giving families the immediate financial support they need.
    - Couples earning up to $150,000 will receive $2,400, plus an additional $500 for each child.
    - Individuals earning up to $75,000 will receive $1,200, plus an additional $500 for each child.
    - These payments will phase out for those earning over $75,000, $112,500 for head of household filers, and $150,000 for married couples filing joint tax returns.
- The legislation provides much needed assistance to Americans out of work.
    - The CARES Act allows States to temporarily increase unemployment benefits and receive Federal reimbursement for the additional amount.
    - Encourages States to waive the typical one week waiting period and provides an additional 13 weeks of benefits
    - Creates a new program to assist the self-employed and independent contractors who are unemployed due to the pandemic.
- The legislation provides relief for homeowners and renters, ensuring that Americans' homes are not threatened by the coronavirus.
    - Enables payment forbearance for federally backed mortgages, requires a foreclosure and eviction moratorium for homeowners with such mortgages, and imposes an eviction moratorium for renters in federally supported housing.
- Suspends penalties for withdrawing up to $100,000 from retirement accounts.
- Allows a high-deductible health plan with a health savings account to cover telehealth services prior to a patient reaching the deductible.

Obtained via MI FOIA by Judicial Watch, Inc.

- The legislation provides $3.5 billion in emergency funding to our child care providers to stay open, keep payroll, and prioritize the child care needs of healthcare, emergency, and sanitation workers all across our country.

BOLSTERING THE ECONOMY: This legislation will strengthen our economy by providing needed financial assistance to America's small businesses and workers.

- Small businesses that have been hurt by coronavirus will receive the help they need to survive and prosper.
- This legislation provides small businesses and nonprofits comprised of 500 or fewer employees with almost $350 billion in partially forgivable loans.
    - The maximum loan amount for 7(a) business loans will be temporarily increased.
    - This legislation also provides $17 billion to forgive 6 months of payments on any existing Small Business Administration non-disaster loans.
- The CARES Act provides critical payroll tax relief for small businesses.
- The legislation expands the emergency disaster loan program by funding $10 billion in advances on loan applications to rapidly help small businesses cover expenses including sick leave, payroll, and rent.
- Businesses adversely affected by the coronavirus are eligible for a tax credit of $5,000 for wages paid to each employee.
- The CARES Act includes $500 billion for the Treasury and Federal Reserve to provide liquidity and purchase business, municipal, and State debt.
    - If needed, the Federal Reserve can leverage funds of more than $4 trillion in financial support during this time of disaster.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Jen, Kyle (DTMB); Gordon, Robert (DHHS); McGowan, Emmitt (MSP)
Cc: Gasper, Joe (MSP); Foster, Tricia; Totten, Mark
Subject: Fwd: HHS COVID-19 Update, 4-21-2020
Date: Tuesday, April 21, 2020 8:41:57 PM

Resending.

Assuming you all have received, but just in case — please note the deadline.

From: Stevens, Lee (OS/IEA) <Lee.Stevens@hhs.gov>
Sent: Tuesday, April 21, 2020 8:32:30 PM
To: Johnston, Darcie (HHS/IEA) <Darcie.Johnston@hhs.gov>; Stevens, Lee (OS/IEA) <Lee.Stevens@hhs.gov>
Subject: HHS COVID-19 Update, 4-21-2020

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Dear Colleague:

Provider Relief Fund Update: As you know, the CARES Act appropriated $100 billion to establish a Provider Relief Fund. This Fund, administered by the Secretary of HHS, is being used to distribute payments to health care entities across the country that have been affected by the coronavirus. To date, $30 billion has been distributed generally to health care entities across the country.

HHS will soon make targeted distributions to hospitals and other facilities that have been particularly affected by the increased burden of caring for those with the coronavirus. To inform how these funds are distributed, HHS is asking all hospitals to provide the following information:

For each facility with a Medicare Tax Identification Number (TIN):

- Total number of Intensive Care Unit beds as of April 10, 2020
- Total number of admissions with a positive diagnosis for COVID-19 from January 1, 2020 to April 10, 2020
- National Provider Identifier

How will providers share the information being requested and what steps do they need to take to be considered for impact funding?

Submitters are being asked to provide this information through an authentication portal established by an HHS vendor, TeleTracking. They will be able to submit this data via data entry at an individual hospital level, entering multiple hospitals at one time, or batch upload of data of multiple hospitals via a designated individual or third party entity.

Obtained via MI FOIA by Judicial Watch, Inc.

The health care provider's site administrator received an email from HHS on Sunday April 12th, or thereafter, with instructions and a link to register on this portal. If providers have not already done so, they should register on the portal as directed in the email.

This process has been created to minimize burden, and should not require more than 10 minutes. If it is not clear who within an organization received this notification, or if providers have questions about the registration process, they can contact TeleTracking Technical Support at 877-570-6903.

To help HHS continue to move provider relief funding out to providers quickly, **submitters must deliver this information by 11:59 p.m. PT, Thursday April** 23. Providers should understand that **submitting the data is a prerequisite to payment**, but is **not a guarantee of eligibility** for any amount.

Other HHS COVID-19 news is as follows.

Testing and Treatment

At-Home Test: The U.S. Food and Drug Administration authorized the first diagnostic test with a home collection option for COVID-19. Specifically, the FDA re-issued the emergency use authorization (EUA) for the Laboratory Corporation of America (LabCorp) COVID-19 RT-PCR Test to permit testing of samples self-collected by patients at home using LabCorp's Pixel by LabCorp COVID-19 Test home collection kit. This reissued EUA for LabCorp's molecular test permits testing of a sample collected from the patient's nose using a designated self-collection kit that contains nasal swabs and saline. Once patients self-swab to collect their nasal sample, they mail their sample, in an insulated package, to a LabCorp lab for testing.

Rapid Diagnostic Test: BARDA entered into a partnership with Tangen Biosciences to develop a rapid diagnostic test using technology that might help health departments monitor the pandemic more efficiently in their community and results are provided to users and integrated through a cloud-based mobile platform that could can convey the identified test results to public health agencies. This could help public health departments assess the spread in the community and decrease the number of infections.

Compounding Drugs with Shortages: FDA has released a temporary policy for compounding of certain drugs for hospitalized patients by pharmacy compounders not registered as outsourcing facilities guidance for industry. Many hospitals are currently experiencing difficulties accessing FDA-approved drug products used for patients with COVID-19. As a temporary measure during the public health emergency related to COVID-19, or for such shorter time as FDA may announce by updating or withdrawing this guidance based on evolving needs and circumstances, FDA does not intend to take action against a pharmacy for compounding a drug that is essentially a copy of a commercially available drug, or for providing a drug to a hospital without obtaining a patient-specific prescription.

Reporting Clinical Trial Data: CMS is encouraging clinicians who participate in the Quality Payment Program (QPP), such as physicians, physician assistants, nurse practitioners, and others, to

Obtained via MI FOIA by Judicial Watch, Inc.

contribute to scientific research and evidence to fight the Coronavirus Disease 2019 (COVID-19) pandemic. Clinicians may now earn credit in the Merit-based Incentive Payment System (MIPS), a performance-based track of QPP that incentivizes quality and value, for participation in a clinical trial and reporting clinical information by attesting to the new *COVID-19 Clinical Trials* improvement activity. This action will provide vital data to help drive improvement in patient care and develop innovative best practices to manage the spread of COVID-19 within communities.

Treatment Guidelines: NIH developed Treatment Guidelines to inform clinicians how to care for patients with COVID-19. The recommendations in these Guidelines are based on scientific evidence and expert opinion. Each recommendation includes two ratings: a letter (A, B, or C) that indicates the strength of the recommendation and a Roman numeral (I, II, or III) that indicates the quality of the evidence that supports the recommendation.

Treatment Acceleration Program: FDA launched the Coronavirus Treatment Acceleration Program (CTAP) to speed approval of drugs and therapies. To date, 72 therapies are now being tested and another 211 are in active planning for clinical trials. Commissioner Hahn posted a blog about the program and notes that the program uses every available method to move new treatments to patients as quickly as possible, while at the same time finding out whether the treatments are helpful or harmful.

Diagnostics Update to Date: During the COVID-19 pandemic, the FDA has worked with more than 340 test developers who have said they will be submitting emergency use authorization (EUA) requests to FDA for tests that detect the virus. To date, the FDA has issued 41 individual emergency use authorizations for test kit manufacturers and laboratories. In addition, 16 authorized tests have been added to the EUA letter of authorization for high complexity molecular-based laboratory developed tests (LDTs). The FDA has been notified that more than 210 laboratories have begun testing under the policies set forth in our COVID-19 Policy for Diagnostic Tests for Coronavirus Disease-2019 during the Public Health Emergency Guidance. The FDA also continues to keep its COVID-19 Diagnostics FAQ up to date.

PPE and Supplies

Expanding Ventilator Capacity: On April 20, President Trump launched the Dynamic Ventilator Reserve Program, an innovative public-private partnership to access up to 65,000 additional ventilators in hospitals across the country that can be redeployed when not in use.

Update on Face Masks: The FDA issued a face mask emergency use authorization (EUA) in response to concerns relating to insufficient supply and availability of face masks for use by members of the general public, including health care personnel in healthcare settings as personal protective equipment (PPE), to cover their noses and mouths, in accordance with Centers for Disease Control and Prevention (CDC) recommendations, to prevent the spread of the SARS-CoV-2 virus during the pandemic. Manufacturers of face masks that are used as described in the EUA and meet the requirements in the EUA, do not need to take any action, other than complying with the Conditions of Authorization in the EUA, to be authorized under this EUA.

Obtained via MI FOIA by Judicial Watch, Inc.

Funding, Resources and Toolkits

Nearly $1 Billion in COVID-19 Services and Supports for Older Adults and People with Disabilities: HHS announced nearly $1 Billion in CARES Act funding to states, Tribes and community-based organizations to help meet the needs of older adults and people with disabilities as communities implement measures to prevent the spread of COVID-19. The grants will fund home-delivered meals; care services in the home; respite care and other support to families and caregivers; information about and referral to supports; and more. The majority of these additional funds ($905 million) are being awarded today to states, territories, and tribes for subsequent allocation to local service providers. Grant amounts are determined based on the formulas defined under the program authorizing statutes.

Funding for Tribes: Through the CARES Act, HRSA received $15M to allocate to tribes, tribal organizations, urban Indian health organizations, and health service providers to tribes. The funding will provide support for the Tribes to prevent, prepare, and respond to COVID-19 in rural communities. The Notice of Funding Opportunity can be found here and applications are due May 6, 2020.

Resources for Human Services Leaders: The Administration on Children and Families created a resource that is geared towards state leaders and is intended to provide current mandatory program flexibilities, guidance and resources in ACF programs, as well as information on other federal programs that serve vulnerable children and families. Information will be updated periodically.

Toolkit on Healthcare Workforce: The Technical Resource Assistance Center posted the COVID-19 workforce virtual toolkits. This toolkit includes resources and tools for decision-makers managing healthcare workforce challenges in response to COVID-19 emergency. Additionally, information on federal regulatory and funding flexibility, healthcare workforce training, liability protection, scope of practice, and workforce protection is also included on the site.

Toolkit on Alternative Care Sites: HHS released this Toolkit and guidance to help state, local, tribal, and territorial (SLTT) entities address potential capacity and capability gaps in healthcare systems during the 2020 SARS-CoV2 virus (COVID-19) pandemic. It is intended to provide guidance and technical assistance to SLTT entities in establishing and operationalizing Alternate Care Sites (ACS) used to care for COVID-19-positive or presumed positive patients. If an ACS is used to treat non-COVID-19 patients, additional considerations will apply.

Waivers and Flexibilities:

CMS Waiver Flexibility: CMS has approved 53 COVID-related emergency waivers, 39 state amendments, 16 COVID-related Medicaid Disaster Amendments and one CHIP COVID-related Disaster Amendment. States are using a toolkit CMS developed to expedite the application and approval of Medicaid state waivers and State Plan Amendments.

Obtained via MI FOIA by Judicial Watch, Inc.

Rural Health Clinic and Federally-Qualified Health Center Flexibilities: CMS released information for RHCs and FQHCs on Telehealth and Virtual Communications Flexibilities During COVID-19. To support RHCs and FQHCs and their patients, Congress and CMS made changes to requirements and payments during the COVID-19 Public Health Emergency, including: New payment for telehealth services, including how to bill Medicare; Expansion of virtual communication services; Revision of home health agency shortage requirement for visiting nursing services; Consent for care management and virtual communication services; and Accelerated/advance payments.

Extension on the Interoperability and Patient Access Final Rule: Today, the Office of the National Coordinator for Health IT (ONC) and the Centers for Medicare & Medicaid Services (CMS), in conjunction with the HHS Office of Inspector General (OIG) announced a policy of enforcement discretion to allow compliance flexibilities regarding the implementation of the interoperability final rules announced on March 9th in response to the coronavirus disease (COVID-19) public health emergency. ONC will exercise enforcement discretion for 3 months at the end of certain ONC Health IT Certification Program compliance dates associated with the ONC Cures Act Final Rule. CMS will provide hospitals an additional 6 months to implement the new requirements.

Information for Specific Populations

Extension of an Order to Suspend Certain Individuals into the US: CDC announced an extension of an Order issued March 20, 2020 under Sections 362 and 365 of the Public Health Service Act, and associated implementing regulations, that suspends the introduction of certain persons from countries where an outbreak of a communicable disease exists. The Order shall continue in operation for an additional 30 days.

Guidance for Childcare Programs: CDC updated their guidance for childcare programs that remain open. The updates include additional options for screening children upon arrival to ensure that children who have a fever or other signs of illness are not admitted to the facility and noting that the additional options may be useful when personal protective equipment (PPE) is in short supply.

Safety Practices for Workers Exposed to a Person with COVID-19: CDC updated their guidance on implementing safety practices for critical infrastructure workers who may have had exposure to a person with suspected or confirmed COVID-19. To ensure continuity of operations of essential functions, CDC advises that critical infrastructure workers may be permitted to continue work following potential exposure to COVID-19, provided they remain asymptomatic and additional precautions are implemented to protect them and the community. Critical Infrastructure workers who have had an exposure but remain asymptomatic should adhere to outlined practices prior to and during their work shift.

Aligning Federal Agency Operations with Opening Up America Guidelines: The White House released a document on aligning federal agency operations with the national guidelines for opening up America again. In partnership with state, local, tribal, and territorial governments, and the private sector, the Federal government is actively planning to ramp back up government operations to the maximum extent possible, as local conditions warrant, consistent with the National guidelines for

Obtained via MI FOIA by Judicial Watch, Inc.

Opening Up America Again.

Information for Laboratories: CDC updated their information for laboratories. This page includes interim guidance and resources for laboratory professionals working with specimens from persons under investigation (PUI) for coronavirus disease 2019 (COVID-19).

Information for Institutes of Higher Education: CDC updated their guidance for institutes of higher education. The updates now include a decision-tree for school closures.

Updated Information for Homeless Shelters: CDC released additional information on screening clients at homeless shelters. The following is a screening tool that can be used to identify people with symptoms that indicate they might have a respiratory infection. Although not every person who has respiratory infection symptoms will have coronavirus disease 2019 (COVID-19), using a tool may be helpful in identifying people who may need medical care.

Report on Effect of Cleaning and Disinfectant Chemicals and COVID-19: CDC published a report, Cleaning and Disinfectant Chemical Exposures and Temporal Associations with COVID-19 — National Poison Data System, United States, January 1, 2020–March 31, 2020. This report describes a temporal association between COVID-19 cleaning recommendations—from public health agencies and the media—and an increase in reports related to cleaners and disinfectants reported to the National Poison Data System (NPDS).

Thank you for all of your work in so many aspects of the COVID-19 fight. Most of all, we thank our healthcare workers.
If you have questions, email Darcie.Johnston@hhs.gov.

Laura

Laura C. Trueman
Director, Office of Intergovernmental and External Affairs
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington D.C. 20201

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Jen, Kyle (DTMB); Gordon, Robert (DHHS)
Subject: Fwd: HHS COVID-19 Update, 4-21-2020
Date: Tuesday, April 21, 2020 8:41:10 PM

Perhaps you have seen, just in case

From: Stevens, Lee (OS/IEA) <Lee.Stevens@hhs.gov>
Sent: Tuesday, April 21, 2020 8:32:30 PM
To: Johnston, Darcie (HHS/IEA) <Darcie.Johnston@hhs.gov>; Stevens, Lee (OS/IEA) <Lee.Stevens@hhs.gov>
Subject: HHS COVID-19 Update, 4-21-2020

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Dear Colleague:

Provider Relief Fund Update: As you know, the CARES Act appropriated $100 billion to establish a Provider Relief Fund. This Fund, administered by the Secretary of HHS, is being used to distribute payments to health care entities across the country that have been affected by the coronavirus. To date, $30 billion has been distributed generally to health care entities across the country.

HHS will soon make targeted distributions to hospitals and other facilities that have been particularly affected by the increased burden of caring for those with the coronavirus. To inform how these funds are distributed, HHS is asking all hospitals to provide the following information:

For each facility with a Medicare Tax Identification Number (TIN):

- Total number of Intensive Care Unit beds as of April 10, 2020
- Total number of admissions with a positive diagnosis for COVID-19 from January 1, 2020 to April 10, 2020
- National Provider Identifier

How will providers share the information being requested and what steps do they need to take to be considered for impact funding?

Submitters are being asked to provide this information through an authentication portal established by an HHS vendor, TeleTracking. They will be able to submit this data via data entry at an individual hospital level, entering multiple hospitals at one time, or batch upload of data of multiple hospitals via a designated individual or third party entity.

The health care provider's site administrator received an email from HHS on Sunday April 12th, or thereafter, with instructions and a link to register on this portal. If providers have not already done so, they should register on the portal as directed in the email.

Obtained via MI FOIA by Judicial Watch, Inc.

This process has been created to minimize burden, and should not require more than 10 minutes. If it is not clear who within an organization received this notification, or if providers have questions about the registration process, they can contact TeleTracking Technical Support at 877-570-6903.

To help HHS continue to move provider relief funding out to providers quickly, **submitters must deliver this information by 11:59 p.m. PT, Thursday April** 23. Providers should understand that **submitting the data is a prerequisite to payment**, but is **not a guarantee of eligibility** for any amount.

Other HHS COVID-19 news is as follows.

Testing and Treatment

At-Home Test: The U.S. Food and Drug Administration authorized the first diagnostic test with a home collection option for COVID-19. Specifically, the FDA re-issued the emergency use authorization (EUA) for the Laboratory Corporation of America (LabCorp) COVID-19 RT-PCR Test to permit testing of samples self-collected by patients at home using LabCorp's Pixel by LabCorp COVID-19 Test home collection kit. This reissued EUA for LabCorp's molecular test permits testing of a sample collected from the patient's nose using a designated self-collection kit that contains nasal swabs and saline. Once patients self-swab to collect their nasal sample, they mail their sample, in an insulated package, to a LabCorp lab for testing.

Rapid Diagnostic Test: BARDA entered into a partnership with Tangen Biosciences to develop a rapid diagnostic test using technology that might help health departments monitor the pandemic more efficiently in their community and results are provided to users and integrated through a cloud-based mobile platform that could can convey the identified test results to public health agencies. This could help public health departments assess the spread in the community and decrease the number of infections.

Compounding Drugs with Shortages: FDA has released a temporary policy for compounding of certain drugs for hospitalized patients by pharmacy compounders not registered as outsourcing facilities guidance for industry. Many hospitals are currently experiencing difficulties accessing FDA-approved drug products used for patients with COVID-19. As a temporary measure during the public health emergency related to COVID-19, or for such shorter time as FDA may announce by updating or withdrawing this guidance based on evolving needs and circumstances, FDA does not intend to take action against a pharmacy for compounding a drug that is essentially a copy of a commercially available drug, or for providing a drug to a hospital without obtaining a patient-specific prescription.

Reporting Clinical Trial Data: CMS is encouraging clinicians who participate in the Quality Payment Program (QPP), such as physicians, physician assistants, nurse practitioners, and others, to contribute to scientific research and evidence to fight the Coronavirus Disease 2019 (COVID-19) pandemic. Clinicians may now earn credit in the Merit-based Incentive Payment System (MIPS), a performance-based track of QPP that incentivizes quality and value, for participation in a clinical trial and reporting clinical information by attesting to the new *COVID-19 Clinical Trials* improvement

Obtained via MI FOIA by Judicial Watch, Inc.

activity. This action will provide vital data to help drive improvement in patient care and develop innovative best practices to manage the spread of COVID-19 within communities.

Treatment Guidelines: NIH developed Treatment Guidelines to inform clinicians how to care for patients with COVID-19. The recommendations in these Guidelines are based on scientific evidence and expert opinion. Each recommendation includes two ratings: a letter (A, B, or C) that indicates the strength of the recommendation and a Roman numeral (I, II, or III) that indicates the quality of the evidence that supports the recommendation.

Treatment Acceleration Program: FDA launched the Coronavirus Treatment Acceleration Program (CTAP) to speed approval of drugs and therapies. To date, 72 therapies are now being tested and another 211 are in active planning for clinical trials. Commissioner Hahn posted a blog about the program and notes that the program uses every available method to move new treatments to patients as quickly as possible, while at the same time finding out whether the treatments are helpful or harmful.

Diagnostics Update to Date: During the COVID-19 pandemic, the FDA has worked with more than 340 test developers who have said they will be submitting emergency use authorization (EUA) requests to FDA for tests that detect the virus. To date, the FDA has issued 41 individual emergency use authorizations for test kit manufacturers and laboratories. In addition, 16 authorized tests have been added to the EUA letter of authorization for high complexity molecular-based laboratory developed tests (LDTs). The FDA has been notified that more than 210 laboratories have begun testing under the policies set forth in our COVID-19 Policy for Diagnostic Tests for Coronavirus Disease-2019 during the Public Health Emergency Guidance. The FDA also continues to keep its COVID-19 Diagnostics FAQ up to date.

PPE and Supplies

Expanding Ventilator Capacity: On April 20, President Trump launched the Dynamic Ventilator Reserve Program, an innovative public-private partnership to access up to 65,000 additional ventilators in hospitals across the country that can be redeployed when not in use.

Update on Face Masks: The FDA issued a face mask emergency use authorization (EUA) in response to concerns relating to insufficient supply and availability of face masks for use by members of the general public, including health care personnel in healthcare settings as personal protective equipment (PPE), to cover their noses and mouths, in accordance with Centers for Disease Control and Prevention (CDC) recommendations, to prevent the spread of the SARS-CoV-2 virus during the pandemic. Manufacturers of face masks that are used as described in the EUA and meet the requirements in the EUA, do not need to take any action, other than complying with the Conditions of Authorization in the EUA, to be authorized under this EUA.

Funding, Resources and Toolkits

Nearly $1 Billion in COVID-19 Services and Supports for Older Adults and People with Disabilities:

Obtained via MI FOIA by Judicial Watch, Inc.

HHS announced nearly $1 Billion in CARES Act funding to states, Tribes and community-based organizations to help meet the needs of older adults and people with disabilities as communities implement measures to prevent the spread of COVID-19. The grants will fund home-delivered meals; care services in the home; respite care and other support to families and caregivers; information about and referral to supports; and more. The majority of these additional funds ($905 million) are being awarded today to states, territories, and tribes for subsequent allocation to local service providers. Grant amounts are determined based on the formulas defined under the program authorizing statutes.

Funding for Tribes: Through the CARES Act, HRSA received $15M to allocate to tribes, tribal organizations, urban Indian health organizations, and health service providers to tribes. The funding will provide support for the Tribes to prevent, prepare, and respond to COVID-19 in rural communities. The Notice of Funding Opportunity can be found here and applications are due May 6, 2020.

Resources for Human Services Leaders: The Administration on Children and Families created a resource that is geared towards state leaders and is intended to provide current mandatory program flexibilities, guidance and resources in ACF programs, as well as information on other federal programs that serve vulnerable children and families. Information will be updated periodically.

Toolkit on Healthcare Workforce: The Technical Resource Assistance Center posted the COVID-19 workforce virtual toolkits. This toolkit includes resources and tools for decision-makers managing healthcare workforce challenges in response to COVID-19 emergency. Additionally, information on federal regulatory and funding flexibility, healthcare workforce training, liability protection, scope of practice, and workforce protection is also included on the site.

Toolkit on Alternative Care Sites: HHS released this Toolkit and guidance to help state, local, tribal, and territorial (SLTT) entities address potential capacity and capability gaps in healthcare systems during the 2020 SARS-CoV2 virus (COVID-19) pandemic. It is intended to provide guidance and technical assistance to SLTT entities in establishing and operationalizing Alternate Care Sites (ACS) used to care for COVID-19-positive or presumed positive patients. If an ACS is used to treat non-COVID-19 patients, additional considerations will apply.

Waivers and Flexibilities:

CMS Waiver Flexibility: CMS has approved 53 COVID-related emergency waivers, 39 state amendments, 16 COVID-related Medicaid Disaster Amendments and one CHIP COVID-related Disaster Amendment. States are using a toolkit CMS developed to expedite the application and approval of Medicaid state waivers and State Plan Amendments.

Rural Health Clinic and Federally-Qualified Health Center Flexibilities: CMS released information for RHCs and FQHCs on Telehealth and Virtual Communications Flexibilities During COVID-19. To support RHCs and FQHCs and their patients, Congress and CMS made changes to requirements and payments during the COVID-19 Public Health Emergency, including: New payment for telehealth

Obtained via MI FOIA by Judicial Watch, Inc.

services, including how to bill Medicare; Expansion of virtual communication services; Revision of home health agency shortage requirement for visiting nursing services; Consent for care management and virtual communication services; and Accelerated/advance payments.

Extension on the Interoperability and Patient Access Final Rule: Today, the Office of the National Coordinator for Health IT (ONC) and the Centers for Medicare & Medicaid Services (CMS), in conjunction with the HHS Office of Inspector General (OIG) announced a policy of enforcement discretion to allow compliance flexibilities regarding the implementation of the interoperability final rules announced on March 9th in response to the coronavirus disease (COVID-19) public health emergency. ONC will exercise enforcement discretion for 3 months at the end of certain ONC Health IT Certification Program compliance dates associated with the ONC Cures Act Final Rule. CMS will provide hospitals an additional 6 months to implement the new requirements.

Information for Specific Populations

Extension of an Order to Suspend Certain Individuals into the US: CDC announced an extension of an Order issued March 20, 2020 under Sections 362 and 365 of the Public Health Service Act, and associated implementing regulations, that suspends the introduction of certain persons from countries where an outbreak of a communicable disease exists. The Order shall continue in operation for an additional 30 days.

Guidance for Childcare Programs: CDC updated their guidance for childcare programs that remain open. The updates include additional options for screening children upon arrival to ensure that children who have a fever or other signs of illness are not admitted to the facility and noting that the additional options may be useful when personal protective equipment (PPE) is in short supply.

Safety Practices for Workers Exposed to a Person with COVID-19: CDC updated their guidance on implementing safety practices for critical infrastructure workers who may have had exposure to a person with suspected or confirmed COVID-19. To ensure continuity of operations of essential functions, CDC advises that critical infrastructure workers may be permitted to continue work following potential exposure to COVID-19, provided they remain asymptomatic and additional precautions are implemented to protect them and the community. Critical Infrastructure workers who have had an exposure but remain asymptomatic should adhere to outlined practices prior to and during their work shift.

Aligning Federal Agency Operations with Opening Up America Guidelines: The White House released a document on aligning federal agency operations with the national guidelines for opening up America again. In partnership with state, local, tribal, and territorial governments, and the private sector, the Federal government is actively planning to ramp back up government operations to the maximum extent possible, as local conditions warrant, consistent with the National guidelines for Opening Up America Again.

Information for Laboratories: CDC updated their information for laboratories. This page includes interim guidance and resources for laboratory professionals working with specimens from persons

Obtained via MI FOIA by Judicial Watch, Inc.

under investigation (PUI) for coronavirus disease 2019 (COVID-19).

Information for Institutes of Higher Education: CDC updated their guidance for institutes of higher education. The updates now include a decision-tree for school closures.

Updated Information for Homeless Shelters: CDC released additional information on screening clients at homeless shelters. The following is a screening tool that can be used to identify people with symptoms that indicate they might have a respiratory infection. Although not every person who has respiratory infection symptoms will have coronavirus disease 2019 (COVID-19), using a tool may be helpful in identifying people who may need medical care.

Report on Effect of Cleaning and Disinfectant Chemicals and COVID-19: CDC published a report, Cleaning and Disinfectant Chemical Exposures and Temporal Associations with COVID-19 — National Poison Data System, United States, January 1, 2020–March 31, 2020. This report describes a temporal association between COVID-19 cleaning recommendations—from public health agencies and the media—and an increase in reports related to cleaners and disinfectants reported to the National Poison Data System (NPDS).

Thank you for all of your work in so many aspects of the COVID-19 fight. Most of all, we thank our healthcare workers.
If you have questions, email Darcie.Johnston@hhs.gov.

Laura

Laura C. Trueman
Director, Office of Intergovernmental and External Affairs
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington D.C. 20201

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Gordon, Robert (DHHS); Readinger, Patricia
Subject: Fwd: HHS Releases Funding and Other Resources for COVID-19
Date: Wednesday, March 11, 2020 4:00:22 PM

From: Baker, Michael (OS/IEA) <Michael.Baker@hhs.gov>
Sent: Wednesday, March 11, 2020 3:55:56 PM
To: Baker, Michael (OS/IEA) <Michael.Baker@hhs.gov>
Subject: HHS Releases Funding and Other Resources for COVID-19

Dear Partner –

Thank you for your continued engagement and partnership with us to address and mitigate the spread of COVID-19. We highly value our strong ongoing partnership, and hope to continue to be a resource to you as you implement community mitigation techniques. As you might imagine, a number of HHS divisions are releasing COVID-19-related information on funding and guidance. We thought it would be helpful to batch up information on key issues to keep you up-to-date.

Funding for States to Address COVID-19
Perhaps of keenest interest to you and your health officials is an update on funding for states and communities to address mitigation of COVID-19. Today, the Department of Health and Human Services (HHS) is announcing upcoming action by the Centers for Disease Control and Prevention (CDC) to provide resources to state and local jurisdictions in support of our nation's response to the coronavirus disease 2019 (COVID-19).

The $8.3 billion dollar Supplemental passed by Congress included statutory language which prescribed the exact formula for disbursing the money: states will receive 90% of their 2019 CDC PHEP grants. This marks the first tranche of funding to states from the $8.3 billion supplemental. Today, CDC is contacting State Health Officers to move forward with awarding over $560 million to states, localities, territories, and tribes. CDC will use existing networks to reach out to state and local jurisdictions to access this initial funding. To view the list of CDC funding actions to jurisdictions, click here.

Helping Communities Know Mitigation Strategies
Yesterday, CDC released their "Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission." Essentially, this is a guide for communities describing possible mitigation strategies for communities dealing with transmission at three different levels: (1) None/Minimal, (2) Moderate, or (3) Substantial. Community mitigation strategies, which are non-pharmaceutical interventions, are often the most available interventions to help slow the transmission of COVID-19 in communities. The Mitigation Plans include a set of actions that persons and communities can take to slow the spread of respiratory virus infections. The Community Mitigation Plan can be found here.

Guidance on Infection Control For Healthcare Workers
Yesterday, CDC released updated guidance on infection prevention and control recommendations. Healthcare workers are fighting this outbreak on the front lines, and this guidance is intended to provide assistance to healthcare settings that are handling suspected or

Obtained via MI FOIA by Judicial Watch, Inc.

confirmed cases of COVID-19. This guidance is applicable to all U.S. healthcare settings, but not for non-healthcare settings. There is separate guidance for that. The new guidance on infection control can be found here.

Guidance on Laboratories
The CDC has been actively working to address the need for testing across the country. In addition to public health laboratories, private labs are doing testing. In addition to reviewing the Updated Guidance on Evaluating and Testing Persons for Coronavirus Disease 2019, the CDC recently updated the FAQ website for laboratories, and we encourage you to read through the site to answer preliminary questions, though we stand ready to answer other questions that you may have.

OMB Flexibilities
On March 9, 2020, OMB issued a memo that provides administrative relief for recipients and applicants of Federal financial assistance who are directly impacted by COVID-19. The grant flexibilities include 10 actions that HHS can take to provide short-term administrative and financial management relief, allowing funds to be awarded quicker and giving grantees the ability to focus on their critical response, research, or services. More information can be found here.

General Preparation Information
On March 9, 2020, the White House Coronavirus Task Force released practical steps that we recommend posting and sharing to keep workplaces, school, home and commercial establishments safe. This information can be found here.

As the President, the Vice President, and the entire White House team continue to stress, the COVID-19 response is a whole-of-government effort. Each department has a number of specific resources. We encourage you to explore those resources as necessary to respond to the situation in your communities.

If you have any questions on these items or other issues, please feel free to reach out.

Thanks,

Darcie L. Johnston
Director, Intergovernmental Affairs
U.S. Department of Health and Human Services
Darcie.Johnston@hhs.gov

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Gordon, Robert (DHHS)
Subject: Fwd: Hotels and Dorms
Date: Wednesday, April 22, 2020 8:58:28 AM

All of his information is below.

From: Smith, Dana <SmithD131@michigan.gov>
Sent: Monday, April 20, 2020 1:55 PM
To: Hardesty, Thomas G; Huls, JoAnne; McGee, Tracey
Cc: Esty, Sarah (DHHS); Genre, Donna J
Subject: RE: Hotels and Dorms

Hi Thom,

I'm so glad the time I offered works for everybody. Please cc me on the invite as well and let me know if you need any other assistance.

Best,

Dana L. Smith
Executive Assistant to
JoAnne Huls, Chief of Staff
Jen Flood, Director, Legislative Affairs and Public Affairs
Executive Office of the Governor
O:517-241-1695; C:517-927-4919

From: Hardesty, Thomas G <hardestyt@oakgov.com>
Sent: Monday, April 20, 2020 1:53 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>; McGee, Tracey <mcgeet@oakgov.com>
Cc: Smith, Dana <SmithD131@michigan.gov>; Esty, Sarah (DHHS) <EstyS@michigan.gov>; Genre, Donna J <genred@oakgov.com>
Subject: RE: Hotels and Dorms

1:30 works for both of us. We will schedule the conference call if that is ok, we have some paperwork we can share that way if it's okay with you

Thom

From: Huls, JoAnne <HulsJ1@michigan.gov>
Sent: Monday, April 20, 2020 11:37 AM
To: Hardesty, Thomas G <hardestyt@oakgov.com>

Obtained via MI FOIA by Judicial Watch, Inc.

Cc: Smith, Dana <SmithD131@michigan.gov>; Esty, Sarah (DHHS) <EstyS@michigan.gov>
Subject: Re: Hotels and Dorms

Hi Thom,

Thanks Hilarie,

Thom, would you be willing to join a call with Sarah Esty (from DHHS) and I to talk about hotels/dorms for voluntary isolation and quarantine as we work to create the infrastructure to contain any further outbreak of Covid-19?

I'm including Dana on this email to facilitate the scheduling for tomorrow.

Thanks for all that you are doing, and wishing you the best,
JoAnne

From: Hardesty, Thomas G <hardestyt@oakgov.com>
Sent: Tuesday, April 14, 2020 8:28:12 PM
To: Chambers, Hilarie <chambershi@oakgov.com>; Huls, JoAnne <HulsJ1@michigan.gov>
Subject: RE: Hotels and Dorms

Anything we can do to assist please let me know. My cell number is 248-343-0863.

Thom Hardesty

-----Original Message-----
From: Chambers, Hilarie <chambershi@oakgov.com>
Sent: Tuesday, April 14, 2020 8:10 PM
To: hulsj1@michigan.gov; Hardesty, Thomas G <hardestyt@oakgov.com>; Chambers, Hilarie <chambershi@oakgov.com>
Subject: Hotels and Dorms

Thom - I am connecting you with the Governor's chief of Staff. JoAnn is going to put another member of their team in touch with you about the process we have in place with hotels and dorms. They are beginning to work on isolation spaces.

Joann - Thom confirmed we have a good process but it has not been taken up by many people yet.

Let us know anything we can do.

Hilarie Chambers
(Cell) 248-535-9073

Sent from my iPhone

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark
Subject: Fwd: infographic - living with COVID risk
Date: Tuesday, November 3, 2020 3:14:45 PM
Attachments: irish version.pdf

From: Thomas R. Frieden <trfrieden@resolvetosavelives.org>
Sent: Tuesday, November 3, 2020 9:55 AM
To: Gordon, Robert (DHHS)
Subject: FW: infographic - living with COVID risk

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

---

From: Tom Frieden <trfrieden@resolvetosavelives.org>
Date: Sunday, November 1, 2020 at 6:59 PM
To: Thomas Farley <Thomas.Farley@Phila.gov>
Subject: FW: infographic - living with COVID risk

FYI. Alert levels have a lot of potential, we think. Accountability, informing people, and accelerating progress/shared understanding.

Obtained via MI FOIA by Judicial Watch, Inc.

National Framework for living with COVID-19

Coronavirus COVID-19 National Programme

Very low rate of COVID-19 infections Low R-Number → **Very high rate of COVID-19 infections High R-Number**

	Level 1	Level 2	Level 3	Level 4	Level 5
Social & Family Gatherings	Max: **10** from **3** other households	Max: **6** from **3** other households	Max: **6** from **1** other household	No visitors	No visitors
Weddings	Max: **100**	Max: **50**	Max: **25**	Max: **6**	Max: **6**
Indoor Events	Depending on venue size **100** | **200**	Depending on venue size **50** | **100**	No organised events	No organised events	No organised events
Outdoor Events	Depending on venue size **200** | **500**	Depending on venue size **100** | **200**	Gatherings of up to **15**	Gatherings of up to **15**	
Sports Training	Normal training with protective measures	**Indoors** Pods of **6** **Outdoors** Pods of **15**	**1** Individual only Pods of **15** Non-contact	**1** Individual only Pods of **15** Non-contact	Individual training only
Matches & Events	**100** indoor | **200** outdoor | **500** stadia	**50** indoor | **100** outdoor | **200** stadia	Except specific exemptions	Except specific exemptions	No events
Gyms, Pools & Leisure Centres	**Open** with protective measures	**Open** with protective measures	**Individual** training only	Closed	Closed
Religious Services	**50** (or sub-groups of 50)	**50** (or sub-groups of 50)	Services move online **Funerals** **25**	Services move online **Funerals** **25**	Services move online **Funerals** **10**
Bars serving food, Cafés & Restaurants	**Open** with protective measures	**Open** Groups of **6** from up to **3** households	Range of restrictions up to and including no indoor dining	**Outdoor** dining only Max: **15** Takeaway/Delivery	**Takeaway/Delivery** only
Wet Pubs	**Open** with protective measures	**Open** Groups of **6** from up to **3** households	Range of restrictions up to and including no indoor service*	**Outdoor** only Max: **15** persons Takeaway/Delivery	**Takeaway/Delivery** only
Hotels, Guesthouses B&Bs	**Open** with protective measures	**Open** with protective measures	Services limited to **Residents** only	**Existing Guests & Essential Purposes** only	**Essential Purposes** only
Retail & Services (Mandatory face coverings)	**Open** with protective measures	**Open** with protective measures	**Open** with protective measures	Primarily outdoor **Essential retail/services**	**Essential Retail** only
Indoor Cultural Venues	**Open** with protective measures	**Open** with protective measures	**Venues closed** Libraries available for e-services/call & collect	**Venues closed** Online services available	**Venues closed** Online services available
Workplace (Work from home if possible)	**Staggered attendance**	**Essential** Meetings, Induction & Training only	**Attend only if absolutely necessary**	**Essential & other designated workers** only	**Essential workers** only
Domestic Travel	**No restrictions**	**No restrictions**	**Stay in your county** except for work, education & essential purposes	**Stay in your county** Except for essential work, education & essential purposes	**Stay at home** Exercise within 5km
Public Transport (Cycle or walk if possible; Mandatory face coverings)	**Off-peak hours**	**50%** Capacity **Peak hours reserved** for essential workers and purposes	**50%** Capacity **Only when necessary**	**25%** Capacity **Avoid public transport**	**25%** Capacity **Avoid public transport**
Schools & Childcare	**Open** with protective measures	**Open** with protective measures	**Open** with protective measures	**Open** with protective measures	Recommendations based on situation and evidence at time
Adult & Higher Education	**Open** with protective measures	**Open** with protective measures	**Open** Escalate all appropriate protective measures / limit congregation	**Move online** On-site attendance only when essential	Recommendations based on situation and evidence at time
Care Homes	**Open** with protective measures	**Open** with enhanced protective measures	**Visiting suspended**, aside from critical and compassionate circumstances		
Over 70s & Medically Vulnerable	Exercise judgement regarding engaging with others and in activities outside home.				

*Pubs currently remain closed in Dublin

More detailed information is available at **gov.ie/COVID19**

Rialtas na hÉireann
Government of Ireland

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Gordon, Robert (DHHS); Khaldun, Joneigh (DHHS); Totten, Mark
Subject: Fwd: INVITE: State-Federal Technical Assistance on Modeling & Trends (Monday, April 6, 9:00 a.m. ET)
Date: Friday, April 3, 2020 7:15:29 PM
Attachments: image001.png

If you find it helpful

From: Pottebaum, Nic D. EOP/WHO <Nicholas.D.Pottebaum@who.eop.gov>
Sent: Friday, April 3, 2020 7:12:02 PM
To: Pottebaum, Nic D. EOP/WHO <Nicholas.D.Pottebaum@who.eop.gov>
Cc: Hoelscher, Douglas L. EOP/WHO <Douglas.L.Hoelscher@who.eop.gov>; Swint, Zachariah D. EOP/WHO <Zachariah.D.Swint2@who.eop.gov>; Campana, Ariella M. EOP/WHO <Ariella.M.Campana@who.eop.gov>
Subject: INVITE: State-Federal Technical Assistance on Modeling & Trends (Monday, April 6, 9:00 a.m. ET)



Governors' Senior Staff & State Leaders,

Prior to Monday's (4/6) governors briefing with the Vice President, we are holding a separate briefing call on **State-Federal Technical Assistance on Modeling and Trends to Prepare and Respond to COVID-19 with Ambassador Debi Birx, M.D.,** (*White House Coronavirus Coordinator*) and Senior Administration leaders from the White House, U.S. Department of Health & Human Services, and Federal Emergency Management Agency (FEMA).

The purpose of this call is to provide key modeling information, trends, and technical guidance and explore cross-walk of modeling data to health care capacity data to ensure informed decisions to prepare, respond, and mitigate COVID-19. This call is intended for governors, governors senior staff, state emergency managers, state health officers, state epidemiologists, and other key states leaders.

Briefing Call for State Leaders on Federal-State Technical Assistance on Modeling & Trends

- **Date:** Monday, April 6
- **Time:** 9:00 a.m. ET (please note time zone)
- **Call-In Registration**: **CLICK HERE**

Note: This call is intended for only state officials who are advising their governor on healthcare capacity and needs. Capacity for this call is limited.

Below you will find additional information:

Obtained via MI FOIA by Judicial Watch, Inc.

- Contacting Your FEMA Regional Administrator
- Testing Resources Including Swab & Reagent Flexibilities
- Optimizing the Supply of Personal Protect Equipment
- Recommended Guidance for Extended Use and Limited Reuse of N95 Filtering Facepiece Respirators in Healthcare Settings
- Comments by Amb. Birx on "Whole-of-State" Approach by Governors – April 2, 2020 Task Force in Press Briefing

Please let us know if you have any questions.

Thanks,
Nic
--
Nicholas D. Pottebaum
Special Assistant to the President and Deputy Director
White House Office of Intergovernmental Affairs
O: 202-456-2132 | C: 202-881-7803| E: Nicholas.D.Pottebaum@who.eop.gov

ADDITIONAL INFORMATION

Contacting Your FEMA Regional Administrator

The Federal Emergency Management Agency (FEMA) has activated the National Response Coordination Center (NRCC) 24/7. All requests to the Federal government ***must be formally communicated*** by your **State emergency manager** to your **FEMA Regional Administrator.** This is the same process as natural disasters (e.g., hurricane recovery, flood recovery, tornado recovery, etc.). Reminding your team that if they are not utilizing the connectivity between the state operations center and the FEMA team, they aren't doing right – the good news most folks are now utilizing this path and with your help, we can all ensure effective processes elevate key priorities and questions. In particular, please ensure good connectivity between your state public health director and your state emergency manager.

Testing Resources Including Swab & Reagent Flexibilities

This website offers frequently asked questions relating to the development and performance of diagnostic tests for COVID-19, including information on what commercial laboratories are offering testing**, utilizing alternative swab supplies/methods (flexibilities in the types of swabs your healthcare professionals can use)**, diversification on the types of reagents that can be used, etc. This information should be shared and reviewed by your state public health lab.

- Link to Food & Drug Administration FAQ on Testing including swab and reagent flexibilities.
- **Commercial Testing**: We would encourage all governors to focus on utilizing and expanding commercial testing options. If you have not yet connected with the representatives from Abbott, Roche, and Thermo Fisher, and other private sector testing platforms, we would encourage you to do so as that is where the high-speed testing solution is moving forward.
- **Technical Assistance for State Labs:** 24/7 Technical Assistance for Labs: 1-888-463-6332.

Optimizing the Supply of Personal Protect Equipment

Obtained via MI FOIA by Judicial Watch, Inc.

The Centers for Disease Control & Prevention has updated their guidance on strategies to optimize the supply of PPE. This document contains information for each different type of PPE and specific ways to extend the capacity and supply of PPE.

Strategies for Optimizing the Supply of N95 Respirators
CDC has updated their guidance and graphics on the Use of Personal Protective Equipment when Caring for Individuals with Suspected or Confirmed COVID-19. The updated information shows how to appropriately don and doff PPE with graphics showing both how to wear an N-95 respirator as well as a facemask as an acceptable alternative. More information here.

Comments by Amb. Birx on "Whole-of-State" Approach by Governors – April 2, 2020 Task Force in Press Briefing (full transcript)
"DR. BIRX: Secondly, I just want to make the point that we really applaud the governors that are looking at a whole-of-state or a whole-of-metro approach. And what do I mean by that? The United States, going into this, had about 160,000 ventilators across the United States and another 60- to 70,000 anesthesia machines. That's about five times what most of the European countries have.

But it's a matter of distribution to need. And I really applaud the governors that are bringing together their public hospitals with their more private hospitals and their visibility across their state. Because what we tried to talk about yesterday is every state, every county is different. And that's why we're looking at it at that level of granularity.

And as we move through this epidemic, the needs need to be very tailored to those counties and, frankly, those hospitals. I mean, there's a reason why the President and Mr. Kushner have been very much involved in finding out what the public hospitals need. Why is that? Because the public hospital sometimes have the weakest supply chain because they're often sometimes not as attractive to private sector distributors or they may be too busy caring for the needs of patients to be really on top of their order forms and their supply chains.

So really listening to the community that's at the front of this fight and getting feedback from those specific communities, no matter where they are, and listening to the frontline healthcare workers, because it's their reality that is important to all of us, whether you're the mayor or the governor or the federal government. And if they're saying they need something, we have to work together to supply that.

And so that's what you're seeing with this triangulation. Every county will move through this differently, and that allows us to move around these vital issues that protect the frontline healthcare workers and protect the patients, through the ventilators, to make sure that the supply chain is aligned with the need as it happens.

Now, you have to have very good data in order to be willing to work in that level of granularity. And that's what we've been working on to really develop that level of granularity to ensure that.

So I just wanted to say one other thing about testing, just to give you the bottom-line data of what we're seeing. We appreciate the groups who are reporting; not everyone is reporting yet. And this is part of us trying to understand at a very granular level.

We do have two states that do have 35 percent positives, and that's New York and New Jersey. So that confirms very clearly that that's a very clear and important hot zone.

Obtained via MI FOIA by Judicial Watch, Inc.

Louisiana, though, has 26 percent of their tests are positive. Michigan, Connecticut, Indiana, Georgia, Illinois -- so that should tell you where the next hotspots are coming -- are at 15 percent test positive. And then Colorado, D.C., Rhode Island, and Massachusetts are at 13 percent.

There's a significant number of states still under 10 percent: everyone that I didn't discuss. California and Washington remain steady at an 8 percent rate.

So what we're seeing finally is testing improving -- more testing being done; still a high level of negatives -- in states without hotspots, allowing them to do more of the surveillance and containment.

And then prioritizing this new rapid test kit to those areas that may not have the same amount of access -- to the Indian Health Services, and to the public health institutions, and the public health and state labs so that they can use that and start forward leaning into surveillance.

Now, we know there are people waiting for tests, and they're waiting for tests because when these areas became very -- when they got onto the logarithmic curve, we prioritized people whose decisions -- where the test decision would make it critical for their care. And so we prioritized hospitals and we prioritized nurses and doctors and frontline workers."

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Huls, JoAnne
To:	Gordon, Robert (DHHS)
Subject:	Fwd: Modeling information from Michigan Medicine
Date:	Tuesday, March 24, 2020 3:58:09 PM
Attachments:	Michigan Medicine SIR for State Distribution3.24.xlsx MM COVD19 Model Update Mar 24.pdf

How does this jive with what we ahve?

From: Ross, Kim <roskimbe@med.umich.edu>
Sent: Tuesday, March 24, 2020 2:25:36 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>; Groen, Meghan <GroenM@michigan.gov>; Flood, Jennifer <FloodJ1@michigan.gov>; Elizabeth Hertel <Elizabeth.Hertel@trinity-health.org>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Cc: Parekh, Vikas <viparekh@med.umich.edu>; Pardo, Jennifer <jlbrenn@med.umich.edu>; Garifullin, Max <mgariful@med.umich.edu>
Subject: Modeling information from Michigan Medicine

(Forwarding this message on behalf of Michigan Medicine Capacity Management Team)

We are pleased to share our work related to modeling the potential impact of the Novel Coronavirus epidemic on Michigan Medicine and the projections for demand for inpatient and ICU bed capacity. Our modeling team would be happy to answer any questions and have a video conference to further discuss the model and how it can be applied for state and regional planning. We have attached 2 items to this email. The first is a slide deck that reviews our model structure, inputs and various scenarios focused on Michigan Medicine. The 2nd file is an Excel version of our model which has parameters than can be adjusted to model various scenarios.

The foundation of our model is a standard SIR epidemiological framework. We estimate prevalence of infection and N of infected individuals using the number of hospitalized patients in our system on Day 1 of the model and through application of our regional market share in SE Michigan and an estimated rate of hospitalization. The model could be applied to a region or county as long as population numbers were adjusted and there was a reliable input on the number of Confirmed positive patients hospitalized in the region. Our model has various assumptions regarding the impact of social distancing and primarily uses estimates of doubling time to account for these impacts. Doubling time trajectory can be modified by changing the parameter in that column.

For information, we have also had discussion with Drs. Eisenberg and Martin from the University of Michigan School of Public Health who we understand have also shared their models with you and are working together on future model modifications.

Thank you for the opportunity to share our work and assist in statewide and regional planning. Our team stands ready to help in any way we can.

Sincerely,

Obtained via MI FOIA by Judicial Watch, Inc.

Vikas Parekh, MD
Professor of Internal Medicine
Michigan Medicine
Associate Chief Clinical Officer – Adult Hospitals
Medical Director, Capacity Management
University of Michigan Health System

Jenny Pardo
Senior IT Project Manager, Adult Hospitals
UMHS

Max Garifullin
Senior Staff Specialist, Capacity Management
UMHS

****
Electronic Mail is not secure, may not be read every day, and should not be used for urgent or sensitive issues

Obtained via MI FOIA by Judicial Watch, Inc.

	Date	2xDays	Rate	Susceptible	Infectious	Recovered	New Infected
1	11-Mar	3	7.4464E-08	4,449,823	217	0	0
2	12-Mar	3	7.4464E-08	4,449,751	274	16	57
3	13-Mar	3	7.4464E-08	4,449,660	345	35	71
4	14-Mar	3	7.4464E-08	4,449,545	435	60	90
5	15-Mar	3	7.4464E-08	4,449,401	548	91	113
6	16-Mar	3	7.4464E-08	4,449,220	690	130	142
7	17-Mar	3	7.4464E-08	4,448,991	869	179	179
8	18-Mar	3	7.4464E-08	4,448,703	1,095	241	226
9	19-Mar	3	7.4464E-08	4,448,340	1,380	320	285
10	20-Mar	3	7.4464E-08	4,447,883	1,739	418	359
11	21-Mar	3	7.4464E-08	4,447,307	2,190	542	452
12	22-Mar	3	7.4464E-08	4,446,582	2,759	699	569
13	23-Mar	3	7.4464E-08	4,445,668	3,476	896	716
14	24-Mar	3	7.4464E-08	4,444,518	4,378	1,144	902
15	25-Mar	3	7.4464E-08	4,443,069	5,514	1,457	1,136
16	26-Mar	4	5.8572E-08	4,441,245	6,945	1,851	1,430
17	27-Mar	4	5.8685E-08	4,439,438	8,255	2,347	1,310
18	28-Mar	4	5.8685E-08	4,437,287	9,816	2,936	1,561
19	29-Mar	4	5.8685E-08	4,434,731	11,671	3,638	1,855
20	30-Mar	5	4.9564E-08	4,431,694	13,875	4,471	2,204
21	31-Mar	5	4.9671E-08	4,428,646	15,932	5,462	2,057
22	1-Apr	5	4.9671E-08	4,425,141	18,298	6,600	2,367
23	2-Apr	5	4.9671E-08	4,421,119	21,013	7,907	2,715
24	3-Apr	5	4.9671E-08	4,416,505	24,127	9,408	3,114
25	4-Apr	5	4.9671E-08	4,411,212	27,696	11,132	3,569
26	5-Apr	5	4.9671E-08	4,405,144	31,786	13,110	4,090
27	6-Apr	5	4.9671E-08	4,398,189	36,471	15,380	4,685
28	7-Apr	5	4.9671E-08	4,390,221	41,834	17,985	5,363
29	8-Apr	5	4.9671E-08	4,381,098	47,968	20,974	6,134
30	9-Apr	5	4.9671E-08	4,370,660	54,980	24,400	7,012
31	10-Apr	5	4.9671E-08	4,358,724	62,989	28,327	8,009
32	11-Apr	5	4.9671E-08	4,345,087	72,127	32,826	9,138
33	12-Apr	5	4.9671E-08	4,329,520	82,542	37,978	10,415
34	13-Apr	5	4.9671E-08	4,311,769	94,397	43,874	11,855
35	14-Apr	5	4.9671E-08	4,291,552	107,871	50,617	13,474
36	15-Apr	5	4.9671E-08	4,268,557	123,161	58,322	15,289
37	16-Apr	5	4.9671E-08	4,242,444	140,477	67,119	17,316
38	17-Apr	5	4.9671E-08	4,212,842	160,045	77,153	19,568
39	18-Apr	5	4.9671E-08	4,179,352	182,103	88,585	22,059
40	19-Apr	5	4.9671E-08	4,141,549	206,899	101,592	24,796
41	20-Apr	5	4.9671E-08	4,098,986	234,683	116,371	27,784
42	21-Apr	5	4.9671E-08	4,051,205	265,702	133,134	31,019
43	22-Apr	5	4.9671E-08	3,997,738	300,190	152,112	34,488
44	23-Apr	5	4.9671E-08	3,938,129	338,357	173,555	38,167
45	24-Apr	5	4.9671E-08	3,871,943	380,375	197,723	42,018

Obtained via MI FOIA by Judicial Watch, Inc.

46	25-Apr	5	4.9671E-08	3,798,788	426,360	224,892	45,985
47	26-Apr	5	4.9671E-08	3,718,338	476,355	255,347	49,995
48	27-Apr	5	4.9671E-08	3,630,358	530,310	289,372	53,954
49	28-Apr	5	4.9671E-08	3,534,730	588,058	327,251	57,748
50	29-Apr	5	4.9671E-08	3,431,483	649,302	369,256	61,243
51	30-Apr	5	4.9671E-08	3,320,812	713,593	415,634	64,292
52	1-May	5	4.9671E-08	3,203,106	780,328	466,605	66,735
53	2-May	5	4.9671E-08	3,078,955	848,742	522,343	68,414
54	3-May	5	4.9671E-08	2,949,153	917,920	582,967	69,178
55	4-May	5	4.9671E-08	2,814,689	986,818	648,533	68,898
56	5-May	5	4.9671E-08	2,676,723	1,054,297	719,020	67,479
57	6-May	5	4.9671E-08	2,536,548	1,119,165	794,327	64,868
58	7-May	5	4.9671E-08	2,395,541	1,180,231	874,267	61,067
59	8-May	5	4.9671E-08	2,255,107	1,236,364	958,570	56,132
60	9-May	5	4.9671E-08	2,116,617	1,286,541	1,046,881	50,178
61	10-May	5	4.9671E-08	1,981,357	1,329,906	1,138,777	43,364
62	11-May	5	4.9671E-08	1,850,473	1,365,797	1,233,770	35,891
63	12-May	5	4.9671E-08	1,724,936	1,393,777	1,331,327	27,980
64	13-May	5	4.9671E-08	1,605,518	1,413,639	1,430,883	19,862
65	14-May	5	4.9671E-08	1,492,783	1,425,400	1,531,857	11,760
66	15-May	5	4.9671E-08	1,387,093	1,429,276	1,633,671	3,876
67	16-May	5	4.9671E-08	1,288,618	1,425,660	1,735,762	0
68	17-May	5	4.9671E-08	1,197,366	1,415,079	1,837,595	0
69	18-May	5	4.9671E-08	1,113,205	1,398,163	1,938,672	0
70	19-May	5	4.9671E-08	1,035,894	1,375,604	2,038,541	0
71	20-May	5	4.9671E-08	965,114	1,348,127	2,136,799	0
72	21-May	5	4.9671E-08	900,487	1,316,459	2,233,093	0
73	22-May	5	4.9671E-08	841,605	1,281,309	2,327,126	0
74	23-May	5	4.9671E-08	788,041	1,243,350	2,418,648	0
75	24-May	5	4.9671E-08	739,373	1,203,208	2,507,459	0
76	25-May	5	4.9671E-08	695,185	1,161,453	2,593,402	0
77	26-May	5	4.9671E-08	655,079	1,118,597	2,676,363	0
78	27-May	5	4.9671E-08	618,682	1,075,095	2,756,263	0
79	28-May	5	4.9671E-08	585,643	1,031,341	2,833,056	0
80	29-May	5	4.9671E-08	555,642	987,675	2,906,723	0
81	30-May	5	4.9671E-08	528,383	944,386	2,977,271	0
82	31-May	5	4.9671E-08	503,597	901,715	3,044,727	0
83	1-Jun	5	4.9671E-08	481,042	859,863	3,109,135	0
84	2-Jun	5	4.9671E-08	460,496	818,990	3,170,554	0
85	3-Jun	5	4.9671E-08	441,763	779,223	3,229,053	0
86	4-Jun	5	4.9671E-08	424,665	740,663	3,284,712	0
87	5-Jun	5	4.9671E-08	409,042	703,382	3,337,617	0
88	6-Jun	5	4.9671E-08	394,751	667,431	3,387,858	0
89	7-Jun	5	4.9671E-08	381,664	632,844	3,435,532	0
90	8-Jun	5	4.9671E-08	369,667	599,638	3,480,735	0

Obtained via MI FOIA by Judicial Watch, Inc.

Projected Admits and Census

Adm to MM / day	GenCare	ICU	Total
2	1	1	2
1	1	1	3
1	2	2	3
1	2	2	4
1	3	3	5
1	3	3	6
2	4	4	8
2	4	5	9
3	5	6	11
3	6	7	13
4	8	9	17
5	12	11	23
7	14	14	28
8	17	18	35
10	22	22	44
13	28	28	56
12	32	33	65
14	38	39	77
17	45	46	91
20	53	54	107
19	59	61	120
22	67	68	135
25	75	77	151
29	86	86	171
33	98	95	194
38	110	108	219
43	124	123	246
49	141	139	280
56	162	157	319
65	184	180	364
74	209	206	415
84	237	235	472
96	271	269	540
109	310	307	617
124	353	350	703
141	403	399	801
159	458	454	912
180	521	516	1036
203	591	585	1176
228	669	662	1331
256	756	748	1504
285	853	843	1695
317	959	947	1905
351	1075	1060	2135
387	1200	1183	2384

Counties
Wayne
Oakland
Macomb
Washtenaw
Livingston
Total

Hospital System
Hospitalization
Market Share
Initial Admitted
(=) Total Infected Initial

Recovery
Recovery (days)
Recovery Rate
LOS
ICU %
ICU LOS
Post ICU GC
Combined

Social Distancing
0%
10%
20%
30%
40%
50%

Modifiable Parameters =

This Model was developed by Th
(Jenny Pardo, Max Garifullin, Vik
It uses elements of other publish
All modeling has increasing erro

Obtained via MI FOIA by Judicial Watch, Inc.

423	1336	1315	2651
460	1479	1455	2935
496	1631	1602	3233
531	1788	1753	3542
563	1949	1907	3856
591	2111	2060	4171
614	2269	2209	4478
629	2420	2348	4768
636	2559	2473	5031
634	2680	2578	5258
621	2779	2659	5438
597	2851	2709	5560
562	2890	2724	5614
516	2893	2700	5594
462	2857	2636	5493
399	2780	2528	5308
330	2661	2378	5039
257	2502	2189	4690
183	2304	1963	4268
108	2073	1707	3780
36	1813	1427	3240
0	1546	1146	2692
0	1295	887	2182
0	1062	657	1719
0	852	457	1309
0	667	292	959
0	511	163	674
0	385	72	457
0	274	18	292
0	163	0	163
0	72	0	72
0	18	0	18
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0

Obtained via MI FOIA by Judicial Watch, Inc.

	Notes
1,753,893	*Doubling Time used here are a "baseline" severe scenario
1,259,201	Social distancing interventions may increase doubling time beyond these val
874,759	Empirical data from elsewhere suggests a 5-7 day lag between intervention (
370,963	and change in doubling time
191,224	
4,450,040	We use a SE Michigan 5 county model and population, this could be easily m
16%	This rate is our best estimate from early US data but could be adjusted
5.8%	This is the Michigan Medicine market share in the 5 counties
2	This was the Number of patients admitted to MM on Day 1
217	The above inputs are used to calculated this number
14	This is the CDC estimate and Wuhan China data
0.071428571	
7	For Non-ICU patients, estimated
50%	Current early US data suggests range of 35% to 65% ICU use among hospitali
9	
3	
12	Total LOS for ICU level patients, from Wuhan China data
Doubling Time	
3.0	These are modeled changes to doubling time based on social distancing
3.4	The changes are sensitive to the initial doubling time used
3.9	
4.7	
5.8	
7.7	
	Any parameter highlighted in blue can be modified

ıe Michigan Medicne Capacity and Operational Analytics team
ĸas Parekh)
ıed and publically available models
r as the time horizon increases so outputs must be understood in that context

Obtained via MI FOIA by Judicial Watch, Inc.

Obtained via MI FOIA by Judicial Watch, Inc.

such as school closure)

Obtained via MI FOIA by Judicial Watch, Inc.

Covid-19 Regional and Michigan Medicine Volume Modeling

Vikas Parekh, MD –
Medical Director, Capacity Management – UMHS and ACCO – Adult Hospitals
Max Garifullin, Capacity Management
Jennifer Pardo, Adult Hospitals

Supporting Slides
Mar 24, 2020

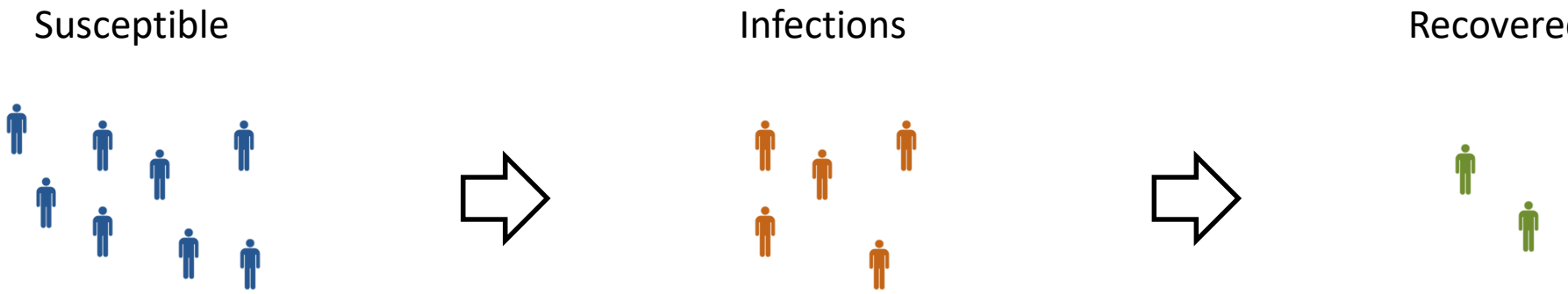
Obtained via MI FOIA by Judicial Watch, Inc.

Agenda

- Epidemiological Model, SIR
- Key parameters and assumptions
- Validation to date
- Factors with largest impact
- Scenarios with social distancing

Obtained via MI FOIA by Judicial Watch, Inc.

SIR Epidemiological Model



Model Parameters

Rate of spread of disease modeled as 3 day doubling time initially (based on international and national data)

Infected individuals are able to spread the disease for 14 days. **16%** of infected individuals have need for hospitalization, and **8%** of infected individuals need intensive care (using early US data)

Patients who are hospitalized will stay in the hospital for 7 days. Patients requiring intensive care will stay in the hospital for 12 days.

Population includes 5 counties in SE Michigan (Wayne, Oakland, Macomb, Washtenaw, Livingston)

Obtained via MI FOIA by Judicial Watch, Inc.

Model Use: Parameters and outputs

[1] Model inputs are shown in blue and can be customized to various populations and health care dynamics

Hospital System	
Hospitalization	16%
Market Share	5.8%
Initial Admitted	2
(=) Total Infected Initial	147
Recovery	
Recovery (days)	14
Recovery Rate	0.071428571
LOS	7
ICU %	50%
ICU LOS	9
Post ICU GC	3
Combined	12

[2] Adjust doubling time

[3] SIR Integration based on the current rate and initial infected

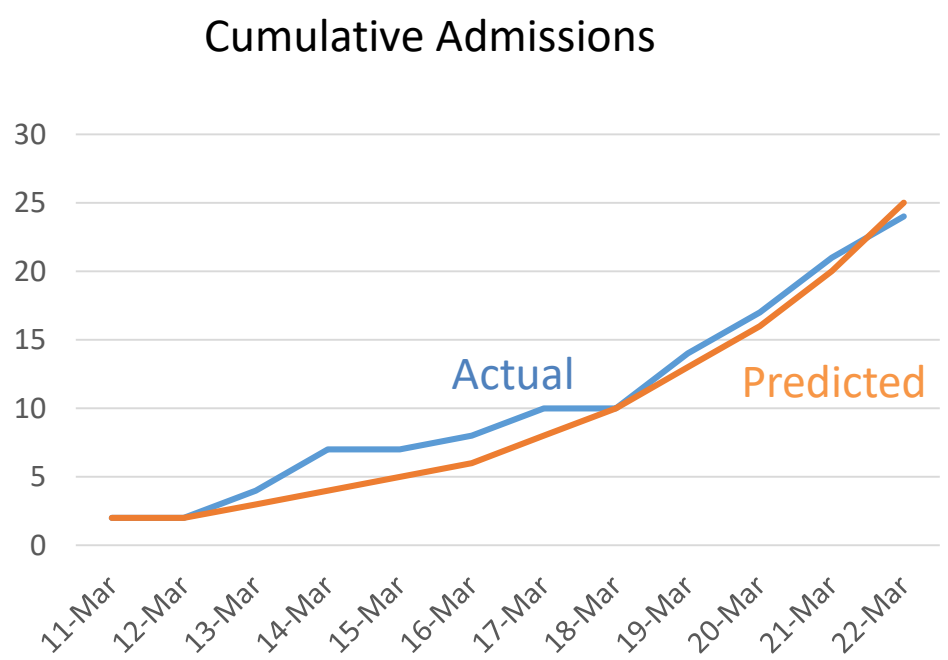
[4] Model outputs include predicted new admits per day and predicted general care and ICU census

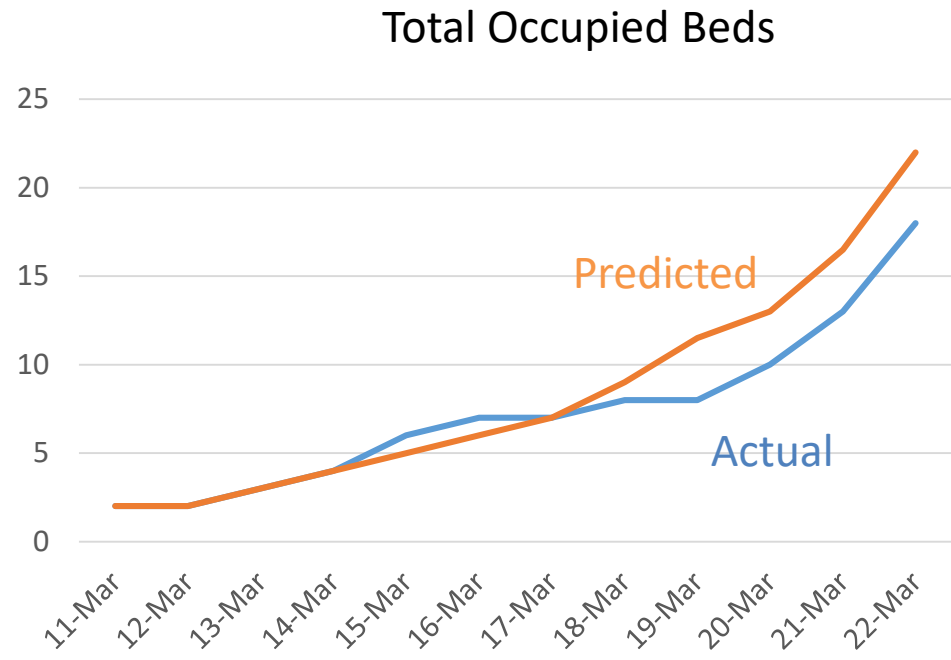
Date	Doubling Time	Susceptible	Infectious	Recovered	New Infected	Adm to MM / day	GenCare	ICU	Total
11-Mar	3	4,449,823	217	0	0	2	1	1	2
12-Mar	3	4,449,751	274	16	57	1	1	1	3
13-Mar	3	4,449,660	345	35	71	1	2	2	3
14-Mar	3	4,449,545	435	60	90	1	2	2	4
15-Mar	3	4,449,401	548	91	113	1	3	3	5
16-Mar	3	4,449,220	690	130	142	1	3	3	6
17-Mar	3	4,448,991	869	179	179	2	4	4	8
18-Mar	3	4,448,703	1,095	241	226	2	4	5	9
19-Mar	3	4,448,340	1,380	320	285	3	5	6	11

Obtained via MI FOIA by Judicial Watch, Inc.

Outputs to date and MM validation

Model validation against actual cumulative admissions and bed occupancy to-date is accurate to +/- 1 day

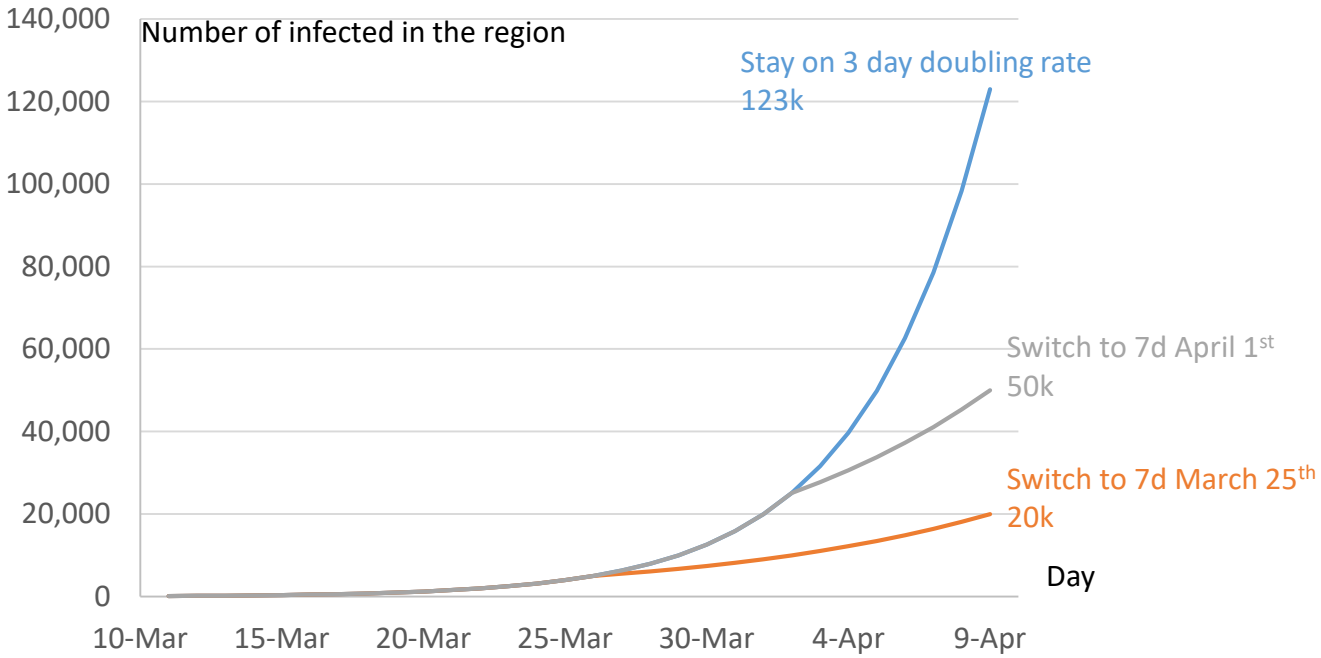




Obtained via MI FOIA by Judicial Watch, Inc.

Which parameters impact the system the most

[1] Timing and magnitude of the infection rate (doubling time)



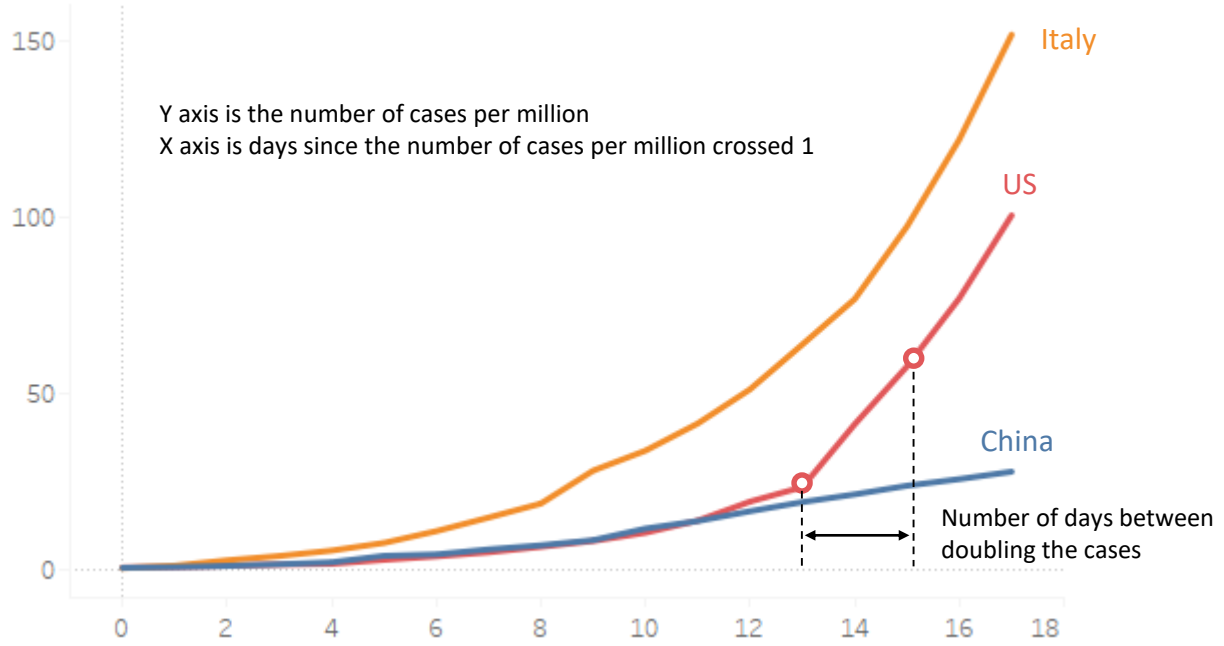
[2] Healthcare utilization assumptions

- Admission rate
- LOS
- ICU use rate

Obtained via MI FOIA by Judicial Watch, Inc.

Social Distancing and Doubling Time

Population adjusted case numbers



Impact of reduction in contacts

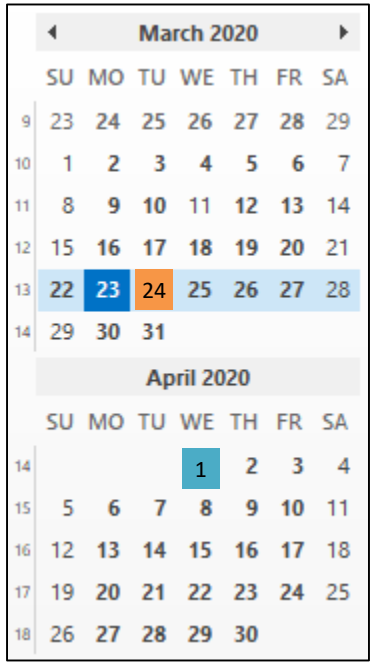
Social Distancing	Doubling time
0%	3.0
10%	3.4
20%	3.9
30%	4.7
40%	5.8
50%	7.7

Some % of the population cannot reduce contacts

Currently US is trending at 2.5 – 3 days between doubling the number of cases
Data Source: JHU CSSE

Obtained via MI FOIA by Judicial Watch, Inc.

Translating National and International Data to the Model



	Italy Scenario	CA/WA Scenario	NY Scenario
16-Mar	3	3	3
17-Mar	3	3	3
18-Mar	3	3	3
19-Mar	3	3	3
20-Mar	3	3	3
21-Mar	3	3	3
22-Mar	3	3	3
23-Mar	3	3	3
24-Mar	3	4	3
25-Mar	4	4	3
26-Mar	4	4	3
27-Mar	4	4	3
28-Mar	4	5	3
29-Mar	5	5	4
30-Mar	5	5	4
31-Mar	5	5	4
1-Apr	5	6	4
2-Apr	5	6	4
3-Apr	5	6	4
4-Apr	5	6	4
5-Apr	5	6	5
6-Apr	5	7	5
7-Apr	5	7	5

Each cell is the doubling time at a certain date

Italy added 1 day to their doubling time after each intervention and impact lags by 6-7 days:

- Moderate social distancing, impact in 6-7 days
- Epicenter region lock-down, impact in 6-7 days
- Closing businesses across Italy, impact in 6 days

CA/WA and NY scenarios are based on expected changes in doubling time over time, given current trajectory

Obtained via MI FOIA by Judicial Watch, Inc.

Modeling Various Scenarios and Assumptions

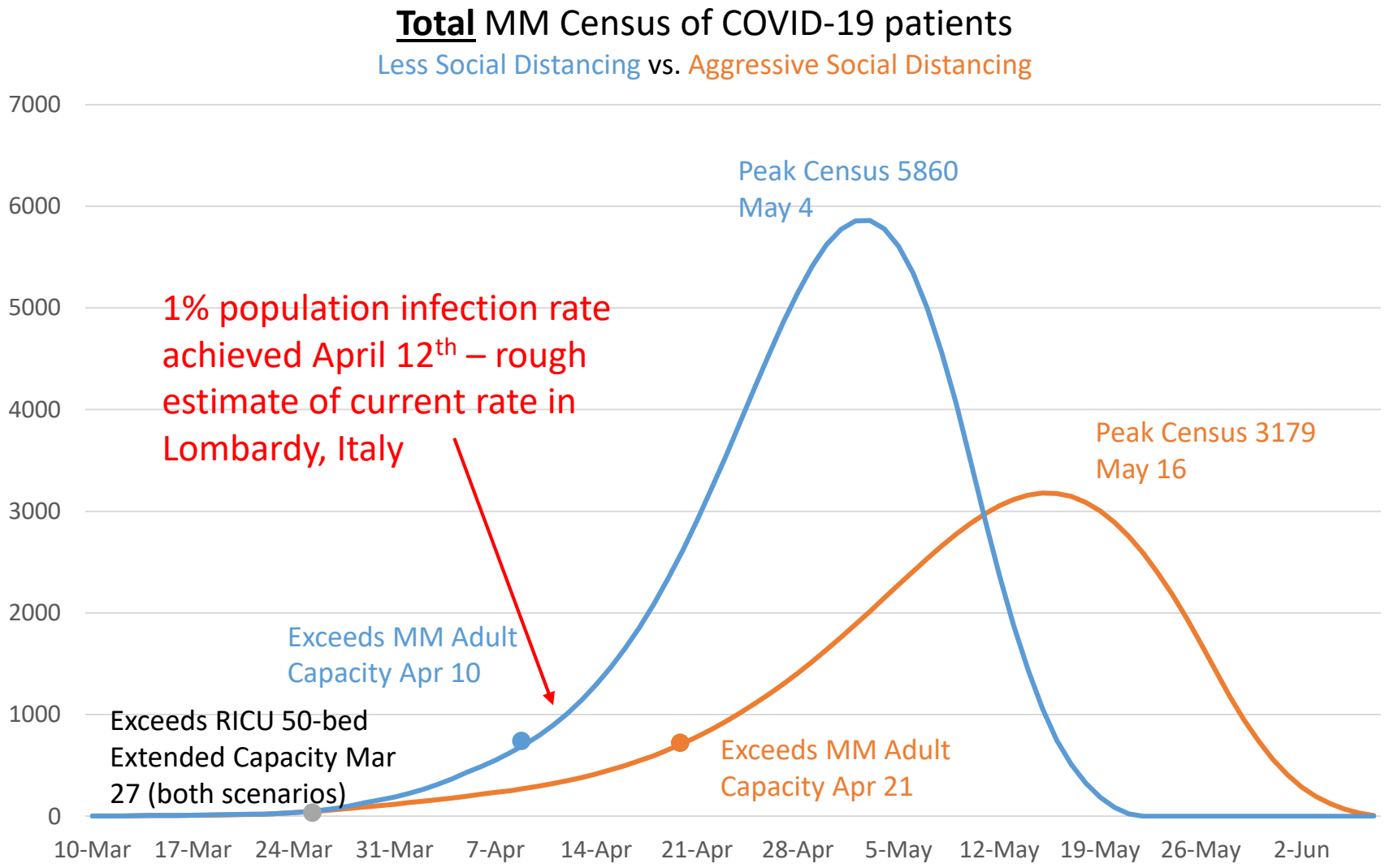
Scenario	Social Distancing / Doubling Time	Similar Region	Hospitalization Rate
Scenario 1a	Aggressive / longer	CA/WA	16%
Scenario 1b	Average / shorter	NY	16%
Scenario 2a	Aggressive / longer	CA/WA	20%
Scenario 2b	Aggressive / longer	CA/WA	12%
Scenario 2c	Average / shorter	NY	20%
Scenario 2d	Average / shorter	NY	12%

Test impact of social distancing only

Test impact of social distancing and hospitalization rates

Obtained via MI FOIA by Judicial Watch, Inc.

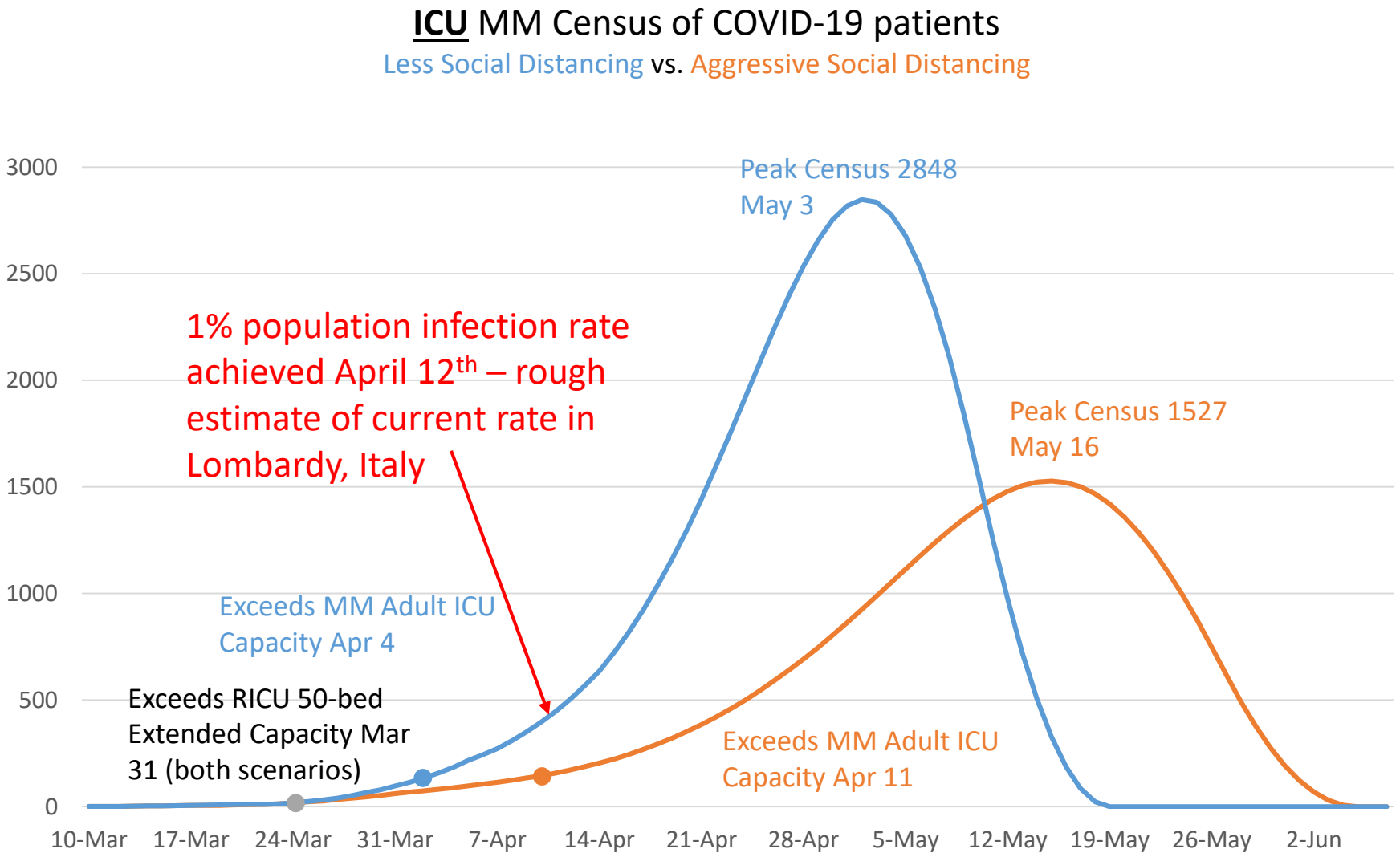
Modeling Social Distancing Total Census [Scenarios 1a and 1b]



Assumes 16% hospitalization rate, 8% ICU rate

Obtained via MI FOIA by Judicial Watch, Inc.

Modeling Social Distancing ICU Census [Scenarios 1a and 1b]



Assumes 16% hospitalization rate, 8% ICU rate

Obtained via MI FOIA by Judicial Watch, Inc.

Detailed Output for Aggressive Social Distancing (Model 1a)

					Predicted for SE Michigan				Predicted for MM			
	Date	2xDays	Rate		Susceptible	Infectious	Recovered	New Infected	Adm to MM / day	GC	ICU	Total
1	11-Mar	3	7.4464E-08	4,449,824	4,449,824	216	0	0	2	1	1	2
2	12-Mar	3	7.4464E-08	4,449,824	4,449,753	272	15	56	0	1	1	2
3	13-Mar	3	7.4464E-08	4,449,824	4,449,663	342	35	71	0	1	1	2
4	14-Mar	3	7.4464E-08	4,449,824	4,449,550	431	59	89	2	2	2	4
5	15-Mar	3	7.4464E-08	4,449,824	4,449,407	543	90	112	3	4	4	7
6	16-Mar	3	7.4464E-08	4,449,824	4,449,227	684	129	141	0	4	4	7
7	17-Mar	3	7.4464E-08	4,449,824	4,449,000	862	178	178	1	4	4	8
8	18-Mar	3	7.4464E-08	4,449,824	4,448,715	1,086	239	224	2	4	5	9
9	19-Mar	3	7.4464E-08	4,449,824	4,448,355	1,368	317	282	0	4	5	9
10	20-Mar	3	7.4464E-08	4,449,824	4,447,902	1,724	415	355	4	6	6	12
11	21-Mar	3	7.4464E-08	4,449,824	4,447,331	2,171	538	448	3	7	8	14
12	22-Mar	3	7.4464E-08	4,449,824	4,446,612	2,735	693	564	4	8	10	18
13	23-Mar	3	7.4464E-08	4,449,824	4,445,706	3,446	888	710	3	10	10	20
14	24-Mar	3	7.4464E-08	4,449,824	4,444,565	4,340	1,134	895	8	15	13	27
15	25-Mar	4	5.8572E-08	4,449,824	4,443,129	5,467	1,444	1,126	10	19	18	36
16	26-Mar	4	5.866E-08	4,443,129	4,441,706	6,499	1,835	1,032	10	23	22	45
17	27-Mar	4	5.866E-08	4,443,129	4,440,013	7,728	2,299	1,229	11	26	27	53
18	28-Mar	4	5.866E-08	4,443,129	4,438,000	9,189	2,851	1,461	14	32	34	65
19	29-Mar	5	4.9543E-08	4,443,129	4,435,608	10,925	3,507	1,736	16	39	40	79
20	30-Mar	5	4.9627E-08	4,435,608	4,433,207	12,545	4,288	1,620	15	46	46	91
21	31-Mar	5	4.9627E-08	4,435,608	4,430,447	14,409	5,184	1,864	17	52	52	104
22	1-Apr	5	4.9627E-08	4,435,608	4,427,279	16,548	6,213	2,139	20	57	61	117
23	2-Apr	6	4.3712E-08	4,435,608	4,423,643	19,002	7,395	2,454	23	66	68	134
24	3-Apr	6	4.3831E-08	4,423,643	4,419,969	21,319	8,752	2,317	22	74	74	148
25	4-Apr	6	4.3831E-08	4,423,643	4,415,839	23,926	10,275	2,607	24	83	81	164
26	5-Apr	6	4.3831E-08	4,423,643	4,411,208	26,848	11,984	2,922	27	90	89	179

Assumptions:
Doubling time follows aggressive social distancing approach
16% hospitalization rate
8% ICU rate

Obtained via MI FOIA by Judicial Watch, Inc.

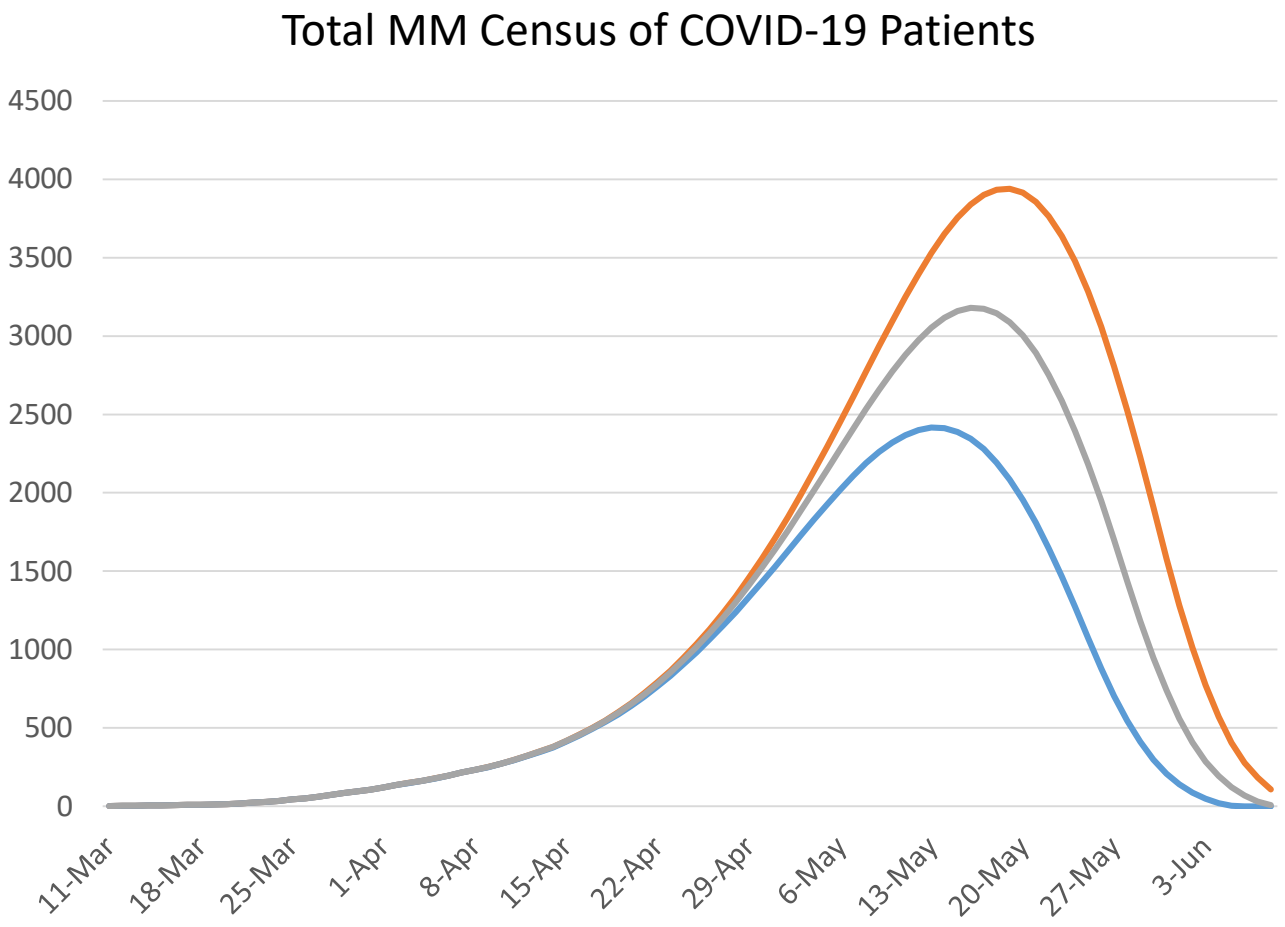
Modeling Social Distancing Key Dates for Michigan Medicine

	Aggressive Social Distancing	Less Social Distancing	Previous Model (3/16/2020)
Gen Care + ICU Census Exceeds Capacity of RICU (50 bed)	March 27	March 27	March 30
ICU Census Exceeds Capacity of RICU (50 beds)	March 31	March 31	April 6
ICU Census Exceeds Adult ICU Capacity (140 beds)	April 11	April 4	
Total Census Exceeds Total Adult Capacity (671 beds)	April 21	April 9	April 11
Hospitalized Patient Census Peak	May 16	May 4	

Key modifications from Previous Model:
Modified doubling time from 3 days to dynamic (as previously described)
Baseline hospitalization rate modified from 12% to 16%
Percent of total hospitalized who need ICU modified from 20% to 50%
LOS ICU modified from 9 days to 12 days
Shifted model 6 days prior to account for date when first COVID-19 positive patients arrived
MM Market Share modified from 8.5% to 5.8%

Obtained via MI FOIA by Judicial Watch, Inc.

Admission Rates under Aggressive Social Distancing [1a, 2a, 2b]



Hospitalization Rate	Peak & Date	Exceeds MM Capacity
12%	May 12 – 2,416	April 20
16% (as in Wuhan)	May 15 – 3,179	April 20
20% (as in US to-date)	May 19 – 3,940	April 21

Due to exponential increase in the population, the point of crossing Adult capacity is within 3 days for all scenarios and roughly aligns with April 21st

The rate impacts magnitude of the peak

Obtained via MI FOIA by Judicial Watch, Inc.

Percent Active Infected Relative to Population

Date	SE MI Population	Active Infected	Percent of Population	Census
12-May	4,450,040	682,942	15%	2975
13-May	4,450,040	720,409	16%	3054
14-May	4,450,040	757,453	17%	3116
15-May	4,450,040	793,728	18%	3159
16-May	4,450,040	828,878	19%	3179
17-May	4,450,040	862,549	19%	3175
18-May	4,450,040	894,391	20%	3145
19-May	4,450,040	924,075	21%	3088
20-May	4,450,040	951,296	21%	3004
21-May	4,450,040	975,781	22%	2891
22-May	4,450,040	997,298	22%	2752
23-May	4,450,040	1,015,661	23%	2585
24-May	4,450,040	1,030,732	23%	2395
25-May	4,450,040	1,042,424	23%	2182
26-May	4,450,040	1,050,702	24%	1949

During times at and around peak hospital census, approximately 20% of population is estimated to have active COVID-19 infection

Obtained via MI FOIA by Judicial Watch, Inc.

Active Infected in Population: 1%= Lombardy, Italy

Date	SE MI Population	Active Infected	% Active Infected	Hospital Census
11-Mar	4,450,040	216	0%	2
12-Mar	4,450,040	272	0%	2
13-Mar	4,450,040	342	0%	2
14-Mar	4,450,040	431	0%	4
15-Mar	4,450,040	543	0%	7
16-Mar	4,450,040	684	0%	7
17-Mar	4,450,040	862	0%	8
18-Mar	4,450,040	1,086	0%	9
19-Mar	4,450,040	1,368	0%	9
20-Mar	4,450,040	1,724	0%	12
21-Mar	4,450,040	2,171	0%	14
22-Mar	4,450,040	2,735	0%	18
23-Mar	4,450,040	3,446	0%	20
24-Mar	4,450,040	4,340	0%	27
25-Mar	4,450,040	5,467	0%	36
26-Mar	4,450,040	6,499	0%	45
27-Mar	4,450,040	7,728	0%	53
28-Mar	4,450,040	9,189	0%	65
29-Mar	4,450,040	10,925	0%	79
30-Mar	4,450,040	12,545	0%	91
31-Mar	4,450,040	14,409	0%	104
1-Apr	4,450,040	16,548	0%	117
2-Apr	4,450,040	19,002	0%	134
3-Apr	4,450,040	21,319	0%	148
4-Apr	4,450,040	23,926	1%	164
5-Apr	4,450,040	26,848	1%	179
6-Apr	4,450,040	30,121	1%	196
7-Apr	4,450,040	33,786	1%	217
8-Apr	4,450,040	37,272	1%	233
9-Apr	4,450,040	41,143	1%	251
10-Apr	4,450,040	45,405	1%	272

Date	SE MI Population	Active Infected	% Active Infected	Hospital Census
11-Apr	4,450,040	50,095	1%	296
12-Apr	4,450,040	55,255	1%	322
13-Apr	4,450,040	60,926	1%	350
14-Apr	4,450,040	67,156	2%	380
15-Apr	4,450,040	73,995	2%	416
16-Apr	4,450,040	81,496	2%	456
17-Apr	4,450,040	89,716	2%	498
18-Apr	4,450,040	98,714	2%	545
19-Apr	4,450,040	108,555	2%	595
20-Apr	4,450,040	119,303	3%	653
21-Apr	4,450,040	131,028	3%	715
22-Apr	4,450,040	143,799	3%	782
23-Apr	4,450,040	157,688	4%	854
24-Apr	4,450,040	172,766	4%	932
25-Apr	4,450,040	189,104	4%	1016
26-Apr	4,450,040	206,772	5%	1105
27-Apr	4,450,040	225,832	5%	1201
28-Apr	4,450,040	246,346	6%	1301
29-Apr	4,450,040	268,362	6%	1408
30-Apr	4,450,040	291,922	7%	1520
1-May	4,450,040	317,053	7%	1638
2-May	4,450,040	343,765	8%	1760
3-May	4,450,040	372,052	8%	1885
4-May	4,450,040	401,881	9%	2014
5-May	4,450,040	433,198	10%	2146
6-May	4,450,040	465,919	10%	2278
7-May	4,450,040	499,928	11%	2408
8-May	4,450,040	535,077	12%	2536
9-May	4,450,040	571,185	13%	2658
10-May	4,450,040	608,037	14%	2774
11-May	4,450,040	645,382	15%	2881

Obtained via MI FOIA by Judicial Watch, Inc.

Summary

Under each scenario, census of COVID-19 patients exceeds capacity of RICU this week

Social distancing and state shut-down interventions will lower the peak hospital bed need but have limited impact on when we will exceed the capacity of this hospital

Model outputs have higher degree of uncertainty beyond 1 week view and will be updated periodically

Obtained via MI FOIA by Judicial Watch, Inc.

References

Obtained via MI FOIA by Judicial Watch, Inc.

References

Johns Hopkins University CSSE https://data.humdata.org/dataset/novel-coronavirus-2019-ncov-cases
CDC https://www.cdc.gov/coronavirus/2019-ncov/index.html
Lancet https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext
JAMA: Clinical Characteristics of 138 Hospitalized Patients With 2019 Novel Coronavirus–Infected Pneumonia in Wuhan, China
https://worldpopulationreview.com/us-counties/mi/

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Huls, JoAnne
To:	Gordon, Robert (DHHS); Hertel, Elizabeth (DHHS); Foster, Tricia
Cc:	Totten, Mark
Subject:	Fwd: offer to help- Palantir
Date:	Sunday, March 29, 2020 2:27:53 PM
Attachments:	Palantir- Covid-19 Response.pdf COVID-19 COMMS Outreach W GIFS[1].emltpl

Take or leave

From: Jack Oliver <jack@jackloliver.com>
Sent: Sunday, March 29, 2020 2:19:59 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>
Cc: Kevin Kawasaki <kkawasaki@palantir.com>
Subject: offer to help- Palantir

Joanne

Palantir Technologies is currently serving under contract as a technical agent to the Department of Health and Human Services National Response Coordination Center and the Centers for Disease Control and Prevention (CDC) on response efforts for COVID-19.
Palantir has assembled public data to form a Global Common Operating Picture for COVID-19. Includes public data sources from numerous state agencies worldwide e.g. granular case reports, population statistics, mortality rates, hospital locations and capacity, marine traffic, international border status. Federal data is also available upon HHS approval.

We are providing the data, predictive modeling technology, and engineering services to state and local governments completely pro-bono.
You can find a video demonstration of our platform here [view.highspot.com]. We can also show you a live version on the data relevant for MI from a brief 15min presentation.
We can get a member of your team onboarded immediately. As a first step, please put us in touch with someone on your team focused on any of the following: Data collection, analytics, predictive modeling, forecasting,…etc.
All the best,

jack

Obtained via MI FOIA by Judicial Watch, Inc.

Palantir Technologies is currently serving under contract as a technical agent to the Department of Health and Human Services National Response Coordination Center and the Centers for Disease Control and Prevention (CDC), under the leadership of the White House Coronavirus Task Force, on response efforts for COVID-19. As part of this effort, the Government is seeking to understand the spread of the virus and the implications on critical resources in the U.S. supply chain.

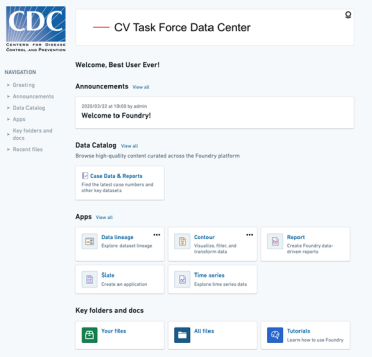


Fig. 1 - CDC Palantir Foundry Landing Page

Much of the information relevant to these areas rests within the private sector. The Government is requesting private sector partners consider sharing relevant information to contribute to this common picture and facilitate the United States response. The Government is looking for information on inventories, supply chains, and manufacturing capacity of key resources including medical equipment and devices, key pharmaceutical inputs and products, and basic needs for the continuing support of the population. This information will be used to develop a common operating picture and to guide short and long term responses to mitigate the impact of the COVID 19 pandemic. The common operating picture will limit access to proprietary information to data needed to make operational decisions. For example, City officials will have names of hospitals to facilitate resupplying or redirecting resources to hospitals in greatest need. This information will be critical for United States officials to make optimal decisions in response to spread of COVID-19. Please let us know if you would be willing to partner with CDC through Palantir Technologies to expedite information sharing.

Please let us know if you'd like access to the common operating picture being constructed via the CDC and HHS through Palantir Technologies and can contribute relevant information to build a more complete picture.

What is Available Today in the Common Operating Picture

- Immediate access. The platform is available to federal government users, state and local government users, and commercial users, subject to government approval. Some data access will be limited or permitted based on prior approvals or data privacy, security, compliance, and HIPAA concerns.
- Robust, updating, integrated data asset growing by the day. Data integrated into a synthesized object and geospatial view currently includes:
    - Critical infrastructure (hospitals including capacity, pharmacies, areas of need and risk, EMS data)
    - Consolidated COVID-19 data (CDC case reporting data, CDC lab data)
    - Related medical data (ILI-Net and NRVESS)
    - Stockpile and supply chain data.
- Local context and alerting capability on above data feeds and related events
- Ability to leverage or construct forecasting models on consolidated and integrated data

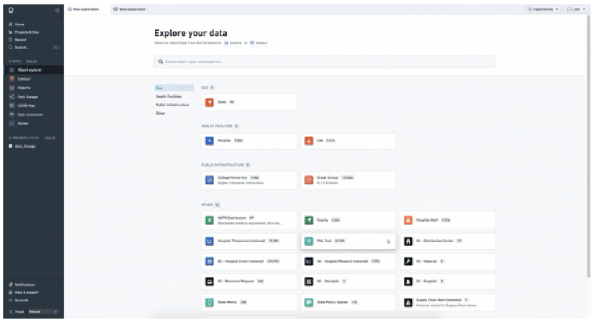


Fig 2. Enabling up-to-date data with direct connections

Obtained via MI FOIA by Judicial Watch, Inc.

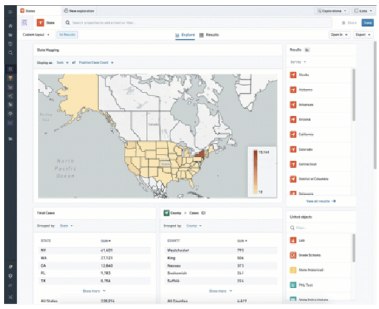


Fig. 3 - Embedding Local Context and alerts on top of states

What Will Be Included Next in the Common Operating Picture

- Data will be integrated and augmented daily, with immediate priorities including
  - Additional commercial lab data
  - Additional EMS status and bypass data
  - Federal data views on hospital utilization, availability, and staffing data

What You Can Contribute Back to the Common Operating Picture

Please consider how your organization can contribute data back to this common operating picture to improve the decision-making for other organizations. Information can be securely shared within this environment to ensure only the appropriate organizations have access to only agreed upon views or aggregations of the underlying information.

In particular, the following data would be uniquely valuable to influence decision-making for the public and private sector:

- Hospital Information
  - Hospital/ICU bed-level capacity, admittance and current utilization
  - Inventory levels of key healthcare equipment
- COVID-19 Test Information
  - Current inventories/stockpiles of COVID-19 test kits and materials
  - Current orders and shipments of the above goods
  - Production schedules for the above goods
- Healthcare Equipment, Supplies, & PPE
  - Current inventories or stockpiles of critical goods such as ventilators, masks, respirators, gloves, gowns, disinfectants, etc… at as granular a level as shareable (store/DC, zip-code, etc.)
  - Current orders and shipments of the above goods
  - Production schedules for the above goods
- Pharmaceutical Goods and Medicines
  - Current inventories or stockpiles of critical goods such as COVID-19 therapeutics, drug raw materials, etc.
  - Current orders, prescriptions, or shipments of the above goods
  - Production schedules for the above goods
- Basic Needs
  - Current inventories or stockpiles of basic needs such as food and other staples
  - Current orders, prescriptions, or shipments of the above goods
  - Production schedules for the above goods

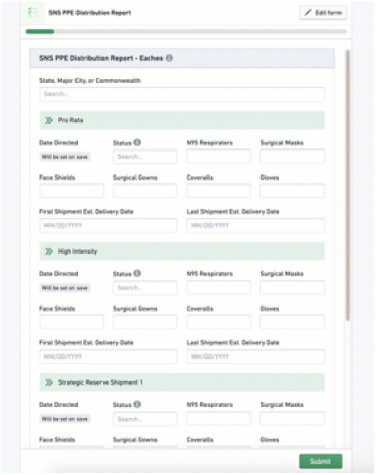


Fig. 4 - Ushering in supply chain with ASPR Data Integration and creating the ASPR future form

© 2020 Palantir Technologies Inc.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark
Subject: Fwd: Rapid Response Staffing
Date: Friday, July 31, 2020 4:45:43 PM
Attachments: Rapid_Response_Staffing_Guidance_for_LTC_Facilities_Final_Updated_7-22_696958_7.pdf

---

This is revised.

From: Emerson, Erin (DHHS) <EmersonE@michigan.gov>
Sent: Friday, July 31, 2020 4:42 PM
To: Gordon, Robert (DHHS)
Subject: Rapid Response Staffing

Obtained via MI FOIA by Judicial Watch, Inc.

Michigan Department of Health & Human Services

Rapid Response Staffing in Long-Term Care Facilities

Updated July 22, 2020

The Michigan Department of Health and Human Services will be offering Rapid Response Staffing Resources in select counties to assist long-term care facilities who may be experiencing a staffing shortage. Rapid Response Staffing Resources will be available to nursing homes, assisted living centers, homes for the aged, and adult foster care homes.

Rapid Response Regions: Staffing will be available in

- West Michigan: Kent, Ottawa, Allegan, Muskegon, Newago, Montcalm Counties
- Southeast Michigan: Wayne, Oakland, Macomb, Livingston, Washtenaw Counties

Currently, MDHHS is only able to offer staffing support in the above listed counties.

Rapid Response Staffing Availability:
MDHHS will provide short term (72 hours or less) of consecutive staffing assistance to facilities facing staffing shortages. Staffing services will be supplied by 22nd Century Technologies, Inc. (TSCTI)

- Facilities will be able to request a maximum of one registered nurse and four certified nursing assistance/resident care assistants per shift
- Staffing will provide up to a total of 72 consecutive hours of staffing coverage

Facilities requesting staffing assistance **must demonstrate that they meet the criteria** in Appendix A by completing a brief survey within 24 hours of requesting staffing support. The survey requests basic details about the facility, number of staff who have missed shifts, whether emergency staffing protocols have been enacted, and if the facility has reached out to staffing agency for assistance. Any questions about Rapid Response Staffing can be sent to MDHHS-LTCStaffing@michigan.gov. Please note, requests for staffing assistance cannot be made via email.

If a facility fails to meet the criteria or fails to submit the survey within 24 hours of requesting staffing, the facility will be billed by MDHHS for the staffing costs.

To Request Rapid Response Staffing:

Contact 22nd Century Technologies, Inc (TSCTI) at 800-674-8380

Facilities must meet all criteria in Appendix A and complete the survey within 24 hours of requesting staffing resources.

By requesting staffing supports, facilities agree they have met the required criteria and will complete the survey. Failure to either meet the criteria when requesting staff resources or completing the survey will result in MDHHS invoicing the facility directly for the cost of staffing supports.

Obtained via MI FOIA by Judicial Watch, Inc.



Requesting Facility Responsibilities:
The Requesting Facility must:

- Provide onsite supervision, at all times, while temporary staffing agency employees are working.
- Conduct orientation of temporary staffing agency employees to types of care provided and regulatory oversight requirements that are applicable to duties being assigned.
- Assess and only assign temporary staffing agency employees to duties that meet their specific qualifications and skills.
- Orient temporary staffing agency employees to patient or resident care plans as applicable to duties assigned.

Obtained via MI FOIA by Judicial Watch, Inc.

Appendix A: Long-Term Care Facility Emergency Staffing Criteria

Criteria for Requesting Staffing Support			
Facility Type	Demonstrated Need for Staffing Assistance	Enacted Emergency Protocol for Staffing	Facility Reached Out to a Staffing Agency but No Staff Available
Nursing Home	*Emergency Staffing*: 50% or more of scheduled nursing care staff (RNs, LPNs, and CNAs) have missed two shifts in a row and the absences are unrelated to a strike or labor dispute	• If the home shares ownership or operational management with 5 or more nursing homes, have requested backup support from those homes • If part of a corporate structure with regional staff, have called upon those employees to provide care and supervision to residents. • Have conducted outreach to local Emergency Operations Center to explore coverage with medical volunteers • Have called upon staff in administration (Administrator, Director of Nursing, other department heads) to assist with providing direct care, supervision and non-ADL needs	Yes, staffing agency did not have staff available No, did not reach out to a staffing agency
Homes for the Aged	*Emergency* Staffing: 50% or more of scheduled staff have missed two shifts in a row and the absences are unrelated to a strike or labor dispute	• If the home shares ownership or operational management with 5 or more homes, have requested backup support from those homes • If part of a corporate structure with regional staff, have called upon those employees to provide care and supervision to residents • If part of a continuing care retirement community, have requested staffing support from other areas of the CCRC operation • Enlisted members of management staff to assist with resident care and supervision where appropriate • Have conducted outreach to local Emergency Operations Center to explore coverage with medical volunteers	Yes, staffing agency did not have staff available No, did not reach out to a staffing agency

Obtained via MI FOIA by Judicial Watch, Inc.

Assisted Living Centers	*Emergency* Staffing: 50% or more of scheduled staff have missed two shifts in a row and the absences are unrelated to a strike or labor dispute	• If the home shares ownership or operational management with 5 or more homes, have requested backup support from those homes • If part of a corporate structure with regional staff, have called upon those employees to provide care and supervision to residents • If part of a continuing care retirement community, have requested staffing support from other areas of the CCRC operation • Enlisted members of management staff to assist with resident care and supervision where appropriate • Have conducted outreach to local Emergency Operations Center to explore coverage with medical volunteers	Yes, staffing agency did not have staff available No, did not reach out to a staffing agency
Adult Foster Care Home Licensed as Large or Congregate	*Emergency Staffing*: 50% or more of scheduled staff have missed one shift and the absences are unrelated to a strike or labor dispute	• If the home shares ownership or operational management with 3 or more AFC homes, have requested backup support from those homes • If part of a corporate structure with regional staff, have called upon those employees to provide care and supervision to residents. • Enlisted members of management staff to assist with resident care and supervision where appropriate	Yes, staffing agency did not have staff available No, did not reach out to a staffing agency
Adult Foster Care Home Licensed as Family or Small	*Emergency Staffing*: 50% of scheduled staff have missed one shift or there is reason to believe that staff will not be able to report for the next shift and the absences are unrelated to a strike or labor dispute	• If the home shares ownership or operational management with 3 or more AFC homes, have requested backup support from those homes.	Yes, staffing agency did not have staff available No, did not reach out to a staffing agency

Obtained via MI FOIA by Judicial Watch, Inc.

Appendix B: Frequently Asked Questions

1. **Who is eligible to receive Emergency Staffing Resources?**
   Long-term care facilities (nursing homes, assisted living center, homes for the aged, and adult foster care homes) are eligible to receive emergency staffing resources if they have met MDHHS criteria, which includes:
   - Reside in one of the following counties: Kent, Ottawa, Allegan, Muskegon, Newago, Montcalm, Wayne, Oakland, Macomb, Livingston, Washtenaw
   - Demonstrated need for staffing, with specific staffing thresholds for each facility type
   - Enacted all the steps in the emergency protocol for staffing listed by facility type
   - Reached out to other staffing agencies without success of obtaining additional staff

2. **How do I access Emergency Staffing Resources if my facility meets all the criteria?**
   Once a facility has met all of the criteria, they can contact **22nd Century Technologies, Inc. (TSCTI) at 800-674-8380**. Facilities also must submit a survey certifying they have met criteria to MDHHS no later than 24 hours after submitting a request to TSCTI. **Failure to submit the survey or failure to meet the specified criteria *will result in the LTC facility being billed for all staffing services provided by* TSCTI.**

3. **How much and what types of staffing support will be available?**
   Facilities should only request the number of staff needed to fill in vacant positions. Facilities can request up to 5 staff members per shift that can include one registered nurse and up to four certified nursing assistants and/or residents care assistants.

4. **What if I need more than 5 staff members?**
   Facilities requiring more than the five allocated staff members can work with TSCTI or another temporary staffing agency to obtain additional staffing, however, the facility will have to pay for any staff support over the initial five covered under emergency staffing.

5. **How many shifts will TSCTI cover?**
   TSCTI will provide 72 consecutive hours of staffing services.

6. **What if I need staffing for longer than 72 hours?**
   LTC facilities that require longer term staffing than 72 hours, or who do not meet the criteria listed in Appendix A, or who reside outside of the select counties, can contact TSCTI at 800-674-8380 or another temporary staffing agency, who may have additional staffing resources available. LTC facilities will be responsible for contracting for services directly with the staffing agency. MDHHS will not pay for these services.

   Additionally, Medefis, an AMN Technology, is providing a portal to connect healthcare facilities with a network of regional and national staffing agencies to supply additional nursing professionals. There is no cost to the healthcare facility to join. Interested facilities can contact Brian Tobin at 402-315-1103 or Brian.Tobin@medefis.com.

7. **What if my facility finds another staffing contractor, will MDHHS pay for that?**
   No, if a facility is able to access another staffing agency then the facility *does not* meet the criteria for emergency staffing resources. MDHHS is only providing support for emergency staffing needs through TSCTI to facilities who have been unable to obtain staffing elsewhere.

Obtained via MI FOIA by Judicial Watch, Inc.

8. **What if my facility is not in one of the listed counties?**
   LTC facilities outside of the listed county can still request staffing support from TSCTI or another temporary staffing agency, however, the facility will be responsible for entering into an agreement with staffing contractor and paying for staffing resources.

9. **My facility is having difficulties filling out the survey documenting that the criteria for staffing was met, who should I contact?**
   The facility can contact MDHHS at MDHHS-LTCStaffing@michigan.gov. Please note, staffing requests cannot be emailed. If a facility is unable to complete the survey within 24 hours, and contacts the inbox during that window, the facility will not be penalized for failure to submit the survey. This inbox is staffed Monday-Friday 8am-5pm

10. **What type of tasks can the staff from TSCTI perform?**
    The staffing resources will support LTC facilities based on facility and resident need, but will be prepared to assist with activities of daily living (bathing, dressing, transferring, toileting, eating); provide infection prevention assistance; and provide environmental cleaning assistance. If a facility has a specific need or request, they should discuss that with TSCTI.

11. **Will TSCTI conduct licensing and background checks?**
    Yes, the individuals who will provide staffing support to long-term care facilities will be vetted by TSCTI including a criminal background check and a licensure check prior to being assigned to a facility. TSCTI will have this information available upon facility request.

12. **Will staff from TSCTI undergo TB and COVID-19 screenings?**
    As part of vetting by TSCTI, staff do have to provide negative TB test results. Currently, TSCTI is not including COVID-19 testing as part of their vetting process. However, temperature checks are taken for staffing coming in and out of facilities.

13. **Do the staff from TSCTI have to comply with the Emergency Order for weekly testing of Nursing Facility staff?**
    Yes, in some situations. Rapid Response Staffing Resources will only be available for a maximum of 72 consecutive hours. If nursing facilities are completing their routine, weekly testing of staff during the period that TSCTI is providing staffing support, then TSCTI staff should be tested. If TSCTI staff are no longer in the building when weekly testing occurs, they do not have to be tested as part of the facility.

14. **My facility is experiencing a strike or labor dispute, can we request Rapid Response Staffing Resources?**
    No, facilities experiencing a staffing shortage due to a strike or labor dispute do not meet criteria for Rapid Response Staffing Resources, as defined in Appendix A. If a facility requests Rapid Response Staffing Resources for a labor dispute or strike, the facility may be subject to recoupment or other consequences. Facilities can independently request staffing support from temporary staffing agencies in these circumstances. The facility will be solely responsible for entering into an agreement with staffing contractor and paying for staffing resources. MDHHS will not pay for services.

15. **I have additional questions that were not answered here, who should I contact?**
    Question can be sent to MDHHS at MDHHS-LTCStaffing@michigan.gov. Please note, staffing requests cannot be emailed, and this inbox is staffed Monday-Friday 8am-5pm.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark; Pohl, Zack
Cc: Khaldun, Joneigh (DHHS); Sutfin, Lynn (DHHS); Massey, Kate (DHHS); Emerson, Erin (DHHS)
Subject: Fwd: Request for comment
Date: Wednesday, August 26, 2020 3:35:15 PM

Big escalation of bogus argument. Happy to help w response.

From: Sutfin, Lynn (DHHS) <SutfinL1@michigan.gov>
Sent: Wednesday, August 26, 2020 3:25 PM
To: Emerson, Erin (DHHS); Massey, Kate (DHHS); Gordon, Robert (DHHS)
Cc: Bouknight, Rey (DHHS); Darling, Darice (DHHS)
Subject: FW: Request for comment

As this was addressed to the Governor, I have directed him to Gov Comms. Wanted you to be aware.

From: Boucher, Dave <dboucher@freepress.com>
Sent: Wednesday, August 26, 2020 2:51 PM
To: Sutfin, Lynn (DHHS) <SutfinL1@michigan.gov>
Subject: Request for comment

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Good afternoon,

We just received this press release from the Department of Justice: https://www.justice.gov/opa/pr/department-justice-requesting-data-governors-states-issued-covid-19-orders-may-have-resulted

-- Does Michigan plan to comply with the request?
-- Does DHHS agree with the assertion that actions taken by the state "may have resulted in the deaths of thousands of elderly nursing home residents"?
-- Does the state require nursing homes to admit people who have COVID-19?

Any information as soon as possible would be appreciated.

Thanks,

Dave Boucher

Obtained via MI FOIA by Judicial Watch, Inc.

Government and politics reporter

Detroit Free Press, part of the USA TODAY NETWORK

Mobile: 313-938-4591

Twitter: @Dave_Boucher1

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Foster, Tricia; Gordon, Robert (DHHS)
Subject: Fwd: RJX and Covid-19-Information from Dr. Jurgen Luders
Date: Sunday, March 29, 2020 5:14:26 PM

Where does this go? You will note that this person is a friend of the Governors, so I would like them to be responded to (as we do all people :)).

If this isn't state - I'll send them to our fed team.
Thanks

From: Forsyth, Andrea <AForsyth@plunkettcooney.com>
Sent: Saturday, March 28, 2020 9:30:56 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>
Subject: Re: RJX and Covid-19-Information from Dr. Jurgen Luders

Thank you! I can connect you with Dr. Luders directly if you like. Please let me know if you'd like his phone number.

> On Mar 28, 2020, at 8:19 PM, Huls, JoAnne <HulsJ1@michigan.gov> wrote:
>
> **[EXTERNAL]**
>
> Hi Andrea,
>
> I'm going to study your email to the Governor and I'll figure out the right person for you to talk to next.
>
> All the best,
> JoAnne
>
> ---
>
> **From:** Forsyth, Andrea <AForsyth@plunkettcooney.com>
> **Sent:** Saturday, March 28, 2020 6:55:43 PM
> **To:** Gretchen Whitmer [redacted]
> **Cc:** Whitmer, Gretchen <WhitmerG1@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
> **Subject:** Re: RJX and Covid-19-Information from Dr. Jurgen Luders
>
> Thank you! Home and healthy and grateful for your leadership! Please let me know if there is anything I can do to help. Seriously...anything.
>
> I hope you're well. Take care of yourself. I would love to catch up when things finally settle down.

Obtained via MI FOIA by Judicial Watch, Inc.

Keep up the good work!

Much love, Andrea

On Mar 28, 2020, at 4:30 PM, Gretchen Whitmer [redacted] wrote:

[EXTERNAL]

thank you Andrea - - your friendship means a lot to me! I am copying my
COS on this so we ascertain what the right next step is! Be well and stay home!

On Sat, Mar 28, 2020 at 1:39 PM Forsyth, Andrea <AForsyth@plunkettcooney.com> wrote:

> Gretchen:
>
> Please see the email below from Dr. Jurgen Luders, as well as the attached PDF. Jurgen is Chief of Neurosurgery at Mercy Health here in G.R. He is also Chief Medical Officer for Reven, a pharmaceutical company. Jurgen's wife, Becky, contacted me this morning to see if I could get this information into your hands and help facilitate a meeting between you, Jurgen and his team to discuss Reven's drug RJX as it pertains to treatment of COVID-19.
>
> Again, Jurgen's email is below and the proposed RJX trial is attached hereto as a PDF.
>
> Please let me know if I can do anything to facilitate a meeting. I know Jurgen and his wife quite well. He is a brilliant doctor and really good guy.
>
> I'm so proud of your leadership during this crazy time. You are

Obtained via MI FOIA by Judicial Watch, Inc.

doing an amazing job. I am, and always will be, on TEAM WHITMER!

Much love,

Andrea

[EXTERNAL]
From: **Dr. Jurgen Luders** <jurgen.luders@reven.com>
Date: Sat, Mar 28, 2020 at 1:15 PM
Subject: RJX and Covid-19
To: aforsyth75@gmail.com <aforsyth75@gmail.com>
CC: Peter Lange <peter.lange@reven.com>, Michael Volk <michael.volk@reven.com>, Brian Denomme <brian.denomme@reven.com>, Dr. Robert Kowalski <robert.kowalski@reven.com>

Andrea,

I hope you are doing well during this time.

As Becky told you I am Chief Medical Officer for a pharmaceutical company called Reven.

Reven's drug RJX has completed Phase I and is approved for Phase II trials here in the USA. RJX targets cellular metabolism which has anti-viral and immune system boosting properties for patients who ALREADY have COVID-19. The mode of action directly targets and corrects the damage that the COVID-19 virus inflicts upon the immune system and to the respiratory system. It is not a vaccination and is not being promoted as a replacement for current standard of care. RJX will complement existing treatments and will also allow for the demand of ventilators to drop and decrease hospital length of stay. Our

Obtained via MI FOIA by Judicial Watch, Inc.

Phase one trial showed drastic improvement in oxygen profusion which should restore the lungs to accept normal inhalation without the need of ventilators. RJX has no known adverse side effects in the thousands of patients treated over the last 10 years globally. We would be glad to forward our Phase I data if you desire.

Due to the rapid escalation of cases on the east side of the state and the impact it is having on our health care system we are seeking to start clinical trials as soon as possible.

We are hoping to get a short conference with Governor Whitmer to see how we could get these trials expedited.

I attached a copy of our proposed trial to use RJX in treating patients infected with the Covid-19 virus.

I really appreciate your help in trying to get a meeting facilitated.

Jurgen Luders, MD

Board Certified, American Board of Neurological Surgeons

Co-Chief Medical Officer
Reven Pharmacueticals

<Outlook-m3xqmo2k.png>

www.reven.com

Confidentiality Notice: This e-mail transmission may contain confidential or legally privileged information that is intended only for the individual or entity named in the e-mail address. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or reliance upon the contents of this e-mail is strictly prohibited. If you received this message in error, please delete all copies from your email program.

Certain statements in this communication, particularly statements regarding future economic performance and finances, plans, expectations and objectives of management, are forward-looking statements which reflect the Company's current views with respect to future events and

Obtained via MI FOIA by Judicial Watch, Inc.

financial performance. When used in this communication, such forward-looking statements use words such as (may), (would), (could), (will), (expect), (believe), (anticipate), (plan), (intend), (estimate), (project), (continue) and other similar terminology of a forward-looking nature or negatives of those terms.

Although management of the Company believes that the expectations reflected in such forward-looking statements are reasonable, all forward-looking statements address matters that involve known and unknown risks, uncertainties, assumptions, and other factors. Accordingly, there are or will be a number of significant factors which could cause the Company's actual results, performance or achievements, or industry results, to be materially different from any future results, performance or achievements expressed or implied by such forward-looking statements. Many of the factors that will determine the Company's future results, performance or achievements are beyond its ability to control or predict. The Company cannot assure investors that actual results will be consistent with the forward-looking statements in this communication and investors are cautioned not to put undue reliance on any forward-looking statements.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Hertel, Elizabeth (DHHS); Gordon, Robert (DHHS)
Subject: Fwd: RJX and Covid-19-Information from Dr. Jurgen Luders
Date: Wednesday, April 1, 2020 11:19:36 AM

Who can talk to this person?

From: Forsyth, Andrea <AForsyth@plunkettcooney.com>
Sent: Wednesday, April 1, 2020 11:12:37 AM
To: Huls, JoAnne <HulsJ1@michigan.gov>
Subject: RE: RJX and Covid-19-Information from Dr. Jurgen Luders

Hi JoAnne.

Dr. Jurgen Luders asked me to follow up with you on this. Yesterday he informed me that they are working on getting trials started through Trinity Heath, as well as University of Michigan. Dr. Luders would appreciate any opportunity to speak with the appropriate person on Governor Whitmer's team. He is very excited about the possibility of expanding this in order to help the outbreak here in Michigan.

Should we wish to contact him directly, Dr. Luders' cell phone number is [redacted].

As you are aware, he is Chief Medical Officer at Reven Pharmaceuticals. He is also head of neurosurgery at Mercy Health. His profile is here:

https://www.mercyhealth.com/provider/jurgen-luders-md-neurosurgery

Please let me know if you need any additional information.

Thank you,
Andrea Forsyth

From: Huls, JoAnne [mailto:HulsJ1@michigan.gov]
Sent: Saturday, March 28, 2020 8:19 PM
To: Forsyth, Andrea
Subject: Re: RJX and Covid-19-Information from Dr. Jurgen Luders

[EXTERNAL]

Hi Andrea,

I'm going to study your email to the Governor and I'll figure out the right person for you to talk to next.

All the best,
JoAnne

Obtained via MI FOIA by Judicial Watch, Inc.

From: Forsyth, Andrea <AForsyth@plunkettcooney.com>
Sent: Saturday, March 28, 2020 6:55:43 PM
To: Gretchen Whitmer [redacted]
Cc: Whitmer, Gretchen <WhitmerG1@michigan.gov>; Huls, JoAnne <HulsJ1@michigan.gov>
Subject: Re: RJX and Covid-19-Information from Dr. Jurgen Luders

Thank you! Home and healthy and grateful for your leadership! Please let me know if there is anything I can do to help. Seriously...anything.

I hope you're well. Take care of yourself. I would love to catch up when things finally settle down.

Keep up the good work!

Much love, Andrea

On Mar 28, 2020, at 4:30 PM, Gretchen Whitmer [redacted] wrote:

[EXTERNAL]

thank you Andrea - - your friendship means a lot to me! I am copying my COS on this so we ascertain what the right next step is! Be well and stay home!

On Sat, Mar 28, 2020 at 1:39 PM Forsyth, Andrea <AForsyth@plunkettcooney.com> wrote:

> Gretchen:
>
> Please see the email below from Dr. Jurgen Luders, as well as the attached PDF. Jurgen is Chief of Neurosurgery at Mercy Health here in G.R. He is also Chief Medical Officer for Reven, a pharmaceutical company. Jurgen's wife, Becky, contacted me this morning to see if I could get this information into your hands and help facilitate a meeting between you, Jurgen and his team to discuss Reven's drug RJX as it pertains to treatment of COVID-19.
>
> Again, Jurgen's email is below and the proposed RJX trial is attached hereto as a PDF.

Obtained via MI FOIA by Judicial Watch, Inc.

Please let me know if I can do anything to facilitate a meeting. I know Jurgen and his wife quite well. He is a brilliant doctor and really good guy.

I'm so proud of your leadership during this crazy time. You are doing an amazing job. I am, and always will be, on TEAM WHITMER!

Much love,

Andrea

[EXTERNAL]
From: **Dr. Jurgen Luders** <jurgen.luders@reven.com>
Date: Sat, Mar 28, 2020 at 1:15 PM
Subject: RJX and Covid-19
To: aforsyth75@gmail.com <aforsyth75@gmail.com>
CC: Peter Lange <peter.lange@reven.com>, Michael Volk <michael.volk@reven.com>, Brian Denomme <brian.denomme@reven.com>, Dr. Robert Kowalski <robert.kowalski@reven.com>

Andrea,

I hope you are doing well during this time.

As Becky told you I am Chief Medical Officer for a pharmaceutical company called Reven.

Reven's drug RJX has completed Phase I and is approved for Phase II trials here in the USA. RJX targets cellular metabolism which has anti-viral and immune system boosting properties for patients who ALREADY have COVID-19. The mode of action directly targets and corrects the damage that the COVID-19 virus inflicts upon the immune system and to the respiratory system. It is not a vaccination and is not being promoted as a replacement for current standard of care. RJX will complement existing treatments and

Obtained via MI FOIA by Judicial Watch, Inc.

will also allow for the demand of ventilators to drop and decrease hospital length of stay. Our Phase one trial showed drastic improvement in oxygen profusion which should restore the lungs to accept normal inhalation without the need of ventilators. RJX has no known adverse side effects in the thousands of patients treated over the last 10 years globally. We would be glad to forward our Phase I data if you desire.

Due to the rapid escalation of cases on the east side of the state and the impact it is having on our health care system we are seeking to start clinical trials as soon as possible.

We are hoping to get a short conference with Governor Whitmer to see how we could get these trials expedited.

I attached a copy of our proposed trial to use RJX in treating patients infected with the Covid-19 virus.

I really appreciate your help in trying to get a meeting facilitated.

Jurgen Luders, MD

Board Certified, American Board of Neurological Surgeons

Co-Chief Medical Officer
Reven Pharmaceuticals

<Outlook-m3xqmo2k.png>
www.reven.com

Confidentiality Notice: This e-mail transmission may contain confidential or legally privileged information that is intended only for the individual or entity named in the e-mail address. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or reliance upon the contents of this e-mail is strictly prohibited. If you received this message in error, please delete all copies from your email program.

Certain statements in this communication, particularly statements regarding future economic performance and finances, plans, expectations and objectives of management, are forward-looking statements which reflect the Company's current views with respect to future events and financial performance. When used in this communication, such forward-looking statements use words such as (may), (would), (could), (will), (expect), (believe), (anticipate), (plan), (intend), (estimate), (project), (continue) and other similar terminology of a forward-

Obtained via MI FOIA by Judicial Watch, Inc.

looking nature or negatives of those terms.

Although management of the Company believes that the expectations reflected in such forward-looking statements are reasonable, all forward-looking statements address matters that involve known and unknown risks, uncertainties, assumptions, and other factors. Accordingly, there are or will be a number of significant factors which could cause the Company's actual results, performance or achievements, or industry results, to be materially different from any future results, performance or achievements expressed or implied by such forward-looking statements. Many of the factors that will determine the Company's future results, performance or achievements are beyond its ability to control or predict. The Company cannot assure investors that actual results will be consistent with the forward-looking statements in this communication and investors are cautioned not to put undue reliance on any forward-looking statements.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Khaldun, Joneigh (DHHS); Hertel, Elizabeth (DHHS); Gordon, Robert (DHHS)
Cc: Totten, Mark
Subject: Fwd: Time-sensitive request for PPE for deathcare professionals
Date: Monday, March 30, 2020 11:01:24 AM
Attachments: image001.jpg

Just passing along.

From: Christina Von Den Bergh <cvondenbergh@nfda.org>
Sent: Monday, March 30, 2020 11:00:12 AM
To: Huls, JoAnne <HulsJ1@michigan.gov>
Subject: Time-sensitive request for PPE for deathcare professionals

Dear Governor Whitmer:

The National Funeral Directors Association is the world's leading and largest funeral service association representing 20,000 funeral directors and 11,000 funeral homes. During a pandemic or any mass-fatality disaster, it can be hard to contemplate the sad inevitability that there will be mass-fatalities, but deathcare represents a critical part of the public/private partnership that helps states heal and recover. **Deathcare professionals serve on the frontlines.**

While deathcare professionals stand ready to provide meaningful assistance during the COVID-19 pandemic by caring for the dead and their grieving families, they cannot do so safely without personal protective equipment (PPE). We have heard from members in "hot spots" experiencing high rates of death that they will run out of PPE in as soon as seven days, sooner if the death rate continues to escalate.

Deathcare professionals are at high-risk for exposure to COVID-19 as they care for and prepare decedents for burial or cremation. And, it's not just the deathcare professional who is at-risk. For example, if a funeral director were to become infected, he or she could unknowingly become a source of community spread as they interact with staff in their funeral home, their own family and others in the community in which they work.

The Department of Homeland Security's (DHS) Cybersecurity and Infrastructure Security Agency (CISA) issued guidance on March 19 (and updated guidance on March 28) that classified mortuary workers as "critical infrastructure workers." *In fact, mortuary workers were put into the "Healthcare and Public Health" category alongside other frontline caregivers like doctors and nurses.*

We recognize PPE supplies are extremely limited at this time. However, we ask that as governors determine priorities for allocating PPE, they include deathcare professionals among the priority groups for receiving these vital supplies. Doing so protects the health, not only of deathcare professionals, but the entire community in which they work.

On behalf of our members and the more than 141,000 deathcare professionals in our country, we are grateful for the leadership of our nation's governors and stand ready, as always, to care for the dead and the families left behind.

Sincerely,



Christine Pepper, MBA, CAE

Obtained via MI FOIA by Judicial Watch, Inc.

Chief Executive Officer

National Funeral Directors Association
13625 Bishop's Drive Brookfield, WI 53005
Main: 800.228.6332
Fax: 262.789.6977

2020 NFDA International Convention & Expo
Ernest N. Morial Convention Center | New Orleans, LA
October 18-21

NFDA Email Usage Policy

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Gordon, Robert (DHHS); Khaldun, Joneigh (DHHS); LyonCallo, Sarah (DHHS)
Cc: Bagley, Nick
Subject: Illinois
Date: Thursday, July 16, 2020 5:46:02 AM
Attachments: 21818-Actions_to_Combat_a_Resurgence_of_COVID-19.pdf

Just FYI, below and attached.

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

https://www2.illinois.gov/Pages/news-item.aspx?ReleaseID=21818

Gov. Pritzker Announces New Mitigation Plan to Prevent Resurgence of COVID-19 in Illinois as State Surpasses Two Million Tests

New Plan Outlines General and Industry-Specific COVID-19 Mitigation Efforts for the State's 11 Emergency Medical Services Regions

Obtained via MI FOIA by Judicial Watch, Inc.

New Plan Outlines General and Industry-Specific COVID-19 Mitigation Efforts for the State's 11 Emergency Medical Services Regions

CHICAGO - Governor Pritzker and Illinois Department of Public Health (IDPH) Director Dr. Ngozi Ezike today announced a new COVID-19 mitigation plan focused on combating a resurgence of cases while maintaining the progress the state has made towards bending the curve over the last four months. As states across the country experience a surge of new COVID-19 cases, Illinois remains an outlier with lower hospitalization and infection rates and one of the highest rates of testing in the U.S.

The resurgence plan recognizes that the state is in its strongest position to combat the virus since the pandemic began, with a robust testing operation regularly yielding more than 30,000 tests per day, expanded tracing operations with 1,450 contact tracers, a growing stockpile of personal protective equipment, and hospital surge capacity. The plan also accounts for months of additional data and research as public health experts reach a greater scientific understanding of this virus and how it spreads.

"Illinois now has the lowest infection rates among all our neighboring states and one of the lowest positivity rates in the country - and it's because of the individual actions of millions of our residents," **said Governor JB Pritzker.** "Opening up our economy does not have to come with a spike in cases. Other countries have done it successfully while reducing cases and infection rates. But that requires vigilance on the part of all of us. It's imperative that individuals, families, workers and businesses follow the recommendations doctors have given about vital mitigations and that we act quickly if we see any outbreaks and upticks, signs that could lead to a surge of coronavirus infections."

"This plan ensures we are looking at all available data to make timely decisions to protect the health of our communities," **said IDPH Director Dr. Ngozi Ezike.** "By assessing key metrics that indicate both the disease burden and the capacity of each COVID-19 region to respond, we can then take targeted actions within specific regions to help mitigate the spread of this deadly disease while keeping as much of our state open as possible."

The resurgence prevention plan developed by IDPH outlines three tiers of general and industry-specific mitigations that can be acted upon to prevent a renewed spread of COVID-19. To provide for a more granular approach, the mitigations outlined will be applied on a regional basis based on the 11 Emergency Medical Services (EMS) regions

Obtained via MI FOIA by Judicial Watch, Inc.

that have traditionally guided IDPH in its statewide public health work.

METRICS AND MITIGATIONS

The administration has relied on science and data to guide its approach to battling COVID-19 from the very beginning and will continue to do so when determining the metrics and mitigations necessary to prevent a resurgence of cases in Illinois.

The following metrics will be used to determine when the spread of the virus in a region requires additional mitigations:

· Sustained increase in 7-day rolling average (7 out of 10 days) in the positivity rate and one of the following severity indicators:

o Sustained 7-day increase in hospital admissions for a COVID-19 like illness
o Reduction in hospital capacity threatening surge capabilities (ICU capacity or medical/surgical beds < 20%)

· OR three consecutive days averaging ≥ 8% positivity rate

The updated guidance from IDPH establishes three tiers of mitigations that can be implemented should a region meet the resurgence metrics.

Some mitigation strategies in higher risk settings, like indoor bars and restaurants, will be automatically applied in a region that meets resurgence criteria to prevent rapid spread of COVID-19. A larger list of mitigation strategies relating to settings like retail, fitness, and salons and personal care will be available if testing and contact tracing data at the local level indicate those mitigations to be prudent.

The list of optional measures included in the updated guidance is not exhaustive. Other industries could require additional mitigation if indicated by the region's data.

PLAN REGIONS

Mitigations will be applied on a regional basis based on the Emergency Medical Services (EMS) Regions that have traditionally guided IDPH in its statewide public health work. Expanding to 11 regions allows for a more granular approach in this phase of the response to COVID-19. The new regions follow county lines to account for counties that are in more than one region of the EMS system.

Obtained via MI FOIA by Judicial Watch, Inc.

The new regions are:

1. **NORTH:** Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago
2. **NORTH-CENTRAL:** Bureau, Fulton, Grundy, Henderson, Henry, Kendall, Knox, La Salle, Livingston, Marshall, McDonough, McLean, Mercer, Peoria, Putnam, Rock Island, Stark, Tazewell, Warren, Woodford
3. **WEST-CENTRAL:** Adams, Brown, Calhoun, Cass, Christian, Greene, Hancock, Jersey, Logan, Macoupin, Mason, Mason, Menard, Montgomery, Morgan, Pike, Sangamon, Schuyler, Scott
4. **METRO EAST:** Bond, Clinton, Madison, Monroe, Randolph, St. Clair, Washington
5. **SOUTHERN:** Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Marion, Massac, Perry, Pope, Pulaski, Saline, Union, Wabash, Wayne, White, Williamson
6. **EAST-CENTRAL:** Champaign, Clark, Clay, Coles, Crawford, Cumberland, De Witt, Douglas, Edgar, Effingham, Fayette, Ford, Iroquois, Jasper, Lawrence, Macon, Moultrie, Piatt, Richland, Shelby, Vermillion
7. **SOUTH SUBURBAN:** Kankakee, Will
8. **WEST SUBURBAN:** DuPage, Kane
9. **NORTH SUBURBAN:** Lake, McHenry
10. **SUBURBAN COOK:** Suburban Cook
11. **CHICAGO:** City of Chicago

A map of the resurgence plan regions will be available on the state's coronavirus website: www.coronavirus.illinois.gov.

COVID-19 TESTING AND TRACING

Since March, the Pritzker administration has implemented policies and programming to reduce the spread of COVID-19. Measures have included issuing a stay at home order to prevent hospitals from becoming overwhelmed, expanding the state's contact tracing program, and building upon testing availability across Illinois.

The administration has been proactive in expanding testing access since the onset of the pandemic. Illinois was the first state to establish COVID-19 testing capabilities to reduce reliance on the Centers for Disease Control (CDC). Today, the state is currently experiencing a weekly average of more than 33,000 tests per day, recently surpassing 2 million tests total. This expanded testing programming contributed to a significant decrease in the state's seven-day rolling average positivity rate, now averaging just over

Obtained via MI FOIA by Judicial Watch, Inc.

3.0 percent.

The state has also worked to expand its contact tracing operation, with approximately 1,450 contact tracers now working across Illinois. Over the next week, 26 local health departments will receive additional funding from the state, representing over $127 million of available grant funds for contact tracing. With these funds, local health departments will hire approximately 1,330 contact tracers over the next few months and significantly expand their contact tracing efforts.

Obtained via MI FOIA by Judicial Watch, Inc.

Actions to Combat a Resurgence of COVID-19

From the onset of the COVID-19 pandemic, Illinois followed the science and listened to public health experts by putting mitigations in place and then deliberately and gradually lifting many of them. As other states see their cases and positivity rates surge, Illinois has one of the lowest positivity rates in the nation because we let public health guide our decisions.

Even so, the virus is still out there and as mitigations are lifted, it is likely that cases will rise. The administration is committed to being fully prepared for any resurgence and transparent with the public as to what that planning looks like. Just as Illinois took a gradual and regional approach to safely reopen our state, Governor Pritzker and the Illinois Department of Public Health have put forward a deliberate plan that will utilize several layers of mitigations to combat a resurgence of COVID-19 and prevent uncontrollable spread.

This plan recognizes that the state is in its strongest position to combat the virus since the pandemic began, with a robust testing operation regularly yielding more than 30,000 tests per day, expanded tracing operations with 1,450 contact tracers, a growing stockpile of personal protective equipment, and hospital surge capacity. The plan also accounts for months of additional data and research as public health experts reach a greater scientific understanding of this virus and how it spreads.

This updated guidance establishes a menu of mitigation options organized by risk level. The following health metrics will be used to determine when the spread of the virus in a region requires additional mitigations:

What Could Cause a Region to Become More Restrictive?

- Sustained increase in 7-day rolling average (7 out of 10 days) in the positivity rate

AND ONE OF THE FOLLOWING:

- Sustained 7-day increase in hospital admissions for a COVID-19 like illness
- Reduction in hospital capacity threatening surge capabilities (ICU capacity or medical/surgical beds under 20%)

OR

- Three consecutive days averaging greater than or equal to 8% positivity rate

Obtained via MI FOIA by Judicial Watch, Inc.

Mitigations will be applied on a regional basis based on the Emergency Medical Services (EMS) Regions that have traditionally guided IDPH in its statewide public health work. Expanding to 11 regions allows for a more granular approach in this phase of the response to COVID-19. The new regions follow county lines to account for counties that are in more than one region of the EMS system. The new regions are as follows:

1. **NORTH:** Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago
2. **NORTH-CENTRAL:** Bureau, Fulton, Grundy, Henderson, Henry, Kendall, Knox, La Salle, Livingston, Marshall, McDonough, McLean, Mercer, Peoria, Putnam, Rock Island, Stark, Tazewell, Warren, Woodford
3. **WEST-CENTRAL:** Adams, Brown, Calhoun, Cass, Christian, Greene, Hancock, Jersey, Logan, Macoupin, Mason, Mason, Menard, Montgomery, Morgan, Pike, Sangamon, Schuyler, Scott
4. **METRO EAST:** Bond, Clinton, Madison, Monroe, Randolph, St. Clair, Washington
5. **SOUTHERN:** Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Marion, Massac, Perry, Pope, Pulaski, Saline, Union, Wabash, Wayne, White, Williamson
6. **EAST-CENTRAL:** Champaign, Clark, Clay, Coles, Crawford, Cumberland, De Witt, Douglas, Edgar, Effingham, Fayette, Ford, Iroquois, Jasper, Lawrence, Macon, Moultrie, Piatt, Richland, Shelby, Vermillion
7. **SOUTH SUBURBAN:** Kankakee, Will
8. **WEST SUBURBAN:** DuPage, Kane
9. **NORTH SUBURBAN:** Lake, McHenry
10. **SUBURBAN COOK:** Suburban Cook
11. **CHICAGO:** City of Chicago



All public health criteria included in this document are subject to change. As research and data on this novel coronavirus continue to develop, this plan can and will be updated to reflect the latest science and data.

Obtained via MI FOIA by Judicial Watch, Inc.

Once a region meets the resurgence criteria, the following tiered menu of mitigation options will be considered. If sustained increases in health metrics continue unabated, further mitigations could be added from additional tiers.

Actions to Combat a Resurgence of COVID-19

Triggers: *(1) sustained increase in positivity rate and A) sustained increase in hospital admissions or B) reduction in hospital capacity threatening surge capabilities; or (2) ≥ 8% positivity rate over three consecutive days*

SETTING	TIER 1	TIER 2	TIER 3
Bars and restaurants	Reduce indoor dining capacity and suspend indoor bar service	Suspend indoor dining and bar service	Suspend in-person dining; takeout only
Hospitals	Reduce elective surgeries and procedures; limit visitation at hospitals; implement twice daily bed-reporting	Suspend elective surgeries and procedures; implement surge capacity; assess need to open Alternate Care Facility	Open Alternate Care Facility
Meetings, social events and religious gatherings	Additional limits on gatherings and room capacity	Greater limits on gatherings and room capacity	Strictest limit to gatherings and room capacity
Offices	Institute remote work for high risk individuals; continued emphasis on telework for as many workers as possible	Reduce office capacity with recommendations to resume remote work where possible	Institute remote work for all non-essential workers
Organized group recreational activities & gyms* (fitness centers, sports, etc.)	Reduce indoor capacity	Suspend organized indoor recreational activities	Suspend organized indoor and outdoor recreational activities
Retail*	Reduce in-person capacity	Suspend in-person non-essential retail; online and curbside pick-up available for all	Suspend all non-essential retail; only essential retail open (i.e. grocery stores, pharmacies)
Salons and personal care*	Institute temporary location shutdown tied to outbreak	Institute temporary location shutdown tied to outbreak with possible broader mitigations	Suspend salon and personal care operations

** Optional measures based on a region's on-the-ground condition. This list is not exhaustive and other industries may be added if indicated by the data.*

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Whitmer, Gretchen; Totten, Mark; Khaldun, Joneigh (DHHS)
Subject: importance of masks
Date: Thursday, April 23, 2020 8:24:02 AM
Attachments: image001.png

Doesn't get to specific issues now being discussed, but this is a good article on potential power of masks

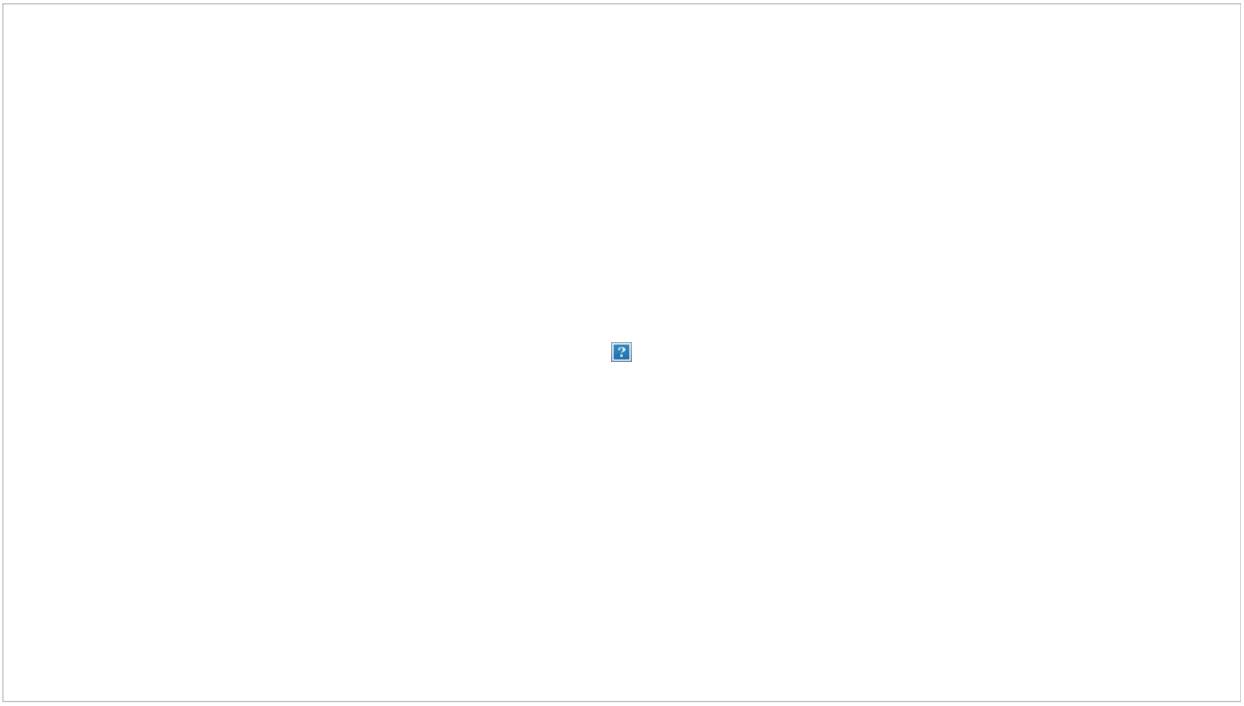
https://www.theatlantic.com/health/archive/2020/04/dont-wear-mask-yourself/610336/

Excerpts

To better understand what level of mask-wearing we need in the population to get this pandemic under control, we assembled a transdisciplinary team of 19 experts and looked at a range of mathematical models and other research to learn what would happen if most people wore a mask in public. We wrote and submitted an academic paper as well as a layperson's summary. Every infectious disease has a reproduction rate, called R. When it's 1.0, that means the average infected person infects one other person. The 1918 pandemic flu had an R of 1.8—so one infected person infected, on average, almost two others. COVID-19's rate, in the absence of measures such as social distancing and masks, is at least 2.4. A disease dies out if its R falls under 1.0. The lower the number, the faster it dies out.

The effectiveness of mask-wearing depends on three things: the basic reproduction number, R_0, of the virus in a community; masks' efficacy at blocking transmission; and the percentage of people wearing masks. The blue area of the graph below indicates an R_0 below 1.0, the magic number needed to make the disease die out.

Models show that if 80 percent of people wear masks that are 60 percent effective, easily achievable with cloth, we can get to an effective R_0 of less than one. That's enough to halt the spread of the disease. Many countries already have more than 80 percent of their population wearing masks in public, including Hong Kong, where most stores deny entry to unmasked customers, and the more than 30 countries that legally require masks in public spaces, such as Israel, Singapore, and the Czech Republic. Mask use in combination with physical distancing is even more powerful.



While cloth masks are sufficient for protecting others, people who are immunocompromised or those who have a few left over from fire season or hobbies may be considering wearing N95s, to better protect themselves. One note of caution: Many nonmedical N95s have exhalation valves (to make them less stuffy to wear) that let out unfiltered air, and thus won't stop the wearer from infecting others—so they shouldn't be worn around other people unless the valve is covered over with tape or cloth.

The community use of masks for source control is a "public good": something we all contribute to that eventually benefits everyone—but only if almost everyone contributes, which can be a challenge to persuade people to do. It's like emission filters in our car exhausts and chimneys: They need to be installed in all cars, factories, and houses to guarantee clean air for everyone. Usually, laws, regulations, mandates, or strong cultural norms ensure maximal participation. And once that happens, the result

Obtained via MI FOIA by Judicial Watch, Inc.

can be amazing.

For example, in Hong Kong, only four confirmed deaths due to COVID-19 have been recorded since the beginning of the pandemic, despite high density, mass transportation, and proximity to Wuhan. Hong Kong's health authorities credit their citizens' near-universal mask-wearing as a key factor (surveys show almost 100 percent voluntary compliance). Similarly, Taiwan ramped up mask production early on and distributed masks to the population, mandating their use in public transit and recommending their use in other public places—a recommendation that has been widely complied with. The country continues to function fully, and their schools have been open since the end of February, while their death total remains very low, at only six. In the Czech Republic, masks were not used during the initial outbreak, but after a grassroots campaign led to a government mandate on March 18, masks in public became ubiquitous. The results took a while to be reflected in the official statistics: The first five days of April still saw an average of 257 new cases and nine deaths per day, but the most recent five days of data show an average of 120 new cases and five deaths per day. Of course, we can't know for sure to what degree these success stories are because of masks, but we do know that in every region that has adopted widespread mask-wearing, case and death rates have been reduced within a few weeks.

Robert Gordon
Director
Michigan Department of Health & Human Services
gordonr3@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark
Subject: interesting article
Date: Tuesday, September 1, 2020 12:04:32 PM

About voice level and COVID transmission. Relates to conversation earlier.

https://www.theatlantic.com/ideas/archive/2020/08/wear-your-mask-and-stop-talking/615796/

Robert Gordon
Director
Michigan Department of Health & Human Services
gordonr3@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark; Pinals, Debra (DHHS); Harris, Toni (AG)
Subject: Jails
Date: Wednesday, March 18, 2020 5:08:51 AM

This came from a friend who does indigent defense.

Sent from my iPhone

Begin forwarded message:

> **From:** Robert Gordon [redacted]
> **Date:** March 18, 2020 at 4:27:12 AM EDT
> **To:** "Gordon, Robert (DHHS)" <GordonR3@michigan.gov>
> **Subject: Fwd: Heads up**
>
> ---------- Forwarded message ---------
> From: **Eve Primus** <ebrensik@umich.edu>
> Date: Tue, Mar 17, 2020 at 11:03 PM
> Subject: Heads up
> To: Robert Gordon [redacted]
>
> I am writing to make you aware of something that might be thrown at you sometime soon. If you don't know it already, there is a Michigan statute that seems to provide broad authority for the director of HHS to order the removal of people from designated places where public health dangers require it. As you know, jails are notorious breeding grounds for the transmission of viral infections. You may find that people in the indigent defense sector will ask you to invoke this authority to remove people in jails in light of COVID-19. My sense so far is that this is going to be a request related to county jails where things are a mess rather than the Michigan Department of Corrections, which seems to be trying to do things responsibly.
>
> I thought you would want to know.
>
> Best,
> Eve

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark; Pohl, Zack
Subject: making the case
Date: Friday, October 2, 2020 7:08:00 PM
Attachments: JSC Slides final 092220.pptx

If you'd like to make the public case for sustaining the orders by hook or by crook, we could build from slides 4-9 in the attached. The voiceover is that Michigan brought deaths under control through the Governor's early orders, and we kept deaths under control through her later orders. We could show the marked contrast with states that did not do this. States in wave one like Louisiana that were clobbered in wave two; States hit terribly in wave two, like Florida and Arizona; and near us, Wisconsin, crippled by a similar terrible court decision. Michigan has gone from 3rd in per capita deaths at the start to 9th now. Illinois is going to pass us in the next couple days, and Florida and Georgia will do so in the next week or two. See here.

Robert Gordon
Director
Michigan Department of Health & Human Services
gordonr3@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

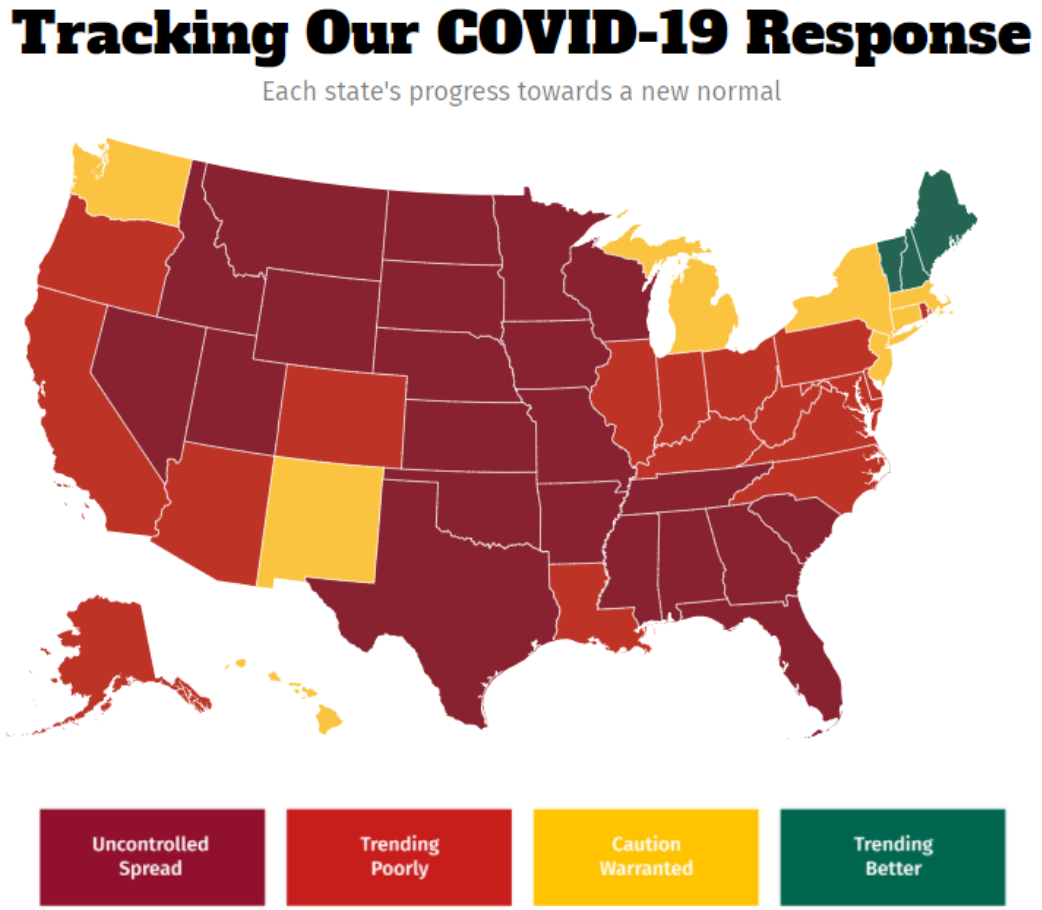
MDHHS Data & Performance

September 23, 2020

Obtained via MI FOIA by Judicial Watch, Inc.

Michigan: Current state of response relative to other states (1/2)

Data based on symptoms/cases, hospital capacity, testing capacity



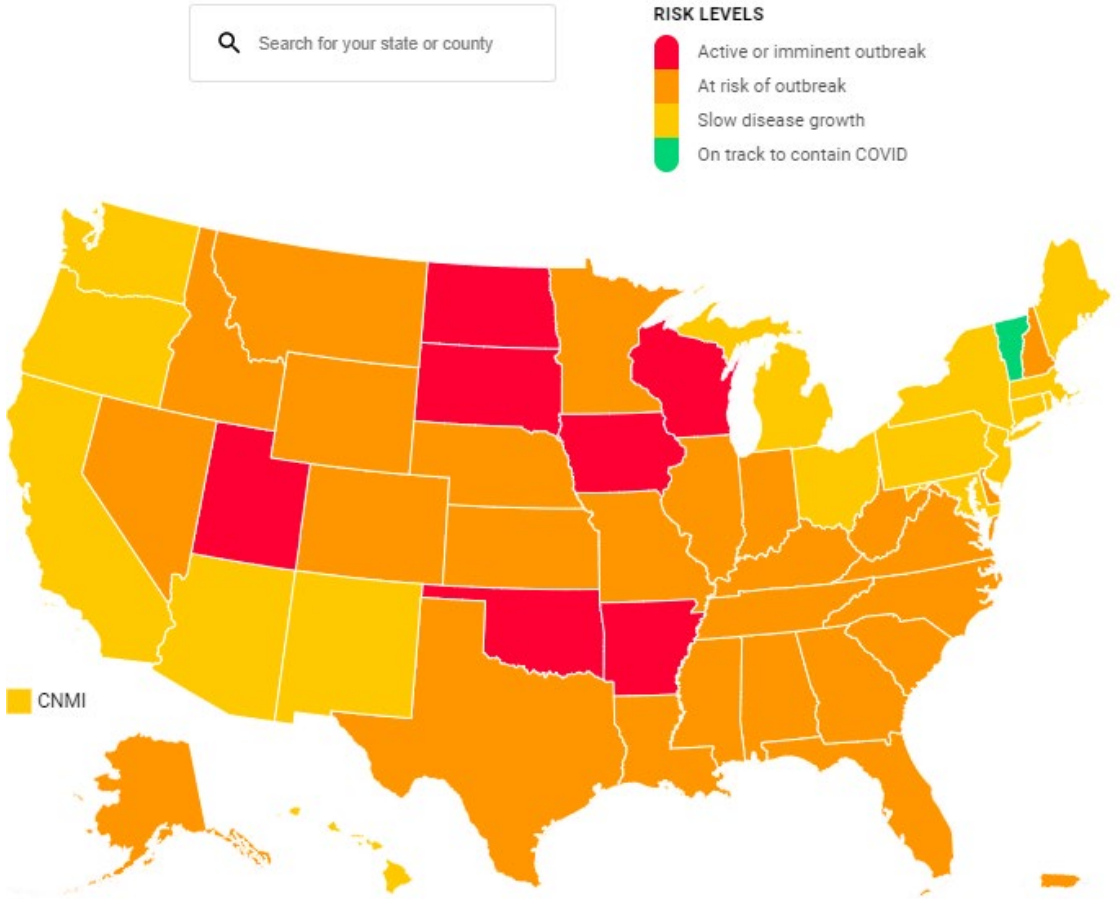
MDHHS Source: https://www.covidexitstrategy.org/

US DIGITAL RESPONSE.org | UNITED STATES of CARE | Duke Robert J. Margolis, MD Center for Health Policy | RESOLVE TO SAVE LIVES | Vital Strategies

Obtained via MI FOIA by Judicial Watch, Inc.

Michigan: Current state of response relative to other states (2/2)

Data based on daily new cases, infection rate, positive test rate, ICU headroom, tracing capacity



CovidActNow.org

Georgetown University Medical Center | Stanford Medicine Clinical Excellence Research Center | GRAND ROUNDS

HARVARD GLOBAL HEALTH INSTITUTE | SCHMIDT FUTURES

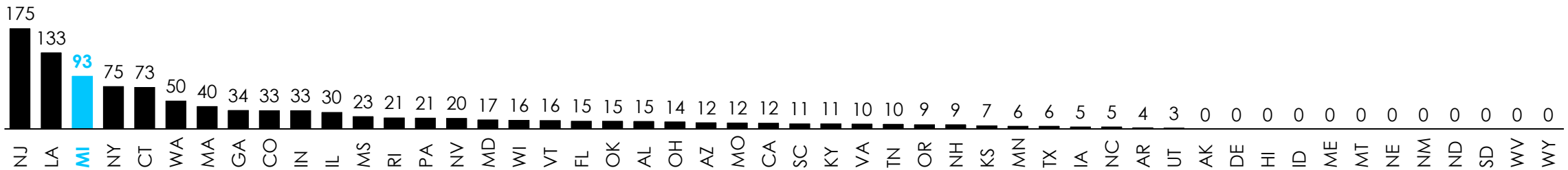
MDHHS Source: https://covidactnow.org/

Obtained via MI FOIA by Judicial Watch, Inc.

COVID-19 provisional deaths per million population by state

Period 1: Mar 1 – Apr 4

3rd highest

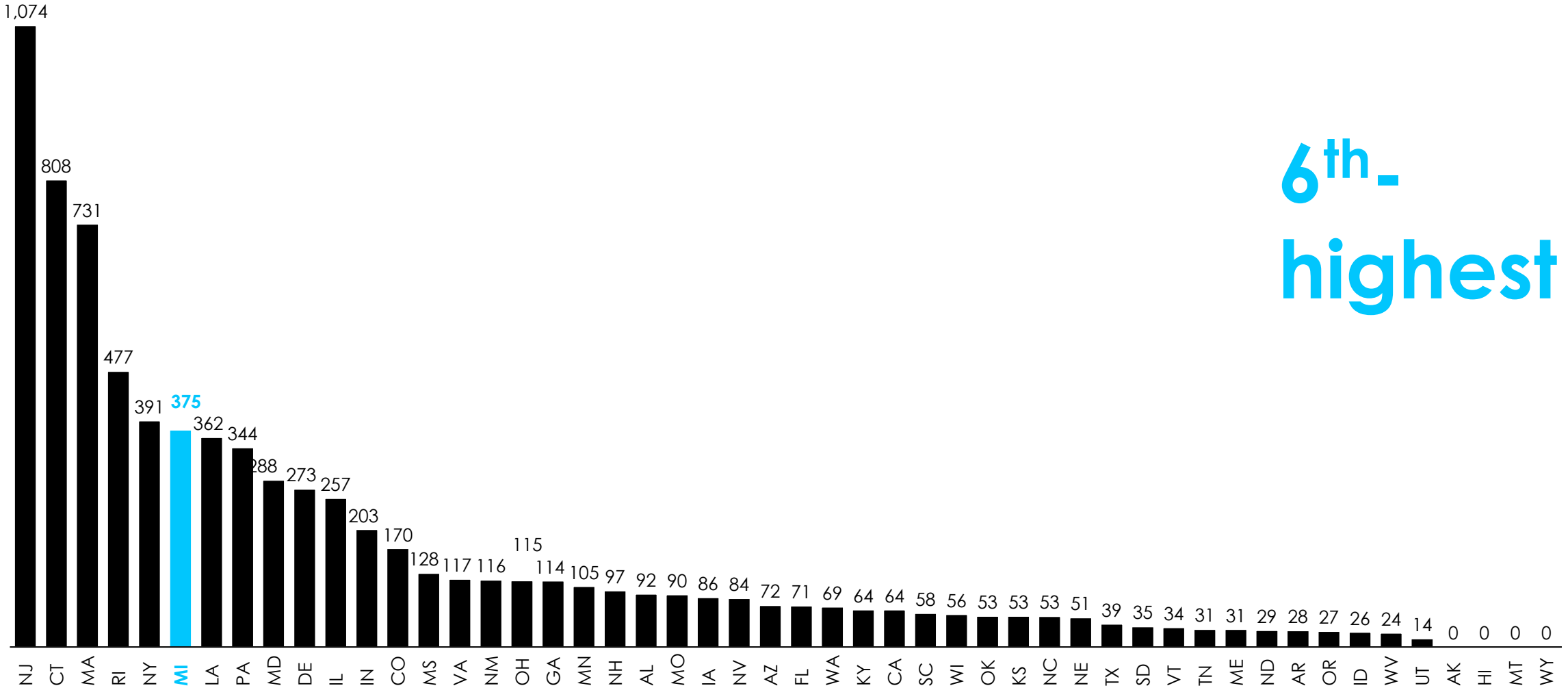


MDHHS Source: CDC Provisional COVID-19 Death Counts by Week Ending Date and State – Sep 22, 2020; U.S. Census Bureau Population Estimates as of July 1, 2019

Obtained via MI FOIA by Judicial Watch, Inc.

COVID-19 provisional deaths per million population by state

Period 2: Apr 5 – May 9



6th highest

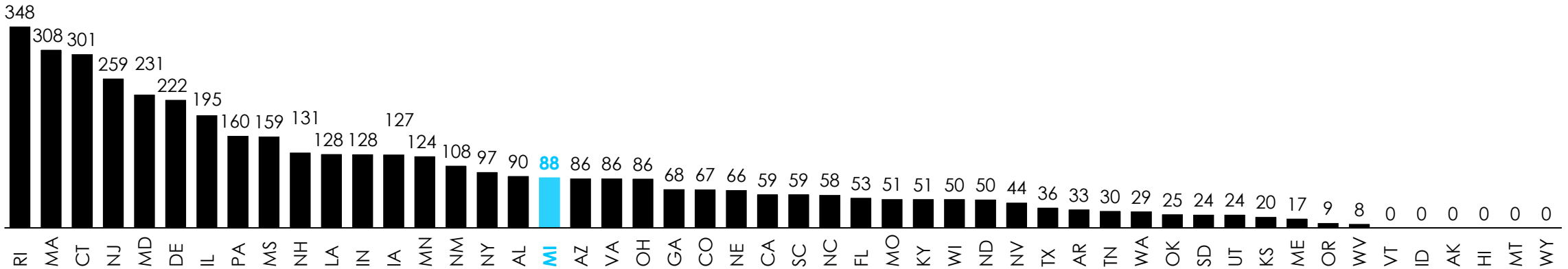
MDHHS Source: CDC Provisional COVID-19 Death Counts by Week Ending Date and State – Sep 22, 2020; U.S. Census Bureau Population Estimates as of July 1, 2019

Obtained via MI FOIA by Judicial Watch, Inc.

COVID-19 provisional deaths per million population by state

Period 3: May 10 – Jun 13

18th-highest



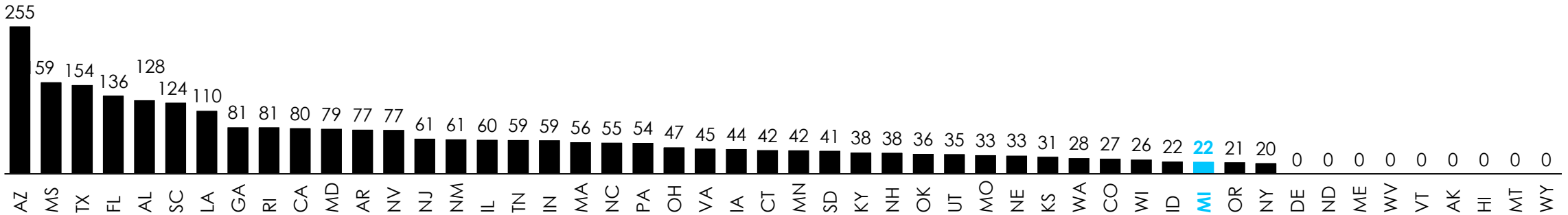
MDHHS Source: CDC Provisional COVID-19 Death Counts by Week Ending Date and State – Sep 22, 2020; U.S. Census Bureau Population Estimates as of July 1, 2019

Obtained via MI FOIA by Judicial Watch, Inc.

COVID-19 provisional deaths per million population by state

Period 4: Jun 14 – Jul 18

39th- highest



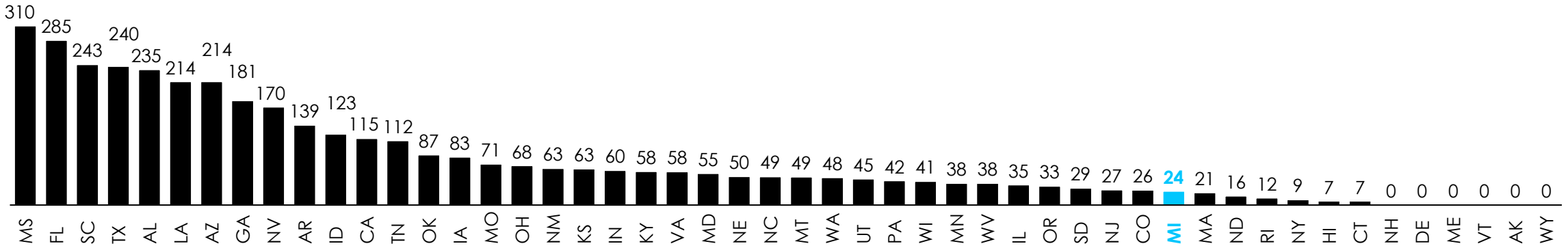
MDHHS Source: CDC Provisional COVID-19 Death Counts by Week Ending Date and State – Sep 22, 2020; U.S. Census Bureau Population Estimates as of July 1, 2019

Obtained via MI FOIA by Judicial Watch, Inc.

COVID-19 provisional deaths per million population by state

Period 5: Jul 19 – Aug 22

38th-highest



MDHHS Source: CDC Provisional COVID-19 Death Counts by Week Ending Date and State – Sep 22, 2020; U.S. Census Bureau Population Estimates as of July 1, 2019

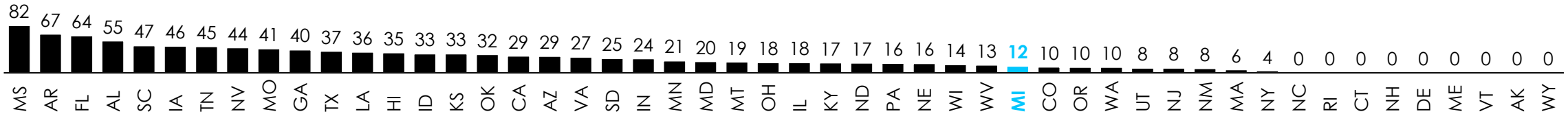
Obtained via MI FOIA by Judicial Watch, Inc.

COVID-19 provisional deaths per million population by state

Period 5: Aug 23 – Sep 21[1]

33rd- highest

Most recent data will likely change significantly in coming weeks



1 Partial data (more deaths expected to be attributed to these days as more data is received); also pending data for several additional dates for 5-week period equivalent to prior pages

Source: CDC Provisional COVID-19 Death Counts by Week Ending Date and State – Sep 22, 2020; U.S. Census Bureau Population Estimates as of July 1, 2019

Obtained via MI FOIA by Judicial Watch, Inc.

Michigan data quality (1/2)

Michigan

Current data quality grade: A+

Cases

Historical data

Total cases Definition	129,662
New cases today (Calculated)	1,575
Change over 7 days (Calculated)	3.8%+

Viral (PCR) tests

Historical data

Total tests (in test encounters) Definition	Not Reported
Total tests (in specimens) Definition	3,405,774
Total tests (in people) Definition	Not Reported

Antibody tests

Historical data

Total tests Definition	285,076

Hospitalization

Historical data

Ever hospitalized Definition	Not Reported
└ Now hospitalized Definition	501
Ever in ICU Definition	Not Reported
└ Now in ICU Definition	146
Ever on ventilator Definition	Not Reported
└ Now on ventilator Definition	64

Outcomes

Historical data

Recovered Definition	90,216
Total deaths Definition	6,981
└ Probable deaths Definition	316
└ Confirmed deaths Definition	6,665

The COVID Tracking Project at The Atlantic

MDHHS Source: https://covidtracking.com/data/#state-mi

Michigan data quality (2/2)

Obtained via MI FOIA by Judicial Watch, Inc.

Top performers on covid-19 response

An analysis by Resolve to Save Lives, a nonprofit headed by former CDC director Tom Frieden and part of global health organization Vital Strategies, has ranked states and the District of Columbia on their reporting of key covid-19 data.

✔ Fully meets criteria ● Partially meets criteria, problems with data and/or stratification ○ Not reported

	CASES	LINKED	TESTS	PERCENT POSITIVE	SYNDROMIC SURVEILLANCE	HOSPITALIZATION	OCCUPIED	CONGREGATE FACILITIES	DEATHS
Minn.	●	●	●	✔	✔	●	✔	●	●
Ore.	●	●	●	●	●	●	●	●	●
Utah	●	●	●	●	✔	●	✔	●	●
Tenn.	●	○	●	●	✔	●	●	●	●
Ariz.	●	○	●	●	✔	●	●	●	●
Va.	●	○	●	●	●	●	●	●	●
Colo.	●	○	●	●	✔	●	○	●	●
Fla.	●	○	●	✔	✔	●	○	○	●
Ga.	●	○	●	●	○	●	○	●	✔
Ill.	●	○	●	●	●	●	●	●	●
Mich.	●	○	●	●	●	●	●	●	●
N.C.	●	○	●	●	●	●	●	●	●
Vt.	●	●	●	●	●	●	○	●	●
Del.	●	○	●	●	✔	●	○	○	●
D.C.	●	○	●	●	○	●	●	●	●
Iowa	●	○	●	●	○	●	●	●	●
Mass.	●	○	●	●	○	●	●	●	●
Nev.	●	○	●	✔	○	●	○	●	●
Ohio	●	○	●	●	○	●	○	●	●
Okla.	●	○	●	●	○	●	○	●	●
Pa.	●	○	●	●	●	●	○	●	●
Tex.	●	○	●	●	○	●	●	●	●
Wis.	●	○	●	●	○	●	●	●	●

The Washington Post

RESOLVE TO SAVE LIVES

MDHHS Source: https://www.washingtonpost.com/health/2020/07/21/coronavirus-states-data/

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Huls, JoAnne; Foster, Tricia; Totten, Mark; Bagley, Nick; Pohl, Zack; Stibitz, Brom (DTMB); Khaldun, Joneigh (DHHS); LyonCallo, Sarah (DHHS); Bouknight, Rey (DHHS); Egan, Sean (LEO); Moon, Jason (LEO); Donofrio, Jeff (LEO)
Cc: Smith, Dana; Smith, Tammy; Crockett, Tracy; Durkee, Amaya; Volovsek, Emily; Pleyte, Beth (DTMB); Rockefeller, Cheryl (DHHS); Lounds, Elizabeth (DHHS); Schrader, Lori (DHHS); Chrzaszcz, Monica (LEO)
Subject: Mask Usage

Join Microsoft Teams Meeting <https://teams.microsoft.com/l/meetup-join/19%3ameeting_NDI1NTU0MjYtMzEyOS00NzYzLTliNDgtYjg5MGMwMmI5NDNm%40thread.v2/0?context=%7b%22Tid%22%3a%22d5fb7087-3777-42ad-966a-892ef47225d1%22%2c%22Oid%22%3a%22d97b02d9-726d-4468-b67a-4fb8e35da719%22%7d>

[redacted]

[redacted]

Local numbers <https://dialin.teams.microsoft.com/95e14c4b-c14d-430f-a556-75831bdf54bf?id=381301322> | Reset PIN <https://mysettings lync.com/pstnconferencing> | Learn more about Teams <https://aka.ms/JoinTeamsMeeting> | Meeting options <https://teams microsoft.com/meetingOptions/?organizerId=d97b02d9-726d-4468-b67a-4fb8e35da719&tenantId=d5fb7087-3777-42ad-966a-892ef47225d1&threadId=19_meeting_NDI1NTU0MjYtMzEyOS00NzYzLTliNDgtYjg5MGMwMmI5NDNm@thread.v2&messageId=0&language=en-US>

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark; Huls, JoAnne; Pohl, Zack
Cc: Bouknight, Rey (DHHS)
Subject: McKinsey role-4:30 deadline on press inquiry
Date: Sunday, April 5, 2020 2:55:20 PM

Raz has objected to telling press that McKinsey is working with us because they do not yet have a signed contract and do not have permission as a matter of their internal governance.

I have not been in the conversations with McKinsey about arrangements—can you advise on how to handle given her position? I'm sure that if we leave McKinsey out of today's response due to a legal matter, we all will want to include them soon.

The reporter's deadline is 4:30pm. Thanks.

From: Razili Lewis <Razili_Lewis@mckinsey.com>
Sent: Sunday, April 5, 2020 2:23 PM
To: Sutfin, Lynn (DHHS) <SutfinL1@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Subject: RE: Michigan Apex Clarification

Lynn please call me

Razili Lewis
Partner, McKinsey & Company
mobile: 248-506-9868

From: Sutfin, Lynn (DHHS) <SutfinL1@michigan.gov>
Sent: Sunday, April 5, 2020 1:55 PM
To: LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Razili Lewis <Razili_Lewis@mckinsey.com>
Subject: [EXT]Re: Michigan Apex Clarification

Thanks to the edits. Are we good with this being the response?

Sent from my iPhone

> On Apr 5, 2020, at 12:48 PM, LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov> wrote:

Obtained via MI FOIA by Judicial Watch, Inc.

From: Sutfin, Lynn (DHHS) <SutfinL1@michigan.gov>
Sent: Sunday, April 05, 2020 12:44 PM
To: LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Razili Lewis <razili_lewis@mckinsey.com>
Subject: FW: Michigan Apex Clarification
Importance: High

Making sure this is still my response to this question before responding. The highlighted yellow addresses his last question and I welcome feedback.

Hi Brian,

We are making use of multiple sources of modeling including work from University of Michigan, IHME's https://covid19.healthdata.org/projections, the COVIDACTNOW.ORG site, running rough projections using assumptions in a paper from Imperial College, and working with McKinsey Group.

Each model is dependent on the data used to develop it including how timely and specific the data are to geography, onset date of illness, case count, community spread data, observance of shelter in place orders/social distancing, death data, etc.

We continue to urge Michiganders to follow Governor Whitmer's Stay Home, Stay Safe Order and to practice social distancing to help slow the spread of COVID-19 in our state.

From: Brown, Tiffany <BrownT56@michigan.gov>
Sent: Sunday, April 5, 2020 12:26 PM
To: Abel, Brian <Brian.Abel@WXYZ.COM>; Sutfin, Lynn (DHHS) <SutfinL1@michigan.gov>; Wheaton, Bob (DHHS) <WheatonB@michigan.gov>
Cc: Leddy, Robert <LeddyR@michigan.gov>; Lewis, Chelsea <LewisC23@michigan.gov>
Subject: Re: Michigan Apex Clarification

Hi Brian,

Looping in my colleagues with MDHHS to help with your inquiry.

—Tiff

From: Abel, Brian <Brian.Abel@WXYZ.COM>
Sent: Sunday, April 5, 2020 12:18 PM
To: Brown, Tiffany
Cc: Leddy, Robert; Lewis, Chelsea

Obtained via MI FOIA by Judicial Watch, Inc.

Subject: Michigan Apex Clarification

Good afternoon,
Dr. Birx with the White House Coronavirus Task Force yesterday said the multiple hotspots (including Detroit) could apex at the same time in the next 6-7 days, citing predictions from healthdata.org
However on Thursday, Gov. Whitmer suggested Michigan is probably a month away from the apex.
Reaching out to see where the discrepancy is and if it is a difference in modeling, which modeling the Governor is using for her prediction.
Also reaching out for comment on what Michiganders should consider a more accurate assessment to prepare for considering a 3 week difference in those predictions.

Thank you.
Sincerely,
Brian

Brian Abel | **Anchor/Reporter**

248-763-6719

@BrianAbelTV



Scripps Media, Inc., certifies that its advertising sales agreements do not discriminate on the basis of race or ethnicity. All advertising sales agreements contain nondiscrimination clauses.

+==========+
This email is confidential and may be privileged. If you have received it in error, please notify us immediately and then delete it. Please do not copy it, disclose its contents or use it for any purpose.
+==========+

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark; Pohl, Zack; Kolodin, Zach; Flood, Jennifer
Cc: Rick, Matthew (DHHS); Wheaton, Bob (DHHS); McDowell, Gary (MDARD); Freeman, Dale (DHHS); Taverna, Andrea (DHHS-Contractor); LyonCallo, Sarah (DHHS); Khaldun, Joneigh (DHHS)
Subject: Migrant lawsuit filed
Date: Wednesday, August 12, 2020 11:08:31 AM
Attachments: Castillo complaint.pdf
image001.jpg
image002.jpg
image003.jpg
image004.jpg
image005.png

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

From: Wheaton, Bob (DHHS) <WheatonB@michigan.gov>
Sent: Wednesday, August 12, 2020 10:55 AM
To: Rick, Matthew (DHHS) <RickM@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: FW: Migrant lawsuit

[redacted]

[redacted]

From: Lisa Roose-Church <lisa@mirsnews.com>
Sent: Wednesday, August 12, 2020 10:40 AM
To: Wheaton, Bob (DHHS) <WheatonB@michigan.gov>

Obtained via MI FOIA by Judicial Watch, Inc.

Subject: Re: Migrant lawsuit

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Here's the lawsuit as requested; sorry it took me so long.

On Wed, Aug 12, 2020 at 9:43 AM Wheaton, Bob (DHHS) <WheatonB@michigan.gov> wrote:

> Would you be able to forward me the lawsuit? I know Michigan Farm Bureau was talking about suing and seeking migrant workers to be part of the suit, so I'm guessing this is their lawsuit.
>
> ---
>
> **From:** Lisa Roose-Church <lisa@mirsnews.com>
> **Sent:** Wednesday, August 12, 2020 9:41 AM
> **To:** Wheaton, Bob (DHHS) <WheatonB@michigan.gov>
> **Subject:** Re: Migrant lawsuit
>
> **CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov**
>
> Thank you!
>
> On Wed, Aug 12, 2020 at 9:34 AM Wheaton, Bob (DHHS) <WheatonB@michigan.gov> wrote:
>
> > Hi Lisa,
> >
> > Director Gordon hasn't seen the lawsuit, but I'm checking to see if our Legal Services team has. Would you be able to forward me the lawsuit?
> >
> > I will be in touch with a statement.
> >
> > Thanks,
> >
> > **Bob Wheaton, Public Information Officer**
> > Michigan Department of Health & Human Services
> > Office of Communications
> > 517-281-1701
> >
> > 
> >
> > *This message, including any attachments, is intended solely for the use of the named recipient(s) and may contain confidential information. Any unauthorized review, use, disclosure, or distribution of confidential information contained in this email is expressly prohibited. If you are not the intended recipient, please contact the sender by reply email*

Obtained via MI FOIA by Judicial Watch, Inc.

and delete all copies of the original message.

From: Lisa Roose-Church <lisa@mirsnews.com>
Sent: Wednesday, August 12, 2020 8:59 AM
To: Wheaton, Bob (DHHS) <WheatonB@michigan.gov>
Subject: Fwd: Migrant lawsuit

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Hi Bob

See below please, apparently Lynn is out

Thank you
Lisa

---------- Forwarded message ---------
From: **Lisa Roose-Church** <lisa@mirsnews.com>
Date: Tue, Aug 11, 2020 at 11:44 PM
Subject: Migrant lawsuit
To: Sutfin, Lynn (DHHS) <SutfinL1@michigan.gov>

Hi Lynn,

I'm working on a story about the lawsuit filed Tuesday by migrant workers (in federal court, Western District) over DHHS Director Gordon's directive about mandatory testing in agricultural and food processing employees.

Has DHHS/Gordon seen the lawsuit? Are either commenting?

Yes, I'm sending this late - wanted to do it while I was thinking of it, but I know you won't see or be able to respond until Wednesday.

Thank you
Lisa

--

Lisa Roose-Church

Obtained via MI FOIA by Judicial Watch, Inc.

Judicial Correspondent
Michigan Information & Research Service Inc.
910 W. Ottawa Street
Lansing, MI 48915
Direct office: 517-999-7438
Office: 517-482-2125, Ext. 204
Cell: 989-780-2683
Email: lisa@mirsnews.com
Twitter: @LisaRooseChurch



--

CONFIDENTIALITY NOTICE: This email communication may contain private, confidential, or legally privileged information intended for the sole use of the designated and/or duly authorized recipient(s). If you are not the intended recipient or have received this email in error, please notify the sender immediately by email and permanently delete all copies of this email including all attachments without reading them.

--

Lisa Roose-Church
Judicial Correspondent
Michigan Information & Research Service Inc.
910 W. Ottawa Street
Lansing, MI 48915
Direct office: 517-999-7438
Office: 517-482-2125, Ext. 204
Cell: 989-780-2683
Email: lisa@mirsnews.com
Twitter: @LisaRooseChurch



--

CONFIDENTIALITY NOTICE: This email communication may contain private, confidential, or legally privileged information intended for the sole use of the designated and/or duly authorized recipient(s). If you

Obtained via MI FOIA by Judicial Watch, Inc.

> *are not the intended recipient or have received this email in error, please notify the sender immediately by email and permanently delete all copies of this email including all attachments without reading them.*

--

Lisa Roose-Church
Judicial Correspondent
Michigan Information & Research Service Inc.
910 W. Ottawa Street
Lansing, MI 48915
Direct office: 517-999-7438
Office: 517-482-2125, Ext. 204
Cell: 989-780-2683
Email: lisa@mirsnews.com
Twitter: @LisaRooseChurch



--

CONFIDENTIALITY NOTICE: This email communication may contain private, confidential, or legally privileged information intended for the sole use of the designated and/or duly authorized recipient(s). If you are not the intended recipient or have received this email in error, please notify the sender immediately by email and permanently delete all copies of this email including all attachments without reading them.

--

Lisa Roose-Church
Judicial Correspondent
Michigan Information & Research Service Inc.
910 W. Ottawa Street
Lansing, MI 48915
Direct office: 517-999-7438
Office: 517-482-2125, Ext. 204
Cell: 989-780-2683
Email: lisa@mirsnews.com
Twitter: @LisaRooseChurch

Obtained via MI FOIA by Judicial Watch, Inc.



--

CONFIDENTIALITY NOTICE: This email communication may contain private, confidential, or legally privileged information intended for the sole use of the designated and/or duly authorized recipient(s). If you are not the intended recipient or have received this email in error, please notify the sender immediately by email and permanently delete all copies of this email including all attachments without reading them.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Huls, JoAnne
Subject: Needs
Date: Thursday, March 19, 2020 2:26:49 PM

This is a portion of something Jonathan prepared last night. Most of it is just FYI in case useful, but I'll try to catch you on one item.

I think the biggest things we need help with are:

1. **Data integration** – we are struggling today to bring together disparate data sources (inventories from different parts of the state, epidemiological models, EMResource, etc.)
2. **Robust analytics** – our team has done great work to date on a lot of preparedness issues, but we could use help in modelling out the impact of different interventions on disease spread and hospital capacity. (As it happens, I don't think we generally have the advanced data modeling skills internally either, but more importantly, this is an issue of time)

Specific items we could use help with

Overall modeling and data

- Overall model of the progression of the disease at a sub-county level (dynamic model that will adapt as the situation on the ground changes)
- Work with SOM team to refine its data model to better ingest and integrate data from EMResource, MiHIN, other systems to give real-time tracking of the spread of COVID-19, # of available beds, ICU beds, PPE, ventilators, respirators, etc.

Beds

- Full projections at a sub-geographic level of needs for beds, ventilators, respirators, PPE
- Take emergency preparedness plans from hospitals and model overall impact – help SOM develop additional plans in partnership with hospitals to address even larger surge
- Build a financial model to construct additional beds/facilities (how do we finance it)

Supplies

- Develop a system that fully integrates the state's data to understand where all of the PPE (and other key equipment) is in case the state needs to reallocate
- Identify areas in the supply chain that the state is not leveraging today

Personnel

- Projections of specific supply shortages based on potential infection rates / utilization
- Policy solutions to address the shortages, projections of the impact of those solutions, and implementation plans for each

Obtained via MI FOIA by Judicial Watch, Inc.

From: Whitmer, Gretchen
To: Gordon, Robert (DHHS)
Subject: New study investigates California"s possible herd immunity to COVID-19
Date: Wednesday, April 8, 2020 2:18:30 PM

The antibody test is going to be crucial

https://gcc01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.ksbw.com%2Farticle%2Fnew-study-investigates-californias-possible-herd-immunity-to-covid-19%2F32073873&data=02%7C01%7CGordonR3%40michigan.gov%7C9a2a2bd11d9d425ebc8208d7dbc93d28%7Cd5fb7087377742ad966a892ef47225d1%7C0%7C0%7C637219667101746171&sdata=VnF0OewlK7WMSBGB9Zpq%2BCpRFuVjC%2FrsETsQG731pQQ%3D&reserved=0

Sent from my iPhone

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Roos, Brenna (MSP); Grossi, Christina (AG); Khaldun, Joneigh (DHHS)
Cc: Foster, Tricia; Huls, JoAnne; Hertel, Elizabeth (DHHS); Gordon, Robert (DHHS); Gasper, Joe (MSP); Razili Lewis; Rogers, Paul (DMVA); Keenan, Kelly (AG); Pascoe, DJ (AG); McGivney, Jessica (AG); Pell, David (AG); Burger, Penelope (MSP); Jen, Kyle (DTMB)
Subject: NEXT STEPS - PPE decontamination options
Date: Friday, April 3, 2020 2:24:02 PM

I want to summarize our efforts around a process for decontamination and re-use of PPE, and then hand-off this project to Brenna Roos, Private Sector Liaison at MSP/EMHSD, who will be the SOM POC to advance this effort, working with several partners inside and outside state government. I've added possible key SOM partners on this email for awareness. If you see a role for you or your team here, I'd ask that you connect with Brenna.

We are pursuing on parallel tracks three options, which I will describe below and identify next steps. We do not have certainty yet that any will work, but we want to push and see what's possible. Brenna, let's have a follow-up call later today or first thing tomorrow morning to discuss. I will be connecting you on existing email trails with Non-SOM POC's for #2 and #3 shortly.

1. **Battele, an Ohio corporation, has a new product and/or service that decontaminates PPE.**

    a. Current status:
        i. FDA approved the product and/or service last Sunday. Group of MSU experts said this product appeared sound.
        ii. The website says they sell a mobile product that is encased in a shipping container and can be sent to hospitals for on-site use. Tricia mentioned this morning they are offering a service where states send used PPE to Ohio for decontamination. We need to check with Battelle – perhaps they are doing both right now.
        iii. Tricia Foster handed off the name to the hospitals, so they could pursue if they were interested. (Tricia, please tell us if there's more going on here that I may not be aware.)

    b. Next steps:
        i. Confirm that Battelle is providing both a service and a product.
        ii. Gather information from Battelle about service/product, including timing of availability.
        iii. Determine if any hospitals are pursuing this avenue.
        iv. Determine if the state and its medical facilities should contract with Battelle.

    c. Non-SOM POC: N/a, though Tricia may have the contact name at Battelle. Tricia can perhaps also confirm if Laura Appel from MHA is point among hospitals.

1. **MSU likely has capacity to decontaminate PPE.**

    a. Current status:

Obtained via MI FOIA by Judicial Watch, Inc.

i. President Simon has personally pulled together a group of experts to identify what role MSU might play.
ii. MSU uses a similar process to Battelle product: a stream of hydrogen peroxide with proper filtration mechanisms.
iii. MSU options include 2 existing units, one in East Lansing and one in Grand Rapids, that can each decontaminate 200 masks about every 4 hours. In addition, MSU likely can create an additional facility, with much larger capacity, in East Lansing to decontaminate PPE. They need about 5 days to retrofit and test this additional facility if we want them to pursue.
iv. MSU has already started to pilot test exposures of varied N95 mask styles to ensure integrity of wear over time is maintained regardless of mask type
v. CDC has issued recommendations on 3/31/20 for using these processes for decontamination, which are available on CDC website.
vi. Duke University has been doing this process for North Carolina.
vii. MSU has also been in conversations with Sparrow Health System ("they appear committed to help with transport and organization of materials"), as well as Henry Ford Health System ("they are accepting of transporting and organizing materials").

b. Next steps
i. Determine if we want to parallel track pursuit of SOM option alongside Battelle and MTU.
ii. Determine whether MSU process requires FDA approval or not? (POC: Christina Grossi, COO, Department of Attorney General – has team reviewing now.)
iii. Determine whether MDHHS supports pursuit of this project from a scientific/medical perspective. (POC: Dr. Khaldun or her designee)
iv. Identify who this project would support. (Just a few SOM operations? Hospitals?)
v. Determine whether we have the means to create the logistics operation necessary to support this option.
vi. Determine availability of financial support for MSU and other partners.

c. Non-SOM POC: Dr. Claire Hankenson, MSU, fclaire@msu.edu, 517-243-5344 (m).

2. **Michigan Tech University has a mobile unit they are willing to deliver anywhere in the state.**

a. Current status:
i. Engineers and scientists have created a mobile decontamination unit that uses heat.
ii. MTU is reporting that their method is an "approved method" under the CDC guidance.
iii. Their lobbyists told me: "It is available for the state to use wherever it is need. We just need to know where and work out getting it delivered."

Obtained via MI FOIA by Judicial Watch, Inc.

b. Next steps:
    i. Same as above for MSU, although the logistics pieces may be less challenging as the unit could be on-site.

c. Non-SOM POC: Bill Kordenbrock, MTU Director of Government Relations, billk@mtu.edu; 906-281-2653 (m).

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark; Bagley, Nick; Pohl, Zack
Subject: Opportunities around masks
Date: Tuesday, April 14, 2020 3:32:38 PM

Our vendor Applecart reported based on their data collection for us that we are doing very well on our messaging on social distancing and hand washing—but not on masks. Most people don't see the need.

Appears to be an aspect of social distancing where we have room for growth. And valuable both for intrinsic public health benefits (about which much written at this point) and for signaling effect on behavior.

Great if this could be an order; also meaningful would be a symbolic statement like wearing a mask at a press conference. Here's RI Governor today. Also could amp up MiMask challenge, which launched with a bang but seems to me dormant right now.

Thanks.

Robert Gordon
Director
Michigan Department of Health & Human Services
gordonr3@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark; Bagley, Nick; Khaldun, Joneigh (DHHS)
Subject: outdoor masks
Date: Wednesday, June 24, 2020 6:41:38 AM

Saw this depressing Detroit clip just now. Gov. Newsom last week issued an order requiring masks in public spaces, indoor and outdoor. We have not done the outdoor piece. Wonder if we should.

As best I can tell, experts are still unclear on level of outdoor transmission, and lack of spike in heavy protest areas gives hope. On the other hand, the protestors largely did wear masks, and recent evidence on masks overall is strong.

Message would be not that we want to stop reopening, but rather that we want to sustain it versus the scary turn in other states. Realize we will run into the "freedom" crowd, but we could even make the order without penalties. This is not about force of state, but about breaking through with a signal that changes norms. In fantasy world there are prominent Republicans who agree to be reasonable here, like in this video, but based on the Detroit clip, getting a diverse urban group on board would help too.

Robert Gordon
Director
Michigan Department of Health & Human Services
gordonr3@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Totten, Mark; Foster, Tricia; Gordon, Robert (DHHS); Hertel, Elizabeth (DHHS)
Subject: Over 600 Henry Ford Health workers test positive for COVID-19
Date: Monday, April 6, 2020 3:51:26 PM

This article is interesting for many reasons.
The thing that stuck out to me is how much information is in here.
How many people have tested positive, how many on vents, how many days they are in the hospital, how many have come off, staff who have been positives, etc.

All information the Governor has been asking for.

Is this what is getting caught up in EMS? How do we get this exact information — statewide — into us?

Check out this article from The Detroit News:

Over 600 Henry Ford Health workers test positive for COVID-19

https://gcc01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.detroitnews.com%2Fstory%2Fnews%2Flocal%2Fmichigan%2F2020%2F04%2F06%2Fover-600-henry-ford-health-workers-test-positive-covid-19%2F2955929001%2F&data=02%7C01%7CGordonR3%40michigan.gov%7C5ab81cc27af24bde195b08d7da63e3ea%7Cd5fb7087377742ad966a892ef47225d1%7C0%7C0%7C637217994861799586&sdata=Mftzk1VdX9QvUKWhQEcJhlgw8f%2F3I0qJt%2FKOyRn1Ma8%3D&reserved=0

jh

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Pohl, Zack; Belden, Eileen; Huls, JoAnne; Laidlaw, Emily; Groen, Meghan
Cc: Hertel, Elizabeth (DHHS); Schwarzkopf, Emily (DHHS); Roubal, Lewis (DHHS); Flood, Jennifer; Jen, Kyle (DTMB)
Subject: Potential addition for unemployment release
Date: Monday, March 16, 2020 9:20:22 AM
Attachments: 2020.03.14 ESA Gov memo v.7.1.pptx

Per some convos earlier, this is a policy change that we are looking to make today that we would like for you to publicize. We have discussed with Kyle, and Emily is now getting in touch with Jen about leg notifications. The policy is explained in more detail on slide 8 of the attached but short version is as follows:

"Effective today, MDHHS is making it easier for families to get assistance without coming into DHHS or Michigan Works! offices. In the Family Independence Program (FIP), the Department will temporarily defer the requirement to attend an orientation and engage in employment activities through MDHHS and MichiganWorks!. This will allow individuals to receive assistance more quickly and will avoid requiring them to congregate in state offices and go out in public looking for work."

Robert Gordon
Director, Michigan Department of Health & Human Services
gordonr3@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

COVID-19 Human Services Response

Michigan Department of Health and Human Services

March 15, 2020

Discussion document

Obtained via MI FOIA by Judicial Watch, Inc.

Reduce the impact of COVID-19 on deeply poor and working poor families and individuals

Need for action

- Fill in gaps of UI and other programs to ensure vulnerable families receive support
- Expedite access and speed of service delivery in the face of urgent needs
- Reduce risk of virus transmission and exposure in accessing aid

Guiding Principles

- Urgent action
- Simplification
- Timely access to benefits
- Expanded reach

Obtained via MI FOIA by Judicial Watch, Inc.

Targeting workers and families who fall through the cracks of other programs

Main employment-based financial supports

Paid Sick Leave	Worker's Comp
Traditional UI	Expanded UI

Examples of workers not included:

- Not eligible (e.g., self-employed, in occasional work, informal economy)
- Reduced hours but still employed, don't meet earnings requirements
- Unaware of UI or related programs, or assume ineligibility

Obtained via MI FOIA by Judicial Watch, Inc.

Expanding access to existing programs

Family Independence Program (FIP) *(cash assistance)*

- **Suspend job search and job readiness activities** that require recipients to leave their home (**MDHHS administrative action**)
- **Defer new FIP applicants from attending orientation and employment readiness** programs that require recipients to leave their home (**MDHHS administrative action**)

State Emergency Relief *(utility shut off and eviction)*

- For heat, electric and water emergencies, **waive program co-payment requirements, payment maximums and short-falls** to ease the burden of application (**MDHHS administrative action**)
- For eviction and foreclosure emergencies, allow policy exceptions that would **waive required co-payments** (**MDHHS administrative action**)

Food Assistance Program (FAP/SNAP)

- Implement fed **suspension of FAP time limits and work requirements** on able-bodied adults without dependents (**MDHHS implementation of federal action**)
- Implement fed **increase in FAP benefits** for families with children (**MDHHS implementation of federal package**)
- Implement fed **increase in WIC** for families with young children (**MDHHS implementation of federal package**)
- Coordinate with Michigan Dept of Ed and SNAP outreach partners to **ensure access to food** (**MDHHS administrative action**)

Obtained via MI FOIA by Judicial Watch, Inc.

Establish a new Short-term COVID-19 cash program

Family Independence Program (FIP) (45% FPL)	Food Assistance Program (138% FPL)	State Emergency Relief (150% FPL)	Medicaid (135% FPL Adults 200%+ kids)	COVID-19 Family Support (Temporary Aid to Working Poor)
Existing Low Income Supports				New Program

DHHS proposes to administratively create a **short-term COVID-19 cash supplement program for working-poor families** struggling with basic needs

- Increase eligibility for income support to meet basic needs for working poor families impacted by COVID-19 who are **in the gap between FIP and UI**
- Provide a **one-time cash grant** to working poor families to address short-term income crisis needs including: short-term earnings losses due to reduced employment; increased family care costs during the school closures; added health care needs due to infections not covered otherwise

Obtained via MI FOIA by Judicial Watch, Inc.

COVID-19 Support Programs for Residents

Existing program changes provide for additional assistance to families. The addition of the Family Support Program extends cash benefits to a larger population of residents.

- No changes
- Expansion/modification in progress
- Expansion/modification completed

	Deep Poor (0-40% FPL)	Low-income (40-120% FPL)	Working Poor (120-150% FPL)
Family Independence Program (FIP)	✓	✗	✗
State Emergency Relief (SER): Housing and Energy	✓	✓	✓
Food Assistance Program (FAP/SNAP)	✓	✓	✓
Food Assistance Program (WIC)	✓	✓	✓
Utility Shut-off Protection	✓	✓	✓
COVID-19 Family Support Program	✗	✓	✗

We expect that many working poor families will lose income as a result of COVID-19, moving into the low-income category

New program

MDHHS

Food Assistance Program

Obtained via MI FOIA by Judicial Watch, Inc.

Program description	The FAP program helps supplement diets by providing emergency food assistance at no cost. Benefits can be used to purchase food at grocery stores, convenience stores, and some farmers' markets and co-op food programs
COVID-19 Impact	Income disruptions for low income residents will put pressure on very tight food budgets. Certain FAP recipients are required to participate in employment and training activities to avoid exhausting benefit limits. Children will lose access to school meal programs

	Program Changes	Duration	Individuals Impacted	Monthly Costs
1	Implement federal suspension of ABAWD time limits and work requirements	May 31, 2020 or as directed by pub. health	ABAWD Adults (50,000)	N/A
2	Increase FAP and WIC benefits to help families with children meet food needs	May 31, 2020 or as directed by pub. health	477,000 children	N/A
3	Coordinate with Michigan Dept of Ed and SNAP outreach partners	May 31, 2020 or as directed by pub. health	342,000 children	N/A

Anticipated Result

- Access to benefits for FAP recipients continues.
- Increase food benefits for FAP and WIC families with children
- Supports social distancing public health guidance

Obtained via MI FOIA by Judicial Watch, Inc.

Family Independence Program

Program description	Provides a small monthly cash grant to assist with meeting basic needs. Amount of grant is based on group size and existing income. Maximum grant amount approximates 45% FPL with average families receiving $350 per month.
COVID-19 Impact	Program requires recipients to attend employment readiness activities in congregate settings. Job search and other program requirements involve individual travel and thereby increase risk of acquiring or spreading virus. School closures impact availability of childcare providing an additional barrier to program compliance.

Program Changes	Duration	Individuals Impacted	Monthly Costs
1 Temporarily suspend job search or readiness activities that require recipient to leave their home	May 31, 2020 or as directed by public health	7,500 families	$100,000
2 Defer new FIP applicants from attending orientation and employment readiness programs	May 31, 2020 or as directed by public health	1,550 families	$2.9 million

Anticipated Result

- Additional applicants will receive financial support faster.
- Individuals receiving benefits will not be required to participate in out of home activities.
- Provides continuity for existing cases by reducing participation penalties.
- Reduced risk of acquiring or spreading virus

Obtained via MI FOIA by Judicial Watch, Inc.

New COVID-19 Temporary Family Support Program

Program description	Fill unmet gap between MDHHS and LEO programs. Provide a one-time cash issuance to low-income families who have been negatively impacted through wage disruption by COVID-19. Families with income less than 120% of the FPL. The benefit is calculated based on a two-month FIP payment standard for the respective group size.
COVID-19 Impact	Low-income Families reliant upon service jobs have had disruption to their work hours and are at risk of job instability. School closures impact availability of childcare adding an additional challenge to maintaining basic needs.

	Program Changes	Duration	Individuals Impacted	Monthly Costs
1	New program using TANF diversion administration	May 31, 2020 or as directed by public health	10,000	$12.4 million

Anticipated Result

- Provides short-term cash benefit low income families.
- Fast delivery of benefit allows for continued family stability and ability to meet financial obligations.

MDHHS

State Emergency Relief

Obtained via MI FOIA by Judicial Watch, Inc.

Program description	The State Emergency Relief (SER) Program provides immediate help to individuals and families facing emergencies that threaten health and safety such as eviction, foreclosure, heat, electric or water service disruptions.
COVID-19 Impact	Income disruptions for low income residents with limited resources will mean they are unable to meet monthly heat, electric and rent obligations. School closures will reduce work opportunities for adults with young children.

	Program Changes	Duration	Individuals Impacted	Monthly Costs
1	Heat, electric and water: waive program co-pays, payment maximum and short-falls	May 31, 2020 or as directed by public health	4,500	$2.5 million
2	Eviction or foreclosure emergencies: waive required co-payments.	May 31, 2020 or as directed by public health	250	$146,000

Anticipated Result

- Additional residents in crisis qualify for SER benefits allowing families to stay in their own home
- Continuation of heat, electric and utility service to improve personal health, reduce family strain and decrease need for travel.

Priorities

Obtained via MI FOIA by Judicial Watch, Inc.

1. Implement federal action on food assistance	$0
2. Adopt changes to existing FIP program	$3,000,000
3. Adopt COVID-19 Family Support Program	$12,400,000
4. Adopt changes to SER to streamline accessibility	$2,646,000
Total	$18,046,000

Obtained via MI FOIA by Judicial Watch, Inc.

Appendix: COVID-19 Family Support Cost Methodology

Estimates based on volume of low-income (40-120% FPL) food assistant applicants who are expected to experience income disruption resulting from COVID-19.



Number of monthly FAP applications today[1]	Anticipated 10% increase in FAP applications due to increased need[2]	FAP applications containing children[1]	Est. share of applicants in target population (25%-120% FPL)[3]	Est. average payment amount (based on 2 months of FIP benefit)[4]	Population attesting to being affected by COVID-19[5]	Adjustment to include admin. costs[6]	Projected total monthly cost

Source notes:
1 – MDHHS Greenbook
2 - Government Accounting Office, Best Practices for Estimating and Managing Program Costs, 2007
3 - FNS Table A.3: Income Distribution of households
4 - MDHHS Greenbook and FIP Payment Standards
5 - MDHHS and U of M presumption
6 - MDHHS Cost Allocation Standard

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Rogers, Paul (DMVA); Gasper, Joe (MSP); Foster, Tricia; Huls, JoAnne
Cc: Khaldun, Joneigh (DHHS)
Subject: Potential MING role supporting long-term care needs
Date: Tuesday, June 2, 2020 5:04:53 PM
Attachments: MING Rapid Response Staffing Proposal v4 060220.docx

---

General Rogers and Colleagues,

As discussed on the call last week, DHHS we see three broad areas of challenge regarding Long-Term Care Facilities: accurate reporting, adequate testing, and operational safety. Under the last heading, the greatest need is ensuring sufficient staffing at facilities that face shortages due to positive testing of staff and other COVID-related challenges.

As a potential means to meet that staffing need, please find attached a two-page paper describing a potential role for MING providing temporary staffing support at long-term care facilities. There is also a possible role for MING in assisting exclusively with infection control, but we felt the staffing need was most urgent.

We moved in the direction of a precise mission as requested, though there are still details tbd, depending in part on MING capabilities. If this is not an appropriate MING function, we will look to stand up teams as outlined here under direct DHHS and LHD supervision.

Would be grateful for your thoughts.

Best,
Robert

Robert Gordon
Director
Michigan Department of Health & Human Services
gordonr3@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Rogers, Paul (DMVA); Gasper, Joe (MSP); Foster, Tricia; Huls, JoAnne
Cc: Khaldun, Joneigh (DHHS)
Subject: Potential MING role supporting long-term care needs
Date: Tuesday, June 2, 2020 5:04:53 PM
Attachments: MING Rapid Response Staffing Proposal v4 060220.docx

---

General Rogers and Colleagues,

As discussed on the call last week, DHHS we see three broad areas of challenge regarding Long-Term Care Facilities: accurate reporting, adequate testing, and operational safety. Under the last heading, the greatest need is ensuring sufficient staffing at facilities that face shortages due to positive testing of staff and other COVID-related challenges.

As a potential means to meet that staffing need, please find attached a two-page paper describing a potential role for MING providing temporary staffing support at long-term care facilities. There is also a possible role for MING in assisting exclusively with infection control, but we felt the staffing need was most urgent.

We moved in the direction of a precise mission as requested, though there are still details tbd, depending in part on MING capabilities. If this is not an appropriate MING function, we will look to stand up teams as outlined here under direct DHHS and LHD supervision.

Would be grateful for your thoughts.

Best,
Robert

Robert Gordon
Director
Michigan Department of Health & Human Services
gordonr3@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

Michigan National Guard Long-Term Care Rapid Response Team

June 2, 2020

Issue: Long-term care (LTC) settings (nursing facilities, assisted living, adult foster care, homes for the aged) are facing increased staffing challenges and shortages as a result of COVID-19. Universal testing of LTC facilities has left many facilities with staffing shortages as asymptomatic positive staff must complete a 10-day isolation period before return to work.

Staffing shortages are resulting in unnecessary hospitalizations of COVID-19 positive residents as LTC facilities struggle to maintain necessary staffing levels. Ensuring residents can continue to remain safely in their homes is of upmost concern. Transfers and movement of frail older adults and those with cognitive impairments are incredibly stressful and can often exacerbate underlying health conditions.

Rapid Response Team Mission: The goal of the Michigan National Guard Rapid Response Team is to provide immediate staffing support to LTC facilities facing urgent staffing shortages, ensuring LTC facilities remain safe for residents.

Rapid Response Team Roles: Rapid Response Teams will fill two different roles: 1) Emergency Staffing and 2) Stabilization Staffing.

1) Emergency Staffing teams will be short term (48 hours or less) teams that will provide immediate support to a facility in a staffing crisis. Ideally, these teams could be at a facility within 4 hours of MDHHS approving the facility for an Emergency Staffing Team.
2) Stabilization Staffing teams will provide longer term (1 to 14 days) support to a facility. These deployments will be planned out, 24 to 48 hours in advance before a team is needed. The facility and team will meet to establish facility needs, staffing specifications, and discuss care plans or other pertinent information. These teams will fill in for a facility experiencing significant staffing challenges as a result of COVID-19 positive staff members.

Rapid Response Team Composition: Both the Emergency Staffing and the Stabilization Staffing teams will consist of health care professionals, preferably those with experience working in LTC facilities or with populations served by LTC facilities. Teams should be led by at least one registered nurse (RN) or other skilled medical professional (MD, NP, PA) and 4 to 5 additional health care or trained professionals. These could include an additional RN, licensed practical nurses (LPN), certified nursing assistant (CNA), or for AFCs and HFAs, a personal care aide. Additional RNs or other health care professionals may need to be added or removed from the team to meet the needs of a facility.

Teams should be geographically dispersed throughout Michigan (Southeast, West, Central, and North) to ensure statewide coverage. Some areas may require more teams based on population, community spread, and immediate need. We anticipate the Emergency Staffing and Stabilization Staffing could work interchangeably to be responsive to the needs of the facilities in their region.

Although these figures are subject to refinement, we estimate needing 4 Emergency Staffing Teams and 16 Stabilization Staffing teams. The need, duration, location, and intensity of the work will vary greatly depending on the spread of COVID-19 in LTC facilities. MDHHS is making estimates based on similar work conducted in other states, number of facilities within Michigan, and acknowledgement of the challenges in preventing the spread of infection in certain congregate care settings.

DRAFT

Obtained via MI FOIA by Judicial Watch, Inc.

Rapid Response Team Tasks: The Rapid Response Team will provide staffing support to LTC facilities. Task will be varied based on needs of the residents and facilities, but could include:

- Assisting with activities of daily living (bathing, dressing, transferring, toileting, eating)
- Providing infection prevention assistance, including helping with isolation, sharing best practices for infection control and prevention, and proper usage of PPE
- Providing environmental cleaning assistance

Criteria for Requesting MING Support: To ensure that LTC facilities are not shifting responsibilities to MING without first exhausting all available resources, MDHHS is recommending that LTC facilities demonstrate that they have met all the following conditions:

1. Have demonstrated a need for staffing assistance:
    - Emergency Staffing: 50% or more of scheduled staff have missed two shifts in a row
    - Stability Staffing: 25% of staff have tested positive for COVID-19 or are suspected of being COVID-19 positive and therefore unable to work
2. Have enacted their emergency protocol for staffing
    - If part of a chain of 5 or more facilities, have requested backup support from those facilities
3. Have reached out to a staffing agency

Prior to finalizing these criteria, MDHHS will work with MING, LTC associations, and conduct data analysis to finalize criteria thresholds.

MDHHS will also work with MING to set up a process for facilities to apply for Emergency Staffing and Stability Staffing to ensure a process works for all parties.

Time Limited: The expectation is Emergency Staffing teams will provide staffing support for 24 to 48 hours and the Stability Staffing Team from 1 to 14 days. The Stability Staffing is designed to cover facilities while asymptomatic facility staff who test positive complete their 10-day isolation period before return to work. If those individuals develop symptoms, then the symptom-based or test-based strategy should be used. Staffing requests longer than 14 days will be considered on a case-by-case basis. Rapid Response Teams should not need to self-quarantine in between facility assignments if they have properly used PPE and did not have any accidental exposure to a COVID positive individual.

Partnership with MDHHS and Local Health Departments: The Michigan Department of Health and Human Services will work in partnership with Local Health Departments (LHDs) and MING to ensure there is a consistent and understandable process for how LTC facilities can request staffing supports.

Training: MDHHS has been approached by a small team of infection prevention specialists from Doctors Without Borders who would be willing to employ a train the trainer model to assist in bringing the Rapid Response Teams up to speed on infection prevention and control, COVID-19 best practices, or other training needs for the team work in the long-term care setting.

DRAFT

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Khaldun, Joneigh (DHHS); Hertel, Elizabeth (DHHS); Totten, Mark; Razili Lewis
Cc: Hudson, Nicole (DHHS); Bell, James (DHHS); Bowden, Andrea (DHHS)
Subject: PPE issues
Date: Tuesday, April 14, 2020 5:33:30 PM
Attachments: image005.gif
image001.png
EXTERNAL Help For Residential Providers.msg
Appendix K - Direct Care Wage Increase.msg

Per comments just now, I wanted to flag two issues:

1. Given the PPE shortages (see Brom's below), should we be doing more to encourage greater PPE conservation and reuse? My read on our guidance to date is that it tells you how to conserve versus instructing you to do so. I have heard that everyone knows there are shortages and therefore everyone is conserving, but I can imagine this is not uniformly the case, especially when the institutional and individual incentives may not be aligned. I know we have new conservation technology coming online and perhaps that can be part of the message. Options here could include stronger encouragement, or linking further state distribution to reuse, or simply ordering it.

2. I want to ask if there is any more we can do to encourage PPE distribution to some of the field providers at significant risk, especially those serving behavioral health patients and juveniles. The BH providers apparently just met and sent me a raft of emails, but it is worth looking at a couple as they are compelling. Not sure if there is a limited targeted distribution we could make to them or that is just wishful thinking.

If this seems more straightforward to you than I am thinking, that's great and eager to hear. If not, will plan a call, and please let me know who else to include.

Robert

From: Stibitz, Brom (DTMB) <StibitzB@michigan.gov>
Sent: Tuesday, April 14, 2020 2:16 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Cc: Ambrosier, Jared (DTMB) <AmbrosierJ@michigan.gov>; Adam Carlson <acarlson@mha.org>; Bell, James (DHHS) <BellJ10@michigan.gov>; Fiedler, Jay (DHHS) <FiedlerJ@michigan.gov>
Subject: PPE Conservation

Director Gordon,

The product group has worked with McKinsey to compare potential PPE needs ("Expected Need" below) with amounts of product that can likely be obtained ("New Constraint" below). Note that significant gaps exist for ventilators, gowns, and gloves.

Please note also that assumptions used to generate the expected need assume some sterilization/conservation protocols of masks and face shields as well.

As discussed, the product group doesn't have good visibility into what efforts have been made with hospitals (or other PPE users) to attempt to reduce some of the gaps for those items. I am sharing because I believe this should be a function of DHHS rather than DTMB.

I have cc'ed some of the people on products who are willing to help on this.



Obtained via MI FOIA by Judicial Watch, Inc.

Brom Stibitz
Chief Information Officer
Chief Deputy Director
Michigan Department of Technology, Management and Budget
stibitzb@michigan.gov
Cell: 517-927-1647



Obtained via MI FOIA by Judicial Watch, Inc.

From: Becker, Timothy T
To: Jansen, Allen (DHHS); Hertel, Elizabeth (DHHS); Gordon, Robert (DHHS)
Cc: Weaver, Phil
Subject: [EXTERNAL] Help For Residential Providers
Date: Tuesday, April 14, 2020 4:38:49 PM
Attachments: image001.png

This message was sent securely using Zix®

This email came from an external source, please use caution when opening attachments or clicking links.

Thank you all for the extra work you are doing right now to help Michiganders through the current COVID crisis. I know this is a trying and demanding time and your days are long. I'm sending this message to implore for assistance on behalf of all residential providers in Michigan. To this point, it appears most of the resources are being driven towards hospital and that is understandable. However, residential direct care is also very intimate work and low-wage employees are being exposed to great risk. Hope Network has already lost residents to the virus and we have residential care employees in the hospitals, some on ventilators. We have been left to our own efforts to fend for PPE and incurring our own expenses to offer shift premiums to incentivize employees who are taking great person risk to care for the people they love. Our costs at Hope Network are already over six figures directly attributed to PPE and wage incentives. As a larger non-profit we have used our own cash to do this because it is doing right by our employees and the people we care for and we are taking our chances on reimbursements later. Tragically, many providers are still without PPE. I am hopeful you will use all necessary means to advocate on behalf of the behavioral health residential direct care workers as vigorously as the hospitals. They deserve nothing less than our very best at this time. The system is already facing life and death decisions. Thank you for taking the time to hear these concerns and I thank you in advance for anything you can do to help residential providers garner PPE and funds to keep care workers engaged at this critical time. Please let me know if Hope Network can assist in any efforts you are pursuing through this crisis.

Tim Becker
Chief Operating Officer
tbecker@hopenetwork.org
616-726-1896 (office)
616-460-7062 (cell)



"In Christian service, Hope Network empowers people to overcome challenges to achieve their highest level of independence."

This e-mail, and any files transmitted with it, may contain confidential and/or privileged information and may be read or used only by the intended recipient. If you are not the intended recipient, please be advised that you have received the same in error and that any use, dissemination, distribution, forwarding, printing or copying of this e-mail or any attached files is strictly prohibited. If you have received this e-mail in error, please immediately notify the sender and delete this e-mail from your system, or contact the Privacy Officer of Hope Network at (616) 301-8000.
Thank you.

Obtained via MI FOIA by Judicial Watch, Inc.

This message was secured by **Zix**®.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Todd Culver
To: Gordon, Robert (DHHS)
Subject: Appendix K - Direct Care Wage Increase
Date: Tuesday, April 14, 2020 5:22:53 PM
Attachments: Outlook-pdjzmzuw.jpg

Director Gordon:
It is my understanding that MDHHS will be submitting its waiver application to CMS later this week, known as Appendix K, granting temporary flexibility to make changes to a range of HCBS policies and practices. Incompass Michigan and its member organizations urge the Department to include provision for a direct care wage increase in this application.

The workforce crisis experienced by direct care workers, the service providers who employ them, and the vulnerable citizens they support, has advanced to the brink of systemic failure during the COVID-19 pandemic. Critical shortages are also placing a greater burden on parents and family members for needed care. I earnestly request that you take action in response, and take steps to allocate funding in support of higher wages in the form of recognition or hazard pay to those providing direct care on the behavioral health front lines.

Your consideration and support are sincerely appreciated.
Be well,

Todd Culver
CEO
517.484.5588 x 2



Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Foster, Tricia; Totten, Mark; Huls, JoAnne
Cc: Khaldun, Joneigh (DHHS)
Subject: Process improvements
Date: Saturday, March 21, 2020 10:00:44 AM
Attachments: MDHHS COVID 19 Strategy v4.pptx
Request for Assistance COVID Document Tracking.msg

Good morning,

I'm attaching a few slides on overall approach from DHHS perspective. On slide 1, the first two columns represent what we are already doing. The key areas of progress are in columns 3 and 4, which are then detailed more fully on the next two slides.

Slide 2 lays out some new working groups that we would like to stand up on an ongoing basis. These would be teams that do daily touch base calls and then are in touch as issues arise. I have connected with Orlene and Jeff D. and they are supportive as well. EOG would participate from Mark's and/or Emily's shops as appropriate; if you wanted to change the designated lead, that is fine. Dr. J will make sure there is full integration with the CHECC. If there should be more formal coordination with SEOC, happy to add.

Slide 3 describes some DHHS internal process. This work led by Sarah Esty under Dr. J is part of the "protocols" piece that JoAnne covered on Thursday night. Attached is a first internal email that went out yesterday to order that work. We expect by Sunday or Monday to have an internal sharepoint with all of the documents that we have in process, and as soon as practicable, a new organization on our website for all of the documents that we have made public. Once we have this together ourselves, I would suggest scaling it to the SOM.

Happy to discuss.

Thanks,
Robert

Obtained via MI FOIA by Judicial Watch, Inc.

Overall Goals:
(1) Minimize mortality and morbidity
(2) Prevent hunger, homelessness, mental health crises, and similar negative impacts

Directives to the Public/Social Distancing/Testing & Tracing	Health Systems Management & Surge Planning:	Vulnerable Populations	Communication	Administration
Limit spread of infection by reducing demand on the health system	Get the right health system capacity in the right place at the right time	Protect the lives and well-being of high-risk populations *(detail follows)*	Effectively communicate in support of goals 1-3 *(detail follows)*	Secure essential operations and financing while maximizing staff safety *(detail follows)*
In process	***In process***	***Multiple leaders– page 2***	***Rey Bouknight, Sarah Esty – page 3***	***Elizabeth Hertel – page 4***

MDHHS

Obtained via MI FOIA by Judicial Watch, Inc.

Vulnerable populations

	Sub-topic	Lead	Team
Older adults	*Long-term care facilities*	*Kate Massey*	*Jevon McFadden (PHA), Brian Barrie (MSA), Larry Horvarth (LARA), Eliz. Hertel, Farah Hanley (Fin Ops.)*
	Independent Living	*Alexis Travis*	*Kate Massey (MSA), Josh Rivera (ESA)*
	Direct Care Workers	*Kate Massey*	Alexis Travis (AASA), *Kim Gaedeke or Larry Horvath (LARA), Farah Hanley (Budget)*
Economic dislocation	*Food and income support*	*Lew Roubal / Josh Rivera*	*Evan Anderson (LEO), Orlando Todd and Christina Herring (PHA), Erin Emerson (Medicaid)*
	Water and Power	*Robert Gordon*	*Terry Beurer (ESA), Sally Talberg (MPSC), EGLE*
	Homelessness	*LEO?*	*MSHDA, Paula Kaiser Van Dam (DHHS)*
Mental Health / SUD	*Mental Health / SUD*	*Al Jansen*	*Jon Villasurda/Jeff Wiefrich (BHDDA), Dr. Pinals, Dr. Mellos (SHA), Dr. Reid (PHA) Andie Taverna, MSA Rep*

Obtained via MI FOIA by Judicial Watch, Inc.

Communications, volunteers, and donations

	Category	Lead
Communication	DHHS Comms approvals and JIC	Darice Darling, Amy Miller
	Legislators	Emily Schwarzkopf
	Local health depts, local gov't, tribes	CHECC (Linda Scott)
	Website	Jason Holben
	Provider hotline	Matt Buck
	Public hotline	Chris Jackson, Shelly Murrell
	Public inbox	Ashley Hill, Chris Jackson
Volunteers and donations	Inbox and hotline	Lisa Grost, Trevor Youngquist, Tori Arnold
	Medical professionals	CHECC
	Supplies and facilities	Jonathan Warsh

Obtained via MI FOIA by Judicial Watch, Inc.

Communications and Administration

Administration

Operational prioritization	*Robert Gordon*	
Employees	*Elizabeth Hertel*	*Mike Derose*
Budget	*Farah Hanley*	*Senior Leadership*

Obtained via MI FOIA by Judicial Watch, Inc.

From: Taverna, Andrea (DHHS-Contractor)
To: Gordon, Robert (DHHS); Hertel, Elizabeth (DHHS); Khaldun, Joneigh (DHHS); Roubal, Lewis (DHHS); Warsh, Jonathan (DHHS); Beurer, Terrence (DHHS); Travis, Alexis (DHHS); Mellos, George (DHHS); Massey, Kate (DHHS); Rick, Matthew (DHHS); Bouknight, Rey (DHHS); Hanley, Farah (DHHS); Esty, Sarah (DHHS); Ramaswamy, Sudhakar (DHHS); Jansen, Allen (DHHS); Ingersoll, Jean (DHHS); Bowden, Andrea (DHHS); Sims, Teri (DHHS); Rockefeller, Cheryl (DHHS); Erb, Holly (DHHS); Boyd, Jacqueline (DHHS); Harkins, Cynthia (DHHS); elSulayman, Halima (DHHS); Trim, Danielle (DHHS); Aikins, Sherida (DHHS); Richards, Denise (DHHS); McCrimmon, Denise (DHHS); Schrader, Lori (DHHS); Smith, Erin (DHHS); Curtis-Cataline, Shelley (DHHS); Anderson, Paula (DHHS); Schwarzkopf, Emily (DHHS); Emerson, Erin (DHHS); Derose, Michael (MCSC); Pinals, Debra (DHHS); Schreier, Steven (DHHS); Kimichik, Alan (DHHS); Doxie, William (DHHS)
Cc: Esty, Sarah (DHHS); Hudson, Nicole (DHHS); Bell, James (DHHS); Darling, Darice (DHHS)
Subject: Request for Assistance: COVID Document Tracking
Date: Friday, March 20, 2020 4:32:44 PM
Attachments: Document Status Tracker 2020.03.20 4pm.xlsx

Hi all,

Sarah & I have been working on a new single document tracker, as part of efforts to improve MDHHS's internal approvals process and provide more visibility across the department. The goal is to track all documents on COVID that have been approved and released, as well as those being drafted or under approval review. This will help ensure consistency of guidance, that all documents go through the correct approvals process, and that approved guidance is added to the website where appropriate.

Documents to be tracked include guidance, FAQs, forms, protocols, internal MDHHS protocols, MDHHS policy changes, rule waivers, etc., MDHHS provider bulletins, and others.

The spreadsheet is available here (and attached).

Could you/your team please assist with the following by midday tomorrow?

1. Please add to the spreadsheet
    a. Documents currently being drafted
    b. Final documents or resources that should be added to the website
    c. A contact person, if your team is the point of contact for a final document already listed
    d. FYI only – we will be concurrently filling in information for existing documents to allow for easy searching – e.g., finding all existing guidance that touches on telemedicine

2. Please upload to the Sharepoint site:
    a. Approved documents ready for the website: here
    b. Documents that have been shared with external parties/stakeholders but should not be posted to the public website: here
    c. Documents/guidance/protocol/etc. that have been shared broadly within MDHHS: here

Thank you and please shout with any Qs!
Andie

Andrea Taverna
Senior Advisor for Opioids Strategy

Obtained via MI FOIA by Judicial Watch, Inc.

Michigan Department of Health and Human Services
TavernaA1@michigan.gov
Cell: 517-528-3558

Obtained via MI FOIA by Judicial Watch, Inc.

Status	On COVID Website?	Topic(s)	Contact Person	Website Section	Sub-Topic	Resource Type	CHECC Review	Comms Review	JIC Review	Date Published	Full Title and Link
Published	Y		?	Residents	COVID FAQ	FAQ				3/16	Frequently Asked Questions About Coronavirus Disease 2019
Published	Y		Alexis Travis?	Residents	Older Adults	Guidance					Tip Sheet for Older Adults
Published	Y		?	Residents	COVID Positive People	Guidance					Guidance for Individuals Diagnosed with COVID Recovering at Home
Published	Y		?	Residents	Community Mitigation	Guidance					Community Mitigation Strategies
Published	Y		?	Residents	COVID Basics: Translated	Guidance				3/11	Coronavirus Disease 2019 Fact Sheet
Published	Y		Darice Darling?	Residents	Prevention	Guidance					Spread of Germs radio spot
Published	Y		N/A	Residents	Prevention	External Resource					Disinfecting your home if someone is sick
Published	Y		Laura de la Rambel(e?	Residents	Local Health Departments	Directory					Find your local health department
Published	Y		EGLE	Residents	Lead Safety	Guidance					Water Service Restoration for Hand Washing: Flushing Guidance for Lead Plumbing
Published	Y		N/A	Residents	Prevention	External Resource					Water Transmission and COVID-19
Published	Y		N/A	Residents	Supports	External Resource					Substance Abuse and Mental Health Administration Disaster Distress Help Line
Published	Y		N/A	Residents	Prevention	External Resource					Centers for Disease Control Information and Tips
Published	Y		N/A	Residents	Travel Restrictions	External Resource					Centers for Disease Control Travel Restrictions
Published	Y		N/A	Residents	Community Mitigation	External Resource					Interim Guidance: Get Your Mass Gatherings or Large Community Events Ready for Coronavirus Disease 2019 (COVID-19)
Published	Y		Andie Taverna	Health Professionals	SUD	Guidance				3/17	Guidance for Substance Use Disorder Treatment Providers During COVID-19
Published	Y		James Bell	Health Professionals	Dental	Guidance				3/16	Dental Practice Guidance for COVID-19
Published	Y		Nicole Hudson	Health Professionals	Treatment: Admissions	Guidance				3/16	Guidance for Health Care Facilities for Discharge of COVID
Published	Y		Nicole Hudson	Health Professionals	Treatment: Discharges	Guidance				3/16	Guidance for Health Care Facilities for Admission of COVID
Published	Y		Nicole Hudson	Health Professionals	Treatment: Patient Transfers	Form					Hospital to Post-Acute Care Transfer Form for COVID-19
Published	Y		Nicole Hudson	Health Professionals	Treatment: EM	Guidance					Guidance for Health Care Facilities for EM of COVID
Published	Y		Nicole Hudson	Health Professionals	Update & Preparation	Guidance				3/5	COVID-19 Information for Medical Professional & Staff webinar with Dr. Khaldun
Published	Y		?	Health Professionals	Case Report Form	Form					Michigan 2019 Novel Coronavirus (COVID-19) Person Under Investigation (PUI) and Case Report Form
Published	Y		?	Health Professionals	EMS	Provider Bulletin					Michigan EMS Coronavirus Disease (COVID-19) Response
Published	Y		?	Health Professionals	Medical Examiners	Guidance				3/9	COVID-19 Guidance for Medical Examiners and Funeral Directors
Published	Y		N/A	Health Professionals	Collected Resources	External Resource					Center for the Study of Traumatic Stress Coronavirus and Emerging Infectious Disease Outbreak Response Fact Sheets
Published	Y		N/A	Health Professionals	Collected Resources	External Resource					CDC Resources for Health Care Facilities
Published	Y		N/A	Health Professionals	Preparation	External Resource					Prepare to Care for COVID-19: Get Your Practice Ready
Published	Y		N/A	Health Professionals	PPE	External Resource					Strategies for Optimizing the Supply of PPE
Published	Y		N/A	Health Professionals	Preparation	External Resource					Steps Healthcare Facilities Can Take
Published	Y		N/A	Health Professionals	Preparation	External Resource					Interim Guidance for Healthcare Facilities
Published	Y		N/A	Health Professionals	Long-term Care	External Resource					Strategies to Prevent the Spread of COVID-19 in Long-Term Care Facilities
Published	Y		N/A	Health Professionals	PPE	External Resource					Updated CDC N95 mask guidance
Published	Y		MDE	Childcare & Schools	Child Care Facilities	Guidance					Child Development and Care Guidance
Published	Y		N/A	Childcare & Schools	Supports	External Resource					Helpine Young Kids Through the Coronavirus Crisis
Published	Y		MDE	Childcare & Schools	Child Care Facilities	Guidance					Guidance and Considerations for Child Care within Classrooms for Children Ages 6 weeks through 5 years During the COVID-19 State of Emergency
Published	Y		N/A	Childcare & Schools	Schools & Child Care Facilities	External Resource					CDC Interim Guidance for Administrators of US Childcare Programs and K-12 Schools to Plan, Prepare, and Respond to Coronavirus Disease 2019 (COVID-19)
Published	Y		?	Childcare & Schools	Schools Update	Guidance				2/28	MDE-MDHHS Coronavirus Letter
Published	Y		N/A	Childcare & Schools	Collected Resources	External Resource				3/9	Michigan Public Universities Web Resources on COVID-19
Published	Y		LEO	Employers & Workers	Unemployment Insurance	State Program					Unemployment Insurance – Resources for Employees
Published	Y		LEO	Employers & Workers	Unemployment Insurance	State Program					Unemployment Insurance – Resources for Employers
Published	Y		?	Employers & Workers	Food Establishments	Guidance					MDARD and MDHHS Guidance for Food Establishments
Published	Y		MEDC	Employers & Workers	Business Supports	State Program					MEDC Resources for Michigan Businesses During COVID-19
Published	Y		N/A	Employers & Workers	Preparation	External Resource					CDC - Interim Guidance for Businesses and Employers to Plan and Respond to Coronavirus Disease
Published	Y		N/A	Employers & Workers	Community Mitigation	External Resource					Interim Guidance: Get Your Mass Gatherings or Large Community Events Ready for Coronavirus Disease 2019 (COVID-19)
Published	Y		N/A	Employers & Workers	Employee Rights	External Resource					Pandemic Preparedness in the Workplace and the Americans with Disabilities Act
Published	Y		N/A	Employers & Workers	Preparation	External Resource					OHSA Guidance on Preparing Workplaces for COVID-19
Published	Y		N/A	Employers & Workers	Employee Rights	External Resource					OSHA - Information for Employees and Employers Regarding the Coronavirus Disease
Published	Y		N/A	Employers & Workers	Employee Rights	External Resource					US Department of Labor FAQ's on Fair Labor Standards Act and Family Medical Leave Act
Published	ADD		?	Health Professionals	Telemedicine	Provider Bulletin				3/20	COVID-19 Response: Telemedicine Policy Expansion: Prepaid Inpatient Health Plans (PIHPs)/Community Mental Health Services Prorams (CMHSPs) Implications
Published	ADD		?	Health Professionals	Face-to-Face Requirements	Provider Bulletin				3/18	COVID-19 Response: Relaxing Face-to-Face Requirement
Published	ADD		?	Employers & Workers	Supports	State Program					Learn About Available Support Programs
Published	ADD		?	Employers & Workers	Supports	State Program					Apply for Support with Food, Health Care, Housing and Other Services
Published	ADD		?	Residents	Supports	State Program					Apply for Support with Food, Health Care, Housing and Other Services
Published			James Bell							3/13	Guidance for Michigan Department of Health and Human Services Field Office and Adult Services for COVID-19
Published			Nicole Hudson							3/13	Guidance for Michigan Department of Health and Human Services Children's Services Agency & Contracted Child Welfare Providers for COVID-19
Drafting			James Bell				Not yet submitted			3/12	Guidance for Women, Infants and Children Program for COVID-19
Drafting										3/13	Guidance for Aging and Adult Services Agency
In Approvals			Nicole Hudson				Approved	Approved	Under review	3/16	Quick Referral for Health Care Providers
In Aaprovals			James Bell				Under review			3/16	Home Care Worker Guidance
Drafting			Nicole Hudson							3/16	Admit Discharge Protocols for LTC
In Approvals			Nicole Hudson				Under review			3/16	Guidance for Congregate Settings
In Approvals			Nicole Hudson				Under review			3/19	COVID-19 Planning Information for Behavioral Health Providers
Needed											

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Gordon, Robert (DHHS)
Subject: Question
Date: Monday, July 20, 2020 9:24:52 AM
Attachments: Rapid_Response_Staffing_Guidance_for_LTC_Facilities_Final_695568_7.pdf

---

Robert – wanted to talk with you or Elizabeth for 5 minutes today if one of you is available. thx

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

Obtained via MI FOIA by Judicial Watch, Inc.

Michigan Department of Health & Human Services

Rapid Response Staffing in Long-Term Care Facilities

The Michigan Department of Health and Human Services will be offering Rapid Response Staffing Resources in select counties to assist long-term care facilities who may be experiencing a staffing shortage. Rapid Response Staffing Resources will be available to nursing homes, assisted living centers, homes for the aged, and adult foster care homes.

Rapid Response Regions: Staffing will be available in

- West Michigan: Kent, Ottawa, Allegan, Muskegon, Newago, Montcalm Counties
- Southeast Michigan: Wayne, Oakland, Macomb, Livingston, Washtenaw Counties

Currently, MDHHS is only able to offer staffing support in the above listed counties.

Rapid Response Staffing Availability:
MDHHS will provide short term (72 hours or less) of consecutive staffing assistance to facilities facing staffing shortages. Staffing services will be supplied by 22nd Century Technologies, Inc. (TSCTI)

- Facilities will be able to request a maximum of one registered nurse and four certified nursing assistance/resident care assistants per shift
- Staffing will provide up to a total of 72 consecutive hours of staffing coverage

Facilities requesting staffing assistance **must demonstrate that they meet the criteria** in Appendix A by completing a brief survey within 24 hours of requesting staffing support. The survey requests basic details about the facility, number of staff who have missed shifts, whether emergency staffing protocols have been enacted, and if the facility has reached out to staffing agency for assistance. Any questions about Rapid Response Staffing can be sent to MDHHS-LTCStaffing@michigan.gov. Please note, requests for staffing assistance cannot be made via email.

If a facility fails to meet the criteria or fails to submit the survey within 24 hours of requesting staffing, the facility will be billed by MDHHS for the staffing costs.

To Request Rapid Response Staffing:

Contact 22nd Century Technologies, Inc (TSCTI) at 800-674-8380

Facilities must meet all criteria in Appendix A and complete the survey within 24 hours of requesting staffing resources.

By requesting staffing supports, facilities agree they have met the required criteria, will complete the survey, and acknowledge that failure to do so will result in MDHHS invoicing the facility directly for the cost of staffing supports.

Obtained via MI FOIA by Judicial Watch, Inc.

Requesting Facility Responsibilities:

The Requesting Facility must:

- Provide onsite supervision, at all times, while temporary staffing agency employees are working.
- Conduct orientation of temporary staffing agency employees to types of care provided and regulatory oversight requirements that are applicable to duties being assigned.
- Assess and only assign temporary staffing agency employees to duties that meet their specific qualifications and skills.
- Orient temporary staffing agency employees to patient or resident care plans as applicable to duties assigned.

Obtained via MI FOIA by Judicial Watch, Inc.

Appendix A: Long-Term Care Facility Emergency Staffing Criteria

Criteria for Requesting Staffing Support			
Facility Type	Demonstrated Need for Staffing Assistance	Enacted Emergency Protocol for Staffing	Facility Reached Out to a Staffing Agency but No Staff Available
Nursing Home	*Emergency Staffing*: 50% or more of scheduled nursing care staff (RNs, LPNs, and CNAs) have missed two shifts in a row	• If the home shares ownership or operational management with 5 or more nursing homes, have requested backup support from those homes • If part of a corporate structure with regional staff, have called upon those employees to provide care and supervision to residents. • Have conducted outreach to local Emergency Operations Center to explore coverage with medical volunteers • Have called upon staff in administration (Administrator, Director of Nursing, other department heads) to assist with providing direct care, supervision and non-ADL needs	Yes, staffing agency did not have staff available No, did not reach out to a staffing agency
Homes for the Aged	*Emergency* Staffing: 50% or more of scheduled staff have missed two shifts in a row	• If the home shares ownership or operational management with 5 or more homes, have requested backup support from those homes • If part of a corporate structure with regional staff, have called upon those employees to provide care and supervision to residents • If part of a continuing care retirement community, have requested staffing support from other areas of the CCRC operation • Enlisted members of management staff to assist with resident care and supervision where appropriate • Have conducted outreach to local Emergency Operations Center to explore coverage with medical volunteers	Yes, staffing agency did not have staff available No, did not reach out to a staffing agency

Obtained via MI FOIA by Judicial Watch, Inc.

Assisted Living Centers	*Emergency* Staffing: 50% or more of scheduled staff have missed two shifts in a row	• If the home shares ownership or operational management with 5 or more homes, have requested backup support from those homes • If part of a corporate structure with regional staff, have called upon those employees to provide care and supervision to residents • If part of a continuing care retirement community, have requested staffing support from other areas of the CCRC operation • Enlisted members of management staff to assist with resident care and supervision where appropriate • Have conducted outreach to local Emergency Operations Center to explore coverage with medical volunteers	Yes, staffing agency did not have staff available No, did not reach out to a staffing agency
Adult Foster Care Home Licensed as Large or Congregate	*Emergency Staffing*: 50% or more of scheduled staff have missed one shift	• If the home shares ownership or operational management with 3 or more AFC homes, have requested backup support from those homes • If part of a corporate structure with regional staff, have called upon those employees to provide care and supervision to residents. • Enlisted members of management staff to assist with resident care and supervision where appropriate	Yes, staffing agency did not have staff available No, did not reach out to a staffing agency
Adult Foster Care Home Licensed as Family or Small	*Emergency Staffing*: 50% of scheduled staff have missed one shift or there is reason to believe that staff will not be able to report for the next shift	• If the home shares ownership or operational management with 3 or more AFC homes, have requested backup support from those homes.	Yes, staffing agency did not have staff available No, did not reach out to a staffing agency

Obtained via MI FOIA by Judicial Watch, Inc.

Appendix B: Frequently Asked Questions

1. **Who is eligible to receive Emergency Staffing Resources?**
   Long-term care facilities (nursing homes, assisted living center, homes for the aged, and adult foster care homes) are eligible to receive emergency staffing resources if they have met MDHHS criteria, which includes:
   - Reside in one of the following counties: Kent, Ottawa, Allegan, Muskegon, Newago, Montcalm, Wayne, Oakland, Macomb, Livingston, Washtenaw
   - Demonstrated need for staffing, with specific staffing thresholds for each facility type
   - Enacted all the steps in the emergency protocol for staffing listed by facility type
   - Reached out to other staffing agencies without success of obtaining additional staff

2. **How do I access Emergency Staffing Resources if my facility meets all the criteria?**
   Once a facility has met all of the criteria, they can contact **22nd Century Technologies, Inc. (TSCTI) at 800-674-8380**. Facilities also must submit a survey certifying they have met criteria to MDHHS no later than 24 hours after submitting a request to TSCTI. **Failure to submit the survey or failure to meet the specified criteria *will result in the LTC facility being billed for all staffing services provided by* TSCTI.**

3. **How much and what types of staffing support will be available?**
   Facilities should only request the number of staff needed to fill in vacant positions. Facilities can request up to 5 staff members per shift that can include one registered nurse and up to four certified nursing assistants and/or residents care assistants.

4. **What if I need more than 5 staff members?**
   Facilities requiring more than the five allocated staff members can work with TSCTI or another temporary staffing agency to obtain additional staffing, however, the facility will have to pay for any staff support over the initial five covered under emergency staffing.

5. **How many shifts will TSCTI cover?**
   TSCTI will provide 72 consecutive hours of staffing services.

6. **What if I need staffing for longer than 72 hours?**
   LTC facilities that require longer term staffing than 72 hours, or who do not meet the criteria listed in Appendix A, or who reside outside of the select counties, can contact TSCTI at 800-674-8380 or another temporary staffing agency, who may have additional staffing resources available. LTC facilities will be responsible for contracting for services directly with the staffing agency. MDHHS will not pay for these services.

   Additionally, Medefis, an AMN Technology, is providing a portal to connect healthcare facilities with a network of regional and national staffing agencies to supply additional nursing professionals. There is no cost to the healthcare facility to join. Interested facilities can contact Brian Tobin at 402-315-1103 or Brian.Tobin@medefis.com.

7. **What if my facility finds another staffing contractor, will MDHHS pay for that?**
   No, if a facility is able to access another staffing agency then the facility *does not* meet the criteria for emergency staffing resources. MDHHS is only providing support for emergency staffing needs through TSCTI to facilities who have been unable to obtain staffing elsewhere.

Obtained via MI FOIA by Judicial Watch, Inc.

8. **What if my facility is not in one of the listed counties?**
   LTC facilities outside of the listed county can still request staffing support from TSCTI or another temporary staffing agency, however, the facility will be responsible for entering into an agreement with staffing contractor and paying for staffing resources.

9. **My facility is having difficulties filling out the survey documenting that the criteria for staffing was met, who should I contact?**
   The facility can contact MDHHS at MDHHS-LTCStaffing@michigan.gov. Please note, staffing requests cannot be emailed. If a facility is unable to complete the survey within 24 hours, and contacts the inbox during that window, the facility will not be penalized for failure to submit the survey. This inbox is staffed Monday-Friday 8am-5pm

10. **What type of tasks can the staff from TSCTI perform?**
    The staffing resources will support LTC facilities based on facility and resident need, but will be prepared to assist with activities of daily living (bathing, dressing, transferring, toileting, eating); provide infection prevention assistance; and provide environmental cleaning assistance. If a facility has a specific need or request, they should discuss that with TSCTI.

11. **Will TSCTI conduct licensing and background checks?**
    Yes, the individuals who will provide staffing support to long-term care facilities will be vetted by TSCTI including a criminal background check and a licensure check prior to being assigned to a facility. TSCTI will have this information available upon facility request.

12. **Will staff from TSCTI undergo TB and COVID-19 screenings?**
    As part of vetting by TSCTI, staff do have to provide negative TB test results. Currently, TSCTI is not including COVID-19 testing as part of their vetting process. However, temperature checks are taken for staffing coming in and out of facilities.

13. **Do the staff from TSCTI have to comply with the Emergency Order for weekly testing of Nursing Facility staff?**
    Yes, in some situations. Rapid Response Staffing Resources will only be available for a maximum of 72 consecutive hours. If nursing facilities are completing their routine, weekly testing of staff during the period that TSCTI is providing staffing support, then TSCTI staff should be tested. If TSCTI staff are no longer in the building when weekly testing occurs, they do not have to be tested as part of the facility.

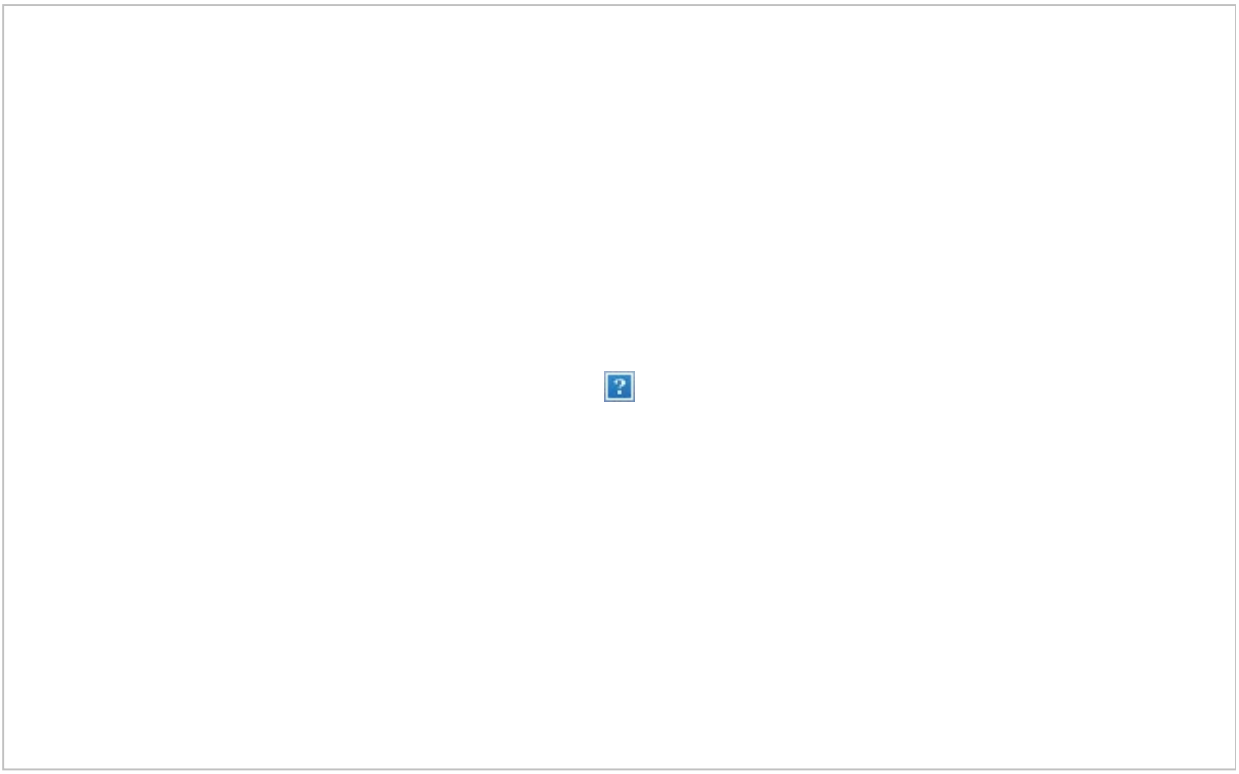
14. **I have additional questions that were not answered here, who should I contact?**
    Question can be sent to MDHHS at MDHHS-LTCStaffing@michigan.gov. Please note, staffing requests cannot be emailed and this inbox is staffed Monday-Friday 8am-5pm.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: LyonCallo, Sarah (DHHS); Khaldun, Joneigh (DHHS)
Cc: Gordon, Robert (DHHS)
Subject: Question on website
Date: Monday, September 21, 2020 8:45:05 AM
Attachments: image001.jpg

A quick question that someone raised for me. The map on the COVID-19 website shows total number of cases. If we only have one map here, do you think that's the best one? The more populated areas are always going to look worse. Wondering if the new cases, absolute per million, would be a better map here.

Thanks, Mark



Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email and any associated documents may contain information that is privileged or otherwise exempt from disclosure. It is intended for use only by the person to whom it is addressed. Please contact me before disclosure. If you have received this email in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

Obtained via MI FOIA by Judicial Watch, Inc.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Huls, JoAnne; Khaldun, Joneigh (DHHS); Hawks, Orlene (LARA)
Cc: Readinger, Patricia; Brousseau, Jessica; Totten, Mark; Foster, Tricia; Fox, Anita (DIFS)
Subject: RE: 2ND E-Mail - HHS COVID-19 Guidance - Governor Whitmer.pdf with Both Enclosures
Date: Tuesday, March 24, 2020 10:53:01 PM

We are doing most of the things requested here, but as we confront rising community spread in Detroit area, it could be worth a scrub to make sure we have not left anything valuable behind. It appears to me that most of the actual authorities are in LARA, with a few in DIFS. (+Director Fox)

Could we set up a conversation in the next day or so to discuss?

I'm not sure the letter actually requires a response, unless you want to take the opportunity to remind them of all the ways they're failing the country.

From: Huls, JoAnne <HulsJ1@michigan.gov>
Sent: Tuesday, March 24, 2020 8:24 PM
To: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Hawks, Orlene (LARA) <HawksO@michigan.gov>
Cc: Readinger, Patricia <ReadingerP@michigan.gov>; Brousseau, Jessica <BrousseauJ@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>
Subject: Fwd: 2ND E-Mail - HHS COVID-19 Guidance - Governor Whitmer.pdf with Both Enclosures

Second email - please let us know response.
Thanks

From: Hunt, Gregorio (HHS/IEA) <Gregorio.Hunt@hhs.gov>
Sent: Tuesday, March 24, 2020 8:19:41 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>
Cc: Johnston, Darcie (HHS/IEA) <Darcie.Johnston@hhs.gov>
Subject: 2ND E-Mail - HHS COVID-19 Guidance - Governor Whitmer.pdf with Both Enclosures

Dear Governor Whitmer,

Attached please find a letter from Secretary Azar and a guidance document regarding your healthcare workforce. Thank you for your attention to this important matter.

Best,
Darcie

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

Obtained via MI FOIA by Judicial Watch, Inc.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Gasper, Joe (MSP)
Cc: Gordon, Robert (DHHS); Foster, Tricia
Subject: Re: 3 Points
Date: Friday, April 3, 2020 4:31:28 PM

Perfect

From: Gasper, Joe (MSP) <GasperJ@michigan.gov>
Sent: Friday, April 3, 2020 4:30:51 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Foster, Tricia <FosterT13@michigan.gov>
Subject: 3 Points

Per your request for 3 new talking points. Are we close to what you're looking for? Director Gordon has seen these and approves. Thank you.

Please see the SEOC/CHECC facts for today.

- Tesla donated and shipped 40 ResMed ventilators (20 each to Henry Ford and Beaumont). Working in coordination with Tesla, Magna, HP, Faurecia are stepping up to 3D print an adaptor required for each unit.
- 10,000 N95 masks were received from the American Red Cross at the DTMB Warehouse for distribution.
- $66,338,107 issued in emergency allotment FAP (food assistance program) benefits last Saturday and Sunday. It went to 386,636 families.
- Bureau of Laboratories added data on the *cumulative number of specimens* tested for COVID-19 to www.michigan.gov/coronavirus Under Cumulative Data Section

Jg

Sent from my iPad

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Gordon, Robert (DHHS); Huls, JoAnne
Subject: RE: Available experts
Date: Friday, March 20, 2020 4:56:25 AM

Thanks, Robert. I will organize a 1 hour meeting with the governor with three 20-minute back-to-back calls.

SEOC does have a daily call, but I would suggest it's not the best use of your time – too granular.

I am working from home today (and as much as possible).

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Thursday, March 19, 2020 11:37 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>
Subject: Available experts

Per your request tonight, below are four individuals the Governor could consult on COVID-19.

Zeke Emanuel, UPenn, [redacted]
Andy Slavitt, USofCare, [redacted]
Josh Sharfstein, Johns Hopkins, [redacted]
Tom Frieden, fmr CDC Director, [redacted]

Those are cells. Let me know if I can help connect, but feel free also to reach out.

I will come to the SEOC tomorrow. Does it do a daily call I could usefully join?

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark
Subject: Accepted: COVID-19 Response

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark
Subject: Accepted: COVID-19 Response

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Totten, Mark
To:	Crockett, Tracy; Foster, Tricia; Huls, JoAnne; Rising, Jay; Flood, Jennifer; Laidlaw, Emily; Pohl, Zack; Khaldun, Joneigh (DHHS); Gordon, Robert (DHHS); Donofrio, Jeff (LEO); GSchedule; LyonCallo, Sarah (DHHS); Kolodin, Zach; Anderson, Evan (LEO)
Cc:	Smith, Dana; Smith, Tammy; Durkee, Amaya; LaForte, Lindsey; Volovsek, Emily; Bowden, Andrea (DHHS); Rockefeller, Cheryl (DHHS); White, Ricardo; Chrzaszcz, Monica (LEO); Lounds, Elizabeth (DHHS)
Subject:	AGENDA - Today"s MI Safe Start Call at 9:30 am
Date:	Tuesday, August 18, 2020 7:30:42 AM
Attachments:	200817 - Data and modeling update.pdf

Apologies I am getting this email to you late: I've been traveling and am still catching-up with my work and schedule. The governor will not be joining us and I anticipate today's discussion will be shorter. For your planning purposes, I will aim to conclude the meeting by 10 am and give you back 30 minutes.

Here's the agenda:

1. Update on outstanding issues (non-professional sports; businesses that remain fully closed).

2. Discussion of MI Safe Start Map and the new risk assessment for MERC Regions 1 (Detroit) and 4 (Saginaw), which has changed from "medium-high" to "high". For purposes of this discussion I've attached our most recent Data and Modeling Update (Aug. 17, 2020), and in particular you will want to reference slide 6. [Tracy, please add this attachment to the invite for today's call.]

3. Any other items.

Talk soon, Mark

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

-----Original Appointment-----
From: Crockett, Tracy <CrockettT1@michigan.gov>
Sent: Monday, May 11, 2020 5:05 PM
To: Crockett, Tracy; Totten, Mark; Foster, Tricia; Huls, JoAnne; Rising, Jay; Flood, Jennifer; Laidlaw,

Obtained via MI FOIA by Judicial Watch, Inc.

Emily; Pohl, Zack; Bagley, Nick; Khaldun, Joneigh (DHHS); Gordon, Robert (DHHS); Donofrio, Jeff (LEO); GSchedule; LyonCallo, Sarah (DHHS)
Cc: Smith, Dana; Smith, Tammy; Durkee, Amaya; LaForte, Lindsey; Volovsek, Emily; Bowden, Andrea (DHHS); Rockefeller, Cheryl (DHHS); White, Ricardo; Chrzaszcz, Monica (LEO); Anderson, Evan (LEO); Lounds, Elizabeth (DHHS); Kolodin, Zach
Subject: CALL: MI Safe Start (Weekly)
When: Tuesday, August 18, 2020 9:30 AM-10:30 AM (UTC-05:00) Eastern Time (US & Canada).
Where: Microsoft Teams Meeting

[redacted] (Toll)
Conference ID: [redacted] | **Host (Mark):** [redacted]

Local numbers | Reset PIN | Learn more about Teams | Meeting options

---

Obtained via MI FOIA by Judicial Watch, Inc.

From: Whitmer, Gretchen (MIEOG)
To: Gordon, Robert (DHHS)
Subject: Automatic reply: Help w/COVID-19
Date: Wednesday, March 18, 2020 10:09:56 PM

Thank you for contacting my office.

This message is to confirm that I have received your e-mail. My office will work quickly to reply to your concerns, however please note that some issues take longer than others to resolve.

If your matter is urgent, please call my office at (517) 335-7858 so that my staff may assist you right away.

Thank you again for taking the time to contact my office.

Sincerely,

Gretchen Whitmer
Governor of Michigan
Office: (517) 335-7858

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark; Pohl, Zack
Subject: Big ideas on social distancing
Date: Saturday, March 28, 2020 4:47:12 PM

---

1. Urgent message tonight for tomorrow: Stay at Home, Pray at Home
2. Masks: 10 Million Masks Project
    a. Commit to mass produce so everyone can have one within X days (note it's a good home project for people who sew)
    b. Not enough today, but that's another reason: STAY AT HOME.
    c. Press conf where Gov doesn't wear mask (because all don't have) but Dr. J wears mask (because it's protective)
    d. Many complexities here we could discuss, but I have talked to serious public health people and it is very plausible leadership
3. New orders on staying at home if sick
4. Offer $ to help you do the right thing
    a. Add messaging to UI application (Jeff checking if possible)
    b. New benefit to help people w low incomes who commit to stay home (update of old relief proposal)
5. Smaller stuff we are doing
    a. Use social media to trace contacts and send stay-at-home messaging (we have new partner coming online to do this by Monday)
    b. Nursing home special push
    c. Isolation wards

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Pohl, Zack; Totten, Mark
Cc: Khaldun, Joneigh (DHHS)
Subject: bullets for messaging
Date: Wednesday, October 21, 2020 10:20:00 AM

Here are the messaging bullets from deck today

- Wear a mask when you are inside with someone not in your family. In your own home, in your parent or child's home, anywhere.
- If you are eating or drinking together with others, take off your mask for as little time as you can. Try to be outside or physically distanced when you do. Minimize talking and volume.
- Limit the amount you eat or drink indoors with people who are not from your family. Bars and restaurants are open, but they are also sources of risk. Same for indoor dining with friends.
- Limit the amount you engage in other kinds of indoor activities outside the home like going to the movies, the mall, bowling, etc. If you socially distance and wear masks, you reduce risk, but risk remains.
- If you are going to church, wear a mask, physically distance, and avoid the singing and hugging that you may normally enjoy.
- All of the above applies with even more force to people at high risk

Robert Gordon
Director
Michigan Department of Health & Human Services
gordonr3@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Pohl, Zack; Totten, Mark
Cc: Khaldun, Joneigh (DHHS)
Subject: bullets for messaging
Date: Wednesday, October 21, 2020 10:20:00 AM

Here are the messaging bullets from deck today

- Wear a mask when you are inside with someone not in your family. In your own home, in your parent or child's home, anywhere.
- If you are eating or drinking together with others, take off your mask for as little time as you can. Try to be outside or physically distanced when you do. Minimize talking and volume.
- Limit the amount you eat or drink indoors with people who are not from your family. Bars and restaurants are open, but they are also sources of risk. Same for indoor dining with friends.
- Limit the amount you engage in other kinds of indoor activities outside the home like going to the movies, the mall, bowling, etc. If you socially distance and wear masks, you reduce risk, but risk remains.
- If you are going to church, wear a mask, physically distance, and avoid the singing and hugging that you may normally enjoy.
- All of the above applies with even more force to people at high risk

Robert Gordon
Director
Michigan Department of Health & Human Services
gordonr3@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Huls, JoAnne; Foster, Tricia; Totten, Mark; Pohl, Zack
Cc: Khaldun, Joneigh (DHHS); Hertel, Elizabeth (DHHS); Warsh, Jonathan (DHHS)
Subject: Call to Service with supporting infrastructure
Date: Tuesday, March 24, 2020 8:35:28 AM
Attachments: California COVID-19.png

Consider whether the Gov should issue a broad call to serve with the World War II theme, "We can do it."

She's already said the most important thing: we all can save lives by staying home.

But now she'd add: we can all do more. People want to, and they can.

To make this work, we would need to be able to receive volunteer requests and route them to real needs at the right scale. This would require hard work online (website/app) and with partners (Triple As, United Ways, etc.). This would cut across our current organization (some in People, some in Places, some in Education). But if you are interested, we could get it done.

More specific:

- Call to Action from the Governor, civic leaders, social media—brand it in some way as #viralkindness, Save Lives Corps, etc.
- Must be consistent with Stay Home, Stay Safe. Don't just "do something."
- Refer to a webpage/app that takes in information, simplified application, which is then provided to multiple sources based on interest geography
    - We have this dated website which captures information as a start, but it needs UX overhaul and likely new functionality.
- Service Opportunities
    - Volunteers with no training
        - Call a senior or person with disabilities to check in (coordinate w AAAs, home help agencies)** [need to check on level of need, but significantly more than we are meeting today]
        - Deliver food to a food bank for distribution [they have been asking for help]
        - Deliver food to a senior's doorstep, no physical contact [may be a bad idea]
        - Other ideas: Sew masks to spec? (Happening) Hygiene kits for the homeless? Blood donations? See attached from California.
    - Medical Corps—we are standing this up already, but would get a big push directly from Gov
        - Easier: Retired, trained elsewhere, close to certified, taking positions that pay [this is moving in People group, but would get branded and lifted up]
        - More complex: those who need new training, which has to be funded and sourced [People group has ideas, we could drive the best]
    - Child Care Corps—volunteers to serve at child care centers for medical professionals—still background checked
    - Potential new areas—potentially this becomes a jobs program for recently unemployed
        - Contact tracing [only useful once we scale tests—but could be collecting names

Obtained via MI FOIA by Judicial Watch, Inc.

and training people]

- Construction of new facilities [out-of-work-construction workers

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark; Foster, Tricia
Subject: Cases & Fatalities
Date: Monday, September 14, 2020 5:12:09 PM
Attachments: Deathwhatifscenarios.xlsx

We have had some conversations around the relationship between cases and fatalities, as well as the role of policy in variation across states. Yesterday Dr. Parekh did the analysis attached and below. The presentation tonight was jammed so it will be in next week's deck, but I wanted to share this now. Welcome feedback if there's further analysis you'd like.

Column F is the key on the first tab.

Thanks,
Robert

From: Parekh, Vikas <viparekh@med.umich.edu>
Sent: Sunday, September 13, 2020 4:09 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Megan Leitch <Megan_Leitch@mckinsey.com>
Cc: Pardo, Jennifer <jlbrenn@med.umich.edu>; Garifullin, Max <mgariful@med.umich.edu>
Subject: For consideration

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Three tabs in the spreadsheet.

Tab 1 is the analysis of what if scenarios in Michigan and what deaths would be in each scenario
Tab 2 is quick compilation of interventions in Michigan, Wisconsin, Illinois and timing
Tab 3 is MI, WI, IL case rates/population over time

Major takeaways of course are that in Tab 1 more cases equal more deaths. If we had case rates like our neighbors we'd have had hundreds of more deaths this summer.

In Tab 2 – hard to know what to make of the difference in reopening timelines – see below.

Tab 3- When I cross against case trajectories I can say it seems mask mandates/tightening of mask mandates in Michigan and Wisconsin seemed to result in a change in case trajectory (Michigan flattened, Wisconsin went down).
Wisconsin rose in May with an odd dip in June before rising again, Michigan started rising in June and Illinois a bit later in late June/early July. Maybe opening restaurants/bars later is correlated with the lag although hard to say. It is clear that Illinois and Wisconsin opened up before getting as low as Michigan in cases/population and that may explain a fair amount of the differences in trajectory. Illinois really didn't make any interventions most of the summer until it hit some regional triggers that went into effect late August/early September.

Obtained via MI FOIA by Judicial Watch, Inc.

Vikas

Obtained via MI FOIA by Judicial Watch, Inc.

What if Scenarios on Deaths in Michigan

		August rate 725/day avg	*use average summer CFR=1 August=10 deaths/day avg*		*use 30.5 days/month*	
Case Rate Scenario	**Similar to**	**Avg Daily new cases (confirmed)**	**Expected Daily Deaths at Steady State**	**Decrease or Increase in Daily Deaths vs. August**	**Difference in Monthly Deaths (N)**	**Difference in Deaths (percent)**
Sustain mid-late June Michigan	NY, NJ during July-August	325	4.6	-5.5	-166	-55%
August rate	n/a	725	10.2	0.0	0	0%
Increase August rate by 25%	Ohio in August	906	12.7	2.7	82	25%
Increase August rate by 50%	Indiana, Wisconsin in August	1088	15.2	5.2	159	50%
Increase August rate by 100%	Illinois in Late August-September	1450	20.3	10.3	314	100%

Obtained via MI FOIA by Judicial Watch, Inc.

From: Centers for Disease Control and Prevention
To: Jeremy Arieh
Subject: CDC COCA Call Tomorrow: Coronavirus Disease 2019 (COVID-19) Update and Infection Prevention and Control Recommendations
Date: Thursday, March 12, 2020 3:06:59 PM

COCA Call - CDC Clinician Outreach and Communication Activity

Coronavirus Disease 2019 (COVID-19) Update and Infection Prevention and Control Recommendations

Overview

During this COCA Call, presenters will focus on current information about

Date: Friday, March 13, 2020

Obtained via MI FOIA by Judicial Watch, Inc.

COVID-19 and provide clinicians with updated information on implementing infection prevention and control measures, assessing risks for exposures, and optimizing the use of personal protective equipment supplies.

Special Request: Due to the high demand we anticipate for this COCA Call, we kindly ask participants to access it in a group format, if possible, to allow for the maximum number of people to participate.

Watch on Facebook: You may also participate in this COCA Call by joining COCA's [redacted]

Advanced registration is not required.

Continuing Education will not be offered for this COCA Call.

There will only be a few slides for this COCA Call. Slides will not advance during the presentation portion of this webinar. You can find the slides under the "Call Materials" tab on the call page.

Time: 2:00pm–3:00pm (ET)

Please click the link below to join:
[redacted]

Or iPhone one-tap:
US: [redacted]

Or Telephone:
US: [redacted]

Webinar ID: [redacted]

International numbers available:
[redacted]

If you are unable to attend this live COCA Call, it will be available to [redacted] a few hours after the call.

Presenters

Nathan Furukawa, MD, MPH
Epidemic Intelligence Service Officer
Centers for Disease Control and Prevention

Michael Bell, MD
Deputy Director, Division of Healthcare Quality Promotion
Centers for Disease Control and Prevention

CAPT Lisa Delaney, MS, CIH (USPHS)
COVID-19 Response Worker Health and Safety Team
Centers for Disease Control and Prevention

The Emergency Risk Communication Branch in the Division of Emergency Operations, Center for Preparedness and Response is responsible for the management of all COCA products.

Obtained via MI FOIA by Judicial Watch, Inc.

For information about this update or other clinical issues, or to send your feedback, please contact us at coca@cdc.gov

- CDC Clinician Outreach and Communication Activity Facebook page—connect with COCA on Facebook
- Clinician Outreach and Communication Activity—resources for healthcare providers
- COCA RSS Feed—subscribe to be notified of conference calls, updates, and CDC guidance for health providers
- Crisis & Emergency Risk Communication Training—training program that draws from lessons learned during public health emergencies, and incorporates best practices from the fields of risk and crisis communication
- Health Alert Network—CDC's primary method of sharing cleared information about urgent public health incidents with public information officers; federal, state, territorial, and local public health practitioners; clinicians; and public health laboratories

CDC Logo

CDC and HHS logos are the exclusive property of the Department of Health and Human Services and may not be used for any purpose without prior express written permission. Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

Links to non-federal organizations are provided solely as a service to our users. Links do not constitute an endorsement of any organization by CDC or the federal government, and none should be inferred. CDC is not responsible for the content of the individual organizations.

Centers for Disease Control and Prevention

1600 Clifton Rd Atlanta, GA 30329 1-800-CDC-INFO (800-232-4636) TTY: 888-232-6348

Questions or Problems | Unsubscribe

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Gordon, Robert (DHHS)
To:	Smith, Tammy; Adams, Zaneta (DMVA); Ajegba, Paul (MDOT); Clark, Liesl (EGLE); Corbin, Susan (LEO); Nessel, Dana (AG); Eichinger, Dan (DNR); Estlund Olson, Liza (OSE); Eubanks, Rachael (TREASURY); Foster, Tricia; Fox, Anita (DIFS); Gasper, Joe (MSP); Hawks, Orlene (LARA); Hernandez, Poppy; Benson, Jocelyn (MDOS); Khaldun, Joneigh (DHHS); Kolb, Chris (DTMB); Lange, Michelle; Rogers, Paul (DMVA); Mark Burton (MEDC); McDowell, Gary (MDARD); Moss, Shenique; Rice, Michael (MDE); Rogers, Paul (DMVA); Schmittdiel, Cheryl (OSE); Speidel, Ryan (DTMB); Stibitz, Brom (DTMB); Totten, Mark; Washington, Heidi E. (MDOC); White, James (MDCR); Winters, Jan (MCSC); Brown, Tiffany; Flood, Jennifer; Tooman, Diane; Smiley, Melissa (MDOS)
Cc:	Abednego, Jaime (OSE); Amiee Evans (MEDC); Bowden, Andrea (DHHS); Bradfield, Mary Joe (MCSC); Burton, Diane (LEO); Carefoot, Karen (MDE); Carlisle-Hayes, Phyllis (LARA); Clifford-Alicea, Anne (DTMB); Crockett, Tracy; Gregory, Robin (DHHS); Hill, Nancy (DIFS); Kabia, Kara (TREASURY); Luebs, Heather (MSP); Plath, Edna (MDOC); Pleyte, Beth (DTMB); Poole, Elaine A. (MDOT); Sanford, Shawn (MDCR); Sawyer, Jennette (MDOS); Smith, Brenda (MDARD); Stafford, Amy (AG); Taylor, Jennifer (DMVA); Taylor, Rebecca (DTMB); Thelen, Mary Beth (EGLE); Tkaczyk, Judy (DNR); Vaughn,Kari L. (DMVA); Vaughn, Kari (DMVA); Smith, Dana; Smiley, Melissa (MDOS); Warsh, Jonathan (DHHS); Grossi, Christina (AG)
Subject:	Contact Tracing: Request for Help from SOM Employees
Date:	Thursday, November 19, 2020 3:09:00 PM
Attachments:	Contact Tracing_A Call to Save Lives.pdf

Dear Colleagues,

Good to see you earlier.

I was moved by the enthusiastic response to the call for help with contact tracing. We are in a moment of great need. We cannot do the vital work of containing the virus without help. Contract tracing is a unique opportunity for SOM employees to help save lives across our state.

I know your departments have tremendous burdens yourselves. We are looking for individuals who are enthusiastic, who have support from their supervisors, and who can work at least half-time for at least three months. We'll take volunteers as soon as they're available.

The attached one-pager explains more and includes a link to a Survey Monkey where individuals can indicate interest.

Please feel free to reach out to Jonathan Warsh (warshj1@michigan.gov) or to me if you have any questions. Many thanks.

Best,
Robert

-----Original Appointment-----
From: Smith, Tammy <SmithT89@michigan.gov>
Sent: Monday, November 9, 2020 12:31 PM
To: Smith, Tammy; Adams, Zaneta (DMVA); Ajegba, Paul (MDOT); Clark, Liesl (EGLE); Corbin, Susan (LEO); Nessel, Dana (AG); Eichinger, Dan (DNR); Estlund Olson, Liza (OSE); Eubanks, Rachael (TREASURY); Foster, Tricia; Fox, Anita (DIFS); Gasper, Joe (MSP); Gordon, Robert (DHHS); Hawks, Orlene (LARA); Hernandez, Poppy; Benson, Jocelyn (MDOS); Khaldun, Joneigh (DHHS); Kolb, Chris (DTMB); Lange, Michelle; Rogers, Paul (DMVA); Mark Burton (MEDC); McDowell, Gary (MDARD); Moss, Shenique; Rice, Michael (MDE); Rogers, Paul (DMVA); Schmittdiel, Cheryl (OSE); Speidel, Ryan (DTMB); Stibitz, Brom (DTMB); Totten, Mark; Washington, Heidi E. (MDOC); White, James (MDCR); Winters, Jan (MCSC); Brown, Tiffany; Flood, Jennifer; Tooman, Diane

Obtained via MI FOIA by Judicial Watch, Inc.

Cc: Abednego, Jaime (OSE); Amiee Evans (MEDC); Bowden, Andrea (DHHS); Bradfield, Mary Joe (MCSC); Burton, Diane (LEO); Carefoot, Karen (MDE); Carlisle-Hayes, Phyllis (LARA); Clifford-Alicea, Anne (DTMB); Crockett, Tracy; Gregory, Robin (DHHS); Hill, Nancy (DIFS); Kabia, Kara (TREASURY); Luebs, Heather (MSP); Plath, Edna (MDOC); Pleyte, Beth (DTMB); Poole, Elaine A. (MDOT); Sanford, Shawn (MDCR); Sawyer, Jennette (MDOS); Smith, Brenda (MDARD); Stafford, Amy (AG); Taylor, Jennifer (DMVA); Taylor, Rebecca (DTMB); Thelen, Mary Beth (EGLE); Tkaczyk, Judy (DNR); Vaughn,Kari L. (DMVA); Vaughn, Kari (DMVA); Smith, Dana; Smiley, Melissa (MDOS); Grossi, Christina (AG)
Subject: Cabinet Briefing
When: Thursday, November 19, 2020 12:00 PM-12:30 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Microsoft Teams Meeting

Microsoft Teams meeting

Join on your computer or mobile app
[redacted]

Or call in (audio only)
[redacted] United States, Pontiac
Phone Conference ID: [redacted]
Find a local number | Reset PIN

Learn More | Meeting options

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Huls, JoAnne; Foster, Tricia; Totten, Mark; Bagley, Nick
Cc: Khaldun, Joneigh (DHHS)
Subject: Containment strategy-testing, tracing, isolation
Date: Saturday, April 18, 2020 10:33:18 AM
Attachments: Containment-Isolation Strategy.pptx
Containment-Testing Strategy.pptx

Good morning all,

Look forward to conversations today on Testing and Tracing. I wanted to share a bit of framing and a request for a third meeting.

Consistent with expert guidance, we see at least a three-part strategy for containing the virus and reducing infections and fatalities as the economy reopens:

1. Testing
2. Tracing
3. Isolation

Technically, "Isolation" is really "Quarantine & Isolation," but the two travel together and we are shorthanding as "Isolation."

I've attached the materials for the Testing conversation in an hour, and will circulate those to the meeting group. The materials for the Tracing conversation will also go out soon. Attached also here is a deck on the topic of Isolation, which includes the hotels but is also broader. I am sure this could be greatly improved on, but it aims to be a start.

I would like to suggest a meeting to discuss isolation issues either today or tomorrow. The DHHS team would be Dr. J, Dr. SLC, Sarah Esty, and me. Thank you.

Best,
Robert

Robert Gordon
Director
Michigan Department of Health & Human Services
gordonr3@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

Containment strategy: Isolation

Draft for discussion

Obtained via MI FOIA by Judicial Watch, Inc.

Long term strategy to contain COVID: Test > Trace > Isolate

COVID-19 spreads primarily through close contact with infected people. Therefore, it is essential for those who are infected or likely infected to isolate themselves from others in order to avoid spreading the illness. Even during times of community transmission, self-isolation is critical to reduce further spread and protect members of a household from their ill family member.

Following the end of community spread of COVID-19, Michigan will need a robust testing, tracing, quarantine, and isolation strategy to respond to emerging outbreaks while easing up on work and travel restrictions. Under a stay-at-home order, community spread is controlled because everyone is at home. When an order begins to lift, community spread naturally increases again, unless sick and exposed people are identified (testing and tracking) and then separate themselves. Without quarantine and isolation, testing and tracing have little effect, and the virus continues to spread.

1

Test

Test as broadly as possible, including symptomatic people and exposed people in high risk settings, to identify sick people quickly before they infect others

2

Trace

For everyone with confirmed or probable COVID, use technology and tracing teams to rapidly identify the person's close contacts who may have been exposed

3

Isolate

Anyone infected should remain in isolation for at least 7 days after onset of systems, and should not leave isolation until they are 3-days fever free.

Close contacts should self-quarantine, with symptoms monitoring, for 14 days before returning to activities.

MDHHS

Obtained via MIFOIA by Judicial Watch, Inc.

Quarantine/isolation are core WHO & CDC recommendations for preventing exposed or ill people from infecting others

Quarantine

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

Quarantine is used to **keep someone who *might* have been exposed to COVID-19 away from others**. Someone in self-quarantine stays separated from others, and they limit movement outside of their home or current place. A person may have been exposed to the virus without knowing it (for example, when traveling or out in the community), or they could have the virus without feeling symptoms. Quarantine helps limit further spread of COVID-19.

Isolation

Isolation is used to **separate sick people from healthy people**. People who are in isolation should stay home. In the home, anyone sick should separate themselves from others by staying in a specific "sick" bedroom or space and using a different bathroom (if possible).



Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

If you feel healthy but:

- Recently had close contact with a person with COVID-19, or
- Recently traveled from somewhere outside the U.S. or on a cruise ship or river boat

Self-Quarantine

- Check your temperature twice a day and watch for symptoms.
- Stay home for 14 days **and** self-monitor.
- If possible, stay away from people who are high-risk for getting very sick from COVID-19.

If you:

- Have been diagnosed with COVID-19, or
- Are waiting for test results, or
- Have symptoms such as cough, fever, or shortness of breath

Self-Isolate

- **Stay in a specific "sick room" or area** and away from other people or animals, including pets. If possible, use a separate bathroom.
- Read important information about caring for yourself or someone else who is sick.

Obtained via MI FOIA by Judicial Watch, Inc.

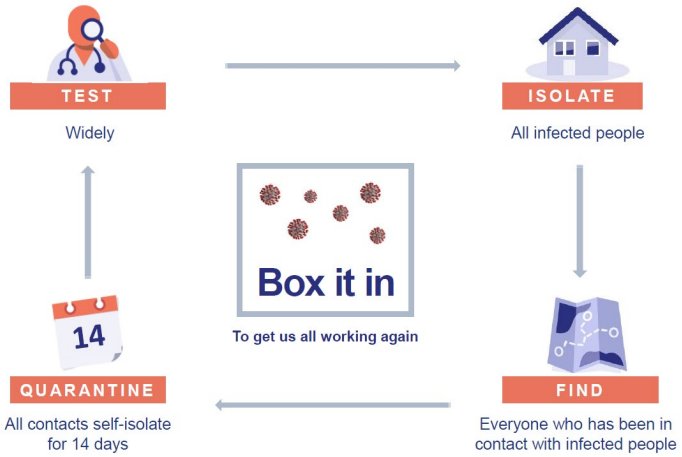
Experts also emphasize the importance of isolation



Dr. Tom Frieden

"[We should] secure safe and attractive spaces to isolate infected people — and others they may have infected — if they don't require hospitalization and cannot be safely cared for at home."

-- Dr. Tom Frieden, "I Used to Run the C.D.C. Here's What It Can Do to Slow This Pandemic." *The New York Times.* April 12, 2020



ISOLATE

Immediate isolation of those infected with COVID-19 is critical to reduce ongoing transmission

We need to identify cases, prevent spread, and support their isolation

ISOLATE TO STOP SPREAD

1. **Immediate isolation**, of individuals who test positive for COVID-19 with intensive control in congregate facilities e.g., nursing homes
2. **Support for ongoing isolation of the mildly ill**, by providing basic services for those who must remain isolation, including food and shelter if they cannot safely go home (e.g., space constraints, homeless, medically vulnerable household members).
3. **Monitor**, in case symptoms worsen and they need additional care
4. **Safely isolate and treat the severely ill**, by having sufficient health care system capacity to treat COVID-19 patients, and sufficient infection prevention and control practices to prevent health care worker infections
5. **Assess and improve**, policies on how to effectively isolate and when to discontinue isolation

RESOURCES FOR ISOLATED CASES AND QUARANTINED CONTACTS

Need incentives to manage isolation and quarantine with strong wraparound services

EXAMPLES AND IDEAS

Care packages could include

- Masks
- Thermometers
- Food, laundry, pharmacy services
- Health education materials
- Passwords for on-demand movies, e-books, learning channels
- Access to high-speed internet & laptops
- Hand sanitizer & alcohol-based cleansers
- Encouraging note from the mayor

Core resources such as

- Daily check-in phone calls
- Instructions of how to keep space clean for those sharing space
- A hotline for counseling, information, social services, and medical support
- Garbage removal
- Access to telehealth and care if ill
- Relocation to safe and desirable place, if requested

Financial support could include

- Stipend from government to those without sick leave or who need to take care of child or elderly dependents
- Work with employers to provide support, with possible tax credits

MDHHS

Obtained via MI FOIA by Judicial Watch, Inc.

Estimating the impact of effective isolation

Many people who have COVID or have a high-risk exposure will not automatically comply with self-isolation procedures. Low compliance rates significantly undermine the effectiveness of testing and tracing.

For example, let's assume that individuals who are rapidly tested after symptom onset and under strict quarantine will reduce the number of people they infect on average (R naught) from 2.4 to 0.4. (Plausible for a targeted vulnerable population with effective policies.)

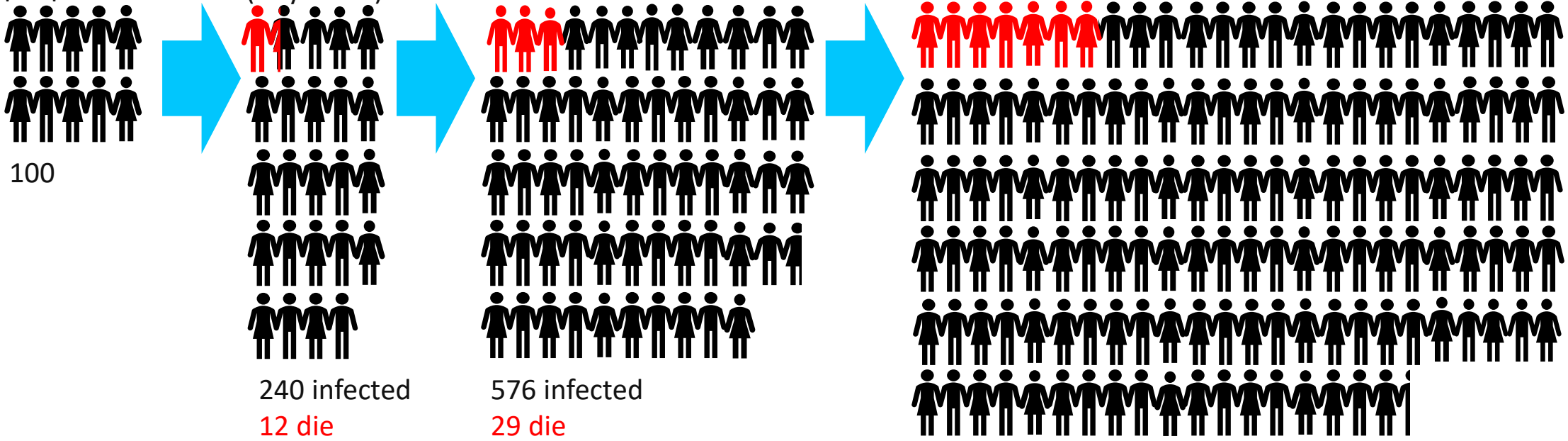
That would mean that every **100 people who go from being non-compliant to strongly compliant** would produce a **reduction of 200 people directly infected**, and assuming several more infection cycles (if each of those 200 people infect 2.4 more people, who then infect more people), it would **potentially avert about 2,100 infections in a month**.

Overall, Michigan is seeing a roughly 7% death rate based on reported positives (2093 deaths with 29263 cases), and the CDC estimates a 10-27% fatality rate among those 85+ (data is not yet available on death rates across all high-risk groups). However, given the likelihood of much higher unreported positives, let's assume a 5% death rate among high-risk groups. In that scenario, the 200 **directly averted infections would save 10 lives**, and the 2,100 **indirectly averted infections would save 107 lives.**

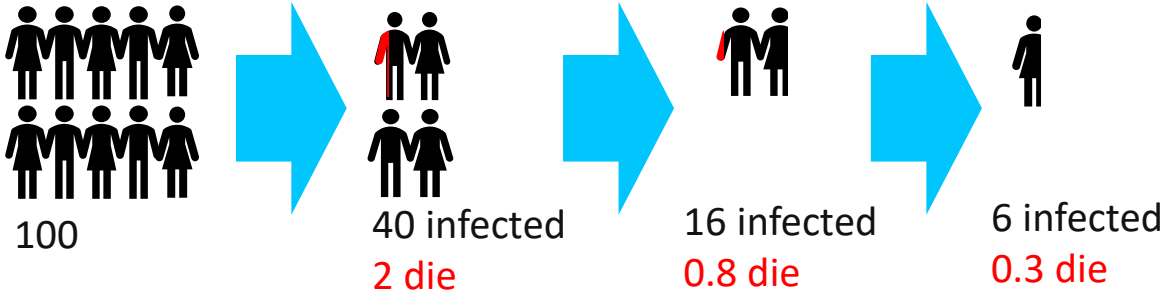
Obtained via MI FOIA by Judicial Watch, Inc.

Estimating the impact of effective isolation

Without effective isolation



With effective isolation



Without effective isolation, after about a month, those original 100 people will have infected ~2,200 people, leading to ~110 deaths.

With effective isolation, those same 100 people will only infect ~65 people, and only ~3 will die.

MDHHS

Obtained via MI FOIA by Judicial Watch, Inc.

Background: Approaches in Other Countries

Penalties:

- Police-enforced **fines** for non-compliance
- **Electronic monitoring** (e.g., ankle tracking)
- **Phone GPS tracking** or other surveillance

Incentives:

- **Free hotel** stay for Q/I
- Payments to individuals to **voluntarily participate in electronic monitoring** while in Q/I at home
- Payments to individuals to **encourage them to stay in a hotel** under Q/I

Examples

- **Singapore** requires people who need to self-isolate to share their phone's location at random times multiple times a day. Police also carry out spot checks in public places. Violators are fine up to $10,000 or up to six months in prison. It also pays self-employed workers $100/day to remain in isolation.
- **Taiwan** provides incentives like stipends and "goodie bags" of masks, snacks, gaming and movie services to those who comply with 14-day home quarantine, while also imposing stiff penalties fines of up to $33,000 on those disobey
- **Israel** plans to use cell phone data to identify people who may have come in contact with a COVID+ person, notify them of the need to self-isolate, and monitor whether they quarantine
- **Singapore, China, and Hong Kong** have established government quarantine facilities for people who cannot self-isolate at home

Obtained via MI FOIA by Judicial Watch, Inc.

Proposed options for Michigan today



	Effectiveness	Cost	Restriction of rights
1 Tell positives to self isolate			
2 Electronic reminders / nudges encourage self-isolation			
3 Mandate for COVID+ and PUIs to self-isolate			
4 Free isolation hotel option			
5 Payment & supports to self-isolate w/ monitoring			

Obtained via MI FOIA by Judicial Watch, Inc.

Proposed next steps

Electronic reminders / nudges for COVID+/ PUIs to self-isolate	▪ Explore technology options, including alignment with the tracing technology tools
Mandate for COVID+ and PUIs to self-isolate	▪ Consider EO for post-economy re-opening ▪ Develop options for EO enforcement
Free isolation hotel option	▪ Set up hotel room block + meal delivery for COVID+ workers at ACSs ▪ Call with Detroit/Wayne, Oakland, Macomb leadership to discuss establishing a small initial regional isolation hotel (as proof of concept)
Payment to self-isolate at home or in a hotel	▪ Develop a proposal on what incentives could look like, including necessary monitoring technology
Other	▪ Work with Local Health Departments, business leader group, and other experts to explore additional options (such as private sector requirements on facilities cleaning, PPE and training materials for families to do successful in-home isolation)

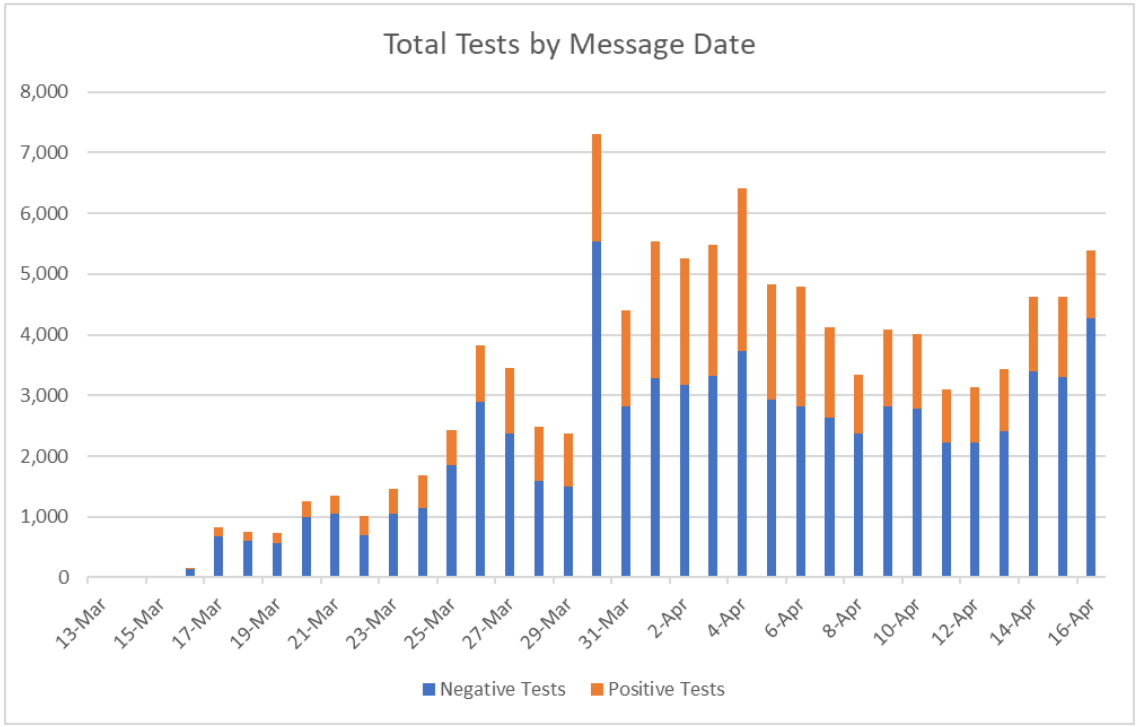
Obtained via MI FOIA by Judicial Watch, Inc.

Containment Strategy: Testing

April 18th, 2020
Discussion document

Obtained via MI FOIA by Judicial Watch, Inc.

Testing up – but still one-third to one-quarter level needed



- Tests/day fell, now rising again
- Currently averaging 4,800/day
- Experts recommended to Gov. 15,000 to 20,000 tests/day as goal
- Tests are undercounted due to reporting issues
  - 15,000+ more total than counted

Obtained via MI FOIA by Judicial Watch, Inc.

Could hit 10,000+ per day by 5/1 with aggressive efforts

Daily Tests	Known and Recommended Capacity Increases
4,800	Average over past 3 days
+1,000	National retail chain drive thrus (Walgreens, Walmart, CVS, Rite Aid)
+300	Match State Lab capacity to congregate care settings
= 6,100	**Known capacity increases**
+1,000	Bring new labs online
+200	Continue political push for more test kits & supplies
+5,000	Rapid, mass implementation of community testing
+500	Expand test eligibility to new populations
+250	Communications push on testing
=13,050	**Plausible capacity with recommended steps**
+TBD	Test capacity by 6/1 will build on steps taken by 5/1

Obtained via MI FOIA by Judicial Watch, Inc.

Testing requires four elements



Labs to process tests

- Labs online
- Test kits
- Reagents
- Swabs



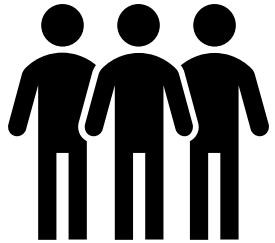
Sites to host tests

- Drive thrus
- On-site tests for key populations
- Home & mobile testing



Staff to perform tests

- Nurses
- Pharmacists
- Assistants/techs



Persons to take tests

- Eligible
- Accessible
- Know test is available

Obtained via MI FOIA by Judicial Watch, Inc.

Lab Capacity: Status

Issue	Status
Labs operational	▪ Nearly 30 online & more coming ▪ Commercial labs have higher throughput; some untapped
Test kits & reagents	▪ States and hospitals competing for limited supplies ▪ Per DTMB, state procurement not promising channel ▪ Highly specialized; limited ability for new manufacturing
Swabs	▪ Key constraint for many labs – but new types available ▪ Difficult for existing labs to switch, but new labs can use new types

Obtained via MI FOIA by Judicial Watch, Inc.

Lab Capacity: Recommendations

Recommendation:
- Push to bring online new **commercial laboratories using new swab types**
- Continue political **asks to companies** for more supplies

- Alternative swabs can be validated and have **steady, ample supply chains**: multi-collect, short nasal, endocervical

- **Theory:** equip high-throughput commercial labs with steady swab supplies
  - **Implementation:** 1) ask labs in process of validating to use alternate swabs and 2) encourage more MI commercial labs to equip for COVID testing

- Continue pushing for more supplies from existing suppliers to assist hospitals that are committed to that equipment

Obtained via MI FOIA by Judicial Watch, Inc.

Test Sites: Status

Issue	Status
Drive thrus	▪ 50+ operational; national retail chains beginning more ▪ (Detroit only): Essential employees
On-site tests for key populations	▪ Group living facilities at very high risk, but responsibility for testing there unclear (see slide 9) ▪ Other key populations with focal point sites: essential workplaces, factories / large worksites, first responders
Home & mobile testing	▪ Lack of transportation and other barriers prevent some from accessing community test sites

Recommendation:

- Begin **on-site testing for key populations**, using commercial lab capacity
- Expand drive thrus and rapidly develop **home & mobile testing** plan

Obtained via MI FOIA by Judicial Watch, Inc.

Test Sites: Recommendations

Recommendation: match lab capacity, test providers, and key populations

Population	Test Site	Lab capacity
Jails, prisons	Within facility	Commercial labs
Health workers	Hospitals; drive thrus	Hospital labs
Essential employees (Detroit)	Drive thrus	Commercial labs
Elderly living facilities	On-site; strike teams?	Commercial labs
Residential facilities & shelters	On-site; strike teams?	Commercial labs
People with access barriers	On-site: home & mobile testing	State Lab
First responders	Drive thrus	Commercial labs
Essential workers and any others returning to work	On-site for large employers; drive thrus for others	Commercial labs

Obtained via MI FOIA by Judicial Watch, Inc.

Test Staff & Strike Teams: Who and How

- **Options for Who:**
  - MI Primary Care Association
  - Pharmacists Association
  - Volunteer Corps
  - Medical or Nursing Students
  - Employers and Businesses
  - Local Health Departments
  - MING
  - Others?

- **Options for How:**
  - Require sites to test, leave to them how
  - Facilitate sites matching with lab & staff capacity (via associations)
  - Command & control: provide testing to sites through centralized process and dispatch of testing staff and/or strike teams

Obtained via MI FOIA by Judicial Watch, Inc.

Persons to take tests

Issue	Status
Eligibility	▪ All individuals with symptoms now eligible ▪ Next frontiers: exposed but asymptomatic group living facilities, health workers, first responders, and essential workers or any others returning to the workplace
Know test is available	▪ Pervasive message that coronavirus testing unavailable; previously accurate but no longer
Accessibility	▪ Transit, poverty, medical access, and other barriers ▪ Home & mobile testing plans (see test sites slide)

Recommendation:

- **Expand eligibility** to 'next frontier' groups and match with testing resources
- Begin **communications push on testing** availability

Obtained via MI FOIA by Judicial Watch, Inc.

Other methods of identifying sick individuals

Several options could **supplement early ID of sick people** when social distancing loosened, in addition to testing

1. **Surveillance**
   - Sentinel: test for COVID in random sample of flu-negative swabs
   - Syndromic: track hospital ED visits for COVID-like symptoms
   - Contact Tracing: robust tracing efforts, see separate deck
2. **Thermometer checks**
   - Temperature checks at workplaces; state or local health monitoring?
3. **Symptom diaries**
   - Workers and citizens to track daily symptoms; call LHD when sick

Obtained via MI FOIA by Judicial Watch, Inc.

Next steps

Daily Tests Target	Recommendation
+1,000	Bring new commercial labs online using alternative swabs
+200	Continue political push for more test kits & supplies
+5,300	Finalize and implement plan on test sites
	Finalize and implement plan on test staff
+500	Expand test eligibility to new populations
+250	Communications push on testing
=7,250	**Total**

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Pohl, Zack; Belden, Eileen
Cc: Khaldun, Joneigh (DHHS); LyonCallo, Sarah (DHHS); Darling, Darice (DHHS); Totten, Mark
Subject: COVID slides for today
Date: Thursday, November 12, 2020 8:24:00 AM
Attachments: 111220 potential slides.pptx

Zack and Eileen,

Per convo last night, here are some slides that either the Governor or Dr. J could voiceover today. Dr. LC developed them with our input. We can have McKinsey make them look nicer once there's agreement on content.

I'm happy to be in a convo about potential edits, but swamped so fine missing as well.

Thanks,

Robert

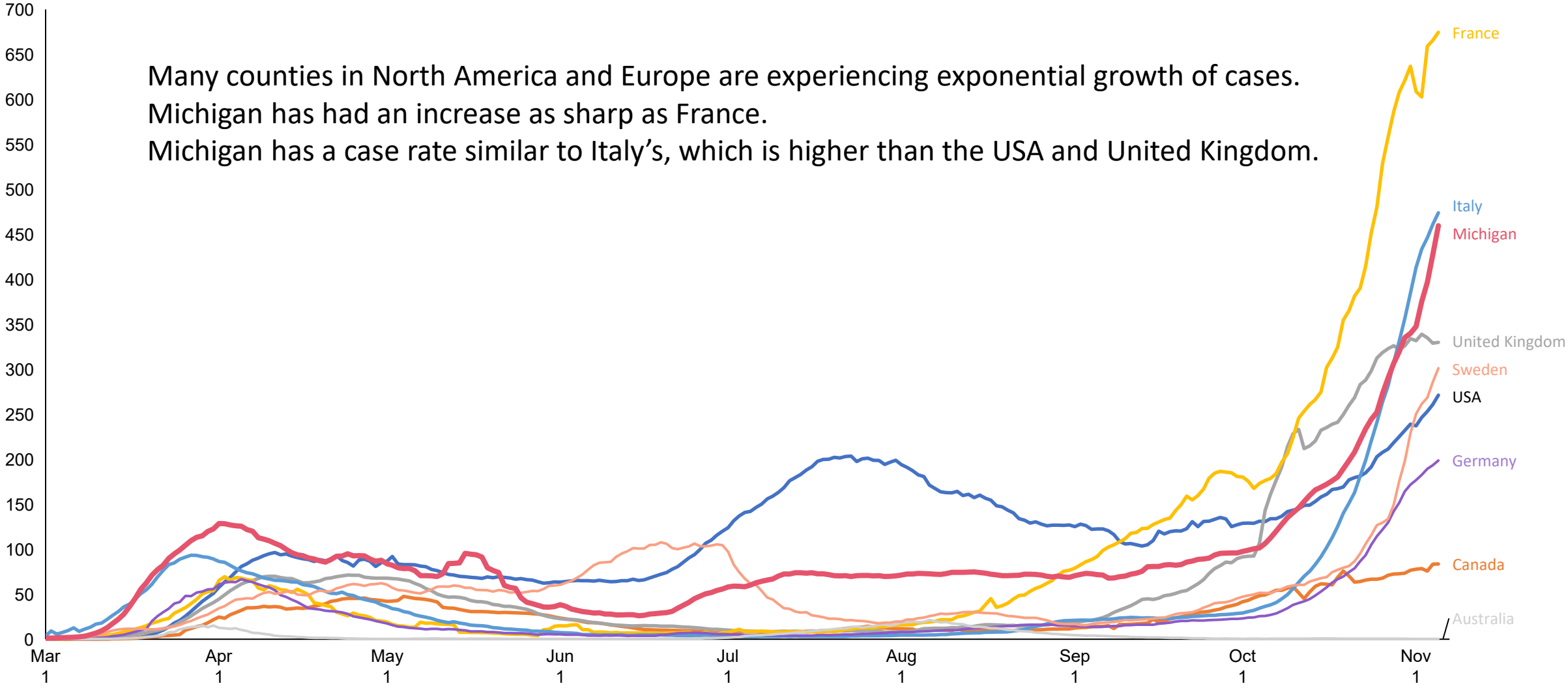
Obtained via MI FOIA by Judicial Watch, Inc.

Potential slides for 11/12

Obtained via MI FOIA by Judicial Watch, Inc.

Average daily new cases per million people by country

7-day rolling average COVID-19 cases per million people



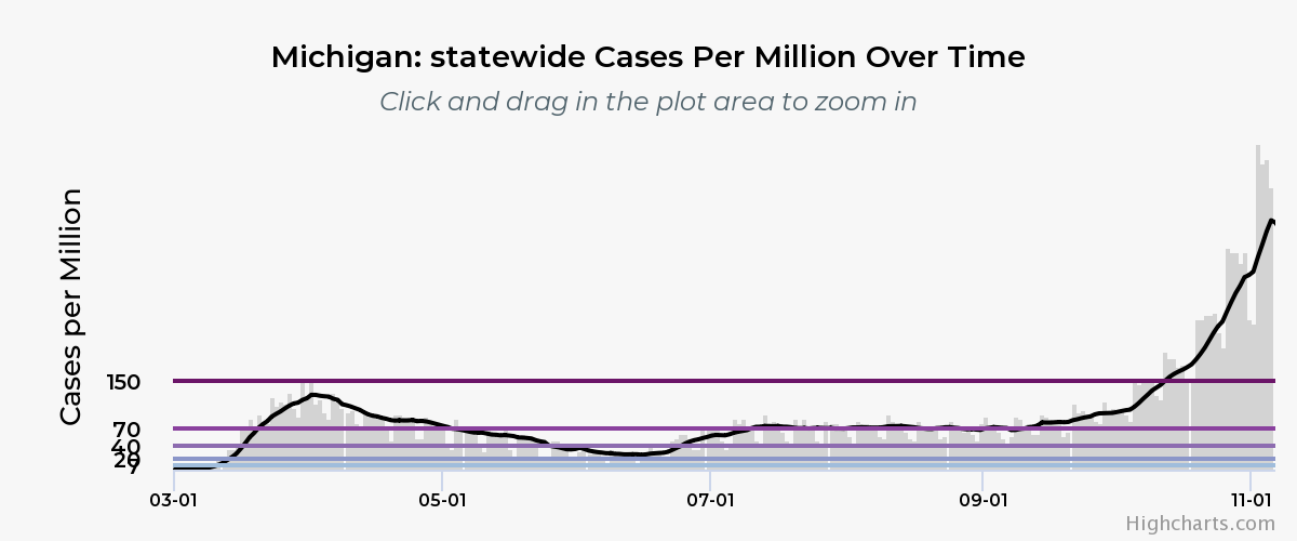
Source: ourworldindata.org/coronavirus; European CDC

Obtained via MI FOIA by Judicial Watch, Inc.

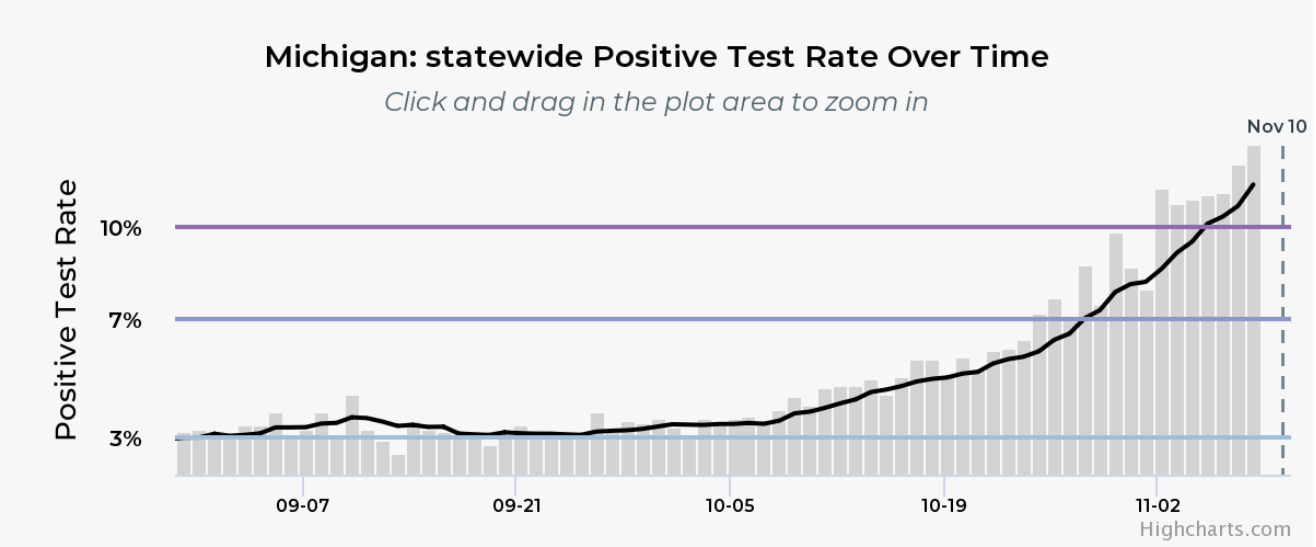
Exponential growth in cases

Cases are now 16 times higher than in June

- Early November highest rates in epidemic
  - 416 cases per million people on Nov 4th
- June 26th: lowest rate in epidemic
  - 26 cases per million people



- Percent of tests are positive over 10%
  - Case numbers will continue to increase



Obtained via MI FOIA by Judicial Watch, Inc.

Spread is happening all over Michigan

Insufficient sample size; fewer than 3 new cases

Fewer than 7 average daily new cases per million

7-20 average daily new cases per million

20-40 average daily new cases per million

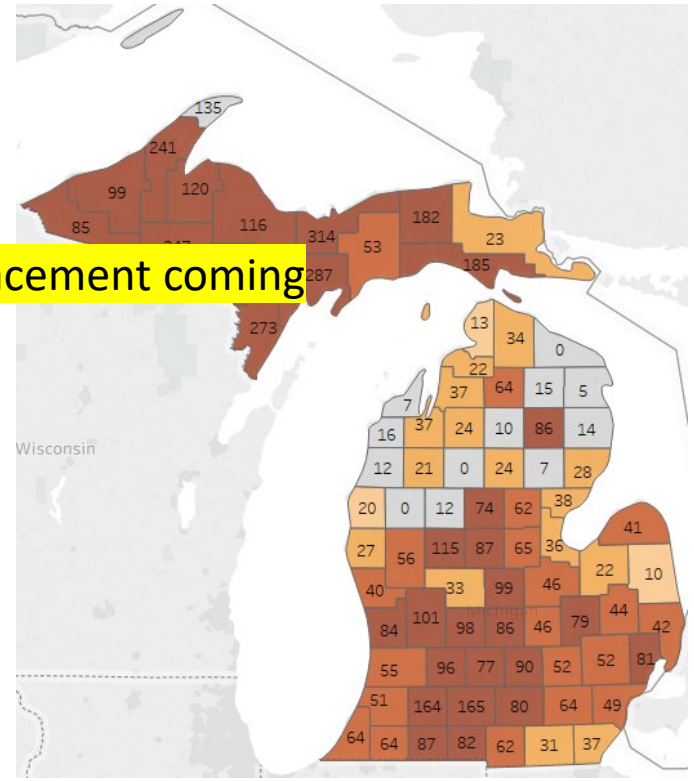
40-70 average daily new cases per million

70-150 average daily new cases per million

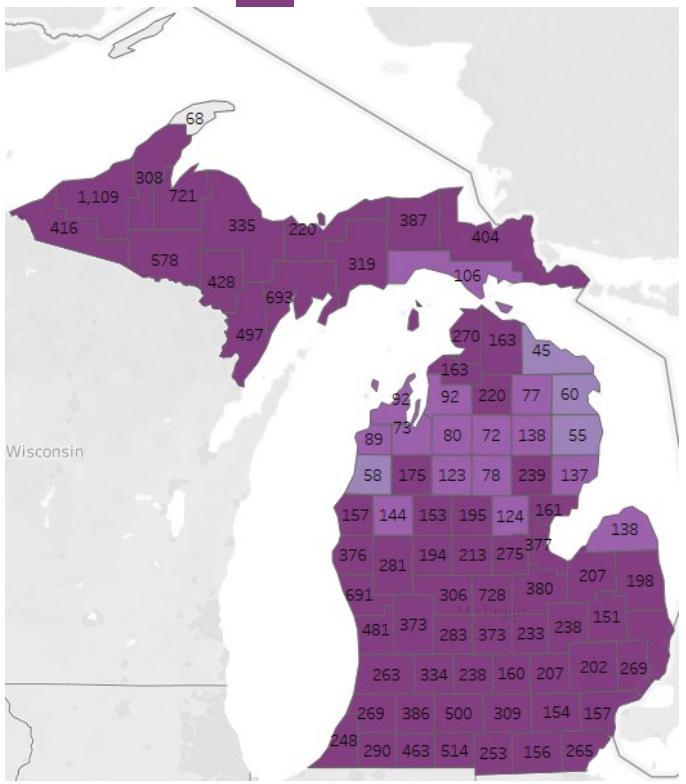
150 average daily new cases per million

10/3-10/10

Replacement coming



11/1-11/7

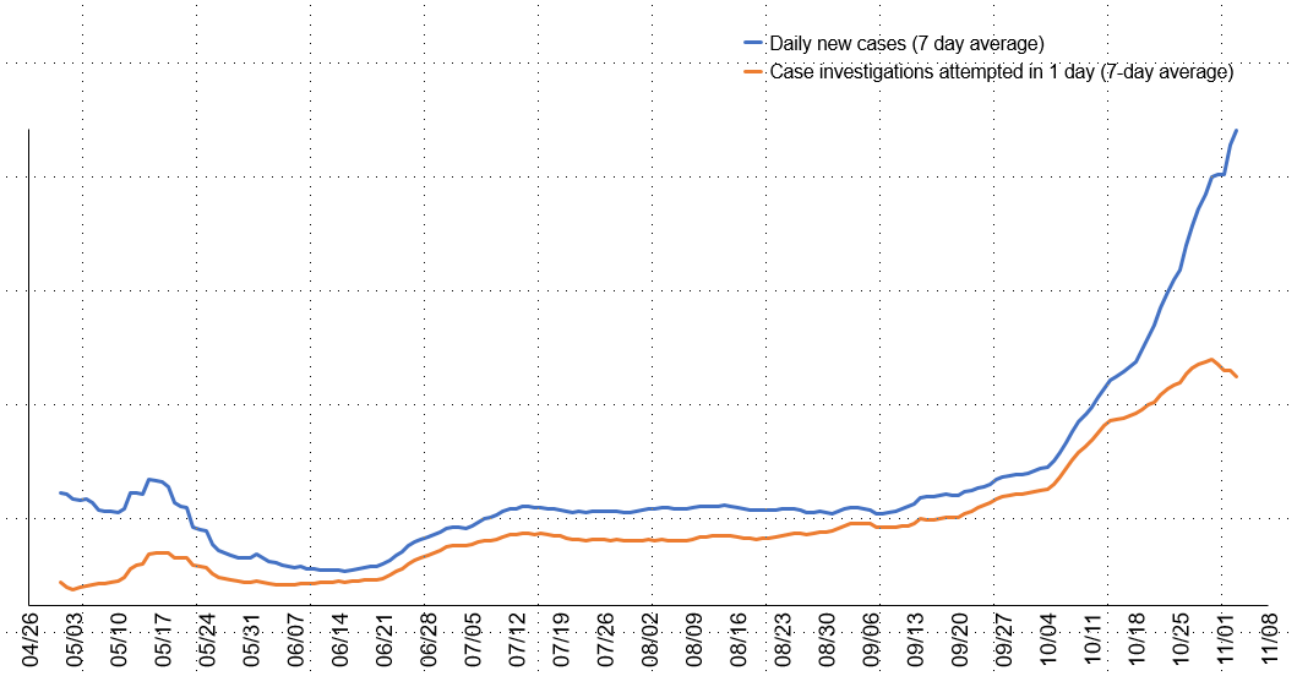


Obtained via MI FOIA by Judicial Watch, Inc.

Case investigations falling behind

The number of cases is now higher than the capacity of health departments

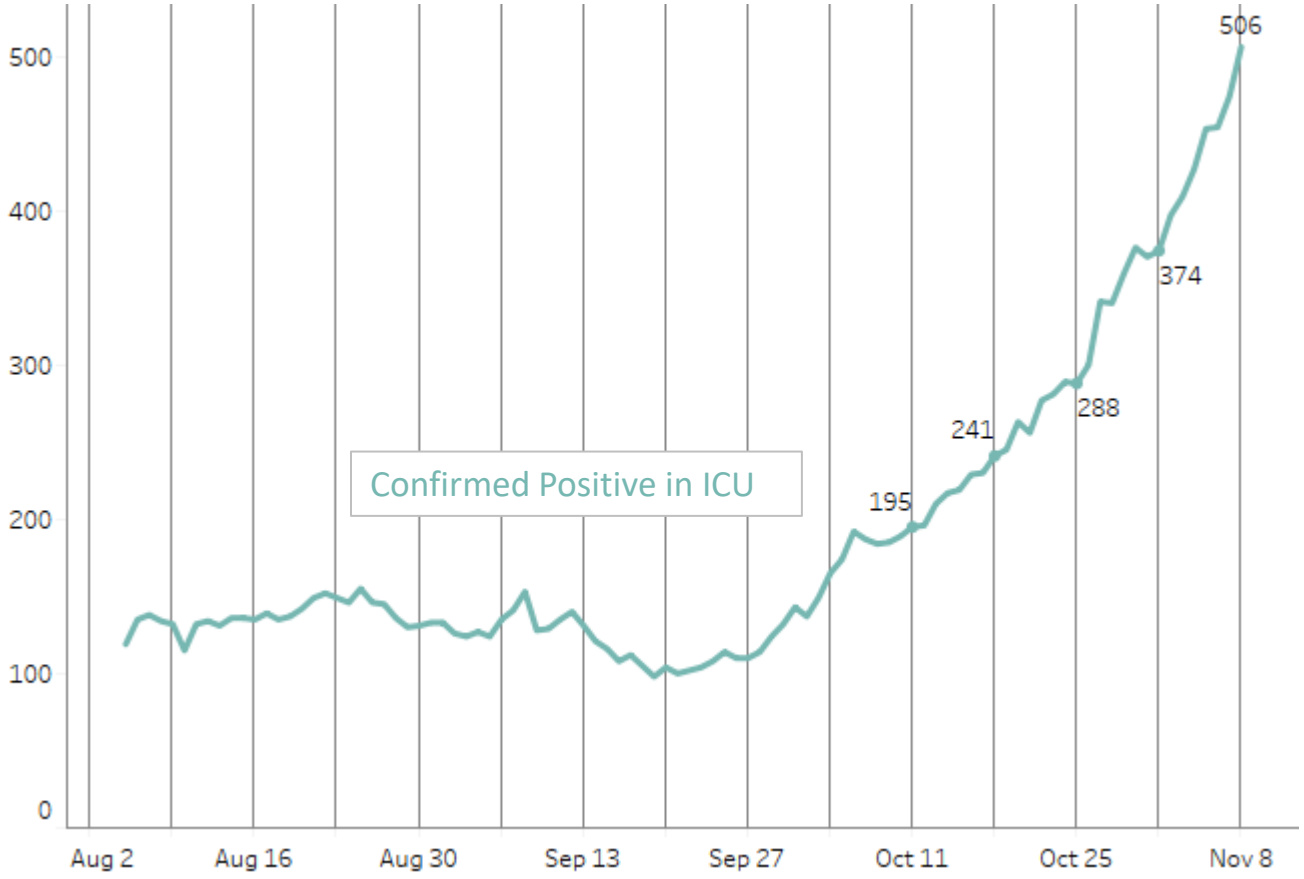
Not all close contacts will be reached.



Obtained via MI FOIA by Judicial Watch, Inc.

Increase in COVID Patients in Intensive Care

Hospitalization Trends 8/1/2020 – 11/8/2020
Confirmed Positive in ICUs



Statewide 20% of Adult ICU beds occupied with COVID

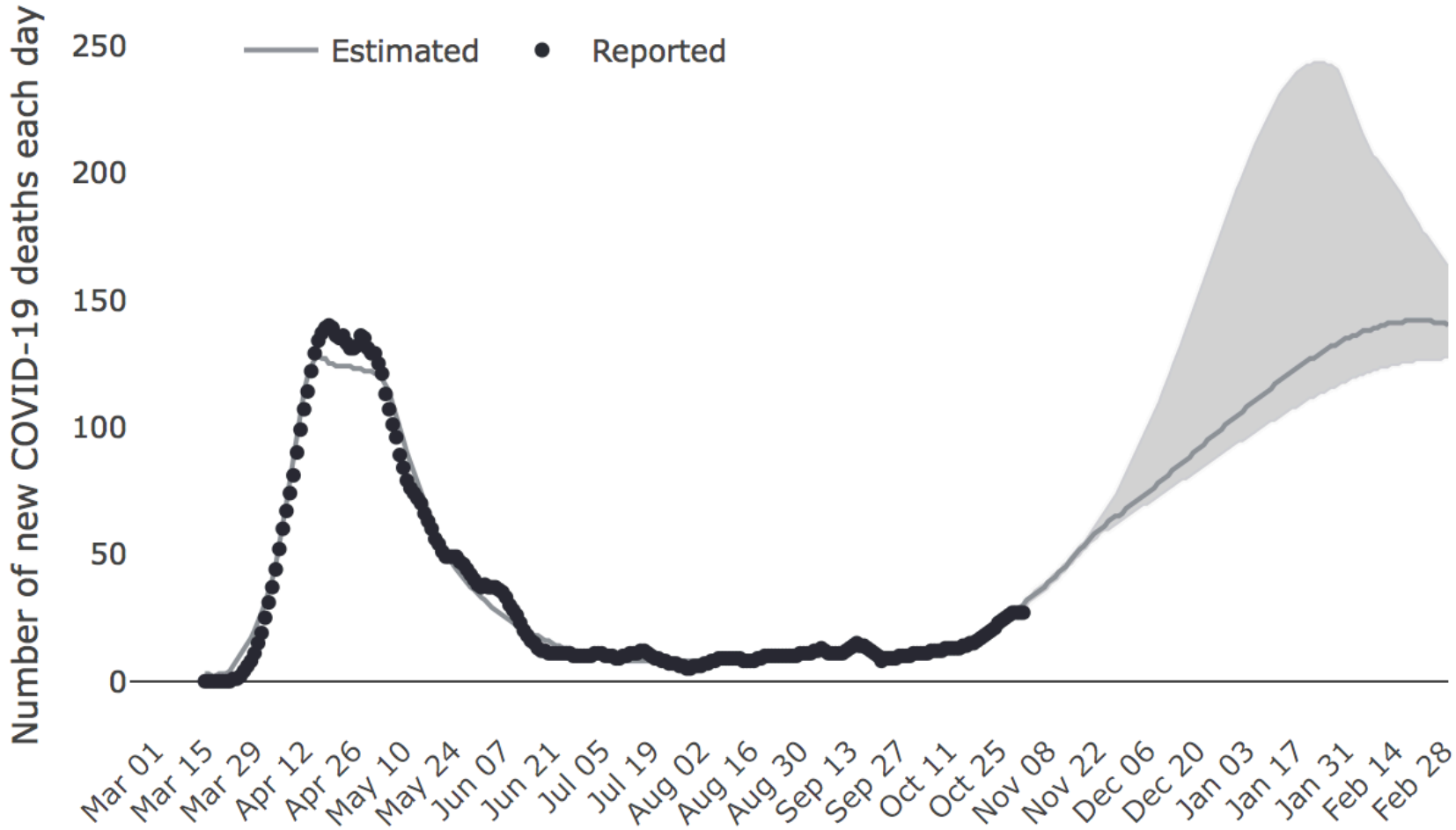
Hospitalizations in ICUs are also increasing at an accelerating rate.

Number of COVID patients in the ICU is 35% higher than last week.

Number of COVID patients in the hospital is 42% higher than last week.

Obtained via MI FOIA by Judicial Watch, Inc.

Longer-term forecasts also project increases in deaths through winter in MI



- Projected deaths over winter may exceed 100 deaths/day if no changes in social distancing or public health measures

Source: COVID-SIM

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Corbin, Susan (LEO); Hawks, Orlene (LARA); McDowell, Gary (MDARD); Gordon, Robert (DHHS); Clark, Liesl (EGLE); Gasper, Joe (MSP)
Cc: Esty, Sarah (DHHS); Kolodin, Zach; Grossi, Christina (AG); Foster, Tricia
Subject: COVID-19 - Enforcement workgroup
Date: Friday, November 27, 2020 6:40:00 AM

Directors –

As a next step in our COVID-19 enforcement measures, I would like to organize an informal workgroup to make sure our departments and agencies are coordinating. I'd like this group to meet 1x a week for most of December, and thereafter we can decide if it makes sense to just stay connected by email. I want to ask if each of you can designate one or more persons that should represent your department in this workgroup. In some cases, you may want more than one person if you have more than one agency or division that is focused on distinct areas of enforcement. Please let me know your designee(s) by cob Monday November 30, and what area/agency they represent. We will then schedule a first meeting for sometime next week, as well.

Many thanks, Mark

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email and any associated documents may contain information that is privileged or otherwise exempt from disclosure. It is intended for use only by the person to whom it is addressed. Please contact me before disclosure. If you have received this email in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Grossi, Christina (AG)
Cc: Gordon, Robert (DHHS); Warsh, Jonathan (DHHS)
Subject: COVID-19 Volunteer Program
Date: Wednesday, March 25, 2020 1:29:24 PM

Christina, I'm connecting you with Jonathan Warsh at DHHS. He is point to set up a program to enlist and organize volunteers to help with the COVID-19 response. I want to ensure the Department of Attorney General is advising and reviewing throughout the program development. I'll leave you and Jonathan to connect.

Thanks, Mark

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Gordon, Robert (DHHS); Khaldun, Joneigh (DHHS)
Cc: Razili Lewis
Subject: Disability and COVID-19
Date: Tuesday, April 14, 2020 6:41:25 AM

I know we are reviewing the issue of disability and the COVID-19 response in our Protocols Team. That process will take some time, but I want us to consider whether we have the governor include a statement at our Wednesday press conference in terms of high-level values. If you agree, do you have someone who could draft a few proposed TPs?

Thanks, Mark

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Flood, Jennifer; Laidlaw, Emily; Groen, Meghan; Stallworth, Tommy; Totten, Mark
Cc: Roubal, Lewis (DHHS); Khaldun, Joneigh (DHHS); Esty, Sarah (DHHS); Schwarzkopf, Emily (DHHS)
Subject: Drug felony bar to SNAP access
Date: Thursday, June 11, 2020 2:36:30 PM
Attachments: MI SNAP One pager for DHHS.pdf

Several groups have reached out in recent days asking if we could change SNAP policy to allow individuals with more than one drug-related felony convictions to receive SNAP. Attached fact sheet makes a compelling case, and DHHS is very supportive of the policy change. As you know, this requires legislative change; reason why is below. I wanted to flag for you in case this is something that the disparities task force wanted to talk about, or that we might have a realistic chance to achieve with the legislature this year. At the least, we'll be interested to talk about it as a priority in the next legislative session. Thanks.

7 CFR 273.11 (m)

Individuals convicted of drug-related felonies. **An individual convicted (under Federal or State law) of any offense which is classified as a felony by the law of the jurisdiction involved and which has as an element the possession, use, or distribution of a controlled substance (as defined in section 102(6) of the Controlled Substance Act, 21 U.S.C. 802(6)) shall not be considered an eligible household member unless the State legislature of the State where the individual is domiciled has enacted legislation exempting individuals domiciled in the State from the above exclusion. If the State legislature has enacted legislation limiting the period of disqualification, the period of ineligibility shall be equal to the length of the period provided under such legislation. Ineligibility under this provision is only limited to convictions based on behavior which occurred after August 22, 1996. The income and resources of individuals subject to disqualification under this paragraph (m) shall be treated in accordance with the procedures at paragraph (c)(1) of this section.**

As indicated above, the only way for a state to not implement the disqualification from SNAP for a second drug-related felony, is for the state legislature to enact legislation limiting this period of disqualification.
Michigan currently has the following:

Section 619 of the Mi Appropriations Act:

Sec. 619. (1) Subject to subsection (2), the department shall not deny title IV-A assistance and food assistance benefits under 21 USC 862a to any individual who has been convicted of a single felony that included the possession, use, or distribution of a controlled substance, for which the act that resulted in the conviction occurred after August 22, 1996, if the individual is not in violation of his or her probation or parole requirements. Benefits shall be provided to an individual, if the individual is the grantee (head of household), as follows:
(a) Family independence program benefits must be paid in the form of restricted payments when the grantee has been convicted, for conduct occurring after August 22, 1996, of a felony for the use, possession, or distribution of a controlled substance.
(b) An authorized representative shall be required for food assistance receipt. If the individual with the conviction is not the grantee, the food assistance shall be provided to the grantee.

Obtained via MI FOIA by Judicial Watch, Inc.

(2) Subject to federal approval, an individual is not entitled to the exemption in this section if the individual was convicted of 2 or more separate felony acts that included the possession, use, or distribution of a controlled substance and both acts occurred after August 22, 1996.

Obtained via MI FOIA by Judicial Watch, Inc.

Center for Employment Opportunities

Michigan's SNAP policy threatens public health and public safety.

- While federal law prohibits people with felony drug convictions from receiving SNAP, it deliberately grants states the discretion to waive that prohibition and allow individuals with felony drug convictions to be eligible for SNAP.
- This policy also has ramifications for the state's ability to draw down federal funding through the SNAP Employment and Training (SNAP E&T) program. If people are not eligible for SNAP, they cannot access E&T funding; in other words, for individuals who are eligible for SNAP, the SNAP E&T funding could help them access additional employment and training services at no cost to the state.
- Michigan lags behind most states which waive the felony drug conviction ban on SNAP benefits in its entirety.
- It is particularly critical that the state waive this restriction in light of COVID-19's continued spread throughout Michigan jails and prisons; the state should anticipate more people will be coming home and should be prepared to support them when they do.
- Lifting eligibility restrictions for SNAP is an opportunity to make decisions around COVID-19 that centers the needs of those who are most hard hit by this pandemic: impoverished communities of color that are overrepresented in the criminal system.
- Allowing more people with criminal convictions to receive food assistance and access job training programs helps the state reduce recidivism and with economic recovery.
- **We are requesting DHHS publicly state their desire to see this language changed in their budget.**

How is this related to COVID-19?

- The impact of COVID-19 on the health and economic stability of every American is unprecedented, and incarcerated people are being hit hardest. It is critical that the resources provided to people coming home from incarceration reflect the immensity of the challenge reentry poses under an economy that is severely retracting.
- This challenge will be most acute in the low-income communities of color from which so many currently incarcerated people come. In addition to health inequities, Blacks and Latinos are bearing more of the negative economic implications from the virus — further compounding historic racial disparities and over-representation in the justice system.

Obtained via MI FOIA by Judicial Watch, Inc.

- Michigan has emerged as one of the country's most hard-hit metro areas with its data revealing alarming racial disparities:
    - **Black Michiganders are overrepresented in COVID-19 related deaths more than any other state.** Black people are 14% of the state's racial demographic but account for over 40% of all COVID-19 related deaths in the state.

Philanthropy in Southeast Michigan has stepped up to provide immediate support to people coming home from incarceration, but government is needed for necessary policy change.

- Philanthropic partners have been working with justice system leaders, reentry providers, and advocates to understand gaps in reentry services in Michigan to address COVID-19.
- With support from philanthropy, The Center for Employment Opportunities (CEO) is administering a program to provide immediate income support to provide a financial safety net for those returning home. In total this project has the potential to offer stipends to 700 people returning home from incarceration to Detroit, resulting in more than $1.5 million in direct payments to people coming home from incarceration in the city.
- A key priority of this effort is improving access to SNAP benefits for people with criminal records who must have food security during a crisis. As a priority, Michigan must use its ability to waive the federal restriction that allows people with certain felony drug convictions to be barred from accessing SNAP for life.
- **State government, and DHHS in particular, can be part of the announcement of this philanthropic partnership by voicing their support for this policy change.**

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Rick, Matthew (DHHS)
Cc: Land, Kathy (DHHS); Gordon, Robert (DHHS); Kolodin, Zach
Subject: Emergency Rule Amending R 325.9031
Date: Saturday, May 16, 2020 9:13:23 PM
Attachments: 2020-205 HS - Covid-19 To Definition Section of Infectious Agents 4-27-20 FINAL_signed.pdf

Matthew,

Please find attached Emergency Rule Amending R 325.9031 (adding COVID-19 to definition section of "infectious agents"), signed by the governor.

Mark

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark

To: Ajegba, Paul (MDOT); Alles, Sheila (MDE); Benson, Jocelyn (MDOS); Brady, Mike (MDOS); Bridget McCormack; Brisbo, Andrew (LARA); Cami Pendell; Clark, Liesl (EGLE); Corbin, Susan (LEO); Deacon, Brad (MDARD); Donofrio, Jeff (LEO); Eichinger, Dan (DNR); Engelman, Mary (MDCR); Estlund Olson, Liza (OSE); Eubanks, Rachael (TREASURY); Foster, Tricia; Fox, Anita (DIFS); Gaedeke, Kimberly (LARA); Gagliardi, Patrick (LARA); Gasper, Joe (MSP); George, Dale (MSP); Gnodtke, John (MCSC); Gordon, Robert (DHHS); Grady, James (MSP); Gray, Steve (UIA); Grossi, Christina (AG); Guilfoyle, Jeffrey (TREASURY); Hawks, Orlene (LARA); Heidel, Gary (MSHDA); Hertel, Elizabeth (DHHS); Huntington, Jeff (LEO); Jen, Kyle (DTMB); Kalm, Rick (MGCB); Keenan, Kelly (AG); Khogali, Loren (LARA); Kolb, Chris (DTMB); Kratofil, Tony (MDOT); Linda Asciutto (MEDC); McDowell, Gary (MDARD); McGowan, Emmitt (MSP); Neill, Brian (MSL); Nessel, Dana (AG); Pascoe, DJ (AG); Rice, Michael (MDE); Rogers, Paul (DMVA); Smiley, Melissa (MDOS); Sonneborn, Suzanne (LARA); Speidel, Ryan (DTMB); Stibitz, Brom (DTMB); Talberg, Sally (LARA); Washington, Heidi E. (MDOC); Winters, Jan (MCSC); Andorfer, Corina; Bagley, Nick; Barton, Scottie; Brown, Melanie; Brown, Tiffany; Dagher, Ghida; Flood, Jennifer; Huls, JoAnne; Kletke, Malcolm; Kolodin, Zach; Laidlaw, Emily; Mariani, Phil; Moss, Shenique; Myers, Shaquila; Pohl, Zack; Readinger, Patricia; Rising, Jay; Shkreli, Suzanna; Singel, Wenona; Tompkins, Jasmine

Subject: EO 2020-32, Emerg order - vet services

Date: Monday, March 30, 2020 2:58:27 PM

Attachments: EO 2020-32 Emerg order - vet services (final signed).pdf

---

Please find attached EO 2020-32, an emergency order regarding veterinarian services.

Mark

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

Obtained via MI FOIA by Judicial Watch, Inc.

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
OFFICE OF THE GOVERNOR
LANSING

GARLIN GILCHRIST II
LT. GOVERNOR

EXECUTIVE ORDER

No. 2020-32

Temporary restrictions on non-essential veterinary services

The novel coronavirus (COVID-19) is a respiratory disease that can result in serious illness or death. It is caused by a new strain of coronavirus not previously identified in humans and easily spread from person to person. There is currently no approved vaccine or antiviral treatment for this disease.

On March 10, 2020, the Michigan Department of Health and Human Services identified the first two presumptive-positive cases of COVID-19 in Michigan. On that same day, I issued Executive Order 2020-4. This order declared a state of emergency across the state of Michigan under section 1 of article 5 of the Michigan Constitution of 1963, the Emergency Management Act, 1976 PA 390, as amended, MCL 30.401-.421, and the Emergency Powers of the Governor Act of 1945, 1945 PA 302, as amended, MCL 10.31-.33.

The Emergency Management Act vests the governor with broad powers and duties to "cop[e] with dangers to this state or the people of this state presented by a disaster or emergency," which the governor may implement through "executive orders, proclamations, and directives having the force and effect of law." MCL 30.403(1)-(2). Similarly, the Emergency Powers of the Governor Act of 1945 provides that, after declaring a state of emergency, "the governor may promulgate reasonable orders, rules, and regulations as he or she considers necessary to protect life and property or to bring the emergency situation within the affected area under control." MCL 10.31(1).

To suppress the transmission of COVID-19, it is crucial to limit in-person contact to the greatest extent possible. While there is currently no evidence that common pets can transmit COVID-19, the provision of veterinary services in-person nonetheless presents the risk of that the virus will be spread from person to person. Furthermore, the provision of veterinary services entails the use of health care resources, such as personal protective equipment, that are in immediate and critically high demand as a result of this pandemic. Accordingly, to mitigate the spread of COVID-19, protect the public health, provide essential protections to vulnerable Michiganders, and ensure the availability of critical health care resources, it is reasonable and necessary to impose temporary restrictions on the in-person provision of non-essential veterinary services.

Obtained via MI FOIA by Judicial Watch, Inc.

Acting under the Michigan Constitution of 1963 and Michigan law, I order the following:

1. Beginning as soon as possible but no later than March 31, 2020 at 5:00 pm, and continuing while the declared emergency is in effect, all veterinary facilities must implement a plan to temporarily postpone all in-person non-essential veterinary services until the declared emergency has ended ("plan").

2. A plan must provide that all veterinary services, essential and non-essential, must be performed by telemedicine to the fullest extent possible while the declared emergency is in effect. If a non-essential service cannot be performed by telemedicine, a plan must require that it be postponed. If an essential service cannot be performed by telemedicine, a plan need not postpone it and may allow it to be performed in person.

3. A veterinary facility must comply with the restrictions contained in its plan.

4. For purposes of this order:

   (a) "Non-essential veterinary services" means all veterinary services other than those that are:

      (1) necessary to preserve the life of a pet, as determined by a licensed veterinarian;

      (2) necessary to treat serious pain that threatens the health and safety of a pet, as determined by a licensed veterinarian;

      (3) necessary to euthanize a pet, as determined by a licensed veterinarian; or

      (4) necessary to treat or prevent the transmission of any infectious disease that can be transmitted between animals and human beings, as determined by a licensed veterinarian.

   (b) "Pet" means any domestic animal not raised for food or fiber.

5. Nothing in this order shall be construed to prohibit any medically indicated vaccination of any animal. Nothing in this order alters any obligation of an owner of an animal to vaccinate their animal as required by law or regulation.

6. This order does not alter any of the obligations under law of a veterinary facility to its employees or to the employees of another employer.

7. The director of the Department of Licensing and Regulatory Affairs shall issue orders or directives pursuant to law as necessary to enforce this order.

8. Consistent with MCL 10.33 and MCL 30.405(3), a willful violation of this order is a misdemeanor.

Obtained via MI FOIA by Judicial Watch, Inc.

Given under my hand and the Great Seal of the State of Michigan.



GRETCHEN WHITMER
GOVERNOR

Date: March 30, 2020

Time: 2:41 pm

By the Governor:

SECRETARY OF STATE

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark; Bagley, Nick; Kolodin, Zach
Cc: Roubal, Lewis (DHHS); Shaefer Luke
Subject: EO request
Date: Friday, March 27, 2020 5:37:41 PM
Attachments: MDHHS-ESA-EO-Request.docx

Mark, Zach, Nick,
We'd love to get this EO approved as soon as possible, realizing you have a lot going on. Lew Roubal is the Department's lead here and Luke Shaefer from U of M Poverty Solutions has played a key part as well.
Thanks,
Robert

From: Shaefer Luke <lshaefer@umich.edu>
Sent: Friday, March 27, 2020 2:47 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Cc: Roubal, Lewis (DHHS) <RoubalL@michigan.gov>; Rick, Matthew (DHHS) <RickM@michigan.gov>
Subject: Draft ESA request for Executive Order action

Robert-

We are requesting that the Governor consider four specific actions in an EO:

(1) waive the requirement in state law to provide 30-day's notice to the Michigan Legislature before implementation of policy changes to programs administered by MDHHS under the authority of the Social Welfare Act

(2) Allow MDHHS to delay redeterminations of eligibility for benefits from the Family Independence Program (FIP) and other economic security programs

(3) Suspend school attendance requirements for the Family Independence Program while Michigan public schools are closed

(4) confirm MDHHS's authority to reinstitute and update a previously utilized program that provides a "lump sum, non-recurring benefit" to low-income families with children, called Short-Term Family Support (STFS), to be re-named the COVID-19 Family Support Program [we will make a final decision on this policy over the weekend, but we will want an EO with the three items above regardless]

Details are in the attached document.

Obtained via MI FOIA by Judicial Watch, Inc.

ENHANCING THE AUTHORITY OF MDHHS TO ENSURE THE ECONOMIC SECURITY OF LOW-INCOME MICHIGAN FAMILIES DURING COVID-19

The COVID-19 emergency is endangering the economic security of large numbers of Michigan families. Last week the Michigan Unemployment Insurance Agency received the largest number of unemployment insurance claims in the State's history. Recent analyses by Goldman Sachs and others find that low-wage workers will be disproportionately impacted, yet research finds that many of them may have difficulty accessing unemployment insurance and will rely instead on public assistance.

Low-income families with children are particularly impacted by the current emergency. More than 1.5 million students in Michigan's public schools are at home without resources available to them at school. Fully 70 percent of these students get free or reduced-price lunch, which is linked to many positive outcomes related to nutrition, health, and cognitive development.

Last week applications for aid submitted to MDHHS grew nearly 40% from the week prior. Conditions are changing very rapidly and the Department needs the utmost flexibility to meet arising needs. MDHHS is pursuing every possible avenue to connect Michigan families with aid while they weather this unprecedented state of emergency. With such a fluid state, short-term changes to policies and administrative requirements are necessary to serve families as effectively as possible.

MDHHS has the authority to change many policies and procedures related to the administration of the economic security programs it administers.[1] However some matters are governed by state law. In an effort to serve low-income Michigan families impacted by COVID-19 as effectively as possible, MDHHS requests that the Governor use her executive authority in the following ways:

(1) waive the requirement in state law to provide 30-day's notice to the Michigan Legislature before implementation of policy changes to programs administered by MDHHS under the authority of the Social Welfare Act

MCL 400.6(3) requires that "…Not less than 30 days before policies developed under this subsection are implemented, they shall be submitted to the senate and house standing committees and appropriation subcommittees with oversight of human services."

So that MDHHS can be responsive to rapidly changing needs of families and the availability of resources through intervention by the Federal Government and other stakeholders, for the duration of the state of emergency, MDHHS requests the authority to make changes to policies and procedures immediately without the delay requisite in the 30-day notice requirement currently in law.

(2) Allow MDHHS to delay redeterminations of eligibility for benefits from the Family Independence Program (FIP) and other economic security programs

MCL 400.57d requires MDHHS to "reassess the recipient's eligibility for Family Independence Program assistance every 12 months after the date the application for Family Independence Program assistance was approved."

---

[1] See, for example, Chapter 400, Section 6, Part 3 of MCL, where the department:
(*3) …may develop policies to establish income and asset limits, types of income and assets to be considered for eligibility, and payment standards for assistance programs administered under this act.*

Obtained via MI FOIA by Judicial Watch, Inc.

For the duration of the state of emergency in order to reduce strain on MDHHS eligibility systems while the volume of need is extremely elevated and to protect families from the risk of losing benefits coverage, MDHHS requests that the Governor use her executive authority to temporarily suspend this requirement to conduct redeterminations. This mirrors action taken by the Federal Government to temporarily suspend redeterminations for Medicaid benefits, which MDHHS also administers.

(3) Suspend school attendance requirements for the Family Independence Program while Michigan public schools are closed

According to MCL 400.57b "a family independence program assistance group shall not receive family independence program assistance if a member of the program group does not meet the attendance requirements of section 1561 of the revised school code, 1976 PA 451, MCL 380.1561, with respect to a child under the age of 16. Except as provided in subsection (7) and beginning after the date on which the department implements the policy described in subsection (7), if a member of the program group does not meet the attendance requirements of section 1561 of the revised school code, 1976 PA 451, MCL 380.1561, with respect to a child age 16 and above, the child shall be removed from the program group. The department shall implement policies in accordance with this subsection that are effective and binding on all program groups and are exempt from the rule promulgation requirements of the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328."

The act goes on to require that " (7) Not later than June 11, 2016, the department shall implement a policy that it must follow before terminating a family independence program assistance group from receiving family independence program assistance as provided in subsection (6) or before removing a child from the program group as provided in subsection (6). The department shall apply the policy described in this subsection before removing a family independence program assistance group from receiving family independence program assistance as described in subsection (6) and before removing a child from a family independence program assistance group as described in subsection (6)."

For the duration of the public emergency, in light of the closure of public schools in Michigan, MDHHS requests that the Governor use her executive authority to temporarily suspend this requirement by law that children of families receiving Family Independence Program assistance meet school attendance requirements, and suspend all attendance and enrollment verifications that the Department is required to conduct. Regarding the school attendance and enrollment, we are requesting that department could accept the statement of the client that the minor child or minor parent is enrolled in school.

(4) **MDHHS seeks authority to reinstitute and update a previously utilized program that provides a "lump sum, non-recurring benefit" to low-income families with children**, called Short-Term Family Support (STFS).

Based on the recommendation of the United States Department of Health and Human Services, Administration for Children & Families, MDHHS seeks the authority to re-institute this program. The program will be renamed the **COVID-19 Family Support Program**. The goal is to provide immediate, one-time income support to families negatively impacted by the COVID-19 who do not qualify for the Family Assistance Program (FIP) and have difficulty accessing unemployment insurance. This group will include many working poor—sometimes called "ALICE"—households.

Obtained via MI FOIA by Judicial Watch, Inc.

The Department will use its authority to set policies related to eligibility and payment standards, as provided in Chapter 400, Section 6, Part 3 of MCL, under which the department:
(*3) …may develop policies to establish income and asset limits, types of income and assets to be considered for eligibility, and payment standards for assistance programs administered under this act.*

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark
Cc: Khaldun, Joneigh (DHHS); LyonCallo, Sarah (DHHS)
Subject: For Gov remarks
Date: Tuesday, October 20, 2020 7:58:00 AM

Mark,
Per our convo

- Significant number of outbreaks in churches as of last week are listed below. Dr. LC may now have more.
- Basic message for churches is: outdoors if possible; if it has to be inside, socially distance (<50% capacity, 6 feet), wear masks, not the time to sing or touch
- Outbreaks from small indoor gatherings, even two families. Hence: be outdoors whenever you can. If you have to be inside, minimize size of groups, in and out of home. Wear a mask if you are with people from outside your family, even in your house. Eating a meal with another family is source of risk; if you're going to do it, try to socially distance, minimize the time.

We'll look to have more later or tomorrow am.
Thanks,
Robert

From: LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>
Sent: Thursday, October 15, 2020 6:16 PM
To: Foster, Tricia <FosterT13@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: RE: Can you forward the list of faith location

A few others. The formats differ by regions

Region 8

- Luce (157% increase) – Curtis Baptist Church (2 cases), Curtis Clinic (2 cases), Curtis School (3 cases)

Region 5
Region 5 Outbreaks (cases reported in the past two weeks, 9/30-10/13)

Status	Type of Outbreak	County	Facility/Name	Number Cases
Ongoing	Worksite/Church	Calhoun	Victory Life Church	3
New	Mass Gathering	Barry	Nashville Baptist	1
New	Mass Gathering	Kalamazoo	Radiant Church	45
New	Mass Gathering	Barry	Peace Church	12
Ongoing	Mass Gathering	Calhoun	Wedding [redacted]	3
Ongoing	Mass Gathering	Cass	Moose Lodge	1
Ongoing	Mass Gathering	Calhoun	Wedding [redacted]	7
Ongoing	Mass Gathering	Cass	First Pentacostal Church	3
Ongoing	Mass Gathering	Calhoun	[redacted] Party	2

Region 3 – Oscoda amish communities

Obtained via MI FOIA by Judicial Watch, Inc.

Region 2N

- New outbreaks since 10/6
    - Churches/Faith Organizations
        - Apostolic Church – Port Huron, MI
            - 20 cases, all St Clair County residents
                - Exposures likely occurred at church service on 9/27 and a prayer study on 9/30
            - OUTBREAK ID APOSTOLIC CHURCH PORT HURON, & APOSTOLIC CHURCH PORT HURON SECOND
    - Large Gatherings/Events
        - Wedding in Bowling Green, KY
            - 4 cases, all Oakland residents
            - Outbreak ID 9.26 WEDDING CHARLESTON BOWLING GREEN KENTUCKY

From: LyonCallo, Sarah (DHHS)
Sent: Thursday, October 15, 2020 6:08 PM
To: Foster, Tricia <FosterT13@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: RE: Can you forward the list of faith location

Do you want other regions as well?

Region 6:

- Churches
    - *New* Bethal Church in Kent County
        - 6 cases
        - Outbreak ID: COVID19BETHEL10-20
    - *New* New Community Church in Kent County
        - 3 cases
        - No outbreak ID yet
    - *New* Potter's House Church in Isabella County
        - 4 cases
        - Outbreak ID: POTTERS HOUSE 10/2020
    - *Ongoing* Mel Trotter Ministries in Kent County
        - 3 cases
        - No outbreak ID yet
    - *Ongoing* Family Life Church of God Belding in Ionia County
        - 6 cases
        - Outbreak ID: FAMILY LIFE CHURCH OF GOD BELDING C19 9-2020
    - *Ongoing* Maranatha Baptist Church in Isabella County
        - 3 cases
        - Outbreak ID: MARANATHA 10/2020
    - *Ongoing* City Church Rockford in Kent County

Obtained via MI FOIA by Judicial Watch, Inc.

- 50 cases
- Outbreak ID: COVID19_CITYCHURCHROCKFORD-092020

Region one

- Clinton (26% increase – 25 more cases than previous 2 week period)
  - *New* Hope Bible Baptist Church in Maple Rapids (7 cases total, 1 Clinton, 6 Gratiot). Referral Date range 9/28 – 10/5. Outbreak ID COVIDHOPEBIBLEBAPTISTCHURCHMR2020
  - *New* [redacted] Funeral on 9/26-9/27 (12 cases total, 6 in Clinton). Referral Date Range 9/29 - 10/5. Outbreak ID COVIDOSENTOSKIFUNERAL09/2020
- Jackson (33% increase – 68 more cases than previous 2 week period)
  - *New* Bethel Church 3 cases. Referral date range 10/5 – 10/7. Outbreak ID BethelChurchCovid
  - 1 case in Jackson county jail reported 10/10/20

- Lenawee (34% increase – 33 more cases than previous 2 week period)
  - *New* Christian Mission workplace. 2 employee cases. Referral date range 10/9-10/10. Outbreak ID CHRISTIAN MISSION 10-2020
  - *New* Solid Rock Church. 3 cases. Referral date range 10/3-10/5. Outbreak ID SRCHURCH 10-2020

From: Foster, Tricia <FosterT13@michigan.gov>
Sent: Thursday, October 15, 2020 6:04 PM
To: LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: Can you forward the list of faith location

Outbreaks you showcased at 5 pm please? Working on this topic with the team right now. Ty

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Totten, Mark
To:	Donofrio, Jeff (LEO); Kolb, Chris (DTMB); Eubanks, Rachael (TREASURY); Hawks, Orlene (LARA); Grossi, Christina (AG); Khaldun, Joneigh (DHHS); McGowan, Emmitt (MSP)
Cc:	Corbin, Susan (LEO); Jen, Kyle (DTMB); Guilfoyle, Jeffrey (TREASURY); Gaedeke, Kimberly (LARA); Keenan, Kelly (AG); Gordon, Robert (DHHS); Huls, JoAnne; Rising, Jay
Subject:	FOR RESPONSE TODAY - COVID-19 Task Force on Economy/Workplace, Fri 3/6 11am-12:30pm
Date:	Monday, March 2, 2020 5:04:50 PM

As I mentioned earlier today (see below), the governor is forming a **COVID-19 Task Force on Economy/Workplace**. The first meeting will take place this Friday 3/6 from 11am-12:30p at the State Emergency Operations Center (SEOC). Please find the relevant details below. In addition, I want to ask the people identified per the instructions below to respond separately to me ***today*** and identify who from your department or agency will participate on the task force, in addition to your Emergency Management Coordinator (EMC). If you are asked for 2 designees, I would encourage you to designate one deputy-level person and one subject-matter expert.

- **Scope:** All aspects of the economy and Michigan's workforce including employment policies and practices; supply chain; business continuity; general economic impact; and state revenue.

- **Participants:**
  1. LEO [***Dir. Donofrio*** – *in addition to your EMC, please designate 1 deputy-level participant; 1 participant from MIOSHA; 1 participant from Employment Relations; 1 participant from Wage and Hour Division (if separate from ER); 1 participant from Workforce Development; and 1 participant from UIA*]
  2. SBO [***Dir. Kolb*** – *please designate 1 person*]
  3. Treasury [***Treasurer Eubanks*** – *in addition to your EMC, please designate 1-2 persons*]
  4. LARA [***Dir. Hawks*** – *in addition to your EMC, please designate 1-2 persons*]
  5. Department of Attorney General [***COO Grossi*** – *please designate 1-2 persons*]
  6. Executive Office of the Governor
  7. MDHHS – Health [***Dr. Khaldun*** – *please let me know who will participate*]
  8. MSP/EMHSD [***Captain McGowan*** – *please let me know who will participate*]

- **Time/location of initial meeting:** Friday, March 6, 11am-12:30p am at the State Emergency Operations Center, located at the Michigan State Police Headquarters, 7150 Harris Drive, Dimondale, MI 48821. Please enter at the main entrance, center of the building, and check-in at the security desk. You will be taken to the SEOC meeting room from there. *You should arrive at least 10 minutes early to allow for check-in.*

I will be in touch with any further details about the meeting as needed. Thanks, Mark

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909

Obtained via MI FOIA by Judicial Watch, Inc.

tottenm1@michigan.gov
(517) 241-0061

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

From: Totten, Mark
Sent: Monday, March 2, 2020 9:00 AM
To: Totten, Mark <TottenM1@michigan.gov>
Subject: NEXT STEPS - COVID-19 preparations

Dear directors and agency heads,

As you know, the state is preparing for the likely spread of the coronavirus (COVID-19). Governor Whitmer is moving swiftly to address this threat and ensure Michigan is prepared. This last Friday, the governor activated the State Emergency Operations Center (SEOC) at Level 3 (monitoring and assessment). This decision to manage the response through the state's emergency management system will ensure a unified effort that integrates state, local, and federal government, as well as key partners in the private sector. The Michigan State Police – Emergency Management and Homeland Security Division (MSP-EMHSD) coordinates this system; the Michigan Department of Health and Human Services (MDHHS) will serve as lead department; many other departments and agencies will play important roles; and at all times the governor will oversee the response.

As part of this effort, the governor has directed the formation of four task forces, which will each convene at SEOC for an initial meeting this week:

1. The COVID-19 Task Force on State Operations (covering all aspects of state ops, including employment and facilities);
2. The COVID-19 Task Force on Health Care (covering the provision of medical services);
3. The COVID-19 Task Force on Education (covering K-12 and universities/colleges); and
4. The COVID-19 Task Force on Economy/Workforce (covering general economic impact, workforce, supply chain, business continuity, and related issues)

Scheduling information will go out this morning. Participants on each task force will include: relevant state departments and agencies; the executive office of the governor; MDHHS-Health; MSP-EMHSD; and the Department of Attorney General. Although the initial meeting this week will include state participants, partners in the private sector are critical and will be integrated into this effort. In addition to these four bodies, we may form others as needed. In addition, we are also preparing guidance to share with several external stakeholders this week.

Please make every effort to support these preparations. These meetings will be scheduled this week and will require flexibility. Also, please ensure that you or a deputy have a direct connection to your

Obtained via MI FOIA by Judicial Watch, Inc.

department's or agency's emergency management coordinator (EMC), each of whom plays an important role in the emergency management system, which the governor has activated.

Thank you for your help. I especially want to thank Dr. Joneigh Khaldun, the state's Chief Medical Executive (MDHHS), and her team, as well as Captain Emmitt McGowan, Deputy State Director of Emergency Management and Homeland Security (MSP), and his team, for the important work they have already begun.

Mark Totten

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Totten, Mark
To:	Rice, Michael (MDE); Donofrio, Jeff (LEO); Grossi, Christina (AG); Khaldun, Joneigh (DHHS); McGowan, Emmitt (MSP)
Cc:	Alles, Sheila (MDE); Corbin, Susan (LEO); Keenan, Kelly (AG); Laidlaw, Emily; Huls, JoAnne; Gordon, Robert (DHHS)
Subject:	FOR RESPONSE TODAY - COVID-19 Task Force on Education, Fri 3/6, 1:30-3p
Date:	Monday, March 2, 2020 5:19:24 PM

As I mentioned earlier today (see below), the governor is forming a **COVID-19 Task Force on Education**. The first meeting will take place this Friday 3/6 from 1:30-3p at the State Emergency Operations Center (SEOC). Please find the relevant details below. In addition, I want to ask the people identified per the instructions below to respond separately to me ***today*** and identify who from your department or agency will participate on the task force, in addition to your Emergency Management Coordinator (EMC). If you are asked for 2 designees, I would encourage you to designate one deputy-level person and one subject-matter expert.

- **Scope:** K-12, and possibly colleges and universities.

- **Participants:**
  1. MDE [***Supt. Rice*** – in addition to your EMC, please designate 1-2 persons]
  2. LEO [***Dir. Donofrio*** – *in addition to your EMC, please designate 1-2 persons*]
  3. Department of Attorney General [***COO Grossi*** – *please designate 1-2 persons*]
  4. Executive Office of the Governor
  5. MDHHS – Health [***Dr. Khaldun*** – *please let me know who will participate*]
  6. MSP/EMHSD [***Captain McGowan*** – *please let me know who will participate*]

- **Time/location of initial meeting:** Friday, March 6, 1:30-3pm at the State Emergency Operations Center, located at the Michigan State Police Headquarters, 7150 Harris Drive, Dimondale, MI 48821. Please enter at the main entrance, center of the building, and check-in at the security desk. You will be taken to the SEOC meeting room from there. *You should arrive at least 10 minutes early to allow for check-in.*

I will be in touch with any further details about the meeting as needed. Thanks, Mark

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Khaldun, Joneigh (DHHS); Hawks, Orlene (LARA); Adams, Zaneta (DMVA); Grossi, Christina (AG); McGowan, Emmitt (MSP)
Cc: Gordon, Robert (DHHS); Gaedeke, Kimberly (LARA); Keenan, Kelly (AG); Huls, JoAnne; Groen, Meghan
Subject: FOR RESPONSE TODAY - COVID-19 Task Force on Health Care, Fri 3/6 9-10:30am
Date: Monday, March 2, 2020 4:00:28 PM

As I mentioned earlier today (see below), the governor is forming a **COVID-19 Task Force on Health Care**. The first meeting will take place this Friday 3/6 from 9-10:30a at the State Emergency Operations Center (SEOC). Please find the relevant details below. In addition, I want to ask the people identified per the instructions below to respond separately to me ***today*** and identify who from your department or agency will participate on the task force, in addition to your Emergency Management Coordinator (EMC), as we will likely announce the task force by press release tomorrow morning. If you're asked for 2 designees, I would encourage you to designate one deputy-level person and one subject-matter expert.

- **Scope:** The provision of medical services through state and private health care providers.

- **Participants:**
  1. MDHHS [***Dr. Khaldun*** – *please let me know who will participate*]
  2. Department of Licensing and Regulatory Affairs [***Dir. Hawks*** – *in addition to your EMC, please designate 1-2 persons, presumably including someone with expertise in the licensing of hospitals*]
  3. Michigan Veteran Affairs Agency [***Dir. Adams –*** *in addition to your EMC, please designate 1-2 persons*]
  4. Department of Attorney General [***COO Grossi*** – *please designate 1-2 persons*]
  5. Executive Office of the Governor
  6. MSP/EMHSD [***Captain McGowan*** – *please let me know who will participate*]

- **Time/location of initial meeting:** Friday, March 6, 9-10:30am at the State Emergency Operations Center, located at the Michigan State Police Headquarters, 7150 Harris Drive, Dimondale, MI 48821. Please enter at the main entrance, center of the building, and check-in at the security desk. You will be taken to the SEOC meeting room from there. *You should arrive at least 10 minutes early to allow for check-in.*

I will be in touch with any further details about the meeting as needed. Thanks, Mark

---

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

Obtained via MI FOIA by Judicial Watch, Inc.

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

From: Totten, Mark
Sent: Monday, March 2, 2020 9:00 AM
To: Totten, Mark <TottenM1@michigan.gov>
Subject: NEXT STEPS - COVID-19 preparations

Dear directors and agency heads,

As you know, the state is preparing for the likely spread of the coronavirus (COVID-19). Governor Whitmer is moving swiftly to address this threat and ensure Michigan is prepared. This last Friday, the governor activated the State Emergency Operations Center (SEOC) at Level 3 (monitoring and assessment). This decision to manage the response through the state's emergency management system will ensure a unified effort that integrates state, local, and federal government, as well as key partners in the private sector. The Michigan State Police – Emergency Management and Homeland Security Division (MSP-EMHSD) coordinates this system; the Michigan Department of Health and Human Services (MDHHS) will serve as lead department; many other departments and agencies will play important roles; and at all times the governor will oversee the response.

As part of this effort, the governor has directed the formation of four task forces, which will each convene at SEOC for an initial meeting this week:

1. The COVID-19 Task Force on State Operations (covering all aspects of state ops, including employment and facilities);
2. The COVID-19 Task Force on Health Care (covering the provision of medical services);
3. The COVID-19 Task Force on Education (covering K-12 and universities/colleges); and
4. The COVID-19 Task Force on Economy/Workforce (covering general economic impact, workforce, supply chain, business continuity, and related issues)

Scheduling information will go out this morning. Participants on each task force will include: relevant state departments and agencies; the executive office of the governor; MDHHS-Health; MSP-EMHSD; and the Department of Attorney General. Although the initial meeting this week will include state participants, partners in the private sector are critical and will be integrated into this effort. In addition to these four bodies, we may form others as needed. In addition, we are also preparing guidance to share with several external stakeholders this week.

Please make every effort to support these preparations. These meetings will be scheduled this week and will require flexibility. Also, please ensure that you or a deputy have a direct connection to your department's or agency's emergency management coordinator (EMC), each of whom plays an important role in the emergency management system, which the governor has activated.

Obtained via MI FOIA by Judicial Watch, Inc.

Thank you for your help. I especially want to thank Dr. Joneigh Khaldun, the state's Chief Medical Executive (MDHHS), and her team, as well as Captain Emmitt McGowan, Deputy State Director of Emergency Management and Homeland Security (MSP), and his team, for the important work they have already begun.

Mark Totten

_____

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Foster, Tricia (DTMB); Winters, Jan (MCSC); Estlund Olson, Liza (OSE); Grossi, Christina (AG); Khaldun, Joneigh (DHHS); McGowan, Emmitt (MSP)
Cc: Gnodtke, John (MCSC); Keenan, Kelly (AG); Huls, JoAnne; Gordon, Robert (DHHS); Gasper, Joe (MSP); Crockett, Tracy
Subject: FOR RESPONSE TODAY- COVID-19 Task Force on State Ops, Wed 3/4 2:30-4pm
Date: Monday, March 2, 2020 3:12:01 PM

As I mentioned earlier today (see below), the governor is forming a **COVID-19 Task Force on State Operations**. The first meeting will take place this Wednesday 3/4 from 2:30-4p at the State Emergency Operations Center (SEOC). Please find the relevant details below. In addition, I want to ask the people identified below to respond separately to me ***today*** and identify who from your department or agency will participate on the task force, as we will likely announce the task force by press release tomorrow morning. Directors and agency heads do not have to designate themselves as participants, but I would ask that you have at least one deputy-level designee if you are not participating.

- **Scope:** All aspects of state operations, including but not limited to international travel of state workers; cleaning of state facilities; availability of hygienic products; other practices and protections within state facilities; interactions with the public; and work-from-home policies and supporting technologies.

- **Participants:**
  1. Department of Technology, Management, and Budget [***Dir. Foster*** – *please designate 1-2 people total*]
  2. Michigan Civil Service Commission [***Dir. Winters*** – *please designate 1-2 people total*]
  3. Office of the State Employer [***Dir. Estlund-Olson*** – *please designate 1-2 people total*]
  4. Department of Attorney General [***COO Grossi*** – *please designate 1-2 people total*]
  5. Executive Office of the Governor
  6. MDHHS – Health [***Dr. Khaldun*** – *please let me know who will participate*]
  7. MSP/EMHSD [***Captain McGowan*** – *please let me know who will participate*]

- **Time/location of initial meeting:** Wednesday, March 4, 2:30-4pm at the State Emergency Operations Center, located at the Michigan State Police Headquarters, 7150 Harris Drive, Dimondale, MI 48821. Please enter at the main entrance, center of the building, and check-in at the security desk. You will be taken to the SEOC meeting room from there. *You should arrive at least 10 minutes early to allow for check-in.*

I will be in touch with any further details about the meeting as needed. Thanks, Mark

---

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue

Obtained via MI FOIA by Judicial Watch, Inc.

Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

From: Totten, Mark
Sent: Monday, March 2, 2020 9:00 AM
To: Totten, Mark <TottenM1@michigan.gov>
Subject: NEXT STEPS - COVID-19 preparations

Dear directors and agency heads,

As you know, the state is preparing for the likely spread of the coronavirus (COVID-19). Governor Whitmer is moving swiftly to address this threat and ensure Michigan is prepared. This last Friday, the governor activated the State Emergency Operations Center (SEOC) at Level 3 (monitoring and assessment). This decision to manage the response through the state's emergency management system will ensure a unified effort that integrates state, local, and federal government, as well as key partners in the private sector. The Michigan State Police – Emergency Management and Homeland Security Division (MSP-EMHSD) coordinates this system; the Michigan Department of Health and Human Services (MDHHS) will serve as lead department; many other departments and agencies will play important roles; and at all times the governor will oversee the response.

As part of this effort, the governor has directed the formation of four task forces, which will each convene at SEOC for an initial meeting this week:

1. The COVID-19 Task Force on State Operations (covering all aspects of state ops, including employment and facilities);
2. The COVID-19 Task Force on Health Care (covering the provision of medical services);
3. The COVID-19 Task Force on Education (covering K-12 and universities/colleges); and
4. The COVID-19 Task Force on Economy/Workforce (covering general economic impact, workforce, supply chain, business continuity, and related issues)

Scheduling information will go out this morning. Participants on each task force will include: relevant state departments and agencies; the executive office of the governor; MDHHS-Health; MSP-EMHSD; and the Department of Attorney General. Although the initial meeting this week will include state participants, partners in the private sector are critical and will be integrated into this effort. In addition to these four bodies, we may form others as needed. In addition, we are also preparing guidance to share with several external stakeholders this week.

Please make every effort to support these preparations. These meetings will be scheduled this week

Obtained via MI FOIA by Judicial Watch, Inc.

and will require flexibility. Also, please ensure that you or a deputy have a direct connection to your department's or agency's emergency management coordinator (EMC), each of whom plays an important role in the emergency management system, which the governor has activated.

Thank you for your help. I especially want to thank Dr. Joneigh Khaldun, the state's Chief Medical Executive (MDHHS), and her team, as well as Captain Emmitt McGowan, Deputy State Director of Emergency Management and Homeland Security (MSP), and his team, for the important work they have already begun.

Mark Totten

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Gordon, Robert (DHHS); Hawks, Orlene (LARA); Gagliardi, Patrick (LARA); Corbin, Susan (LEO); Pickelman, Barton (LEO); McDowell, Gary (MDARD); Clark, Liesl (EGLE); Gasper, Joe (MSP)
Cc: Kolodin, Zach; Foster, Tricia; Rick, Matthew (DHHS); Esty, Sarah (DHHS); Deacon, Brad (MDARD); Gaedeke, Kimberly (LARA); Grossi, Christina (AG); Brya, Michelle (AG); Taylor, Debbie (AG); Manning, Peter (AG); Howd, Raymond (AG); Potchen, Joseph (AG)
Subject: FOR REVIEW - COVID-19 enforcement actions
Date: Friday, November 20, 2020 6:54:46 AM

Directors and Agency Heads,

I want to flag for your attention the Nov. 15, 2020 Emergency Order that MDHHS issued under MCL 333.2253, which took effect this past Wednesday. We face an extraordinary crisis, with our numbers surging and hospitals threatened to be overrun. This most recent order aims to reduce our numbers and control spread. Success, however, depends on compliance with all relevant COVID-19 laws, rules, and orders. As the governor stated in Executive Directive 2020-8:

> Without effective enforcement, we will move backwards. Individuals, businesses, and the economy will all suffer. At work and at play—on the job and in social gatherings—compliance is critical to moving forward . . . . *State departments and agencies must ensure that enforcement of COVID-19-related laws receives the priority this pandemic demands*. [Emphasis added.]

Toward the end of increasing compliance, and on behalf of the governor, I ask that you do the following:

1. Review Executive Directive 2020-8.

2. As needed, work closely with your assigned Assistant Attorney General on any legal issues surrounding enforcement.

3. By Tuesday 11/24, please provide me a brief status report on your COVID-19 enforcement efforts. A 1-2 page memo should be sufficient. You can send to me and copy Deputy Legal Counsel Zach Kolodin, who is copied on this email. Please briefly describe your enforcement program and the resources dedicated to enforcement, summarize any recent enforcement actions, and provide links to any press releases associated with these actions. This report will allow the executive office to remain aware of enforcement efforts across state government. Of course, particular enforcement decisions remain within the professional discretion and judgment of the individual departments and agencies.

4. If you are announcing enforcement actions through press release, please coordinate those efforts through the JIC.

Thank you for your cooperation and your important work at this moment.

Mark Totten

Obtained via MI FOIA by Judicial Watch, Inc.

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email and any associated documents may contain information that is privileged or otherwise exempt from disclosure. It is intended for use only by the person to whom it is addressed. Please contact me before disclosure.** If you have received this email in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Gordon, Robert (DHHS); Khaldun, Joneigh (DHHS)
Subject: FOR REVIEW - Sunday (4/12) morning calls
Date: Saturday, April 11, 2020 1:42:31 PM

Director Gordon and Dr. Khaldun,

Please find below a summary of Sunday's calls. I've linked several short articles by our guests. If you can only read one, read Dr. Gottlieb's report. The purpose of these calls is for the governor to ask her questions, and the rest of us will primarily listen.

All our guests are prepared to answer these two questions: 1) What conditions should Michigan satisfy before removing or relaxing the stay-at-home order? 2) What challenges would you expect Michigan will face in satisfying these conditions?

10:00 – 10:20am, Dr. Zeke Emanuel, Univ. of Penn. Dr. Emanuel is Vice Provost for Global Initiatives and chair of the Department of Medical Ethics and Health Policy at the University of Pennsylvania. From January 2009 to January 2011, he served as special advisor for health policy to the director of the White House Office of Management and Budget. *Recent article*: "We Can Safely Restart the Economy in June. Here's How." *NYT* 3/28/20.

10:30 – 10:50am, Dr. Emily Toth Martin, Univ. of Mich. Dr. Martin is an Associate Professor of Epidemiology at the School of Public Health, University of Michigan. Her research focuses on the epidemiology of viral respiratory diseases and interventions to prevent transmission.

11:00 – 11:20am, Dr. Josh Sharfstein, John Hopkins Univ. Dr. Sharfstein is the Vice Dean for Public Health Practice and Community Engagement at John Hopkins Bloomberg School of Public Health. Previously, he served as the Secretary of the Maryland Department of Health and Mental Hygiene, the Principal Deputy Commissioner of the U.S. Food and Drug Administration, and as Commissioner of Health for Baltimore City. *Recent article*: "Testing is Just the Beginning in the Battle Against COVID-19," NYT 3/30/20.

11:30 – 11:50am, Dr. Scott Gottlieb, American Enterprise Institute. Dr. Gottlieb recently stepped down as head of the Food and Drug Administration (FDA) under President Trump and is now a Resident Fellow at the American Enterprise Associate. He co-authored perhaps the most widely-read report right now on where states go after their stay-at-home orders: Gottlieb, et al., *National Coronavirus Response: A Road Map to Reopening* (Mar. 28, 2020).

12:00 – 12:20pm, Dr. Ashish Jha, Harvard Univ. Professor of Global Health at Harvard T.H. Chan School of Public Health, and the Director of the Harvard Global Health Institute. He is a practicing General Internist and also Professor of Medicine at Harvard Medical School. *Recent article*: "This is How We Can Beat the Coronavirus," *The Atlantic* 3/19/20.

Mark

Obtained via MI FOIA by Judicial Watch, Inc.

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Huls, JoAnne; Foster, Tricia; Flood, Jennifer
Cc: Stallworth, Tommy; Khaldun, Joneigh (DHHS)
Subject: Free masks next steps
Date: Saturday, July 11, 2020 9:08:28 AM

Disparities Task Force was enthusiastic about free mask distribution. Tommy suggested several distribution channels, below, and we are now working on them thru DHHS, with the thought to pilot initially in Detroit, Grand Rapids, and Gaylord. Welcome amendments. Rey told me Gov is planning presser for Wed on masks, and we are aiming to be ready for announcement then.

I am not sure if big grocery retailers like Meijer, Kroger, Walmart, etc. are already providing free masks. It is a nice idea, especially as an alternative to kicking someone out. We could give them the masks, but these companies could also do it themselves. Nice PR for them that helps reset norms for other businesses. Maybe they could join Gov at press conference talking about it. Plausible?

Best,
Robert

Distribution suggestions
- Protest organizers and local health depts for distribution at demonstrations
-County Area Agencies on Aged for distribution to seniors
-Bureau of Substance Abuse Prevention and Treatment for distribution to AA and NA meetings
- Local health depts/municipalities for distribution at known congregation areas such as parks, lakes, churches, barber and beauty shops

Robert Gordon
Director
Michigan Department of Health & Human Services
gordonr3@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark; Bagley, Nick; Foster, Tricia
Subject: From Region 6 and 8 health officers
Date: Monday, July 20, 2020 11:40:59 AM
Attachments: HO-MD Letter to Governor FINAL 200717.docx

Obtained via MI FOIA by Judicial Watch, Inc.

July 17, 2020

Dear Governor Whitmer,

As Health Officers and Medical Directors for 46 counties and 13 local health departments in Northern Michigan and the Upper Peninsula, covering MERC Regions 6 and 8 as well as portions of Regions 2 and 4, we are writing to convey our grave concern for the vulnerability of our region to the COVID-19 pandemic.

Since both MERC Regions 6 and 8 remain in Phase 5 with most sectors of business open and larger gatherings allowed, we are attracting thousands of visitors to our area every day from downstate. This exponentially increases our population and therefore our risk for COVID-19 transmission. Of immediate and urgent concern is an extremely limited capacity for testing, lack of compliance with your Executive Orders, including masking, as well as a disproportionate allocation of resources that does not consider the true burden of a population surge.

Despite our best efforts at collaborating with MDHHS, private labs, private providers, and our local hospitals, we continue to struggle with testing capacity. In several of our jurisdictions, over 50% of total COVID-19 cases were confirmed in just the last four weeks. People with symptoms and those with exposures to others with COVID-19 are waiting up to five days for an appointment for testing and another five days for the turnaround of results. In some cases, people from Northern Michigan are driving to the Detroit area for a test with rapid results because they cannot get one here. Federally qualified health centers are limiting testing to those with symptoms and those with known exposures due to a crippling volume of calls and orders from other providers. Every site that sets up testing becomes quickly overwhelmed by the demand.

We sincerely support and appreciate your efforts in strengthening masking requirements. Unfortunately, local law enforcement has publicly stated in some of our areas that they will not be responding to routine masking complaints because they are concerned about straining the emergency response system. Masking complaints are being diverted to local health departments, where our staff are trying to sort them out and respond; however, they are not equipped to respond to escalated situations or issue citations. In addition, state agencies, such as MDARD and EGLE, are refusing to help enforce Executive Orders, which puts local health departments in an even more difficult position.

Given all these factors, it is unlikely we will be able to safely contain transmission of COVID-19 and remain in Phase 5 for the start of the school year. As public health professionals, we highly value a quality education as one of the most important social determinants of health and believe deeply in prioritizing a safe start to the school year.

Finally, our public health infrastructure is at risk. We are exhausting all available resources to assure a robust response to the pandemic and are now facing further threat of funding cuts and reductions. Not only does this compromise our ability to protect our communities throughout the pandemic but further erodes a chronically underfunded baseline. One example of this is the notification we received last week that the Northern Michigan Community Health Innovation Region (CHIR) will not be receiving FY21 funding. The CHIR addresses social determinants of health and access to care needs at both the individual and population levels through dynamic and innovative local partnerships. Its infrastructure enabled us to pivot quickly with the onset of COVID-19 to meet needs and respond to gaps across a 10-county region. We have developed a braided funding strategy and efficiently built further expansion across Northern Michigan, but MDHHS funding is critical public health infrastructure that keeps it going. This work has been and will remain so important in maintaining the health of communities throughout and after this crisis and must be led locally

Obtained via MI FOIA by Judicial Watch, Inc.

for prime effectiveness. It should be incorporated into a social determinants of health strategy and built upon and expanded to other regions of the State, not replaced by a State-led initiative.

We need your help. There is a disproportionate distribution of resources for testing across the State and we need resolution to complexities limiting enforcement of your important and protective Executive Orders. We have determined that the following actions will equip us to protect our communities and respectfully request that you consider these steps:

1. Develop a plan to immediately increase access to daily testing in all areas of Northern Michigan and the Upper Peninsula with input for locations from local public health.
2. Address and revise the formula used to allocate funding through MDHHS to local health departments for COVID-19 response–total population and total cases is causing inequities in access to testing and protection from spread for our residents and visitors.
3. Inform the Michigan Department of Treasury that District Health Departments DO qualify for the Public Health Payroll Reimbursement through the CARES Act – our applications are being denied and these are due today!
4. Issue a joint memo from your office, the Office of the Attorney General, and MDHHS that details and directs the steps for consistent enforcement of Executive Orders across the State (We have submitted recommendations to the Office of Local Health Services prepared by a public health attorney who has offered to assist in drafting this if needed).
5. Empower and hold accountable state agencies, such as MDARD and EGLE, who can assist in compliance with the Executive Orders through enforcement of the functions they regulate.
6. Include funding in your FY21 budget for the Northern Michigan Community Health Innovation Region as part of the State's overall Social Determinants of Health strategy.

It is only through these actions that we will be able to contain the spread of COVID-19 and we desperately request your assistance in protecting the citizens across Northern Michigan and the Upper Peninsula and the thousands of visitors traveling to our area and returning to their homes.

Sincerely,

Lisa Peacock, Health Officer
Benzie Leelanau District Health Department
Health Department of Northwest Michigan

Joshua Meyerson, MD, Medical Director
Benzie Leelanau District Health Department
District Health Department #4
Health Department of Northwest Michigan

Steve Hall, Health Officer
Central Michigan District Health Department

Jennifer Morse, MD, Medical Director
Central Michigan District Health Department
District Health Department #10

Daren Deyaert, Health Officer
Dickinson-Iron District Health Department

Obtained via MI FOIA by Judicial Watch, Inc.

Robert Van Howe, MD, Medical Director
Dickinson Iron District Health Department
Public Health Delta and Menominee Counties
Western UP District Health Department

Denise Bryan, Health Officer
District Health Department #2
District Health Department #4

Mark Hamed, MD, Medical Director
District Health Department #2

Karen Senkus, Health Officer
Chippewa County Health Department

Joseph Garlinghouse, MD, Medical Director
Chippewa County Health Department

Kevin Hughes, Health Officer
District Health Department #10

Wendy Hirschenberger, Health Officer
Grand Traverse County Health Department

Michael Collins, MD, Medical Director
Grand Traverse County Health Department

Nicholas Derusha, Health Officer
LMAS District Health Department

James Terrian, MD, Medical Director
LMAS District Health Department

Jerry Messana, Health Officer
Marquette County Health Department

Kevin Pigott, MD, Medical Director
Marquette County Health Department

Michael Snyder, Health Officer
Public Health Delta and Menominee Counties

Cathryn Beer, Health Officer
Western UP District Health Department

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark
Subject: FW:
Date: Friday, March 27, 2020 5:56:09 AM

From: Emanuel, Ezekiel J <zemanuel@upenn.edu>
Sent: Friday, March 27, 2020 5:36 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Nicole Schiegg <nicole@nicoleschiegg.com>
Subject:

Robert meet Nicole,

Nicole is a pubic helath PR person and might be able to help on COVID-19 either personally or give you advice on who can.

Ezekiel J. Emanuel, M.D., Ph.D.

Vice Provost of Global Initiatives

Chair, Department of Medical Ethics and Health Policy (on Leave 2019-2020)

Levy University Professor

Co-Director, Healthcare Transformation Institute

Perelman School of Medicine and The Wharton School

University of Pennsylvania

Phone: 215-898-7226 or 215-573-8104

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark
Subject: FW:
Date: Friday, March 27, 2020 5:55:21 AM

I'll call you in a little bit

From: Emanuel, Ezekiel J <zemanuel@upenn.edu>
Sent: Friday, March 27, 2020 5:41 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Sacha Samotin <sacha@applecart.co>
Subject:

Robert meet Sacha,

Sacha is a former Penn student--the tops-- who runs a company that uses social media and behavioral economic technquies--prompts by people you know-- to get people to vote and do other socially positive things.

He has had some great ideas about how to do that for COVID-19. This might address your PR campaign issues.

In full disclosure, I have an investment in Sacha's company. But that is because it is super effective at what it does.

Ezekiel J. Emanuel, M.D., Ph.D.

Vice Provost of Global Initiatives

Chair, Department of Medical Ethics and Health Policy (on Leave 2019-2020)

Levy University Professor

Co-Director, Healthcare Transformation Institute

Perelman School of Medicine and The Wharton School

University of Pennsylvania

Phone: 215-898-7226 or 215-573-8104

Obtained via MI FOIA by Judicial Watch, Inc.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Huls, JoAnne; Foster, Tricia
Subject: FW: [Non-DoD Source] RE: RRF Addition of Request for Title 10 Forces for COVID-19 Support
Date: Thursday, April 2, 2020 7:50:23 PM

You should read this chain. Big Problem. Just discussing with General Rogers. Wondering if you want to intervene with MSP tonight.

-----Original Message-----
From: Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>
Sent: Thursday, April 2, 2020 7:48 PM
To: Rogers, Paul (DMVA) <paul.d.rogers14.mil@mail.mil>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Grady, James (MSP) <GradyJ@michigan.gov>
Cc: Gasper, Joe (MSP) <GasperJ@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: RE: [Non-DoD Source] RE: RRF Addition of Request for Title 10 Forces for COVID-19 Support

Inspector Grady, is this with you? Let me know if you need help - Col Martin on my People team has been closely involved with these issues and would be an invaluable resource.

-----Original Message-----
From: Rogers, Paul D MG USARMY NG MIANG (USA) <paul.d.rogers14.mil@mail.mil>
Sent: Thursday, April 2, 2020 7:22 PM
To: Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Grady, James (MSP) <GradyJ@michigan.gov>
Cc: Gasper, Joe (MSP) <GasperJ@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: RE: [Non-DoD Source] RE: RRF Addition of Request for Title 10 Forces for COVID-19 Support

Folks,

This is a critical need. We must act quickly to request support on behalf of Michigan. I actually thought this request went out yesterday.

The simple answer is 'yes'. Build the strongest argument possible and request at least two FMS equivalents. If you feel we can justify three FMS equivalents out of the 15 available then do it. Please get this submitted tonight. Staff limitations will be our downfall.

With regards to DOD providing care to COVID patients....that changed as of today. The DoD personnel are now permitted to administer care in a COVID facility.

Just food for thought....

Dallas already has 400 Navy medical providers deployed.

New York has thousands

California has thousands

Washington State has hundreds

Chicago is targeted for two FMS teams

Michigan has Zero!

Time is not our friend and there is a finite number of federal resources. Please do not delay.

Obtained via MI FOIA by Judicial Watch, Inc.

Paul

-----Original Message-----
From: Warsh, Jonathan (DHHS) [mailto:WarshJ1@michigan.gov]
Sent: Thursday, April 2, 2020 7:08 PM
To: Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Grady, James (MSP) <GradyJ@michigan.gov>
Cc: Gasper, Joe (MSP) <GasperJ@michigan.gov>; Rogers, Paul D MG USARMY NG MIANG (USA) <paul.d.rogers14.mil@mail.mil>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: [Non-DoD Source] RE: RRF Addition of Request for Title 10 Forces for COVID-19 Support

All active links contained in this email were disabled. Please verify the identity of the sender, and confirm the authenticity of all links contained within the message prior to copying and pasting the address to a Web browser.

Adding in Col Gasper and Gen Rogers. Can we just amend our RFR to request 2 FMS units. Seems from the email below that there are resources going to Chicago and FEMA knows we are a bigger hotspot.

Also, apparently at President Trump's briefing an hour ago, he said federal resources would be going to Javits in NYC andwill be treating COVID patients.

Thoughts???

From: Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>
Sent: Thursday, April 2, 2020 7:01 PM
To: Grady, James (MSP) <GradyJ@michigan.gov>
Cc: Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>
Subject: RE: RRF Addition of Request for Title 10 Forces for COVID-19 Support

Yes, we do. However, my understanding is that military personnel may not be utilized to care for covid patients. That being said, I think we would be able to utilize them somewhere.

From: Grady, James (MSP) <GradyJ@michigan.gov < Caution-mailto:GradyJ@michigan.gov > >
Sent: Thursday, April 2, 2020 6:45 PM
To: Hertel, Elizabeth (DHHS) <HertelE@michigan.gov < Caution-mailto:HertelE@michigan.gov > >
Subject: Fwd: RRF Addition of Request for Title 10 Forces for COVID-19 Support

Obtained via MI FOIA by Judicial Watch, Inc.

Ms. Hertel,

Does your agency have any interest in utilizing military medical staff for TCF to satisfy personnel needs?

James

Insp. James Grady

Asst. Division Commander

Emergency Management and

Homeland Security Division

Michigan State Police

7150 Harris Dr.

Dimondale, MI, 48821

Cell: 248-469-2000

GradyJ@Michigan.Gov < Caution-mailto:GradyJ@Michigan.Gov >

Begin forwarded message:

From: "Martinez, Patrick A Lt Col USAF (USA)" <patrick.a.martinez4.mil@mail.mil < Caution-mailto:patrick.a.martinez4.mil@mail.mil > >
Date: April 2, 2020 at 6:32:03 PM EDT
To: "sidney.n.martin.mil" <sidney.n.martin.mil@mail.mil < Caution-mailto:sidney.n.martin.mil@mail.mil > >, "sean.m.southworth.mil" <sean.m.southworth.mil@mail.mil < Caution-mailto:sean.m.southworth.mil@mail.mil > >, "Grady, James (MSP)" <GradyJ@michigan.gov < Caution-mailto:GradyJ@michigan.gov > >, "McGowan, Emmitt (MSP)" <McGowanE1@michigan.gov < Caution-mailto:McGowanE1@michigan.gov > >, "Nobach, Tonya (MSP)" <NobachT@michigan.gov < Caution-mailto:NobachT@michigan.gov > >
Cc: "Terrill, Jeffrey M BG USARMY NG MIARNG (USA)" <jeffrey.m.terrill.mil@mail.mil < Caution-mailto:jeffrey.m.terrill.mil@mail.mil > >, "Hiipakka, Scott W COL USARMY NG MIARNG (USA)" <scott.w.hiipakka.mil@mail.mil < Caution-mailto:scott.w.hiipakka.mil@mail.mil > >, "Ressler, Steven P COL USARMY ARNORTH (USA)" <steven.p.ressler.mil@mail.mil < Caution-mailto:steven.p.ressler.mil@mail.mil > >, "Miller, Shannon T COL USARMY ARNORTH (US)" <shannon.t.miller.mil@mail.mil < Caution-mailto:shannon.t.miller.mil@mail.mil > >
Subject: RE: RRF Addition of Request for Title 10 Forces for COVID-19 Support

ALCON,
Clarification....my assessment is that Michigan is the "hot spot" and has NOT been able to gain staffing resources. Chicago has had an opportunity to work staffing resources for their 500 bed FMS.

The requirements will be competing requirements approved far above the DCE/DCO level. A group is formed called a Unified Control Group (UCG) looking at all staffing requirements from throughout the country to staff the FMSs.

Obtained via MI FOIA by Judicial Watch, Inc.

The 15, T-10 Resources are preparing to deploy/support. However; just have to be careful about messaging this.

"Identify the Requirement." The process in place will address "fair and equitable" distribution of resources.

Again, Michigan is a "hot spot." Nothing is being promised. Just work the process. Your "scope of work" is critical.

V/r,
Lt Col Martinez

PATRICK A. MARTINEZ, Lt Col, USAF, MSC
Joint Regional Medical Plans and Operations Officer Southeast Branch
Region V & IV, NORAD-NORTHCOM Surgeon Office
1492 First Street; Bldg. 922
Dobbins Air Reserve Base, GA 30069
OFFICE: (678) 655-5308
GOV CELL: (404) 844-8482
PERS CELL: (470) 526-2001
EMAIL: Patrick.a.martinez4.mil@mail.mil < Caution-mailto:Patrick.a.martinez4.mil@mail.mil >

_____

From: Martin, Sidney N Col USAF 110 MDG (USA)
Sent: Thursday, April 02, 2020 6:24 PM
To: Southworth, Sean M Col USAF 110 ATKW (USA); Grady, James (MSP); mcgowane1@michigan.gov < Caution-mailto:mcgowane1@michigan.gov > ; Nobach, Tonya (MSP)
Cc: Terrill, Jeffrey M BG USARMY NG MIARNG (USA); Hiipakka, Scott W COL USARMY NG MIARNG (USA); Ressler, Steven P COL USARMY ARNORTH (USA); Martinez, Patrick A Lt Col USAF (USA); Miller, Shannon T COL USARMY ARNORTH (US)
Subject: RE: RRF Addition of Request for Title 10 Forces for COVID-19 Support

Just talked to LtCol Patrick Martinez from the earlier tcon. They have 15 T-10 FMS teams ready to ga and will go on first come first serve basis. He know Chicago is requesting 2 even though right now the have plenty of resource. He needs the request along with the scope of work language tonight!!! He said content is more important than how it looks and they are willing to help correct things. They are working tonight.

-----Original Message-----
From: Martin, Sidney N Col USAF 110 MDG (USA)
Sent: Thursday, April 2, 2020 5:59 PM
To: Southworth, Sean M Col USAF 110 ATKW (USA) <sean.m.southworth.mil@mail.mil < Caution-mailto:sean.m.southworth.mil@mail.mil > >; Grady, James (MSP) <GradyJ@michigan.gov < Caution-mailto:GradyJ@michigan.gov > >;mcgowane1@michigan.gov < Caution-mailto:mcgowane1@michigan.gov > ; Nobach, Tonya (MSP) <NobachT@michigan.gov < Caution-mailto:NobachT@michigan.gov > >
Cc: Terrill, Jeffrey M BG USARMY NG MIARNG (USA) <jeffrey.m.terrill.mil@mail.mil < Caution-mailto:jeffrey.m.terrill.mil@mail.mil > >; Hiipakka, Scott W COL USARMY NG MIARNG (USA) <scott.w.hiipakka.mil@mail.mil < Caution-mailto:scott.w.hiipakka.mil@mail.mil > >; Ressler, Steven P COL USARMY ARNORTH (USA) <steven.p.ressler.mil@mail.mil < Caution-mailto:steven.p.ressler.mil@mail.mil > >; Martinez, Patrick A Lt Col USAF (USA) <patrick.a.martinez4.mil@mail.mil < Caution-mailto:patrick.a.martinez4.mil@mail.mil > >; Miller, Shannon T COL USARMY ARNORTH (US) <shannon.t.miller.mil@mail.mil < Caution-mailto:shannon.t.miller.mil@mail.mil > >
Subject: RE: RRF Addition of Request for Title 10 Forces for COVID-19 Support

President Trump just announced on CNN evening brief that Javits Center staffed by military will treat covid

Obtained via MI FOIA by Judicial Watch, Inc.

Sidney N. Martin, Col, MC, SFS
ANG Asst USAFE & AF/Africa SG
Medical Director Northern Strike 2020
(810)919-4458
Civ email: docfly16@aol.com < Caution-mailto:docfly16@aol.com >

-----Original Message-----
From: Southworth, Sean M Col USAF 110 ATKW (USA)
Sent: Thursday, April 2, 2020 5:18 PM
To: Grady, James (MSP) <GradyJ@michigan.gov < Caution-mailto:GradyJ@michigan.gov > >;mcgowane1@michigan.gov < Caution-mailto:mcgowane1@michigan.gov > ; Nobach, Tonya (MSP) <NobachT@michigan.gov < Caution-mailto:NobachT@michigan.gov > >
Cc: Terrill, Jeffrey M BG USARMY NG MIARNG (USA) <jeffrey.m.terrill.mil@mail.mil < Caution-mailto:jeffrey.m.terrill.mil@mail.mil > >; Hiipakka, Scott W COL USARMY NG MIARNG (USA) <scott.w.hiipakka.mil@mail.mil < Caution-mailto:scott.w.hiipakka.mil@mail.mil > >; Martin, Sidney N Col USAF 110 MDG (USA) <sidney.n.martin.mil@mail.mil < Caution-mailto:sidney.n.martin.mil@mail.mil > >; Ressler, Steven P COL USARMY ARNORTH (USA) <steven.p.ressler.mil@mail.mil < Caution-mailto:steven.p.ressler.mil@mail.mil > >; Martinez, Patrick A Lt Col USAF (USA) <patrick.a.martinez4.mil@mail.mil < Caution-mailto:patrick.a.martinez4.mil@mail.mil > >; Miller, Shannon T COL USARMY ARNORTH (US) <shannon.t.miller.mil@mail.mil < Caution-mailto:shannon.t.miller.mil@mail.mil > >
Subject: RRF Addition of Request for Title 10 Forces for COVID-19 Support

Inspector Grady,

After the 1500 DCE call today in Chicago, there is a chance that Title 10 Active Duty Forces may become available for treating COVID-19 patients. Currently, DOD Medical personnel cannot be employed in direct conduct of this mission. With this potential change, it was recommended we add in our RRF for Medical Support verbiage to that effect, “Michigan requests Title 10 Medical Personnel for the treatment of COVID-19 patients if such forces are assigned to this mission set.” Hopefully we have the opportunity to continue to add to our request in the near term.

Thank you,

v/r

SEAN M. SOUTHWORTH, Colonel, MI ANG

SEOC Emergency Management Coordinator

Joint Forces Headquarters Michigan Room 207A

Cell 269-986-2002

Cell 248-568-0367

Obtained via MI FOIA by Judicial Watch, Inc.

sean.m.southworth.mil@mail.mil < Caution-mailto:sean.m.southworth.mil@mail.mil >

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark; Bagley, Nick
Subject: FW: Association Letter to Whitmer on health care provider
Date: Monday, April 6, 2020 10:15:01 PM
Attachments: Association Letter to Whitmer on health care provider.docx
image002.jpg

See attached request. I would have expected that DCWs were critical care in the EO as written. If they weren't, that is an oversight, which I would think we could correct with much less verbiage than this.

From: Travis, Alexis (DHHS) <TravisA1@michigan.gov>
Sent: Monday, April 6, 2020 7:56 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Cc: Esty, Sarah (DHHS) <EstyS@michigan.gov>
Subject: Association Letter to Whitmer on health care provider

Hi Robert,
Sarah and I had a call with Bob Stein and Brenda Roberts from MALA today. The call was primarily to discuss alternative care sites, however they also shared the attached letter to the Governor. They are requesting that DCWs be added to the definition of health care provider in Executive Order 2020-21. I support this request and actually think it might help with justification of PPE for the DCW. Hoping we can discuss in more detail when we talk tomorrow.
Thanks,
AT

Alexis D. Travis, PhD
Senior Deputy Director
Aging and Adult Services Administration
Michigan Department of Health & Human Services
TravisA1@Michigan.gov
(517) 284-0145



This message, including any attachments, is intended solely for the use of the named recipient(s) and may contain confidential and/or privileged information. Any unauthorized review, use, disclosure, or distribution of any confidential and/or privileged information contained in this email is expressly prohibited. If you are not the intended recipient, please contact the sender by reply email and destroy any and all copies of the original message.

Obtained via MI FOIA by Judicial Watch, Inc.

April 5, 2020

Dear *Governor* Whitmer,

This letter is submitted on behalf of Incompass Michigan, Michigan Assisted Living Association and Michigan Center for Assisted Living (a division of Health Care Association of Michigan) which collectively represent statewide networks of providers whose services include residential, assisted living and vocational. The services are provided to individuals with disabilities and older adults.

The above referenced services are critical to preserving the health, safety and welfare of thousands of Michigan citizens. The personal care services include assisting individuals with eating/feeding, toileting, grooming, dressing, transferring, ambulation, personal hygiene and bathing. The community living supports include assisting, reminding, observing, guiding or training individuals with meal preparation, laundry, household care and activities of daily living.

The pandemic has exacerbated an existing workforce crisis. COVID-19 has further threatened the ability of providers to maintain services due to a shortage of health care providers. The expanded FMLA, sick leave and unemployment benefits have created an ability for our current employees and prospective employees to make choices about not returning to work. The individuals supported by members of our associations are among the most vulnerable citizens in Michigan needing services on a 24-hour basis in many instances. The health, safety and protection of these individuals cannot be ensured without a stable health care provider network. We are urgently requesting that you revise Executive Order 2020-21 to include the following definition of health care provider.

- **The definition of "health care provider" includes the following and remains in effect until the end of the declared state of emergency and disaster.**

1. **Direct care workers and other staff employed in licensed adult foster care facilities and licensed homes for the aged to provide room, board, personal care, supervision and/or protection are health care providers. In addition, direct care workers and other staff providing personal care, vocational services and community living supports funded through the public mental health system are also health care providers.**

2. **Direct care workers and other staff employed in facilities exempt from homes for the aged licensure are health care providers.**

3. **Direct care workers and other staff providing services to persons with disabilities or traumatic brain injuries in licensed and non-licensed settings are health care providers. Such services consist of room, board, personal care, supervision and/or protection.**

Obtained via MI FOIA by Judicial Watch, Inc.

As health care providers, such workers identified above must be temporarily exempted from certain leave benefits under the Families First Coronavirus Response Act to ensure that they are available to protect the health, safety and protection of vulnerable citizens in Michigan. These workers are commended for their sacrifice to protect the health, safety and protection of Michigan citizens during the state of emergency and disaster in Michigan.

Sincerely,

Todd W. Culver
Chief Executive Officer
Incompass Michigan
417 Seymour Ave, Ste 5
Lansing, MI 48933 517-484-5588

Linda I Lawther
President / CEO
Michigan Center for Assisted Living 7413 Westshire Drive
Lansing, MI 48917
517.627.1561x102

Robert. L. Stein
General Counsel
Michigan Assisted Living Association
21500 Haggerty Road, Suite 240
Northville, MI 48167
Direct Dial: 734-525-2400

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Huls, JoAnne
Subject: FW: BioFire has EUA
Date: Wednesday, March 25, 2020 4:04:28 PM

From: Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>
Sent: Wednesday, March 25, 2020 3:56 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Subject: Fwd: BioFire has EUA

Any word back on Gov calls to companies?

One of the key ones just got formal FDA approval.

Sent from my iPhone

Begin forwarded message:

> **From:** "Soehnlen, Marty (DHHS)" <SoehnlenM@michigan.gov>
> **Date:** March 25, 2020 at 3:47:09 PM EDT
> **To:** "Taverna, Andrea (DHHS-Contractor)" <TavernaA1@michigan.gov>
> **Subject: Fwd: BioFire has EUA**
>
> This is one of the companies we really want lots of materials to hand out to hospitals. Their EUA is formally approved.
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> > **From:** "Mosher, Laura B. (DHHS)" <mosherl@michigan.gov>
> > **Date:** March 25, 2020 at 3:44:58 PM EDT
> > **To:** "Robeson, Bruce A. (DHHS)" <robesonb@michigan.gov>, "Riner, Diana (DHHS)" <RinerD@michigan.gov>, "Soehnlen, Marty (DHHS)" <SoehnlenM@michigan.gov>
> > **Cc:** "Rodeman, Kevin M (DHHS)" <rodemank@michigan.gov>, "Day, Julie (DHHS)" <DayJ3@michigan.gov>
> > **Subject: BioFire has EUA**
> >
> > BioFire now has an EUA for their FilmArray SARS-CoV2
> >
> > BioMérieux Rapid Coronavirus Test Gets FDA Emergency Use Authorization
> > Mar 24, 2020

Obtained via MI FOIA by Judicial Watch, Inc.

staff reporter
Save for later

NEW YORK –BioMérieux said on Tuesday that an assay developed by its subsidiary BioFire Defense to rapidly detect COVID-19, the disease caused by SARS-CoV-2 virus, was granted Emergency Use Authorization by the US Food and Drug Administration.

The BioFire COVID-19 test detects SARS-CoV-2 from nasopharyngeal swabs in transport media in approximately 45 minutes. The test can be run on the BioFire FilmArray system as well as the higher-throughput FilmArray Torch, as previously reported. These platforms require minimal skill and training to operate. They are closed and fully-automated systems that integrate sample preparation, amplification, and detection.

BioMérieux has also received authorization to sell the BioFire COVID-19 test External Control Kit. This positive control material may be used for quality control and laboratory verification of the test, the firm said in a statement.

The BioFire COVID-19 test was developed by leveraging an existing contract between BioFire Defense and the US Department of Defense. It is the second of three tests to be launched by BioMérieux for COVID-19 detection, and the firm said it will also pursue EUA for the two others.

It has already launched a test in France, called SARS-CoV-2 R-Gene, for open real-time PCR platforms, and it is working to expand its FilmArray Respiratory Panel 2 test to include SARS-CoV-2 detection. The new panel will be called FilmArray RP2.1 and will also detect 21 other pathogens that cause respiratory infections.

In addition to the COVID-19 test and respiratory panel, the FilmArray system runs a broad menu of other syndromic multiplex-PCR tests for infectious disease, including pneumonia, bloodstream infections, gastrointestinal infections, meningitis, and encephalitis. BioMérieux said in a recent earnings report that it has placed 10,400 FilmArray instruments to date.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark; Bagley, Nick
Subject: FW: Checking-in more broadly
Date: Sunday, April 19, 2020 7:17:49 PM
Attachments: 200418 Restart Actions from Around the World 16april20.pptx
BCG Perspective - Restart Management in the Corona crisis.pdf

---

Some useful stuff from BCG. Strong recommendation for regional approach (tho I don't understand the units of measure)

Obtained via MI FOIA by Judicial Watch, Inc.



BOSTON CONSULTING GROUP

COVID response practices

Actions from Around the World

APRIL 2020

Obtained via MI FOIA by Judicial Watch, Inc.

Context for this document

The situation surrounding COVID-19 is dynamic and rapidly evolving.

This document is to be used as a preliminary discussion document. It is intended to share practices from other countries that are working to re-open their country/economy.

This presentation does not: (i) constitute medical, legal or safety advice, and is not a substitute for the same; nor (ii) should be seen as formal endorsement or recommendation of a particular decision.

Obtained via MI FOIA by Judicial Watch, Inc.

Contents

Summary of how other countries are approached re-opening timeline and metrics

Deep dive into Public Health & Economy Stability actions taken by the following countries:

- Singapore
- Germany
- India
- South Korea
- China

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Notable actions taken to suppress COVID-19

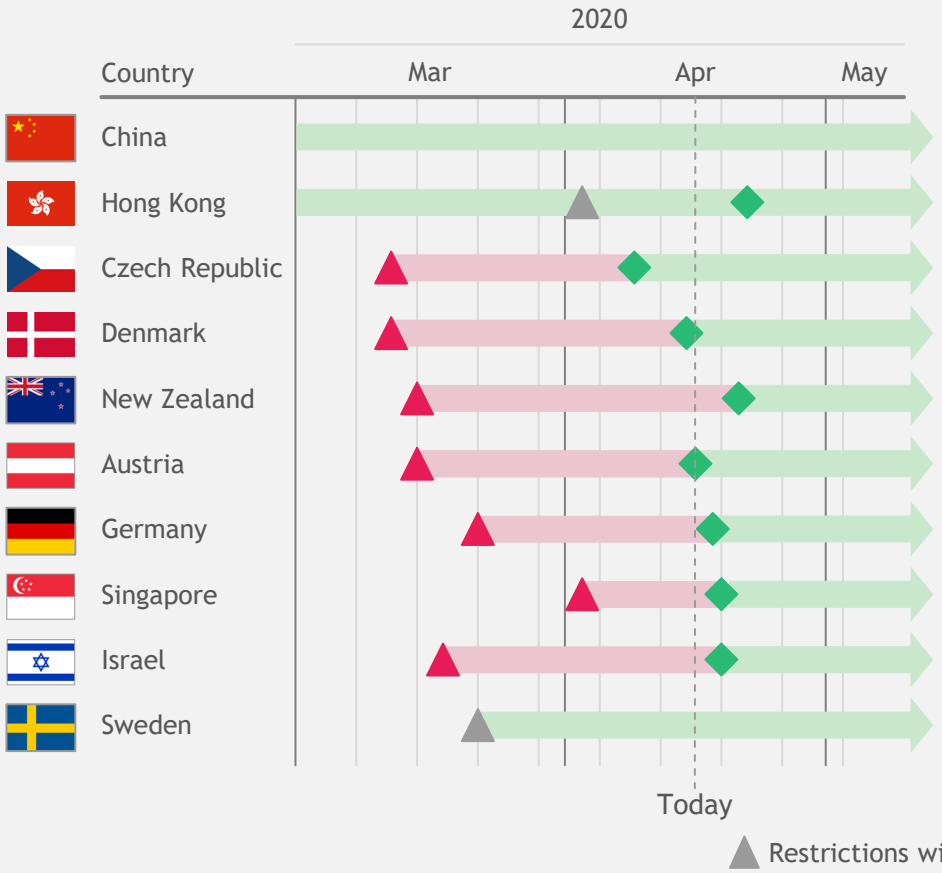
Prevention	Coordinated communications		Mass media messaging, including social media (government WhatsApp accounts), physical media (billboards, subways), text campaigns and even government AI-powered chatbots
	Distancing measures		Traffic lights in Sydney CBD automated to reduce unnecessary contact with high touch surface
			Releasing of tens of thousands of prisoners in an effort to stem the spread of the virus
	Wide-spread population tracking		Use of credit card transactions, smartphone location data and CCTV video to track confirmed cases
			Voluntary health declaration mobile app to report on self or suspected cases in neighborhood
			Facial recognition to scan for people with temperatures in crowds, and identify those not wearing required face masks
			Personal QR code app to monitor movement of individuals and certify those able to go back to work; individual must monitor and record their temperature and update their profile daily in order to maintain their health status level
Testing & Quarantining	Private sector collaboration		Online collaboration between government and private sector to crowdsource the development and testing of digital solutions
			Accepting funding applications from start -ups and SMEs with innovative solutions to tackle Coronavirus outbreak
	Enforcement		Fines of up to $10,000 or 6 months in prison for non-compliance for individuals
			Onus on employers to ensure compliance (e.g., potential to be barred from hiring foreign talent if foreign employees found non-compliant) & potential for visa to be revoked for foreign employees
			App developed for self-quarantined persons to report status to health offices
Treatment	Outpatient monitoring		Select municipalities deploying “Corona Taxis” in which health care workers visit outpatients with mild symptoms to preventatively determine whether they are likely to need future hospitalization
			Local health team calls individuals twice daily to ask about symptoms

Source: Internal Singapore COVID-19 response updated 3/27/2020, Internal Compendium of Digital Govt. Responses to COVID-19 updated 4/2/2020, various news reports

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Re-entry strategies beginning to cascade by country



Summary

China	Staged reopening with mandatory monitoring, testing, and contact tracing with strict workforce guidelines (e.g. for manufacturing, groups of 20 work, eat, and live together)
Hong Kong	Avoided lockdown with exception of schools because they consider schools as "high risk" areas
Czech Republic	Sequenced re-opening based on transmission risk of activity (e.g. open small shops and open-air sports facilities first), with strict distancing rules and monitoring through testing and tracing
Denmark	WIP
New Zealand	Full containment and reboot approach enabled by tight border controls and early action (low case count); Additional protections outlined for the vulnerable (e.g. over age 70 advised to stay home)
Austria	Gradual reopening of small shops first, then schools, with strict containment strategy restrictions and widespread testing and tracing
Germany	Staged opening balancing economic enablers (education) and transmission risk, enabled by two pronged tracing approach: tech-enabled app and manual contact reconstruction
Singapore	Despite avoiding shutdown with testing and contact tracing, Singapore closed nonessential businesses and schools on 4/3
Israel	4-phased reopening while protecting at-risk populations. Initial opening 1 includes finance and tech given ability to enforce strict protective compliance employ 10% of population
Sweden	'Low-scale lockdown' approach avoided total economic shutdown but increasing case counts suggest potential shutdown in near term

Proposed re-entry plans dependent on disease evolution in each country

Notes: '(Began…)' refers to the start date of a country's lockdown, lockdown definition varies among countries but generally refers to date most non-essential businesses were ordered to shut down
Source: Lit search; BCG Analysis

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Sequencing of re-opening activities

Risk level

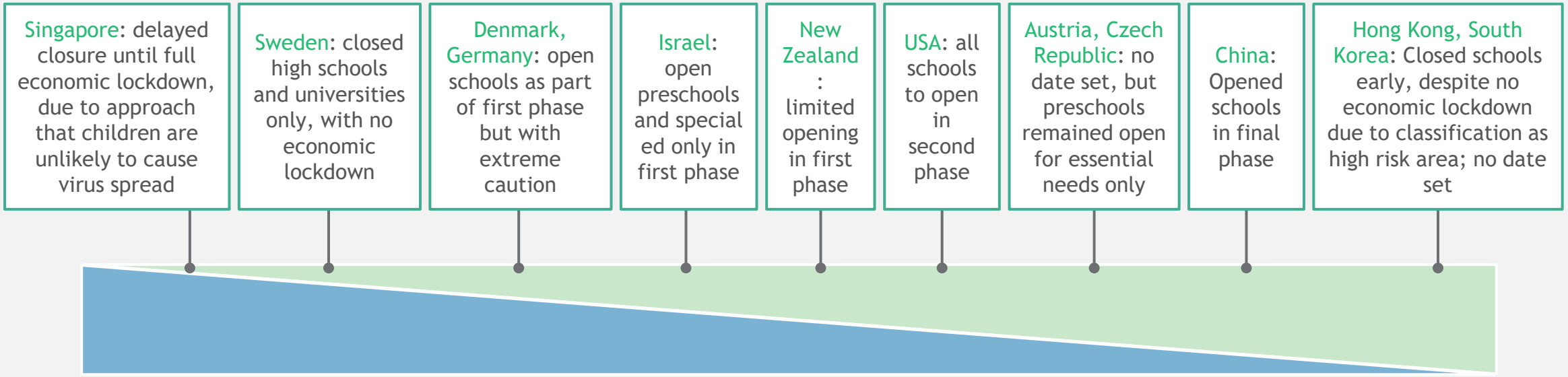
	Stage 1	Stage 2	Stage 3	Stage 4
China	• PPE production (Medical clothing, N95 masks, Medical goggles) • Epidemic control services (Ambulances, Related medicines)	• Epidemic control activities • Medicine • Energy supply • Transportation • Logistics • Food	• Manufacturing • Construction and real estate • Trade • Commercial services • Retail	• Restaurants • Hotels • Education • Nursing homes • Farmers markets
Germany[1]	• Education • Manufacturing	• Sector services • Office operations	• Cultural/leisure • Bars, clubs • Sports associations	• Large groups • Celebrations • Sporting events
New Zealand	• Schools (some students only)	• *Allowed activities based on risk level*	• *Allowed activities based on risk level*	• *Allowed activities based on risk level*
Czech Republic	• Non-essential shops • Open-air sports facilities	• Shops and services • Ease travel restrictions		
Israel[2]	• Tech & finance • Import/export (some) • Public transportation • Education (spec. ed, preschool)	• Commerce • Retail stores • Education (elementary)	• Cafes, restaurants, hotels • Education (non-university)	• Leisure & entertainment • Culture, sports • Large shopping malls • Flights
Austria	• Small shops & craft services • Hardware & garden stores	• All retail shops & hairdressers • Secondary schools and professional degrees	• Staggered opening of hotels, bars/restaurants	

1. Germany maintain conditions for 7 days before moving on to next stage; 2. Israel must maintain conditions for 2 weeks before moving on to next stage
Notes: Unless otherwise indicated, duration of stage is not specified as of date of research

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Timing of school opening relative to economic opening varies by country



Early stage reopening

Re-opening: Schools open earlier than rest of economy

Late stage reopening

Re-opening: Schools open later than rest of economy

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Five common themes from global re-entry announcements



Conditional planning

- Plans conditional on social compliance and virus trajectory
- Reverting to stricter restrictions possible if virus re-emerges



Less specificity to give flexibility

- Many timing announcements made with significant details still unknown (e.g. union/employer arrangements)



Phasing of re-entry

- Restrictions are being lifted in 1-2 week intervals
- Some common priorities for early focus (e.g. opening primary schools)



Restricted business openings

- Stricter guidelines around non-medical protective gear, sanitization and social distancing
- Uncertainty about how demand will recover



Continued social distancing

- Continued focus on maintaining social distancing and personal hygiene
- Large events such as sports, concerts and festivals have been deprioritized in all countries

Sources: Reuters; CNN; Sky News; Time; Secondary research

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Key metrics to re-open economic activity

	Disease conditions	Healthcare capacity	Virus Monitoring	Approach to re-opening or locking down
China	• No indigenous cases reported for 14+ days		• Testing • Tracing	• Sign of containment: no new indigenous cases reported for at least 14 days in area[1]
Germany	• New infection rate: 0.25 cases/100K adults	• ICU capacity: 40% free	• Testing (500-600K/day) • Tracing	• Regional healthcare readiness to be assessed based on stated condition measures
New Zealand	• Sustained reduction in cases and very low case numbers			• Must lower already small case number before re-opening, while also aware of need to get economy running
Singapore	• <10 new cases/day; lockdown due to 2 weeks of 50+ cases/day		• Testing • Tracing	• Tracking rise in new cases, local unlinked cases, and existence of clusters
Czech Republic	• Sustained reduction in cases		• Testing (33 teams) • Tracing	• Single-digit percentage daily rise in new cases implies ability to manage pandemic: "We are not facing massive increases in the numbers of patients - identified or hospitalised." (Health Minister Vojtech)
Israel	• < 10 new cases/day; lockdown if 40+ cases/day		• Testing (10K/day) • Tracing	• The main precondition is a drop in the infection rate to 10 new cases/day
Austria	• Sustained reduction in cases		• Testing • Tracing	• Number of cases stable and increasing containment measures, including tracking. The goal is "to get out of the crisis faster than others" (PM Kurz)
Sweden				• Restrictions are "low-scale" approach that "is much more sustainable" (Chief epidemiologist Tegnell)
Hong Kong			• Testing • Tracing	• Only shut down schools; to reopen, must have zero local indigenous cases for four weeks

1. Ministry of Foreign Affiars of the People's Republic of China: *NHC: China Scores Key Gains in Epidemic Control*, 13 March 2020
Note: Sources referenced and consistent with following deep dives unless otherwise indicated

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Many countries are leveraging technology to expand contact tracing

Non-comprehensive

Already deployed

- Singapore
- Israel
- South Korea
- Russia
- Poland
- China
- Austria

Under development

- UK
- France
- Germany

Various corporate and academic efforts are also under development, including an MIT solution and a joint initiative by Google and Apple

Similar solutions deployed across countries

Opt-in Bluetooth or GPS technology is used to track interactions and alert potentially-infected individuals

Interaction **data can be stored locally** on cellphones to provide privacy (e.g. no central database)

Countries also use contact tracing apps for communication, health tracking, & clearances

Communication

Baidu & WeChat prominently display medical center locations, gov. guidance, and information for accessing assistance

Health tracking

Corona Data Donation app allows people to voluntarily share fitness tracker data to help track overall community spread

Clearance

Personal QR codes used for immigration clearance for those traveling from Taiwan to China, Hong Kong, and Macau

Copyright © 2020 by Boston Consulting Group. All rights reserved.

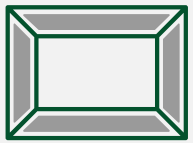
Obtained via MI FOIA by Judicial Watch, Inc.

Germany | Summary of actions taken



Summary:

- Germany has enacted multiple levers including widespread, meticulous tracking of those potentially infected, and a large scale lockdown until May 3rd
- So far the country has experienced a relatively low fatality rate relative to other countries



Country-specific context:

- High-capacity health care system with high % of supplies relative to population size and with digitized advancements
- State-by-state decision making and coordination
- Population of ~80 million with largest GDP (nominal) in Europe



Current figures:

- 142,569 confirmed cases
- 4,405 confirmed deaths

Source: John Hopkins, Bloomberg, IMF

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Germany | Actions taken to suppress COVID-19

Unique levers to flag

Prevention	Stringent social distancing measuring	• Nation-wide ban on public gatherings of more than 2 people including religious/faith communities • Hotel and temp accommodation offerings restricted to 'necessary use only', select states restricting use for tourists • Select states and municipalities enacting mandatory curfews and social distancing non-compliance fines (up to €500 for individuals and €10k for non-exempt businesses)
	Plan to launch geo-app tracking	• Planned launch of Bluetooth app with other EU countries to alert users if they are in close proximity to confirmed cases, heavy focus on ensuring privacy protection
Testing & Quarantining	Heavy state-by-state coordination in wide spread testing	• Widespread roll out of testing initiatives not limited to those with symptoms through private labs and special drive-in test stations (as of 4/2, conducting 50,000 test per day) • Meticulous state-by-state tracking and contact tracing for all individuals tested in advance test results considered best practice across Europe despite coordination delays
	Preventative quarantining	• Preventative 14 day self-quarantining for all individuals in contact with confirmed patients • Govt. subsidy to employers for workers missing work due to quarantine to align incentives • Select municipalities deploying "Corona Taxis" in which health care workers visit outpatients with mild symptoms to preventatively determine whether they are likely to need future hospitalization
	Crowdsourcing of digital solutions	• Online collaboration between Govt. and private sector to crowdsource the development and testing of digital solutions
Treatment	Early medical preparation	• Early ordering of 10,000 additional ventilators ahead of COVID spread in country • Orders to increase in medical ICU beds despite high starting benchmark • Govt. allocation order on to pharma companies and wholesalers not to supply drugs beyond usual demand to counteract stockpiling by individual market participants

2-Day hackathon generated 1,900 ideas to tackle COVID crisis (~42k registrations, 28k participants)

~30 critical care beds per 100,000 people (compared to ~12.5 per 100,000 people in the Italy and ~18 per 100,000 in NYC)

Source: Interal Compendium of Digital Govt. Responses to COVID-19 updated 4/2/2020, NPR, FT

Obtained via MI FOIA by Judicial Watch, Inc.

Germany | Actions to maintain economic stability

Unique levers to flag

Support to Core Services & Supply Chain	• €600B economic stabilization fund (€400B guarantees for liabilities, €100B direct state investment, and €100bn state-owned bank KfW re-financing) • Additional €150B social spending stimulus, includes €50B emergency financial assistance plan for micro-enterprises (under 10 employees) and self-employees persons • Allowing the entry of 40,000 migrant workers (with strict testing and quarantine requirements) from Eastern Europe to supply Bavaria with the agricultural workforce it needs
Ensure Business Liquidity	• KfW backed loans up to 80% for large enterprise, up to 90% for SMEs with ~2% subsidized interest rate (up to of €1B to SMEs emergency subject to limitations) • Potential plan for additional means to ensure 'unlimited liquidity' available through KfW, the State Bank (details TBD) • Waiver of late payment fines with no penalty interest until 12/31/2020 • Reduction of tax prepayments (mainly income/corp/trade tax, solidarity surcharge) for freelancer and businesses • Obligation to file for insolvency suspended until 9/30/2020 for affected businesses
Stabilize Employment & Personal Finances	• Quarantined individuals entitled to compensation from the state if WFH not allowed • Workers entitled wage if work is missed due to illness • Enhanced rules on reduced hours compensation benefit to suit current needs • Full reimbursement of social security contributions by Govt. for flex workforce (previously 80% of contributions to be paid by employer in addition to employee share) • Temporary reduction of flex workforce employees' working hours and gross remuneration pro rata to avoid lay-offs • Tenancies cannot be terminated due to withheld rental payments from 4/1/2020 – 6/30/2020
Stimulate future demand or workforce	• Spending of CSR funds for COVID-19 declared eligible CSR activity

Source: Internal COVID response checklist, Internal COVID -19 Country Dashboard updated 3/27/2020, TIME

Obtained via MI FOIA by Judicial Watch, Inc.

Phased plan and "new normality": Step-by-step reduction of the current measures in 5-7 weeks

Stage preconditions

Measured at locality

- **New infection rate** 0.25 per 100k
- **ICU capacity** 40% free

	Stage 1	Stage 2	Stage 3	Stage 4
	7 day re-stabilization Infection rate ICU bed capacity	**7 day re-stabilization** Infection rate ICU bed capacity	**7 day re-stabilization** Infection rate ICU bed capacity	**7 day re-stabilization** Infection rate ICU bed capacity
Stage description	*Economy enablers*	*Low transmission risk*	*Medium transmission risk*	*High transmission risk*
Resuming activities	• Education • Manufacturing	• Sector services • Office operations	• Cultural / leisure • Bars, clubs • Sports associations	• Large groups • Celebrations • Sporting events
Restrictions	**Education** • Mix of in person days and learn form home days • Required buffer distance **Manufacturing** • Work shift groups created • Machines sanitized **Public** • Severe distancing continues	**Restaurants** • Guests 2m apart **Sales** • 1 customer per 10 m^2 **Public** • High risk (e.g.over 50) exempted from returning to work	**Public** • "New Normal" begins • Mixing between groups permitted • Quick detection and control paramount	**Public** • Special conditions apply • Participant event registration required • Random testing, especially in high risk communities

Fight

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Testing and tracing: Three components necessary to control infection from reaching a critical size

Testing

Contact Tracing



Test strategy

Parallel testing approach to create a "closed-mesh" network to detect chains of infections early



Manual reconstruction

Notify all contacts of infected person to test and quarantine; requires 12-15K FTEs to implement from call center



Tracing app

Catches additional contacts not identified by infected person; contact will receive notification through opt-in voluntary app

Each chain of infection yields only ~0.5 undetected chains, enabling containment of virus[1]

1. With these three measures, only 4 - 12% of infected individuals will "slip" through the net; any chain of infection found generates average of 0.34-0.77 new, undetected chains of infection; most important point is that the number must be below 1 on average in order to contain spread of virus

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Test strategy: "Close-meshed" network detects chains of infection before becoming uncontrollable

To use available tests optimally, three approaches are pursued in parallel:

Group to be tested	Methodology	Location of Testing	Average tests/day
Symptom carriers and contacts	• All symptom carriers and individuals in contact with infected persons are tested	• Drive-through stations • Mobile teams	100-130K
Occupational groups (healthcare workers)	• All healthcare workers tested every other day to balance available test capacity with possible number of infections • Two test samples evaluated with one test kit (pooling[1])	• Point-of-care diagnostics • Mobile teams	200K
Randomized samples	• In each geographic "test cell", 5K randomly selected individuals tested every second day • Ten test samples evaluated with one test kit (pooling[1]) • Target sampling based on RKI[2] "data donation"	• *More detail on following slide*	220K
			500-600K

Unique approach; detailed on following slide

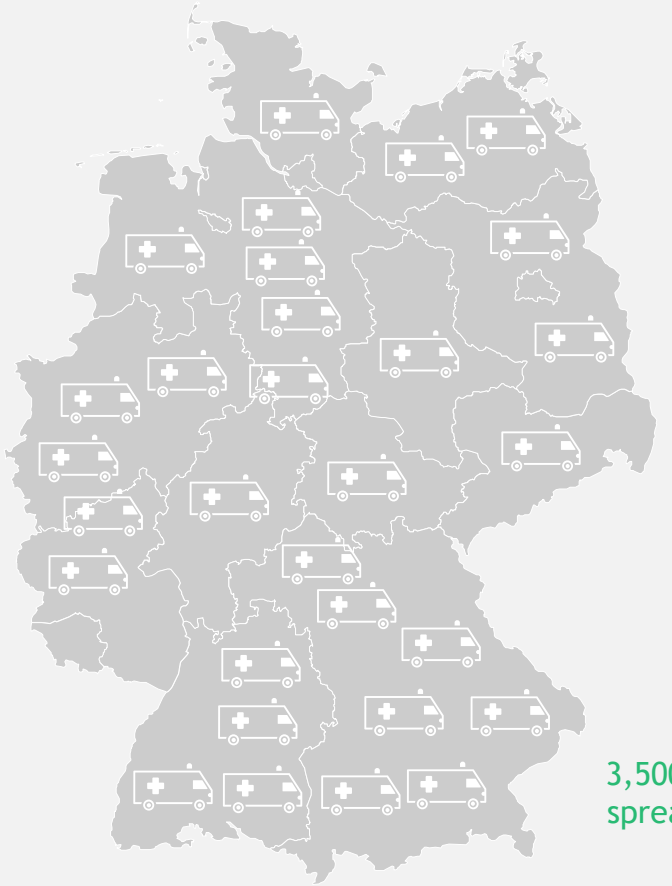
99% of infection chains will be found and controlled through this "close-meshed" approach[3]

1. "Pooling" refers to practice of gathering small sets of data with assumed similar characteristic and using the combined larger set to obtain a more precise estimate; 2. Robert-Koch Institute; 3. 1% of the infection chains will "slip through", i.e. will be uncontrollable because only be found after more than 30 days, and by then will have already increased to above a potential group size of more than 30 individuals.

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Randomized testing will carried out via a nationwide network



Illustrative
3,500 locations will be spread out throughout Germany

Dimensions of random testing operations

- PCR tests[1] to be replaced by cheaper, faster antigen tests as soon as available
- 3,500 test stations total, located at average max distance of 7km from citizens
- Online/telephone registration to prevent crowds
- 30,000 trained employees to test; staffed by Germany Armed forces, German Red Cross, and other voluntary or full-time staff
- Tests collected 2-3 times/day and evaluated by human or vet labs
- Test results entered in centrally available database within 12 hours of testing

1. Polymerise chain reaction tests: the current dominant way to test for COVID-19

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Voluntary contact tracing app last line of defense to identify those who may have been exposed

App can notify some not identified in manual reconstruction



Leverages testing, contact tracing data

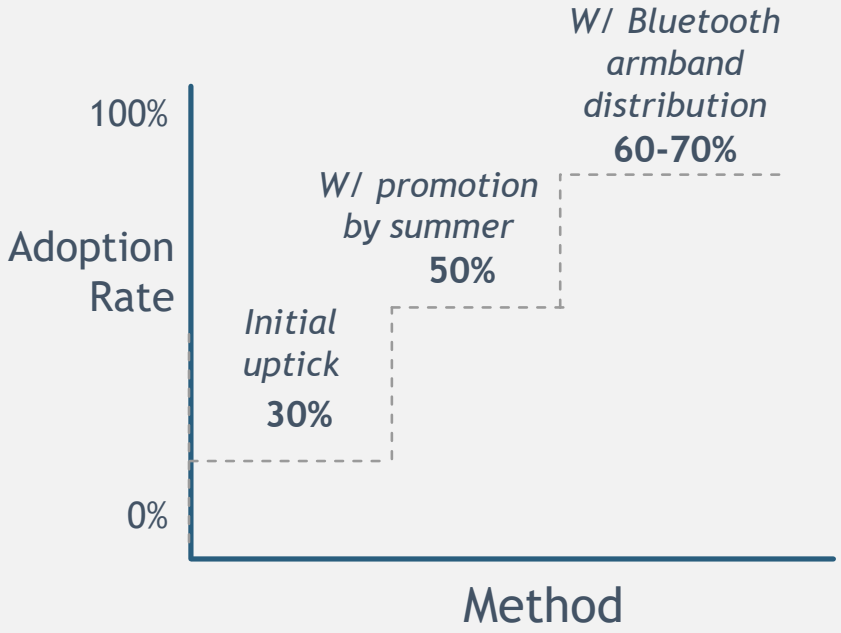


Bluetooth signal to determine contact risk



App sends message to request self-quarantine and immediate testing

Increased adoption of app increases detection rate of infection chains



Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Federal system with local decision-making powers supported by specifically developed control software

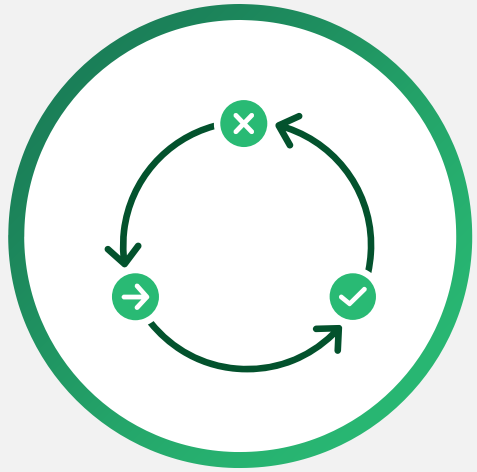
Approach enables central intelligence and coordination at federal level:



Central test database



Overview of available medical resources



Continuous situation analysis

Copyright © 2020 by Boston Consulting Group. All rights reserved.

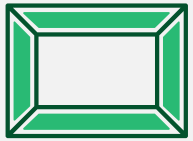
Obtained via MI FOIA by Judicial Watch, Inc.

South Korea | Summary of actions taken



Summary:

- South Korea has avoided a full lockdown through strict social guidelines and health care actions around testing, tracing, and quarantining to combat COVID-19.
- The country successfully held legislative elections in mid-April



Country-specific context:

- Strong low-cost universal healthcare system
- One of the most densely populated countries (population of 52 million)



Current figures:

- 10,653 confirmed cases
- 232 confirmed deaths

Source: John Hopkns, IMF

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Lessons learned from South Korea's 2015 MERS epidemic

	MERS-era challenge	Innovative response
Stimulating industry	Decline in economic growth	The Korea Trade Investment Promotion Agency held an online import/export expo, attracting more than 100 foreign and 200 domestic companies
Providing open communication	Lack of information leading to nationwide panic	South Korea released a detailed public COVID dashboard to inform citizens of the number of identified cases, tests conducted, and other relevant data
Fast-tracking testing	Widespread lack of testing	The country introduced a regulatory system for fast-tracking test approvals. After first confirmed COVID-19 case, the government worked with industry to quickly ramp up testing.
Prioritizing tracking	Inability to track movements and interactions	The country introduced a comprehensive app-based solution for tracking the movement of citizens

Copyright © 2020 by Boston Consulting Group. All rights reserved.

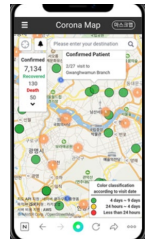
Obtained via MI FOIA by Judicial Watch, Inc.

So. Korea | Actions taken to suppress COVID-19

Unique levers to flag

Prevention	Social trust and awareness	• Govt. public messaging campaign on prevention tips and daily case reports through TV, subway announcements, and targeted smartphone/text message alerts
	Tech-based tracking and alerts	• Govt. use of credit card transactions, smartphone location data and CCTV video to track confirmed cases; legislation passed after 2015 MERS outbreak allowing Govt. authority to collect personal data • Alerts to smartphone users of confirmed-case if in a 100-meter (328-foot) radius of location or patient
Testing & Quarantining	Widespread testing	• Early wide-spread and expanded community-based testing in high prone areas, such as Daegu, and for those with mild/suspected cases (~500,000 individuals tested as of 4/9) • Regulatory system in place to fast track approvals for newly developed testing kits
	Widespread, prioritized quarantining	• Confirmed high-risk individuals prioritized for hospitalization • Confirmed cases with moderate symptoms required to quarantine in repurposed Govt. shelters for observation and treatment, and must test negative twice before being released • Preventative self-quarantining for those who may have been exposed or suspected cases
	Strict monitoring and enforcement	• Govt. developed app for self-quarantined persons to stay in contact with health offices and report on individual progress • Local monitoring team calls to individuals twice daily to make sure the quarantined stay put and to ask about symptoms • Potential for quarantine violators face up to 3M won ($2500) fines (potential to increase fine up to 10M won ($8200) and as much as a year in jail)
Treatment	Ensuring medical capacity	• Rationing of masks to prevent hoarding and export ban on face masks to ensure supply chain • Pharma companies called on by Govt. one week after first confirmed case to ramp production of testing equipment and reagent chemicals needed (100k kits produced daily as of 3/23) • Opened 600 testing centers, including drive through locations, aimed at reducing burden at hospitals and clinics people as fast
	Ed-tech support	• Ed-tech platform launches to help public and medical professional prevent, diagnose, treat virus

App to track confirmed cases on map



Source: Internal COVID response checklist, Internal Compendium of Digital Govt Responses to COVID updated 4/2/2020, Science Mag, NYT

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

So. Korea | Actions to maintain economic stability

Unique levers to flag

Support to Core Services & Supply Chain	• $125T KRW total rescue package equating to 6% of GDP announced including $29T KRW in loans to SMEs, $20T KRW to buy corporate bonds, commercial paper of companies facing credit crunch, $11T KRW to stabilize stock markets • Bank of Korea (BOK) cut interest rates by 50 basis points to 0.75% • BoK committed unrestricted actions to support markets through open market operations
Ensure Business Liquidity	• BOK increased ceiling of SME lending facility by $5T KRW and lowered the interest rate to 0.25% (from 0.5%-0.75%) • Low cost loans facilitated for exporters affected by supply chain disruptions and airlines • Business owners compensated up to $ 5k per employee per year (depending on number of flexible work hours / week) • Tax cuts for landlords reducing rent for commercial tenants and tax deferrals for SMEs and self-employed healthcare, tourism, and hospitality workers • Contribution cuts and 3-month payment deferrals for social security, unemployment, and accident compensation insurance
Stabilize Employment & Personal Finances	• Emergency relief payments for households in the bottom 70% income bracket totaling $1M KRW via Govt-issued certificates • Electricity bill payment deferrals totaling $1.3M KFW • Increased income deduction for individual tax payers for 3/1 to 6/30 period • Govt. wage subsidies to travel-related businesses (e.g., airline, hotels) to sustain payroll over the next six months (up to 90% workforce cost) • Govt. employment retention subsidy per worker increase to 70,000 won ($56.42) from 66,000 won • Plan to expand program that sends a care taker to households during school closures on weekdays for facilities unable to provide adequate child care & day care services,
Stimulate future demand or workforce	• Job training for those who have lost jobs

Source: Internal Economic Activity and Action Dashboard updated 4/2/2020, Internal COVID -19 Country Dashboard updated 3/27/2020

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

South Korea successfully held an April election in the midst of the pandemic

On April 15th, South Korea held safe legislative elections and achieved its highest turnout (66%) since 1992

Tactics used



Hygiene

- Regular disinfecting of polling stations
- Voters will be provided with hand sanitizer and plastic gloves when they enter the voting booths



Social distancing

- One meter distance between people in line
- Temperature checks given at the doors and anyone showing readings higher than 99.5 °F was directed to a special booth separate from others



Expanded access

- Early voting stations set up at Covid-19 patient centers
- Quarantined individuals allowed to leave their homes to vote between 6-7pm provided they called government officials once they returned home
- Expanded vote by mail access for all

Copyright © 2020 by Boston Consulting Group. All rights reserved.

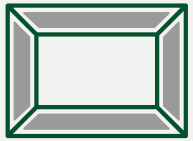
Obtained via MI FOIA by Judicial Watch, Inc.

Singapore | Summary of actions taken



Summary:

- Singapore has been managing the health crisis through various testing and containment measures
- Although it attempted to control the outbreak with other measures, it has moved to lockdown until May 4



Country-specific context:

- Strong healthcare system
- Small population of ~5.6 million in a concentrated area
- 3rd highest per-capita GDP in the world



Current figures:

- 5,992 confirmed case
- 11 confirmed deaths

Source: Internal Singapore COVID-19 response updated 3/27/2020, John Hopkins, IMF

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Singapore | Actions taken to suppress COVID-19

Unique levers to flag

Prevention	Coordinated Govt. response and communications	• Dedicated, inclusive multi-ministry taskforce and centralized disease outbreak response system set up • Official comms channels, including official WhatsApp account and Govt. AI powered chatbots, as single-source of truth to ensure consistency, address misinformation, provide clear directives (e.g., directions for use and limits on at-home masks) • Coordinated efforts with international partners prior to announcing border closures to reduce confusion & preserve relations
	Wide-spread population tracking	• Voluntary Bluetooth-based app to track phones which have been within 2 meters of each other over last 21 days • QR codes deployed in offices and public venues to track all visitors to a location in case of a local outbreak
Testing & Quarantining	Incentives to ensure reporting and compliance	• Free testing and treatment, with compensation for lost earnings, to encourage reporting and containment • Compensation to employers and self-employed for absences and compliance with Stay Home notices • Co-funding for professional cleaning of premises following confirmed case • 3-month pay cuts for govt. officials and management/Board of largest local firms to show solidarity
	Individualized notifications	• 14-day Stay Home Notice when returning from overseas and text messages from immigration authority with GPS reporting link • Occasional random house visits or calls from officers
	Re-purposing locs for quarantine	• Multiple worker housing dormitories repurposed as Govt. isolation areas • Singaporean residents returning from U.S. or U.K. required to quarantine for 14 days at designated hotels
	Severe and enforced punishments	• Fines of up to $10,000 or 6 months in prison for non-compliance for individuals • Onus on employers to ensure compliance (e.g., potential to be barred from hiring foreign talent if foreign employees found non-compliant) & potential for visa to be revoked for foreign employees caught breaching rules (89 visas revoked as of 3/21)
Treatment	Leveraging assistance from scientific and corp community	• Range of local institutions and firms found to fast-track development of testing kits collaborating across public and private institutions • US biotech firm, Gilead Sciences, expanded clinical trials to Singapore • Temasek, Govt-linked company, to provide hand sanitizer to all households • Keppel, major local conglomerate, to provide assistance on utility bills and faster payments to SMEs

As of 3/21, for 40% of confirmed cases, first indication of contraction came from contact by the Ministry of Health

Cultured virus within 1 week & first globally to develop antibody test

Source: Internal Singapore COVID-19 response updated 3/27/2020, Internal Compendium of Digital Govt. Responses to COVID-19 updated 4/2/2020,

Obtained via MI FOIA by Judicial Watch, Inc.

Singapore | Actions to maintain economic stability

Unique levers to flag

Support to Core Services & Supply Chain	• S$6.4B stimulus package announced mid-Feb, increased by $48B end of March (equivalent to 2019 Govt expenditure) including specific support packages for aviation, tourism, arts and land transport sectors • Various govt. departments mandated to ensure value trickles down to intended targets (e.g. reliefs for mall owners reaching retailers and food and beverage outlets through rental rebate) • Special bonuses for front line staff (e.g., medical workers and police) • Advance notice of upcoming travel restriction to allow time to mitigate effect on supply-chain and workforce
Ensure Business Liquidity	• State to pay firms 25% wage subsidy for all local employees (food services to receive 50%, aviation & tourism to receive 75%) • Automatic deferment of income tax payments for companies and self-employed • Year deferral of property tax to support hard-hit venues (e.g., conference centers, hotels, retailers, eateries, tourist attractions) • Rebates, loss acceleration and working capital loans for SMEs
Stabilize Employment & Personal Finances	• Cash pay-out to all Singaporeans (up to S$900), eligible self-employed persons (S$1,000 for 9 months), cash grants and temp relief fund for lower income households out of employment, & additional grocery vouchers • Govt-backed training to upskill workers for tourism, aviation, land transport, arts, retail, food services and logistics • No increase in govt. fees and charges and suspension of loan repayment and interest for Govt. student loans for 1 year
Stimulate future demand or workforce	• Govt. to identify 10,000 new jobs this year and support 8000 traineeships • State to co-fund wage costs for traineeships offered to first time job seekers • Enhanced support for SMEs to adopt digital business practice with up to 90% grants for investment in qualifying digital business programs • Program launched to improve stockpile of essential supplies for future and become 30% food self-sufficient it by 2030

Source: Internal Singapore COVID-19 response published 3/27/2020, Internal Economic Policy and Action Dashboard as of 3/30/2020

Obtained via MI FOIA by Judicial Watch, Inc.

Singapore | Trace Together app leverages Bluetooth proximity on devices to record point of contact



- Automates contact tracing and notification, dramatically increasing capacity of a previously manual process
- Uses Bluetooth 'handshakes' to track who you have been close to over past two weeks
- Opt-in, with many privacy guardrails in place
- This software is open-source

Copyright © 2020 by Boston Consulting Group. All rights reserved.

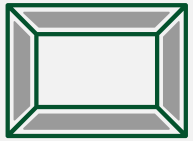
Obtained via MI FOIA by Judicial Watch, Inc.

India | Summary of actions taken



Summary:

- India initiated full lock down through 4/14 and is likely to extend the lockdown another 2 weeks through the end of April. The country is emphasizing social responsibility and scaled information campaigns to manage the health crisis



Country-specific context:

- Health care resources concentrated in urban areas, lacking protective gear, poor sanitary conditions
- Large population of ~1.3 billion with many high density areas
- $180B annual imports and exports linked to high exposure countries (e.g., US, UK, Iran, Italy, Spain, Germany, Switzerland, France)



Current figures:

- 14,792 confirmed cases
- 488 confirmed deaths
- New GDP growth estimated between 2.1-3.5% (down from previously estimated 5.2-6%)

Source: John Hopkins; Internal COVID-19 India Perspective updated 3/30/2020, World Bank

Obtained via MI FOIA by Judicial Watch, Inc.

India | Actions taken to suppress COVID-19

Unique levers to flag

Prevention	Centralized Govt. communications	• Daily updates and Health Ministry briefings on number of cases, status of preparedness, and Govt. taken/planned actions • Govt. mass media message via Google, Facebook, and all 4 major telecommunication companies • Widespread media campaigns such as "Break-the-chain" initiate, via repurposed public advertising displays (e.g., billboards, public transportation vehicles, mall/airport branding)
	Leveraging social responsibility and accountability	• Reinforcing social distancing as desired behavior and a self-imposed social responsibility, communicating simple call to action with "1-Day effort" and Sunday as a choice day to help with feasibility • Moral boosting measures such as 5-minute nationwide clapping for 'Corona warriors' • Physical marking of high risk citizen with quarantining recommendations and end-date at airports and hospitals
Testing & Quarantining	Attempts to increase testing	• First and second tests made free for all • Broadening testing beyond symptomatic travels to include hospitalized patients with severe acute respiratory illness, and direct and high-risk contacts of confirmed patients • Startups specializing in screening and testing devices, currently under validation by National Institute of Virology for tests
	Mandatory quarantining partnering with hotels	• Mandatory quarantining and universal health screening of incoming travelers • Strategic partnership and negotiated pricing with hotels to expand quarantine capacity for passengers coming from high-risk countries, specific focus on hotels close to airports
Treatment	Crowdsourcing new ideas and encouraging DIY innovation	• Online challenge designed to crowdsource ideas from various local startups and entrepreneurs in order to tackle crisis • Communication to medical professionals to use self-made masks and sanitizers to tackle increasing number of patients

Source: Internal Information Dissemination by Government of India on COVID-19 (March 2020), Internal India – Innovative Ideas updated 3/24/2020

Obtained via MI FOIA by Judicial Watch, Inc.

India | Actions to maintain economic stability

Support to Core Services & Supply Chain	• Fiscal stimulus packaged announced 1.7T rps. (~$23B USD) on 3/26 predominantly targeting rural, low-income, healthcare workers (details not yet determined) • Reduced repo rate by 75 basis points to 4.4%. Reverse repo rate was cut by 90 bps to 4%.
Ensure Business Liquidity	• Plans for Govt. support to business liquidity announced but details not yet determined
Stabilize Employment & Personal Finances	• Withdrawal of 75% of credit in the Employees' Provident Fund account or 3 months of wages (whichever lower) • Stimulus package to include food stability measures, free cooking gas to the poor for three months, state-sponsored contributions to retirement funds • $5M rps. (~$66K USD) for medical insurance for front line workers (doctors, nurses, paramedics etc.) • Minimum balance criteria for bank accounts waived off for 3 months
Stimulate future demand or workforce	• Cash prizes for startups and entrepreneurs to find innovative solutions to for COVID response, dual objective to support startup industry • Spending of CSR funds for COVID-19 declared eligible CSR activity

Source: Internal India – Innovative Ideas updated 3/24/2020, Bloomberg Quint, WHO, India Today, The Economic Times

Obtained via MI FOIA by Judicial Watch, Inc.

India is applying a three-level system for reopening

Zone	Definition	No. of districts	Guidelines	Zone exit criteria
Red zone (Hotspots)	Districts contributing to >80% of cases in each state OR Doubling rate of < 4 days	170	• No activity, except for essential services. Special teams to monitor and survey cases. Test ILI and SARI patients also for Covid	• No new case is reported in the next 14 days—Upgrade into a White zone
White zone (Non-hotspots)	Districts with only a few cases. No increase in number	207	• Minimum activity, with limited public transport, agriculture harvesting • Identify and test ILI and SARI patients also for Covid	• No new case is reported for next 14 days and also the known last case tests negative—Upgrade into a Green zone
Green zone	Districts with no confirmed cases in the last 28 days	353	• Enforce social distancing rules in public places and public transport • Identify and test ILI and SARI patients also for Covid	• N/A

Copyright © 2020 by Boston Consulting Group. All rights reserved.

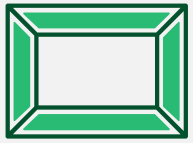
Obtained via MI FOIA by Judicial Watch, Inc.

China | Summary of actions taken



Summary:

- China has re-opened Wuhan city on 4/8 after 10-week full lock down of Hubei province 1/23. Movement of individuals remains restricted with strict tracking and quarantining of incoming travelers from abroad.



Country-specific context:

- Large population (~1.3 billion) concentrated around cities with 90% of the population in the eastern 50% of the country
- Evolving mix of private and public healthcare system determined by age, employer, and rural vs. urban setting



Current figures:

- 83,787 confirmed cases
- 4,636 confirmed deaths
- New GDP growth estimated between 1.5-4.5% (down from previously estimated target ~6%)

Source: John Hopkins, Deutsche Bank and UBS GDP growth estimates

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

China | Actions to maintain economic stability

Unique levers to flag

Support to Core Services & Supply Chaing	• $2T RMB total rescue package primarily focused on propelling money into banks and local government vehicles with intention to trickle down to small businesses and residents • Central bank targeted reserve requirement ratio cut by .5 to 1 percentage points • $50B RMB reverse repurchase operation and seven-day reverse repurchase rate from 2.4% to 2.2% • Multiple measures to core medical workers including temporary work subsidies, bonuses, personal tax deferrals • Update to tax exemption policy for business importing or transporting materials used to prevent/control COVID-19; and eligible equipment to be deductible (vs. depreciated over lifetime) for manufacturers produce key COVID-19 supplies
Ensure Business Liquidity	• COVID-impacted businesses allowed more flexibility to adjust remuneration, rotate shifts and shorten working hours • Average of 5% electricity rate cut for most businesses from two of China's power distributors from 2/1 to 6/30 • VAT cut from 3% to 1% (0% in Hubei) from 3/1 – 5/31 and tax exemptions on medical and prevention supplies provided to employees • Employer contribution relief measures such as deferred social insurance premiums for eligible businesses for six months, 50% reduction in medical insurance for all businesses for 5 months • 3 years extension of carry over loss period to 8 years for hardest hit industries (e.g., transportation, catering, tourism) • Support to SME including additional $1T RMB central bank credit line and penalty-free deferral of debt repayment to 6/30 • Tax reduction of 9-13% for ~1,500 export products
Stabilize Employment & Personal Finances	• Extension of the Chinese New Year holiday until 2/2, with substitutional days off or 200% payment for employees who were ordered to work during extended holiday • Maximum refund raised to 100% of unemployment insurance paid in 2019 for all enterprises in Hubei (only SMEs eligible in other provinces) to ensure businesses continue to pay workers where possible and reduce layoffs
Stimulate future demand or workforce	• Subsidies for small businesses that sign long-term employment contracts with college graduates

Source: WSJ, Internal economic policy and actions dashboard updated 4/9/2020

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

China | Actions taken to suppress COVID-19

Unique levers to flag

Prevention	Tech-tools leveraged for compliance	• Facial recognition to scan for people with temperatures in crowds, and identify those not wearing required face masks • Smart mobile robot for facial recognition/temperature screening, as well as verbal reminders to wear a face mask • Govt. sanctioned QR code app to monitor movement of individuals and certify those able to go back to work; individual must monitor and record their temperature and update their profile daily in order to maintain their health status level
	Re-opening travel restrictions	• Strict internal travel regulation around Hubei province (e.g. only those marked as green "health condition" allowed to move in and out of Hubei province, strict control of individuals leaving/entering residential communities remain)
	Drone deployment	• Partnership with industry to deploy drones to transport supplies to urban medical centers • Currently testing deployment of drones to assist with decontamination via wide-scale spraying
Testing & Quarantining	Testing & Quarantining	• Free-testing for individuals with severe symptoms, with Govt. assistance for COVID-related charges • Govt. using location tracking to identify those in contact with confirmed cases and to monitor and enforce quarantine • Centralized tracking locations with field teams, as part of a larger surveillance system set up post 2003 SARs outbreak
	Strict Govt. enforcement	• Strict stay at home mandates in Hubei province residents effectively used as quarantine measures • Widespread local enforcement and security patrols to ensure compliance with Govt. containment measures
	Restrictions on incoming travel	• After lifting restrictions, mandated testing (using either nucleic acid and antibody test) for all incoming travelers • After lifting restrictions, 28-day quarantine requirements for all incoming travelers to mainland China
Treatment	Increasing treatment capacity and supply	• Temporary hospitals built (e.g., two new hospitals built in under ten days in Wuhan) and additional locations such as stadiums or training centers repurposed to increase the capacity of treatment beds • Tax and national and local education surcharges waived for cash and COVID-response articles donated through Govt. or public welfare social organizations
	Leveraging workforce	• Reassignment of workers in transportation, agriculture, and clerical jobs to meet new workforce needs • 5G technology used to connect Wuhan hospitals with counterparts in Beijing to provide real time consultations

Source: Compendium of Digital Govt Responses to COVID updated 4/2/2020, World Economic Forum, HBR

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Draft as of 4/18 - Work in Process

China | Economy restart in 5 stages by essentialness and transmission risk

Data as of Apr. 8, 2020



5 key stages in restarting economy[1]

1	2	3	4	5
1/29- **Resumed production of key supplies for epidemic control**	2/09- **Resumed work in multiple batches, with strict epidemic control rules and sufficient test supply**	2/21- **National Guidance on prevention measures to ensure safe return to work, eg. social distancing**	3/03- **Enabled regional decision making to improve accuracy of services and optimize efficiency**	4/06- **Restored lifestyle services, activities and locations by region and category, general technical instruction + detailed local decisions**

Industries restarted

1	2	3	4	5
Epidemic control • medical clothing • N95 masks • medical goggles • ambulances • related medicines	Essential businesses: • epidemic control • medicine • energy supply • transportation • logistics • food	Low to medium transmission risk businesses: • manufacturing • construction and real estate • trade • commercial services • retail		High transmission risk businesses • restaurants • hotels • education • nursing homes • farmers markets

Re-start rate of scaled enterprises[2]

40% 67% 87% 99%

1. Milestones set by key national government policies; 2. In China, definition of scaled enterprise varies according by industry sector, generally refers to enterprises with 20mn+ RMB revenue; Sources: Official disclosures & credible media reports

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Disclaimer

The services and materials provided by Boston Consulting Group (BCG) are subject to BCG's Standard Terms (a copy of which is available upon request) or such other agreement as may have been previously executed by BCG. BCG does not provide legal, accounting, or tax advice. The Client is responsible for obtaining independent advice concerning these matters. This advice may affect the guidance given by BCG. Further, BCG has made no undertaking to update these materials after the date hereof, notwithstanding that such information may become outdated or inaccurate.

The materials contained in this presentation are designed for the sole use by the board of directors or senior management of the Client and solely for the limited purposes described in the presentation. The materials shall not be copied or given to any person or entity other than the Client ("Third Party") without the prior written consent of BCG. These materials serve only as the focus for discussion; they are incomplete without the accompanying oral commentary and may not be relied on as a stand-alone document. Further, Third Parties may not, and it is unreasonable for any Third Party to, rely on these materials for any purpose whatsoever. To the fullest extent permitted by law (and except to the extent otherwise agreed in a signed writing by BCG), BCG shall have no liability whatsoever to any Third Party, and any Third Party hereby waives any rights and claims it may have at any time against BCG with regard to the services, this presentation, or other materials, including the accuracy or completeness thereof. Receipt and review of this document shall be deemed agreement with and consideration for the foregoing.

BCG does not provide fairness opinions or valuations of market transactions, and these materials should not be relied on or construed as such. Further, the financial evaluations, projected market and financial information, and conclusions contained in these materials are based upon standard valuation methodologies, are not definitive forecasts, and are not guaranteed by BCG. BCG has used public and/or confidential data and assumptions provided to BCG by the Client. BCG has not independently verified the data and assumptions used in these analyses. Changes in the underlying data or operating assumptions will clearly impact the analyses and conclusions.

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.



Obtained via MI FOIA by Judicial Watch, Inc.



BOSTON CONSULTING GROUP

COVID response practices

Actions from Around the World

APRIL 2020

Obtained via MI FOIA by Judicial Watch, Inc.

Context for this document

The situation surrounding COVID-19 is dynamic and rapidly evolving.

This document is to be used as a preliminary discussion document. It is intended to share practices from other countries that are working to re-open their country/economy.

This presentation does not: (i) constitute medical, legal or safety advice, and is not a substitute for the same; nor (ii) should be seen as formal endorsement or recommendation of a particular decision.

Obtained via MI FOIA by Judicial Watch, Inc.

Contents

Summary of how other countries are approached re-opening timeline and metrics

Deep dive into Public Health & Economy Stability actions taken by the following countries:

- Singapore
- Germany
- India
- South Korea
- China

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Notable actions taken to suppress COVID-19

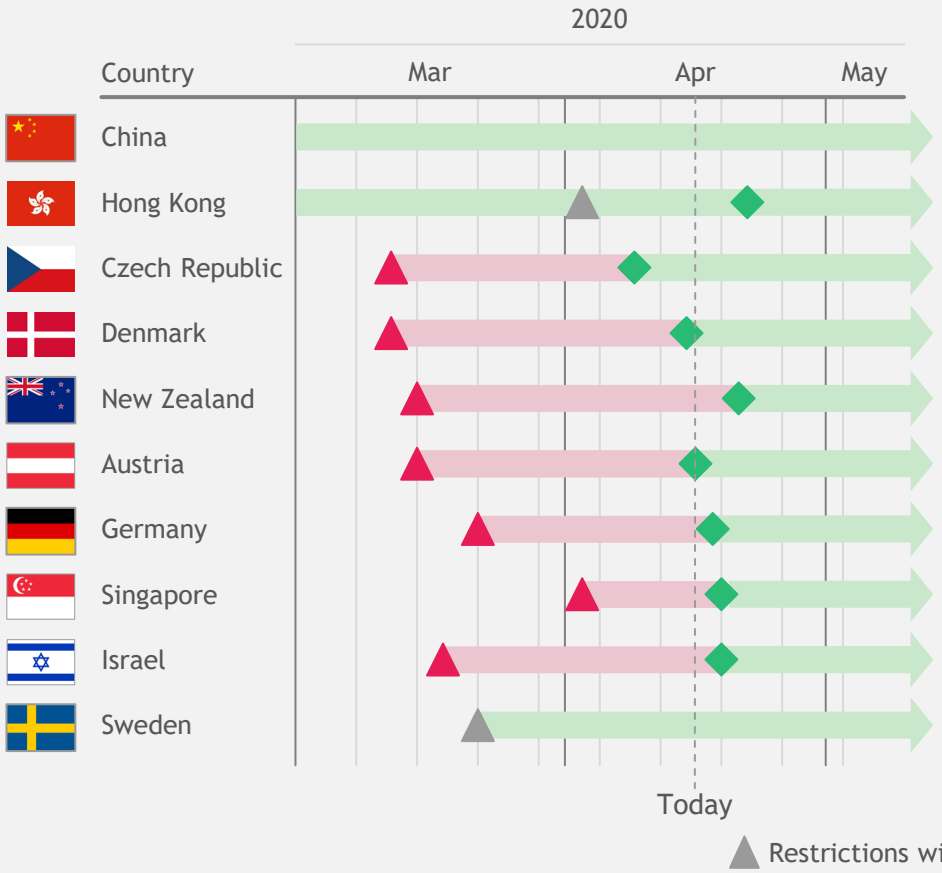
Prevention	Coordinated communications		Mass media messaging, including social media (government WhatsApp accounts), physical media (billboards, subways), text campaigns and even government AI-powered chatbots
	Distancing measures		Traffic lights in Sydney CBD automated to reduce unnecessary contact with high touch surface
			Releasing of tens of thousands of prisoners in an effort to stem the spread of the virus
	Wide-spread population tracking		Use of credit card transactions, smartphone location data and CCTV video to track confirmed cases
			Voluntary health declaration mobile app to report on self or suspected cases in neighborhood
			Facial recognition to scan for people with temperatures in crowds, and identify those not wearing required face masks
			Personal QR code app to monitor movement of individuals and certify those able to go back to work; individual must monitor and record their temperature and update their profile daily in order to maintain their health status level
Testing & Quarantining	Private sector collaboration		Online collaboration between government and private sector to crowdsource the development and testing of digital solutions
			Accepting funding applications from start -ups and SMEs with innovative solutions to tackle Coronavirus outbreak
	Enforcement		Fines of up to $10,000 or 6 months in prison for non-compliance for individuals
			Onus on employers to ensure compliance (e.g., potential to be barred from hiring foreign talent if foreign employees found non-compliant) & potential for visa to be revoked for foreign employees
			App developed for self-quarantined persons to report status to health offices
Treatment	Outpatient monitoring		Select municipalities deploying “Corona Taxis” in which health care workers visit outpatients with mild symptoms to preventatively determine whether they are likely to need future hospitalization
			Local health team calls individuals twice daily to ask about symptoms

Source: Internal Singapore COVID-19 response updated 3/27/2020, Internal Compendium of Digital Govt. Responses to COVID-19 updated 4/2/2020, various news reports

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Re-entry strategies beginning to cascade by country



Summary

China	Staged reopening with mandatory monitoring, testing, and contact tracing with strict workforce guidelines (e.g. for manufacturing, groups of 20 work, eat, and live together)
Hong Kong	Avoided lockdown with exception of schools because they consider schools as "high risk" areas
Czech Republic	Sequenced re-opening based on transmission risk of activity (e.g. open small shops and open-air sports facilities first), with strict distancing rules and monitoring through testing and tracing
Denmark	WIP
New Zealand	Full containment and reboot approach enabled by tight border controls and early action (low case count); Additional protections outlined for the vulnerable (e.g. over age 70 advised to stay home)
Austria	Gradual reopening of small shops first, then schools, with strict containment strategy restrictions and widespread testing and tracing
Germany	Staged opening balancing economic enablers (education) and transmission risk, enabled by two pronged tracing approach: tech-enabled app and manual contact reconstruction
Singapore	Despite avoiding shutdown with testing and contact tracing, Singapore closed nonessential businesses and schools on 4/3
Israel	4-phased reopening while protecting at-risk populations. Initial opening 1 includes finance and tech given ability to enforce strict protective compliance employ 10% of population
Sweden	'Low-scale lockdown' approach avoided total economic shutdown but increasing case counts suggest potential shutdown in near term

Proposed re-entry plans dependent on disease evolution in each country

Notes: '(Began…)' refers to the start date of a country's lockdown, lockdown definition varies among countries but generally refers to date most non-essential businesses were ordered to shut down
Source: Lit search; BCG Analysis

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Sequencing of re-opening activities

Risk level

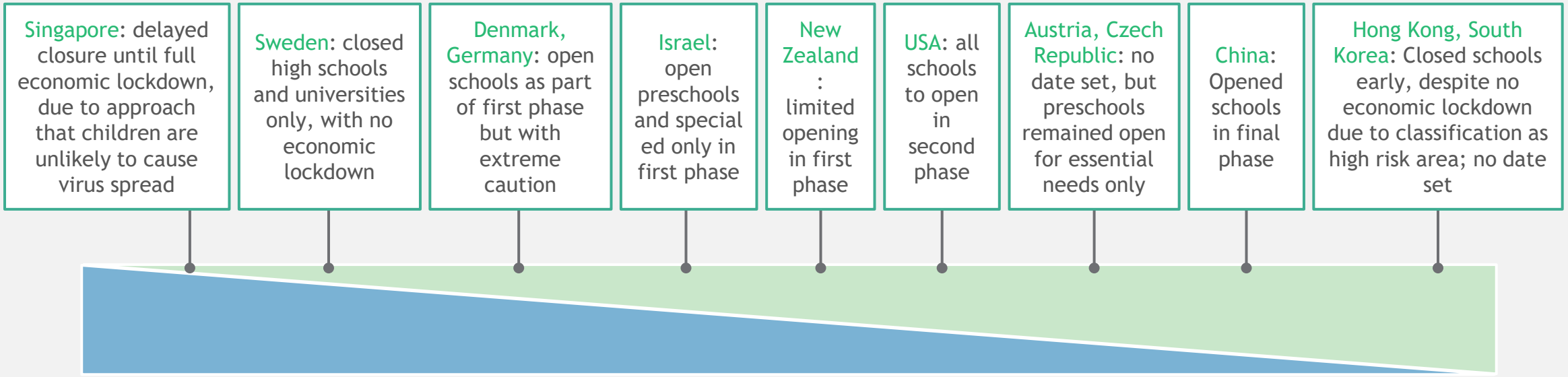
	Stage 1	Stage 2	Stage 3	Stage 4
China	• PPE production (Medical clothing, N95 masks, Medical goggles) • Epidemic control services (Ambulances, Related medicines)	• Epidemic control activities • Medicine • Energy supply • Transportation • Logistics • Food	• Manufacturing • Construction and real estate • Trade • Commercial services • Retail	• Restaurants • Hotels • Education • Nursing homes • Farmers markets
Germany[1]	• Education • Manufacturing	• Sector services • Office operations	• Cultural/leisure • Bars, clubs • Sports associations	• Large groups • Celebrations • Sporting events
New Zealand	• Schools (some students only)	• *Allowed activities based on risk level*	• *Allowed activities based on risk level*	• *Allowed activities based on risk level*
Czech Republic	• Non-essential shops • Open-air sports facilities	• Shops and services • Ease travel restrictions		
Israel[2]	• Tech & finance • Import/export (some) • Public transportation • Education (spec. ed, preschool)	• Commerce • Retail stores • Education (elementary)	• Cafes, restaurants, hotels • Education (non-university)	• Leisure & entertainment • Culture, sports • Large shopping malls • Flights
Austria	• Small shops & craft services • Hardware & garden stores	• All retail shops & hairdressers • Secondary schools and professional degrees	• Staggered opening of hotels, bars/restaurants	

1. Germany maintain conditions for 7 days before moving on to next stage; 2. Israel must maintain conditions for 2 weeks before moving on to next stage
Notes: Unless otherwise indicated, duration of stage is not specified as of date of research

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Timing of school opening relative to economic opening varies by country



Early stage reopening

Re-opening: Schools open earlier than rest of economy

Late stage reopening

Re-opening: Schools open later than rest of economy

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Five common themes from global re-entry announcements



Conditional planning

- Plans conditional on social compliance and virus trajectory
- Reverting to stricter restrictions possible if virus re-emerges



Less specificity to give flexibility

- Many timing announcements made with significant details still unknown (e.g. union/employer arrangements)



Phasing of re-entry

- Restrictions are being lifted in 1-2 week intervals
- Some common priorities for early focus (e.g. opening primary schools)



Restricted business openings

- Stricter guidelines around non-medical protective gear, sanitization and social distancing
- Uncertainty about how demand will recover



Continued social distancing

- Continued focus on maintaining social distancing and personal hygiene
- Large events such as sports, concerts and festivals have been deprioritized in all countries

Sources: Reuters; CNN; Sky News; Time; Secondary research

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Key metrics to re-open economic activity

	Disease conditions	Healthcare capacity	Virus Monitoring	Approach to re-opening or locking down
China	• No indigenous cases reported for 14+ days		• Testing • Tracing	• Sign of containment: no new indigenous cases reported for at least 14 days in area[1]
Germany	• New infection rate: 0.25 cases/100K adults	• ICU capacity: 40% free	• Testing (500-600K/day) • Tracing	• Regional healthcare readiness to be assessed based on stated condition measures
New Zealand	• Sustained reduction in cases and very low case numbers			• Must lower already small case number before re-opening, while also aware of need to get economy running
Singapore	• <10 new cases/day; lockdown due to 2 weeks of 50+ cases/day		• Testing • Tracing	• Tracking rise in new cases, local unlinked cases, and existence of clusters
Czech Republic	• Sustained reduction in cases		• Testing (33 teams) • Tracing	• Single-digit percentage daily rise in new cases implies ability to manage pandemic: "We are not facing massive increases in the numbers of patients - identified or hospitalised." (Health Minister Vojtech)
Israel	• < 10 new cases/day; lockdown if 40+ cases/day		• Testing (10K/day) • Tracing	• The main precondition is a drop in the infection rate to 10 new cases/day
Austria	• Sustained reduction in cases		• Testing • Tracing	• Number of cases stable and increasing containment measures, including tracking. The goal is "to get out of the crisis faster than others" (PM Kurz)
Sweden				• Restrictions are "low-scale" approach that "is much more sustainable" (Chief epidemiologist Tegnell)
Hong Kong			• Testing • Tracing	• Only shut down schools; to reopen, must have zero local indigenous cases for four weeks

1. Ministry of Foreign Affiars of the People's Republic of China: *NHC: China Scores Key Gains in Epidemic Control*, 13 March 2020
Note: Sources referenced and consistent with following deep dives unless otherwise indicated

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Many countries are leveraging technology to expand contact tracing

Non-comprehensive

Already deployed

- Singapore
- Israel
- South Korea
- Russia
- Poland
- China
- Austria

Under development

- UK
- France
- Germany

Various corporate and academic efforts are also under development, including an MIT solution and a joint initiative by Google and Apple

Similar solutions deployed across countries

Opt-in Bluetooth or GPS technology is used to track interactions and alert potentially-infected individuals

Interaction **data can be stored locally** on cellphones to provide privacy (e.g. no central database)

Countries also use contact tracing apps for communication, health tracking, & clearances

Communication

Baidu & WeChat prominently display medical center locations, gov. guidance, and information for accessing assistance

Health tracking

Corona Data Donation app allows people to voluntarily share fitness tracker data to help track overall community spread

Clearance

Personal QR codes used for immigration clearance for those traveling from Taiwan to China, Hong Kong, and Macau

Copyright © 2020 by Boston Consulting Group. All rights reserved.

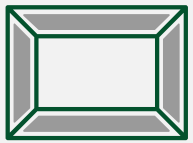
Obtained via MI FOIA by Judicial Watch, Inc.

Germany | Summary of actions taken



Summary:

- Germany has enacted multiple levers including widespread, meticulous tracking of those potentially infected, and a large scale lockdown until May 3rd
- So far the country has experienced a relatively low fatality rate relative to other countries



Country-specific context:

- High-capacity health care system with high % of supplies relative to population size and with digitized advancements
- State-by-state decision making and coordination
- Population of ~80 million with largest GDP (nominal) in Europe



Current figures:

- 142,569 confirmed cases
- 4,405 confirmed deaths

Source: John Hopkins, Bloomberg, IMF

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Germany | Actions taken to suppress COVID-19

Unique levers to flag

Prevention	Stringent social distancing measuring	• Nation-wide ban on public gatherings of more than 2 people including religious/faith communities • Hotel and temp accommodation offerings restricted to 'necessary use only', select states restricting use for tourists • Select states and municipalities enacting mandatory curfews and social distancing non-compliance fines (up to €500 for individuals and €10k for non-exempt businesses)
	Plan to launch geo-app tracking	• Planned launch of Bluetooth app with other EU countries to alert users if they are in close proximity to confirmed cases, heavy focus on ensuring privacy protection
Testing & Quarantining	Heavy state-by-state coordination in wide spread testing	• Widespread roll out of testing initiatives not limited to those with symptoms through private labs and special drive-in test stations (as of 4/2, conducting 50,000 test per day) • Meticulous state-by-state tracking and contact tracing for all individuals tested in advance test results considered best practice across Europe despite coordination delays
	Preventative quarantining	• Preventative 14 day self-quarantining for all individuals in contact with confirmed patients • Govt. subsidy to employers for workers missing work due to quarantine to align incentives • Select municipalities deploying "Corona Taxis" in which health care workers visit outpatients with mild symptoms to preventatively determine whether they are likely to need future hospitalization
	Crowdsourcing of digital solutions	• Online collaboration between Govt. and private sector to crowdsource the development and testing of digital solutions
Treatment	Early medical preparation	• Early ordering of 10,000 additional ventilators ahead of COVID spread in country • Orders to increase in medical ICU beds despite high starting benchmark • Govt. allocation order on to pharma companies and wholesalers not to supply drugs beyond usual demand to counteract stockpiling by individual market participants

2-Day hackathon generated 1,900 ideas to tackle COVID crisis (~42k registrations, 28k participants)

~30 critical care beds per 100,000 people (compared to ~12.5 per 100,000 people in the Italy and ~18 per 100,000 in NYC)

Source: Interal Compendium of Digital Govt. Responses to COVID-19 updated 4/2/2020, NPR, FT

Obtained via MI FOIA by Judicial Watch, Inc.

Germany | Actions to maintain economic stability

Unique levers to flag

Support to Core Services & Supply Chain	• €600B economic stabilization fund (€400B guarantees for liabilities, €100B direct state investment, and €100bn state-owned bank KfW re-financing) • Additional €150B social spending stimulus, includes €50B emergency financial assistance plan for micro-enterprises (under 10 employees) and self-employees persons • Allowing the entry of 40,000 migrant workers (with strict testing and quarantine requirements) from Eastern Europe to supply Bavaria with the agricultural workforce it needs
Ensure Business Liquidity	• KfW backed loans up to 80% for large enterprise, up to 90% for SMEs with ~2% subsidized interest rate (up to of €1B to SMEs emergency subject to limitations) • Potential plan for additional means to ensure 'unlimited liquidity' available through KfW, the State Bank (details TBD) • Waiver of late payment fines with no penalty interest until 12/31/2020 • Reduction of tax prepayments (mainly income/corp/trade tax, solidarity surcharge) for freelancer and businesses • Obligation to file for insolvency suspended until 9/30/2020 for affected businesses
Stabilize Employment & Personal Finances	• Quarantined individuals entitled to compensation from the state if WFH not allowed • Workers entitled wage if work is missed due to illness • Enhanced rules on reduced hours compensation benefit to suit current needs • Full reimbursement of social security contributions by Govt. for flex workforce (previously 80% of contributions to be paid by employer in addition to employee share) • Temporary reduction of flex workforce employees' working hours and gross remuneration pro rata to avoid lay-offs • Tenancies cannot be terminated due to withheld rental payments from 4/1/2020 – 6/30/2020
Stimulate future demand or workforce	• Spending of CSR funds for COVID-19 declared eligible CSR activity

Source: Internal COVID response checklist, Internal COVID -19 Country Dashboard updated 3/27/2020, TIME

Obtained via MI FOIA by Judicial Watch, Inc.

Phased plan and "new normality": Step-by-step reduction of the current measures in 5-7 weeks

Stage preconditions

Measured at locality

- **New infection rate** 0.25 per 100k
- **ICU capacity** 40% free

	Stage 1	Stage 2	Stage 3	Stage 4
	7 day re-stabilization Infection rate ICU bed capacity	**7 day re-stabilization** Infection rate ICU bed capacity	**7 day re-stabilization** Infection rate ICU bed capacity	**7 day re-stabilization** Infection rate ICU bed capacity
Stage description	*Economy enablers*	*Low transmission risk*	*Medium transmission risk*	*High transmission risk*
Resuming activities	• Education • Manufacturing	• Sector services • Office operations	• Cultural / leisure • Bars, clubs • Sports associations	• Large groups • Celebrations • Sporting events
Restrictions	**Education** • Mix of in person days and learn form home days • Required buffer distance **Manufacturing** • Work shift groups created • Machines sanitized **Public** • Severe distancing continues	**Restaurants** • Guests 2m apart **Sales** • 1 customer per 10 m^2 **Public** • High risk (e.g.over 50) exempted from returning to work	**Public** • "New Normal" begins • Mixing between groups permitted • Quick detection and control paramount	**Public** • Special conditions apply • Participant event registration required • Random testing, especially in high risk communities

Fight

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Testing and tracing: Three components necessary to control infection from reaching a critical size

Testing

Contact Tracing



Test strategy

Parallel testing approach to create a "closed-mesh" network to detect chains of infections early



Manual reconstruction

Notify all contacts of infected person to test and quarantine; requires 12-15K FTEs to implement from call center



Tracing app

Catches additional contacts not identified by infected person; contact will receive notification through opt-in voluntary app

Each chain of infection yields only ~0.5 undetected chains, enabling containment of virus[1]

1. With these three measures, only 4 - 12% of infected individuals will "slip" through the net; any chain of infection found generates average of 0.34-0.77 new, undetected chains of infection; most important point is that the number must be below 1 on average in order to contain spread of virus

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Test strategy: "Close-meshed" network detects chains of infection before becoming uncontrollable

To use available tests optimally, three approaches are pursued in parallel:

Group to be tested	Methodology	Location of Testing	Average tests/day
Symptom carriers and contacts	• All symptom carriers and individuals in contact with infected persons are tested	• Drive-through stations • Mobile teams	100-130K
Occupational groups (healthcare workers)	• All healthcare workers tested every other day to balance available test capacity with possible number of infections • Two test samples evaluated with one test kit (pooling[1])	• Point-of-care diagnostics • Mobile teams	200K
Randomized samples	• In each geographic "test cell", 5K randomly selected individuals tested every second day • Ten test samples evaluated with one test kit (pooling[1]) • Target sampling based on RKI[2] "data donation"	• *More detail on following slide*	220K
			500-600K

Unique approach; detailed on following slide

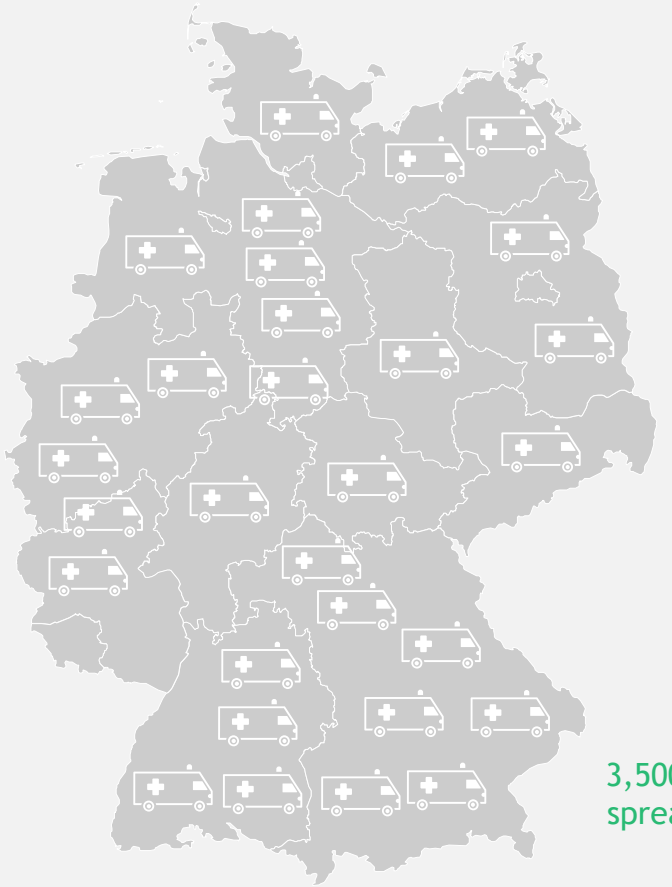
99% of infection chains will be found and controlled through this "close-meshed" approach[3]

1. "Pooling" refers to practice of gathering small sets of data with assumed similar characteristic and using the combined larger set to obtain a more precise estimate; 2. Robert-Koch Institute; 3. 1% of the infection chains will "slip through", i.e. will be uncontrollable because only be found after more than 30 days, and by then will have already increased to above a potential group size of more than 30 individuals.

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Randomized testing will carried out via a nationwide network



Illustrative
3,500 locations will be spread out throughout Germany

Dimensions of random testing operations

- PCR tests[1] to be replaced by cheaper, faster antigen tests as soon as available
- 3,500 test stations total, located at average max distance of 7km from citizens
- Online/telephone registration to prevent crowds
- 30,000 trained employees to test; staffed by Germany Armed forces, German Red Cross, and other voluntary or full-time staff
- Tests collected 2-3 times/day and evaluated by human or vet labs
- Test results entered in centrally available database within 12 hours of testing

1. Polymerise chain reaction tests: the current dominant way to test for COVID-19

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Voluntary contact tracing app last line of defense to identify those who may have been exposed

App can notify some not identified in manual reconstruction



Leverages testing, contact tracing data

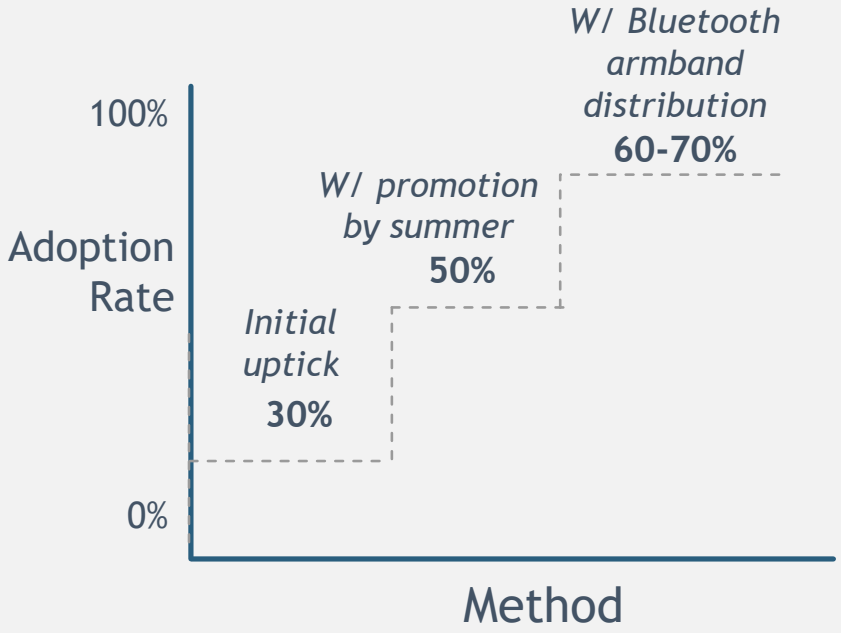


Bluetooth signal to determine contact risk



App sends message to request self-quarantine and immediate testing

Increased adoption of app increases detection rate of infection chains



Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Federal system with local decision-making powers supported by specifically developed control software

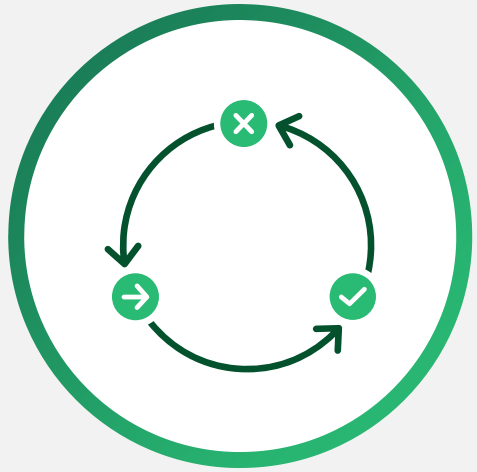
Approach enables central intelligence and coordination at federal level:



Central test database



Overview of available medical resources



Continuous situation analysis

Copyright © 2020 by Boston Consulting Group. All rights reserved.

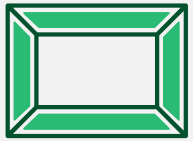
Obtained via MI FOIA by Judicial Watch, Inc.

South Korea | Summary of actions taken



Summary:

- South Korea has avoided a full lockdown through strict social guidelines and health care actions around testing, tracing, and quarantining to combat COVID-19.
- The country successfully held legislative elections in mid-April



Country-specific context:

- Strong low-cost universal healthcare system
- One of the most densely populated countries (population of 52 million)



Current figures:

- 10,653 confirmed cases
- 232 confirmed deaths

Source: John Hopkns, IMF

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Lessons learned from South Korea's 2015 MERS epidemic

	MERS-era challenge	Innovative response
Stimulating industry	Decline in economic growth	The Korea Trade Investment Promotion Agency held an online import/export expo, attracting more than 100 foreign and 200 domestic companies
Providing open communication	Lack of information leading to nationwide panic	South Korea released a detailed public COVID dashboard to inform citizens of the number of identified cases, tests conducted, and other relevant data
Fast-tracking testing	Widespread lack of testing	The country introduced a regulatory system for fast-tracking test approvals. After first confirmed COVID-19 case, the government worked with industry to quickly ramp up testing.
Prioritizing tracking	Inability to track movements and interactions	The country introduced a comprehensive app-based solution for tracking the movement of citizens

Copyright © 2020 by Boston Consulting Group. All rights reserved.

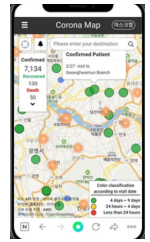
Obtained via MI FOIA by Judicial Watch, Inc.

So. Korea | Actions taken to suppress COVID-19

Unique levers to flag

Prevention	Social trust and awareness	• Govt. public messaging campaign on prevention tips and daily case reports through TV, subway announcements, and targeted smartphone/text message alerts
	Tech-based tracking and alerts	• Govt. use of credit card transactions, smartphone location data and CCTV video to track confirmed cases; legislation passed after 2015 MERS outbreak allowing Govt. authority to collect personal data • Alerts to smartphone users of confirmed-case if in a 100-meter (328-foot) radius of location or patient
Testing & Quarantining	Widespread testing	• Early wide-spread and expanded community-based testing in high prone areas, such as Daegu, and for those with mild/suspected cases (~500,000 individuals tested as of 4/9) • Regulatory system in place to fast track approvals for newly developed testing kits
	Widespread, prioritized quarantining	• Confirmed high-risk individuals prioritized for hospitalization • Confirmed cases with moderate symptoms required to quarantine in repurposed Govt. shelters for observation and treatment, and must test negative twice before being released • Preventative self-quarantining for those who may have been exposed or suspected cases
	Strict monitoring and enforcement	• Govt. developed app for self-quarantined persons to stay in contact with health offices and report on individual progress • Local monitoring team calls to individuals twice daily to make sure the quarantined stay put and to ask about symptoms • Potential for quarantine violators face up to 3M won ($2500) fines (potential to increase fine up to 10M won ($8200) and as much as a year in jail)
Treatment	Ensuring medical capacity	• Rationing of masks to prevent hoarding and export ban on face masks to ensure supply chain • Pharma companies called on by Govt. one week after first confirmed case to ramp production of testing equipment and reagent chemicals needed (100k kits produced daily as of 3/23) • Opened 600 testing centers, including drive through locations, aimed at reducing burden at hospitals and clinics people as fast
	Ed-tech support	• Ed-tech platform launches to help public and medical professional prevent, diagnose, treat virus

App to track confirmed cases on map



Source: Internal COVID response checklist, Internal Compendium of Digital Govt Responses to COVID updated 4/2/2020, Science Mag, NYT

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

So. Korea | Actions to maintain economic stability

Unique levers to flag

Support to Core Services & Supply Chain	• $125T KRW total rescue package equating to 6% of GDP announced including $29T KRW in loans to SMEs, $20T KRW to buy corporate bonds, commercial paper of companies facing credit crunch, $11T KRW to stabilize stock markets • Bank of Korea (BOK) cut interest rates by 50 basis points to 0.75% • BoK committed unrestricted actions to support markets through open market operations
Ensure Business Liquidity	• BOK increased ceiling of SME lending facility by $5T KRW and lowered the interest rate to 0.25% (from 0.5%-0.75%) • Low cost loans facilitated for exporters affected by supply chain disruptions and airlines • Business owners compensated up to $ 5k per employee per year (depending on number of flexible work hours / week) • Tax cuts for landlords reducing rent for commercial tenants and tax deferrals for SMEs and self-employed healthcare, tourism, and hospitality workers • Contribution cuts and 3-month payment deferrals for social security, unemployment, and accident compensation insurance
Stabilize Employment & Personal Finances	• Emergency relief payments for households in the bottom 70% income bracket totaling $1M KRW via Govt-issued certificates • Electricity bill payment deferrals totaling $1.3M KFW • Increased income deduction for individual tax payers for 3/1 to 6/30 period • Govt. wage subsidies to travel-related businesses (e.g., airline, hotels) to sustain payroll over the next six months (up to 90% workforce cost) • Govt. employment retention subsidy per worker increase to 70,000 won ($56.42) from 66,000 won • Plan to expand program that sends a care taker to households during school closures on weekdays for facilities unable to provide adequate child care & day care services,
Stimulate future demand or workforce	• Job training for those who have lost jobs

Source: Internal Economic Activity and Action Dashboard updated 4/2/2020, Internal COVID -19 Country Dashboard updated 3/27/2020

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

South Korea successfully held an April election in the midst of the pandemic

On April 15th, South Korea held safe legislative elections and achieved its highest turnout (66%) since 1992

Tactics used



Hygiene

- Regular disinfecting of polling stations
- Voters will be provided with hand sanitizer and plastic gloves when they enter the voting booths



Social distancing

- One meter distance between people in line
- Temperature checks given at the doors and anyone showing readings higher than 99.5 °F was directed to a special booth separate from others



Expanded access

- Early voting stations set up at Covid-19 patient centers
- Quarantined individuals allowed to leave their homes to vote between 6-7pm provided they called government officials once they returned home
- Expanded vote by mail access for all

Copyright © 2020 by Boston Consulting Group. All rights reserved.

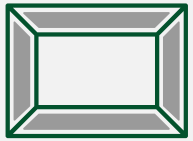
Obtained via MI FOIA by Judicial Watch, Inc.

Singapore | Summary of actions taken



Summary:

- Singapore has been managing the health crisis through various testing and containment measures
- Although it attempted to control the outbreak with other measures, it has moved to lockdown until May 4



Country-specific context:

- Strong healthcare system
- Small population of ~5.6 million in a concentrated area
- 3rd highest per-capita GDP in the world



Current figures:

- 5,992 confirmed case
- 11 confirmed deaths

Source: Internal Singapore COVID-19 response updated 3/27/2020, John Hopkins, IMF

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Singapore | Actions taken to suppress COVID-19

Unique levers to flag

Prevention	Coordinated Govt. response and communications	• Dedicated, inclusive multi-ministry taskforce and centralized disease outbreak response system set up • Official comms channels, including official WhatsApp account and Govt. AI powered chatbots, as single-source of truth to ensure consistency, address misinformation, provide clear directives (e.g., directions for use and limits on at-home masks) • Coordinated efforts with international partners prior to announcing border closures to reduce confusion & preserve relations
	Wide-spread population tracking	• Voluntary Bluetooth-based app to track phones which have been within 2 meters of each other over last 21 days • QR codes deployed in offices and public venues to track all visitors to a location in case of a local outbreak
Testing & Quarantining	Incentives to ensure reporting and compliance	• Free testing and treatment, with compensation for lost earnings, to encourage reporting and containment • Compensation to employers and self-employed for absences and compliance with Stay Home notices • Co-funding for professional cleaning of premises following confirmed case • 3-month pay cuts for govt. officials and management/Board of largest local firms to show solidarity
	Individualized notifications	• 14-day Stay Home Notice when returning from overseas and text messages from immigration authority with GPS reporting link • Occasional random house visits or calls from officers
	Re-purposing locs for quarantine	• Multiple worker housing dormitories repurposed as Govt. isolation areas • Singaporean residents returning from U.S. or U.K. required to quarantine for 14 days at designated hotels
	Severe and enforced punishments	• Fines of up to $10,000 or 6 months in prison for non-compliance for individuals • Onus on employers to ensure compliance (e.g., potential to be barred from hiring foreign talent if foreign employees found non-compliant) & potential for visa to be revoked for foreign employees caught breaching rules (89 visas revoked as of 3/21)
Treatment	Leveraging assistance from scientific and corp community	• Range of local institutions and firms found to fast-track development of testing kits collaborating across public and private institutions • US biotech firm, Gilead Sciences, expanded clinical trials to Singapore • Temasek, Govt-linked company, to provide hand sanitizer to all households • Keppel, major local conglomerate, to provide assistance on utility bills and faster payments to SMEs

As of 3/21, for 40% of confirmed cases, first indication of contraction came from contact by the Ministry of Health

Cultured virus within 1 week & first globally to develop antibody test

Source: Internal Singapore COVID-19 response updated 3/27/2020, Internal Compendium of Digital Govt. Responses to COVID-19 updated 4/2/2020,

Obtained via MI FOIA by Judicial Watch, Inc.

Singapore | Actions to maintain economic stability

Unique levers to flag

Support to Core Services & Supply Chain	• S$6.4B stimulus package announced mid-Feb, increased by $48B end of March (equivalent to 2019 Govt expenditure) including specific support packages for aviation, tourism, arts and land transport sectors • Various govt. departments mandated to ensure value trickles down to intended targets (e.g. reliefs for mall owners reaching retailers and food and beverage outlets through rental rebate) • Special bonuses for front line staff (e.g., medical workers and police) • Advance notice of upcoming travel restriction to allow time to mitigate effect on supply-chain and workforce
Ensure Business Liquidity	• State to pay firms 25% wage subsidy for all local employees (food services to receive 50%, aviation & tourism to receive 75%) • Automatic deferment of income tax payments for companies and self-employed • Year deferral of property tax to support hard-hit venues (e.g., conference centers, hotels, retailers, eateries, tourist attractions) • Rebates, loss acceleration and working capital loans for SMEs
Stabilize Employment & Personal Finances	• Cash pay-out to all Singaporeans (up to S$900), eligible self-employed persons (S$1,000 for 9 months), cash grants and temp relief fund for lower income households out of employment, & additional grocery vouchers • Govt-backed training to upskill workers for tourism, aviation, land transport, arts, retail, food services and logistics • No increase in govt. fees and charges and suspension of loan repayment and interest for Govt. student loans for 1 year
Stimulate future demand or workforce	• Govt. to identify 10,000 new jobs this year and support 8000 traineeships • State to co-fund wage costs for traineeships offered to first time job seekers • Enhanced support for SMEs to adopt digital business practice with up to 90% grants for investment in qualifying digital business programs • Program launched to improve stockpile of essential supplies for future and become 30% food self-sufficient it by 2030

Source: Internal Singapore COVID-19 response published 3/27/2020, Internal Economic Policy and Action Dashboard as of 3/30/2020

Obtained via MI FOIA by Judicial Watch, Inc.

Singapore | Trace Together app leverages Bluetooth proximity on devices to record point of contact



- Automates contact tracing and notification, dramatically increasing capacity of a previously manual process
- Uses Bluetooth 'handshakes' to track who you have been close to over past two weeks
- Opt-in, with many privacy guardrails in place
- This software is open-source

Copyright © 2020 by Boston Consulting Group. All rights reserved.

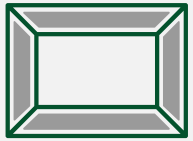
Obtained via MI FOIA by Judicial Watch, Inc.

India | Summary of actions taken



Summary:

- India initiated full lock down through 4/14 and is likely to extend the lockdown another 2 weeks through the end of April. The country is emphasizing social responsibility and scaled information campaigns to manage the health crisis



Country-specific context:

- Health care resources concentrated in urban areas, lacking protective gear, poor sanitary conditions
- Large population of ~1.3 billion with many high density areas
- $180B annual imports and exports linked to high exposure countries (e.g., US, UK, Iran, Italy, Spain, Germany, Switzerland, France)



Current figures:

- 14,792 confirmed cases
- 488 confirmed deaths
- New GDP growth estimated between 2.1-3.5% (down from previously estimated 5.2-6%)

Source: John Hopkins; Internal COVID-19 India Perspective updated 3/30/2020, World Bank

Obtained via MI FOIA by Judicial Watch, Inc.

India | Actions taken to suppress COVID-19

Unique levers to flag

Prevention	Centralized Govt. communications	• Daily updates and Health Ministry briefings on number of cases, status of preparedness, and Govt. taken/planned actions • Govt. mass media message via Google, Facebook, and all 4 major telecommunication companies • Widespread media campaigns such as "Break-the-chain" initiate, via repurposed public advertising displays (e.g., billboards, public transportation vehicles, mall/airport branding)
	Leveraging social responsibility and accountability	• Reinforcing social distancing as desired behavior and a self-imposed social responsibility, communicating simple call to action with "1-Day effort" and Sunday as a choice day to help with feasibility • Moral boosting measures such as 5-minute nationwide clapping for 'Corona warriors' • Physical marking of high risk citizen with quarantining recommendations and end-date at airports and hospitals
Testing & Quarantining	Attempts to increase testing	• First and second tests made free for all • Broadening testing beyond symptomatic travels to include hospitalized patients with severe acute respiratory illness, and direct and high-risk contacts of confirmed patients • Startups specializing in screening and testing devices, currently under validation by National Institute of Virology for tests
	Mandatory quarantining partnering with hotels	• Mandatory quarantining and universal health screening of incoming travelers • Strategic partnership and negotiated pricing with hotels to expand quarantine capacity for passengers coming from high-risk countries, specific focus on hotels close to airports
Treatment	Crowdsourcing new ideas and encouraging DIY innovation	• Online challenge designed to crowdsource ideas from various local startups and entrepreneurs in order to tackle crisis • Communication to medical professionals to use self-made masks and sanitizers to tackle increasing number of patients

Source: Internal Information Dissemination by Government of India on COVID-19 (March 2020), Internal India – Innovative Ideas updated 3/24/2020

Obtained via MI FOIA by Judicial Watch, Inc.

India | Actions to maintain economic stability

Support to Core Services & Supply Chain	• Fiscal stimulus packaged announced 1.7T rps. (~$23B USD) on 3/26 predominantly targeting rural, low-income, healthcare workers (details not yet determined) • Reduced repo rate by 75 basis points to 4.4%. Reverse repo rate was cut by 90 bps to 4%.
Ensure Business Liquidity	• Plans for Govt. support to business liquidity announced but details not yet determined
Stabilize Employment & Personal Finances	• Withdrawal of 75% of credit in the Employees' Provident Fund account or 3 months of wages (whichever lower) • Stimulus package to include food stability measures, free cooking gas to the poor for three months, state-sponsored contributions to retirement funds • $5M rps. (~$66K USD) for medical insurance for front line workers (doctors, nurses, paramedics etc.) • Minimum balance criteria for bank accounts waived off for 3 months
Stimulate future demand or workforce	• Cash prizes for startups and entrepreneurs to find innovative solutions to for COVID response, dual objective to support startup industry • Spending of CSR funds for COVID-19 declared eligible CSR activity

Source: Internal India – Innovative Ideas updated 3/24/2020, Bloomberg Quint, WHO, India Today, The Economic Times

Obtained via MI FOIA by Judicial Watch, Inc.

India is applying a three-level system for reopening

Zone	Definition	No. of districts	Guidelines	Zone exit criteria
Red zone (Hotspots)	Districts contributing to >80% of cases in each state OR Doubling rate of < 4 days	170	• No activity, except for essential services. Special teams to monitor and survey cases. Test ILI and SARI patients also for Covid	• No new case is reported in the next 14 days—Upgrade into a White zone
White zone (Non-hotspots)	Districts with only a few cases. No increase in number	207	• Minimum activity, with limited public transport, agriculture harvesting • Identify and test ILI and SARI patients also for Covid	• No new case is reported for next 14 days and also the known last case tests negative—Upgrade into a Green zone
Green zone	Districts with no confirmed cases in the last 28 days	353	• Enforce social distancing rules in public places and public transport • Identify and test ILI and SARI patients also for Covid	• N/A

Copyright © 2020 by Boston Consulting Group. All rights reserved.

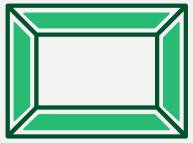
Obtained via MI FOIA by Judicial Watch, Inc.

China | Summary of actions taken



Summary:

- China has re-opened Wuhan city on 4/8 after 10-week full lock down of Hubei province 1/23. Movement of individuals remains restricted with strict tracking and quarantining of incoming travelers from abroad.



Country-specific context:

- Large population (~1.3 billion) concentrated around cities with 90% of the population in the eastern 50% of the country
- Evolving mix of private and public healthcare system determined by age, employer, and rural vs. urban setting



Current figures:

- 83,787 confirmed cases
- 4,636 confirmed deaths
- New GDP growth estimated between 1.5-4.5% (down from previously estimated target ~6%)

Source: John Hopkins, Deutsche Bank and UBS GDP growth estimates

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

China | Actions to maintain economic stability

Unique levers to flag

Support to Core Services & Supply Chaing	• $2T RMB total rescue package primarily focused on propelling money into banks and local government vehicles with intention to trickle down to small businesses and residents • Central bank targeted reserve requirement ratio cut by .5 to 1 percentage points • $50B RMB reverse repurchase operation and seven-day reverse repurchase rate from 2.4% to 2.2% • Multiple measures to core medical workers including temporary work subsidies, bonuses, personal tax deferrals • Update to tax exemption policy for business importing or transporting materials used to prevent/control COVID-19; and eligible equipment to be deductible (vs. depreciated over lifetime) for manufacturers produce key COVID-19 supplies
Ensure Business Liquidity	• COVID-impacted businesses allowed more flexibility to adjust remuneration, rotate shifts and shorten working hours • Average of 5% electricity rate cut for most businesses from two of China's power distributors from 2/1 to 6/30 • VAT cut from 3% to 1% (0% in Hubei) from 3/1 – 5/31 and tax exemptions on medical and prevention supplies provided to employees • Employer contribution relief measures such as deferred social insurance premiums for eligible businesses for six months, 50% reduction in medical insurance for all businesses for 5 months • 3 years extension of carry over loss period to 8 years for hardest hit industries (e.g., transportation, catering, tourism) • Support to SME including additional $1T RMB central bank credit line and penalty-free deferral of debt repayment to 6/30 • Tax reduction of 9-13% for ~1,500 export products
Stabilize Employment & Personal Finances	• Extension of the Chinese New Year holiday until 2/2, with substitutional days off or 200% payment for employees who were ordered to work during extended holiday • Maximum refund raised to 100% of unemployment insurance paid in 2019 for all enterprises in Hubei (only SMEs eligible in other provinces) to ensure businesses continue to pay workers where possible and reduce layoffs
Stimulate future demand or workforce	• Subsidies for small businesses that sign long-term employment contracts with college graduates

Source: WSJ, Internal economic policy and actions dashboard updated 4/9/2020

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

China | Actions taken to suppress COVID-19

Unique levers to flag

Prevention	Tech-tools leveraged for compliance	• Facial recognition to scan for people with temperatures in crowds, and identify those not wearing required face masks • Smart mobile robot for facial recognition/temperature screening, as well as verbal reminders to wear a face mask • Govt. sanctioned QR code app to monitor movement of individuals and certify those able to go back to work; individual must monitor and record their temperature and update their profile daily in order to maintain their health status level
	Re-opening travel restrictions	• Strict internal travel regulation around Hubei province (e.g. only those marked as green "health condition" allowed to move in and out of Hubei province, strict control of individuals leaving/entering residential communities remain)
	Drone deployment	• Partnership with industry to deploy drones to transport supplies to urban medical centers • Currently testing deployment of drones to assist with decontamination via wide-scale spraying
Testing & Quarantining	Testing & Quarantining	• Free-testing for individuals with severe symptoms, with Govt. assistance for COVID-related charges • Govt. using location tracking to identify those in contact with confirmed cases and to monitor and enforce quarantine • Centralized tracking locations with field teams, as part of a larger surveillance system set up post 2003 SARs outbreak
	Strict Govt. enforcement	• Strict stay at home mandates in Hubei province residents effectively used as quarantine measures • Widespread local enforcement and security patrols to ensure compliance with Govt. containment measures
	Restrictions on incoming travel	• After lifting restrictions, mandated testing (using either nucleic acid and antibody test) for all incoming travelers • After lifting restrictions, 28-day quarantine requirements for all incoming travelers to mainland China
Treatment	Increasing treatment capacity and supply	• Temporary hospitals built (e.g., two new hospitals built in under ten days in Wuhan) and additional locations such as stadiums or training centers repurposed to increase the capacity of treatment beds • Tax and national and local education surcharges waived for cash and COVID-response articles donated through Govt. or public welfare social organizations
	Leveraging workforce	• Reassignment of workers in transportation, agriculture, and clerical jobs to meet new workforce needs • 5G technology used to connect Wuhan hospitals with counterparts in Beijing to provide real time consultations

Source: Compendium of Digital Govt Responses to COVID updated 4/2/2020, World Economic Forum, HBR

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Draft as of 4/18 - Work in Process

China | Economy restart in 5 stages by essentialness and transmission risk

Data as of Apr. 8, 2020



5 key stages in restarting economy[1]

1	2	3	4	5
1/29- **Resumed production of key supplies for epidemic control**	2/09- **Resumed work in multiple batches, with strict epidemic control rules and sufficient test supply**	2/21- **National Guidance on prevention measures to ensure safe return to work, eg. social distancing**	3/03- **Enabled regional decision making to improve accuracy of services and optimize efficiency**	4/06- **Restored lifestyle services, activities and locations by region and category, general technical instruction + detailed local decisions**

Industries restarted

1	2	3	4	5
Epidemic control • medical clothing • N95 masks • medical goggles • ambulances • related medicines	Essential businesses: • epidemic control • medicine • energy supply • transportation • logistics • food	Low to medium transmission risk businesses: • manufacturing • construction and real estate • trade • commercial services • retail		High transmission risk businesses • restaurants • hotels • education • nursing homes • farmers markets

Re-start rate of scaled enterprises[2]

40% 67% 87% 99%

1. Milestones set by key national government policies; 2. In China, definition of scaled enterprise varies according by industry sector, generally refers to enterprises with 20mn+ RMB revenue; Sources: Official disclosures & credible media reports

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.

Disclaimer

The services and materials provided by Boston Consulting Group (BCG) are subject to BCG's Standard Terms (a copy of which is available upon request) or such other agreement as may have been previously executed by BCG. BCG does not provide legal, accounting, or tax advice. The Client is responsible for obtaining independent advice concerning these matters. This advice may affect the guidance given by BCG. Further, BCG has made no undertaking to update these materials after the date hereof, notwithstanding that such information may become outdated or inaccurate.

The materials contained in this presentation are designed for the sole use by the board of directors or senior management of the Client and solely for the limited purposes described in the presentation. The materials shall not be copied or given to any person or entity other than the Client ("Third Party") without the prior written consent of BCG. These materials serve only as the focus for discussion; they are incomplete without the accompanying oral commentary and may not be relied on as a stand-alone document. Further, Third Parties may not, and it is unreasonable for any Third Party to, rely on these materials for any purpose whatsoever. To the fullest extent permitted by law (and except to the extent otherwise agreed in a signed writing by BCG), BCG shall have no liability whatsoever to any Third Party, and any Third Party hereby waives any rights and claims it may have at any time against BCG with regard to the services, this presentation, or other materials, including the accuracy or completeness thereof. Receipt and review of this document shall be deemed agreement with and consideration for the foregoing.

BCG does not provide fairness opinions or valuations of market transactions, and these materials should not be relied on or construed as such. Further, the financial evaluations, projected market and financial information, and conclusions contained in these materials are based upon standard valuation methodologies, are not definitive forecasts, and are not guaranteed by BCG. BCG has used public and/or confidential data and assumptions provided to BCG by the Client. BCG has not independently verified the data and assumptions used in these analyses. Changes in the underlying data or operating assumptions will clearly impact the analyses and conclusions.

Copyright © 2020 by Boston Consulting Group. All rights reserved.

Obtained via MI FOIA by Judicial Watch, Inc.



Obtained via MI FOIA by Judicial Watch, Inc.

From:	Gordon, Robert (DHHS)
To:	"Whitmer, Gretchen"; Pohl, Zack; Laidlaw, Emily; Rising, Jay; Huls, JoAnne; Foster, Tricia (DTMB)
Subject:	FW: CSTE COVID-19 Response | Daily PM Message for Mar. 12 (incl. CDC Interim Considerations for School Closures, COCA Call tomorrow)
Date:	Thursday, March 12, 2020 9:16:23 PM
Attachments:	image001.png ATT00001.htm image002.png ATT00002.htm Considerations for school closure Draft 031220 Updated.pdf ATT00003.htm CDC COCA Call Tomorrow Coronavirus Disease 2019 (COVID-19) Update and Infection Prevention and Control Recommendations.msg ATT00004.htm

---

From: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Sent: Thursday, March 12, 2020 9:11 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: Fwd: CSTE COVID-19 Response | Daily PM Message for Mar. 12 (incl. CDC Interim Considerations for School Closures, COCA Call tomorrow)

Begin forwarded message:

> **From:** "LyonCallo, Sarah (DHHS)" <lyoncallos@michigan.gov>
> **Date:** March 12, 2020 at 9:02:51 PM EDT
> **To:** "Khaldun, Joneigh (DHHS)" <KhaldunJ@michigan.gov>
> **Subject: FW: CSTE COVID-19 Response | Daily PM Message for Mar. 12 (incl. CDC Interim Considerations for School Closures, COCA Call tomorrow)**
>
> CDC JUST RELEASED CONSIDERATIONS FOR SCHOOL CLOSURES
>
> ---
>
> **From:** CSTE Emergency Response <Preparedness@cste.org>
> **Sent:** Thursday, March 12, 2020 7:46 PM
> **To:** CSTE Emergency Response <Preparedness@cste.org>
> **Cc:** CSTE Novel Coronavirus 2019 <CSTEncov2019@cste.org>
> **Subject:** CSTE COVID-19 Response | Daily PM Message for Mar. 12 (incl. CDC Interim Considerations for School Closures, COCA Call tomorrow)

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Khaldun, Joneigh (DHHS); LyonCallo, Sarah (DHHS); Totten, Mark
Subject: FW: Dashboard
Date: Wednesday, May 13, 2020 7:55:23 AM
Attachments: image001.jpg

Let me know if thoughts; happy to connect Dr LC or others. Seems like opportunity to listen and learn so long as clear we are not committing to replacing our own experts' judgment.

From: Thomas R. Frieden <trfrieden@resolvetosavelives.org>
Sent: Wednesday, May 13, 2020 7:43 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: Dashboard

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Robert,

We're thinking about optimal (and/or minimal) information that should be available, clearly and simply, from each state.

This is quite relevant to the Safe Start you just released. We are working toward something that can be simple and useful. Is there someone on your team we could work with on this? Would you be interested in piloting/thinking together through it?

Thanks.

Tom

From: "Gordon, Robert (DHHS)" <GordonR3@michigan.gov>
Date: Sunday, May 10, 2020 at 9:06 AM
To: Tom Frieden <trfrieden@resolvetosavelives.org>
Cc: "Warsh, Jonathan (DHHS)" <WarshJ1@michigan.gov>, "LyonCallo, Sarah (DHHS)" <lyoncallos@michigan.gov>
Subject: RE: Draft Contact Tracing Playbook live

Thanks again for this. Would be great if you can connect with the right people on your team our leads on this work: our chief of staff, Jonathan Warsh, and our state epidemiologist, Dr. Sarah LyonCallo.

Best,
Robert

On Sat, May 9, 2020 at 9:21 PM Thomas R. Frieden <trfrieden@resolvetosavelives.org> wrote:

Obtained via MI FOIA by Judicial Watch, Inc.

Correct link:

https://contacttracingplaybook.resolvetosavelives.org

From: Tom Frieden <trfrieden@resolvetosavelives.org>
Date: Saturday, May 9, 2020 at 3:59 PM
To: Robert Gordon <gordonrobert@gmail.com>
Subject: Draft Contact Tracing Playbook live

Robert,

Hope you're well.

Hope this is helpful. If there is someone within the contact tracing work who wants to interact with our team more directly, please send the contact information.

Rapid progress here – see link below. All feedback welcome!

All the best,

Tom

From: Lindsay Steele <lsteele@resolvetosavelives.org>
Date: Saturday, May 9, 2020 at 1:09 PM

Hi all,
I'm pleased to share that the draft US COVID-19 Contact Tracing Playbook is live:
https://covidplaybook.resolvetosavelives.org/
This draft version incorporates feedback we received from health departments and others over the past week. We will continue to add implementation tools to support health departments in implementing the steps in the checklists. Despite missing many of the tools, there is value in sharing this site now with health departments and others working in this area.

I welcome thoughts on this. Also, the Playbook is a "living" document, so you may share any comments or edits with me at any point.

Best,
Lindsay

Lindsay Steele, MSc
Senior Program Officer, Nutrition Policy, Resolve to Save Lives

Obtained via MI FOIA by Judicial Watch, Inc.

Cell: +1-917-828-2260
lsteele@resolvetosavelives.org

resolve_email01 (002)



–

RESOLVE TO SAVE LIVES
An Initiative of Vital Strategies

STAYCONNECTED
resolvetosavelives.org | Facebook | Twitter

#KnowCOVID: Wash hands, cough into elbow, stay home if sick.
Learn more about how to protect yourself and others at VitalStrategies.org/COVID

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Foster, Tricia; Flood, Jennifer; Totten, Mark
Cc: Hertel, Elizabeth (DHHS); Khaldun, Joneigh (DHHS); Massey, Kate (DHHS)
Subject: FW: Detroit News questions RE "bottleneck" reported at hospitals due to lack of CRCs
Date: Friday, November 13, 2020 9:18:00 AM
Attachments: image001.png
CRC Member Involvement.msg
image007.jpg
image008.jpg
image009.jpg
image010.png
image011.png

I want to flag this press inquiry, which highlights a real problem about which we are aware. It appears the nursing homes may be holding out on applying to be CRCs because they want immunity legislation. See also the attached. We need a strategy to accelerate their applications, one way or another.

Jen, if you are on P-Ops today, perhaps we could discuss.

From: Wheaton, Bob (DHHS) <WheatonB@michigan.gov>
Sent: Friday, November 13, 2020 9:12 AM
To: Massey, Kate (DHHS) <MasseyK4@michigan.gov>; Emerson, Erin (DHHS) <EmersonE@michigan.gov>; Commey, Katherine (DHHS-Contractor) <CommeyK@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Richards, Denise (DHHS) <richardsd@michigan.gov>
Subject: FW: Detroit News questions RE "bottleneck" reported at hospitals due to lack of CRCs

Good morning,

Are you able to assist in answering these questions?

Thanks,

Bob Wheaton, Public Information Officer
Michigan Department of Health & Human Services
Office of External Relations & Communications
517-281-1701

Obtained via MI FOIA by Judicial Watch, Inc.

This message, including any attachments, is intended solely for the use of the named recipient(s) and may contain confidential information. Any unauthorized review, use, disclosure, or distribution of confidential information contained in this email is expressly prohibited. If you are not the intended recipient, please contact the sender by reply email and delete all copies of the original message.

From: LeBlanc, Elizabeth <eleblanc@detroitnews.com>
Sent: Friday, November 13, 2020 9:08 AM
To: Sutfin, Lynn (DHHS) <SutfinL1@michigan.gov>; Wheaton, Bob (DHHS) <WheatonB@michigan.gov>; Harns, David (LARA) <HarnsD1@michigan.gov>
Subject: Detroit News questions

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Hello, all.
I'm not sure who would be the best agency to contact about this, but we're working on a story about a reported bottleneck at hospitals seeking a place to discharge nursing home patients with COVID-19. MHA has said the restrictions on transfers they're experiencing right now are the fault of SB 1094 and the lack of skilled nursing facilities that have applied to be Care & Recovery Centers.

Is DHHS aware of this issue? Are you able to better define the issue preventing transfer?
Are there any designated Care & Recovery Centers yet? If so, where?
Is the DHHS or LARA responsible for inspecting/certifying Care & Recovery Centers?
Is it a problem of not having time to inspect/certify Care &Recovery Centers or facilities unable or unwilling to apply to become a CRC?
Is it possible nursing homes just haven't had time between the passage of the law and the second wave to come into compliance with SB 1094?
Is it possible for the government to set up CRCs if no private facilities are willing to do so?

Thanks for any help you're able to provide!
Beth

Beth LeBlanc
Detroit News Lansing Bureau
eleblanc@detroitnews.com
(o) 517.371.3661 | (c) 810.956.2677

Obtained via MI FOIA by Judicial Watch, Inc.

From: David Herbel
To: Gordon, Robert (DHHS)
Cc: safeandcalm
Subject: CRC Member Involvement
Date: Wednesday, November 11, 2020 2:06:11 PM

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Hi Robert,

In speaking with our members again yesterday and this morning the general themes that are holding people back from becoming a CRC are these:

1. Staffing - The dedicated staffing language in our guidance is making it difficult to retain, compensate and find staff. Yesterday LARA reported 8,000 less CENA's in Michigan
2. Regulatory Risk – The regulatory environment with CMS is extremely high. Becoming a CRC that received nuance citations has a lasting impact on their reputation, creates financial exposure and Directed Plans of Correction consume valuable staff time from already overwhelmed staff for paper compliance.
3. Liability/Reputation – There is no legal protections for these organizations from future litigation. Many of our members are Life Plan Communities that have contractual obligation to provide care for their residents on their campus. Their reputation for providing quality is essential to their future admissions and business model. When accepting external COIVD + admissions they increase exposing other members of their campus and increase liability for themselves.
4. Financial – Because our members staff and have different cost structure than other Class I Skilled Nursing Facilities the financial incentives need to cover their historical variable costs and then have an add on for COVID costs. The current financial model might contain incentives for organizations with low variable costs or historically low census numbers, they do not for the majority of LeadingAge Michigan members.

In closing, our members feel the need to be part of the solution and want to help. However, in order to get them enrolled MDHHS may need to work with them individually to address their concerns and reassure them.

Please let me know how to be of more help.

David E. Herbel, BA, MSA, NHA | President & CEO

LeadingAge Michigan

Obtained via MI FOIA by Judicial Watch, Inc.

201 N. Washington Square | Suite 920 |Lansing, MI 48933

Office: 517-323-3687| Cell: 517-290-4109

david@leadingagemi.org | www.leadingagemi.org

From: Gordon, Robert (DHHS) [mailto:GordonR3@michigan.gov]
Sent: Tuesday, November 10, 2020 2:46 PM
To: David Herbel <David@leadingagemi.org>
Subject: RE: Testing - An abundance of caution

We're working on this. Any word on CRC applications from your members, with the increased reimbursement?
Thanks.

From: David Herbel <David@leadingagemi.org>
Sent: Thursday, November 5, 2020 9:47 AM
To: Massey, Kate (DHHS) <MasseyK4@michigan.gov>; Emerson, Erin (DHHS) <EmersonE@michigan.gov>; Grivetti, Sara (DHHS) <GrivettiS1@michigan.gov>; Horvath, Larry (LARA) <horvathl@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Hawks, Orlene (LARA) <HawksO@michigan.gov>
Subject: Testing - An abundance of caution

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Morning All,

In recent conversations with our members, they are very concerned about the safety and welfare of the residents and staff in all our facilities. To keep residents and staff safe, they have instituted very strict safety and testing protocols and policies for staff, residents, families, and anyone who may potentially enter any of our buildings. As such, we understand that LARA and state employees may be resuming licensing surveys, necessitating that staff enter our facilities.

We believe it is incumbent upon us all to inquire about the testing protocols, including the frequency of testing, of anyone who may be entering our buildings, since those persons will likely be in multiple facilities, some of whom may not have policies as strict as those in place at our facilities. While still respecting individual privacy, we request that LARA, Bureau of Fire Services, MIOSHA and others, provide us with their testing policies, procedures, and protocols for persons who may be conducting

Obtained via MI FOIA by Judicial Watch, Inc.

visits to our member facilities. If it is necessary, the LeadingAge Michigan members, where possible, can assist in the testing process by completing rapid point-of-care testing when a state employee wishes to enter our facility.

It is with an abundance of caution and a desire to keep everyone safe. We will be happy to make ourselves available to discuss this topic as needed.

David E. Herbel, BA, MSA, NHA | President & CEO

LeadingAge Michigan

201 N. Washington Square | Suite 920 |Lansing, MI 48933

Office: 517-323-3687| Cell: 517-290-4109

david@leadingagemi.org | www.leadingagemi.org

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark
Subject: FW: Discussion Documents - 6:00 PM MERC Healthcare Advisory Group
Date: Tuesday, November 10, 2020 6:55:00 AM
Attachments: 20201103 MERC Region 1 Hospital Update.pdf
20201103 MERC Health Update.pdf
20201103_US_and_EU_Update_vSent.pdf
20201103 Causes and Controls vSent.pdf

Go to "Causes and Controls" deck, slide 8. I'll suggest Dr. LC ask MERC if we can include it unchanged, with the milestones they selected.

From: LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>
Sent: Tuesday, November 3, 2020 5:27 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: FW: Discussion Documents - 6:00 PM MERC Healthcare Advisory Group
Importance: High

Not sure if you are on this meeting any more – let me know if you woul dlike to hear the discussion.

From: LyonCallo, Sarah (DHHS)
Sent: Tuesday, November 03, 2020 5:22 PM
To: Orellana, Robert (DHHS-Contractor) <OrellanaR@michigan.gov>
Subject: FW: Discussion Documents - 6:00 PM MERC Healthcare Advisory Group
Importance: High

From: Gerard M Anderson <gerry.anderson@dteenergy.com>
Sent: Tuesday, November 03, 2020 5:03 PM
To: Angelique Joynes <ajoynes@allegancounty.org>; Brian Peters <bpeters@mha.org>; Ed Ness <eness1@mhc.net>; Martin, Emily <etmartin@umich.edu>; John Fox (john.fox@beaumont.org) <john.fox@beaumont.org>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; M. Roy Wilson <mrw@wayne.edu>; Mark Schlissel <markschl@umich.edu>; nderusha <nderusha@lmasdhd.org>; nschlic1@gmail.com; Ora Hirsch Pescovitz <pescovitz@oakland.edu>; Samuel Stanley, Jr. <sstan55@pres.msu.edu>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Sharon Kardia <skardia@umich.edu>; Tina Freese Decker <christina.freese@spectrumhealth.org>; Vernice Davis Anthony <vern@vdahealthconnect.com>; Wright Lassiter III (WLASSIT1@hfhs.org) <WLASSIT1@hfhs.org>
Cc: Rockefeller, Cheryl (DHHS) <RockefellerC@michigan.gov>; Colleen Samp <colleen.samp@beaumont.org>; Daniel L Moynihan <daniel.moynihan@dteenergy.com>; Erika Hrabez <erikah@umich.edu>; Anderson, Evan (LEO) <AndersonE19@michigan.gov>; Gabe Rodriguez <gabe.rodriguez@detroitregionalpartnership.com>; Jesselyn Nelson <nelso343@msu.edu>; Kim Raniszeski <kranisz1@hfhs.org>; Laurie Attard <laurie.scarborough2@wayne.edu>; Lynn Patterson <lynn.patterson@spectrumhealth.org>; Nancy M Kosch <nancy.kosch@dteenergy.com>; Vernita Parker <vylong@oakland.edu>
Subject: Discussion Documents - 6:00 PM MERC Healthcare Advisory Group

Obtained via MI FOIA by Judicial Watch, Inc.

Importance: High

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Greetings – the discussion documents for tonight's MERC call are attached.

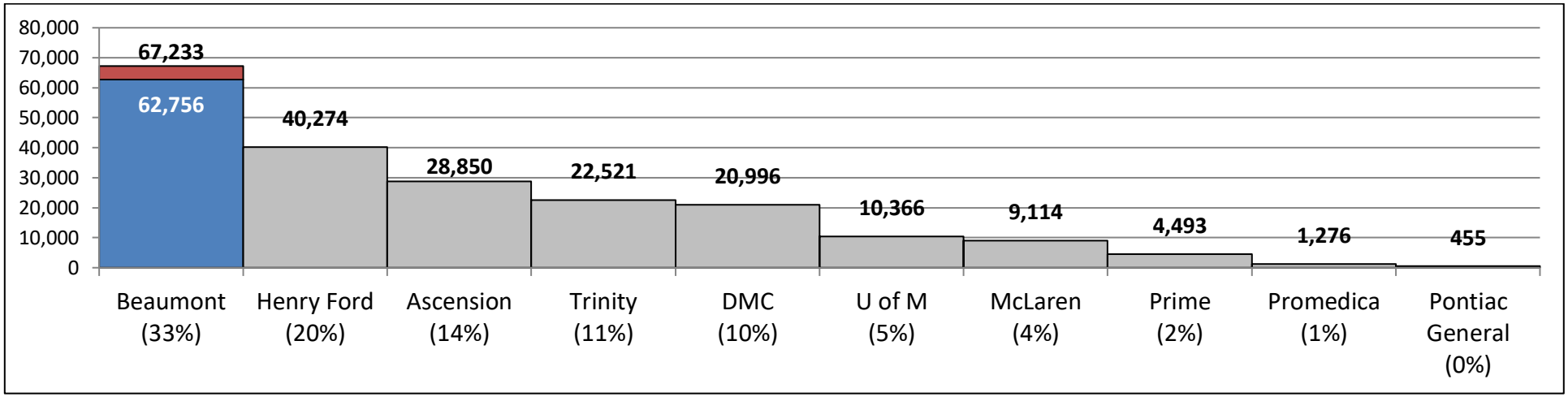
I look forward to talking to you at 6:00 PM.

Obtained via MI FOIA by Judicial Watch, Inc.

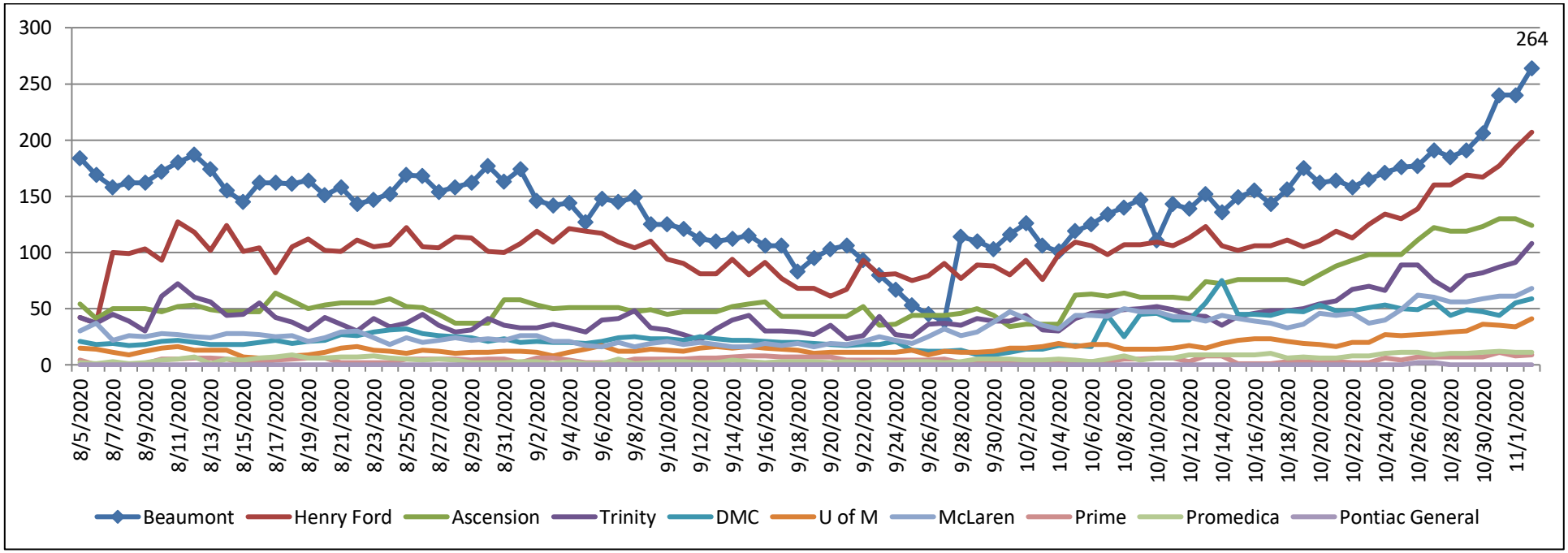
Beaumont HEALTH

Region 2 COVID-19 patient charts from MDHHS – EM Resource

1. **Total COVID Suspected/Confirmed Patient Days (3/27 – present). Top section represents Beaumont data prior to 3/27, which is not available for others.**

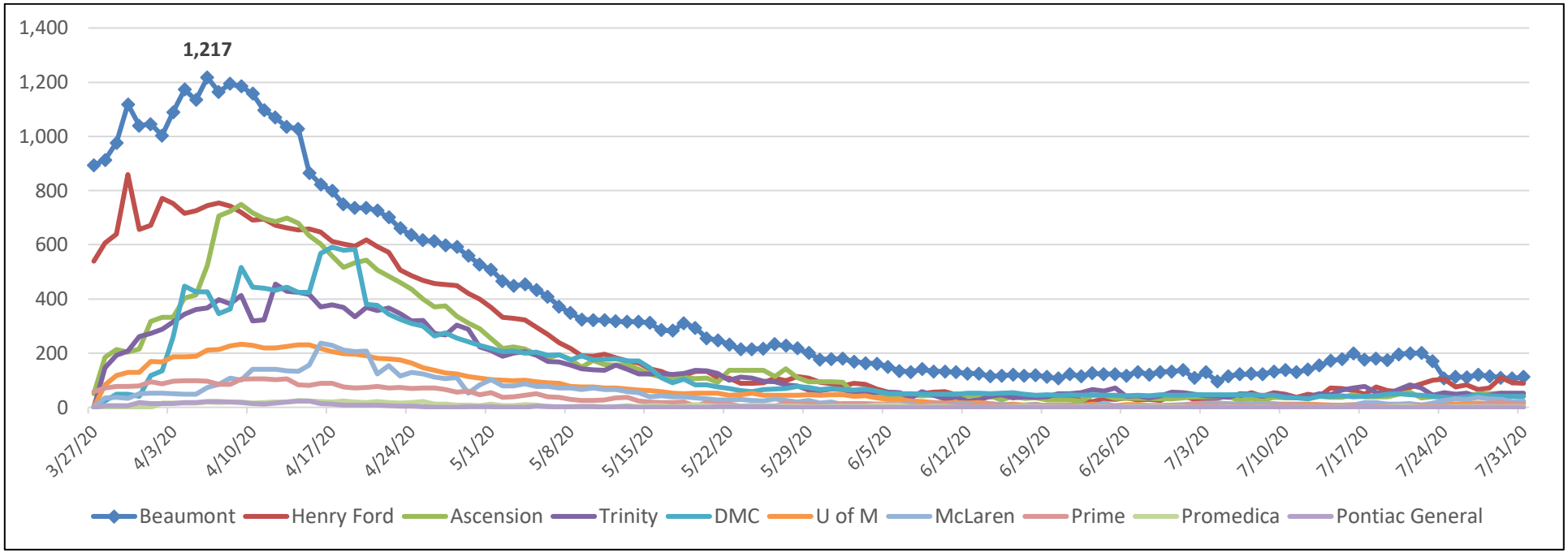


2. **COVID Suspected/Confirmed Census by Date. New HHS definition in EM Resource implemented on 8/4.**



Obtained via MI FOIA by Judicial Watch, Inc.

3. COVID Initial Surge. Positive and PUI Patient Census by Date (3/27 – 7/31).



Obtained via MI FOIA by Judicial Watch, Inc.

MI COVID response

Data and modeling update

November 4, 2020

NOTE: all data as of Oct 31 unless otherwise noted

Draft and pre-decisional

DRAFT

Obtained via MI FOIA by Judicial Watch, Inc.

Executive summary

The State of Michigan has 207.6 cases per million people (Level E) and positivity is 6.5%. Both indicators have been increasing for over five weeks. Five MERC regions had their risk level increased this week due to an increase in case rates (Detroit, Saginaw, Lansing, Traverse City, and Jackson) which means that all regions are now at Level E. Complaints of coronavirus like illness (CLI) in the emergency department increased for the state and six of the eight MERC regions (Detroit, Grand Rapids, Kalamazoo, Saginaw, Lansing, and Traverse City). Four regions remain above than 1% CLI (Grand Rapids, Kalamazoo, Traverse City, and Upper Peninsula). Trends for hospitalizations for COVID continue to increase for the past 4 weeks. There are more than 5% COVID hospitalizations in all regions except Traverse City. The state death rate is 2.4 deaths per million people and has been increasing for the past six weeks. More than 20 weekly deaths are seen in four MERC regions (Detroit, Grand Rapids, Kalamazoo, and Upper Peninsula)

Grand Rapids and **Kalamazoo** MERC regions have 269.8 and 297.5 cases per million, respectively (Level E). Positivity in these regions is above 7.5%. Both metrics are increasing for four or more weeks in each region. *COVID hospitalizations in Grand Rapids and Kalamazoo are 9.1% and 9.6%, respectively*. Deaths per million have been increasing for two weeks for Grand Rapids (2.4) and Kalamazoo (4.8)

Upper Peninsula MERC region has the highest cases per million at 439.2 (Level E). Positivity in this region is at 6.5%. However, both metrics are now decreasing. *COVID hospitalizations in Upper Peninsula is 9.3%*. *Deaths per million for Upper Peninsula (14.1) has increased for the previous two weeks and is the highest of all regions*

The **Detroit** MERC region has 170.6 cases per million people and positivity is 6.3%. Both metrics have increased for the previous four or more weeks. Currently, 6.6% of all available inpatient beds are occupied by a patient with COVID. Detroit region is at 1.4 deaths per million

Saginaw, **Lansing**, and **Jackson** MERC regions have more than 150 cases per million people (Level E). Positivity is between 3.8% and 6.1% in these three regions. There are less than 10% COVID hospitalizations in all regions *except Jackson where it is 10.3%*. In each of these three regions, there are less than 20 weekly deaths

Traverse City MERC regions has 168.2 cases per million people (Level E). Positivity in Traverse City region is 5.1%. COVID hospitalizations is 2.9%. The absolute death rate per million is 0.3 and there are fewer than 20 weekly deaths in this region

Daily diagnostic (PCR) testing averaged 42.9K per day over the last week
All MERC regions remain above 3,000 tests/million and the state overall is 4,756 tests/million

Obtained via MI FOIA by Judicial Watch, Inc.

Comparison across states: Summary

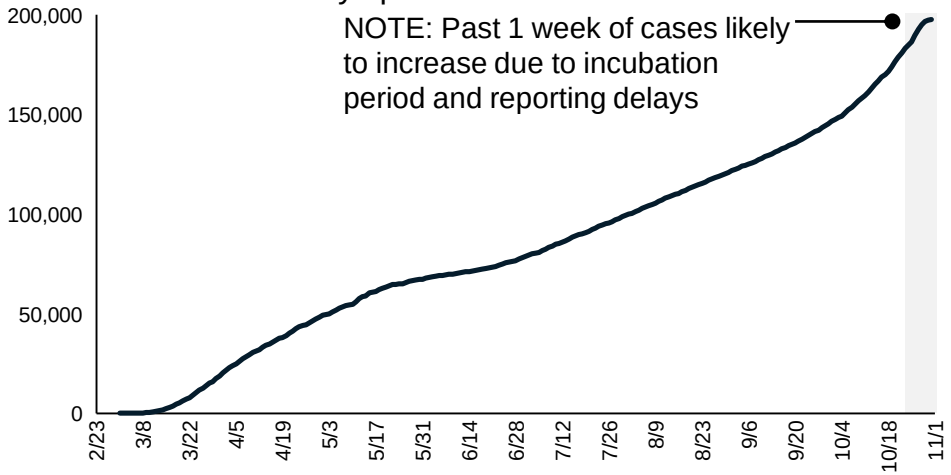
What we see today:

- 44 states seeing increasing 2 week case trends (same as last week)
- 40 states (increased vs. 38) with significant outbreaks (high/increasing cases, increasing/high positivity increasing/high hospitalizations over 2 weeks (>100 per M))
- South Dakota, North Dakota, Montana, Nebraska, Missouri have highest per capita hospitalized patient numbers
- Most rapid 2 week case growth: ME, CO, AK, CT, MA
- Midwest:
  - Wisconsin with continued massive outbreak, rising hospitalizations (>260/M), cases (800/M)
  - Indiana now rivaling Wisconsin in hospitalizations (255/M), cases >400/M – hospitalizations are close to same level as spring peak
  - Illinois now showing rapid case growth (500/M), positivity, and rising hospitalizations (260/M)
  - Ohio with slower growing cases (250/M), hospitalizations (144/M), positivity vs. others in region

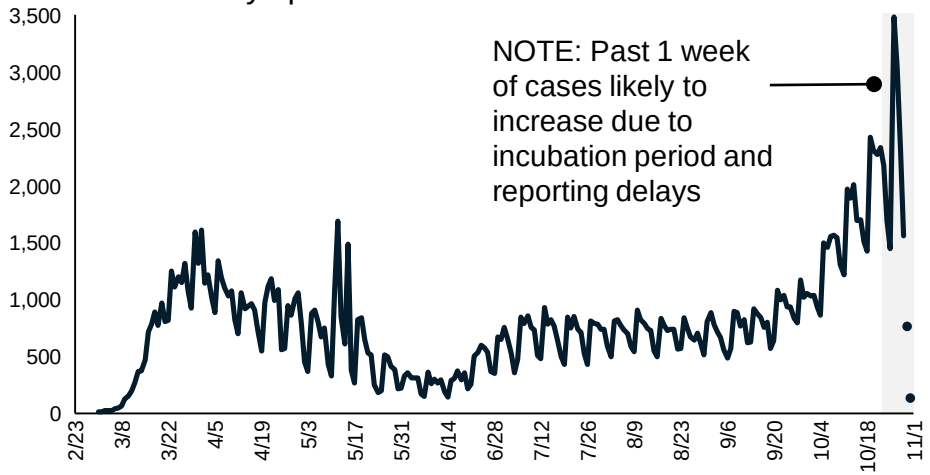
Obtained via MI FOIA by Judicial Watch, Inc.

COVID-19 cases and deaths: State of Michigan

Cumulative confirmed and probable cases, by date of onset of symptoms



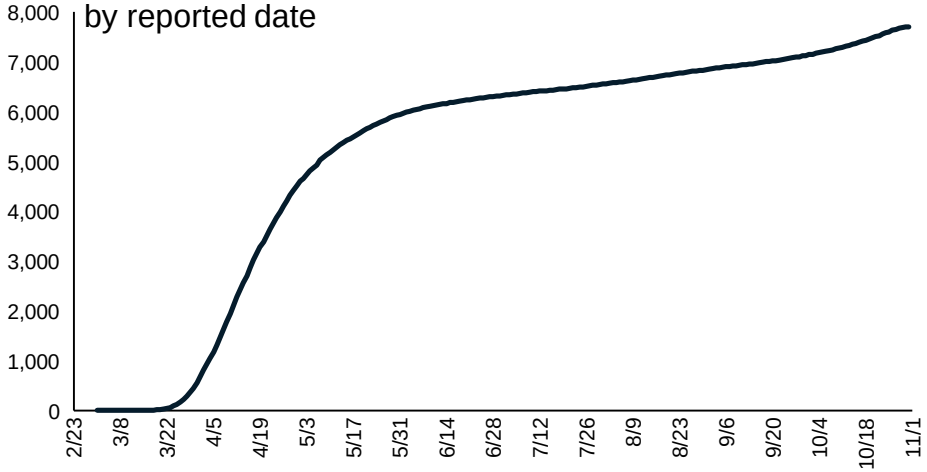
New confirmed and probable cases, by date of onset of symptoms



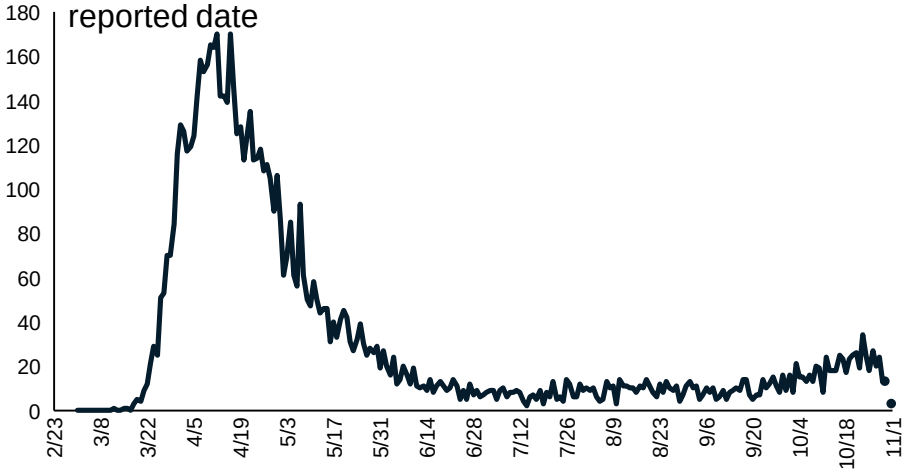
Updates since last week:

Average daily new cases in October (1679) were ~2x that of September average (817)

Cumulative confirmed and probable deaths, by reported date



New confirmed and probable deaths, by reported date



Updates since last week:

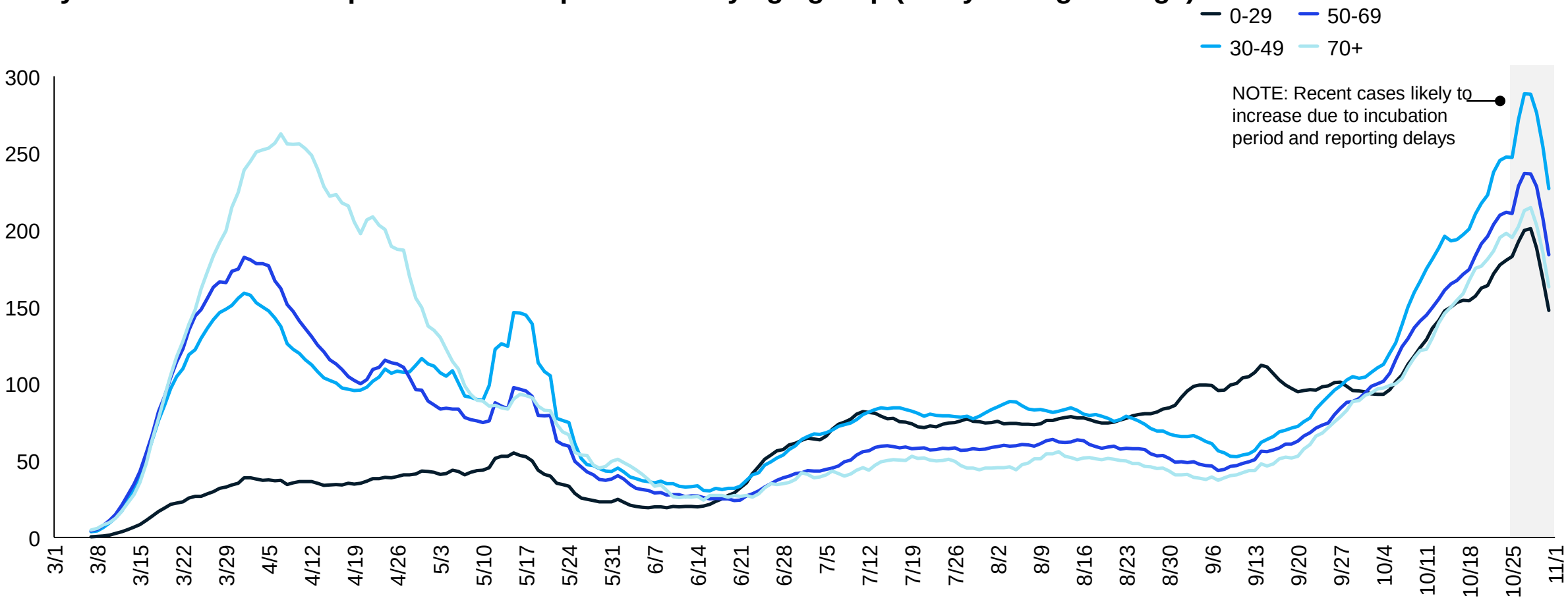
Average daily new deaths are 2.5x higher than in July, and 2x higher than September

Note: Cases information sourced from MDHHS and reflects date of onset of symptoms (refers to lab-confirmed cases). Case spike on 5/12 is a result of batch of test results, not all of which have onset date of symptoms completed yet
Source: MDHHS – Michigan Disease Surveillance System

Obtained via MI FOIA by Judicial Watch, Inc.

Average daily new cases per million residents, by age group

Daily new confirmed and probable cases per million by age group (7-day rolling average)



30-49 age group now has the highest cases per million, though cases per million have increased for all age groups

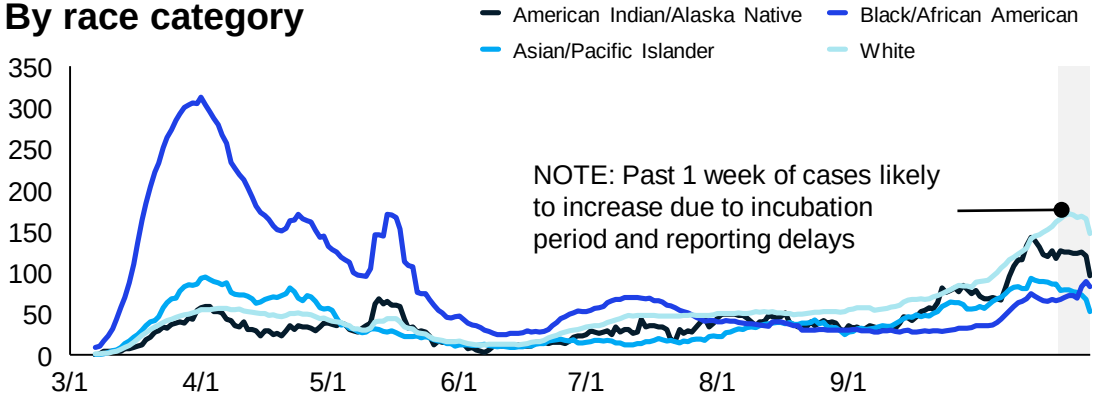
Note: Cases information sourced from MDHHS and reflects date of onset of symptoms
Source: MDHHS – Michigan Disease Surveillance System

Obtained via MI FOIA by Judicial Watch, Inc.

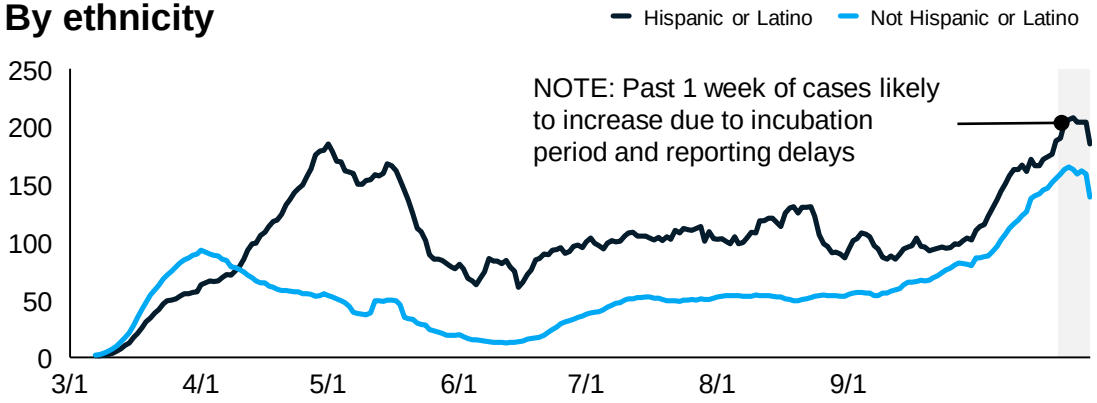
Average daily new cases per million people by race and ethnicity

Daily new confirmed and probable cases per million (7 day rolling average)

By race category

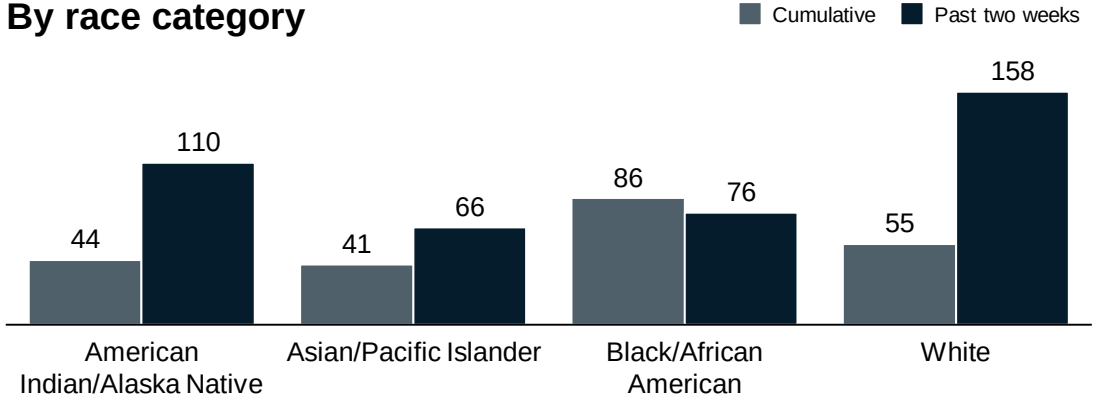


By ethnicity

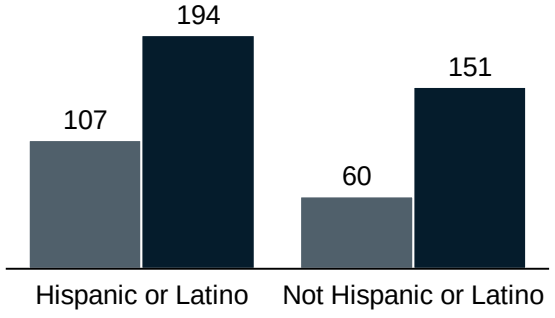


Average daily new confirmed and probable cases per million by race category

By race category



By ethnicity

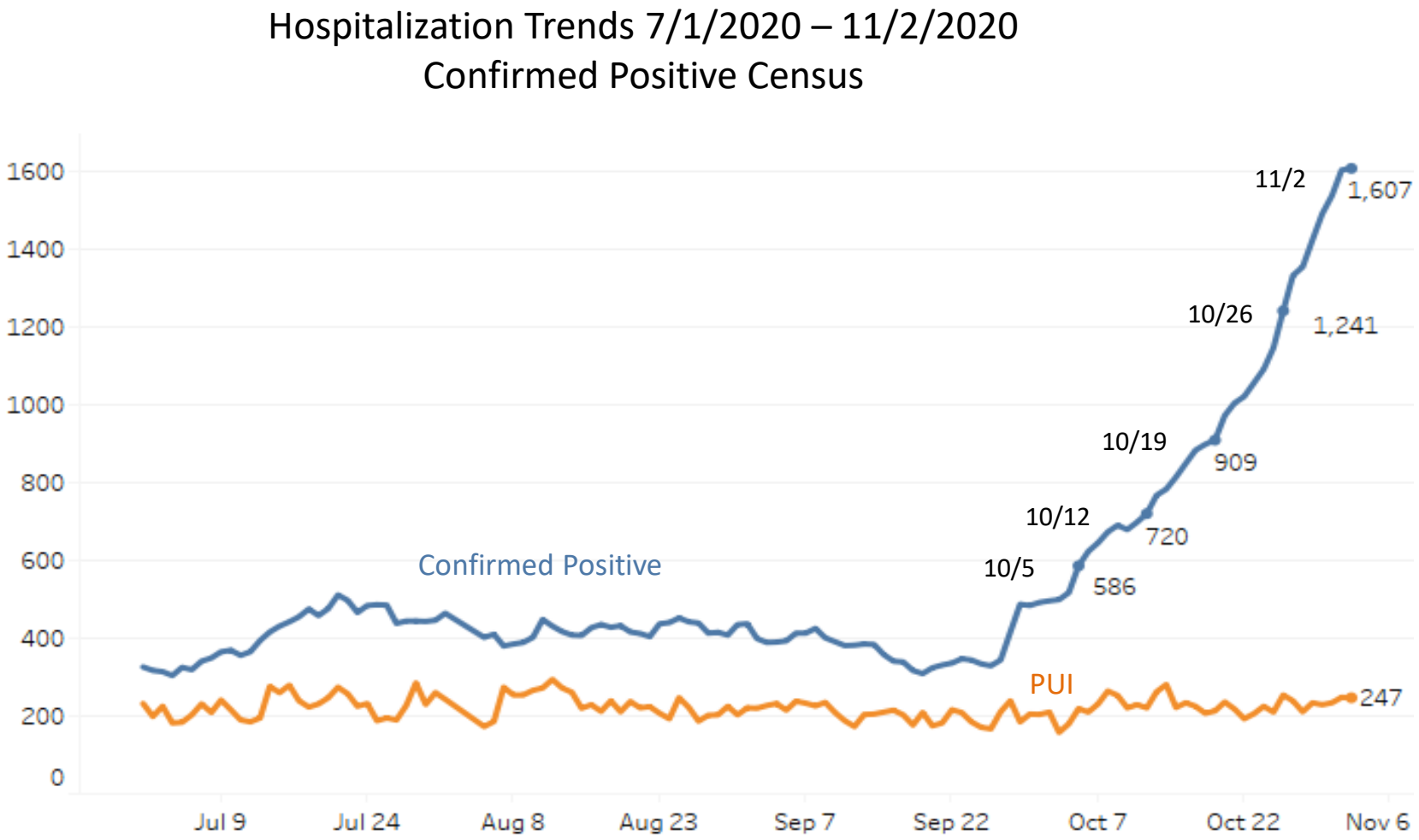


Note: Cases information sourced from MDHHS and reflects date of onset of symptoms; note that Multiple Races, Other, and Unknown race/ethnicity are not included in calculations

Source: MDHHS – Michigan Disease Surveillance System

Obtained via MI FOIA by Judicial Watch, Inc.

Statewide Hospitalization Trends COVID+ Hospital Census



Hospitalizations for confirmed positive patients has been rising over the past 5 weeks.

Weekly growth is >30% - showing acceleration vs. prior week

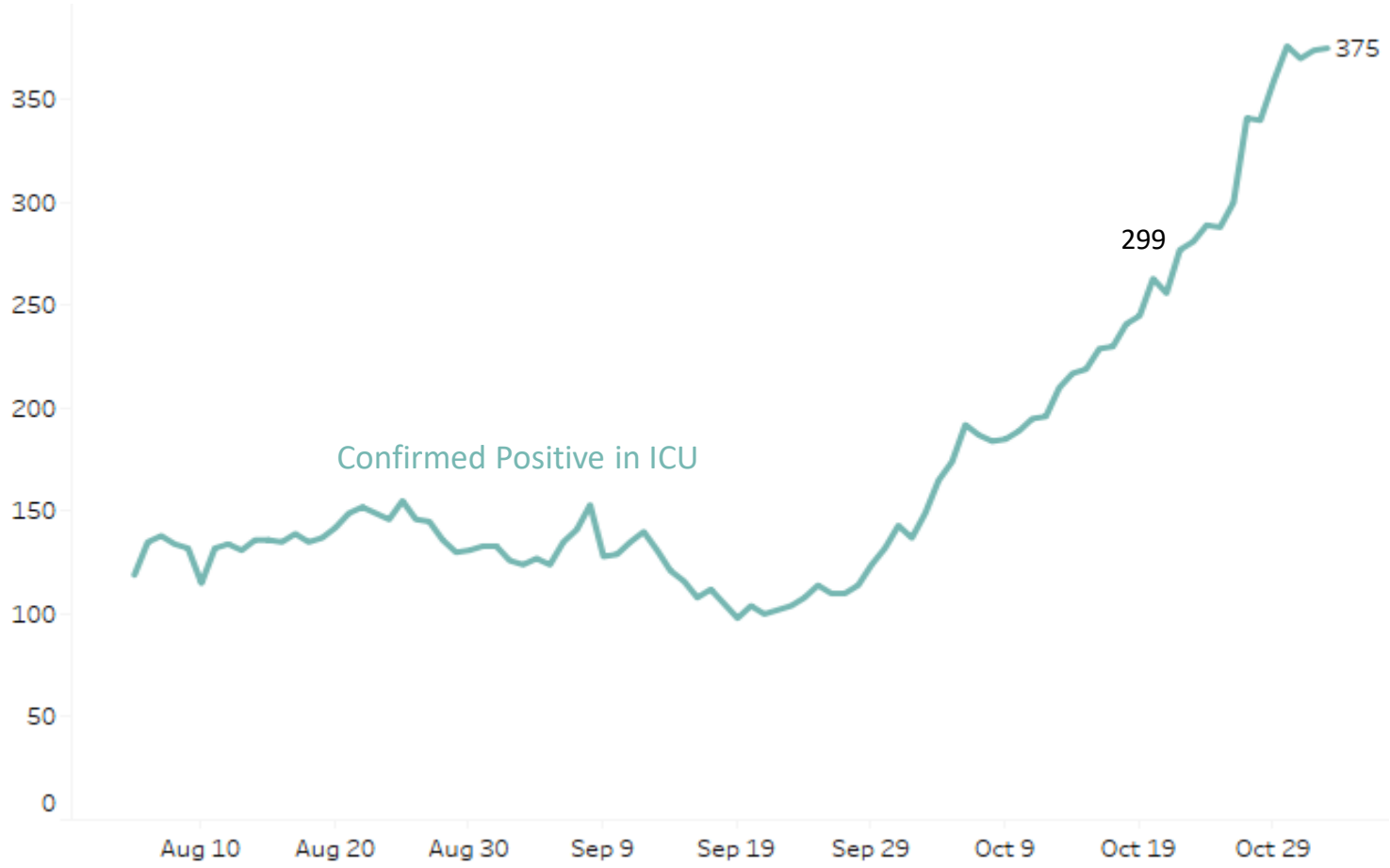
Doubling time is approximately 2.5 weeks now vs. 3 weeks over past month

We are at ~40% of our spring peak levels currently although distribution of patients is very different (60% outside SE Michigan currently vs. ~15% in Spring)

Obtained via MI FOIA by Judicial Watch, Inc.

Statewide Hospitalization Trends: ICU COVID+ Census

Hospitalization Trends 8/1/2020 – 11/2/2020
Confirmed Positive in ICUs



Confirmed Positive hospitalizations in ICUs shows 5 week increasing trend as well.

Weekly growth is 25%

Doubling time is approximately 3 weeks

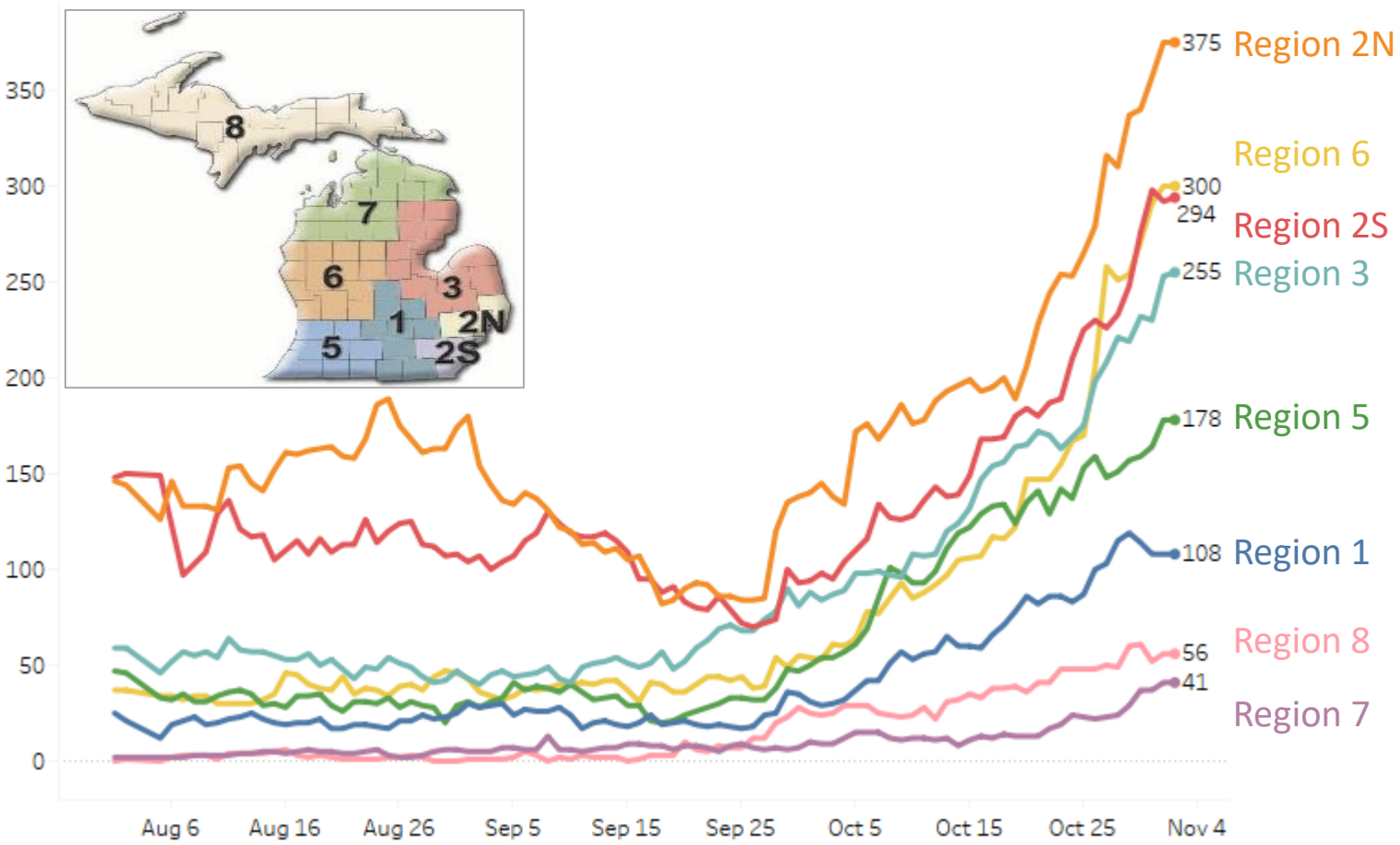
Statewide 15% of Adult ICU beds are occupied by COVID+ patients

	Adult ICU Occupancy	COVID in ICU	% of ICU beds COVID
Region 1	88%	28	15%
Region 2N	82%	64	12%
Region 2S	82%	62	9%
Region 3	88%	68	19%
Region 5	69%	32	16%
Region 6	71%	65	27%
Region 7	76%	24	14%
Region 8	81%	25	43%

Obtained via MI FOIA by Judicial Watch, Inc.

Statewide Hospitalization Trends: Regional COVID+ Census

Hospitalization Trends 8/1/2020 – 11/2/2020
Confirmed Positive by Region



Region 6 and 7 showing rapid growth

Region 1, 5 and 8 show slower growth

On a per population basis Region 3 and 6 have highest hospitalized/Million

Region	Weekly Growth	COVID+ Hospitalized/Million Population
1	17%	101/M
2S	31%	132/M
2N	42%	169/M
3	42%	225/M
5	16%	187/M
6	75%	205/M
7	78%	82/M
8	16%	180/M

Obtained via MI FOIA by Judicial Watch, Inc.

Confirmed and probable case indicators

Table Date: 10/28/2020 (7 days from date table was produced: 10/24/2020)

Risk levels: Low A B C D E

MERC Region Name	MERC Region #	Public Health Region	Absolute cases (per million)	CDC case trend[1]	Absolute deaths (per million)	Death trend	Average percent positivity	Positivity trend	Tests per million	% CLI ED (7-day average)	IP COVID occupied beds (%)	Weekly % CLI trend	Overall risk level
Detroit	1	2N + 2S	170.6	Elevated incidence growth	1.4	Decrease - 1 wk	6.3	Increase - 4 wk	3954.7	0.7	6.6	Increase - 2 wk	E
Grand Rapids	2	6	269.8	Elevated incidence growth	2.4	Increase - 2 wk	7.5	Increase - 5 wk	6042.5	1.5	9.1	Increase - 2 wk	E
Kalamazoo	3	5	297.5	Elevated incidence plateau	4.8	Increase - 2 wk	8.7	Increase - 6 wk	5220.8	1.3	9.6	Increase - 1 wk	E
Saginaw	4	3	199.5	Elevated incidence growth	2.6	< 20 wkly deaths	6.1	Increase - 4 wk	4389.8	0.8	7.2	Increase - 1 wk	E
Lansing	5	1	171.8	Elevated incidence growth	1.7	< 20 wkly deaths	4.4	Increase - 1 wk	4711.9	0.3	8.5	Increase - 1 wk	E
Traverse City	6	7	165.0	Elevated incidence plateau	0.3	< 20 wkly deaths	5.1	Increase - 4 wk	3419.4	1.7	2.9	Increase - 1 wk	E
Jackson	7	1	168.2	Elevated incidence growth	3.3	< 20 wkly deaths	3.8	Increase - 1 wk	7774.7	0.3	10.3	Decrease - 3 wk	E
Upper Peninsula	8	8	439.2	Decline	14.1	Increase - 2 wk	6.5	Decrease - 1 wk	6700.3	1.1	9.3	Decrease - 2 wk	E
Michigan	9	Michigan	207.6	Elevated incidence growth	2.4	Increase - 6 wk	6.5	Increase - 5 wk	4755.6	0.9	N/A	Increase - 7 wk	E

Cases Low: <7 | A: 7-20 | B: 20-40 | C: 40-70 | D: 70-150 | E: >=150

Positivity Low: <3% | A: 3-7% | B: 7-10% | C: 10-15% | D: 15-20% | E: >=20%

1. Epidemic curve classification based on two-week incidence slope. Data omits most recent week to account for lag period.

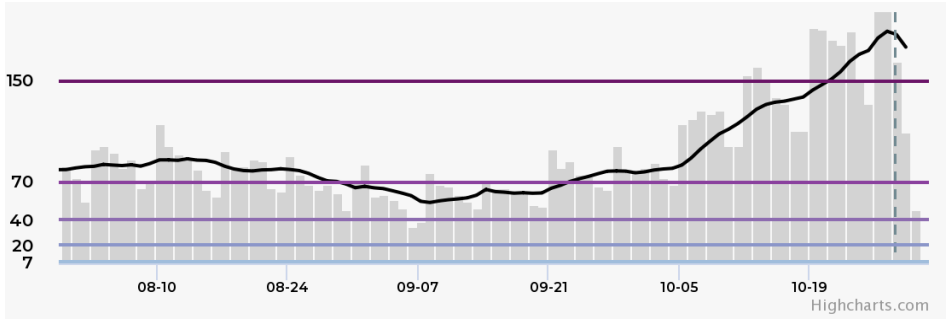
Obtained via MI FOIA by Judicial Watch, Inc.

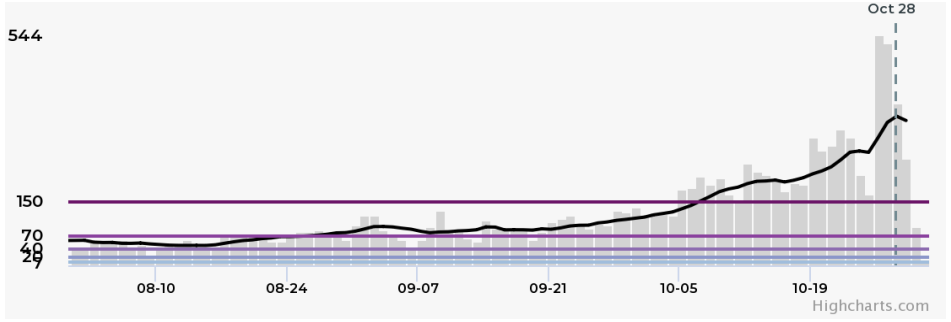
Draft

Recent trends: Detroit

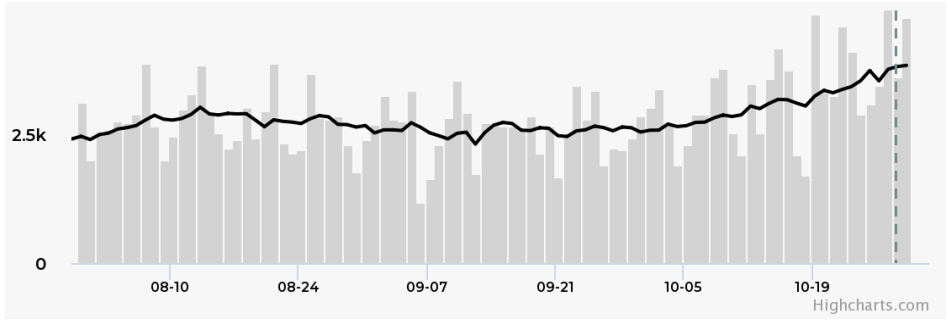
Recent trends: Grand Rapids

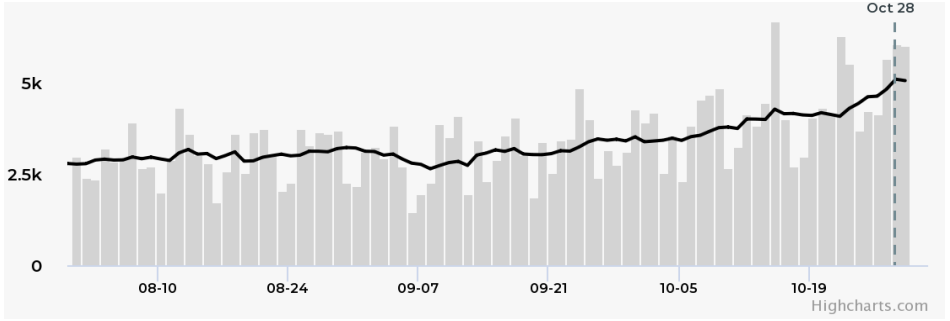
Confirmed & probable cases per million



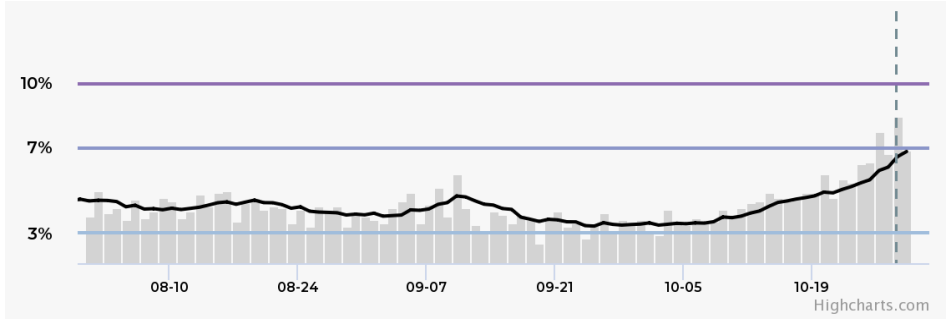


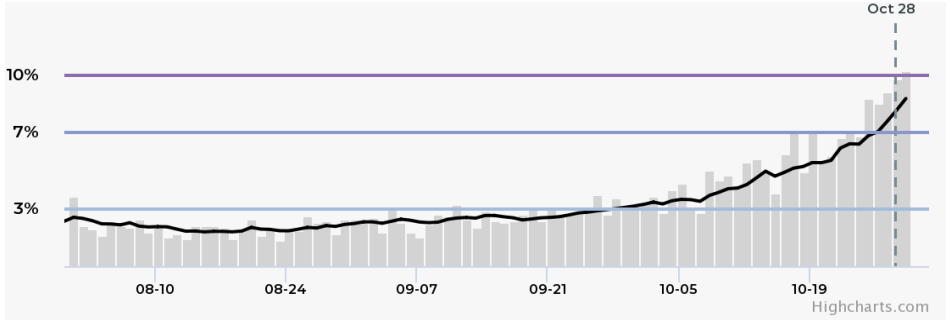
Daily tests per million





Percent positivity





All charts represent data from 8/1/20 – 10/28/20

Source: MI Start Map; MDOC excluded

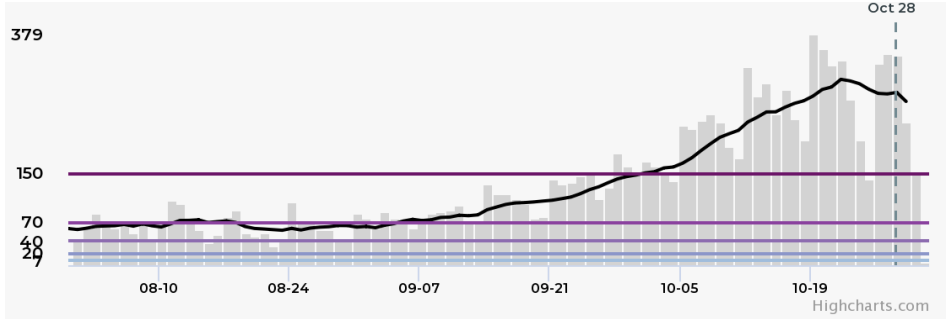
Obtained via MI FOIA by Judicial Watch, Inc.

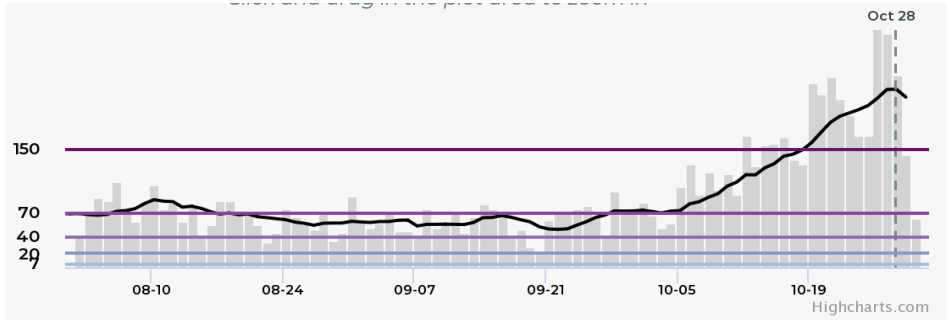
Draft

Recent trends: Kalamazoo

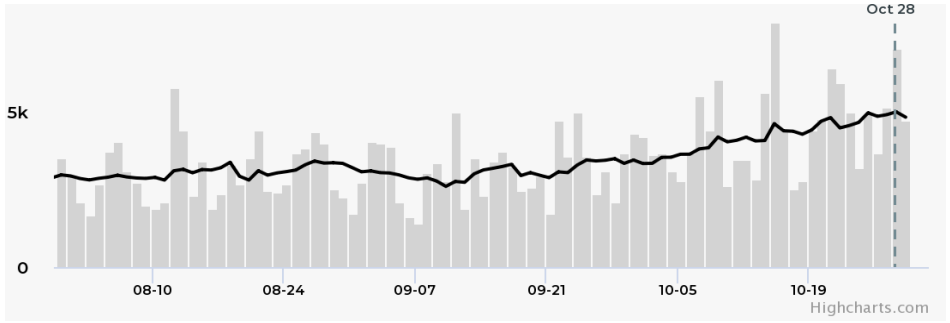
Recent trends: Saginaw

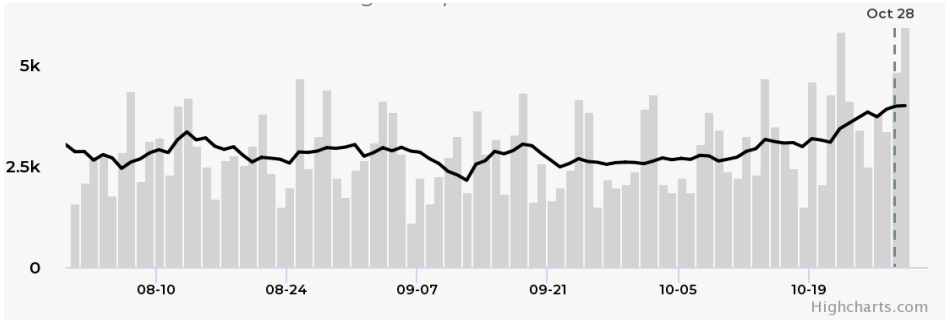
Confirmed & probable cases per MM



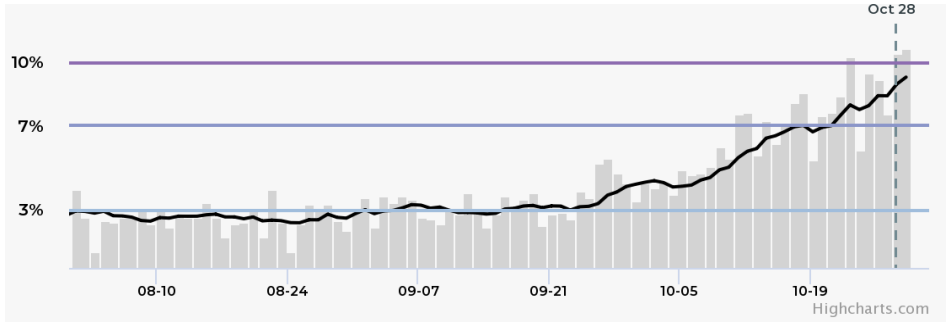


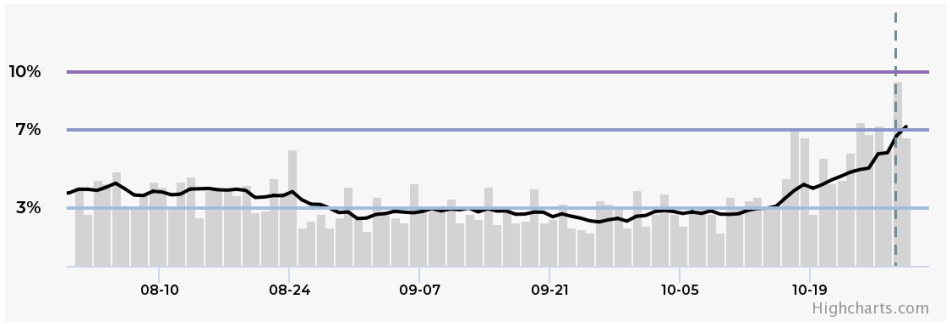
Number of tests





Percent positivity





All charts represent data from 8/1/20 – 10/28/20

Source: MI Start Map; MDOC excluded

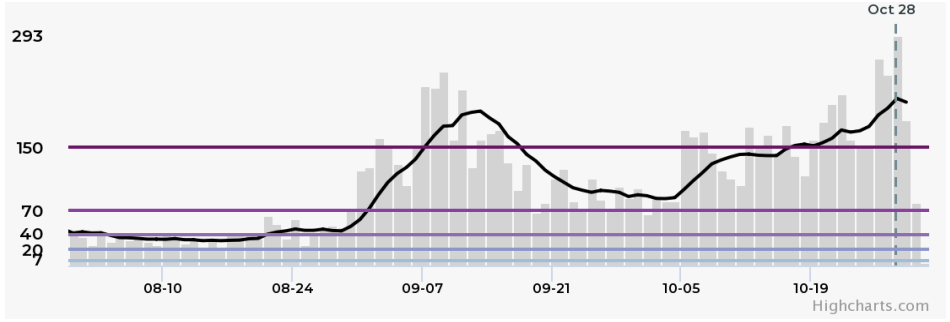
Obtained via MI FOIA by Judicial Watch, Inc.

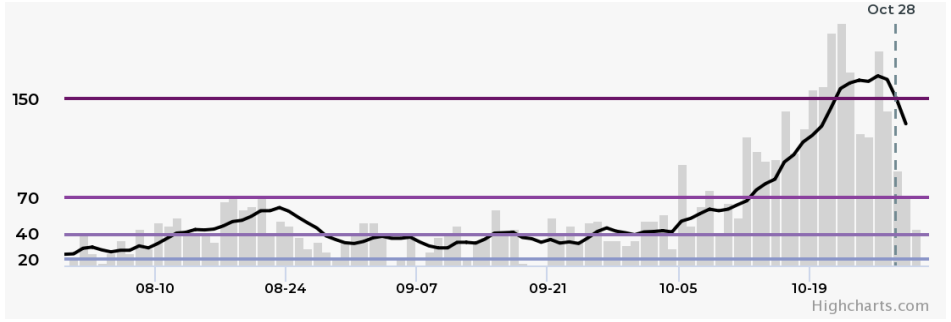
Draft

Recent trends: Lansing

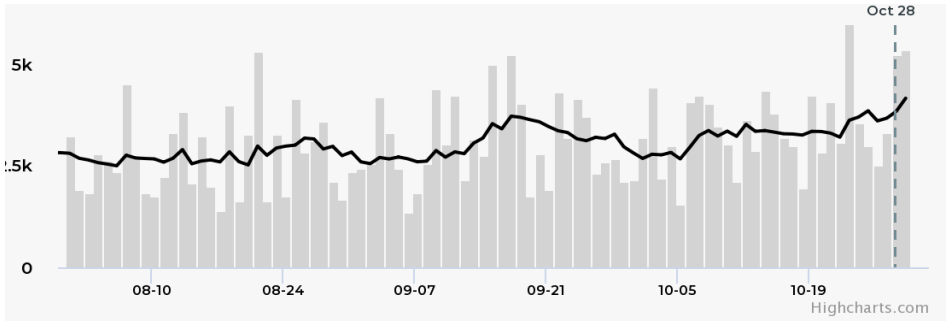
Recent trends: Traverse City

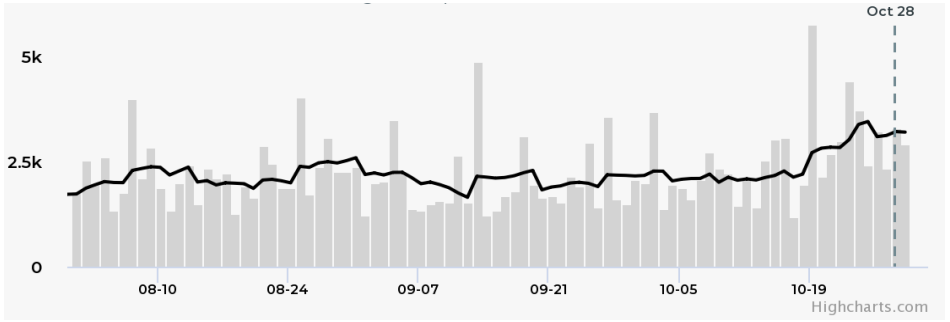
Confirmed & probable cases per million



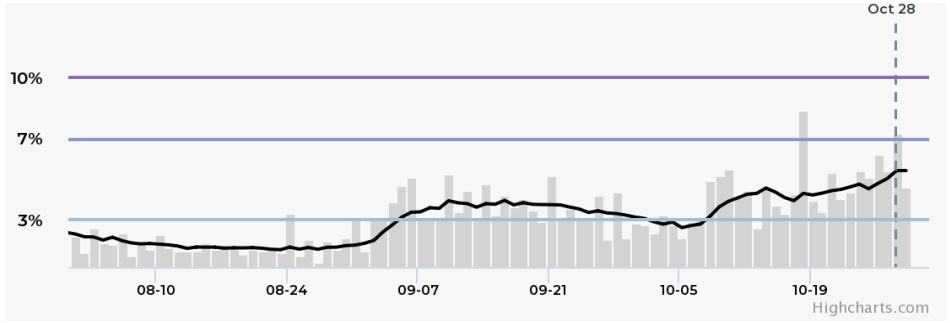


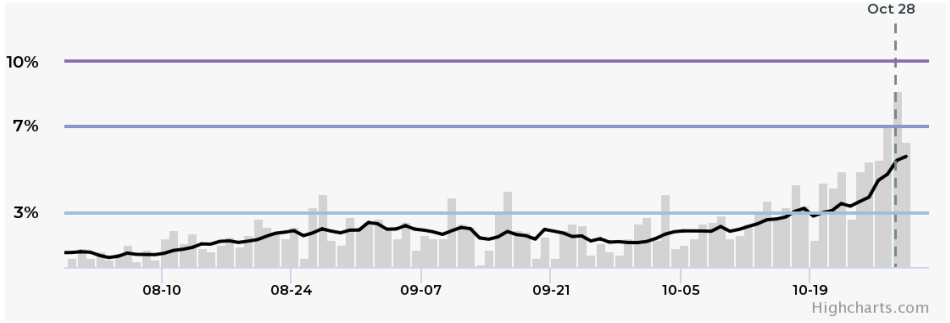
Daily tests per million





Percent positivity





All charts represent data from 8/1/20 – 10/28/20

Source: MI Start Map; MDOC excluded

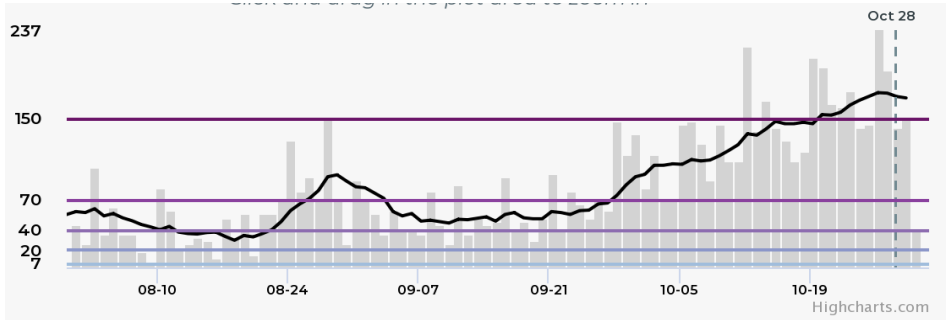
Obtained via MI FOIA by Judicial Watch, Inc.

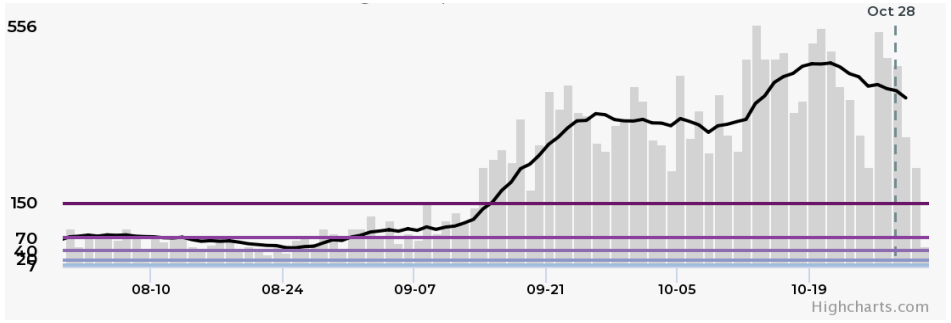
Draft

Recent trends: Jackson

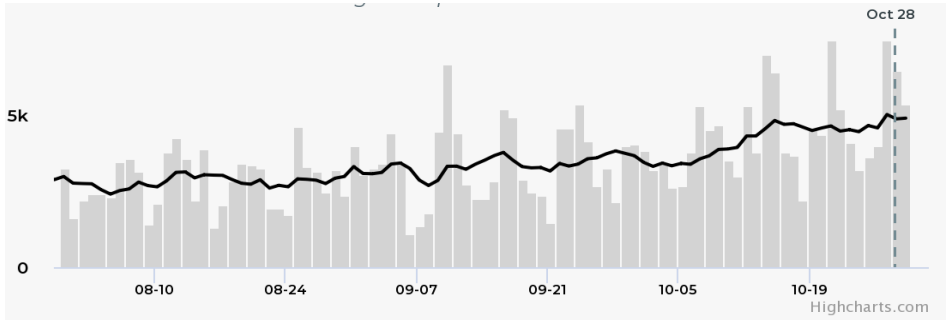
Recent trends: Upper Peninsula

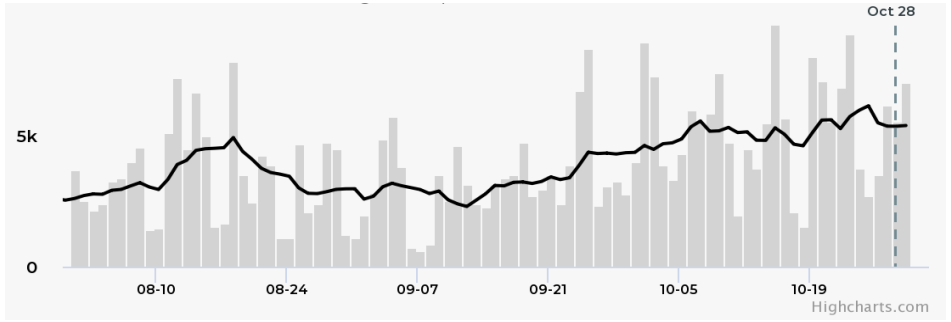
Confirmed & probable cases per million



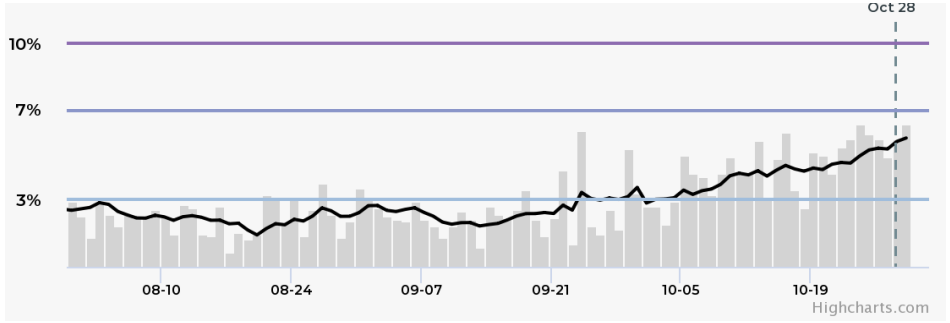


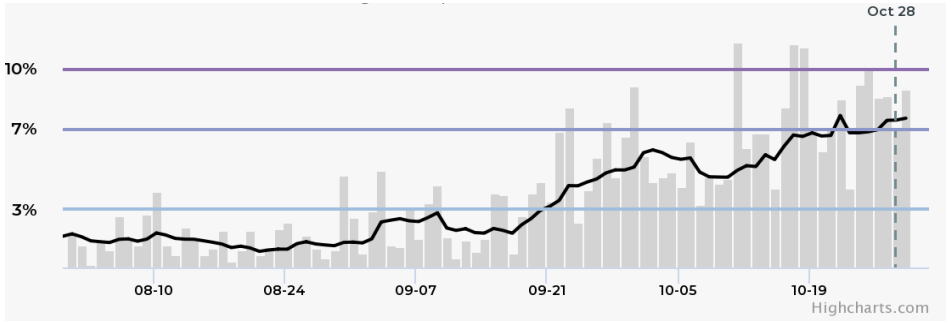
Daily tests per million





Percent positivity





All charts represent data from 8/1/20 – 10/28/20

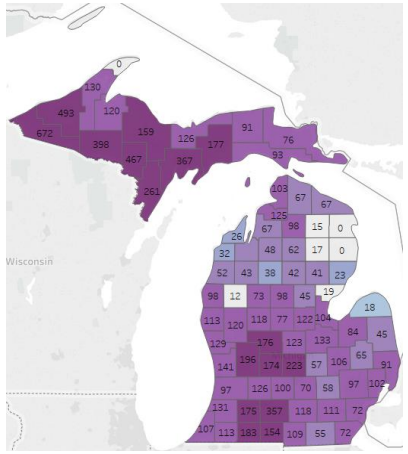
Source: MI Start Map; MDOC excluded

Obtained via MI FOIA by Judicial Watch, Inc.

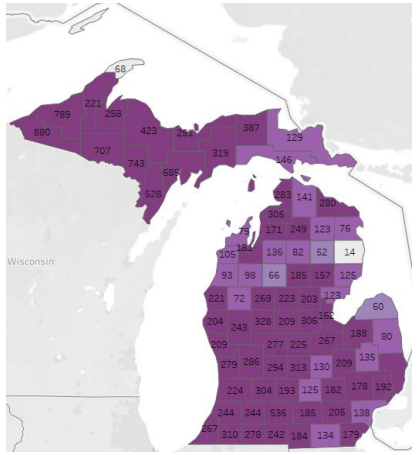
Average daily new confirmed and probable cases per million residents

10/18-10/24

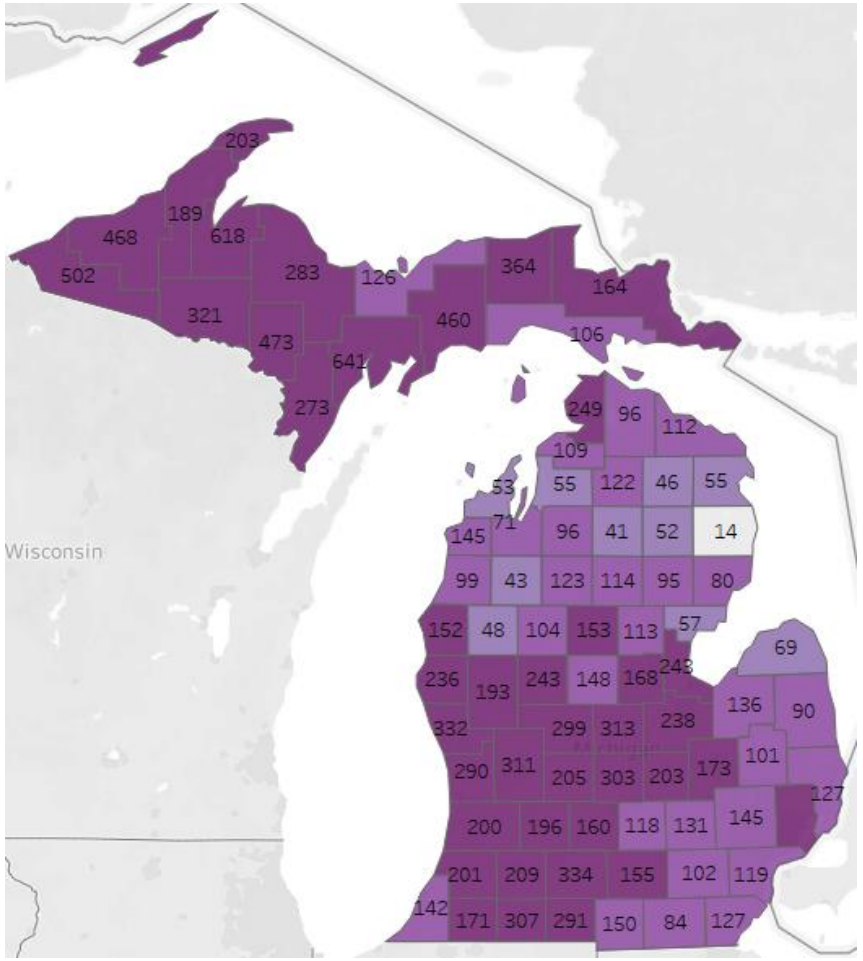
Displayed last week



Current data



10/25-10/31



- **Insufficient sample size;** county has fewer than 3 new cases during the week
- **Fewer than 7** average daily new cases per million
- **7-20** average daily new cases per million
- **20-40** average daily new cases per million
- **40-70** average daily new cases per million
- **70-150** average daily new cases per million
- **150** average daily new cases per million

Updates since last week:

Half of Michigan counties (42 of 83) are averaging 150+ new cases per million per day

Note: Cases information sourced from MDHHS and reflects date of onset of symptoms (refers to confirmed and probable cases)
Source: MDHHS – Michigan Disease Surveillance System

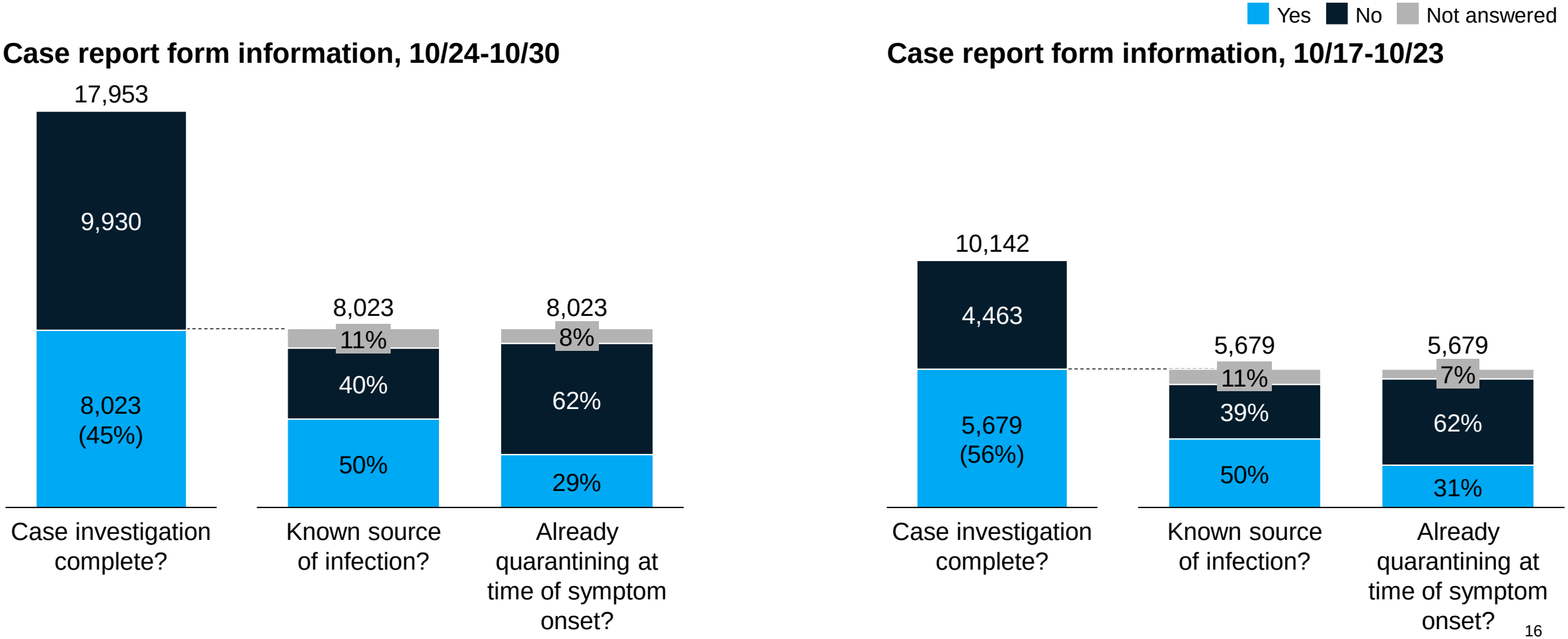
Obtained via MI FOIA by Judicial Watch, Inc.

New Case Investigation Metrics

New Communicable Disease metrics showed improvement at a statewide level since last week:

- 50% of investigated cases having a known source (50% last week)
- 29% of investigated cases noting that they were quarantining before symptoms (31% last week)

Absolute number of complete case investigations remained increased, but number of cases has increased at a faster rate

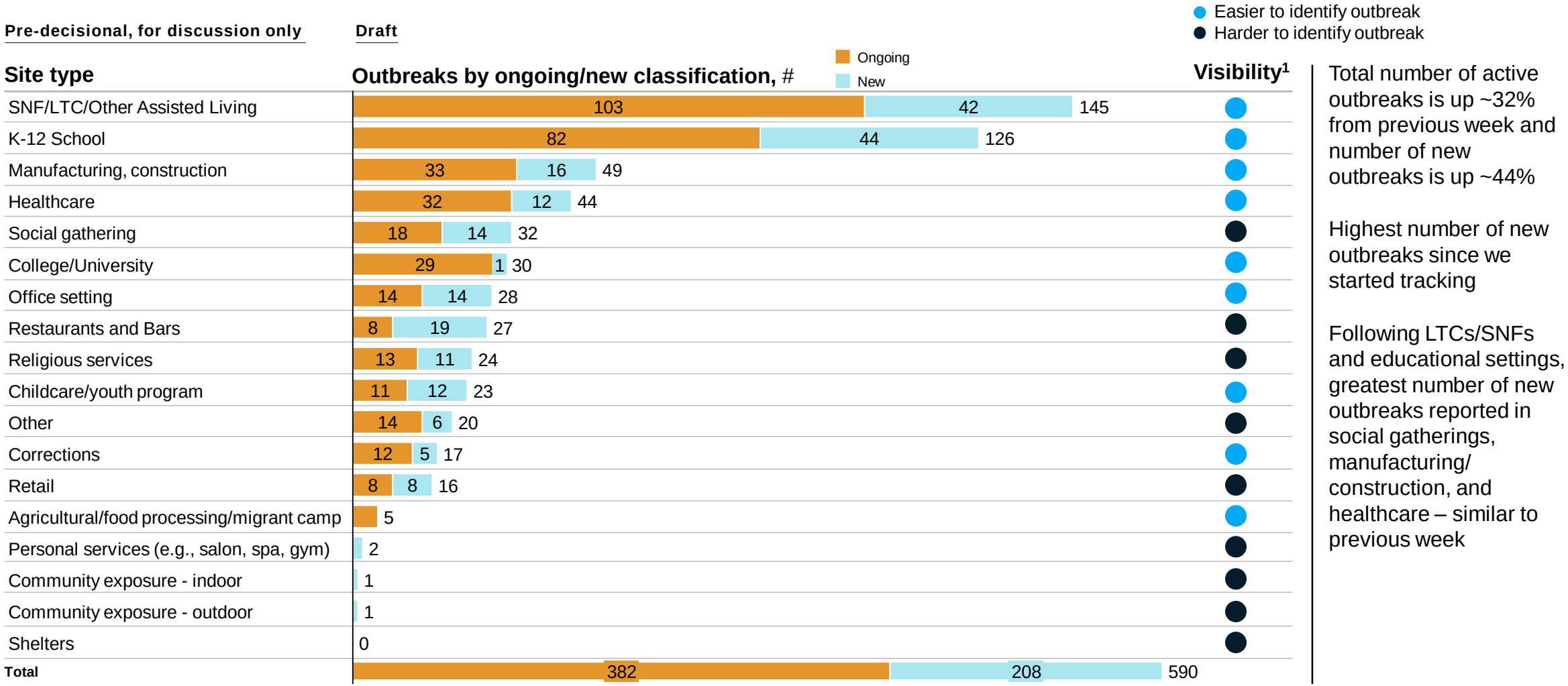


Source: MDHHS – Michigan Disease Surveillance System

Obtained via MI FOIA by Judicial Watch, Inc.

Number of outbreak investigations by site type, week ending October 30

Pre-decisional, for discussion only **Draft**



Total number of active outbreaks is up ~32% from previous week and number of new outbreaks is up ~44%

Highest number of new outbreaks since we started tracking

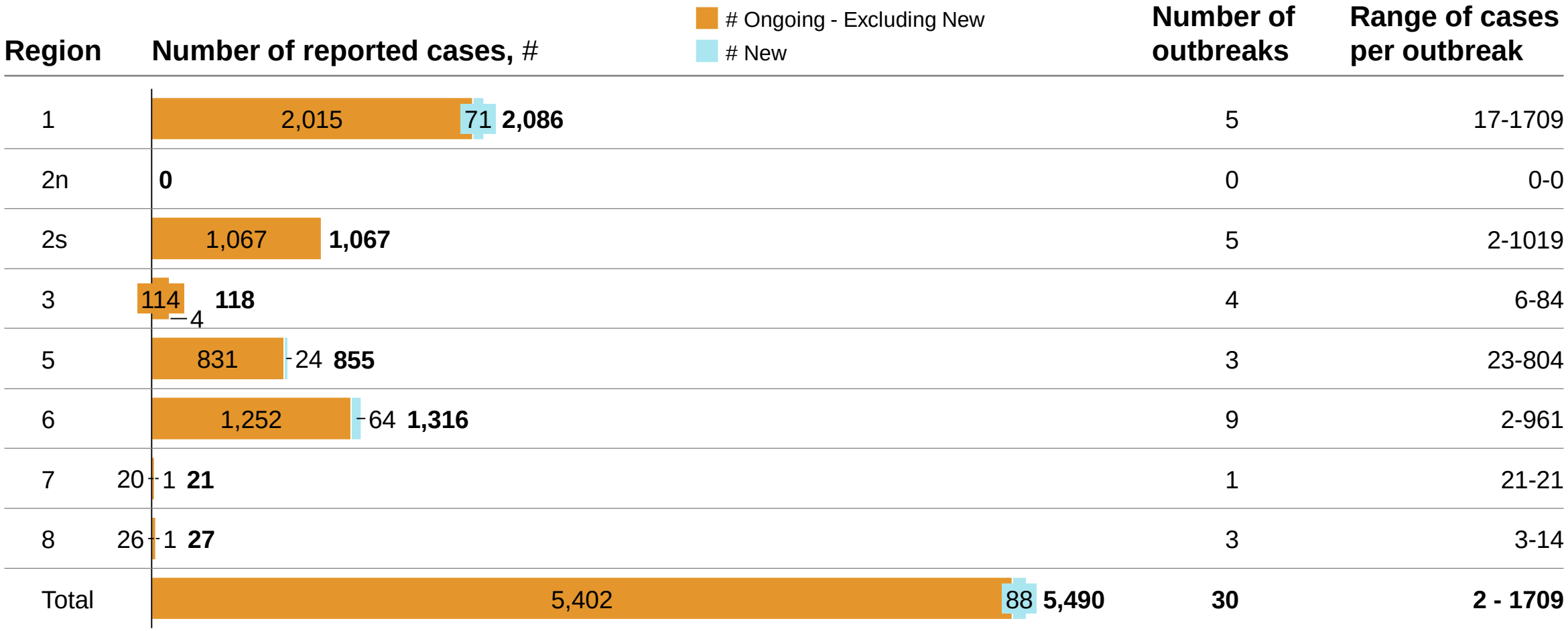
Following LTCs/SNFs and educational settings, greatest number of new outbreaks reported in social gatherings, manufacturing/ construction, and healthcare – similar to previous week

1. Based on a setting's level of control and the extent of time patrons/residents spend in the particular setting, different settings have differing levels of ability to ascertain whether a case derived from that setting

NOTE: Many factors, including the lack of ability to conduct effective contact tracing in certain settings, may result in significant underreporting of outbreaks. This chart does not provide a complete picture of outbreaks in Michigan and the absence of identified outbreaks in a particular setting in no way provides evidence that, in fact, that setting is not having outbreaks.
Source: LHD Weekly Sitreps

Obtained via MI FOIA by Judicial Watch, Inc.

College and university outbreaks, week ending October 30



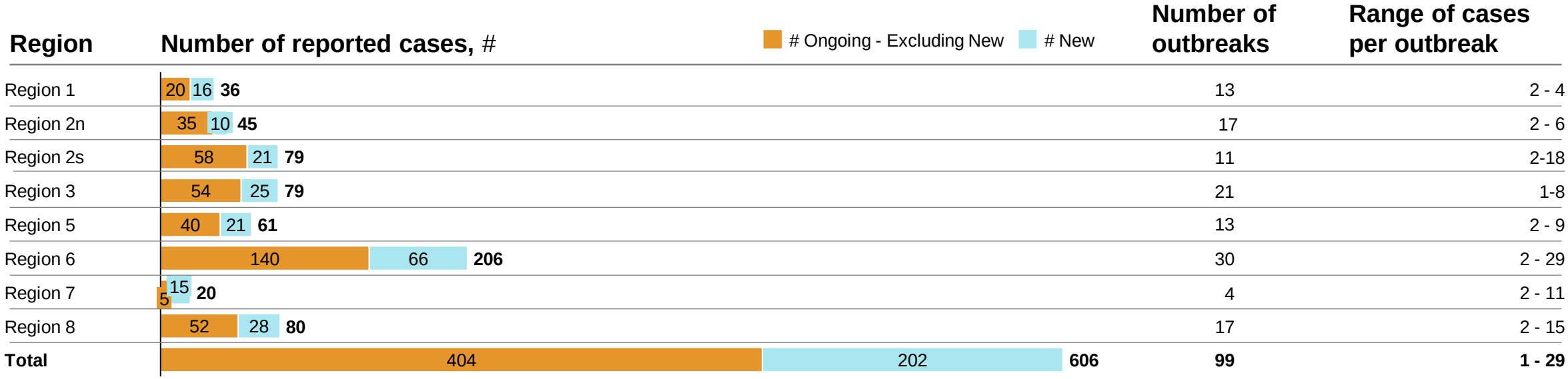
Region	Number of reported cases, #	Number of outbreaks	Range of cases per outbreak
1	2,015 + 71 = **2,086**	5	17-1709
2n	**0**	0	0-0
2s	1,067 = **1,067**	5	2-1019
3	114 + 4 = **118**	4	6-84
5	831 + 24 = **855**	3	23-804
6	1,252 + 64 = **1,316**	9	2-961
7	20 + 1 = **21**	1	21-21
8	26 + 1 = **27**	3	3-14
Total	5,402 + 88 = **5,490**	**30**	**2 - 1709**

NOTE: Many factors, including the lack of ability to conduct effective contact tracing in certain settings, may result in significant underreporting of outbreaks. This chart does not provide a complete picture of outbreaks in Michigan and the absence of identified outbreaks in a particular setting in no way provides evidence that, in fact, that setting is not having outbreaks.

Source: LHD Weekly Sitreps

Obtained via MI FOIA by Judicial Watch, Inc.

K-12 school outbreaks, recent and ongoing, week ending October 30



Region	Number of reported cases, #	Number of outbreaks	Range of cases per outbreak
Region 1	20 16 **36**	13	2 - 4
Region 2n	35 10 **45**	17	2 - 6
Region 2s	58 21 **79**	11	2-18
Region 3	54 25 **79**	21	1-8
Region 5	40 21 **61**	13	2 - 9
Region 6	140 66 **206**	30	2 - 29
Region 7	5 15 **20**	4	2 - 11
Region 8	52 28 **80**	17	2 - 15
Total	404 202 **606**	**99**	**1 - 29**

Grade level	Number of reported cases, #	Number of outbreaks	Range of cases per outbreak
Pre-school - elem	69 50 **119**	29	1 - 10
Jr. high/middle	88 26 **114**	21	1 - 11
High	247 126 **373**	49	2 - 29
Total	404 202 **606**	**99**	**1 - 29**

NOTE: # of outbreaks in K-12 schools is up ~50% in Regions 3 and 8 over the last week, and has more than doubled in Region 2n

Many factors, including the lack of ability to conduct effective contact tracing in certain settings, may result in significant underreporting of outbreaks. This chart does not provide a complete picture of outbreaks in Michigan and the absence of identified outbreaks in a particular setting in no way provides evidence that, in fact, that setting is not having outbreaks.

Source: LHD Weekly Sitreps

Obtained via MI FOIA by Judicial Watch, Inc.

Testing, case investigation, and contact tracing: Current state

Testing | **Case investigation and contact acquisition** | **Initial contact tracing**

Ongoing contact monitoring *still occurring through texting and calls*

Goal	**2K tests** per million per day	**3%** test **positivity, excluding MDOC**	**Fast test to result turnaround** time[6]	**90% calls attempted** in one day	**75% calls completed** in one day	**50% with contacts** in one day	**90% calls attempted** in one day	**75% calls completed** in one day
Performance	4.2K	6.5%	3.1 days	46.7%[1]	33.9%[2]	36.3%[3]	74.7%[4]	32.6%[5]
Trend since last week	*Favorable*	*Unfavorable*	*Stable*	*Unfavorable*	*Unfavorable*	*Unfavorable*	*Unfavorable*	*Stable*

49% of contacts successfully complete intake within five days

1. % of cases documented as "attempted" within one day
2. % of cases documented as "successful" within one day
3. % of cases with at least one contact documented within one day
4. Weighted average of % of cases documented as "attempted" within one day in OMS, LHD survey, and Traceforce
5. Average of % of cases documented as "successful" within one day (Traceforce-only due to data accuracy concerns in other systems)
6. Sourced from weighted average of all lab turnaround times

Source: MDSS and OMS summary statistics. Traceforce summary statistics. LHD Sitrep survey. Testing information from MAG summary files (percent positivity excludes MDOC)

Draft

Pre-decisional, for discussion only

Obtained via MLFOIA by Judicial Watch, Inc.

Daily tests

State	Avg. daily tests
1. New York	120.3K
2. California	108.6K
3. Illinois	69.1K
4. Texas	49.9K
5. Michigan	42.0K
6. Ohio	41.3K
7. North Carolina	31.8K
8. New Jersey	28.9K
9. Florida	28.7K
10. Arizona	22.2K
11. Arkansas	19.1K
12. Georgia	18.0K
13. Virginia	17.7K
14. Tennessee	16.2K
15. Massachusetts	15.2K
16. Alabama	15.2K
17. Pennsylvania	14.4K
18. South Carolina	13.4K
19. Wisconsin	13.3K
20. Washington	12.8K
21. Kentucky	12.8K
22. Minnesota	12.2K
23. Oklahoma	12.0K
24. Connecticut	11.5K
25. Louisiana	11.5K
26. Mississippi	11.4K
27. Colorado	10.5K
28. Alaska	10.3K

Weekly % of pop. tested

State	Weekly % tested
1. Alaska	9.82%
2. Arkansas	4.44%
3. New York	4.33%
4. District of Columbia	3.83%
5. Illinois	3.82%
6. Michigan	2.94%
7. West Virginia	2.86%
8. Mississippi	2.67%
9. Maine	2.60%
10. New Mexico	2.57%
11. Ohio	2.47%
12. Montana	2.37%
13. New Jersey	2.28%
14. Connecticut	2.26%
15. Alabama	2.17%
16. Arizona	2.14%
17. North Carolina	2.12%
18. Oklahoma	2.11%
19. Kentucky	2.00%
20. California	1.92%
21. South Carolina	1.83%
22. Louisiana	1.73%
23. South Dakota	1.70%
24. Tennessee	1.67%
25. Utah	1.61%
26. Wisconsin	1.60%
27. Massachusetts	1.54%
28. Minnesota	1.52%

Percent positive

State	% positive
1. Maine	1.3%
2. New York	1.6%
3. District of Columbia	2.1%
4. Vermont	2.8%
5. California	3.4%
6. Connecticut	3.9%
7. Louisiana	4.9%
8. New Jersey	4.9%
9. Washington	5.1%
10. West Virginia	5.2%
11. New Hampshire	5.8%
12. Mississippi	6.0%
13. Michigan	6.5%
14. Ohio	6.5%
15. Alaska	6.5%
16. Virginia	6.5%
17. North Carolina	6.7%
18. South Carolina	6.9%
19. Massachusetts	7.5%
20. Oregon	8.0%
21. Georgia	8.0%
22. Oklahoma	8.0%
23. Illinois	8.2%
24. New Mexico	8.6%
25. Maryland	8.7%
26. Delaware	9.3%
27. Arkansas	9.8%
28. Tennessee	10.2%

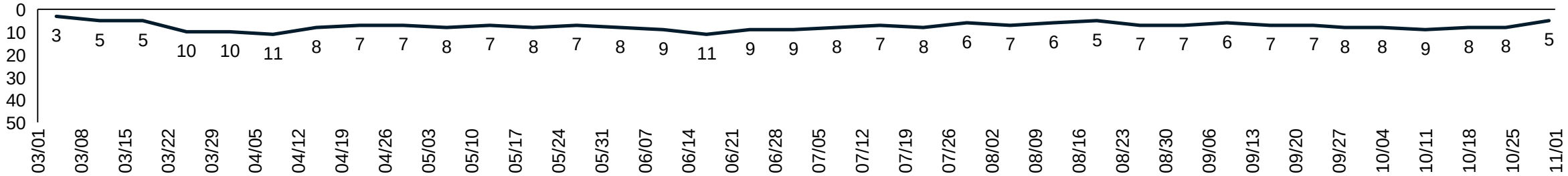
Week ending 10/31/2020 (Michigan average uses most recent MAG data and includes all tests, including MDOC and “Region Unknown”)

SOURCE: Numerical Data – MDSS, COVID Tracking Project, U.S. Census Bureau.

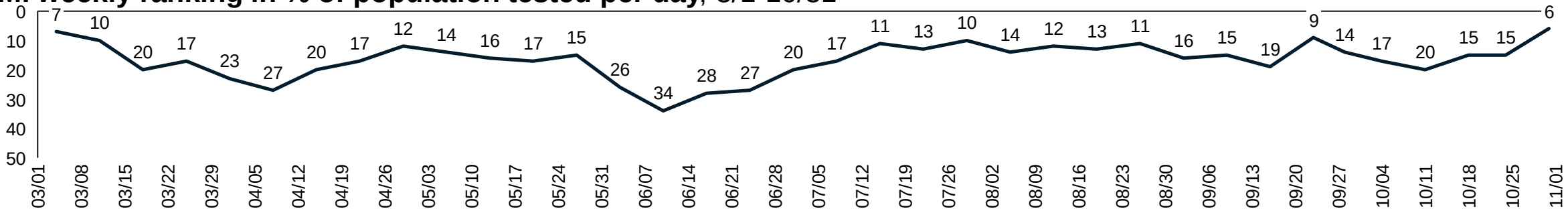
Obtained via MI FOIA by Judicial Watch, Inc.

MI ranking over time among all states

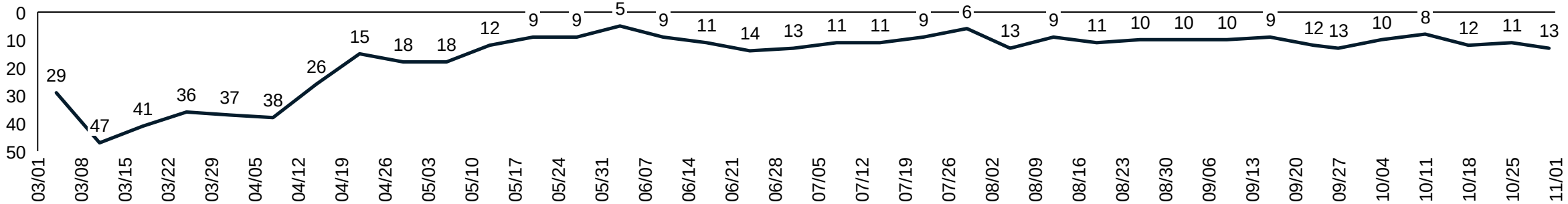
MI weekly ranking in absolute # of tests per day, 3/1-10/31



MI weekly ranking in % of population tested per day, 3/1-10/31



MI ranking in % positivity per day, 3/1-10/31



Obtained via MI FOIA by Judicial Watch, Inc.

Testing turnaround time – Collection to report

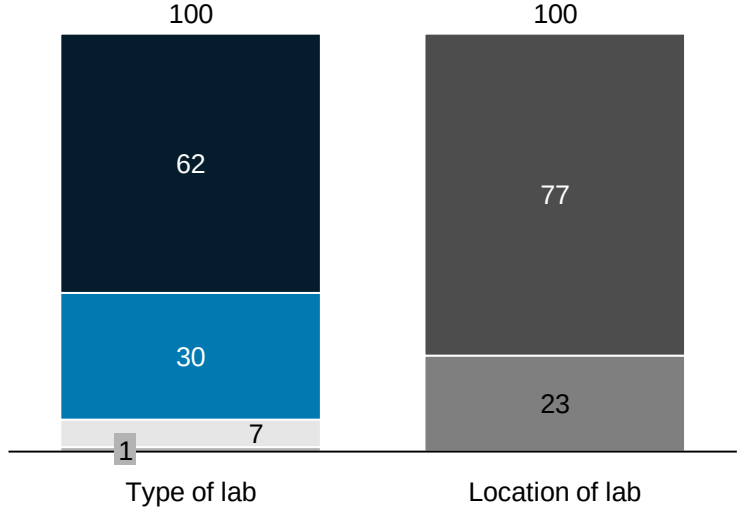
Labs reporting >1K results in past two weeks

Commercial | Hospital | Other | Public health | In-state | Out-of-state

Lab (Asterisk indicates out-of-state)	Average turnaround time, past two weeks (days)	Avg daily tests run, past two weeks (K)
ARTIC DX MEDICAL LABORATORIES	17.0	0.4
*VIKOR SCIENTIFIC	8.9	1.5
*HONU-DASCENA LAB	6.6	0.7
NXGEN	6.0	4.5
*Genet Worx	4.6	0.2
LynxDX	4.3	0.7
VIBRA HEALTH LABORATORY	3.9	0.7
GREAT LAKES MEDICAL LABORATORY	3.6	0.5
Commercial Average	**3.3**	**21.6**
*QUEST WOOD DALE	3.1	1.8
Northwest Labs	3.0	0.6
*BIOREFERENCE LABORATORIES	2.9	1.0
Trident Laboratories	2.8	0.4
Frances Warde Medical Laboratory	2.8	1.2
RHB Laboratories, Inc.	2.7	0.3
St John Hospital and Medical Center	2.7	0.4
LABCORP	2.4	1.4
*BIOTECH CLINICAL LAB INC	2.2	0.8
MGHS	2.1	0.2
LAN	2.0	0.4
SPECTRUM HEALTH ADVANCED TECHNOLOGY LAB	1.9	2.4
Garcia Laboratory	1.9	0.4
MIORD	1.8	1.9
*Curative San Dimas	1.6	2.0
Sparrow Main	1.6	1.4
Saint Joseph Mercy Hospital	1.5	0.6
Lakeland Medical Center, St Joseph	1.5	0.3
CHS	1.4	0.3
MRM	1.4	0.2
SPECTRUM HEALTH REGIONAL LABORATORY	1.4	0.5
Mercy Health Partners Muskegon	1.4	0.2
GENEMARKERS LABORATORY	1.3	1.3
Royal Oak Laboratory	1.2	0.6
Saint Marys Mercy Health Care	1.2	0.3
Oakwood Hospital -Dearborn Laboratory	1.2	0.3
Hospital Average	**1.1**	**10.5**
MetroHealthLab	1.0	0.2
HELIXMDX	1.0	1.5
Saint Joseph Mercy Oakland	0.9	0.2
U of M	0.9	0.8
Bronson Methodist Hospital	0.8	0.5
Henry Ford Allegiance Hospital Laboratory	0.7	0.3
Henry Ford Hospital Dept. of Pathology	0.6	0.8
VHS University Laboratories	0.2	0.2

Source: MDSS/Michigan Medical Advantage Group, MDHHS, testing labs (as of 10/30). NOTE: Smaller labs do not appear on this page

Percent of tests (past two weeks), by type of lab and location



14-day average testing turnaround time is 3.1 days, stable since last week

Obtained via MI FOIA by Judicial Watch, Inc.

Status of COVID-19 Epidemiological Risk

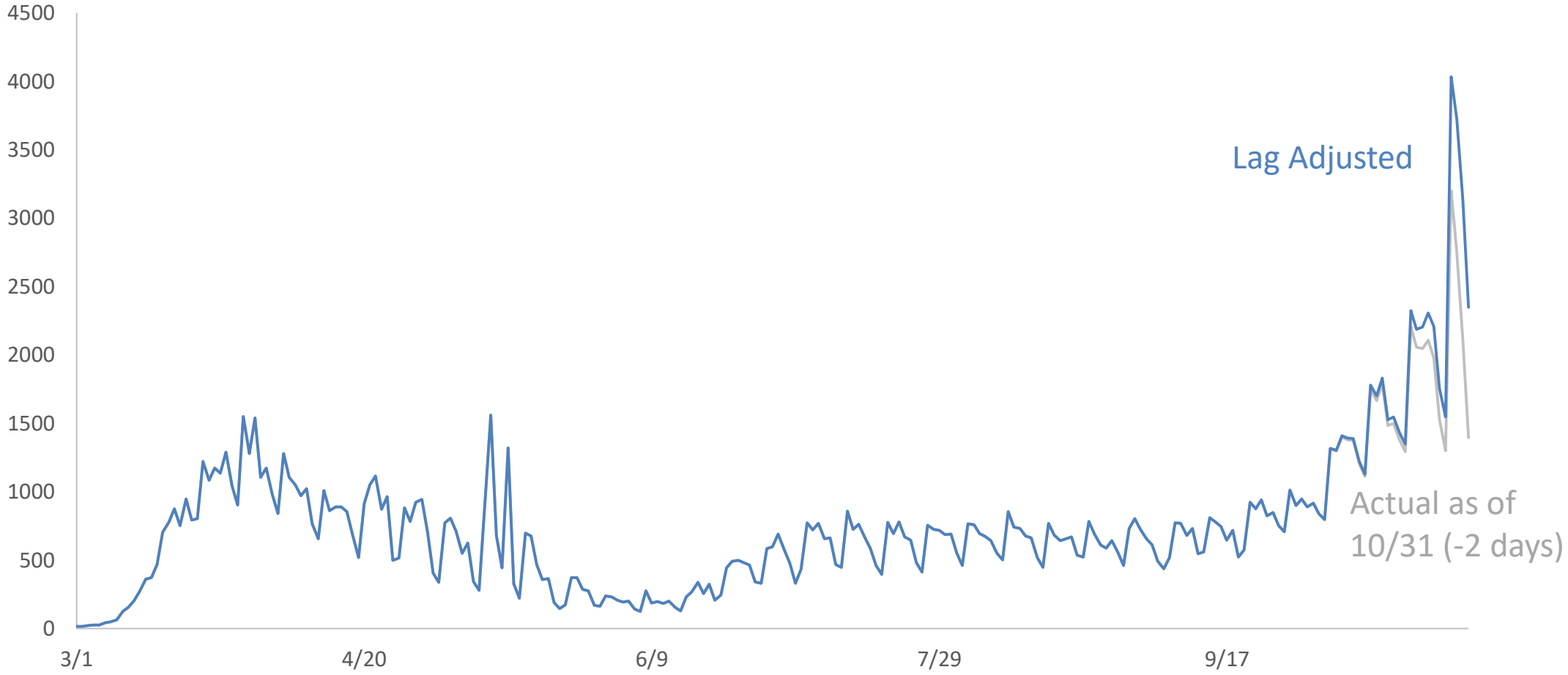
Science round-up

Appendix

Obtained via MI FOIA by Judicial Watch, Inc.

Lag adjusted new COVID+ cases by on-set date

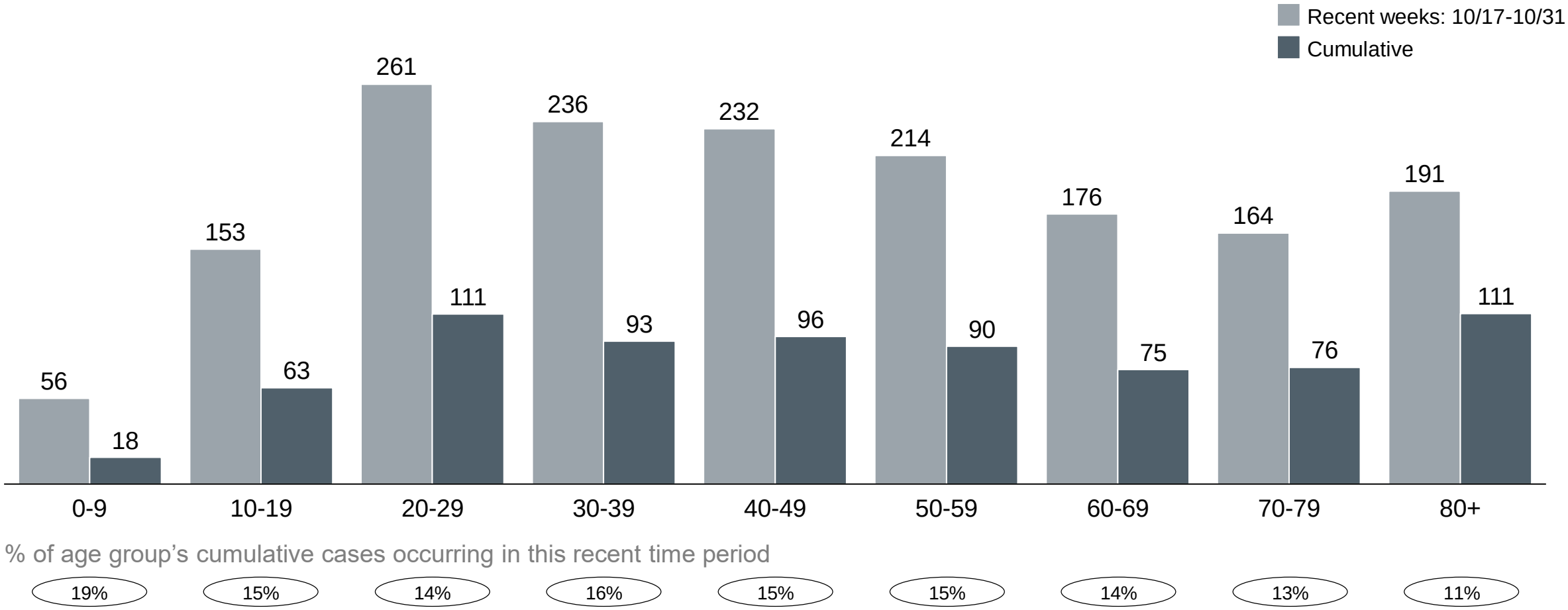
New confirmed cases by onset in gray and lag adjusted in blue



Obtained via MI FOIA by Judicial Watch, Inc.

Cases by age group

Average daily new confirmed and probable cases per million by age group



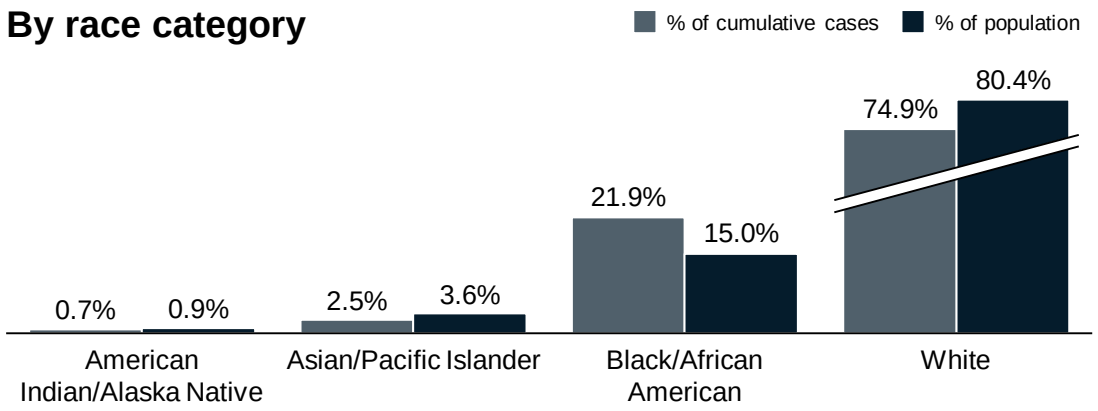
Note: Cases information sourced from MDHHS and reflects date of onset of symptoms
Source: MDHHS – Michigan Disease Surveillance System

Obtained via MI FOIA by Judicial Watch, Inc.

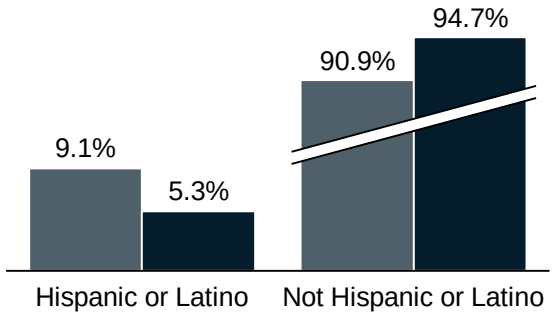
Cases and population comparison by race and ethnicity

Cumulative confirmed and probable cases vs. population, % of total[1]

By race category

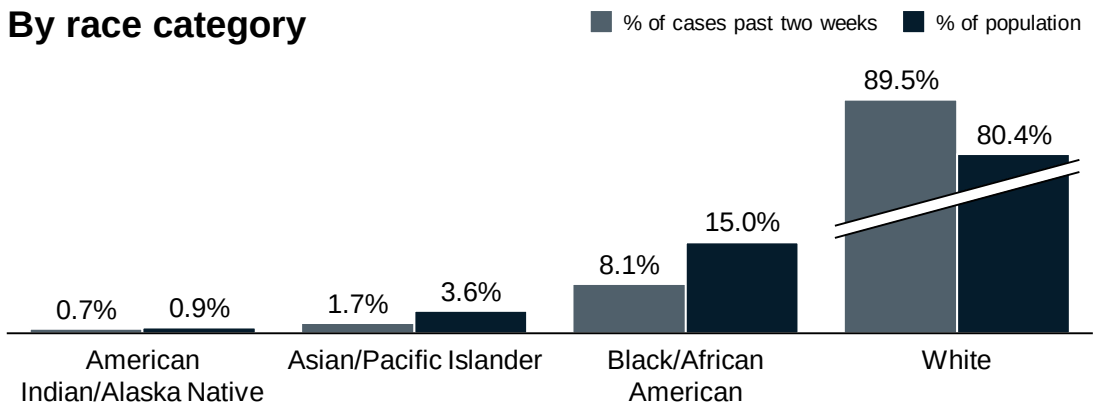


By ethnicity

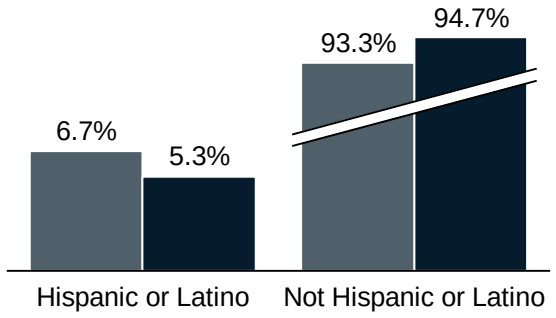


Past two weeks confirmed and probable cases vs. population, % of total[1]

By race category



By ethnicity



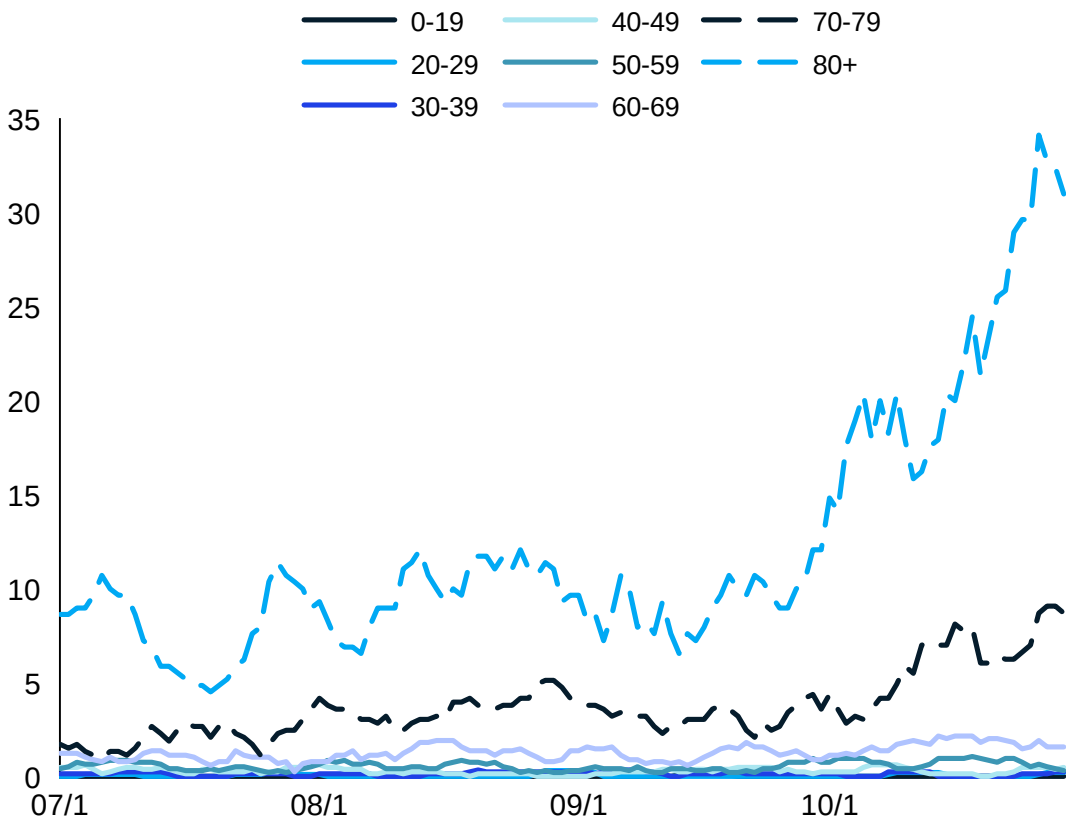
Note: Cases information sourced from MDHHS and reflects date of onset of symptoms; note that Multiple Races, Other, and Unknown race/ethnicity are not included in calculations

Source: MDHHS – Michigan Disease Surveillance System

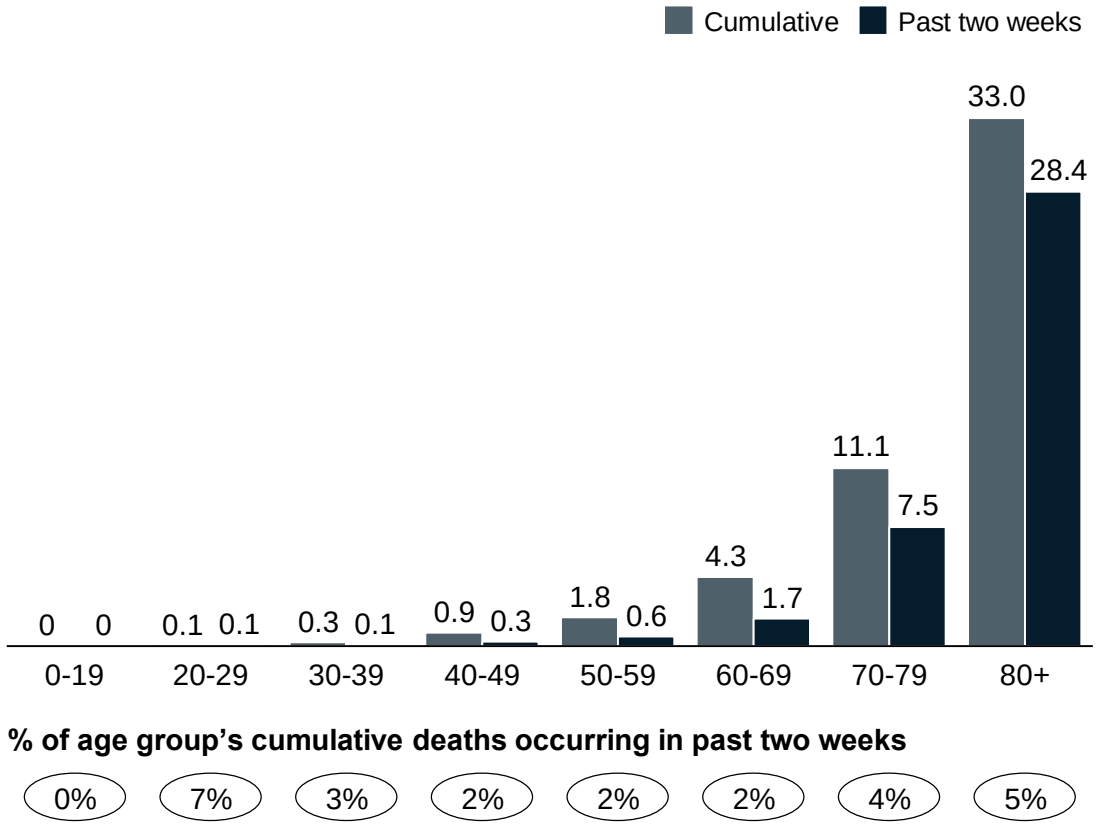
Obtained via MI FOIA by Judicial Watch, Inc.

Average daily new deaths per million people, by age group

Daily new confirmed and probable deaths per million by age group (7 day rolling average)



Average daily new confirmed and probable deaths per million by age group



% of age group's cumulative deaths occurring in past two weeks

0-19	20-29	30-39	40-49	50-59	60-69	70-79	80+
0%	7%	3%	2%	2%	2%	4%	5%

Note: Cases information sourced from MDHHS and reflects date of report

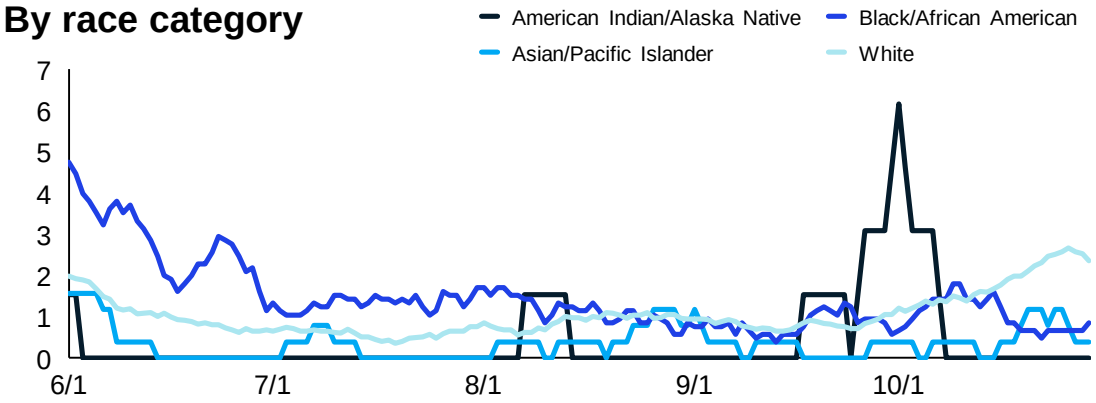
Source: MDHHS – Michigan Disease Surveillance System

Obtained via MI FOIA by Judicial Watch, Inc.

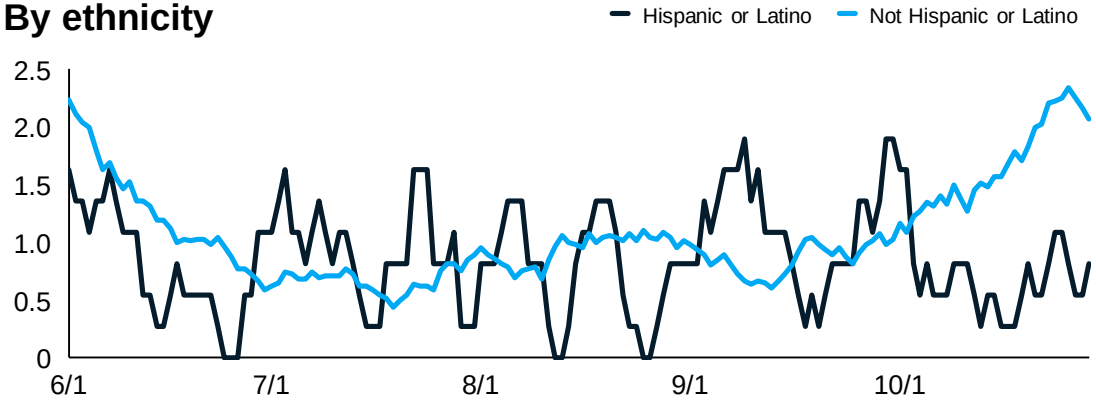
Average daily new deaths per million people by race and ethnicity

Daily new confirmed and probable deaths per million (7 day rolling average)

By race category

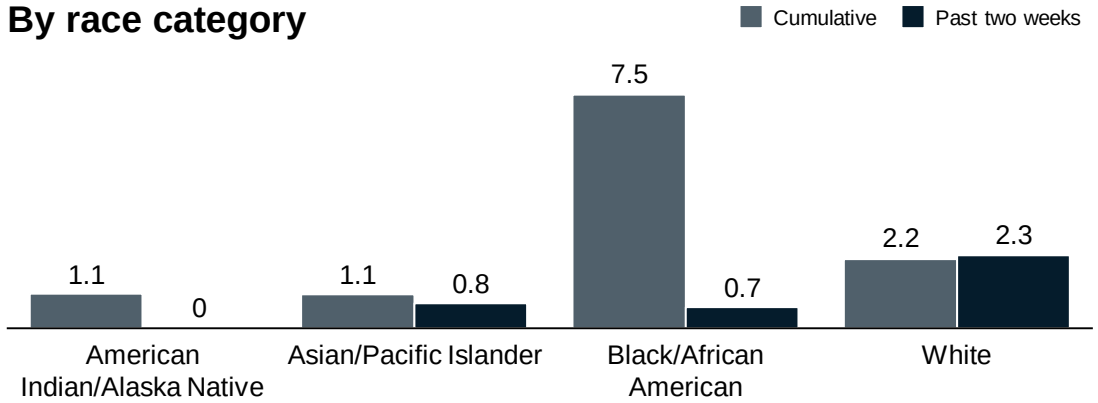


By ethnicity

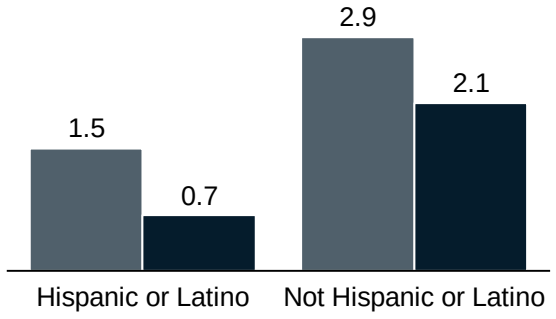


Average daily new confirmed and probable deaths per million by race category

By race category



By ethnicity



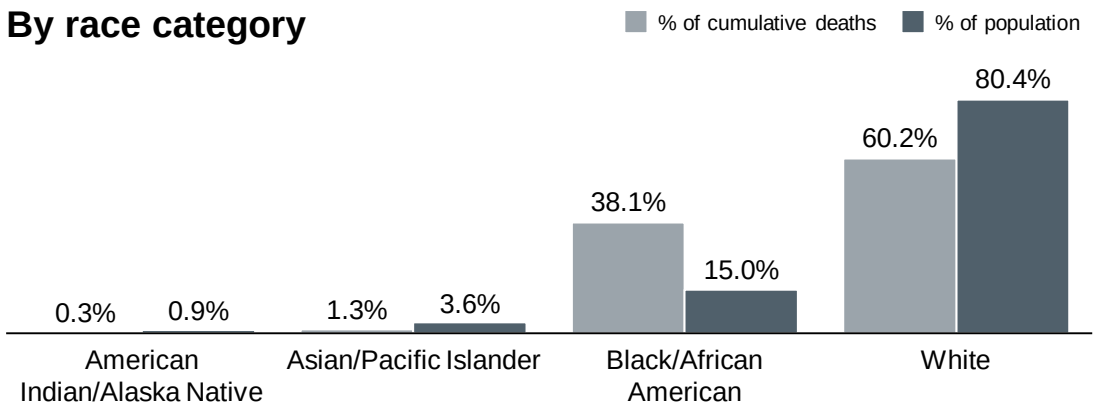
Note: Multiple Races, Other, and Unknown race/ethnicity are not included in calculations
Source: MDHHS – Michigan Disease Surveillance System

Obtained via MI FOIA by Judicial Watch, Inc.

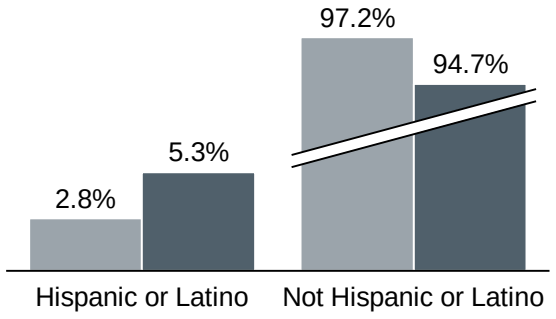
Deaths and population comparison by race and ethnicity

Cumulative confirmed and probable cases vs. population, % of total[1]

By race category

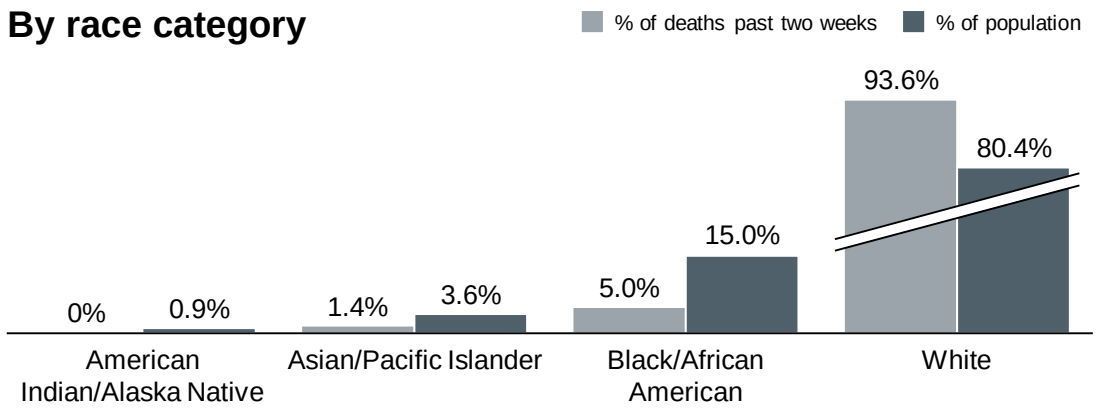


By ethnicity

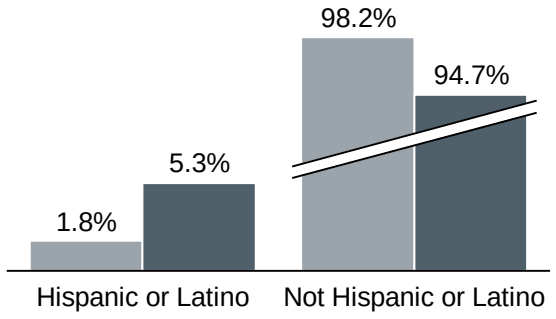


Past two weeks confirmed and probable cases vs. population, % of total[1]

By race category



By ethnicity



1. Calculations do not include deaths attributed to race and/or ethnicity categories Multiple Races, Other, or Unknown, as population sizes are not available for these

Note: Cases information sourced from MDHHS and reflects date of onset of symptoms

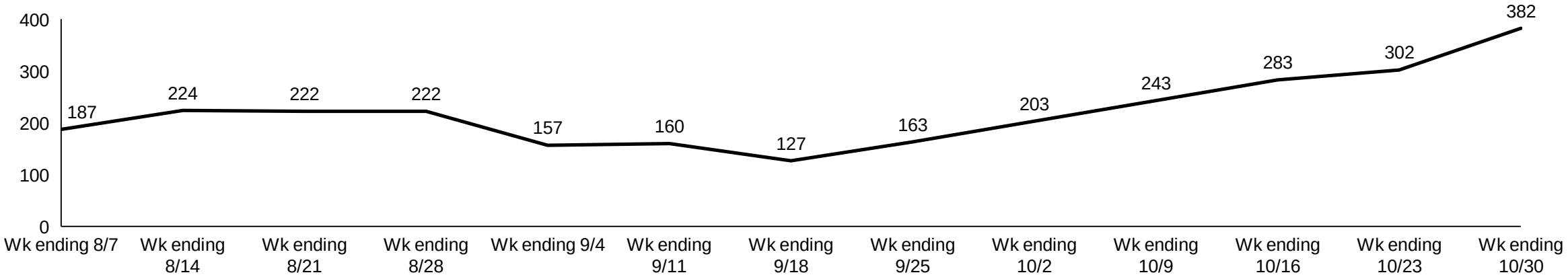
Source: MDHHS – Michigan Disease Surveillance System

Obtained via MI FOIA by Judicial Watch, Inc.

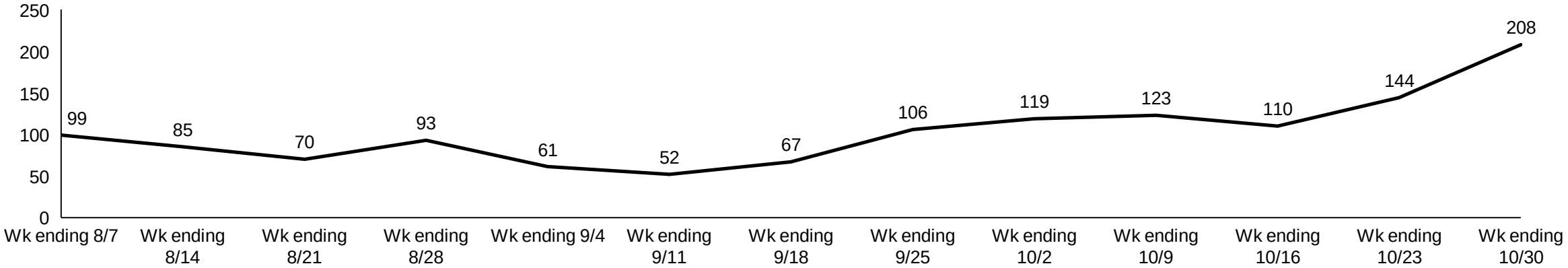
Weekly change in number of outbreaks – statewide

Pre-decisional, for discussion only **Draft**

Ongoing Outbreaks by Region – Weekly-over-Week



New Outbreaks by Region – Week-over-Week



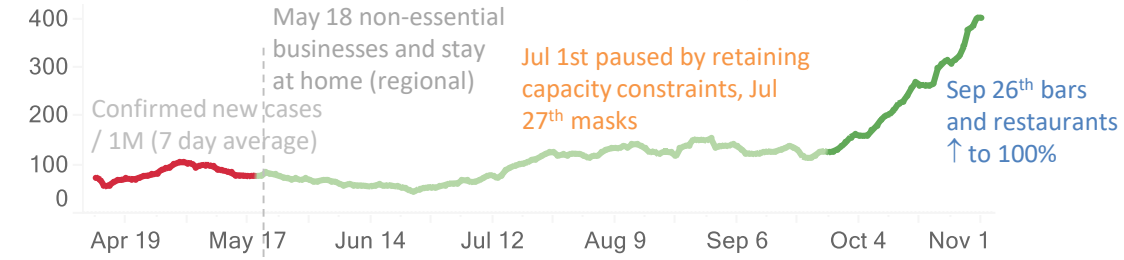
NOTE: Many factors, including the lack of ability to conduct effective contact tracing in certain settings, may result in significant underreporting of outbreaks. This chart does not provide a complete picture of outbreaks in Michigan and the absence of identified outbreaks in a particular setting in no way provides evidence that, in fact, that setting is not having outbreaks.

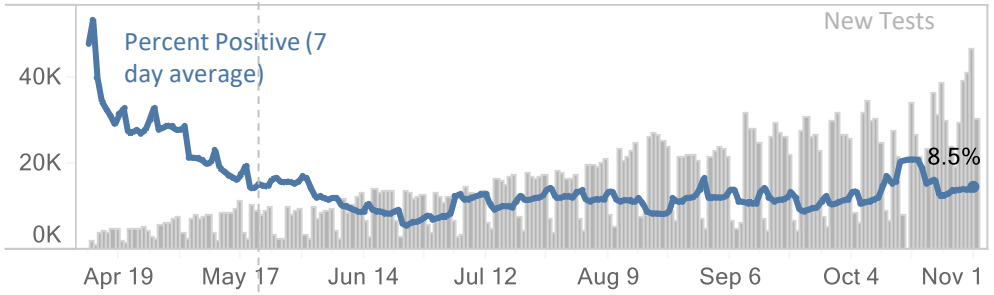
Source: LHD Weekly Sitreps

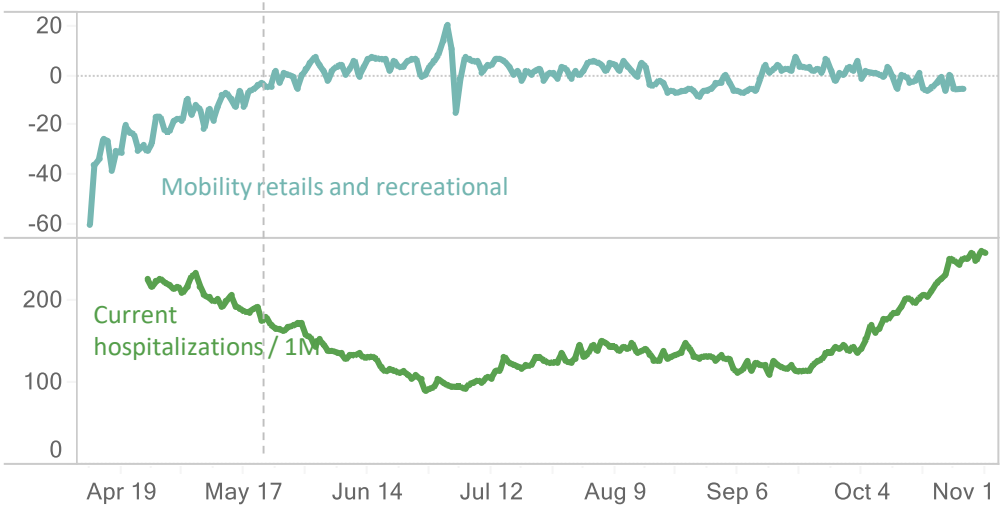
Obtained via MI FOIA by Judicial Watch, Inc.

Indiana and Wisconsin: Detailed examination

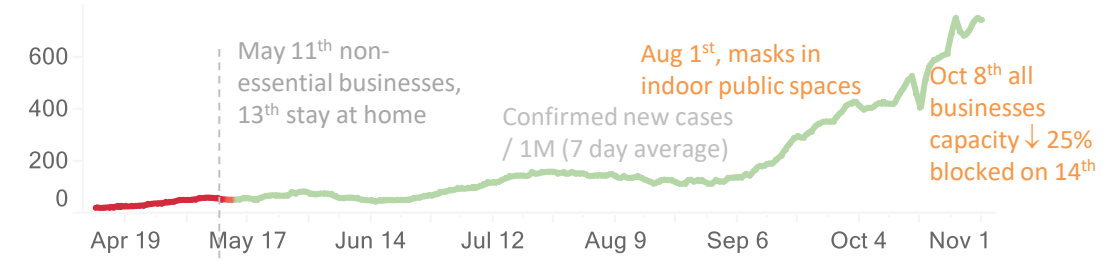
Indiana: relaxed on May 4th

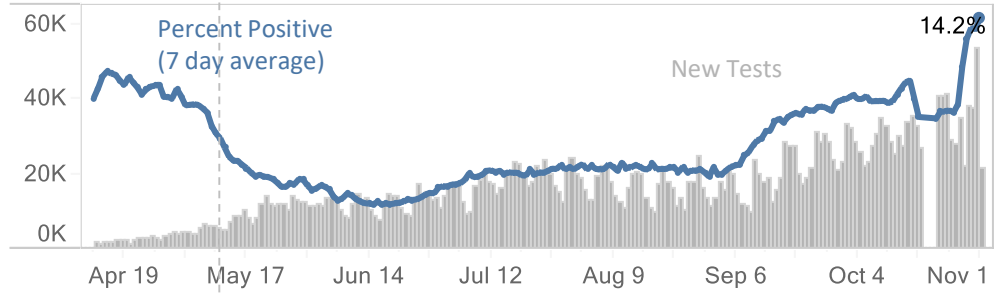






Wisconsin: Relaxed on May 11th



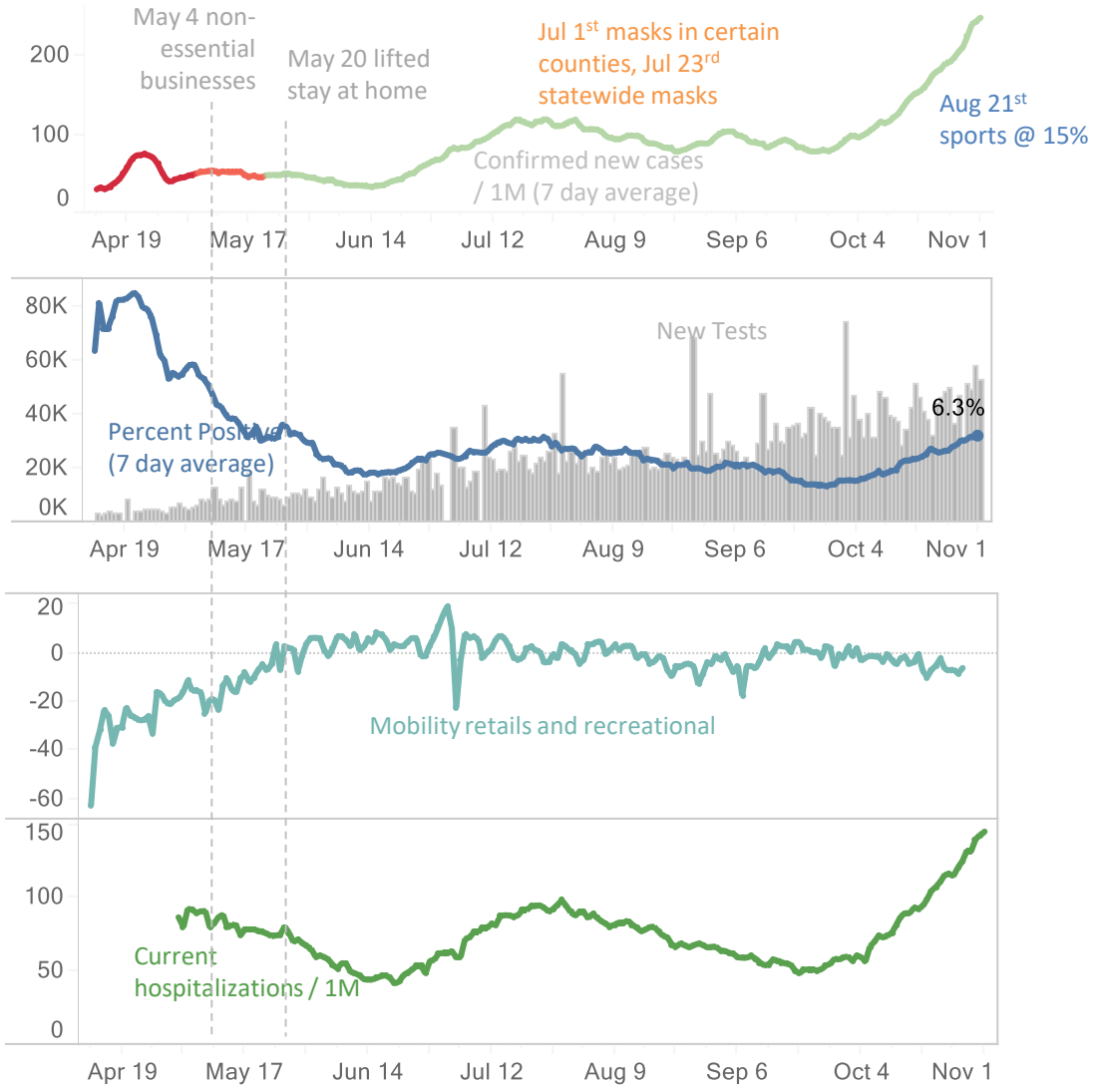




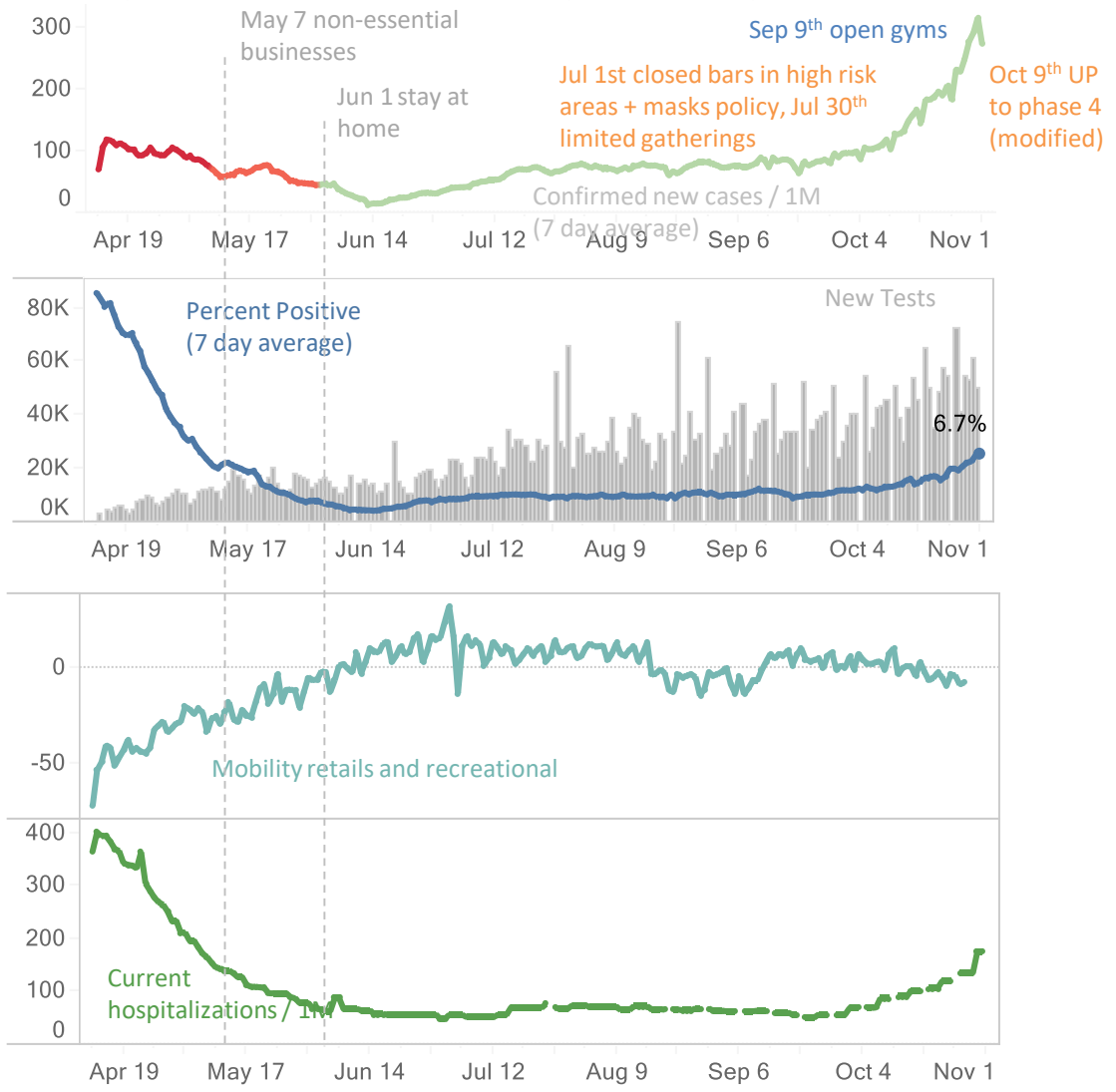
Obtained via MLFOIA by Judicial Watch, Inc.

Ohio and Michigan: Detailed Examination

Ohio: relaxed May 4th



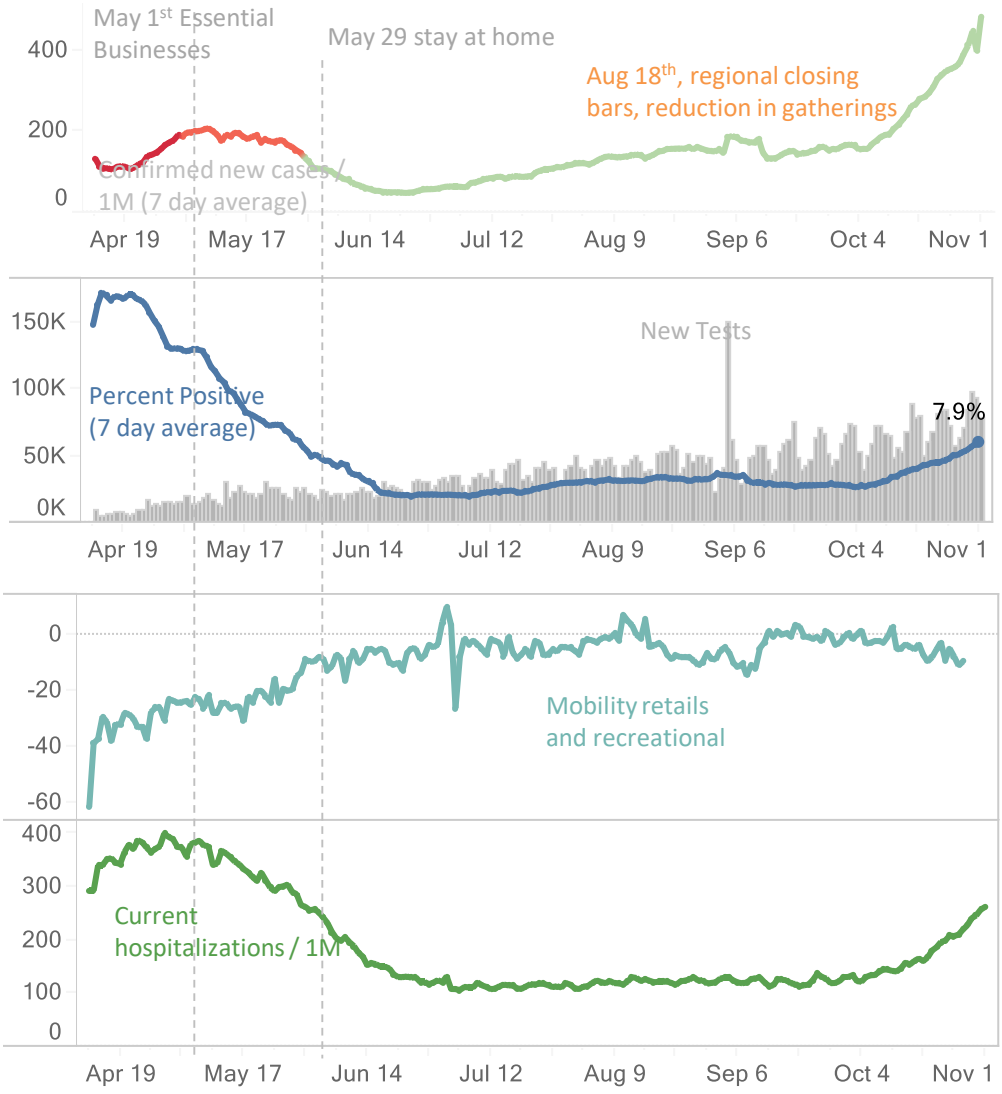
Michigan: Non-essential May 7th, Stay-at-home Jun 1st



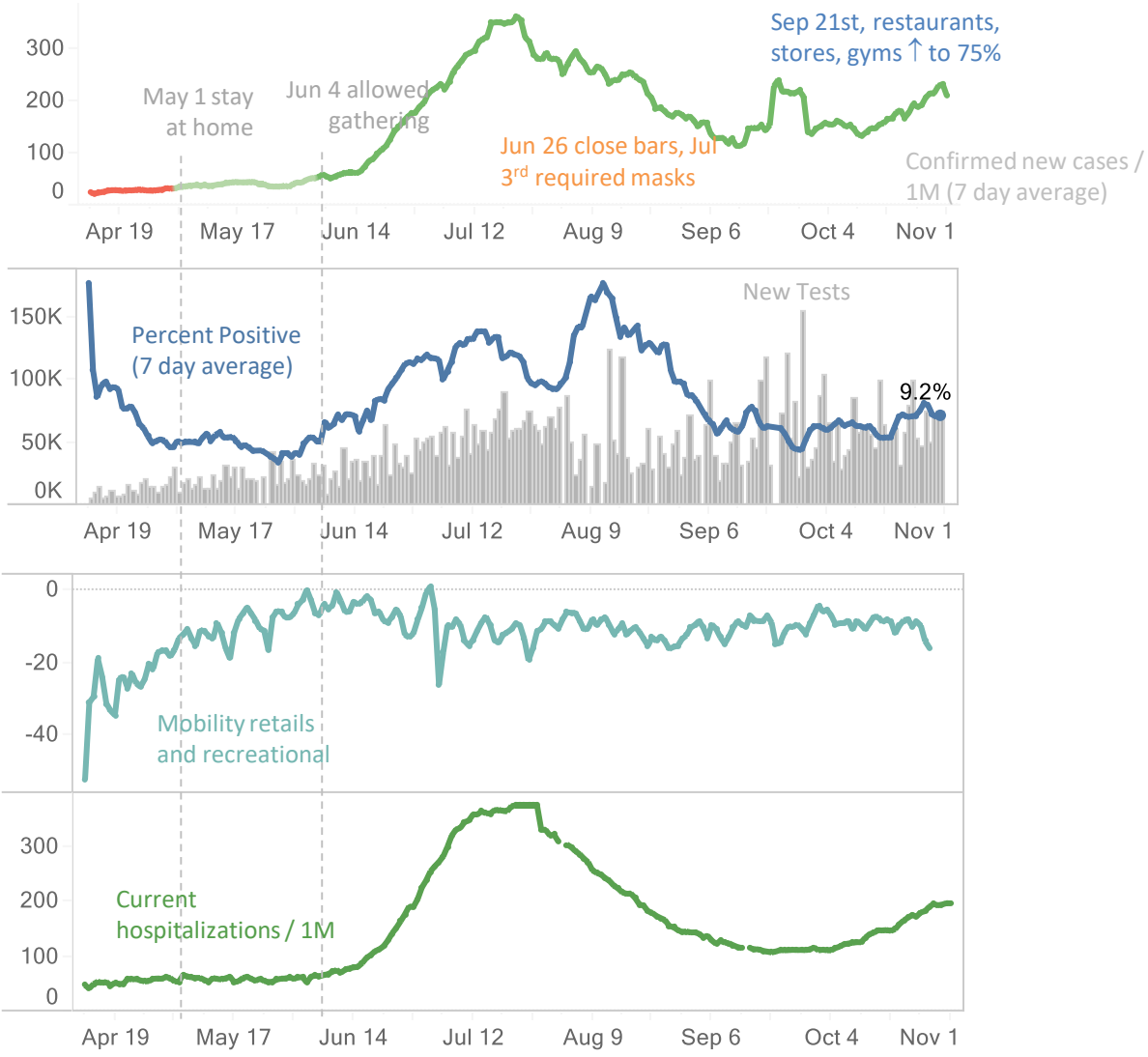
Obtained via MI FOIA by Judicial Watch, Inc.

Illinois and Texas: Detailed Examination

Illinois: relaxed May 1st and May 29th

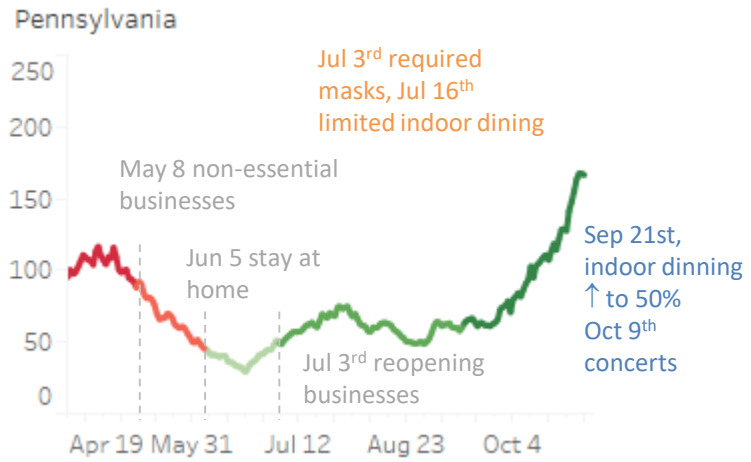


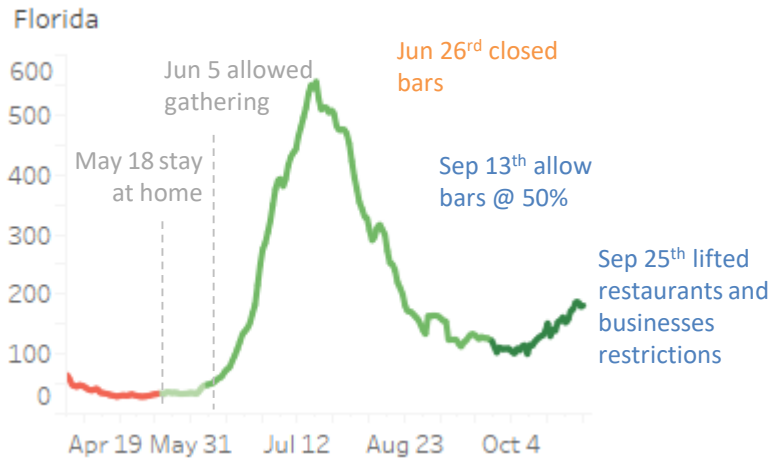
Texas: relaxed May 1st

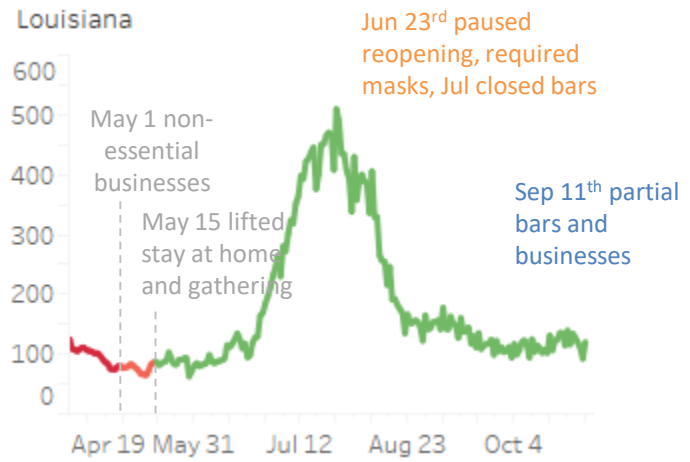


Obtained via MI FOIA by Judicial Watch, Inc.

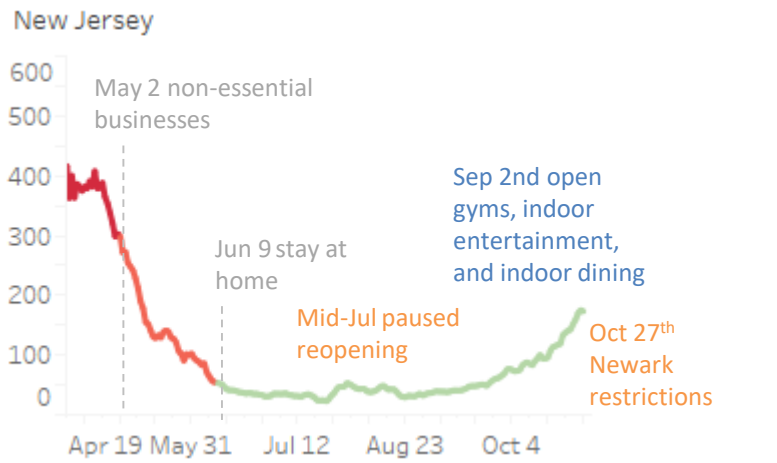
State Comparisons: 7 day avg. of daily new cases per 1M population

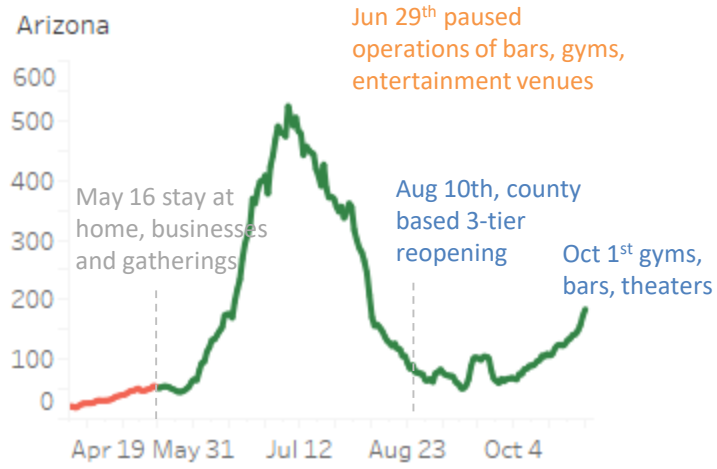










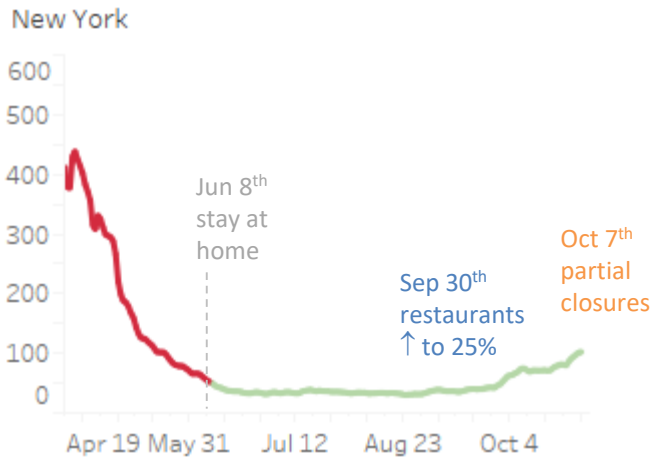


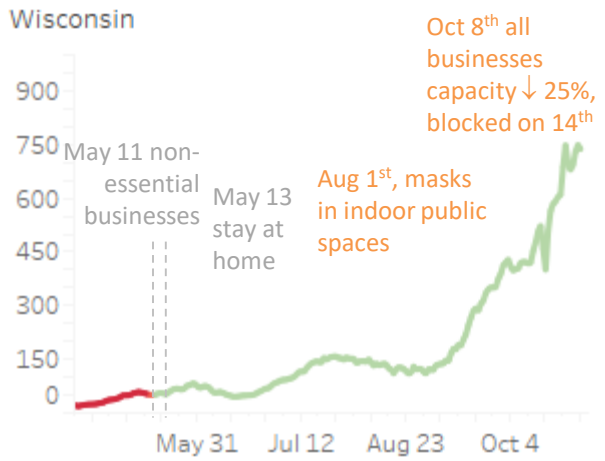
More interventions Less interventions

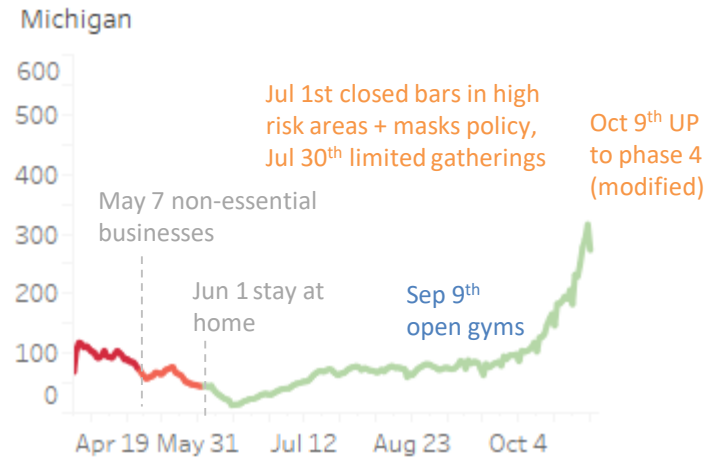
Updated Nov 2nd 2020

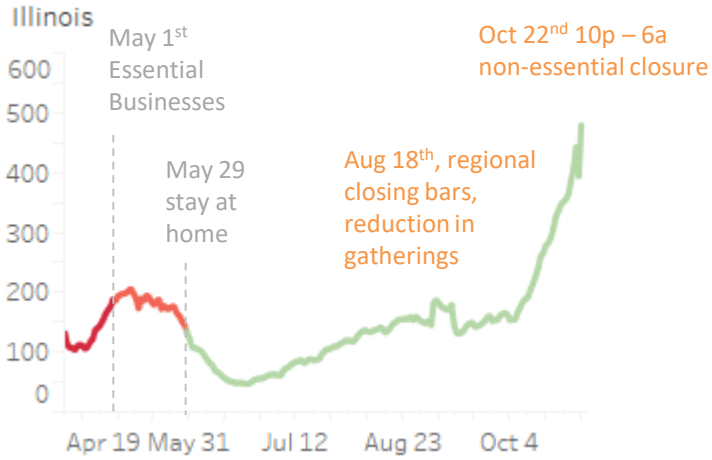
Obtained via MI FOIA by Judicial Watch, Inc.

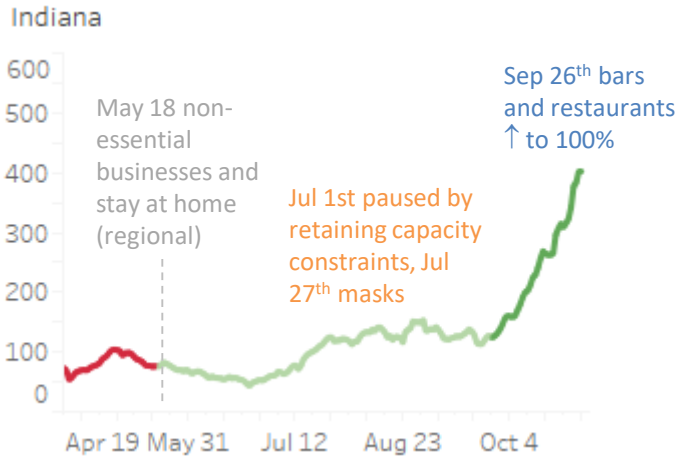
State Comparisons: 7 day avg. of daily new cases per 1M population

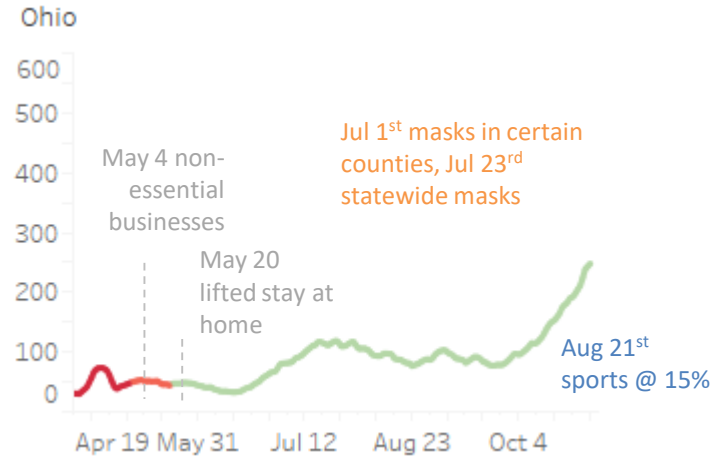










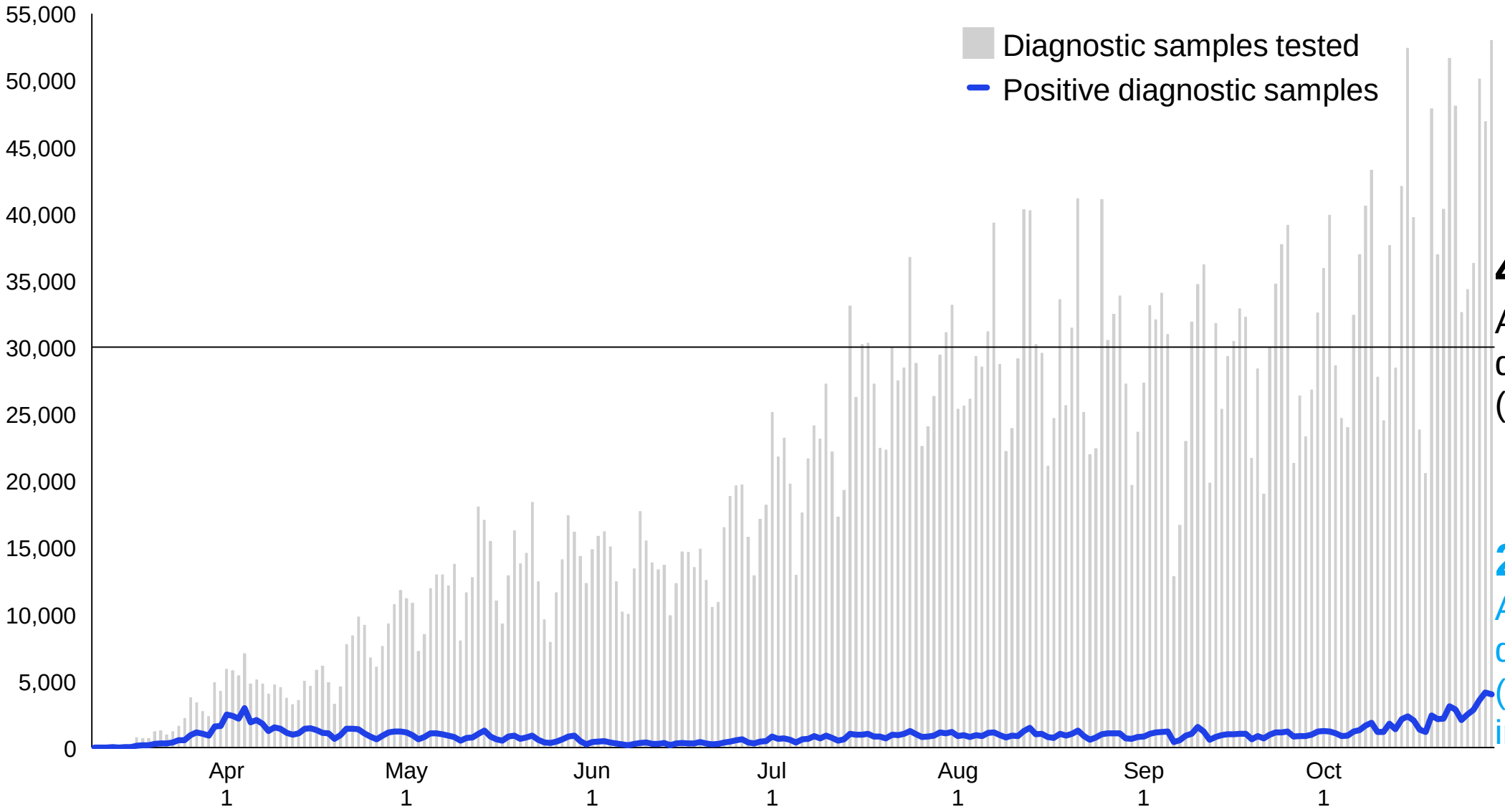


More interventions Less interventions

Updated Nov 2nd 2020

Daily diagnostic tests and positive diagnostic tests, by message date

Obtained via MIFOIA by Judicial Watch, Inc.



41,997
Average daily diagnostic tests (past week)

2,709 (6.5%)
Average positive diagnostic tests (past week, includes MDOC)

Source: MDSS/Michigan Medical Advantage Group, MDHHS, testing labs

Obtained via MI FOIA by Judicial Watch, Inc.

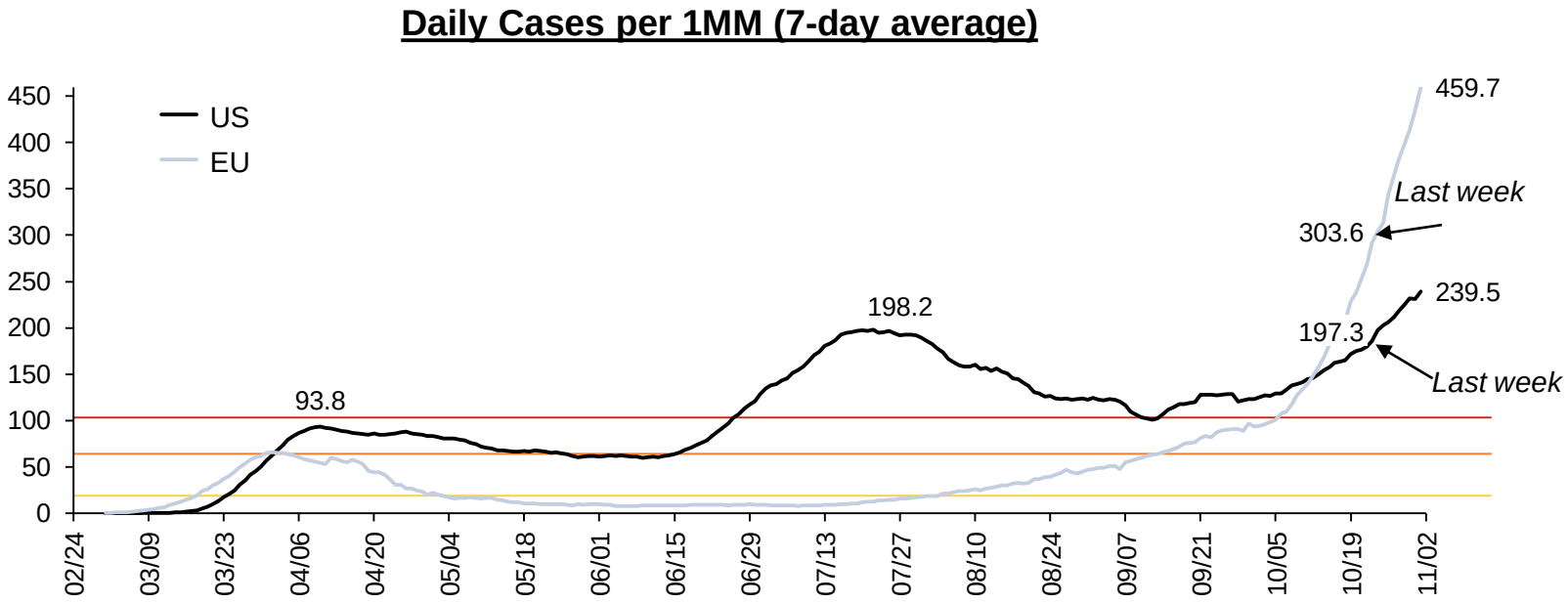
U.S. and European Union Update

Healthcare Advisory Group

November 3rd, 2020

Obtained via MI FOIA by Judicial Watch, Inc.

Europe is experiencing a serious fall second wave and continues its near vertical growth; the US reaches a new high in total cases

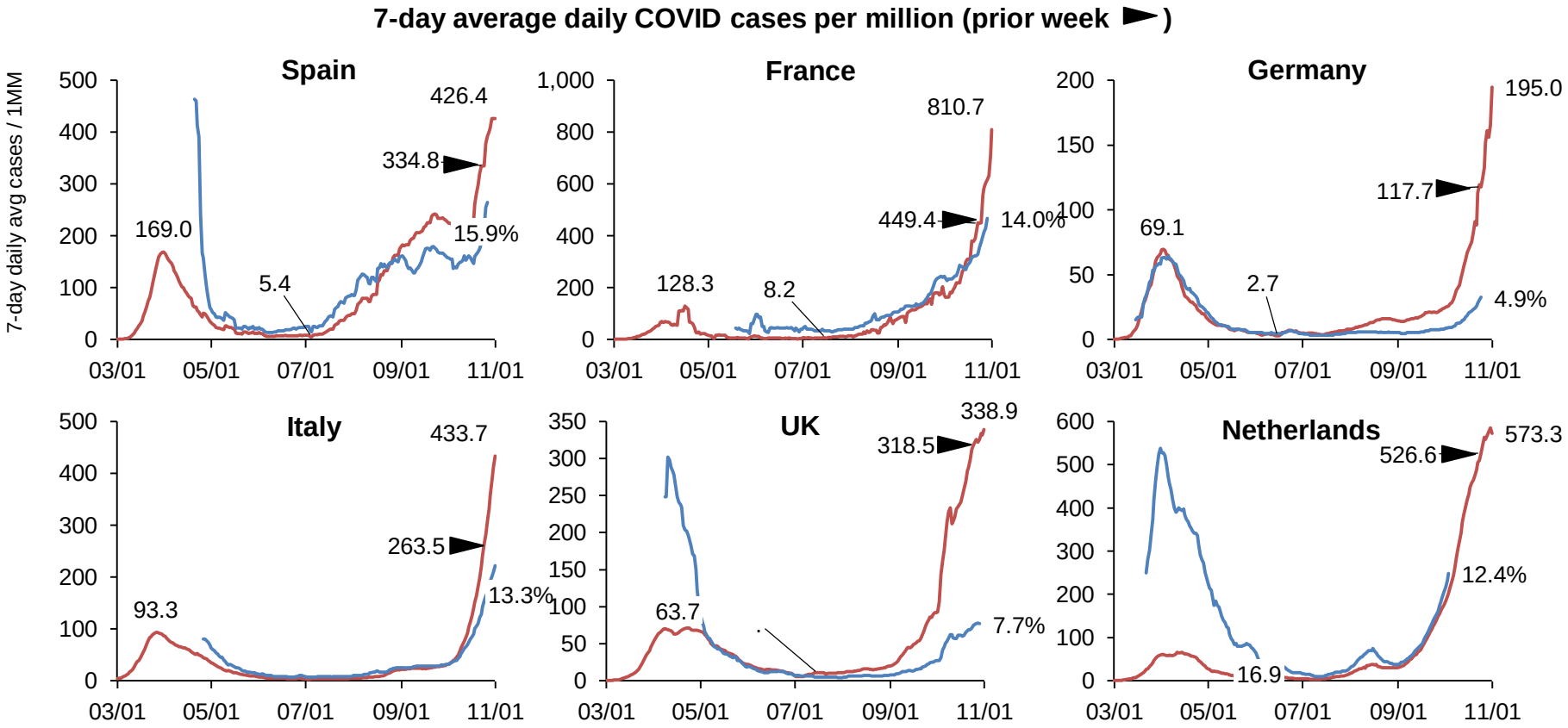


- Europe's case levels have increased 50% in the last week, continuing a significant surge
  - The increase has been seen across the continent, and shows no signs yet of slowing
  - The UK imposed a 4-week partial lockdown similar to those undertaken last week by France and Germany
- U.S. cases continue to reach new highs

1. Source: John Hopkins reporting for all regions, including MI, and based on daily cumulative reporting; daily new cases per 1MM people is shown as a rolling 7-day average

Obtained via MI FOIA by Judicial Watch, Inc.

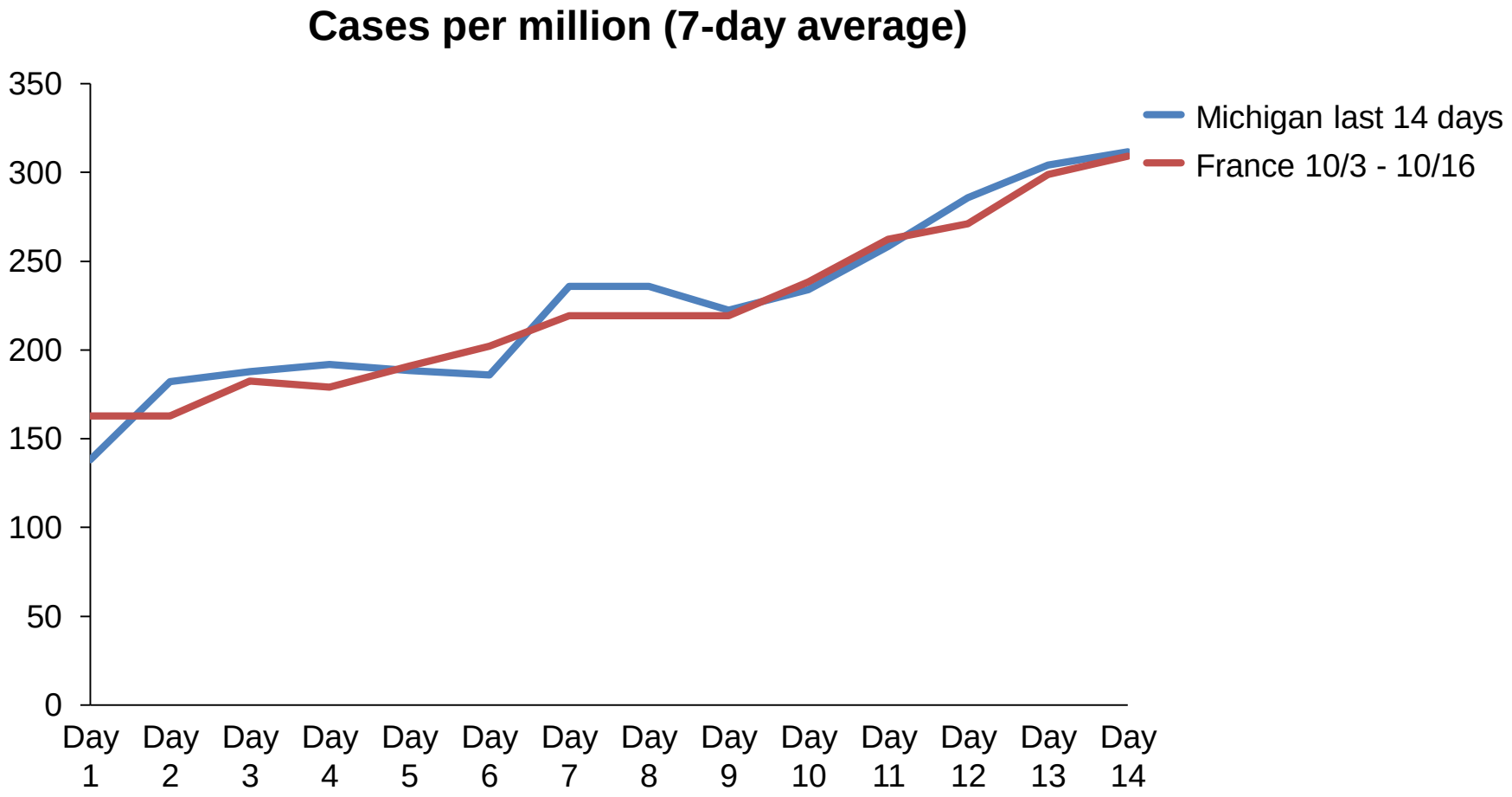
Nearly all European countries continue to experiencing rapid growth trajectories over the past week



- France continues to be the highest cases per million among major EU countries
- France (80%), Germany (66%), and Italy (65%) experienced the biggest percentage increases over the past week

Obtained via MI FOIA by Judicial Watch, Inc.

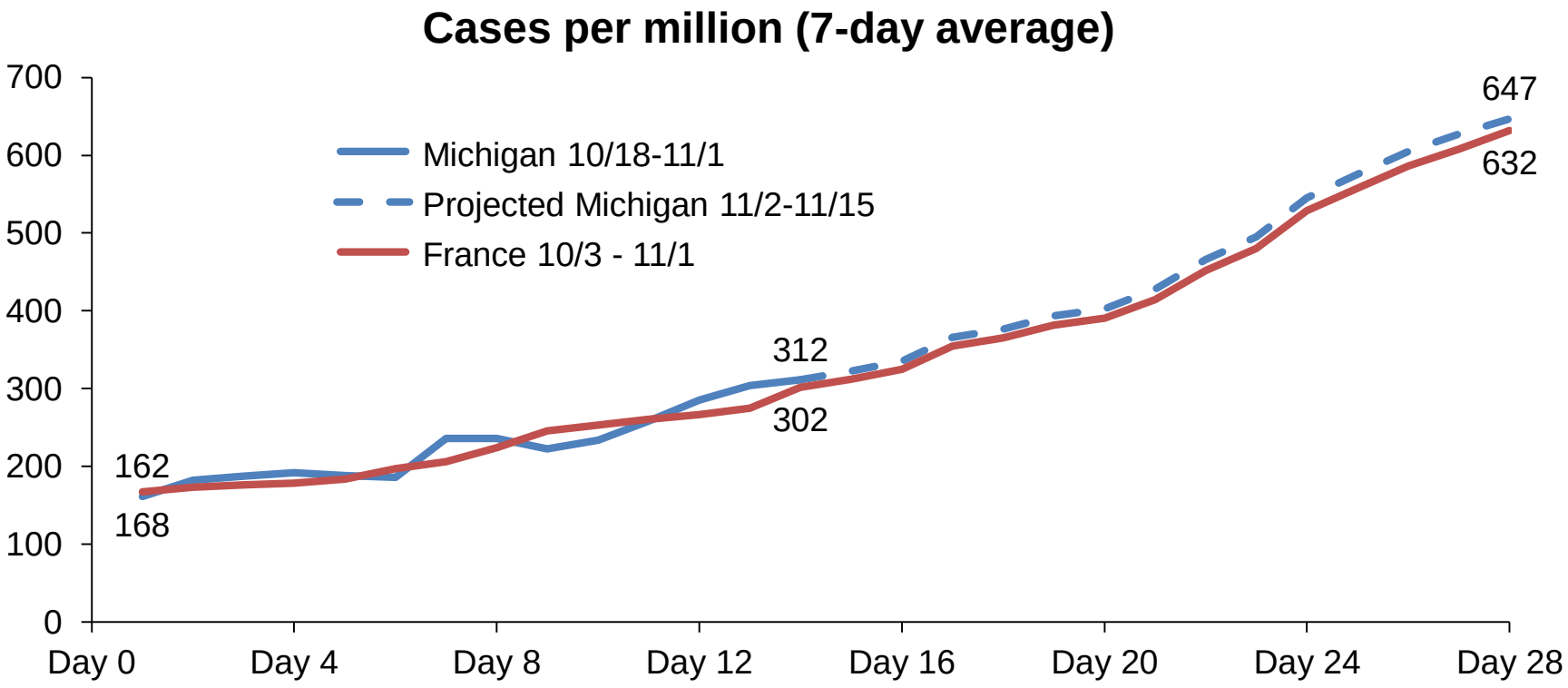
Michigan's case experience in the last 14 days closely tracks France's trajectory from ~2 weeks earlier



1. Source: John Hopkins and Our world in Data reporting for all regions, including MI, and based on daily cumulative reporting; daily new cases per 1MM people is shown as a rolling 7-day average

If Michigan were to continue to track France's trajectory over the coming 2 weeks, case levels would more than double to nearly 650 per million

Obtained via MI FOIA by JudicialWatch, Inc.



Doing everything we can to slow the growth rate over the next two weeks will be critical

1. Source: John Hopkins and Our world in Data reporting for all regions, including MI, and based on daily cumulative reporting; daily new cases per 1MM people is shown as a rolling 7-day average

Obtained via MI FOIA by Judicial Watch, Inc.

Over the week, Germany, France, and the UK have imposed partial lockdowns for 4 weeks

Restriction	Germany	France	United Kingdom
Length of initial restrictions	4 weeks	4 weeks	4 weeks
Restaurants, bars, nightclubs	Open for take-out only	Open for take-out only	Open for take-out only
Leisure businesses (gyms, theaters, etc.)	Closed	Closed	Closed
Gathering sizes	10 individuals	No gatherings	No gatherings
Personal services (barbers, hairdressers, etc.)	Open with protocols	Closed	Closed
Retail	Open with protocols	Non-essential closed	Non-essential closed
Schooling	Open with protocols	High school closed	Open with protocols
Manufacturing/ construction	Open with protocols	Open with protocols	Open with protocols

All these countries have committed stimulus funding to affected businesses

1. Source: Press research

Other countries across the continent have imposed a range of restrictions as well, although none have reverted to broad economic lockdowns

Obtained via M [illegible] Social Media, Inc.

- **Italy**: Cinemas, theaters, swimming pools and gyms are closed. Bars and restaurants must close at 6PM, and consuming food and drinks in public is banned after 6PM. Gatherings for large events, weddings, baptisms, and funerals are banned. Distance learning will be deployed in high schools (or 25% capacity); elementary school will continue in person.

- **Ireland:** Individuals can not travel outside of 5km from their home except for essential work. Bars and restaurants are only open for takeout. Non-essential retail and personal services are closed. No social gatherings are allowed (one other family allowed in bubble). Manufacturing and schools remain open.

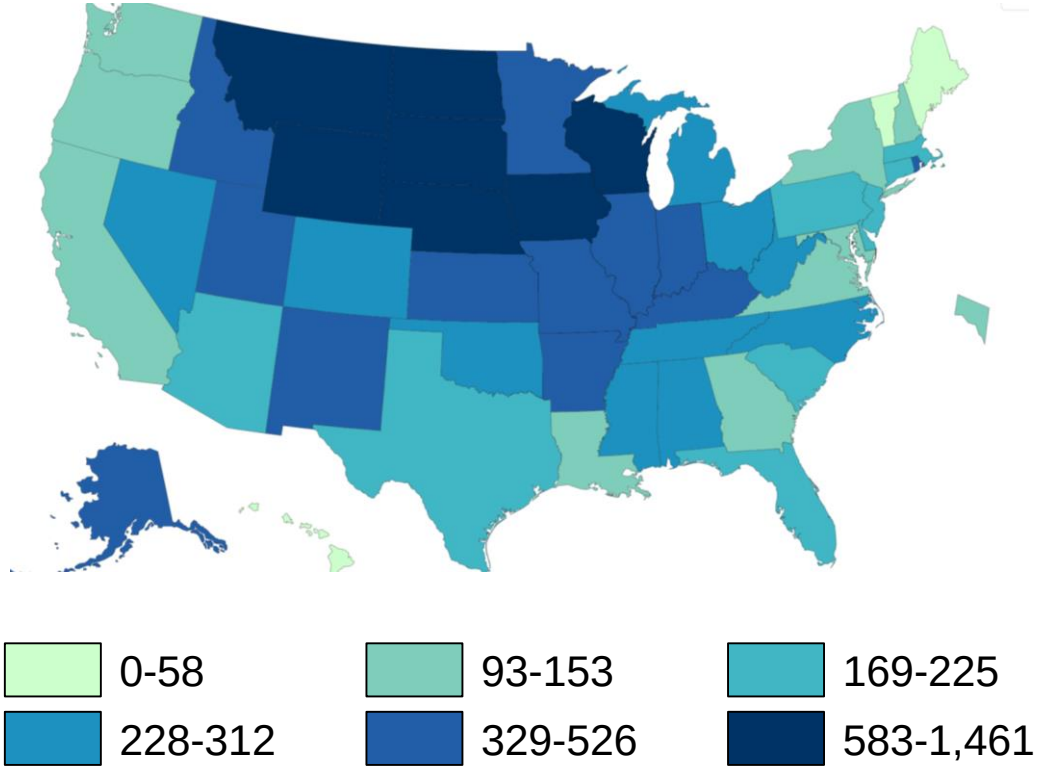
- **Spain** announced a country-wide, state of emergency, including a curfew of 11PM and travel restrictions between regions.

1. Source: Press research

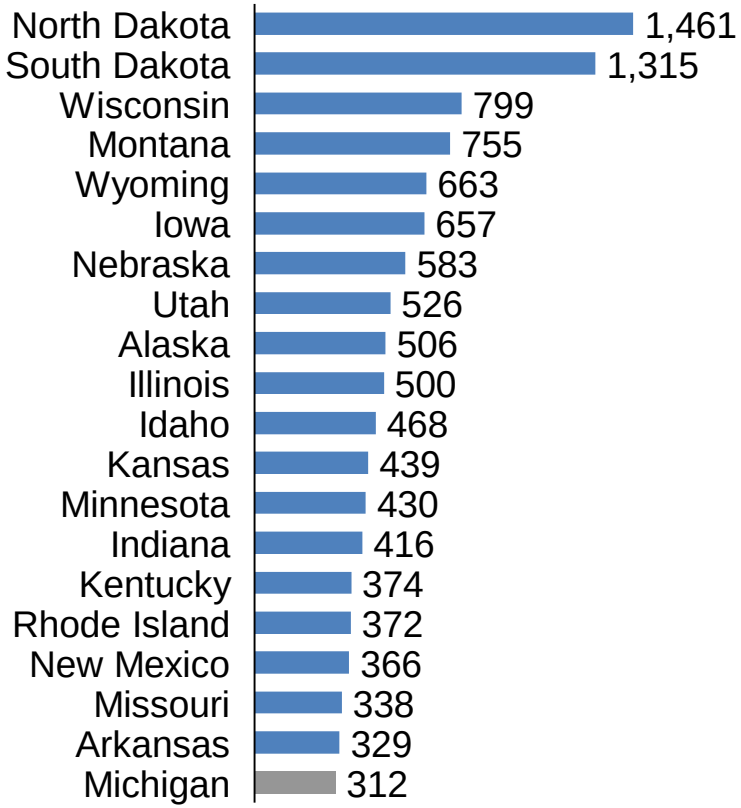
Obtained via MI FOIA by Judicial Watch, Inc.

The US is seeing its most intense case growth across states in the northern portions of the West and Midwest

US 7-day average daily COVID cases per million (map)



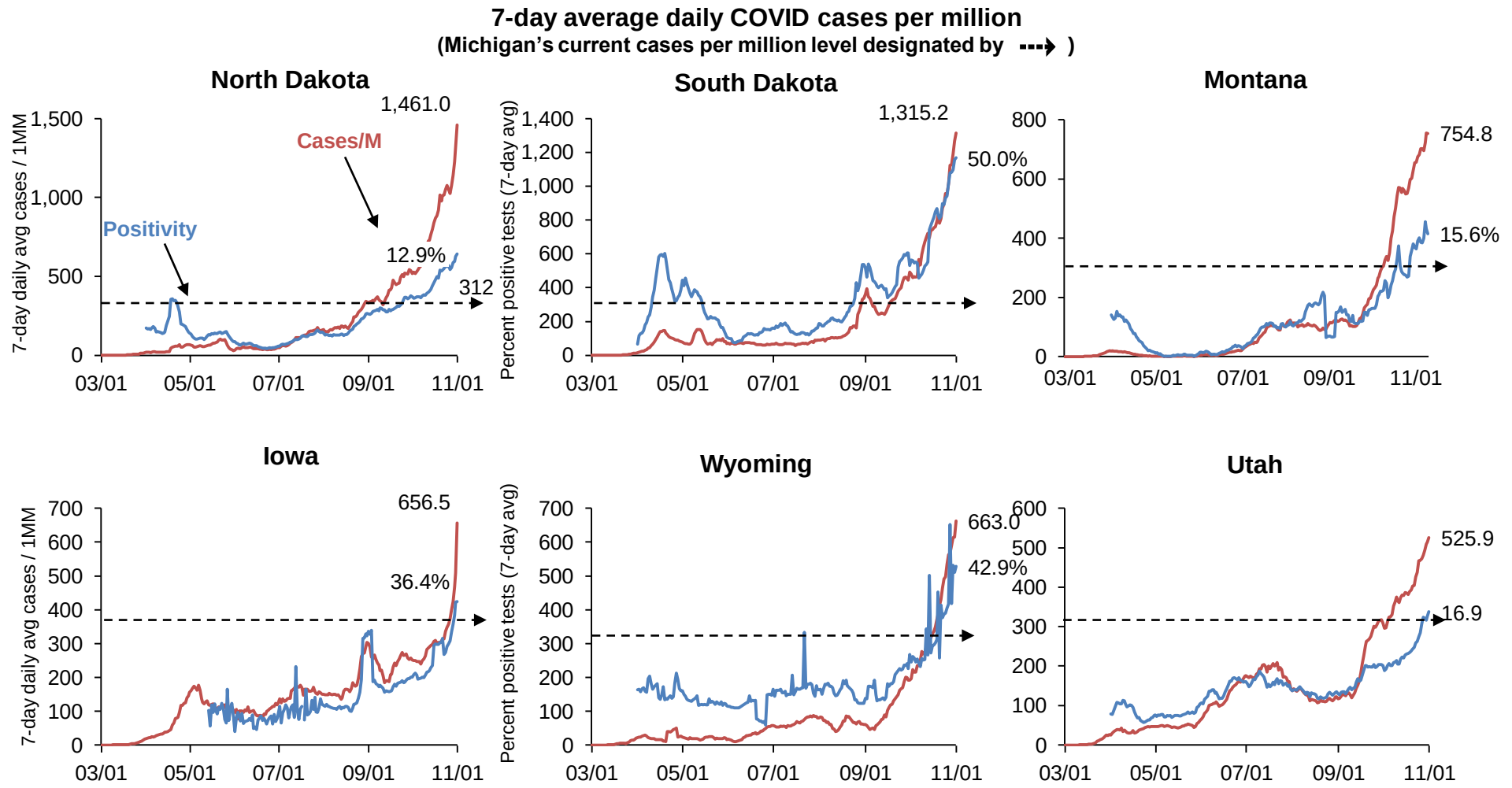
7-day average daily COVID cases per million (top 20 states)



1. Centers for Disease Control

Obtained via MI FOIA by Judicial Watch, Inc.

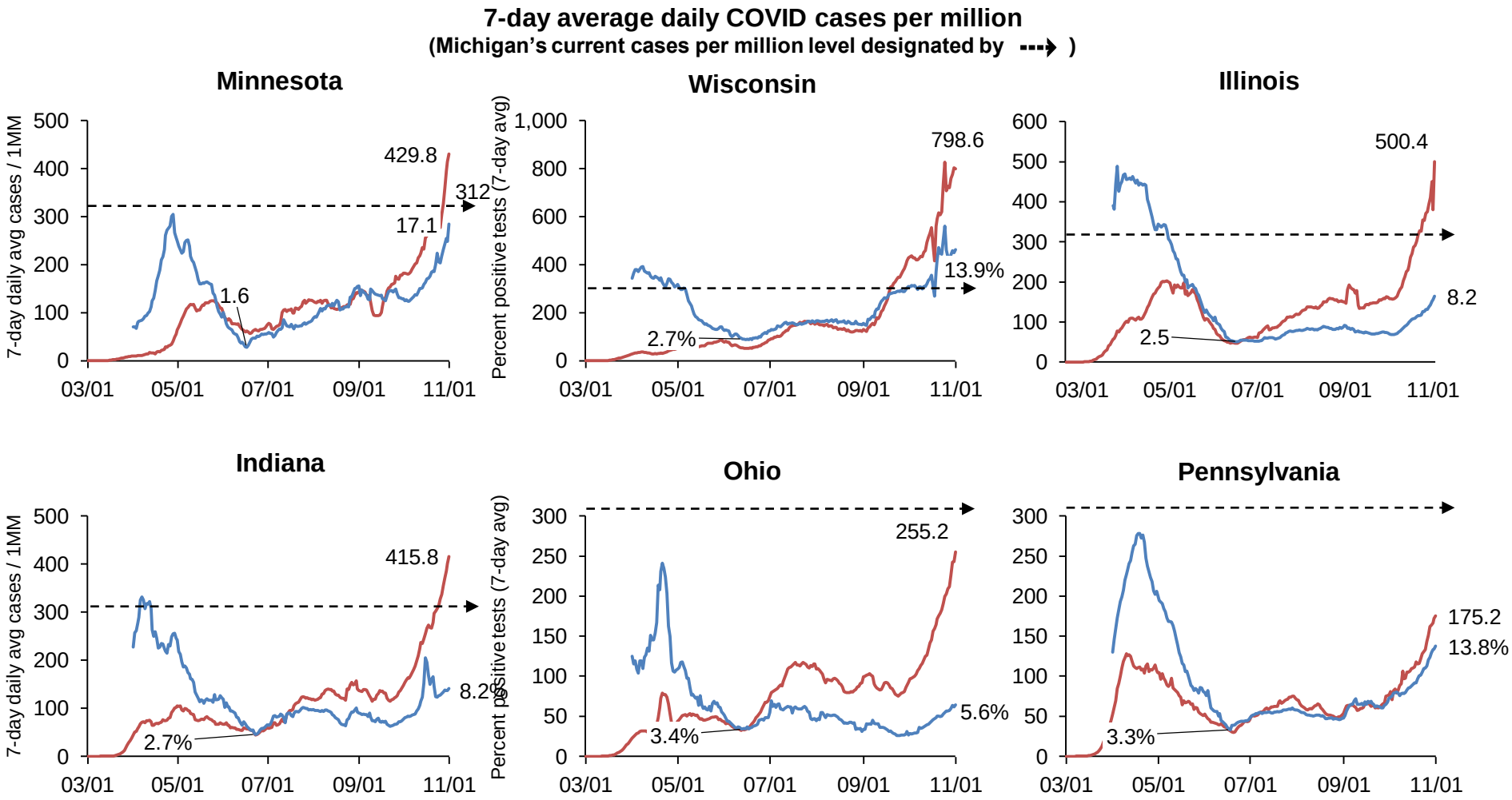
The states we have been following for some time continue to see extremely high cases per million and positivity rates



Source: John Hopkins and Covidexitstrategy reporting for all regions, including MI, and based on daily cumulative reporting; daily new cases per 1MM people is shown as a rolling 7-day average

Obtained via MI FOIA by Judicial Watch, Inc.

We continue to see rapid increases in nearly all of our Great Lakes peer states; Pennsylvania and Ohio are the best performers



Source: John Hopkins and Covidexitstrategy reporting for all regions, including MI, and based on daily cumulative reporting; daily new cases per 1MM people is shown as a rolling 7-day average

Obtained via MI FOIA by Judicial Watch, Inc.

States have had a variety of reactions to this increase in cases

- **No statewide restrictions:** *Wisconsin, South Dakota, Indiana, Montana* – all states with high and rapidly growing case levels – have no statewide restrictions. Some localities (e.g. Milwaukee and Indianapolis) have imposed gathering restrictions, and/or occupancy limits on bars/restaurants and event spaces
- **Restrictions similar to Michigan's**: *Wyoming, Utah, Ohio, Pennsylvania and Minnesota* have restrictions similar to Michigan (10-person in-home gathering limits, occupancy limits on bars, restaurants, and other event spaces – with defined caps between 250 and 1,000)
  - Note: Michigan recently capped indoor gatherings at 50, unless there is fixed seating which allows 500
- **Stronger restrictions than Michigan :** *Idaho and North Dakota* do not allow indoor gatherings of more than 50 people, regardless of venue size.
- **Localized shutdowns**: *Illinois* has taken the strictest approach in the Great Lakes, closing bars and restaurants in Chicago – and indoor gatherings are capped at 25 people regardless of venue size

1. Source: Press research

Obtained via MI FOIA by Judicial Watch, Inc.

Causes of COVID-19 Outbreaks and MERC Next Steps

November 3rd, 2020

Obtained via MI FOIA by Judicial Watch, Inc.

Executive Summary

What has caused recent spikes is not fully known, but signs point to more unprotected indoor gatherings driven by:

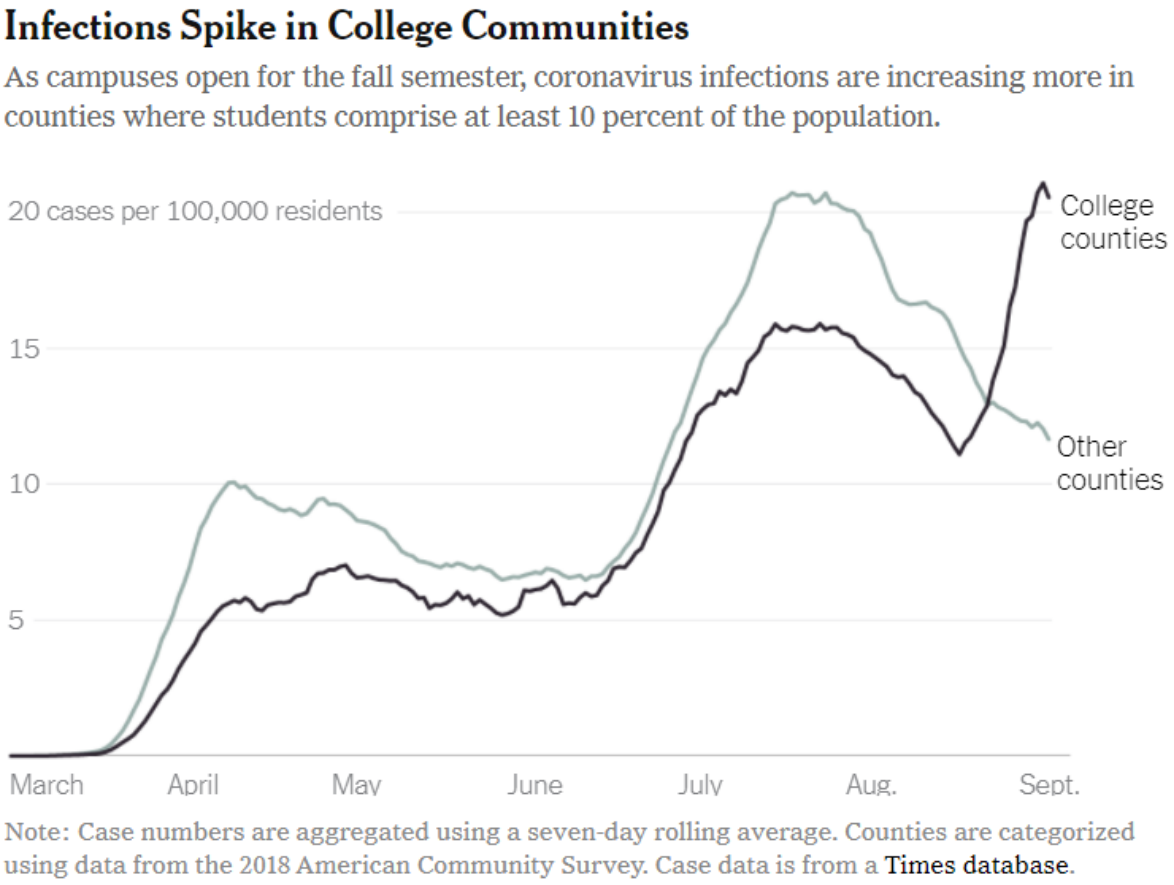
- College students returning to campus
- Shifts in weather patterns moving gatherings inside (too hot or too cold)
- Long periods of discipline resulting in “behavioral fatigue”

What causes these spikes to subside is also not fully known

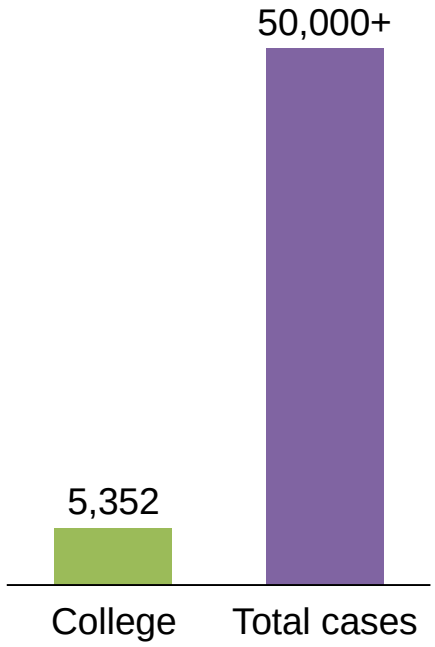
- Recently, states and countries have tried a variety of tactics including gathering limitations, restrictions on bars/restaurants/theaters etc., and other local/regional restrictions
- Spikes tend to come down rather steeply; this leads us to hypothesize that there is a combined, reinforcing effect of the government restrictions and the intense reaction to the spike itself that produces improved behaviors (masking, social distancing, etc.)

The NY Times previously reported that the return to campuses drove an initial spike in cases, and Michigan has seen this firsthand as ~10% of our cases have been college related since September

Obtained via FOIA by Judicial Watch, Inc.



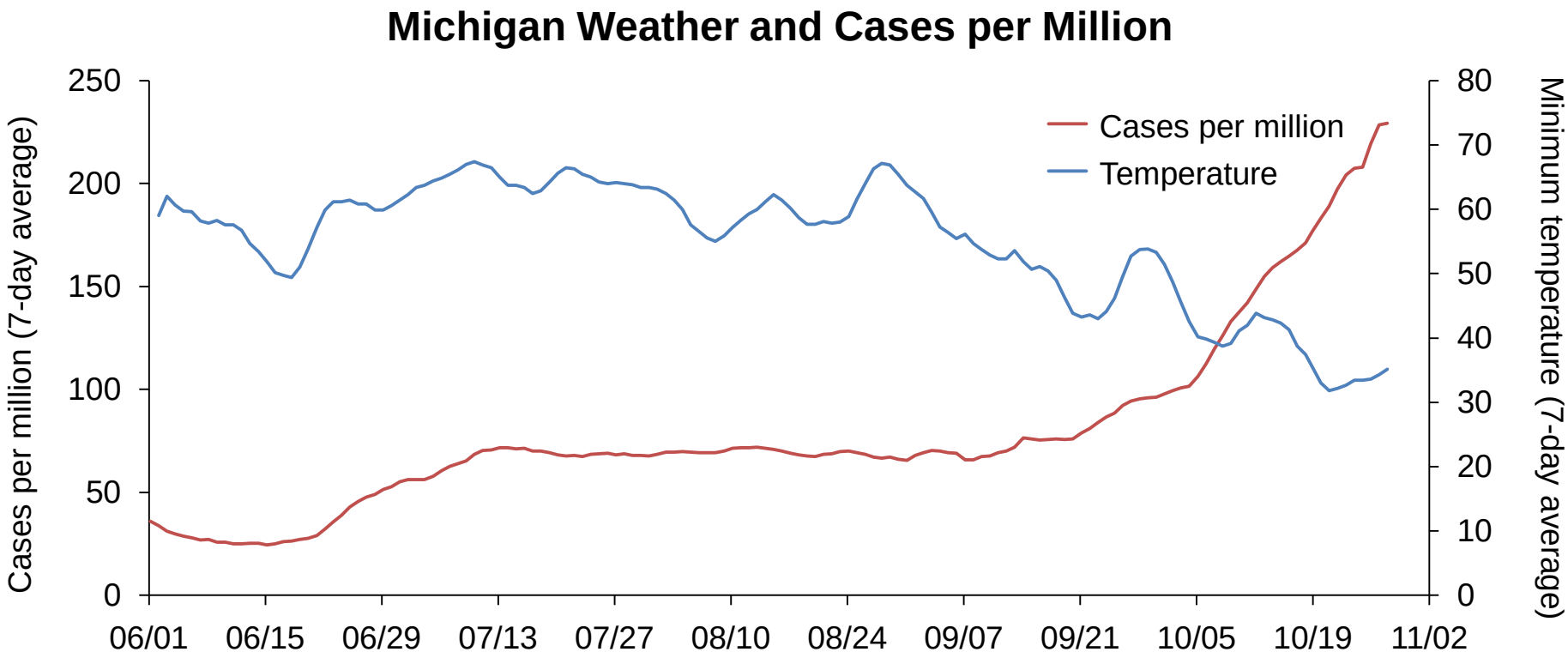
Cases since September 1st



1. NY Times

Obtained via MI FOIA by Judicial Watch, Inc.

Michigan's 2nd wave has also been correlated with falling temperatures

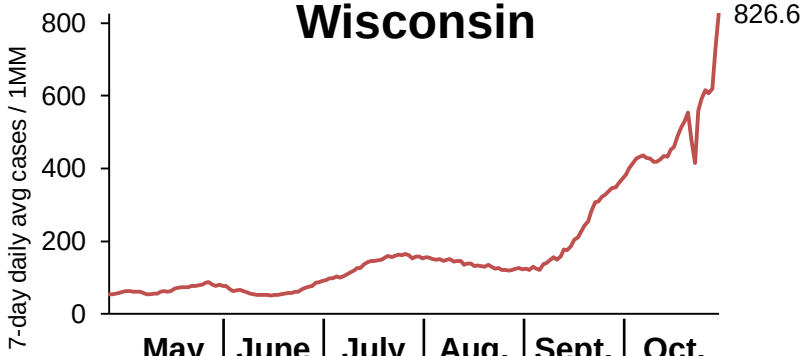


Source: MI Start Map, accuweather.com

Obtained via MI FOIA by Judicial Watch, Inc.

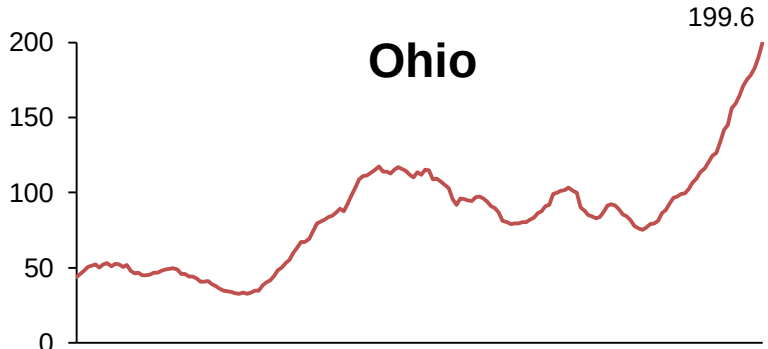
This weather relationship has been seen recently in other Midwest states – as well as in the Sun-belt states in June and July

Wisconsin



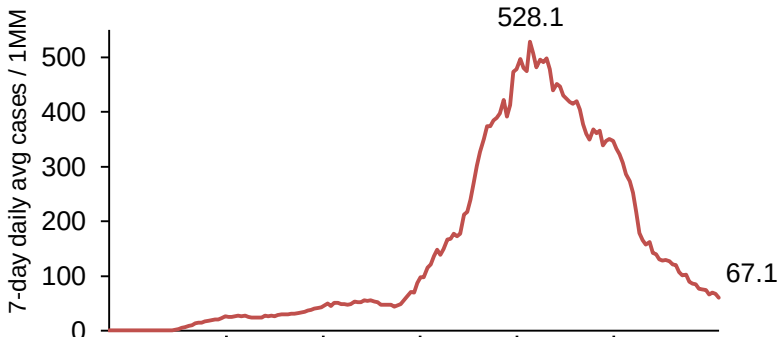
	May	June	July	Aug.	Sept.	Oct.
Avg. Lo Temp	57	66	60	49	36	

Ohio



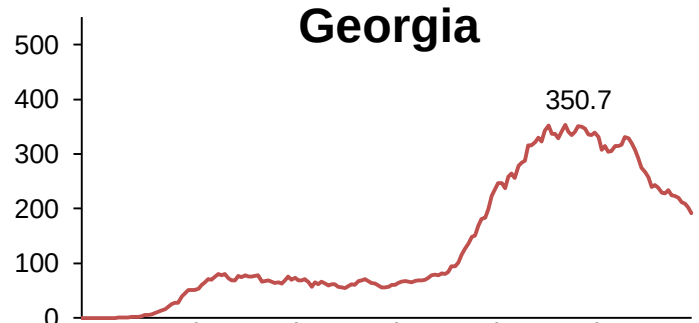
	May	June	July	Aug.	Sept.	Oct.
Avg. Lo Temp	63	68	66	58	44	

Arizona



	March	April	May	June	July	Aug.
Avg. Hi Temp	86	94	104	106	110	

Georgia



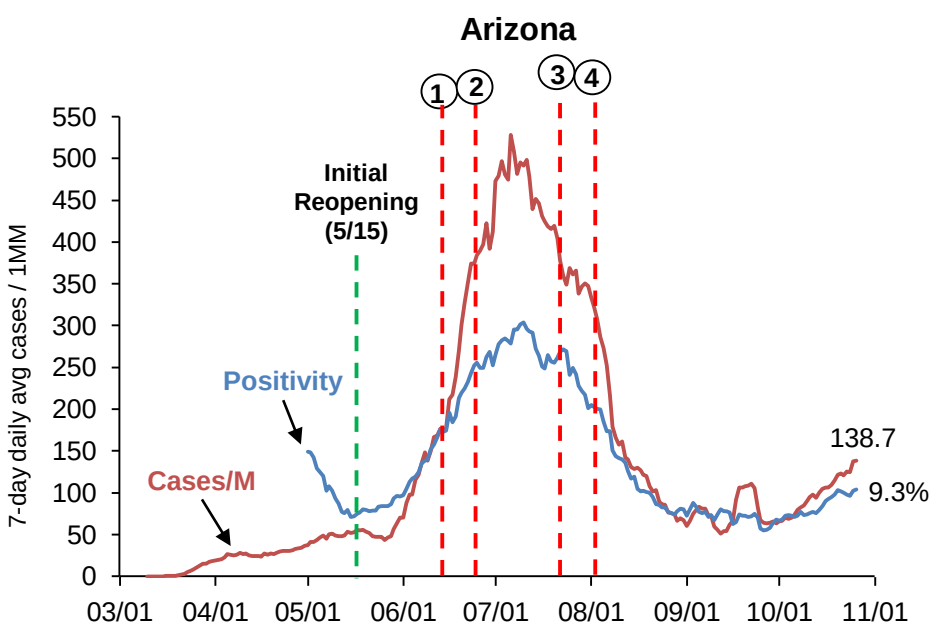
	March	April	May	June	July	Aug.
Avg. Hi Temp	72	78	85	90	91	

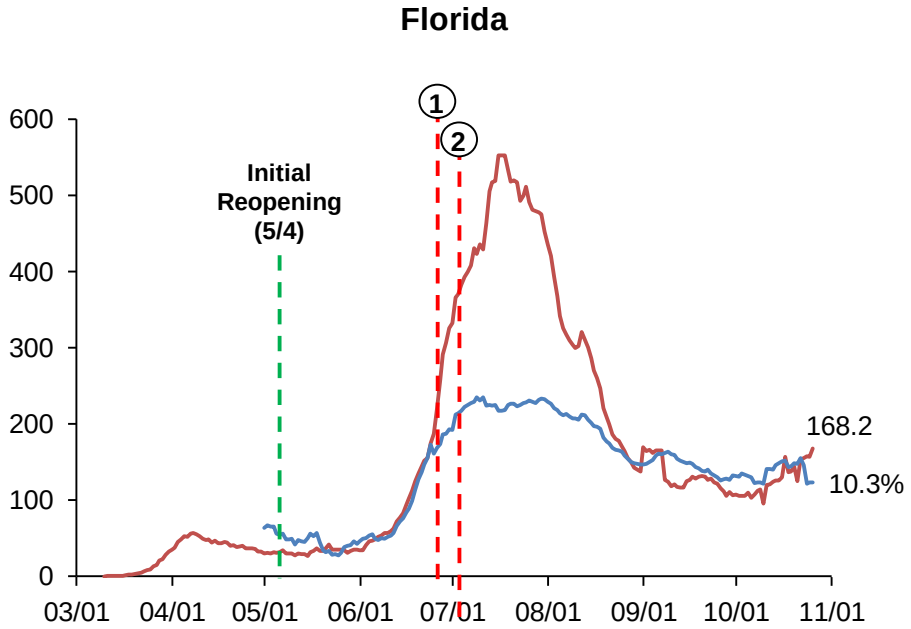
1. Johns Hopkins and accuweather.com

Obtained via MI FOIA by Judicial Watch, Inc.

The Sun-belt waves dissipated due to a combination of state and local responses and improved behaviors

7-day average daily COVID cases per million





① Maricopa county (Phoenix) institutes mask mandate

② Statewide ban on large gatherings; no new event licenses; paused the operations of bars, gyms, movie theaters, waterparks and tubing rentals; delayed school start.

③ Extension of orders pausing operations on gyms, bars, nightclubs, movie theaters, water parks, and tubing.

④ The Governor extended a statewide mask order to Aug. 31

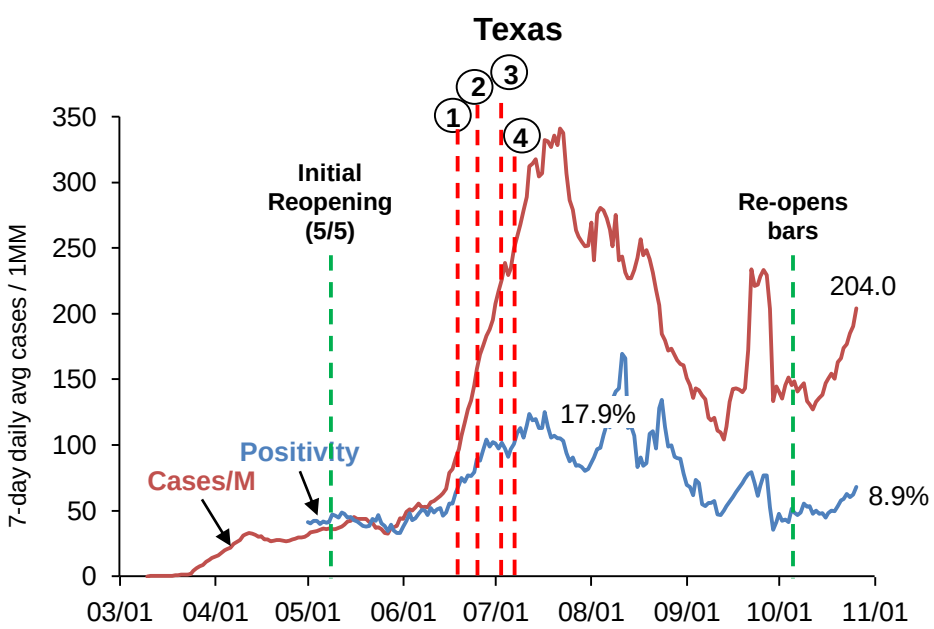
① The Governor ordered the shutdown of bars (followed by selected beach closures and limitations for July 4th)

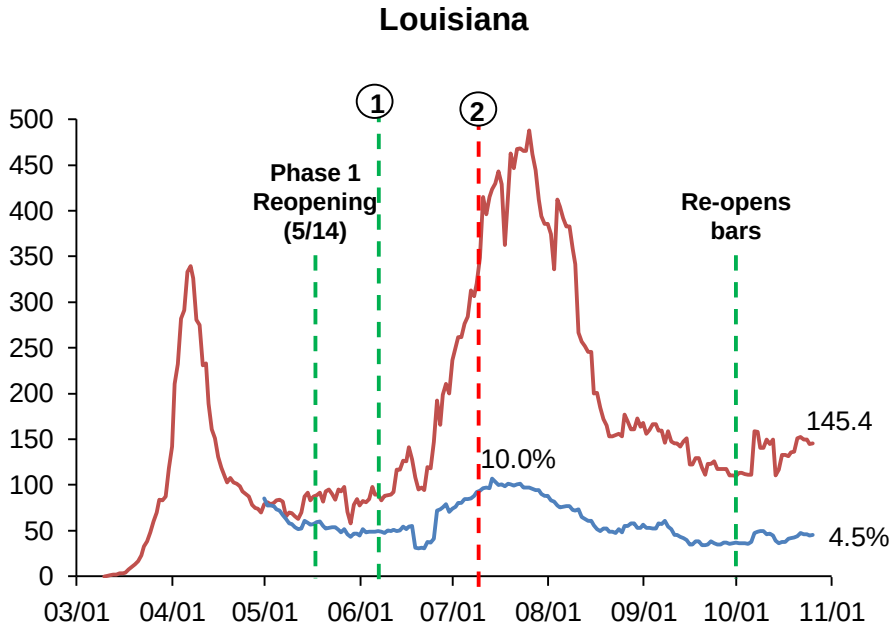
② Miami-Dade county, the epicenter of the outbreak in Florida, imposes local restrictions including the closure of beaches, movie theaters, concert houses, auditoriums, playhouses, bowling alleys, arcades, indoor amusement facilities, and casinos

Obtained via MI FOIA by Judicial Watch, Inc.

The Sun-belt waves dissipated due to a combination of state and local responses and improved behaviors

7-day average daily COVID cases per million





① Texas allowed local counties to restrict gathering sizes

② Closed all bars and reduced density of in-person dining from 75% to 50%. Also closed rafting trips, and limited all outdoor gatherings to fewer than 100

③ Suspended elective procedures and required masks in all counties with over 20 COVID cases

④ Limited all gatherings to fewer than 10 individuals

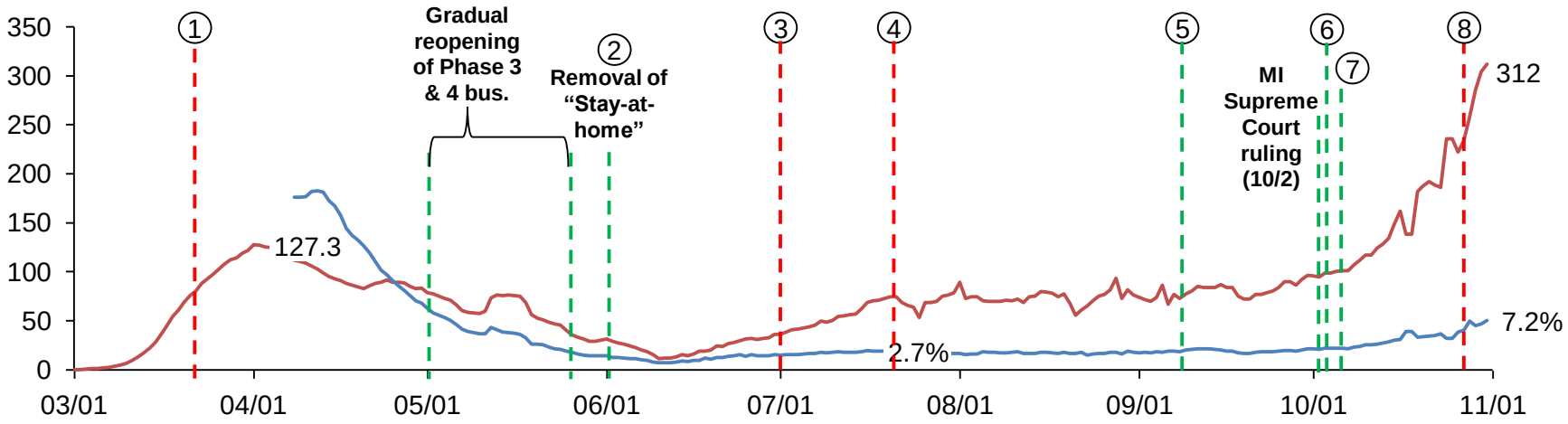
① Louisiana moved to Phase 2 of reopening, allowing restaurants, bars, and other social businesses to open at 50% capacity

② The Governor orders a mask mandate, closes all bars, and limits all gatherings to 50 (indoors and outdoors)

Between early September and mid-October, Michigan removed many of the restrictions that had been in place through much of the summer

Obtained via MI FOIA by Judicial Watch, Inc.

7-day average daily COVID cases per million, and positivity rate



① Michigan puts in place "Stay home, stay safe" order

② Removal of the stay-at-home order allowed gatherings of 10 individuals inside or 100 outside throughout most of the state. Phase 5 businesses remain closed (Gyms, theaters, bowling alleys, entertainment venues etc.)

③ Bars close in all regions but the UP and Traverse City

④ Enhanced mask order

⑤ Gyms, pools, and organized sports reopen

⑥ Theaters, and other entertainment venues can open. Indoor gathering limits move from 10 to 500. Outdoor gathering limits move from 100 to 1,000

⑦ Bars reopen with limits requiring seating and separation

⑧ Gathering limits restricted to the following indoors: 50 for non fixed seating, 500 for fixed seating; Outside: 1,000 or 30% of seating capacity

1. Johns Hopkins and Michigan.gov/coronavirus

Obtained via MI FOIA by Judicial Watch, Inc.

As cases surge across the state, we continue to look for additional steps that can be taken to slow growth

What additional steps should MERC or the Administration take to alleviate the spread of the disease?

- Do you feel the State needs to reinstate restrictions that are closer to what existed across July and August, or more along the lines of what European countries have done?
- Are you – especially the Healthcare leaders – willing to play a vocal role with local media
- Is there more that can be done with communication channels available to your institution / company?
- Other thoughts?

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Pohl, Zack; Huls, JoAnne
Subject: FW: FYI comms info
Date: Tuesday, December 1, 2020 10:45:00 AM
Attachments: FrankLuntz.PPT 11-30.pptx

In case of interest. JoAnne, thought you'd like this from Luntz's piece:

- The "P's" are particularly powerful and impactful: *pandemic* (rather than *coronavirus*), *protocols* (rather than *edicts, rules, mandates*, etc.), *protection* (rather than *safety*), *personal responsibility* (rather than *government control*), and *peace of mind* (rather than *security*).

From: Gordon, Robert (DHHS)
Sent: Tuesday, December 1, 2020 10:41 AM
To: Darling, Darice (DHHS) <DarlingD1@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Subject: FYI comms info

A few more resources:

https://publichealthcollaborative.org/resources/infographic-what-steps-are-taken-to-ensure-that-vaccines-are-safe/

https://www.covidcollaborative.us/content/vaccine-treatments/coronavirus-vaccine-hesitancy-in-black-and-latinx-communities

The attached from Frank Luntz is also interesting.

Robert Gordon
Director, Michigan Department of Health & Human Services
gordonr3@michigan.gov

CHANGING THE COVID CONVERSATION

Obtained via MI FOIA by Judicial Watch, Inc.



A lexicon for communicating the seriousness of the COVID-19 pandemic

Image by Leigh Wells for the *New York Times*

FiL
www.filuntz.com

de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES™

Obtained via MI FOIA by Judicial Watch, Inc.

WHAT WE DID

- The de Beaumont Foundation partnered with Frank Luntz to identify effective ways to convey information about COVID-19 to all Americans, including resistant audiences.
- Conducted a nationwide survey of 1,100 registered voters from across the country, Nov. 21-22, 2020. This included an oversample of 300 African Americans.
- Surveyed a representative sample of the nation's demographics, including age, gender, ethnicity, education, and income
- Tested specific words, sentences, phrases, and attributes Americans need to hear to change their behavior and stop the spread of the coronavirus.



Dr. Frank I. Luntz

Obtained via MI FOIA by Judicial Watch, Inc.

THE KEY TO COVID COMMUNICATION

- It's not just about the consequences of failure. It must also be about the benefits of success.
- You need to communicate that you are taking a "fact-based approach." There can't be even a hint of politics.
- Your protocols are endorsed (and should be delivered) by trusted researchers and medical & public health professionals rather than (untrustworthy) politicians.

Obtained via MI FOIA by Judicial Watch, Inc.

KEY FINDINGS

- The results of this national survey don't reveal a partisan divide. It's a chasm. In every possible way, Democrats and Republicans think differently and act differently.
- One area of agreement is the desire for local control. People have the most faith in public health officials delivering local/localized solutions. Avoid references to the federal government whenever possible.
- Our leading science, medical, and health experts have a higher degree of trust than anyone else. Let them do the talking whenever possible. Even popular politicians are less credible, as are corporate executives.
- The initial goal is to "stop the spread," but the ultimate goal is to "eliminate and eradicate the virus." It's similar to the difference between treatments (good) and cures (better). If you want people to take appropriate actions, focus on the end goal ("back to normal"), not just the process.

Obtained via MI FOIA by Judicial Watch, Inc.

KEY FINDINGS

- Personalize, humanize, and individualize the pandemic and its consequences – because that's what Americans do. So before talking about reopening the economy and schools, emphasize the shared goal of returning to "normal."
- The "P's" are particularly powerful and impactful: *pandemic* (rather than *coronavirus*), *protocols* (rather than *edicts, rules, mandates*, etc.), *protection* (rather than *safety*), *personal responsibility* (rather than *government control*), and *peace of mind* (rather than *security*).
- Give people a reason to comply beyond it's good for them. Remind them that it's good for their families and it will speed up the return to a healthy economy.

Obtained via MI FOIA by Judicial Watch, Inc.

WARNINGS

- Be very careful about letting politics or partisanship slip into your messaging. Everyone is looking for it … and it will kill your credibility. Make sure your language is entirely neutral and that it repeatedly emphasizes “every” and “all.”
- Many Republicans refuse to follow guidelines because they argue the science keeps changing. It’s up to you to communicate – at the outset – that the science is settled.

Obtained via MI FOIA by Judicial Watch, Inc.

21 COVID WORDS FOR THE 21ST CENTURY

personal responsibility	peace of mind
fact-based	a return to normal
a human approach	the science is settled
you deserve	pandemic (not coronavirus)
our best researchers/medical experts	public (not govt) health agencies
because your life really matters	no exceptions/no excuses
access to medical breakthroughs	protocols
eliminate and eradicate the pandemic	essential healthcare workers
our mission/my commitment	a healthier, happier you
stop the spread	local control/decision-making
even one infection can cause an outbreak	

de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES℠

Obtained via MI FOIA by Judicial Watch, Inc.

COVID WORDS TO USE & LOSE

Words to USE	Words to LOSE
the pandemic	the coronavirus
eliminate/eradicate the virus	defeat/crush/knock out the virus
social distancing	physical distancing
an effective/safe vaccine	a vaccine developed quickly
protocols	orders/imperatives/decrees
face masks	facial coverings
essential workers	frontline workers
personal responsibility	national duty
a stay-at-home order	a government lockdown/shutdown
public health agencies	government health agencies

www.filuntz.com

de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES℠

Obtained via MI FOIA by Judicial Watch, Inc.

WORDS THAT WORK

What our leaders need to say to save lives:

*We all want a **return to normal**, and we all want the economy and our schools to open. And we also want to **protect** our family and friends from the **pandemic**.*

*Our **finest medical researchers** are clear: If we fail, there will be even worse **consequences** for our families and our economy.*

*We all have a personal responsibility to **slow the spread of the pandemic** and **eliminate** the virus as quickly as possible.*

*Therefore, it's imperative that we take an **effective, fact-based approach** … by doing things like wearing face masks and practicing **social distancing**.*

*Let's do what needs to be done **now** so we can return to a **strong economy** and **normal day-to-day activities**.*

Obtained via MI FOIA by Judicial Watch, Inc.

THE PARTISAN DIVIDE



Obtained via MI FOIA by Judicial Watch, Inc.

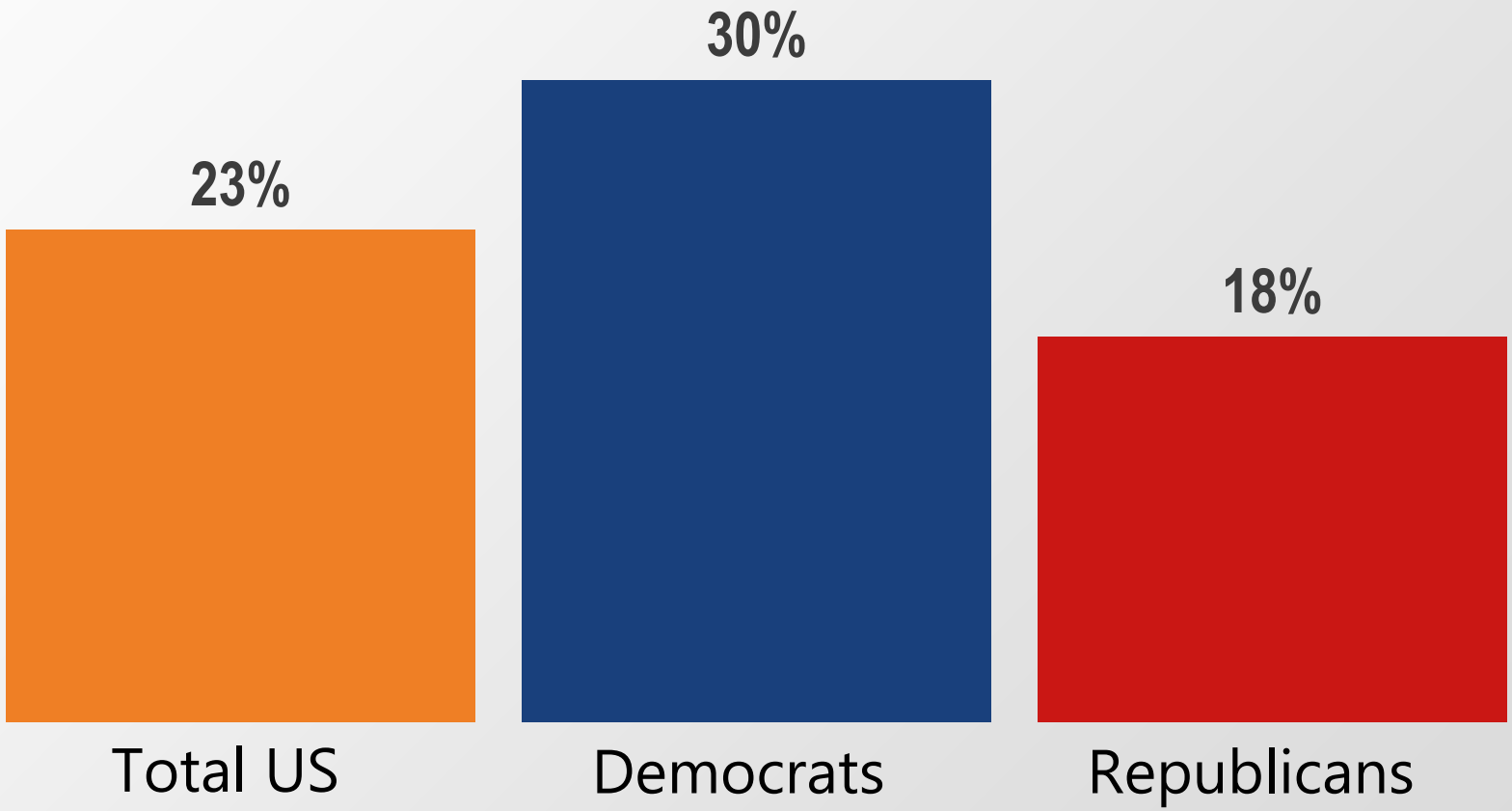
INSIGHT #1

- To no surprise, Republican voters are much more skeptical of the virus and its impact than Democrats or the broader public. Some of this is because of life (and death) experiences.
- Conversely, Republicans are much more afraid of a shutdown/lockdown and its already significant impact on the economy.
- If you are to shift personal behavior among all Americans, you have to change your communication to all Americans. You need to show that doing the right thing now means a faster economic recovery.

Obtained via MI FOIA by Judicial Watch, Inc.

THERE'S A PARTISAN DIVIDE ON DEATH…

Do you personally know someone close to you who has died from COVID-19?

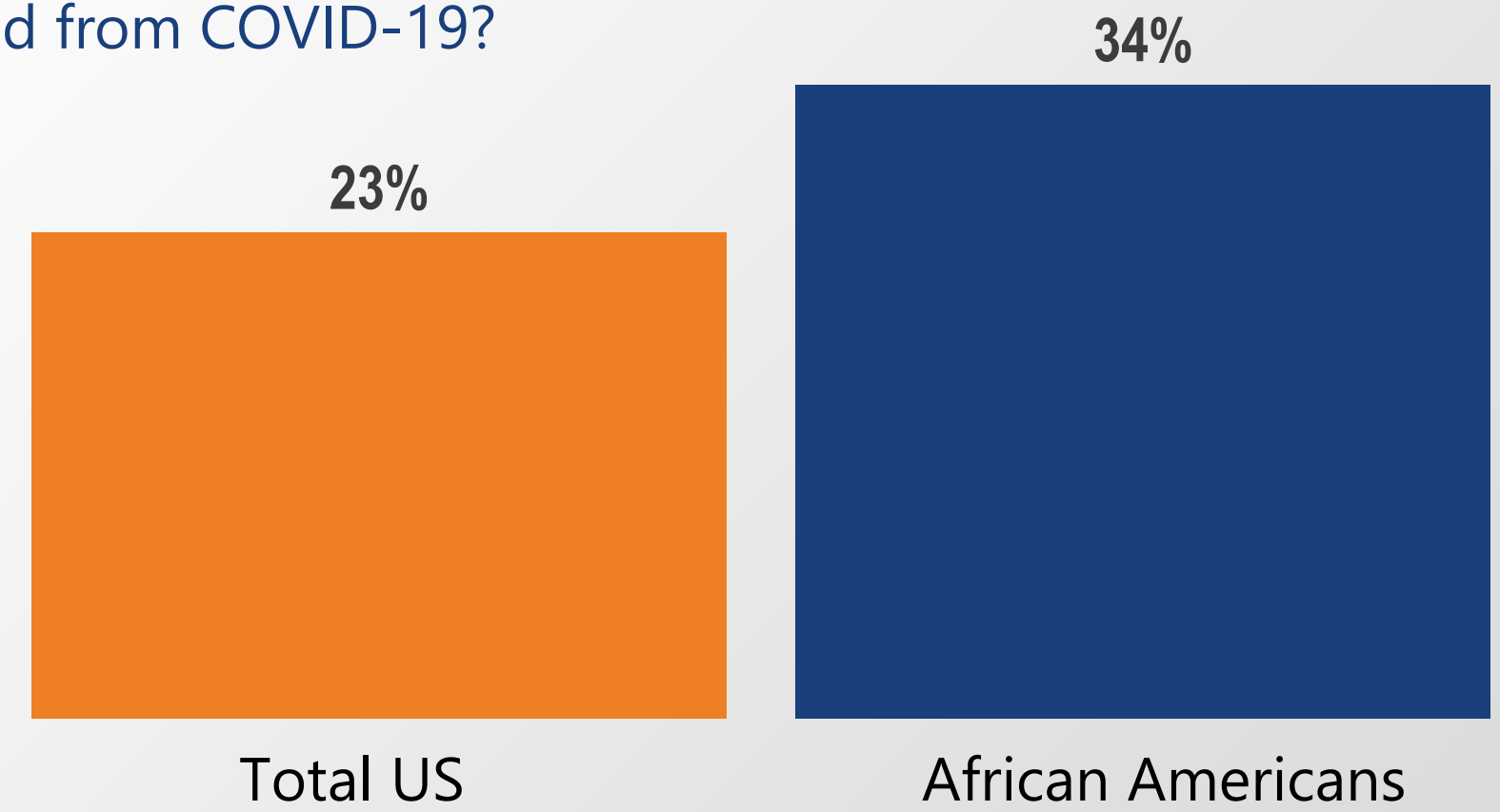


de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES

Obtained via MI FOIA by Judicial Watch, Inc.

…AND A DISPROPORTIONATE IMPACT ON AFRICAN AMERICANS…

Do you personally know someone close to you who has died from COVID-19?



de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES℠

NOTHING SCARES GOPERS MORE THAN AN IRS AUDIT … EXCEPT TESTING POSITIVE FOR COVID

Obtained via MLPOA by Judicial Watch, Inc.

Assuming you file your taxes and had taken a COVID-19 test, which would scare you more -- getting a letter/email telling you that…?

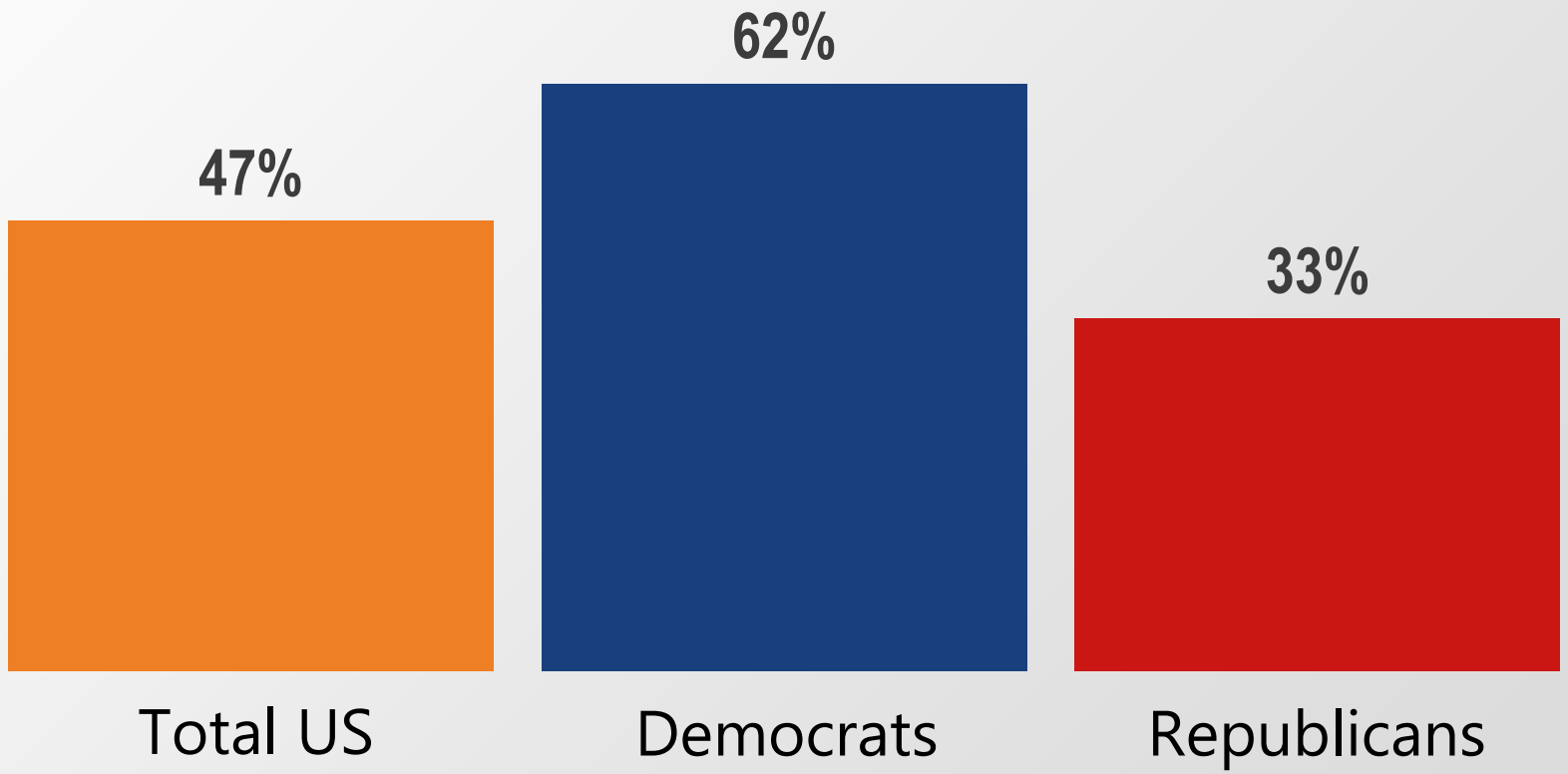
Total	Dem	GOP	
62%	66%	53%	You've tested positive for COVID-19.
38%	34%	47%	You're being audited by the IRS.

de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES

THE PARTISAN GAP IS BEYOND STAGGERING… REPUBLICANS ARE JUST NOT AFRAID

Obtained via MI FOIA by Judicial Watch, Inc.

Overall, how serious is the current situation with COVID-19? (% who say "extremely serious")

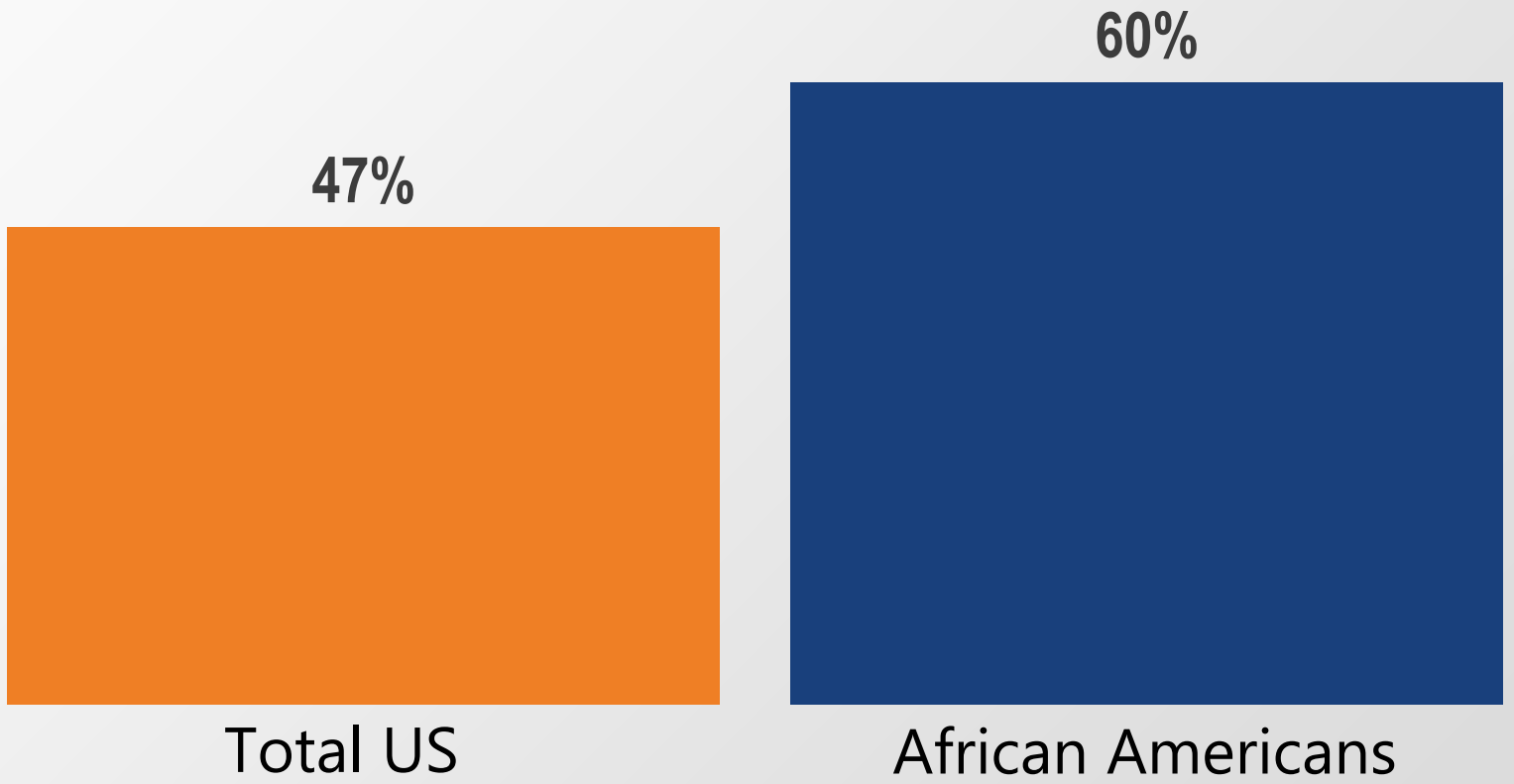


de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES

Obtained via MI FOIA by Judicial Watch, Inc.

BLACK AMERICANS SEE COVID MORE SERIOUSLY THAN THE COUNTRY AS A WHOLE

Overall, how serious is the current situation with COVID-19?
(% who say "extremely serious")



de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES

Obtained via MI FOIA by Judicial Watch, Inc.

WARNING #1

- It’s more than President Trump telling his supporters that the worst is over and/or help is on the way. The messaging from public health experts, governors, and the White House itself is missing the mark – and so it is failing to motivate millions of Americans who do not realize they are in jeopardy.

Obtained via MI FOIA by Judicial Watch, Inc.

INSIGHT #2

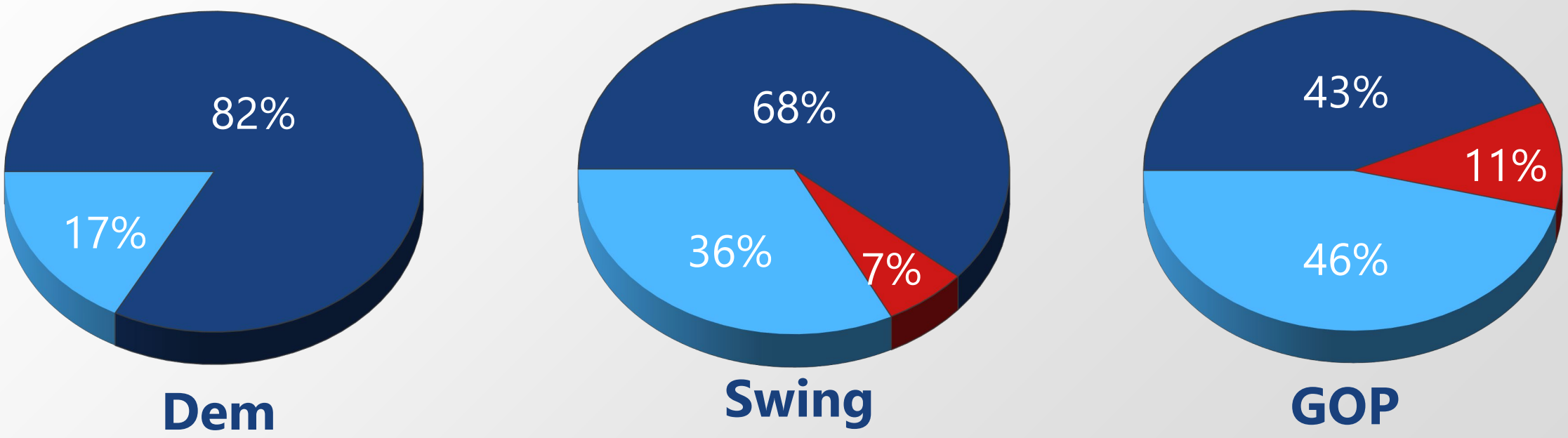
- Voters are more interested in supporting leaders for acting on COVID than punishing them -- especially swing voters. Despite vocal criticism from President Trump, President-elect Joe Biden was rewarded, not punished, for “staying in his basement” for two months.

  (Watch what’s happening to Governor Gavin Newsom because he didn’t follow procedures he recommended for others.)

Obtained via MI FOIA by Judicial Watch, Inc.

THE POLITICAL DOWNSIDE FOR SUPPORTING COVID-19 MEASURES IS NON-EXISTENT

Would you be... to vote for a member of Congress in an election if they encouraged you to take steps to stop the spread of COVID-19?



de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES

STRATEGIES, SOLUTIONS, AND SPOKESPEOPLE

Obtained via MI FOIA by Judicial Watch, Inc.



Obtained via MI FOIA by Judicial Watch, Inc.

INSIGHT #3

- Republicans want to keep opening up, while Democrats think we should close down a bit more. That's why language is so important. Without the right messaging, you will never close the divide and achieve consensus.
- You need to continually anchor your pandemic language balancing between the economy and health. While we acknowledge health is the more persuasive of the two, ignoring economic anxiety is to ignore about 40% of America.

Obtained via MI FOIA by Judicial Watch, Inc.

THERE'S NO AGREEMENT ON THE PATH FORWARD

What should our strategy and approach be with COVID-19 right now?

Dem	GOP	
10%	5%	Keep America closed until a vaccine is ready, no matter how long it takes
15%	4%	Close everything now until the virus is under control
29%	18%	Close the country down a little more since the virus has gotten worse
14%	11%	Keep whatever is open now open and keep whatever is closed now closed
19%	29%	Continue to open America now but slowly
13%	32%	Open everything now/learn to live with the virus

de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES

Obtained via MI FOIA by Judicial Watch, Inc.

ALMOST EVERYONE PRIORITIZES HEALTH/SAFETY …BUT NOT EVERYONE!

Thinking about the impact of coronavirus on the country, are you more concerned about…?

Total	Dem	GOP	
73%	88%	49%	The health and safety of the nation much/somewhat more
28%	12%	51%	The national economy much/somewhat more

de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES

Obtained via MI FOIA by Judicial Watch, Inc.

ALMOST EVERYONE PRIORITIZES HEALTH/SAFETY …BUT NOT EVERYONE!

Thinking about the impact of coronavirus on the country, are you more concerned about…?

Total	African Americans	
73%	**82%**	The health and safety of the nation much/somewhat more
28%	**18%**	The national economy much/somewhat more

de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES℠

Obtained via MI FOIA by Judicial Watch, Inc.

INSIGHT #4

- Health officials, nationally and locally, have the greatest impact in their decision-making. There are only two trusted organizations and people -- the CDC and Dr. Anthony Fauci. No one else is close. And don't forget to utilize survivors of COVID as well.
- Conversely, the FDA ranks dead last, which may be a problem when a vaccine is ready for distribution.
- Congress also lacks credibility.

Obtained via MI FOIA by Judicial Watch, Inc.

COVID DECISIONS SHOULD COME FROM MEDICAL AND PUBLIC HEALTH OFFICIALS

Who should have the ultimate responsibility to decide whether we need more or fewer requirements to address the coronavirus?

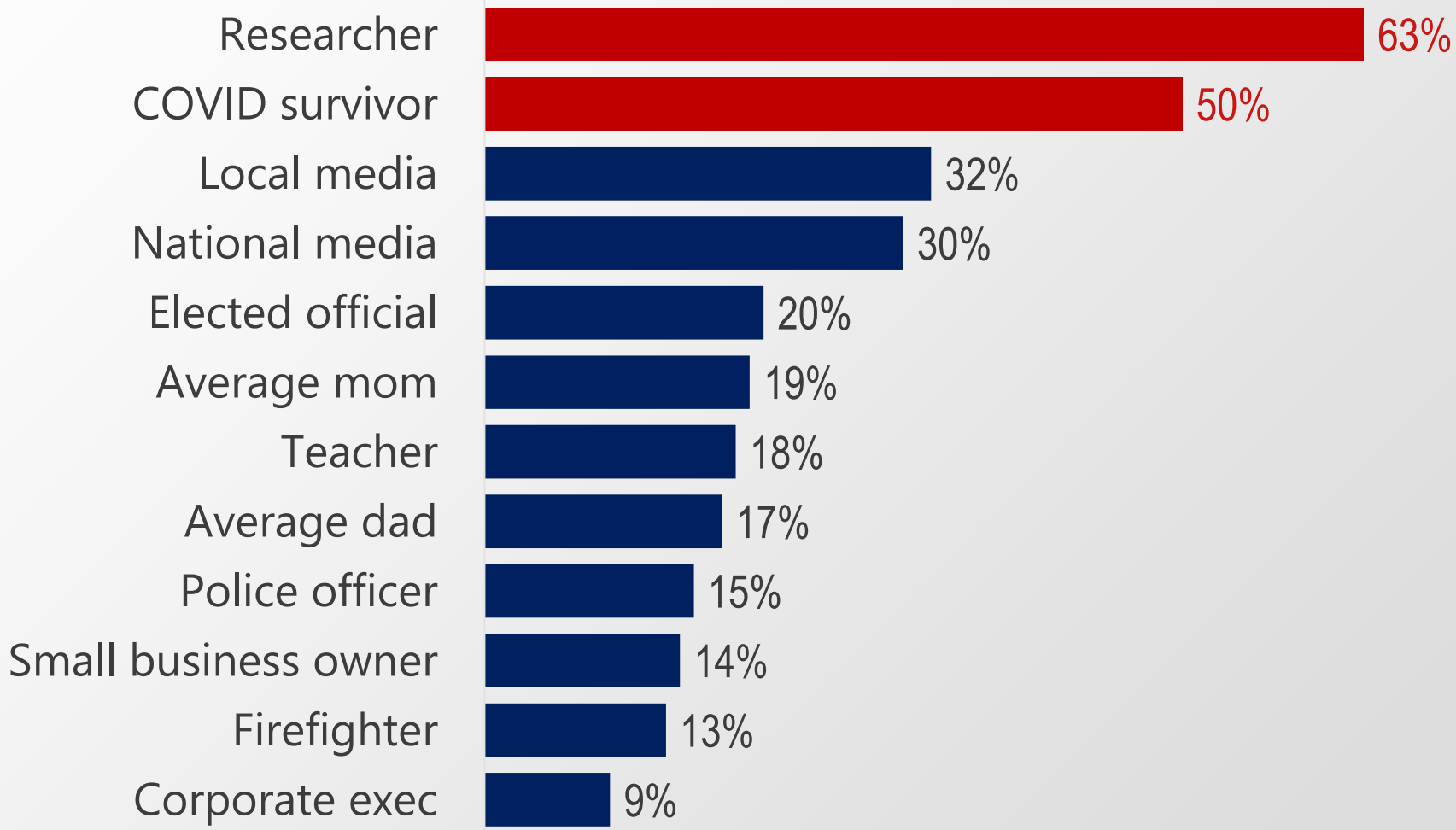
Total	
35%	The nation's highest-ranking medical and public health officials
28%	Your state's highest ranking medical and public health officials
26%	President Trump
26%	Governors
23%	President-elect Biden
23%	You, yourself
13%	Your mayor or city/town leader
10%	The Supreme Court
9%	The state legislatures
6%	Congress

de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES

Obtained via MI FOIA by Judicial Watch, Inc.

BEST MESSENGERS: RESEARCHERS AND SURVIVORS

Other than a doctor/nurse/public health official, who would you trust MOST in calling for ways you personally can contain COVID-19?



de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES

Obtained via MI FOIA by Judicial Watch, Inc.

THE CDC'S DEMISE AS A CREDIBLE ACTOR HAS BEEN GREATLY EXAGGERATED

Whom are you most likely to trust regarding COVID-19?

Total	
40%	the CDC
38%	Dr. Anthony Fauci
22%	your local health official
22%	the White House Coronavirus Task Force
21%	the National Institutes of Health
18%	the World Health Organization (WHO)
16%	the U.S. Secretary of Health and Human Services
14%	the Surgeon General
10%	the FDA

de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES℠

Obtained via MI FOIA by Judicial Watch, Inc.

THE TWO GROUPS THAT MATTER MOST: COVID AT-RISK AND HEALTHCARE WORKERS

At a time like this whom do you believe federal government should be MOST focused on protecting right now?

Total	Dem	GOP	
56%	56%	58%	Americans most vulnerable to COVID-19
49%	55%	46%	America's healthcare workers
33%	28%	31%	America's families
17%	17%	20%	America's workers
13%	11%	13%	America's taxpayers
12%	12%	12%	America's small businesses
10%	8%	11%	America's students



de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES

Obtained via MI FOIA by Judicial Watch, Inc.

INSIGHT #5

- President-elect Joe Biden is fond of calling measures like mask-wearing a patriotic act or a national calling. That's not how the public see it. A much better reason is to appeal to personal responsibility:

  "It's not just about you. It's about your family, your friends, and the people you care about most. You're keeping them safe, and they're keeping you safe."

Obtained via MI FOIA by Judicial Watch, Inc.

INDIVIDUALIZE AND PERSONALIZE MASK-WEARING TO GET BUY-IN

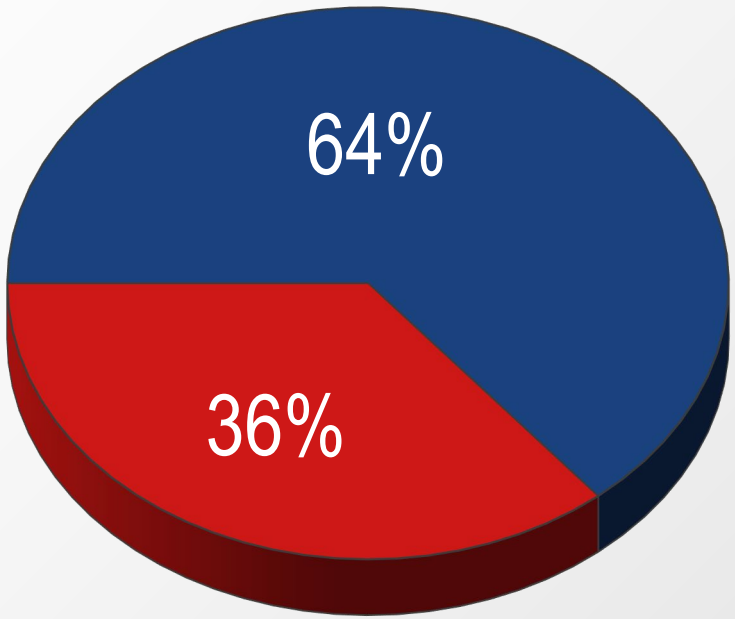
What is the MOST convincing and compelling reason to wear a mask in public?

Total	
42%	To keep your family safe and healthy
40%	To keep yourself safe and healthy
38%	To keep everyone you come in contact with safe and healthy
26%	To keep America safe and healthy
20%	To keep your neighborhood/community safe and healthy
17%	To keep your state safe and healthy
17%	None of these are convincing and compelling

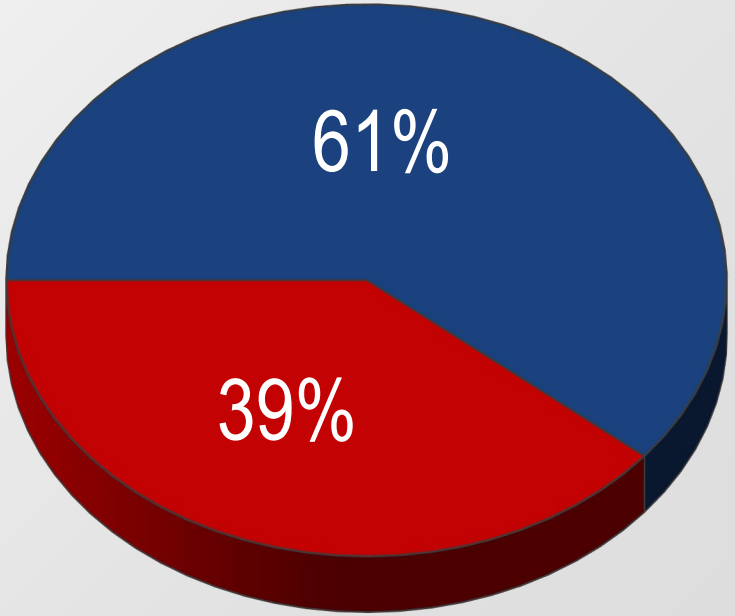
Obtained via MI FOIA by Judicial Watch, Inc.

PERSONAL RESPONSBILITY VS. NATIONAL DUTY

Are efforts to combat the spread of the coronavirus more of a… ?



Total



Swing Voters

Personal responsibility

National duty

de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES℠

Obtained via MI FOIA by Judicial Watch, Inc.

INSIGHT #6

- We asked respondents to tell us what they thought were the most important actions they could take to protect themselves. We tested a litany of measures people are taking or have been recommended. The sustained effort to raise mask wearing in the public eye has had a meaningful and measurable impact.

de Beaumont™

Obtained via MI FOIA by Judicial Watch, Inc.

MOST ACCEPTED MEASURES

Which do you think is MOST sensible, responsible, and impactful? (ranked)

Total	Dem	GOP	
59%	63%	57%	Wearing a face mask in public
42%	42%	41%	Engaging in "social distancing"
33%	39%	29%	Staying at home as much as possible
30%	25%	31%	Frequently washing your hands/using hand sanitizer
26%	26%	27%	Avoiding public crowds

de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES.

Obtained via MI FOIA by Judicial Watch, Inc.

LEAST ACCEPTED/PRIORITIZED

Which of the following do you think is MOST sensible, responsible, and impactful? (ranked)

Total	Dem	GOP	
12%	**16%**	**12%**	Complying with official state policies
10%	**11%**	**8%**	Getting tested immediately if you've come into contact with someone who has COVID-19
10%	**6%**	**8%**	Keeping personal gatherings to 10 people or less
9%	**14%**	**6%**	Not meeting in person for family events and holidays like usual

Obtained via MI FOIA by Judicial Watch, Inc.

LEAST ACCEPTED/PRIORITIZED

Which of the following do you think is MOST sensible, responsible, and impactful? (ranked)

Total	Dem	GOP	
9%	13%	7%	Not going to indoor bars/restaurants
8%	11%	7%	Purchasing medical supplies (masks, gloves, sanitizer, etc.)
8%	9%	6%	Meeting with people virtually like on "Zoom" rather than in-person
7%	8%	4%	Avoiding public transit/rideshare
6%	6%	7%	Complying with businesses and health officials for contract tracing
4%	5%	6%	Buying more goods and services online rather than in-person
9%	2%	17%	None of these, I will not change my behavior

Obtained via MI FOIA by Judicial Watch, Inc.

INSIGHT #7

- Public health leaders need to do a MUCH better job explaining how our understanding of the virus has evolved – as it should have. You'll need to celebrate the "exceptional" and "superior" American scientists, medical professionals, and researchers. This may not sit well with some of your colleagues, but it will work.

- If you want Republican buy-in, you must make the case that the science is settled and that everyone now agrees. Moreover, while the vaccine will be effective, it will still take months to supply it to those who need it. Keep focused on delivering a better future…right now.

Obtained via MI FOIA by Judicial Watch, Inc.

SPEAK TO THE CONSEQUENCES… THEY HAVEN'T GONE AWAY

Why do we need to continue to take measures against the coronavirus even though it has lasted as long as it has?

Dem	GOP	
40%	**35%**	Because COVID-19 is highly infectious, one infection can quickly grow into an outbreak that could shutter a neighborhood, community, or entire city.
28%	**14%**	We understand that people are tired, but public health measures are not the enemy - they are the roadmap for a faster and more sustainable recovery.
17%	**38%**	Scientists and medical professionals are developing and preparing to distribute a safe and effective vaccine that will help us return to normal day-to-day activities.
16%	**13%**	Public health policy measures are in place to prevent crippling surges and make re-opening possible.

Obtained via MI FOIA by Judicial Watch, Inc.

NOTE REPUBLICAN SKEPTICISM OF THE SCIENCE & DEMOCRATIC SKEPTICISM OF PUBLIC OFFICIALS

What would make you NOT take individual precautions to prevent the spread of COVID-19?

Dem	GOP	
28%	41%	The jury is still out how we should best combat the virus, as health recommendations have changed over time
40%	33%	If public officials themselves are not following the precautions they've recommended or mandated
30%	21%	It is too financially difficult on my family
23%	26%	Compliance is a slippery slope for further erosion of personal freedoms
12%	20%	The government has been too restrictive
24%	9%	It's too difficult for my work
12%	15%	I don't believe the virus is severe and these measures are needed
17%	14%	If people around me were not taking these precautions or pressuring me to adopt them

de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES

Obtained via MI FOIA by Judicial Watch, Inc.

THE BEST ARGUMENT FOR PUBLIC HEALTH FUNDING: PANDEMIC PREP

What is the MOST convincing and compelling reason to support greater taxpayer investment in funding public health efforts?

Total	
38%	Better preparation to address future pandemics and major health crises (45% Democrats, 40% Republicans)
31%	Greater access to healthcare for everyone regardless of their background
22%	A greater ability to ensure public spaces are safe with clean air and water
21%	Reduced cost or free vaccine disbursement for every American who wants one
21%	Access to an unbiased source of information about health free from politics
19%	Speeding up the approval process for medications and inspections
19%	More effective, efficient, and accountable health officials
12%	Less reliance on outside contractors for services who may charge more money
17%	None of these are convincing

Obtained via MI FOIA by Judicial Watch, Inc.

LANGUAGE: THE WORDS TO USE & LOSE



Obtained via MI FOIA by Judicial Watch, Inc.

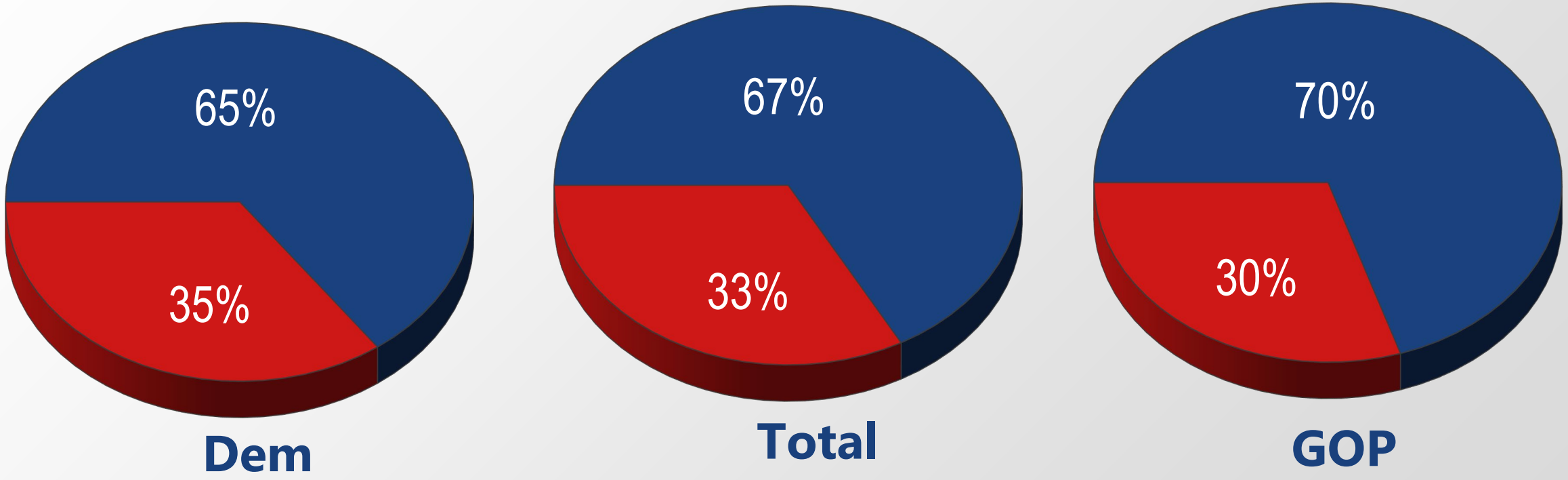
INSIGHT #8

- Language really does matter.
- In this case, always refer to agencies as *"public health"* rather than *"government health."* It's the best way to overcome skepticism with anything related to government.
- What follows is an entire litany of what resonates…and what alienates.

Obtained via MI FOIA by Judicial Watch, Inc.

SAY "PUBLIC," NOT "GOVERNMENT"

Would you be more likely to trust and support taxpayer dollars going to..."health agencies" or "government agencies"?

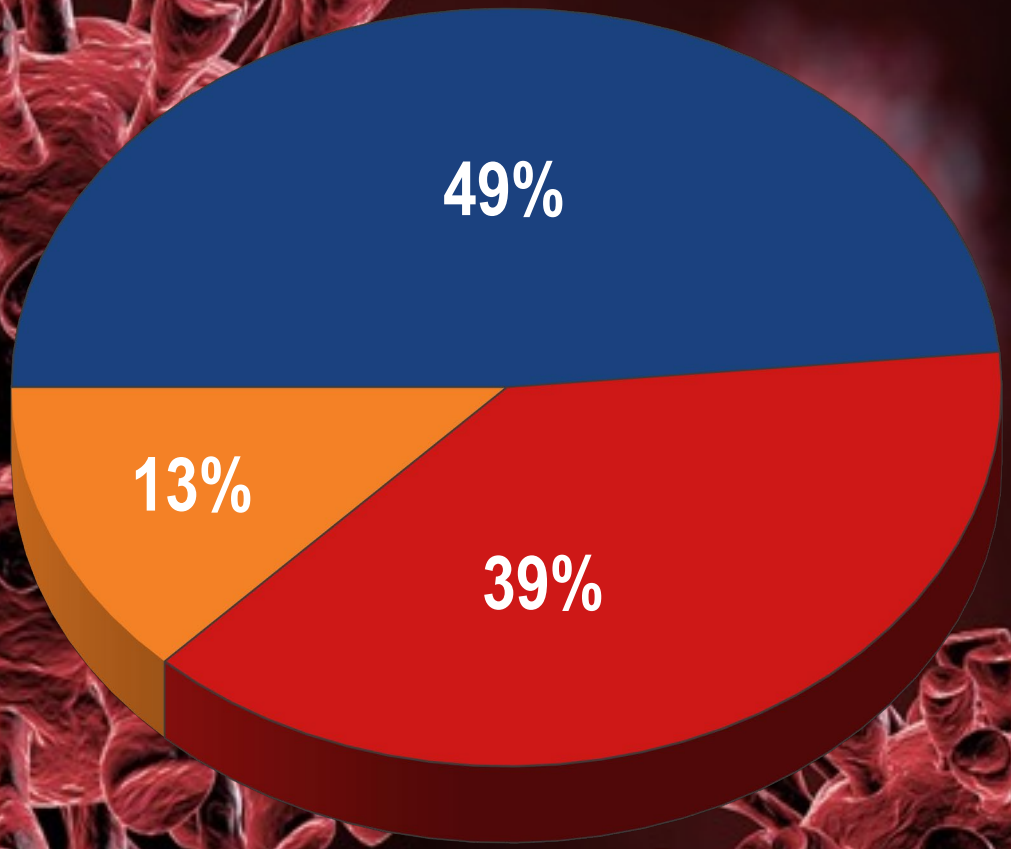


de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES

Obtained via MI FOIA by Judicial Watch, Inc.

CALL IT "THE PANDEMIC"

Which do you feel is more significant, serious, and scary?

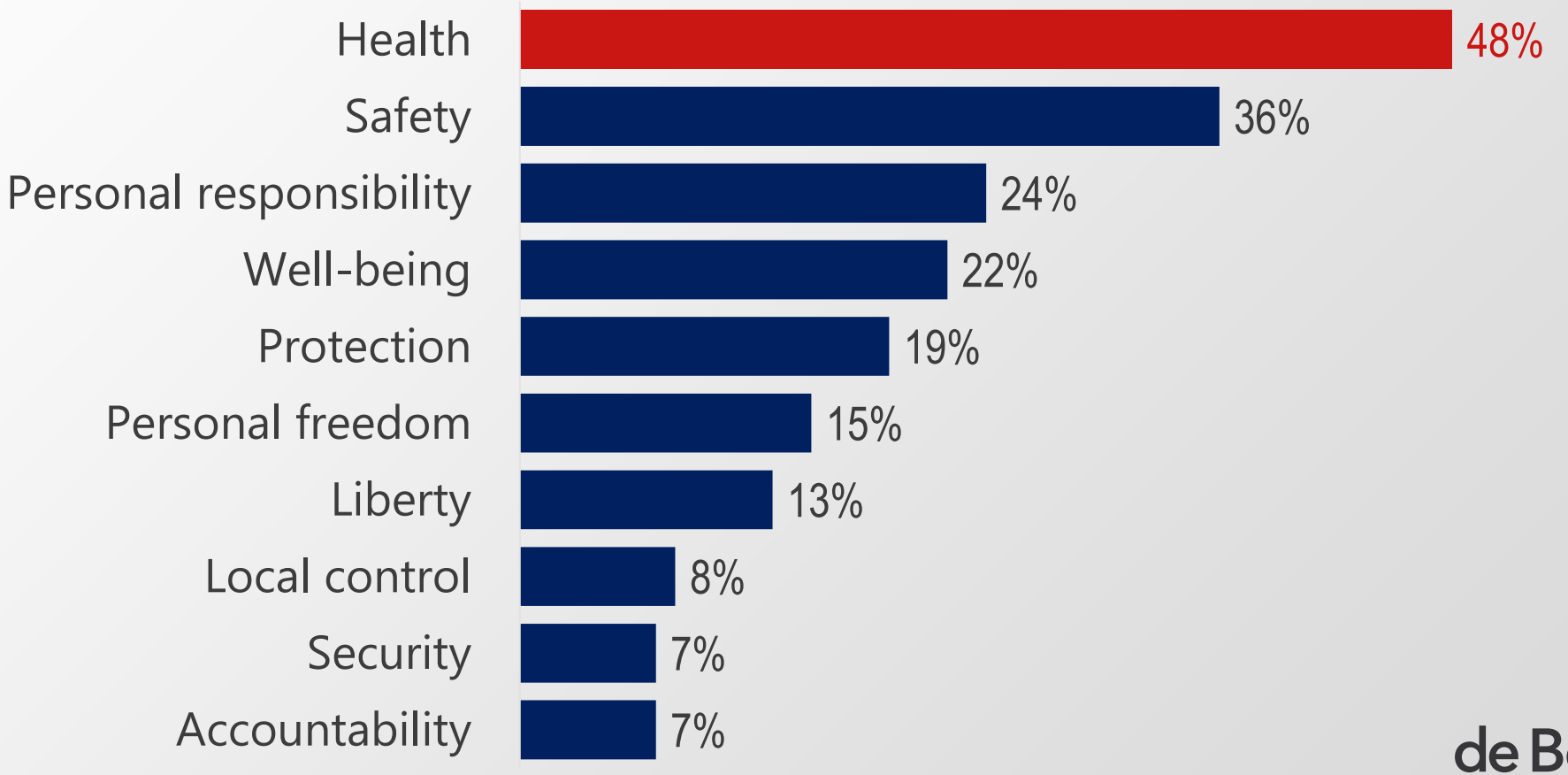


- The pandemic
- The coronavirus
- COVID-19

Obtained via MI FOIA by Judicial Watch, Inc.

LANGUAGE SHOULD CENTER AROUND "HEALTH"; NOTHING ELSE COMES CLOSE

Which is more important to you regarding COVID-19?



de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES℠

Obtained via MI FOIA by Judicial Watch, Inc.

HEALTH IS THE TOP ATTRIBUTE, BUT SAFETY MATTERS MUCH MORE TO AFRICAN AMERICANS

Which is more important to you regarding COVID-19?

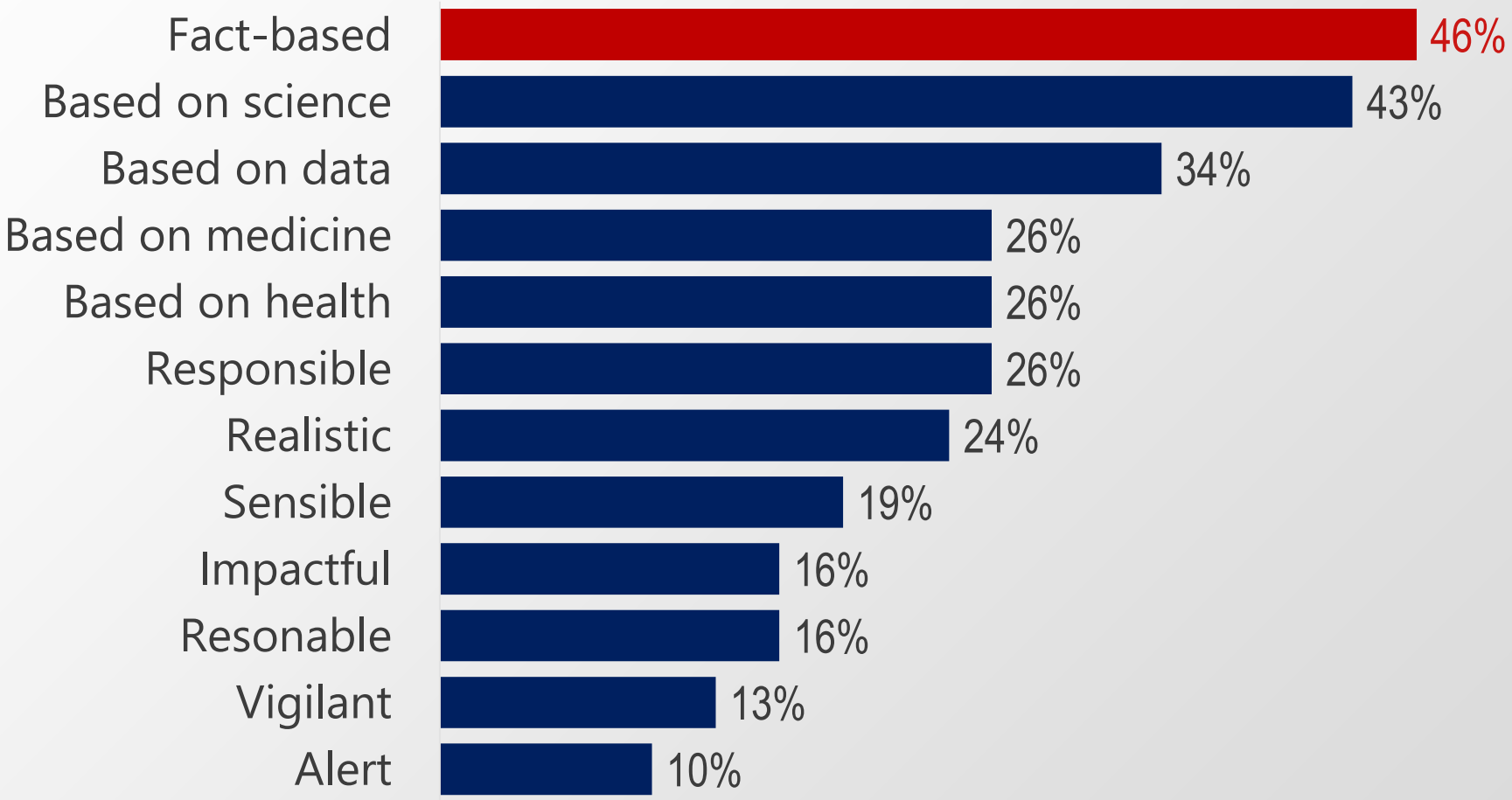
All	AA	
48%	54%	Health
36%	48%	Safety
24%	15%	Well-being
23%	17%	Personal responsibility
18%	25%	Protection
16%	8%	Personal freedom
12%	6%	Liberty
8%	9%	Accountability
8%	11%	Security
7%	6%	Local control

de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES

Obtained via MI FOIA by Judicial Watch, Inc.

COVID-19 POLICYMAKING SHOULD BE "FACT-BASED" AND "BASED ON SCIENCE"

Which is most important to you from to policies to address COVID-19?

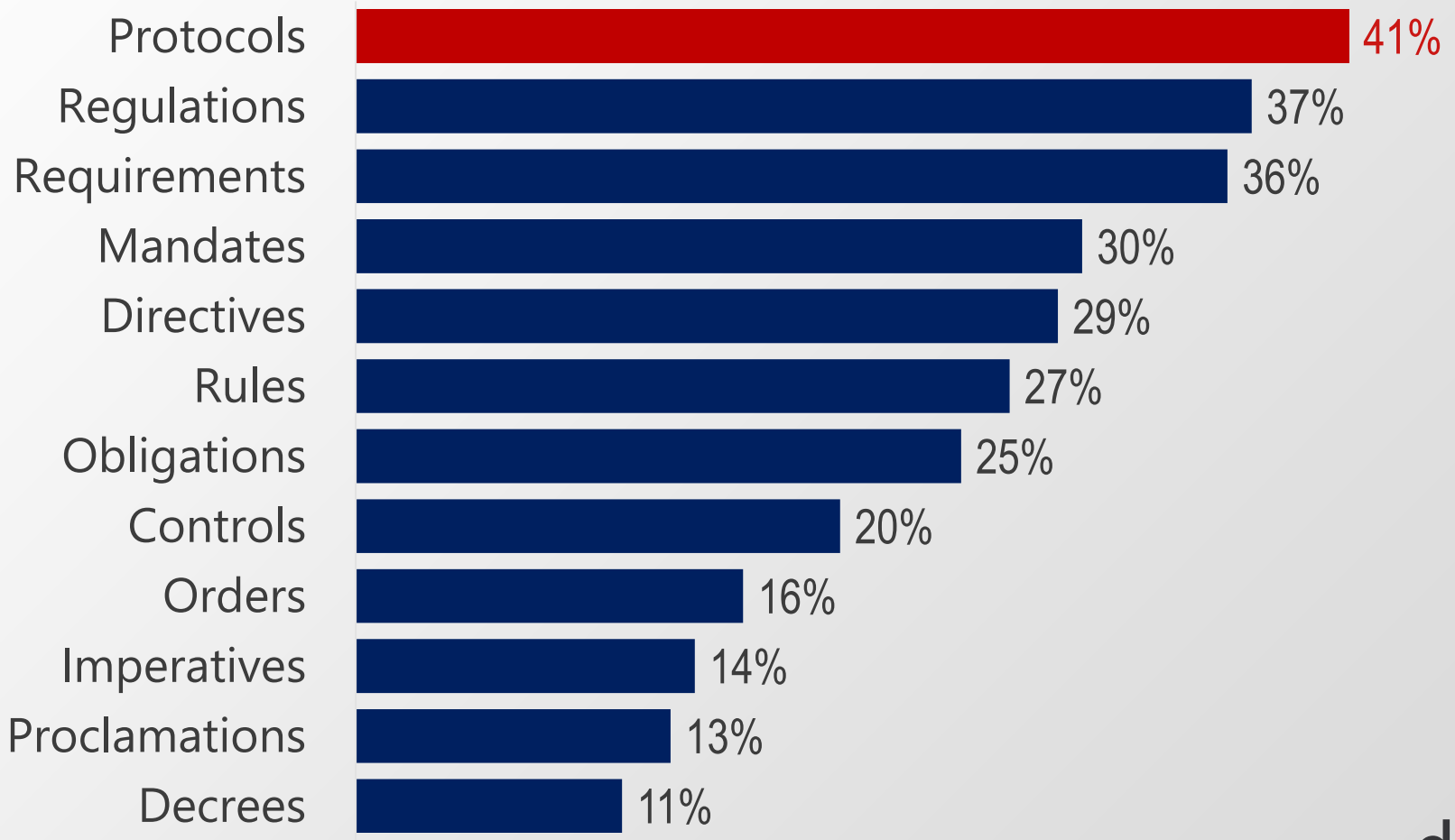


de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES

Obtained via MI FOIA by Judicial Watch, Inc.

"PROTOCOLS" APPEAL ACROSS PARTISAN LINES

When it comes to the rules and regulations required to address COVID-19, gives you the MOST positive reaction?



de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES

Obtained via MI FOIA by Judicial Watch, Inc.

THERE IS CLEAR LANGUAGE THAT WORKS; "LOCKDOWN" WAS A FATAL MISTAKE…

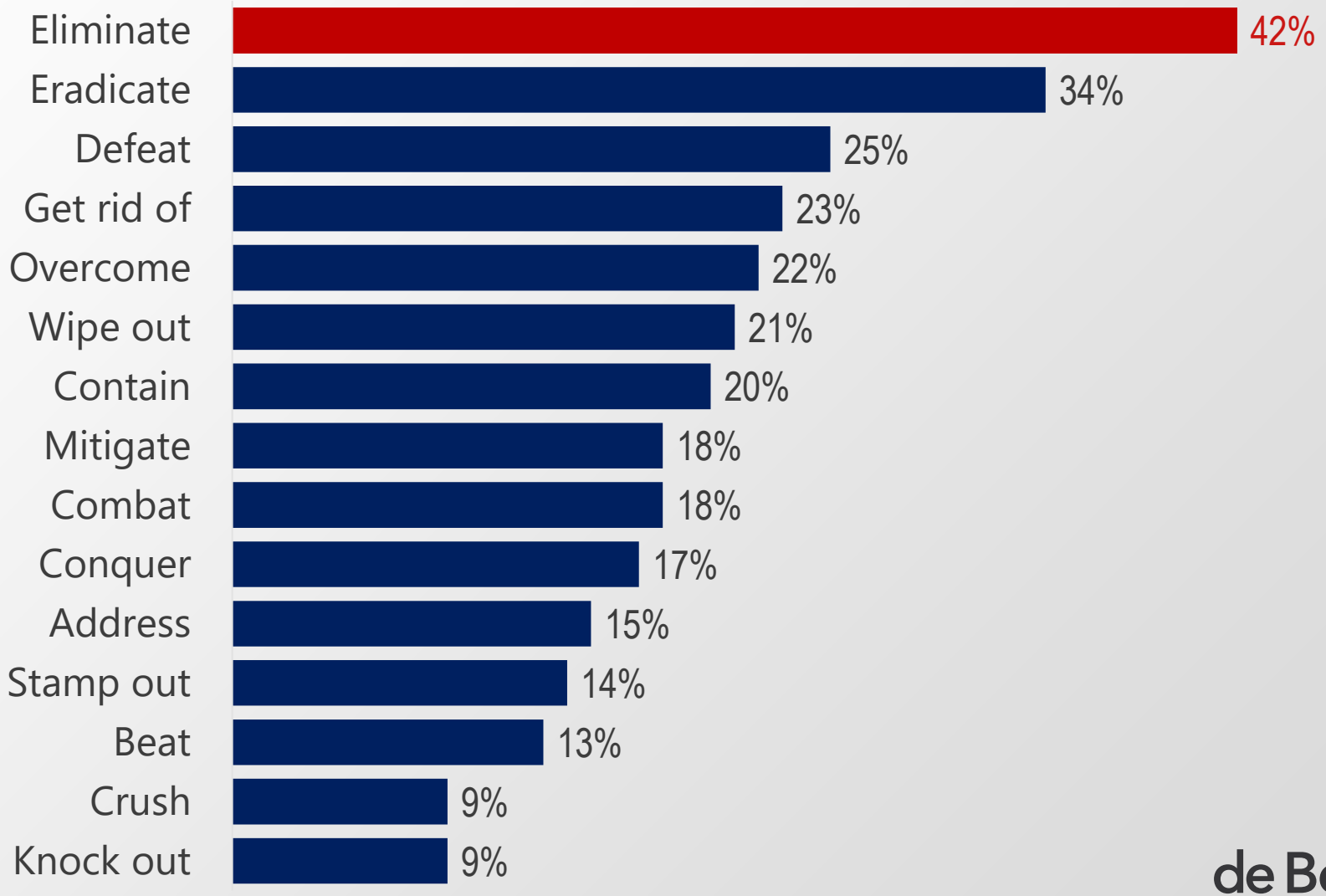
While you may not like any of them, which of these will you tolerate the most?

Total	Dem	GOP	
47%	48%	45%	A stay-at-home order
19%	16%	23%	Aggressive restrictions
15%	17%	11%	A lockdown
10%	9%	12%	A government order
9%	10%	9%	Government controls

Obtained via MI FOIA by Judicial Watch, Inc.

AMERICANS WANT INTENSITY, BUT NOT OVER-CAFFEINATION

What should be the goal of our COVID-19 policies? We want to...the virus.



de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES

Obtained via MI FOIA by Judicial Watch, Inc.

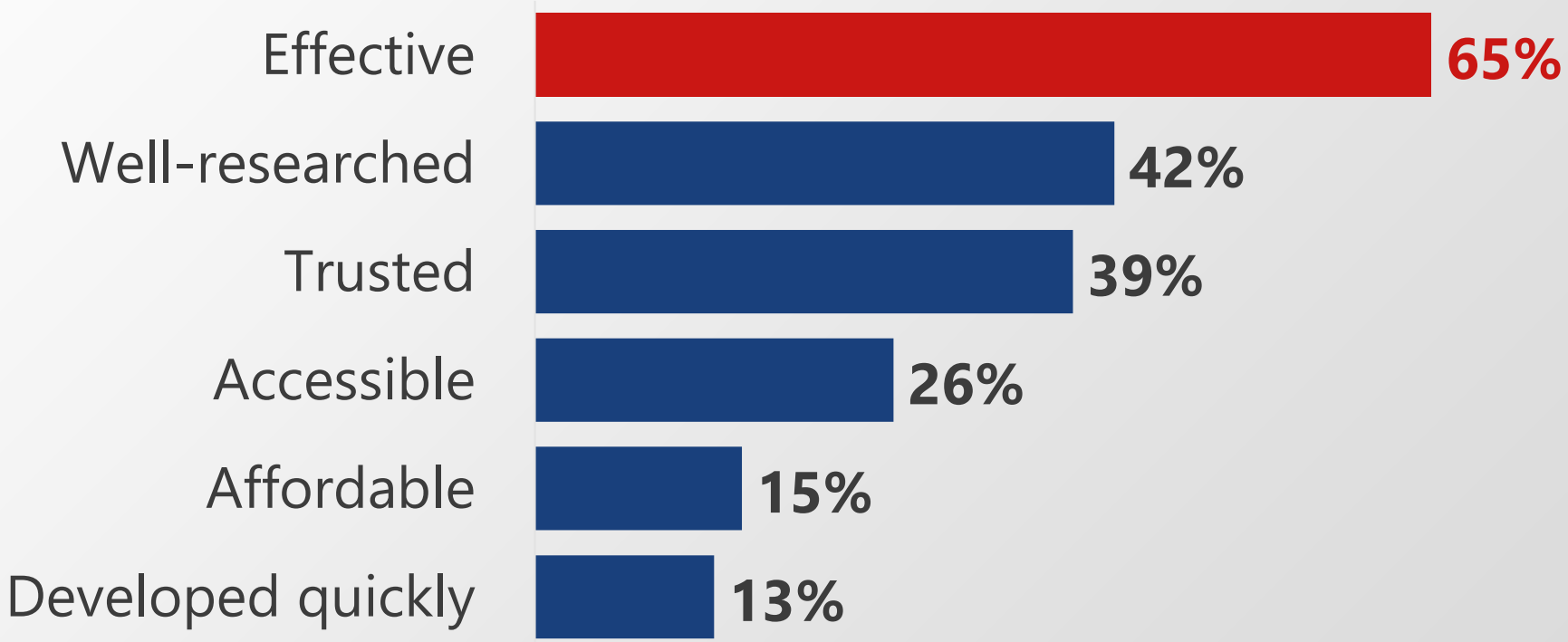
WARNING #3

- The warlike language used by some Republican leaders is a mistake. There are much more effective ways to talk efforts to address COVID. It's assumed that GOP followers like it. They don't.

Obtained via MI FOIA by Judicial Watch, Inc.

AMERICANS WANT A VACCINE THAT WORKS ABOVE ALL ELSE, NOT ONE THAT'S RUSHED

Other than safety, when thinking about a vaccine for COVID-19, is it MOST important to you that it is...?

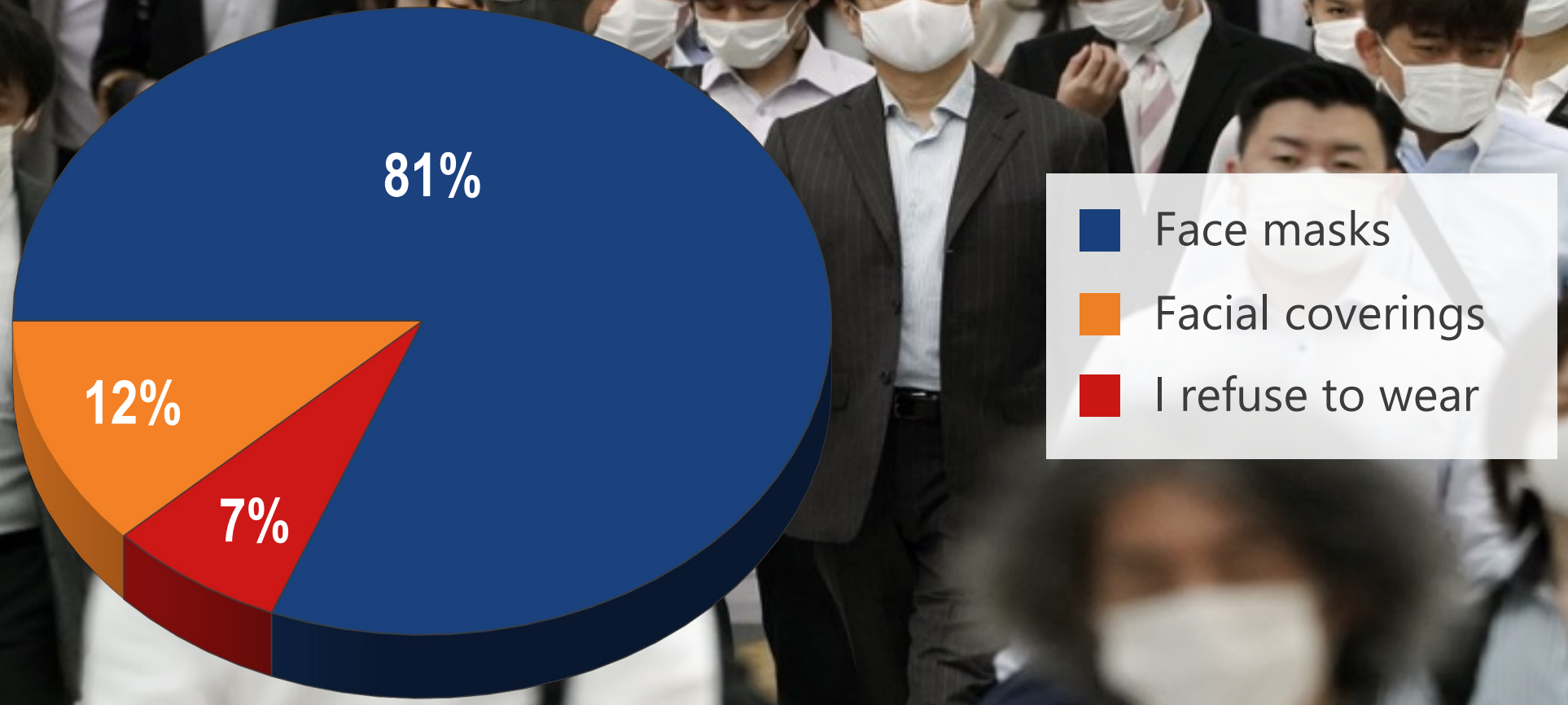


de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES

Obtained via MI FOIA by Judicial Watch, Inc.

ONLY CALL THEM FACE MASKS!!!

If recommended to you by leaders you trusted, would you be more willing to wear…in public places to reduce the spread of COVID-19?



Obtained via MI FOIA by Judicial Watch, Inc.

"It's not what you say.
It's what people hear."
Dr. Frank I. Luntz

http://debeaumont.org/changing-the-covid-conversation

www.filuntz.com

de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES™

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS) on behalf of Bouknight, Rey (DHHS)
To: Totten, Mark; Gordon, Robert (DHHS); Pohl, Zack; Brown, Tiffany; Brown, Melanie; Siegel, Traci
Subject: FW: GMMB & SOM - Comms Planning

-----Original Appointment-----
From: Bouknight, Rey (DHHS) <BouknightR@michigan.gov>
Sent: Saturday, March 28, 2020 8:31 PM
To: Bouknight, Rey (DHHS); Gordon, Robert (DHHS); Pohl, Zack; Brown, Tiffany; Brown, Melanie; Siegel, Traci
Subject: GMMB & SOM - Comms Planning
When: Sunday, March 29, 2020 11:00 AM-12:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Dial In: [redacted] Access Code: [redacted]

Agenda

-Introductions

-GMMB – COVID-19 California Efforts

-GMMB + SOM Objectives

-Statewide

-Southeast Michigan

-How we work together

-Steps

Obtained via MI FOIA by Judicial Watch, Inc.

EMILY SCHLICHTING

[redacted]

education

2017-2020 **HARVARD BUSINESS SCHOOL** **BOSTON, MA**
Master of Business Administration, *high distinction*

2017-2020 **HARVARD KENNEDY SCHOOL** **CAMBRIDGE, MA**
Master of Public Policy, concentration in business and government

2008-2012 **UNIVERSITY OF NEBRASKA-LINCOLN** **LINCOLN, NE**
Bachelor of Arts, *highest distinction*, Political Science and Communication Studies; Phi Beta Kappa

experience

MCKINSEY & COMPANY

2020-present **Associate** **ATLANTA, GA**
summer 2019 **Summer Associate** **CHICAGO, IL**

U.S. SENATE COMMITTEE ON HEALTH EDUCATION LABOR AND PENSIONS **WASHINGTON, DC**

2020, 2017 **Health Policy Advisor, Ranking Member Patty Murray (D-WA)**

- **COVID-19 Policy Development and Negotiation:** Developed policy and negotiated legislation in response to the COVID-19 pandemic, drafting white papers on testing, vaccines, and conducting oversights on the US response (2020)
- **Reconciliation and Budgetary Policy:** Constructed and successfully presented budgetary reconciliation arguments around regulatory economic impacts to Senate Parliamentarian to remove contested provisions in GOP ACA repeal legislation; drafted amendments and helped manage caucus floor strategy (2017)
- **Briefing and Staffing Senators:** Analyzed and interpreted complex policies in rapidly evolving legislative environments. Briefed Senators and other senior leaders in oral briefings and memos around strategic and policy decisions

2013-2014 **Legislative Aide for Health Policy, Chairman Tom Harkin (D-IA)**
Oversaw internship program, managing day-to-day work for a team of 6-8 and handling all hiring/HR processes; managed process for health legislative markups, nominations, and hearings

2019-2020 **WARREN FOR PRESIDENT** **CHARLESTOWN, MA**
Health Policy Advisor, Policy Team
Led development and economic modeling of candidate's health policy plans to establish a single payer system and pandemic preparedness, including health elements of proposed COVID-19 relief packages; assisted with debate preparation for the candidate; collaborated with communications team to develop messaging and respond to relevant press inquiries

summer 2018 **BLUE CROSS BLUE SHIELD OF NEBRASKA** **OMAHA, NE**
Strategy and Innovation Intern
Led revision of enterprise strategic plan to further diversify revenue streams via entry into new channels, including care delivery and consumer tech solutions. Reported to Vice President of Strategy and Innovation and CEO.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES **WASHINGTON, DC**

2015-2017 **Chief of Staff, Office of Assistant Secretary for Legislation, OS**
2014-2015 **Special Assistant for Discretionary Health, Office of Assistant Secretary for Legislation, OS**
Coordinated legislative agenda across 11 federal agencies within HHS, including through:

- **Office and Agenda Management:** Coordinated 30+ staff and senior leads of 11 agencies around unified legislative approach and process; managed legislative agenda for all HHS public health agencies
- **Negotiation:** Managed Congressional legislative negotiations, including developing of internal Administration consensus, on 21st Century Cures to preserve key priorities to protect drug efficacy standards, secure funding for FDA and the VP Biden's Cancer Moonshot, improve health IT, and fund efforts to address the opioid epidemic.
- **Policy Development:** Served as ASL representative in Department regulatory planning process; helped develop public health policy around nutrition, VP Biden's Cancer Moonshot, and more.
- **Congressional Hearing Management:** Managed Secretary Burwell's congressional hearing preparation process and materials, and distilling complex budgetary and policy topics into one-page briefs. Resulted in over 15 successful congressional hearings. Extensive knowledge of budget and budget process.
- **Relationship Management:** Prepared and staffed Secretary for strategic discussions with Members of Congress, helping to manage relationships and deliver on follow ups after key conversations.
- **Managing Senate Confirmations:** Helped manage Senate confirmation processes for HHS officials, including successful confirmation of Robert Califf as Commissioner of FDA

2012-2013 **Truman Albright Fellow, Office of Rural Health Policy, HRSA**
Staffed HHS rural advisory committee; Drafted and managed grant RFP; served as primary reviewer for state Medicaid waivers

awards Forbes 30 Under 30 for Health Care (2017); Harry S. Truman Scholar, Nebraska (2011)

media Testified on consumer impact of health reform in testimony before Senate HELP Committee (2011). Mainstage speaker and panelist at Stanford *Medicine X* conference (2017). Published op-ed on health care policy in *USA Today* (2012).

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: "Whitmer, Gretchen"; Totten, Mark; Bagley, Nick
Subject: FW: good to talk
Date: Sunday, April 12, 2020 11:55:31 AM

More from Zeke E.

From: Emanuel, Ezekiel J <zemanuel@upenn.edu>
Sent: Sunday, April 12, 2020 11:30 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: Re: good to talk

Yes probably worth it--lots of studies. Not as good as N95 but does really cut down on droplets spread and absorption, plus reminds people f public health.

Ezekiel J. Emanuel, M.D., Ph.D.

Vice Provost of Global Initiatives

Chair, Department of Medical Ethics and Health Policy (on Leave 2019-2020)

Levy University Professor

Co-Director, Healthcare Transformation Institute

Perelman School of Medicine and The Wharton School

University of Pennsylvania

Phone: 215-898-7226 or 215-573-8104

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Sunday, April 12, 2020 11:10 AM
To: Emanuel, Ezekiel J <zemanuel@upenn.edu>
Subject: RE: good to talk

OK. Last Q: What's your case for a mask mandate, even with DIY masks? Is it that the masks themselves reduce spread or that wearing masks changes other behavior, and is there evidence on

Obtained via MI FOIA by Judicial Watch, Inc.

the latter?

From: Emanuel, Ezekiel J <zemanuel@upenn.edu>
Sent: Sunday, April 12, 2020 11:05 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: Re: good to talk

YES. That is why social distancing is stillnecessary. And double down in minority communities. Also requiring masks would help.

April 30 is unlikely date

Ezekiel J. Emanuel, M.D., Ph.D.

Vice Provost of Global Initiatives

Chair, Department of Medical Ethics and Health Policy (on Leave 2019-2020)

Levy University Professor

Co-Director, Healthcare Transformation Institute

Perelman School of Medicine and The Wharton School

University of Pennsylvania

Phone: 215-898-7226 or 215-573-8104

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Sunday, April 12, 2020 11:03 AM
To: Emanuel, Ezekiel J <zemanuel@upenn.edu>
Subject: RE: good to talk

Per day? We are miles above that even with below-average testing.

From: Emanuel, Ezekiel J <zemanuel@upenn.edu>
Sent: Sunday, April 12, 2020 10:59 AM

Obtained via MI FOIA by Judicial Watch, Inc.

To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: Re: good to talk

20 new cases per million population is the level S korea is using. Seems about right

Ezekiel J. Emanuel, M.D., Ph.D.

Vice Provost of Global Initiatives

Chair, Department of Medical Ethics and Health Policy (on Leave 2019-2020)

Levy University Professor

Co-Director, Healthcare Transformation Institute

Perelman School of Medicine and The Wharton School

University of Pennsylvania

Phone: 215-898-7226 or 215-573-8104

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Sunday, April 12, 2020 10:30 AM
To: Emanuel, Ezekiel J <zemanuel@upenn.edu>
Subject: good to talk

Toward the end of the call, I think you threw out some numbers about the infection levels you'd want to see to loosen. If I got it right can you repeat?

Best,
Robert

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Huls, JoAnne; Foster, Tricia
Subject: FW: Guidance Doc for the EOG: Optimizing PPE in Crisis Standards
Date: Monday, March 30, 2020 1:24:35 PM
Attachments: PPE Shortage Guidance Final 3-30-2020.pdf

FYI

From: Esty, Sarah (DHHS) <EstyS@michigan.gov>
Sent: Monday, March 30, 2020 12:24 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Cc: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Hudson, Nicole (DHHS) <HudsonN2@michigan.gov>
Subject: RE: Guidance Doc for the EOG: Optimizing PPE in Crisis Standards

Actually please use this version. There was a date and formatting issue with the one I just sent.

From: Esty, Sarah (DHHS)
Sent: Monday, March 30, 2020 12:14 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Cc: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Hudson, Nicole (DHHS) <HudsonN2@michigan.gov>
Subject: Guidance Doc for the EOG: Optimizing PPE in Crisis Standards

Hi Robert,

The attached document has gone through the CHECC and is ready to go to the EOG. Nicole can assist if there are any questions.

Best,
Sarah



Obtained via MI FOIA by Judicial Watch, Inc.

Optimizing Personal Protective Equipment (PPE) During Crisis Capacity

Optimizing Personal Protective Equipment (PPE) during Crisis Capacity

The Centers for Disease Control and Prevention (CDC) provides strategies that can be utilized by healthcare workers to optimize use of PPE during periods of known shortages. These strategies should only be used when there is limited supply that has exceeded the ability to provide conventional standards.

During severe resource limitations, consider excluding healthcare providers (HCP) at higher risk for severe illness from COVID-19 from contact with known or suspected COVID-19 patients (e.g., those of older age, those with chronic medical conditions, or those who may be pregnant).

N-95 Respirators:

- Consider use of respirators beyond the manufacturer-designated shelf life for healthcare delivery.
- Consider use of respirators approved under standards used in other countries similar to NIOSH-approved N-95 respirators.
- Consider limited re-use of N-95 respirators for COVID-19 patients according to CDC guidance.
- In settings where N-95 respirators are so limited that routinely practiced standards of care for wearing **N-95 respirators and equivalent or higher level of protection respirators are no longer possible, and surgical masks are not available**, as a last resort, it may be necessary for HCP to use masks that have never been evaluated or approved by NIOSH or homemade masks.
- Any respirator that becomes visibly soiled, damaged, or difficult to breathe through should be discarded.

Eye Protection:

- Consider extending use of eye protection without removing between patient contacts. This can be done with disposable and reusable devices.
- Eye protection should be removed and reprocessed if it becomes visibly soiled or difficult to see through.
- Face shields that are reprocessed should be dedicated to one healthcare provider and reprocessed whenever it is visibly soiled or removed prior to putting it back on.
- Eye protection should be discarded if damaged (e.g., face shield can no longer fasten securely to the provider, if visibility is obscured and reprocessing does not restore visibility).
- Note: Avoid touching eye protection. If touched, immediately perform hand hygiene. If there is a need to remove eye protection, leave the patient care area.
- During extreme shortages (crisis standards of care) consider using eye protection devices beyond the manufacturer-designated shelf life (visually inspect the product prior to use and if there are concerns such as degraded materials discard the product).

Obtained via MI FOIA by Judicial Watch, Inc.

- Prioritize eye protection for selected activities such as where splashes and sprays are anticipated- includes aerosol generating procedures; during activities where prolonged face to face or close contact with a potentially infectious patient is unavoidable.
- Consider using safety glasses (trauma glasses) that have extensions to cover the side of the eyes.

Isolation Gowns:

- Consider shifting disposable gowns to cloth isolation gowns (this may require augmenting laundry operations personnel).
- Gowns must be routinely inspected and maintained and discarded when thin or ripped.
- Consider use of coveralls (requires training and practice prior to use)
- Consideration can be made to extend the use of isolation gowns (disposable or cloth) so that it is worn by the same healthcare provider when interacting with more than one patient known to be infected with the same infectious disease when the patients are cohorted in the same location. Only to be considered when there are no additional co-infectious diagnoses transmitted by contact.
- Any disposable gown that becomes visibly soiled should be disposed of. Cloth gowns that are visibly soiled should be removed and cleaned.
- During extreme shortages (crisis standards of care) gowns should be prioritized for activities where splashes and sprays are anticipated including aerosol generating procedures and during high-contact patient care activities such as dressing, bathing/showering, transferring, linen changes, assisting with toileting, device care or use and wound care.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Gordon, Robert (DHHS); Foster, Tricia
Subject: FW: HELLO.....and covid (of course)
Date: Tuesday, June 30, 2020 11:19:07 AM
Attachments: COVID Michigan.docx

Hi,
I sent this back in May to a number of folks, resending.

This gent is a friend of my ex husbands but I'm not holding that against him. They are doing work in North Carolina, other states, etc – if we think they can lend resource, and from my brief conversation, they can – we should tap them.

I don't think they were ever contacted.

Thanks

From: McDonald, Gregory <gmcdonald@rti.org>
Sent: Friday, May 8, 2020 1:36:11 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>
Subject: HELLO.....and covid (of course)

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Hello JoAnne – Greg McDonald here, its been years! I know you're busy but wanted to share a little information (attached) about my company that has an office in your fine state of Michigan. We have a small army of infectious disease experts (many were former CDC epidemic intelligence service officers) and we are doing all sorts of amazing work in the covid space helping local, state and the federal government respond. Id love to talk with someone on your team to see if we can help.

Also, if you're free would love to catch up.

Hope all is well,

Greg McDonald
202.460.1217

COVID-19 Response

Obtained via MI FOIA by Judicial Watch, Inc.

You need a partner to respond and build resilient health systems to improve public health. Although COVID-19 is a novel virus presenting extraordinary challenges, our work on a variety of public health threats—including Ebola, Zika, tuberculosis, malaria, opioids and HIV—mitigate effects of infectious diseases.

Capabilities RTI is a nonprofit research institute headquartered in North Carolina with offices in Ann Arbor. Our 5,700 experts' vision is to address the world's most critical problems with science-based solutions in pursuit of a better future.

Using cutting-edge approaches, we take on the most significant and entrenched public health challenges facing the U.S. and countries around the world. Federal agencies, state health departments, major foundations, and others choose us to design, implement, and evaluate scientifically based programs that respond to public health emergencies.

Meet an expert

Pia MacDonald, PhD, MPH, CPH
Senior Director
Center for Applied Public Health Research
RTI International
Mobile: 919-597-9755
Email: pmacdonald@rti.org

Come see our work

Register for our webinars on COVID

Contact Tracing. Governments need data collection personnel, tracing systems, tracing databases, health communication experts, and infrastructure prepared to support contact tracing. With a traditional call center moved virtual, RTI's 1200 staff, including 100 supervisors, work from their homes conducting interviews, locating, and contacting interviewees for different scientific studies and surveys as part of work with governments. Two representative projects include:

- *World Trade Center Health Registry* – After September 11, RTI played a key role with the New York City Department of Health and Hygiene in developing and implementing a system to track affected people.
- *Ebola outbreak in the Democratic Republic of Congo*. As the leading surveillance partner for CDC's Global Health Security Agenda activities in DRC, RTI worked to detect, report, and manage information about suspected Ebola cases and their contacts.

Deploying COVID-19 Resources Efficiently. Governments need to deploy limited resources efficiently. RTI is currently advising the state of North Carolina on its COVID response, providing the Governor with modeling estimates for various transmission scenarios to understand how these affect possible systemic demand.

Assessing COVID-19 Behaviors and Challenges. Public knowledge and perception of COVID-19 affects the success of your response. RTI is currently working with the state of Ohio to track virus-related behaviors and to measure the economic and health challenges of the pandemic.

Evidence-based Communication Strategies to Address Knowledge Gaps. Your citizens need accurate and relevant information. RTI provides research to help policymakers make informed decisions and to understand how those decisions affect their residents. RTI developed and implemented a national survey in both March and April to assess Americans' knowledge of the coronavirus and their support for and practice of community mitigation strategies.

Protecting At-Risk Groups. Vulnerable populations need specific attention and need to take extra precautions to avoid getting sick. Responding to the Zika virus outbreak in Puerto Rico, RTI developed a comprehensive behavior change campaign aimed at protecting pregnant women from the virus.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: whitmerg1@michigan.gov
Subject: FW: interesting article
Date: Tuesday, September 1, 2020 12:05:38 PM

Just FYI.

From: Gordon, Robert (DHHS)
Sent: Tuesday, September 1, 2020 12:04 PM
To: Totten, Mark <TottenM1@michigan.gov>
Subject: interesting article

About voice level and COVID transmission. Relates to conversation earlier.

https://www.theatlantic.com/ideas/archive/2020/08/wear-your-mask-and-stop-talking/615796/

Robert Gordon
Director
Michigan Department of Health & Human Services
gordonr3@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark
Subject: FW: Introduction/Assistance
Date: Wednesday, October 21, 2020 2:54:00 PM
Attachments: image004.jpg
image005.png
image006.png
image007.jpg

From: Matt Saxton <msaxton@misheriff.org>
Sent: Wednesday, October 21, 2020 11:29 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Robert Stevenson <rstevenson@michiganpolicechiefs.org>; Bouknight, Rey (DHHS) <BouknightR@michigan.gov>
Cc: Gasper, Joe (MSP) <GasperJ@michigan.gov>; Ben Bodkin <bbodkin@capitolservices.org>
Subject: RE: Introduction/Assistance

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Good morning Director Gordon,

Thank you for virtually attending the MSA Board Meeting yesterday, I apologize for the poor connection. As promised, the Board discussed the importance of masking up, social distancing, the orders, and the pros and cons of enforcement through education and enforcement through administrative ticketing processes.

MSA's Board of Directors appreciates you sharing the administrative process with law enforcement, but encourages law enforcement and state agencies to approach this issue from a standpoint of education. MSA encourages law enforcement officers to stress an approach of education with those not wearing masks in order to deescalate a potential situation. Further, MSA is prepared to commit to joint PSA's with local agencies, state agencies, and others to encourage Michiganders to "Mask Up" to protect the public safety. That said, MSA believes the administrative ticketing process would be difficult to enforce both legally and from a manpower perspective, and encourages all parties to refrain from emphasizing that message, as it is both counterproductive and negative.

Let's be positive and encourage our fellow citizens to mask up, social distance and be safe by being public examples, rather than encouraging them to increase calls to our offices to report mask violations. MSA looks forward to participating in this educational effort, both with you and with the people our sheriffs serve at home to make sure we curb this latest spike.

Thanks
Matt

Matthew M. Saxton
CEO/Executive Director
Michigan Sheriffs' Association

CONFIDENTIAL – PROTECTED COMMUNICATION
This message is confidential, intended only for the named recipient(s) and may contain information that is privileged, attorney work product, law enforcement sensitive information, intelligence or other information exempt from disclosure under applicable laws. If you are not the intended recipient(s), you are notified that the dissemination, distribution or copying of this message is strictly prohibited. If you receive this message in error, or are not the named recipient(s), please notify the sender at either the email address or telephone number above and delete this email from your computer. Receipt by anyone other than the named recipient(s) is not a waiver of any applicable privilege under federal or state law.

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Monday, October 19, 2020 4:08 PM
To: Robert Stevenson <rstevenson@michiganpolicechiefs.org>; Bouknight, Rey (DHHS) <BouknightR@michigan.gov>; Matt Saxton <msaxton@misheriff.org>
Cc: Gasper, Joe (MSP) <GasperJ@michigan.gov>
Subject: RE: Introduction/Assistance

Bob and Matt,

Thanks again for working with us on enforcement. Please see the attached one-pager on the proposed approach, as described by Colonel Gasper yesterday.

We would be happy to hear your feedback, and would be grateful for your support.

Best,

Robert

From: Robert Stevenson <rstevenson@michiganpolicechiefs.org>
Sent: Monday, October 19, 2020 2:11 PM
To: Bouknight, Rey (DHHS) <BouknightR@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Matt Saxton <msaxton@misheriff.org>
Cc: Gasper, Joe (MSP) <GasperJ@michigan.gov>
Subject: Re: Introduction/Assistance

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Rey,

It is nice to virtually meet you.

The International Association of Chiefs of Police (IACP) Conference is taking place Wednesday – Friday and I am scheduled to attend virtually. Depending on what is taking place at the time of the presser I can maybe cut out and participate. However, I have talked with our President and he should be available.

I'm assuming this will be a virtual attendance?

Bob

Robert Stevenson
Chief Robert Stevenson (Ret.)
Executive Director
Michigan Association of Chiefs of Police
3474 Alaiedon Parkway, Suite 600
Okemos, MI 48864

Obtained via MI FOIA by Judicial Watch, Inc.

517-349-9420
rstevenson@michiganpolicechiefs.org

From: "Bouknight, Rey (DHHS)" <BouknightR@michigan.gov>
Date: Monday, October 19, 2020 at 11:40 AM
To: "Gordon, Robert (DHHS)" <GordonR3@michigan.gov>, Robert Stevenson <rstevenson@michiganpolicechiefs.org>, Matt Saxton <msaxton@misheriff.org>
Cc: "Gasper, Joe (MSP)" <GasperJ@michigan.gov>
Subject: RE: Introduction/Assistance

Thank you, Director Gordon.

Bob and Matt, it's a pleasure to meet you. As Director Gordon mentioned, we're planning a press event to take place this Thursday regarding the enforcement measures related masks and social distancing. This press event will include Director Gordon and Col. Gasper, and we would like to invite the two of you to participate on your associations behalf, and/or other sheriff and police chief representatives. Messaging would reflect statements of support as outlined by Director Gordon below. I was wondering if the two of you would be open to the idea of participating in the press event, understanding that you're still awaiting the document summarizing the proposed enforcement approach? We'd be happy to follow up with additional details as well and address any questions. Thank you.

Best,
Rey

Rey Bouknight II, MPH
Director, Office of External Affairs & Communications
Michigan Department of Health and Human Services
Email: bouknightr@michigan.gov
Office: (517) 284-4771
Cell: (517) 285-3862

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Monday, October 19, 2020 7:54 AM
To: Robert Stevenson <rstevenson@michiganpolicechiefs.org>; Matt Saxton <msaxton@misheriff.org>
Cc: Gasper, Joe (MSP) <GasperJ@michigan.gov>; Bouknight, Rey (DHHS) <BouknightR@michigan.gov>
Subject: RE: Introduction/Assistance

Bob, Matt,

Hope you both had good Sundays.

We're going to follow your advice and not try to pull off an announcement tomorrow. The Governor has a press event scheduled on Wednesday, so we will plan around Thursday. As to what would be most useful, we would greatly value organizational statements of support along the lines Bob describes below, that people who see local violations regarding masks or social distancing can contact local police or sheriffs as appropriate, and they will handle them (with default pathway as report and referral as civil matter; criminal only for egregious). Later today, Colonel Gasper and I will get you a document summarizing this proposed enforcement approach.

We also would value having chiefs and sheriffs as speakers at the event. We're still thinking through what that could look like, and I am copying our communications director, Rey Bouknight.

Happy to discuss, and thanks again for your collaboration.

Best,
Robert

From: Robert Stevenson <rstevenson@michiganpolicechiefs.org>
Sent: Sunday, October 18, 2020 7:44 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Matt Saxton <msaxton@misheriff.org>
Cc: Gasper, Joe (MSP) <GasperJ@michigan.gov>
Subject: Re: Introduction/Assistance

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Robert,

I still believe that is a very aggressive time line.

Please let me know ASAP what exactly the press conference will entail that you want the MACP to endorsement. If it is the wearing of masks and social distancing I don't need Board Approval. We already do that.

If it for the announcement that people that see violations should call their local police agency for all mask complaints and we will come out and handle them, that is totally different and I will need Board approval.

Obtained via MI FOIA by Judicial Watch, Inc.

Looking forward to working together,

Bob

From: "Gordon, Robert (DHHS)" <GordonR3@michigan.gov>
Date: Saturday, October 17, 2020 at 5:12 PM
To: Matt Saxton <msaxton@misheriff.org>
Cc: Robert Stevenson <rstevenson@michiganpolicechiefs.org>, "Gasper, Joe (MSP)" <GasperJ@michigan.gov>
Subject: RE: Introduction/Assistance

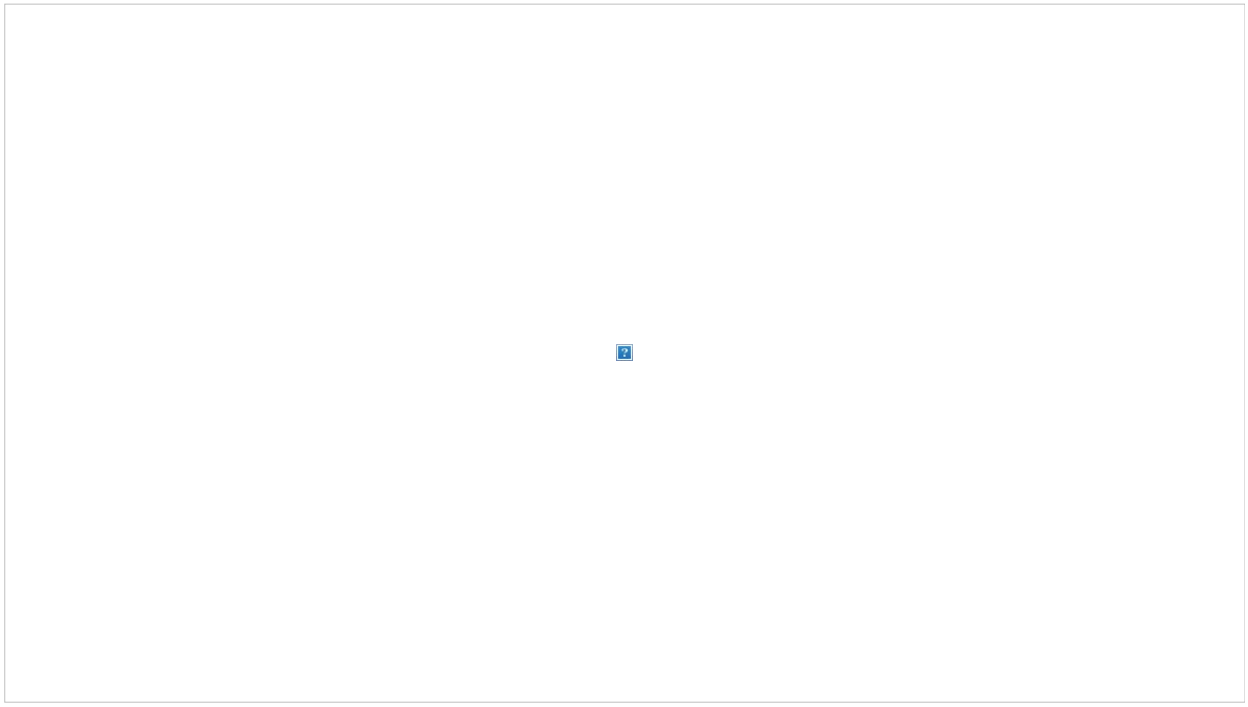
Thanks very much for the call and the serious engagement on such short notice. Colonel Gasper and I could do a call 10:30-11:00 on Tuesday, if that would work.

Below is the hospitalization slide I mentioned. It's almost a week old and things have gotten worse since. I will ask about pathways for getting information on a more regular basis.

We're working on the one-page summary and on further thoughts about Tuesday press. If there's more we can do before Monday, please let us know.

Best,

Robert



From: Matt Saxton <msaxton@misheriff.org>
Sent: Saturday, October 17, 2020 7:52 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Cc: Robert Stevenson <rstevenson@michiganpolicechiefs.org>; Gasper, Joe (MSP) <GasperJ@michigan.gov>
Subject: Re: Introduction/Assistance

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

I can make it work

Matthew M. Saxton
CEO/Executive Director
Michigan Sheriffs' Association
620 South Capitol Avenue, Suite 320A
Lansing, Michigan 48933-2327
517-485-3135



CONFIDENTIAL – PROTECTED COMMUNICATION
This message is confidential, intended only for the named recipient(s) and may contain information that is privileged, attorney work product, law enforcement sensitive information, intelligence or other information exempt from disclosure under applicable laws. If you are not the intended recipient(s), you are notified that the dissemination, distribution or copying of this message is strictly prohibited. If you receive this message in error, or are not the named recipient(s), please notify the sender at either the email address or telephone number above and delete this email from your computer. Receipt by anyone other than the named recipient(s) is not a waiver of any applicable privilege under federal or state law.

On Oct 17, 2020, at 7:39 AM, Gordon, Robert (DHHS) <GordonR3@michigan.gov> wrote:

Obtained via MI FOIA by Judicial Watch, Inc.

Thanks a lot for the fast replies. Should we go for 4pm today? If that works, I can circulate a dial-in.

I look forward to the day when I am no longer sending work emails at 7am on a Saturday.

Best,
Robert

From: Matt Saxton <msaxton@misheriff.org>
Sent: Saturday, October 17, 2020 7:34 AM
To: Robert Stevenson <rstevenson@michiganpolicechiefs.org>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Gasper, Joe (MSP) <GasperJ@michigan.gov>
Subject: Re: Introduction/Assistance

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Good morning Director Gordon,

If you want to pick a couple times for a phone call or a zoom meeting I will do my best to make one work.

I will be in the car for a couple of hours this morning and can move most things around this afternoon to fit in Bob's time frame. I can also do anytime tomorrow afternoon and Monday morning.

Thank you for bringing MSA and MACP to the table to discuss options.

Thanks
Matt

Matthew M. Saxton
CEO/Executive Director
Michigan Sheriffs' Association
620 South Capitol Avenue, Suite 320A
Lansing, Michigan 48933-2327
517-485-3135

CONFIDENTIAL – PROTECTED COMMUNICATION
This message is confidential, intended only for the named recipient(s) and may contain information that is privileged, attorney work product, law enforcement sensitive information, intelligence or other information exempt from disclosure under applicable laws. If you are not the intended recipient(s), you are notified that the dissemination, distribution or copying of this message is strictly prohibited. If you receive this message in error, or are not the named recipient(s), please notify the sender at either the email address or telephone number above and delete this email from your computer. Receipt by anyone other than the named recipient(s) is not a waiver of any applicable privilege under federal or state law.

> On Oct 17, 2020, at 7:01 AM, Robert Stevenson <rstevenson@michiganpolicechiefs.org> wrote:
>
> Director Gordon,
>
> Looks like we exchanged emails at about the same time. I'm not sure what it means when Joe, you and me are up before 0700 hours reading and exchanging emails on a Saturday morning!
>
> Hopefully we can talk sometime this weekend,
>
> Bob
>
> Robert Stevenson
> Chief Robert Stevenson (Ret.)
> Executive Director
> Michigan Association of Chiefs of Police
> 3474 Alaiedon Parkway, Suite 600
> Okemos, MI 48864
> 517-349-9420
> rstevenson@michiganpolicechiefs.org
>
> On 10/17/20, 6:50 AM, "Gordon, Robert (DHHS)" <GordonR3@michigan.gov> wrote:
>
> Thanks a lot, Colonel Gasper, and good morning, Mr. Saxton and Mr. Stevenson,
>
> I appreciate the chance to be in touch with you.
>
> By way of background, last week MDHHS issued an order on masking, social distancing, and capacity limits that is similar to key Executive Orders that are no longer enforceable. The MDHHS order was issued under a statute (MCL 333.2253) enacted by the Michigan Legislature after the Spanish flu in order to control epidemics, specifically by limiting gatherings. That statute that was not before the Supreme Court, and it is narrower than the law the Court struck down.
>
> With COVID-19 cases surging, there is great urgency to encourage masking and social distancing. These are the best tools available to slow the rise in cases, hospitalizations, and deaths. While some people will act because they believe it is important, for others, a credible threat of sanction is likely to be critical.
>
> I know that this is a subject with many complexities and would be eager to talk with you about the approach we have been developing with MSP. I can be available for a conversation at a good time for you, including Monday morning until 10:30. My cell is 517-242-0165.

Obtained via MI FOIA by Judicial Watch, Inc.

Here is the order: https://www.michigan.gov/coronavirus/0,9753,7-406-98178_98455-541962--,00.html

Best,

Robert Gordon
Director
Michigan Department of Health & Human Services
gordonr3@michigan.gov

-----Original Message-----
From: Gasper, Joe (MSP) <GasperJ@michigan.gov>
Sent: Saturday, October 17, 2020 5:37 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Cc: Matt Saxton <msaxton@misheriff.org>; rstevenson@michiganpolicechiefs.org
Subject: Introduction/Assistance

Director Gordon

By way of a virtual introduction I would like to introduce you to Executive Director Matt Saxton of the Michigan Sheriffs' Association and Executive Director Bob Stevenson of the Michigan Association of Chiefs of Police.

Bob and Matt, Director Robert Gordon leads the Michigan Department of Health and Human Services.

MDDHS and MSP are attempting to establish a process to appropriately enforce the current mask order recently issued by Director Gordon. We would like each of you at the table as we continue to work through the details. We are on an aggressive timeline as there is interest in publishing a press release or holding a press conference next week Tuesday or Wednesday.

I'll step back here and let Director Gordon continue the dialogue to include scheduling a call. Thank you.

Jg

Sent from my iPad

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark; Kolodin, Zach
Cc: Bouknight, Rey (DHHS); Esty, Sarah (DHHS)
Subject: FW: Introduction/Assistance
Date: Saturday, October 17, 2020 6:52:00 AM

FYI. Let me know if I should loop one of you into this. Happy also to follow your lead on other contacts. Thanks.

-----Original Message-----
From: Gordon, Robert (DHHS)
Sent: Saturday, October 17, 2020 6:50 AM
To: Gasper, Joe (MSP) <GasperJ@michigan.gov>
Cc: Matt Saxton <msaxton@misheriff.org>; rstevenson@michiganpolicechiefs.org
Subject: RE: Introduction/Assistance

Thanks a lot, Colonel Gasper, and good morning, Mr. Saxton and Mr. Stevenson,

I appreciate the chance to be in touch with you.

By way of background, last week MDHHS issued an order on masking, social distancing, and capacity limits that is similar to key Executive Orders that are no longer enforceable. The MDHHS order was issued under a statute (MCL 333.2253) enacted by the Michigan Legislature after the Spanish flu in order to control epidemics, specifically by limiting gatherings. That statute that was not before the Supreme Court, and it is narrower than the law the Court struck down.

With COVID-19 cases surging, there is great urgency to encourage masking and social distancing. These are the best tools available to slow the rise in cases, hospitalizations, and deaths. While some people will act because they believe it is important, for others, a credible threat of sanction is likely to be critical.

I know that this is a subject with many complexities and would be eager to talk with you about the approach we have been developing with MSP. I can be available for a conversation at a good time for you, including Monday morning until 10:30. My cell is 517-242-0165.

Here is the order: https://www.michigan.gov/coronavirus/0,9753,7-406-98178_98455-541962--,00.html

Best,

Robert Gordon
Director
Michigan Department of Health & Human Services gordonr3@michigan.gov

-----Original Message-----
From: Gasper, Joe (MSP) <GasperJ@michigan.gov>
Sent: Saturday, October 17, 2020 5:37 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Cc: Matt Saxton <msaxton@misheriff.org>; rstevenson@michiganpolicechiefs.org
Subject: Introduction/Assistance

Director Gordon

By way of a virtual introduction I would like to introduce you to Executive Director Matt Saxton of the Michigan Sheriffs' Association and Executive Director Bob Stevenson of the Michigan Association of Chiefs of Police.

Obtained via MI FOIA by Judicial Watch, Inc.

Bob and Matt, Director Robert Gordon leads the Michigan Department of Health and Human Services.

MDDHS and MSP are attempting to establish a process to appropriately enforce the current mask order recently issued by Director Gordon. We would like each of you at the table as we continue to work through the details. We are on an aggressive timeline as there is interest in publishing a press release or holding a press conference next week Tuesday or Wednesday.

I'll step back here and let Director Gordon continue the dialogue to include scheduling a call. Thank you.

Jg

Sent from my iPad

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark
Subject: FW: Lab Exploration (April 10)
Date: Sunday, April 12, 2020 8:30:43 AM
Attachments: image001.png
image002.png
image003.png
image004.png
image005.jpg
LabCharts and Pivot 20200410 - Old Method.xlsx
image006.png

This is on the testing numbers—team spent a long time on it yesterday. Seems to be a few small things versus one big one.

From: Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>
Sent: Saturday, April 11, 2020 6:01 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: FW: Lab Exploration (April 10)

See below message/attached data, if interested. At least some of this trend appears to be data reporting issues, but will keep drilling down.

From: Taverna, Andrea (DHHS-Contractor)
Sent: Saturday, April 11, 2020 5:58 PM
To: LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Soehnlen, Marty (DHHS) <SoehnlenM@michigan.gov>; Buck, Matthew (DHHS) <BuckM@michigan.gov>
Subject: RE: Lab Exploration (April 10)

This is really cool. Agree -- Darline is awesome.

Looking through this, I'm wondering if we actually have two buckets of issues going on – see below.

Potential next step = follow up conversations with these labs (where issue is unexplained)?

Obtained via MI FOIA by Judicial Watch, Inc.

Hypothesis	Lab	Data Trend
Pure data reporting issues	Providence Hospitals – St. John and others	Missing 4/8 data; 4/8 was notably low statewide
	Bio Reference	Spike on 4/4 then much lower numbers – but by all accounts, they've been steadily testing 500 ppl/day in Detroit
	LabCorp	Spike from 4/3 – 6, otherwise much lower daily results
	Quest SJC	Essentially all reporting on one day with 4K tests; national media coverage of severe backlog issues at this lab
Potential substantive changes in service/supplies/patients	Beaumont	Tests trending lower from level around 3/31 – 4/2
	Henry Ford	Spike on 4/4 and falling daily numbers since then; supply issue? data reporting issue?
	BOL	Trending lower while validating new equipment

From: LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>
Sent: Saturday, April 11, 2020 5:29 PM
To: Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>
Subject: FW: Lab Exploration (April 10)

Darline is awesome – please take a look

From: Darline El Reda <delreda@medadvgrp.com>
Sent: Saturday, April 11, 2020 5:18 PM
To: LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>
Subject: Lab Exploration (April 10)

FYI—this is the ad-hoc we did yesterday for Jim Collins.
File is huge because of charts which may not be needed on an ongoing basis.
But, take a look we have lab by day – we can add that to the standard daily reporting starting tomorrow

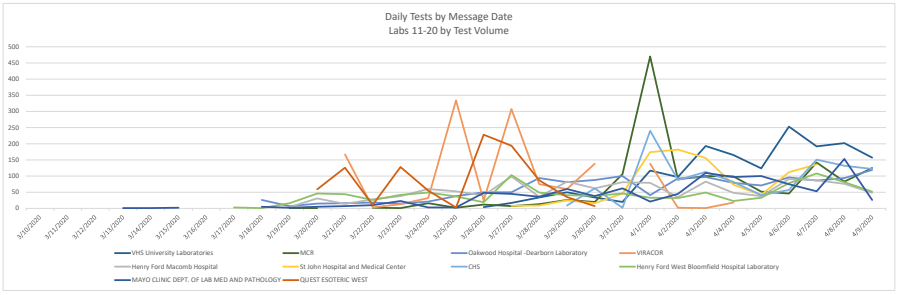
Darline K. El Reda, Dr.PH, MPH
Vice President
Medical Advantage Group | Value Driven. Healthcare. Solutions.
main: 734.344.4284 | **medicaladvantagegroup.com**



The information contained in this communication is confidential and is intended solely for the use of the individual(s) to whom this communication is directed. If you are not the intended recipient, any viewing, copying, disclosure or distribution of this information is prohibited. Please notify the sender by electronic mail or telephone of any unintended receipt and delete the original message.

Obtained via MI FOIA by Judicial Watch, Inc.

Obtained via MI FOIA by Judicial Watch, Inc.



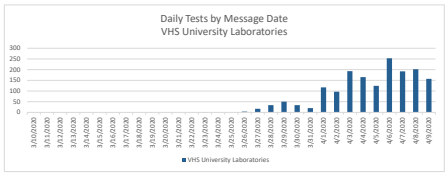
Among labs #11-20 by total volume:

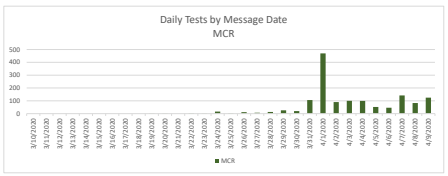
MCR had a high peak on 4/1, but is still sending results.

Viracor sent a lot late March through 4/1, but is still sending a very low number of tests occassionally.

Quest Esoteric West does not appear to be sending results for the past week.

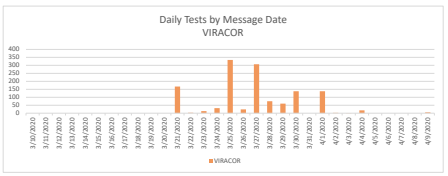
Providence hospital labs are missing results from 4/8.



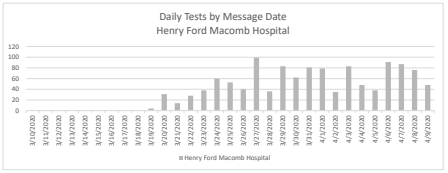


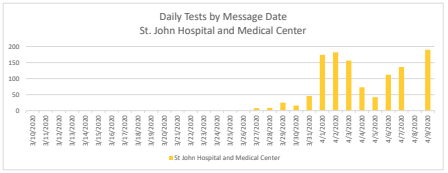
MCR peak 4/1



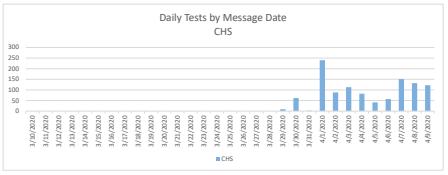


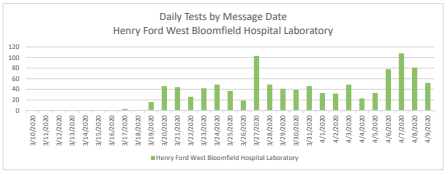
Viracor had a lot of variation, topping out at nearly 350 tests in one day, but almost nothing in the past week

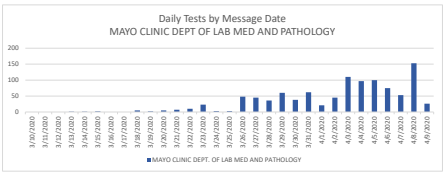


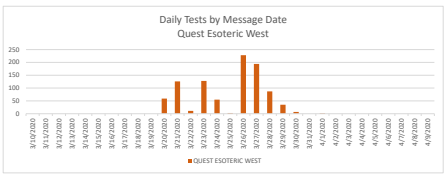


St. John Hospital is part of the Providence system, missing results from 4/8.









Quest Esoteric West shows nothing since 4/1.

Obtained via MI FOIA by Judicial Watch, Inc.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark
Subject: FW: last night"s briefing
Date: Tuesday, June 30, 2020 2:27:33 PM
Attachments: 20200629 Data and modeling update.pptx
20200629 Data and modeling update.pdf

Here you go.

Obtained via MI FOIA by Judicial Watch, Inc.

MI COVID response

Data and modeling update

June 29, 2020

NOTE: all data as of June 27 unless otherwise noted

Draft and pre-decisional

DRAFT

Obtained via MI FOIA by Judicial Watch, Inc.

Executive summary

Indicators are increasing across MI, with varied risk across the state

Lansing region has seen an increase in new cases to >40 per mm, which puts them in a “high” risk level.

Grand Rapids region has also increased in number of cases over the last 2 weeks, raising the region above the 20 cases per mm threshold (medium-high risk). Also concerning is the increase in percent positivity during a time of increased testing

The Detroit, Kalamazoo, Saginaw, and Jackson regions have seen increases in cases over the past week however have remained under the 20 cases per mm level (medium risk). Additionally percent positivity remains below 3%

The Traverse City and UP regions have had increased case counts in the past week, however continue to have low overall case levels and low percent positivity (low risk)

Daily diagnostic (PCR) testing increased to 15.6K per day in the last week, driven primarily by increases by hospital labs

Percent positivity increased to 2.6% (up from 2.3% last week)

Case investigation rates reached new highs over the past week, but contact tracing slightly decreased after some system errors that have since been resolved

Of the ~1850 cases referred over the past week (including weekends), Local Health Departments are reaching 59% within the first day and 67% within two days, allowing for fast elicitation of contacts and communication about available resources

After obtaining contacts from these cases, LHDs and Central Tracers are reaching ~62% of contacts within one day. This number will fluctuate in the coming weeks as more Local Health Departments shift their workflows and acclimate to the new central Traceforce system

Obtained via MI FOIA by Judicial Watch, Inc.

Epi and indicators

- **State-level indicators**
- Regional and county indicators
- State comparison

Testing

Case investigation and tracing

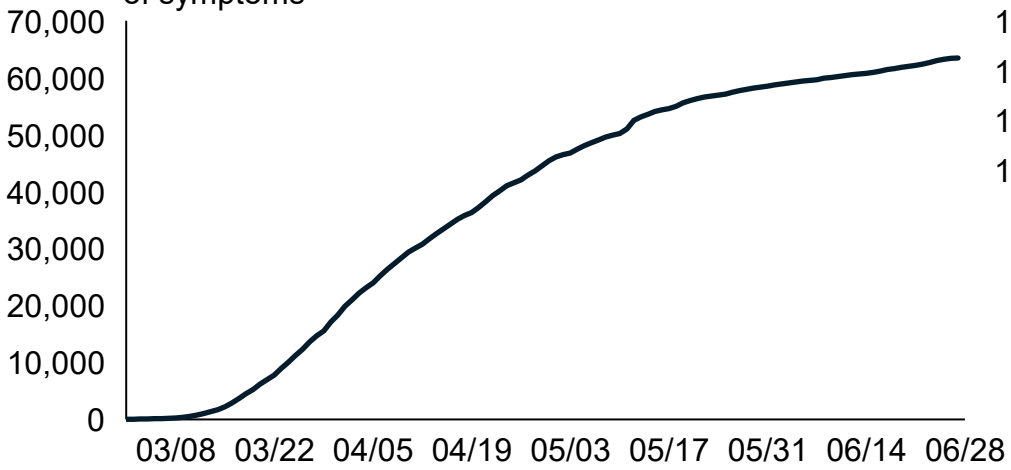
Upcoming data sources

Appendix

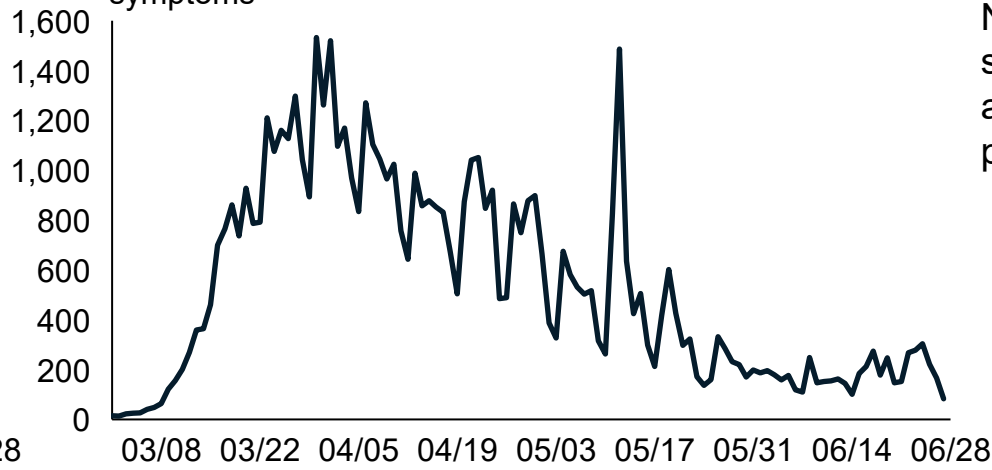
Obtained via MI FOIA by Judicial Watch, Inc.

COVID-19 cases and deaths: State of Michigan

Cumulative lab confirmed cases, by date of onset of symptoms



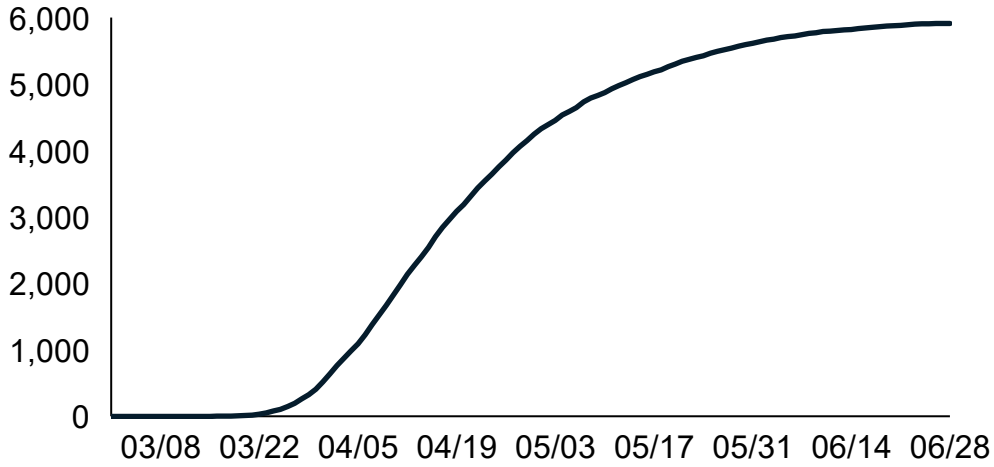
New lab confirmed cases, by date of onset of symptoms



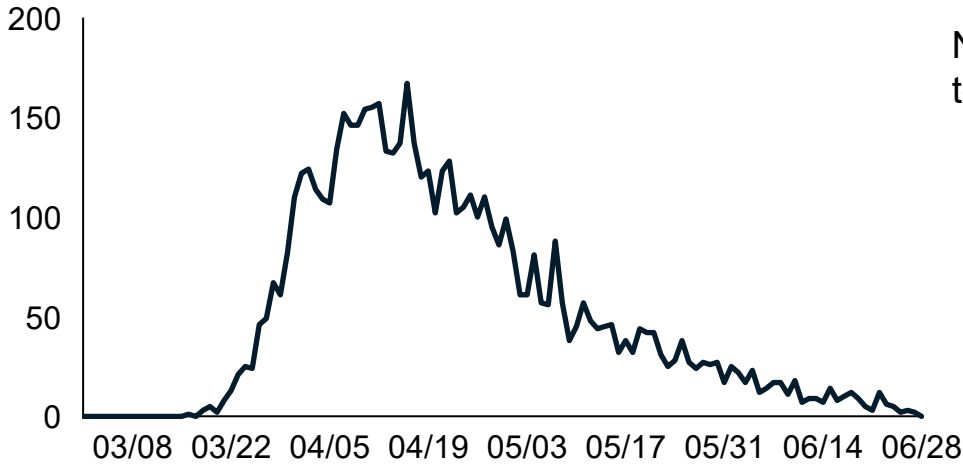
Updates since last week:

New cases per day rose slightly over the past week, after the recent period of plateau

Cumulative deaths, by reported date



New deaths, by reported date



Updates since last week:

New deaths per day continue to decrease

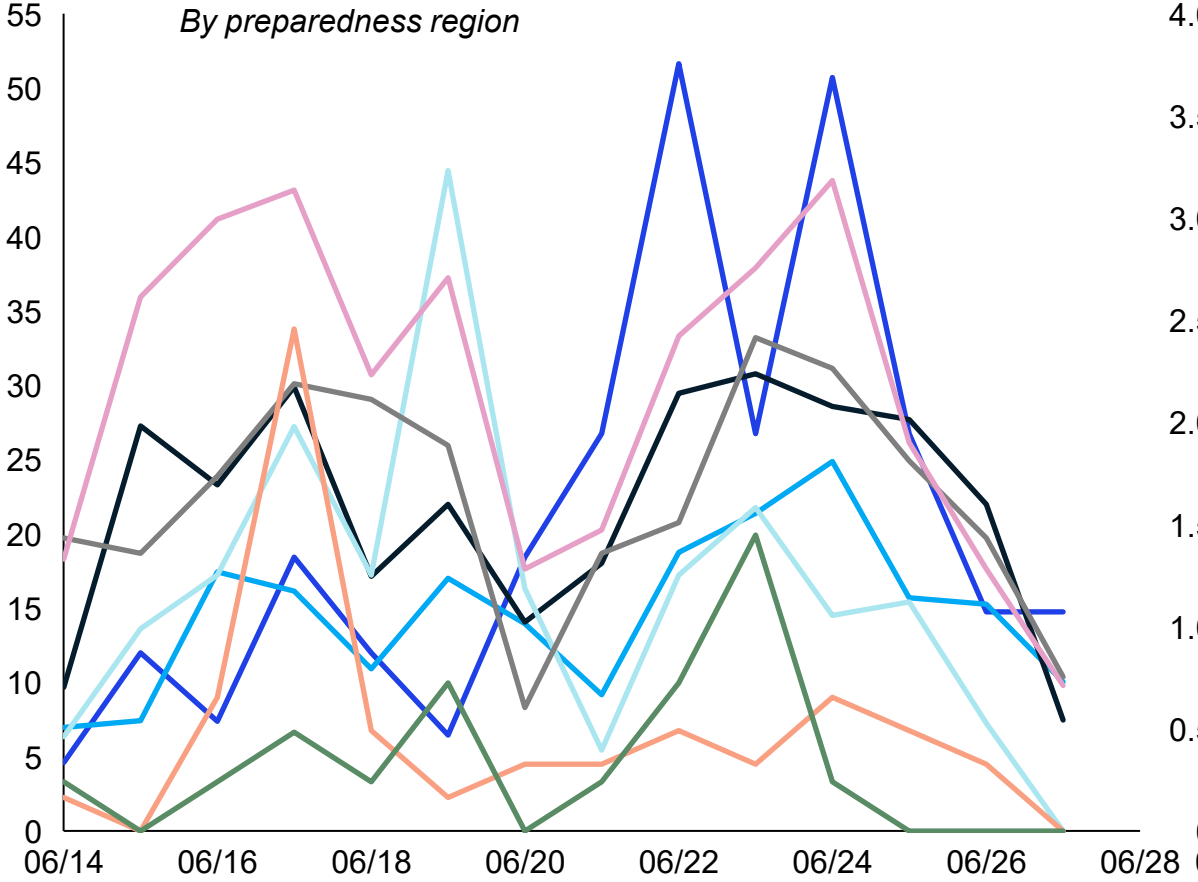
Note: Cases information sourced from MDHHS and reflects date of onset of symptoms (refers to lab-confirmed cases). Case spike on 5/12 is a result of batch of test results, not all of which have onset date of symptoms completed yet
Source: MDHHS – Michigan Disease Surveillance System

Obtained via MI FOIA by Judicial Watch, Inc.

COVID-19 cases and deaths: regional comparison PAST TWO WEEKS

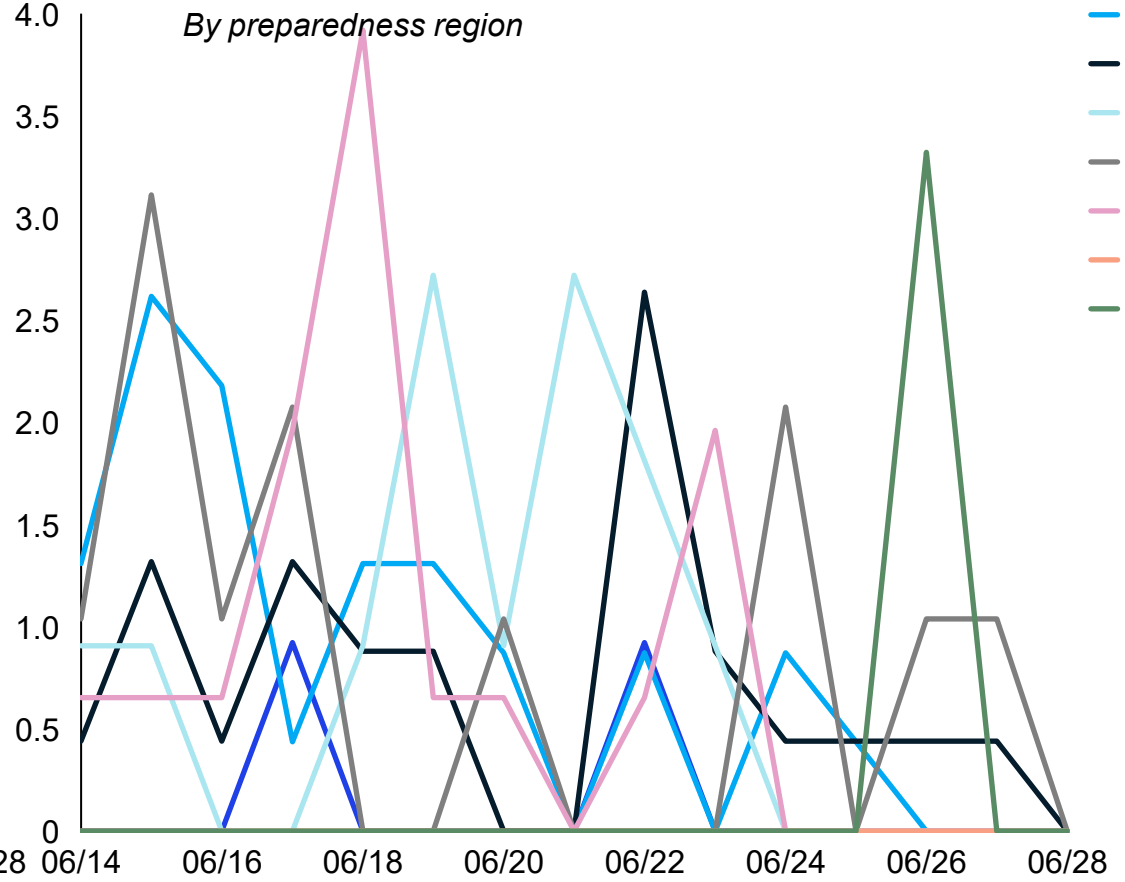
New cases per million, by date of onset of symptoms

By preparedness region



New deaths per million, by reported date

By preparedness region





Updates since last week:

Region one experienced several days of high case growth over the past week

Updates since last week:

Deaths continue to remain low across the state

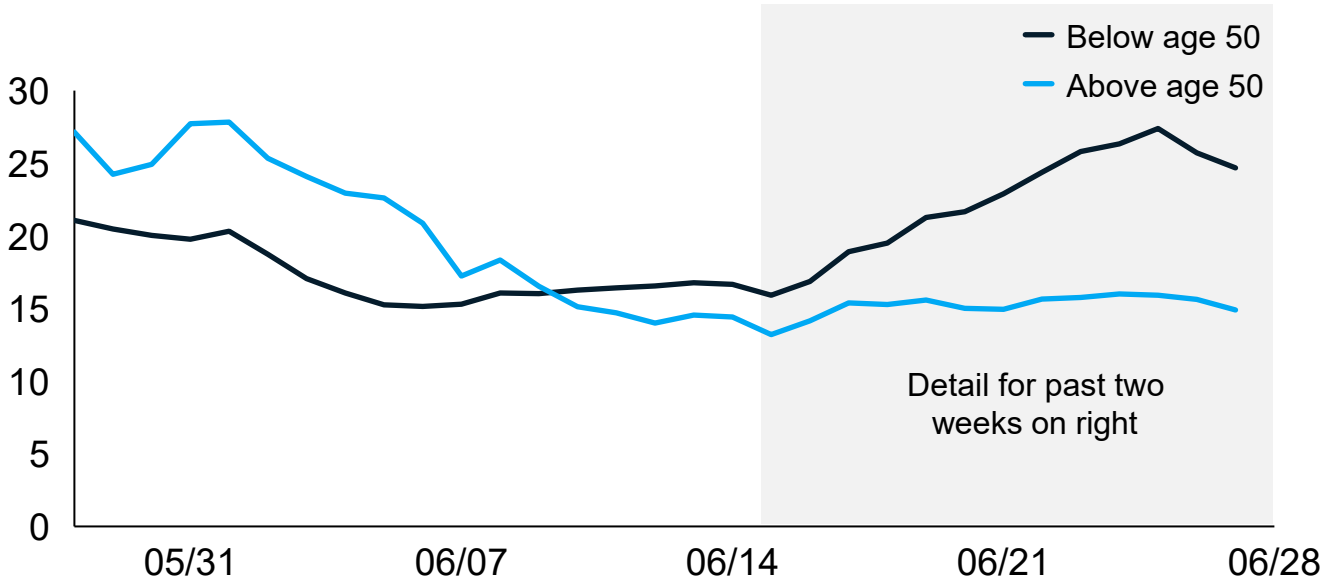
Note: “Cases” refers to lab-confirmed cases. Note: By preparedness region
Source: MDHHS – Michigan Disease Surveillance System

Draft

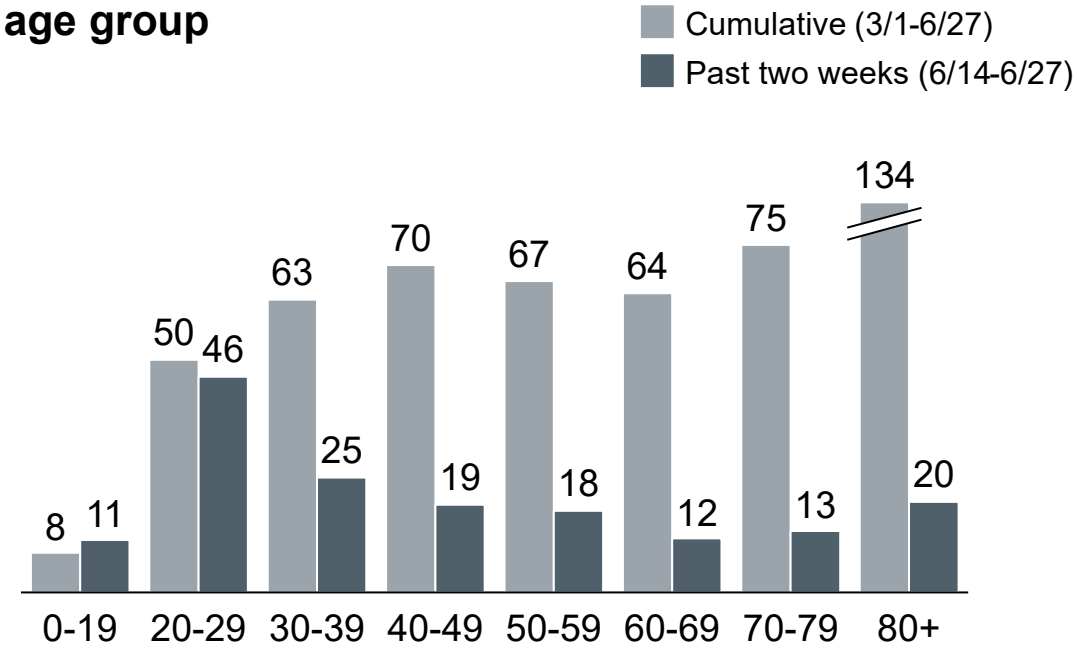
Obtained via MI FOIA by Judicial Watch, Inc.

Average daily new cases per million residents, by age group

Daily new cases per million by age group (7 day rolling average)



Average daily new cases per million by age group



Recent increase in cases from young people could be driven by a recent outbreak in East Lansing and other gatherings, as well as by younger individuals returning to work

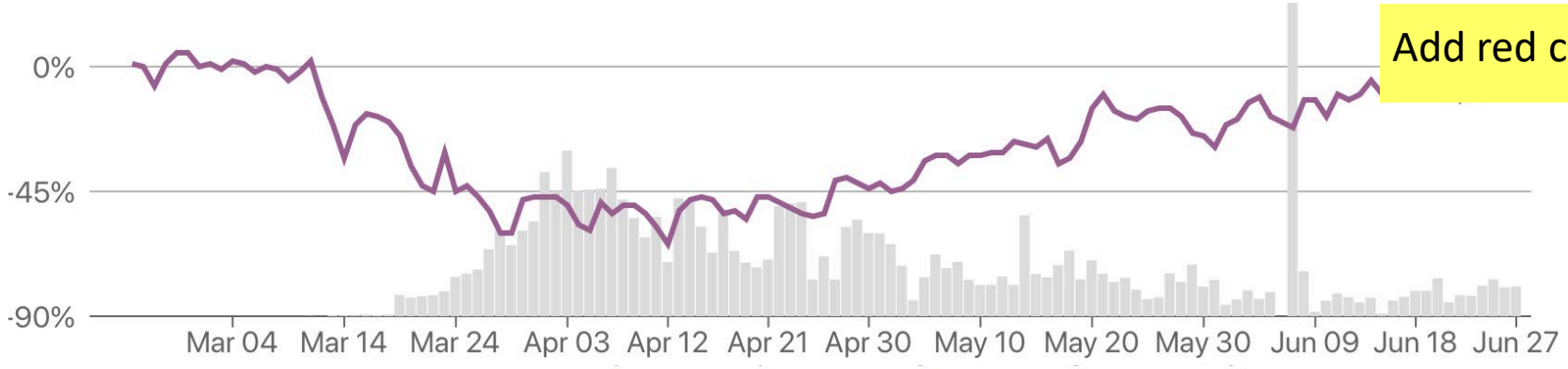
However, this data does not display percent positivity by age group, which is typically considered when analyzing outbreaks

Note: Cases information sourced from MDHHS and reflects date of onset of symptoms (refers to lab-confirmed cases).
Source: MDHHS – Michigan Disease Surveillance System

Obtained via MLFOIA by Judicial Watch, Inc.

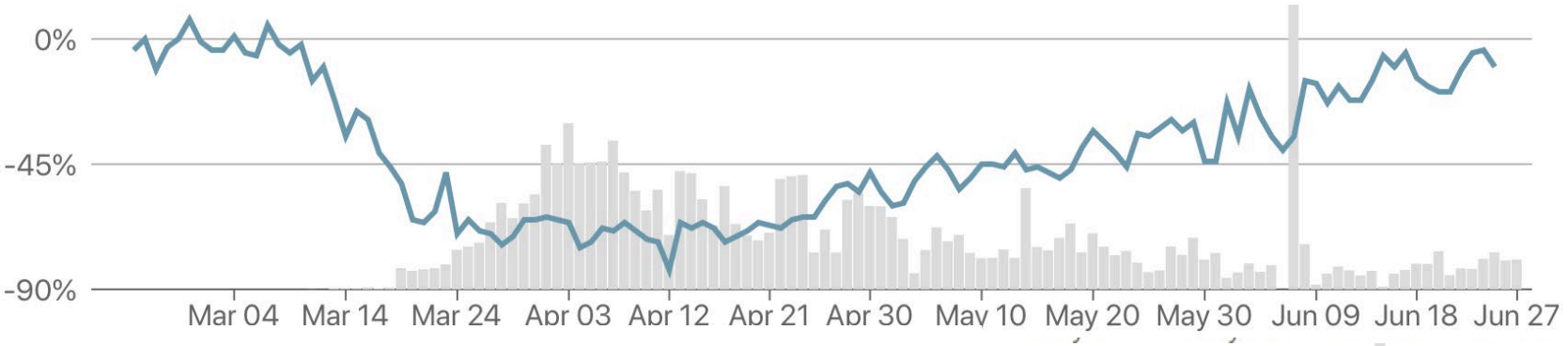
- Metrics indicate social distancing fatigue has been setting in since late April.
- These average mobility and non-essential visits have increased
- Encounter density has plateaued (potentially now increasing again also)

Change in average mobility

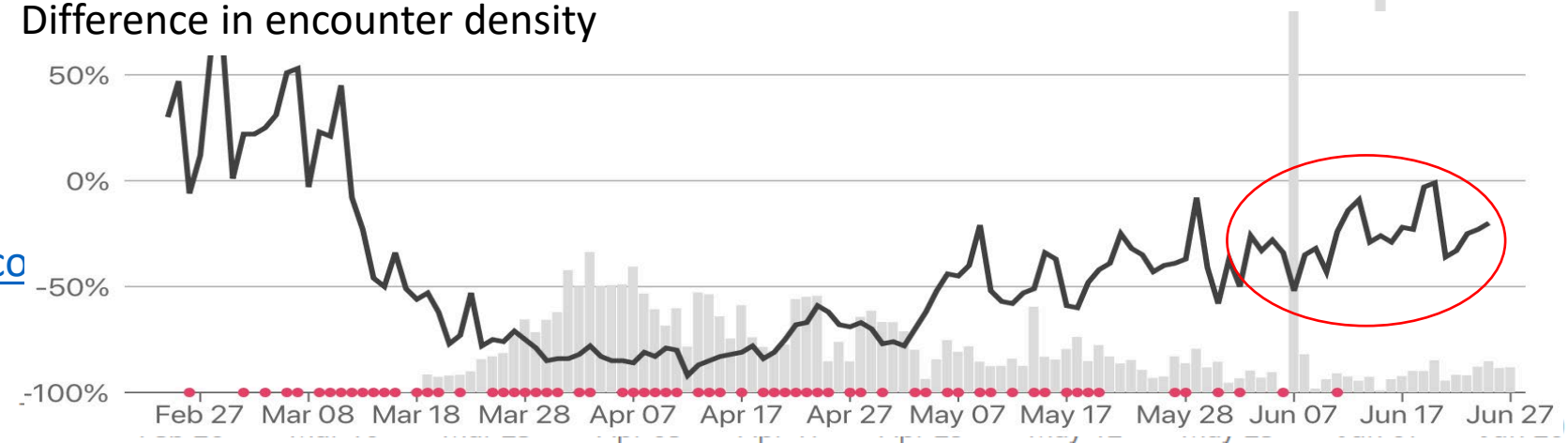


Add red c

Change in non-essential visits



Difference in encounter density



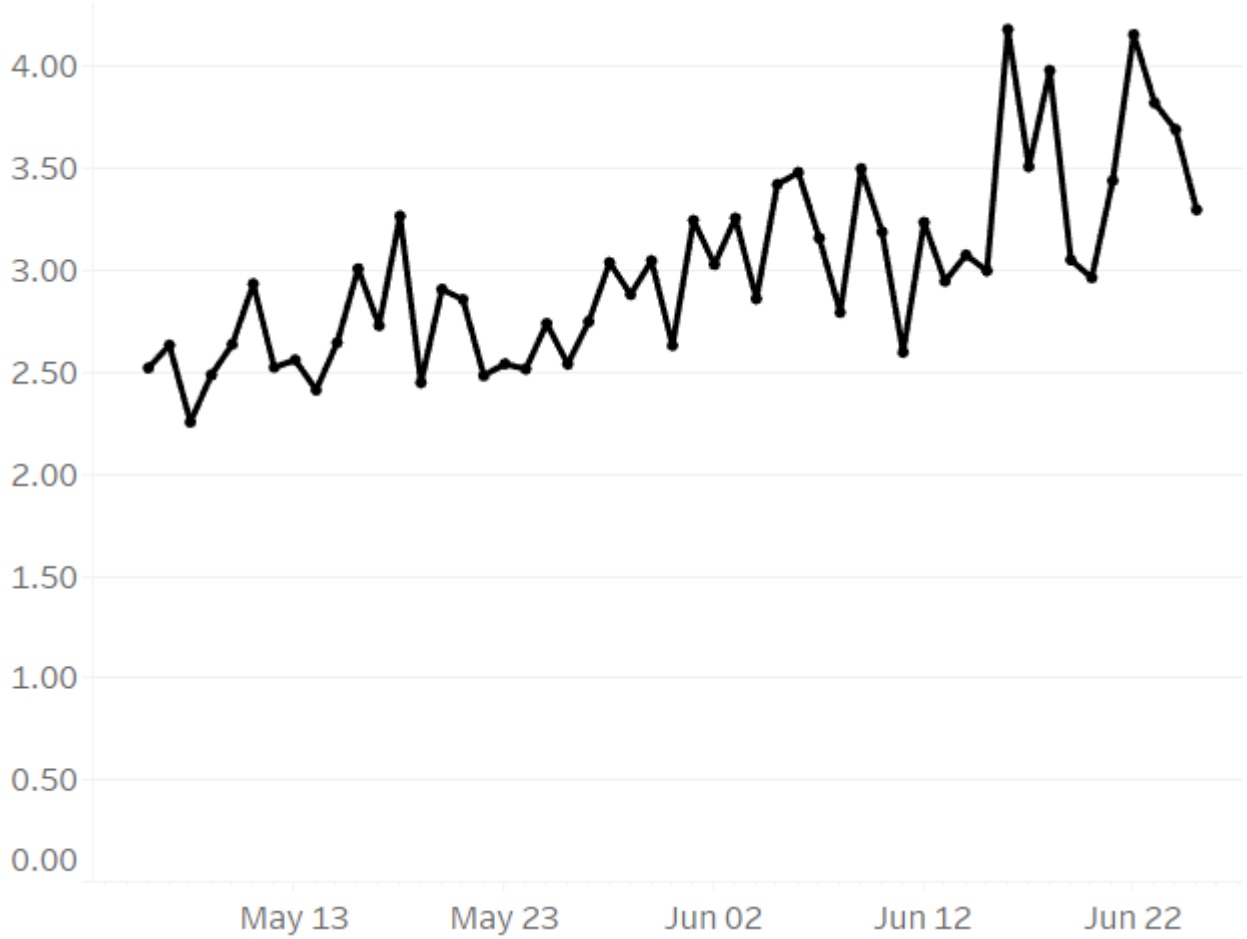
PUBLIC HEALTH

unacast social distancing scoreboard https://www.unacast.com/covid19/social-distancing-scoreboard

Contacts per case: State of Michigan

Obtained via MI FOIA by Judicial Watch, Inc.

Contacts per case, for cases with at least one contact (State of Michigan)



Contacts per case continues to rise, with several days after June 8th where the state averaged 4+ contacts per case

This number of contacts per case depends on actual encounter density, as well as the ability of case investigators to successfully elicit contacts

Source: Michigan Disease Surveillance System

Obtained via MI FOIA by Judicial Watch, Inc.

Epi and indicators

- State-level indicators
- **Regional and county indicators**
- State comparison

Testing

Case investigation and tracing

Upcoming data sources

Appendix

Confirmed Cases

Obtained via MI FOIA by Judicial Watch, Inc.

Note: data excludes MDOC

DATE: 2020-06-27	MERC Region Number	Public Health Region	Absolute cases (per million)	Case trend	Cases, 3-day surge	Absolute deaths (per million)	Death trend	Average percent positivity	Positivity trend	Tests per million
Detroit	1	2N + 2S	18.6	Increase - 2wk	No	0.4	Decrease - 10wk	2.7	Daily Avg < 3%	1353.4
Grand Rapids	2	6	27.2	Increase - 2wk	No	0.4	<20 wkly deaths	3.4	Increase - 1wk	1773.8
Kalamazoo	3	5	22.7	Increase - 1wk	No	0.3	<20 wkly deaths	2.6	Daily Avg < 3%	1421.7
Saginaw	4	3	11.2	Increase - 1wk	No	0.9	<20 wkly deaths	3.2	Decrease - 1wk	1391.7
Lansing	5	1	45.6	Increase - 1wk	No	0.2	<20 wkly deaths	2.8	Daily Avg < 3%	1753.0
Traverse City	6	7	5.2	Increase - 1wk	No	0.0	<20 wkly deaths	0.8	Daily Avg < 3%	889.6
Jackson	7	1	12.2	Increase - 2wk *	No	0.0	<20 wkly deaths	1.1	Daily Avg < 3%	1476.5
Upper Peninsula	8	8	5.2	Increase - 4wk *	No	0.5	<20 wkly deaths	0.4	Daily Avg < 3%	1064.6

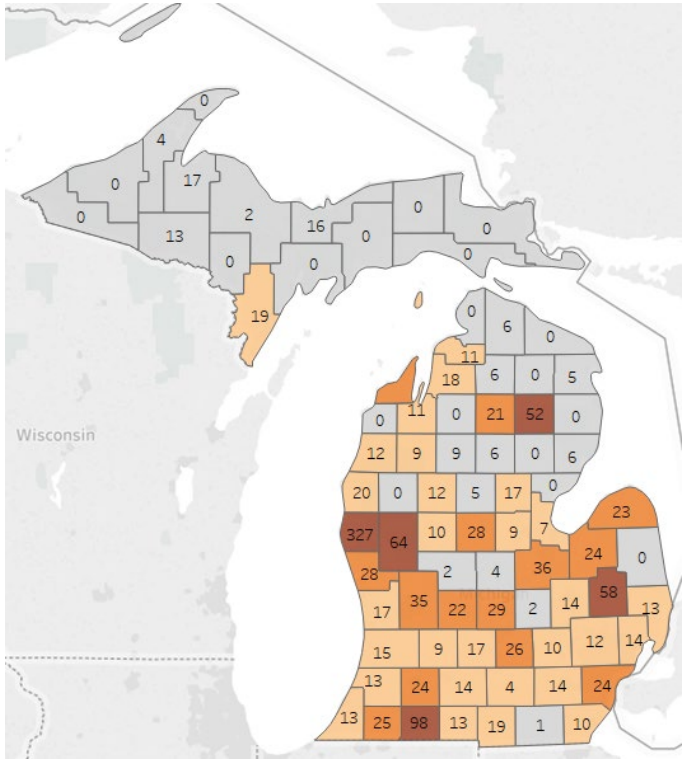
PUBLIC HEALTH

Draft

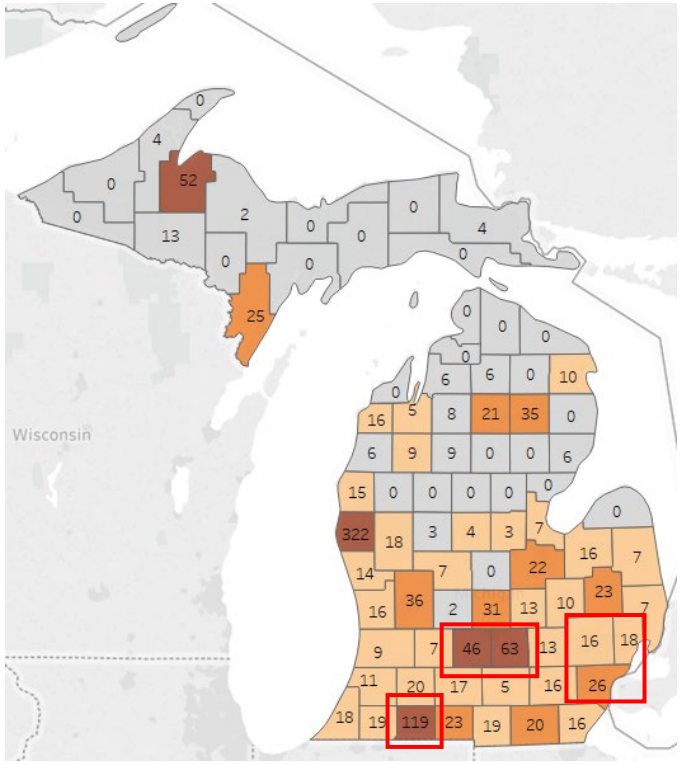
Obtained via MI FOIA by Judicial Watch, Inc.

Average daily new cases per million residents

6/15-6/21



6/21-6/27



Insufficient sample size; county has fewer than 2 new cases during the week

Fewer than 20 average daily new cases per million

20-40 average daily new cases per million

More than 40 average daily new cases per million

Updates since last week:

Overall, outbreaks continue to occur in pockets across the state

Some counties with increases include (not exhaustive):

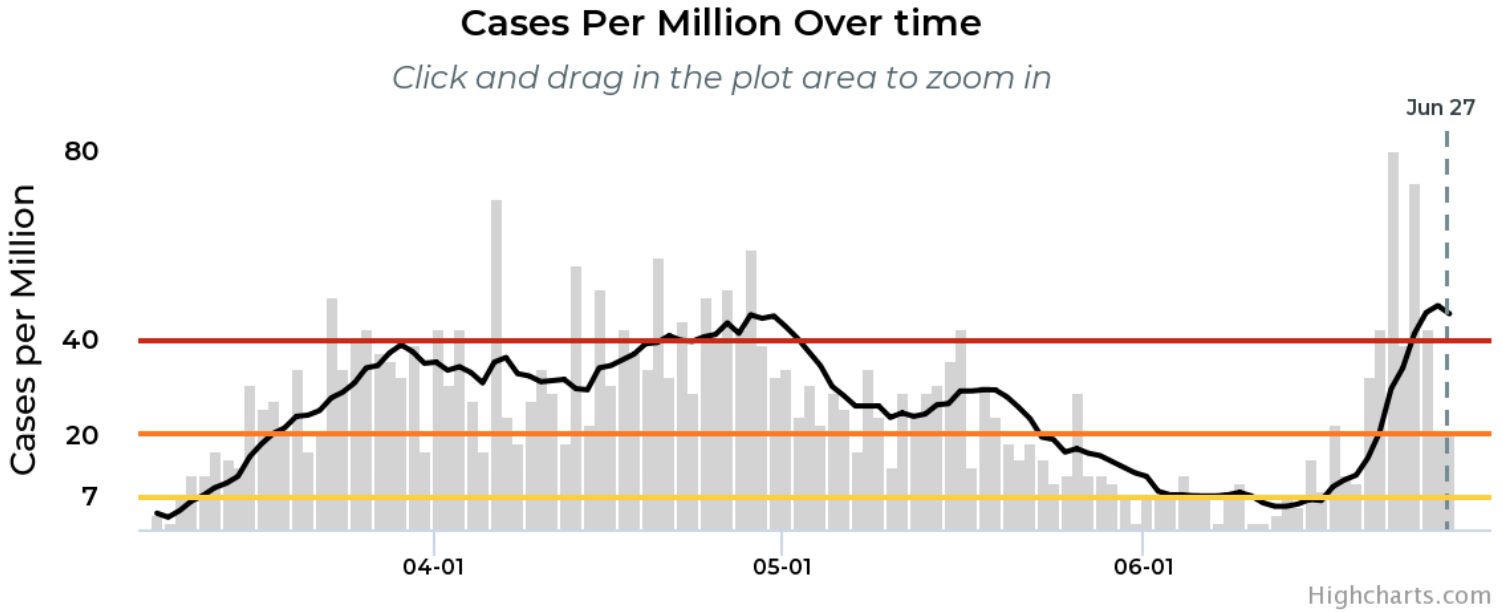
- Ingham, Eaton, St. Joseph, Macomb, Wayne, Oakland

Note: Cases information sourced from MDHHS and reflects date of onset of symptoms (refers to lab-confirmed cases).
Source: MDHHS – Michigan Disease Surveillance System

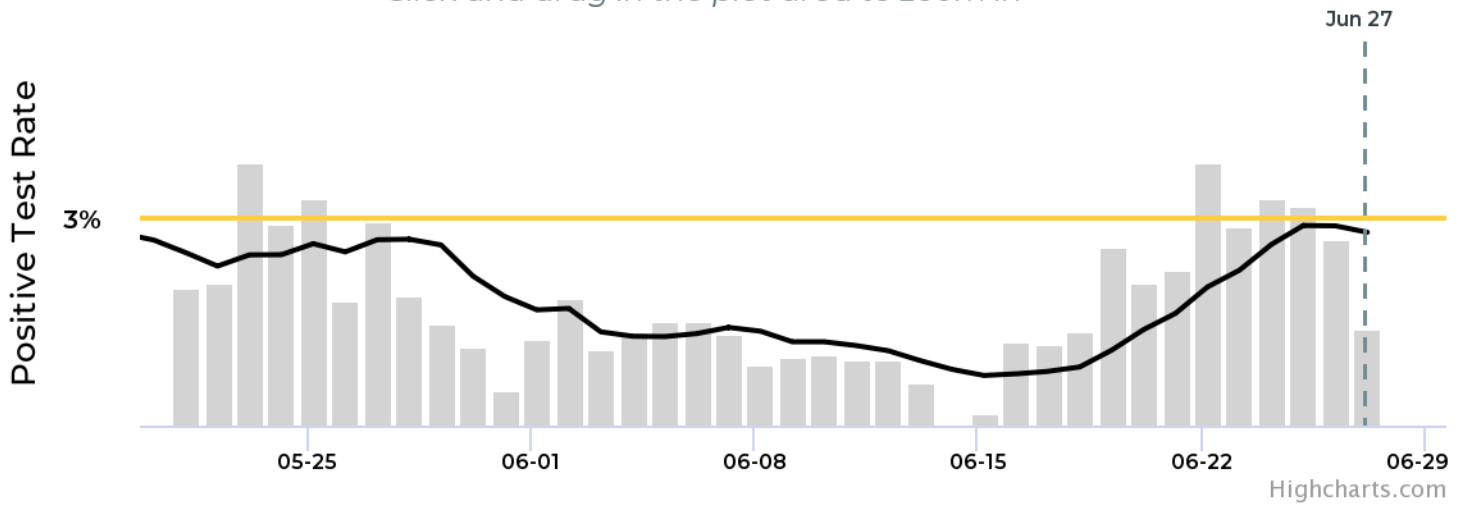
Lansing Region

Obtained via MI FOIA by Judicial Watch, Inc.

Cases Increasing & Above 40 new cases per million per day.



Percent positive increasing. (Want to see decrease here)

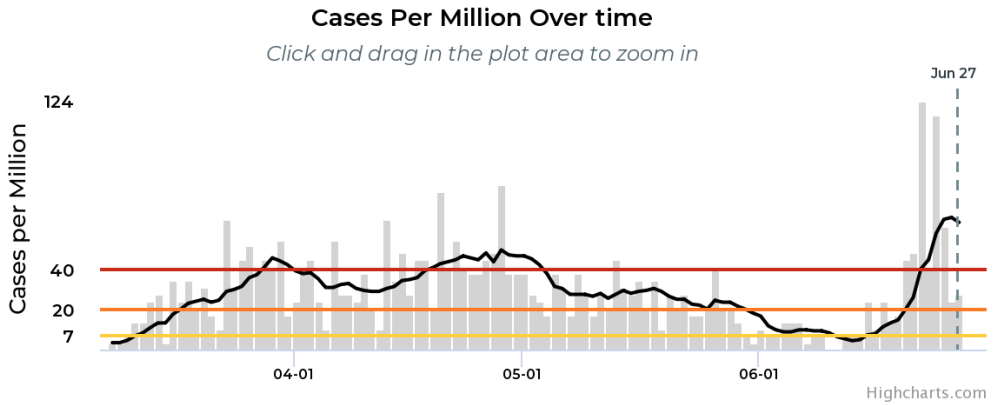


PUBLIC HEALTH

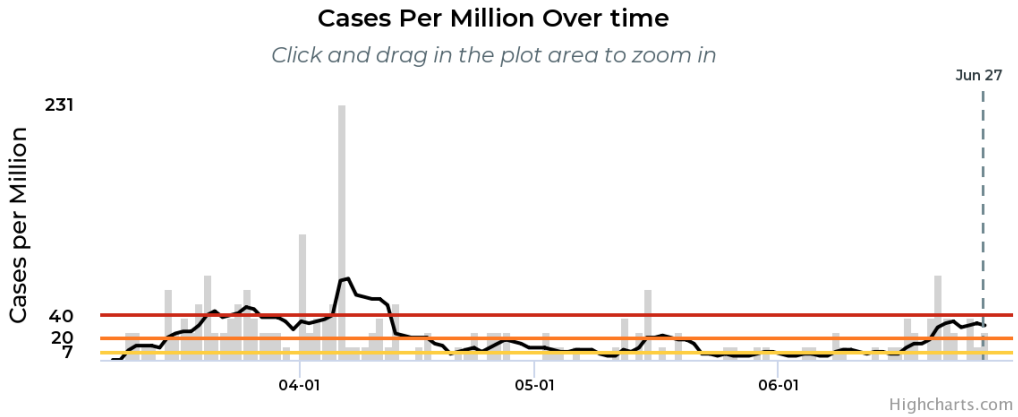
Lansing Region - Counties

Obtained via MI FOIA by Judicial Watch, Inc.

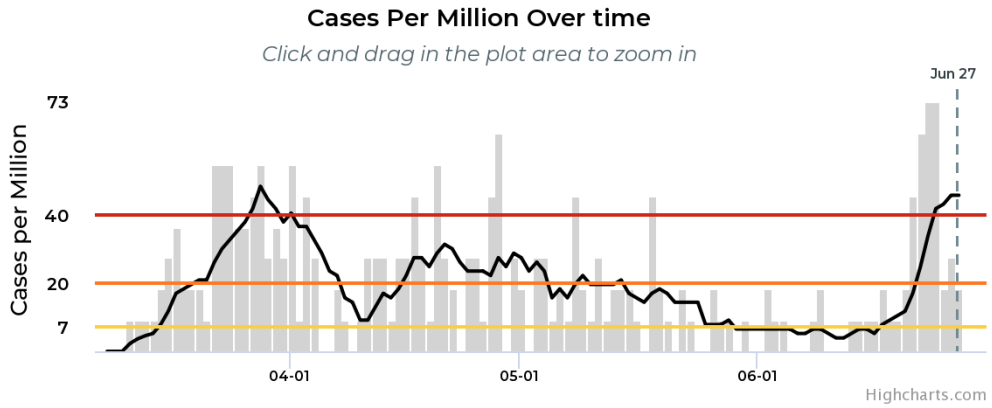
Ingham



Clinton



Eaton

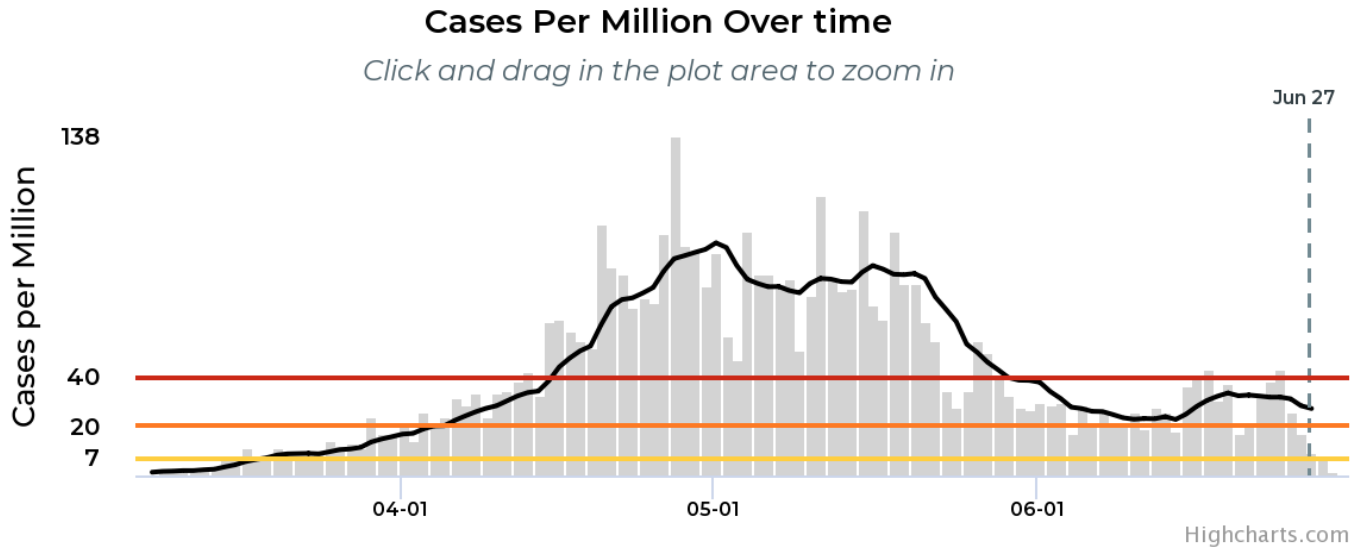


PUBLIC HEALTH

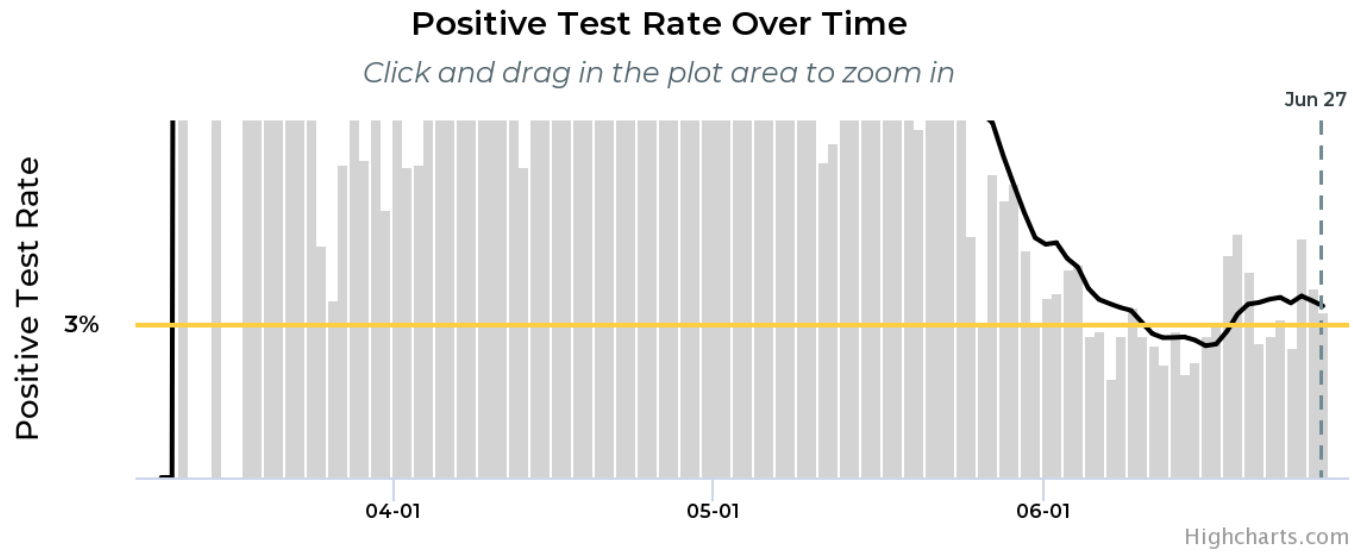
Grand Rapids Region

Obtained via MI FOIA by Judicial Watch, Inc.

Cases Increasing & Above 20 new cases per million per day.



Percent positive increasing, in the scenario of increased testing.

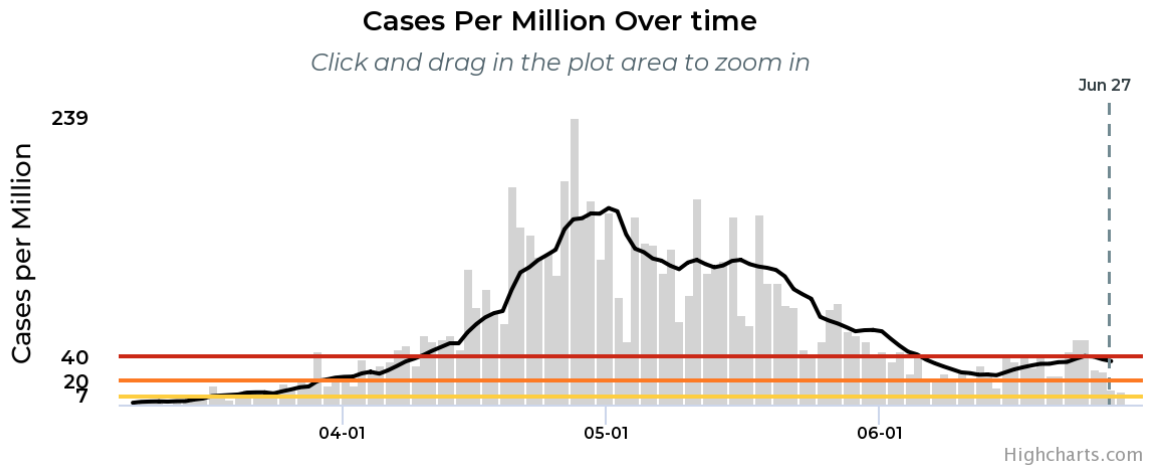


PUBLIC HEALTH

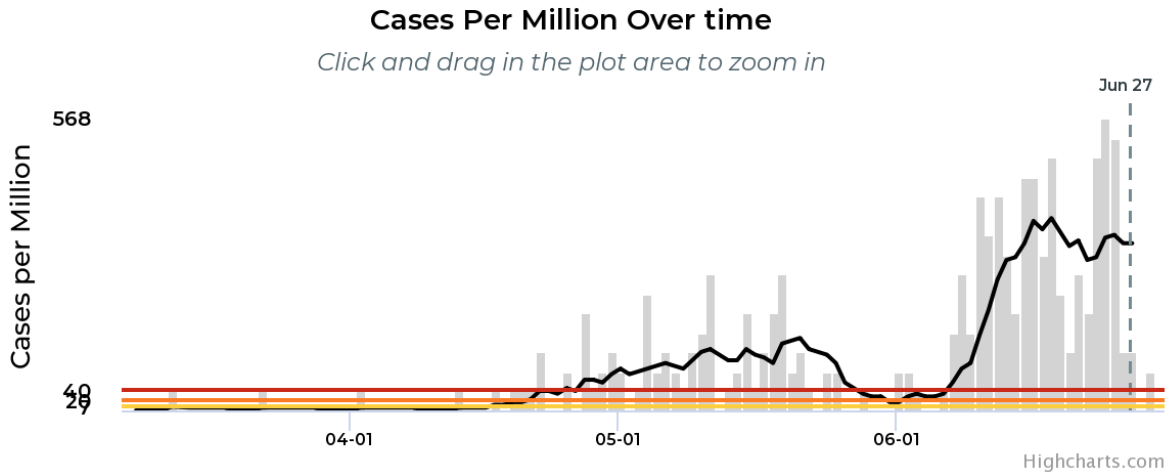
Grand Rapids Region - Counties

Obtained via MI FOIA by Judicial Watch, Inc.

Kent



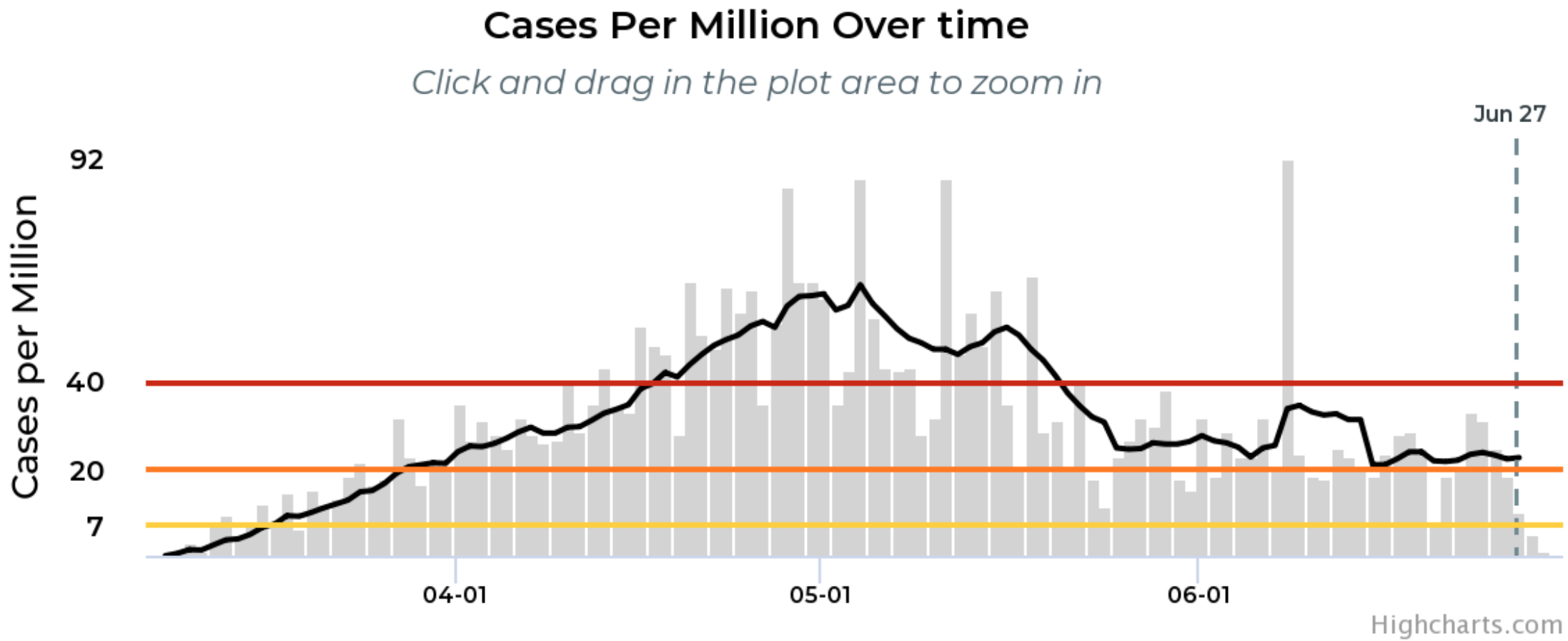
Oceana



PUBLIC HEALTH

Obtained via MI FOIA by Judicial Watch, Inc.

Kalamazoo Region



PUBLIC HEALTH

Obtained via MI FOIA by Judicial Watch, Inc.

Potential schedule for phase changes – **IF indicators continue to improve and meet requirements**

On Radar	Watch	Warning
Traverse City UP	Detroit Jackson Saginaw Kalamazoo	Lansing Grand Rapids

Obtained via MI FOIA by Judicial Watch, Inc.

Epi and indicators

- State-level indicators
- Regional and county indicators
- **State comparison**

Testing

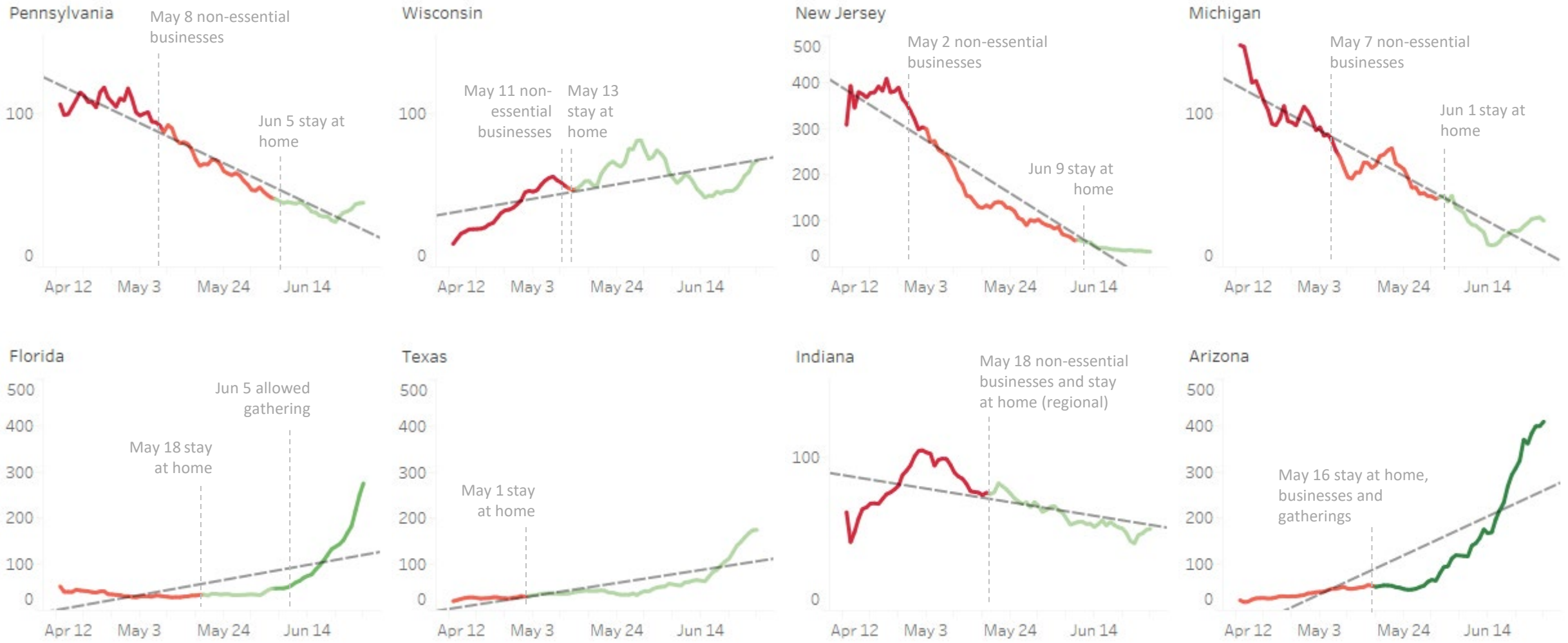
Case investigation and tracing

Upcoming data sources

Appendix

Obtained via MI FOIA by Judicial Watch, Inc.

State Comparisons: 7 day avg. of daily new cases per 1M population

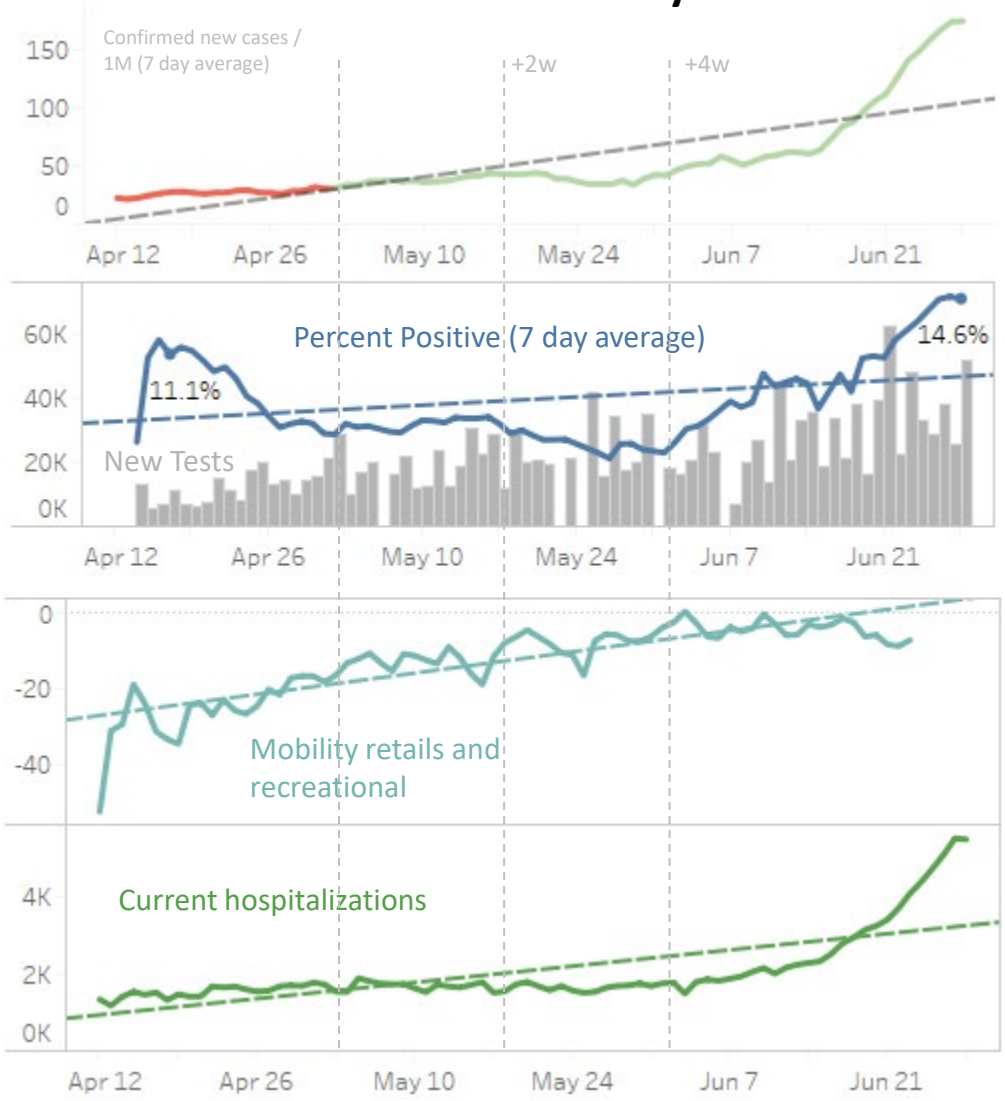


More interventions Less interventions

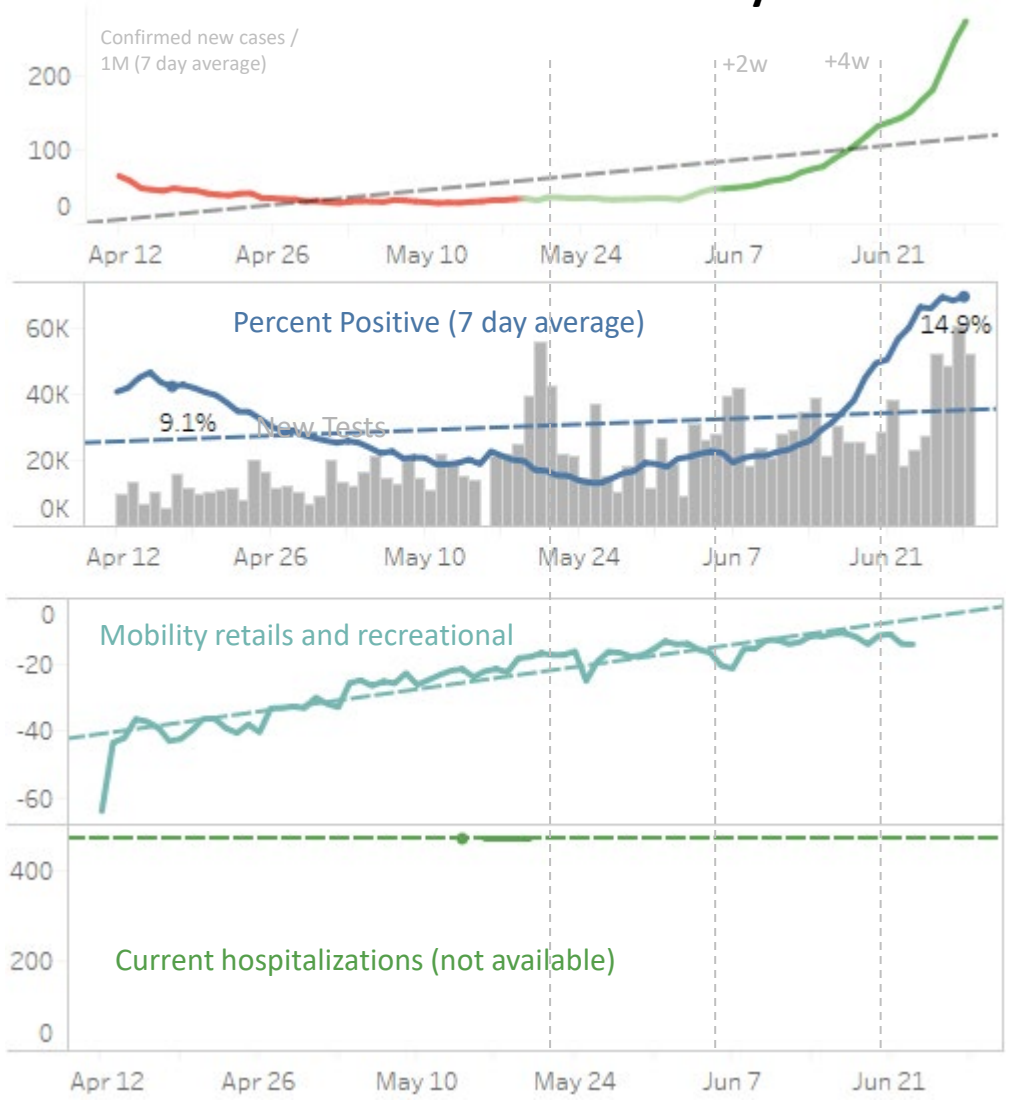
Obtained via MI FOIA by Judicial Watch, Inc.

Texas and Florida: Detailed examination

Texas: relaxed on May 1st



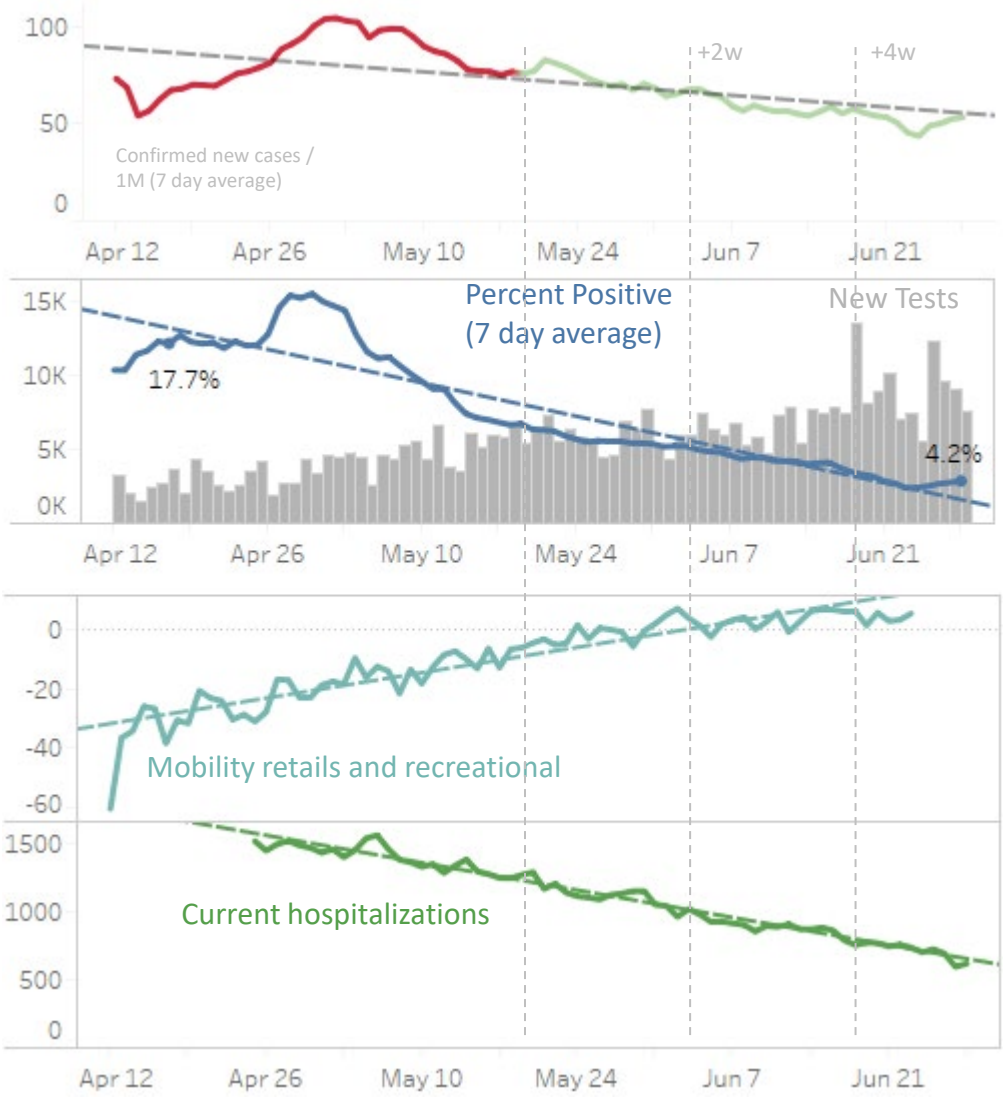
Florida: relaxed on May 4



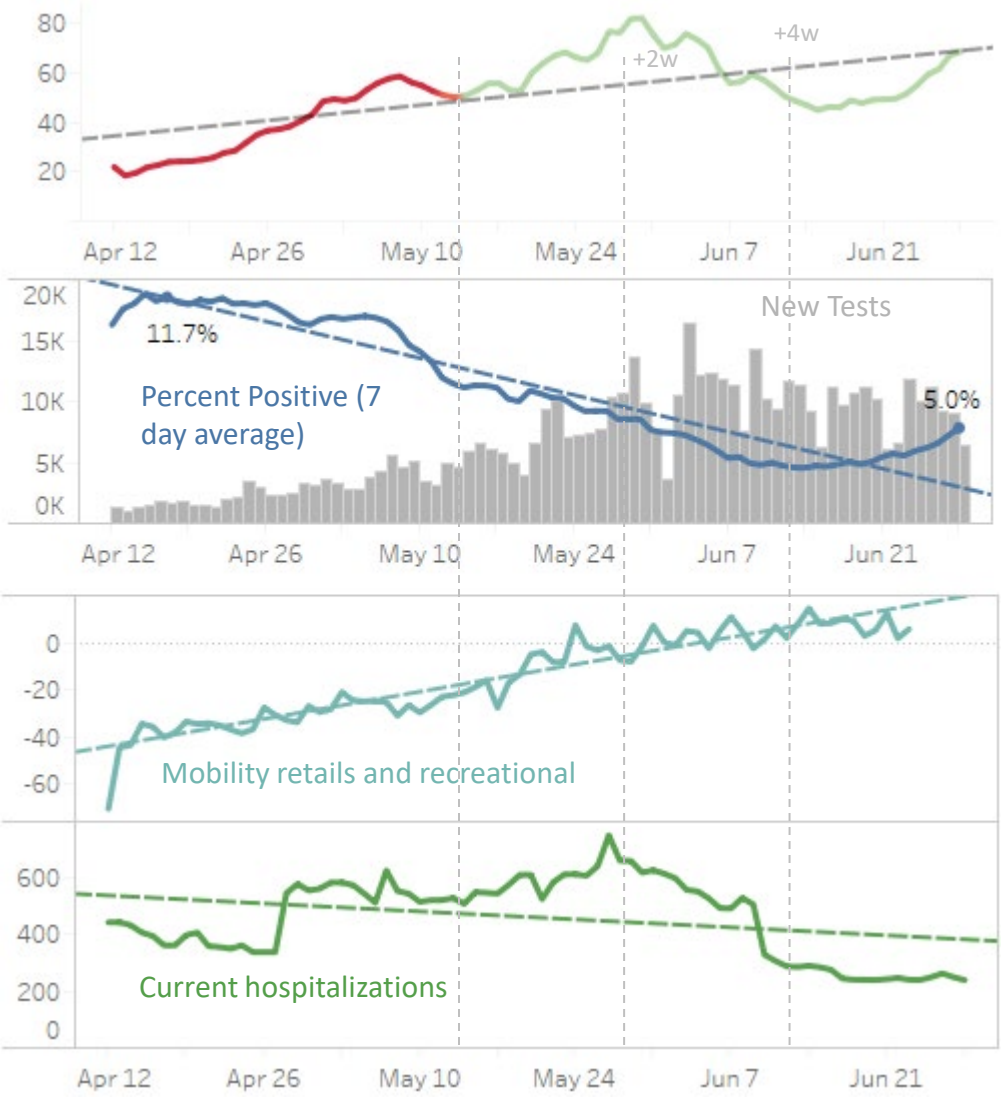
Obtained via MI FOIA by Judicial Watch, Inc.

Indiana and Wisconsin: Detailed examination

Indiana: relaxed on May 4th



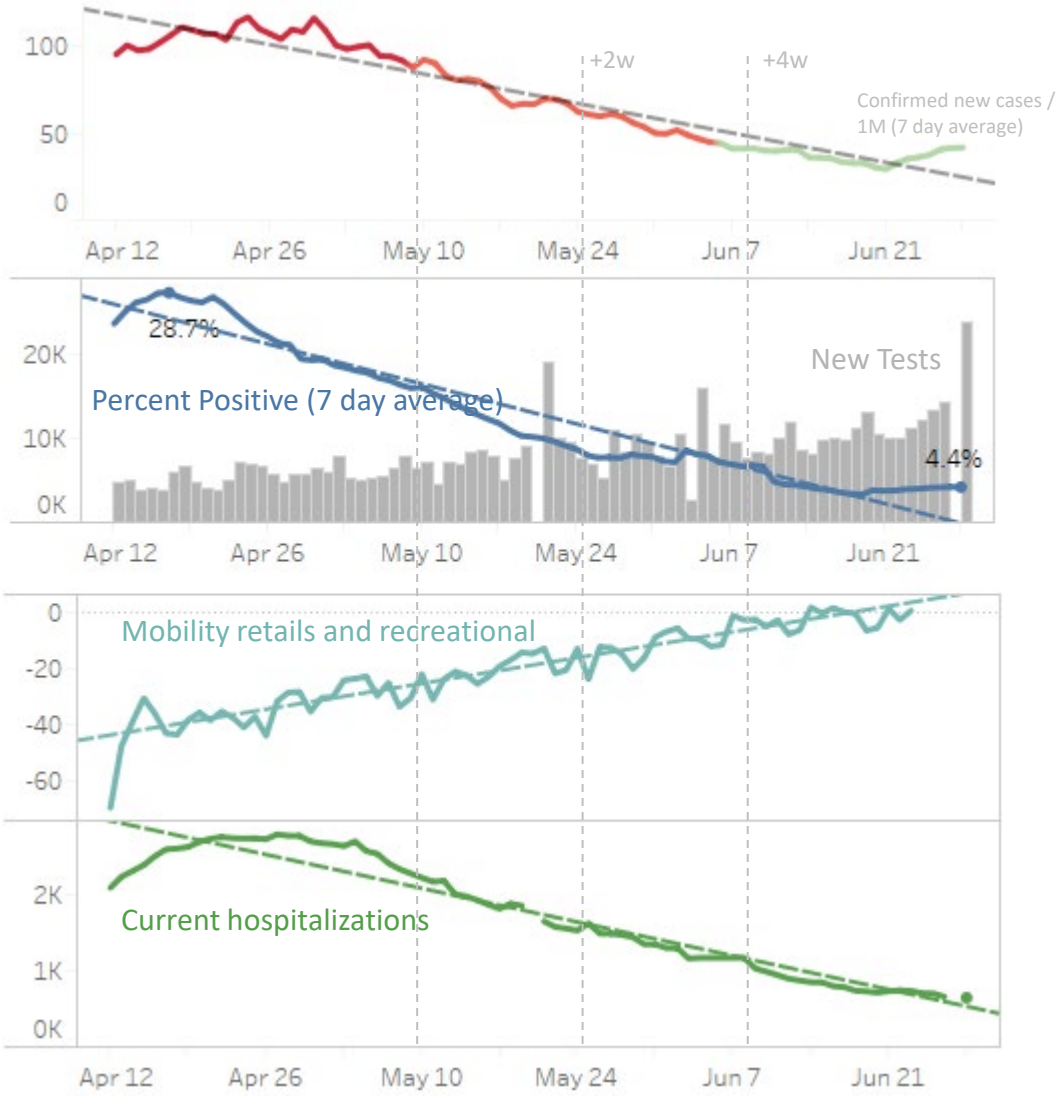
Wisconsin: Relaxed on May 11th



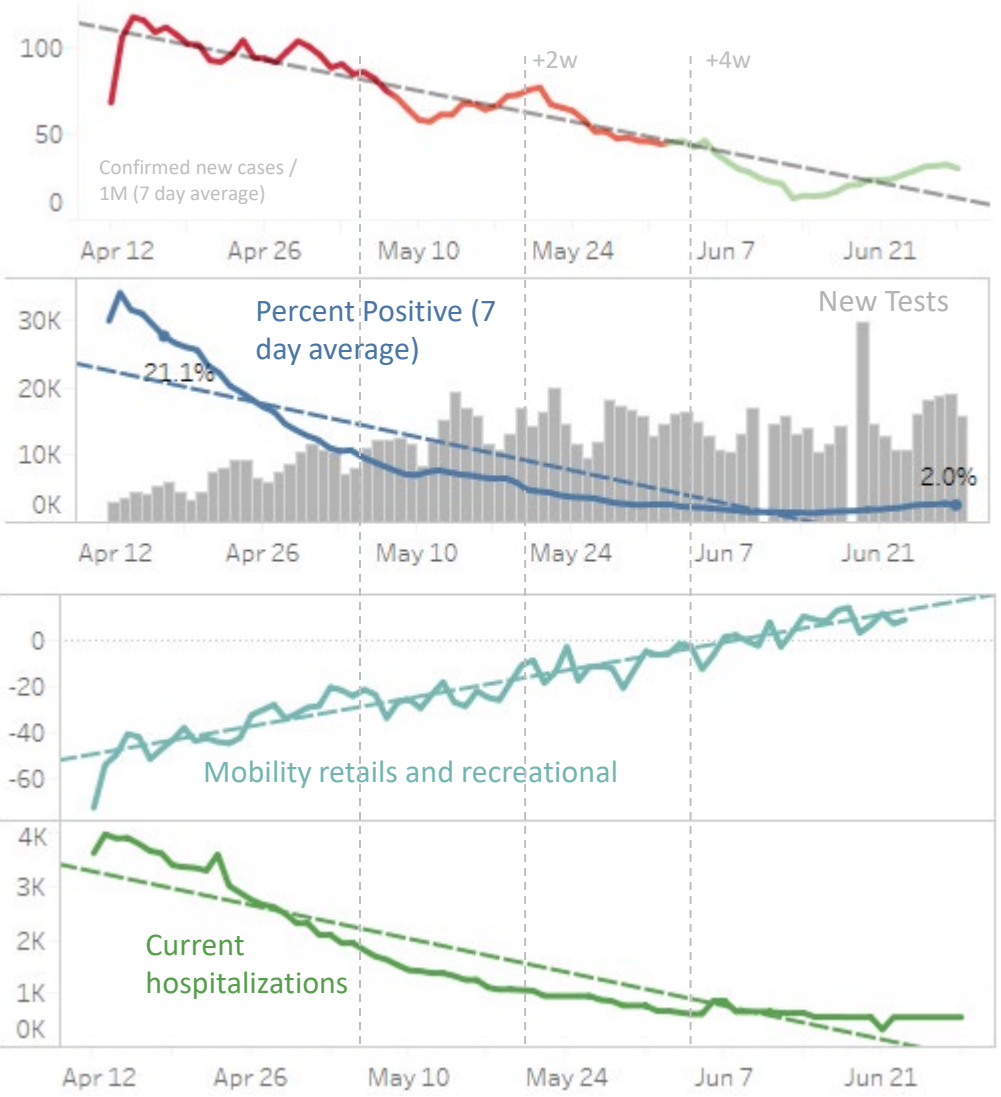
Obtained via MI FOIA by Judicial Watch, Inc.

Pennsylvania and Michigan: Detailed Examination

Pennsylvania: relaxed on May 8th



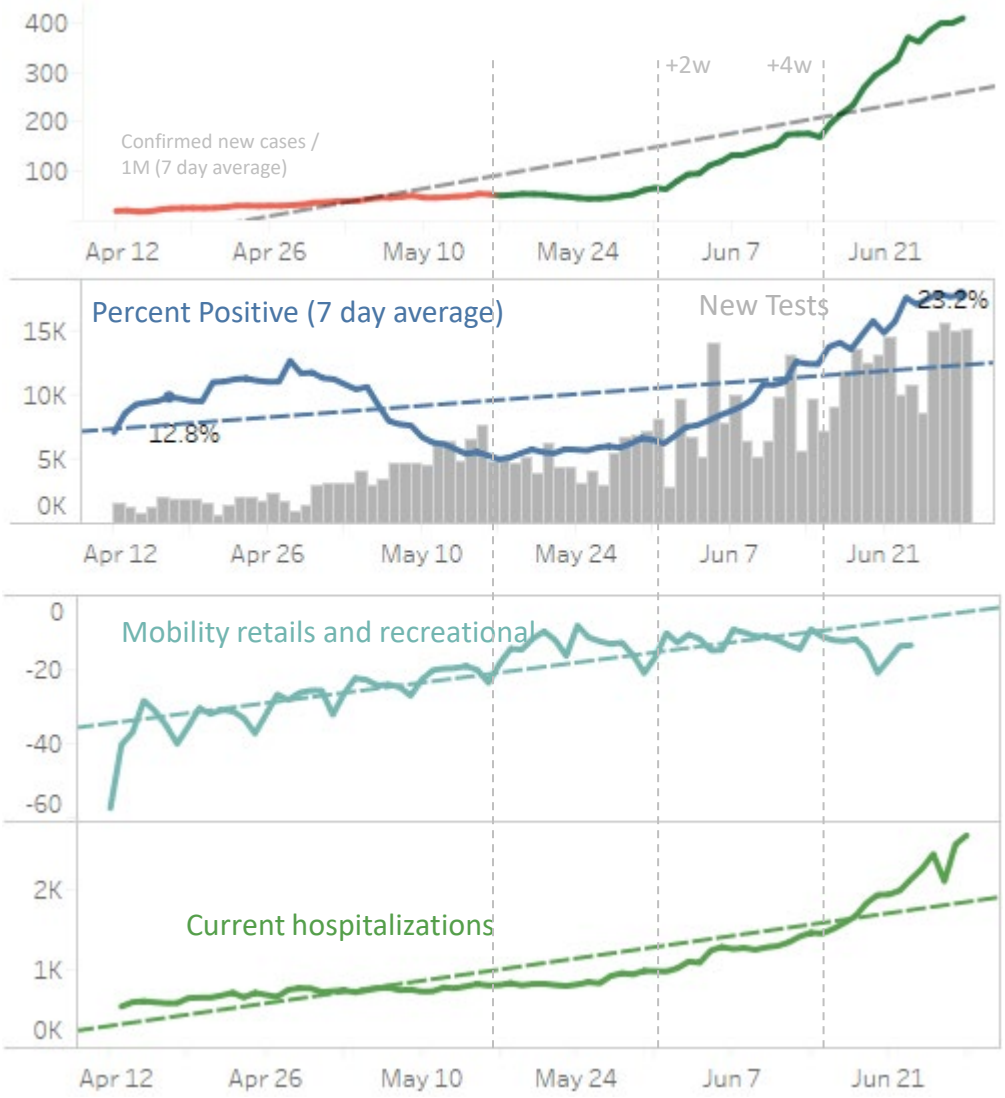
Michigan: Non-essential May 7th, Stay-at-home Jun 1st



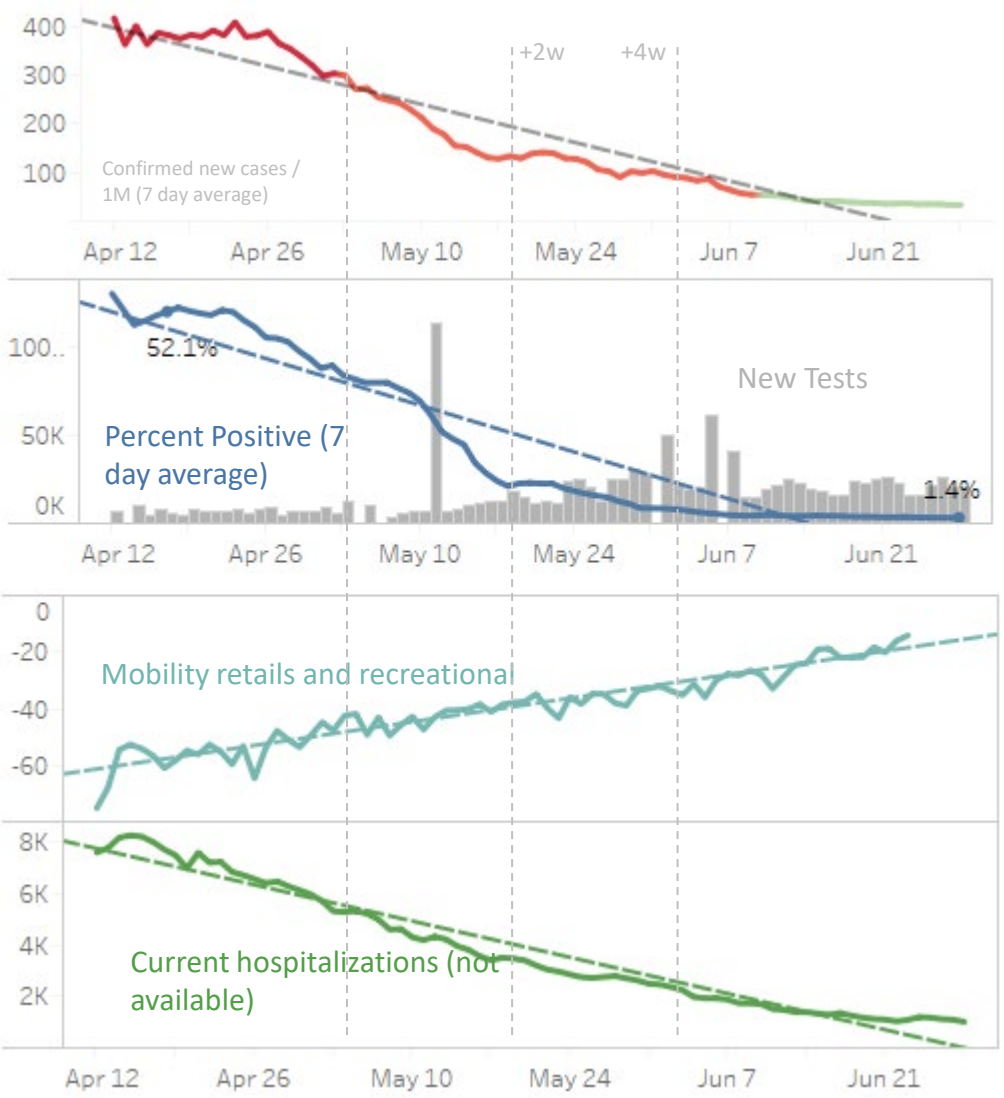
Obtained via MI FOIA by Judicial Watch, Inc.

Arizona and New Jersey: Detailed Examination

Arizona: relaxed all on May 16th



New Jersey: Non-essential May 2nd, Stay-at-home Jun 9th



Obtained via MI FOIA by Judicial Watch, Inc.

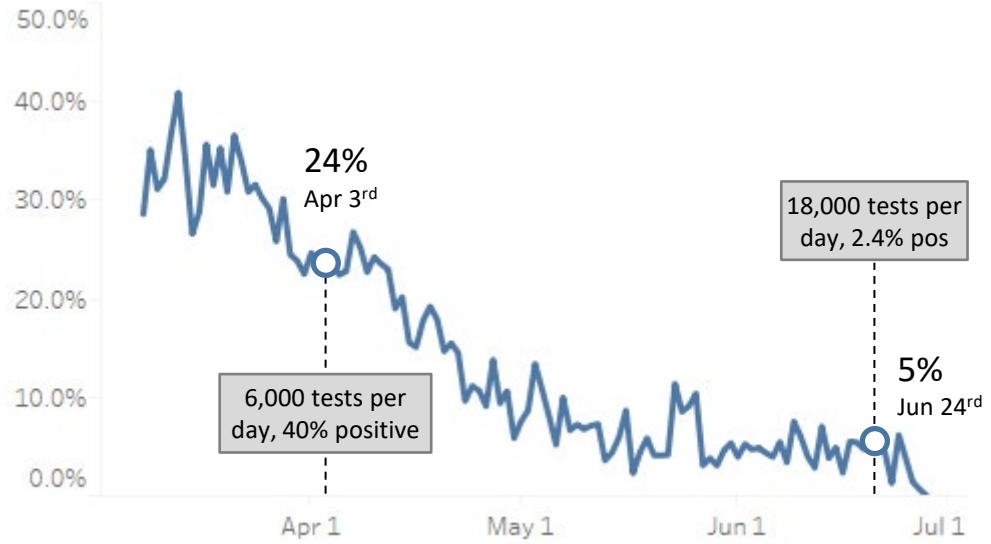
Observations/Learnings

- States which opened on a declining trajectory with % positive below 5% are maintaining stable trends although showing shift to stable/plateau vs. a decline
- Increase in percent positivity continues to be a good predictor of increasing cases in the future
- Some States stayed on a stable or declining trajectory after opening up:
  - Pennsylvania, recent change, cases per 1M stable, % positive stable
  - Indiana, lifted regionally right after peak, case per 1M stable, % positive stable
  - New Jersey, cases per 1M stable/decrease, % positive stable/decrease
- Some bear watching due to trend:
  - Texas, cases per 1M increase, % positive increase, hospitalizations increase
  - Arizona, cases per 1M increase, % positive increase, hospitalizations increase
  - Florida, cases per 1M increase, % positive increase, hospitalizations increase but data not clean
  - Wisconsin, case per 1M increase, % positive increase, hospitalizations stable

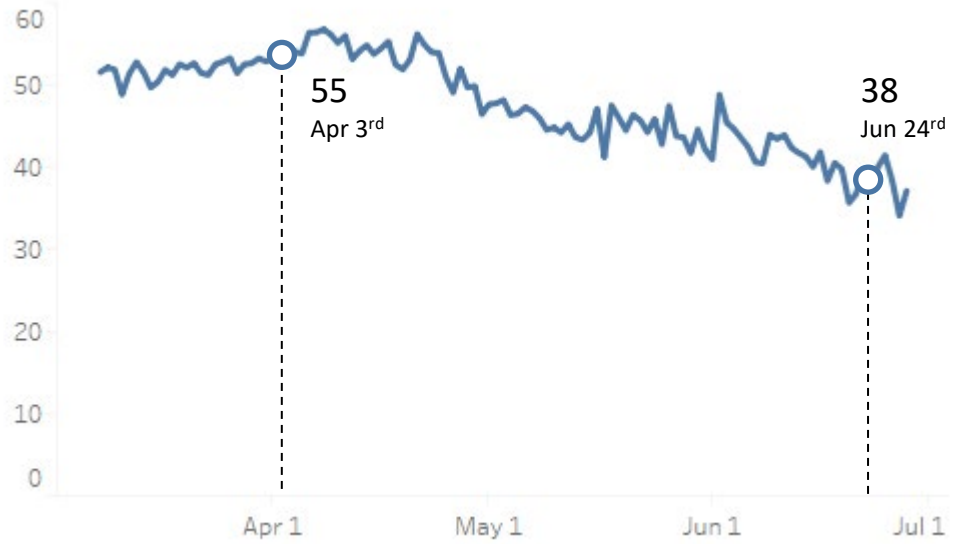
Obtained via MI FOIA by Judicial Watch, Inc.

What an average confirmed case in MI means now vs. April

Percent Admissions for Positive Cases



Average Age for Positive Cases



Date	Testing	Percent Positive	Admit Rate	Admits /day	Positive tests : Admits	Tests : Admits
Apr 3rd	6,000	40%	24%	576	4 positive tests to 1 admit	10 tests to 1 admit
Jun 24th	18,000	2.4%	5%	22	20 positive tests to 1 admit	833 tests to 1 admit

~6x lower ratio of admits for each positive case we find

Obtained via MI FOIA by Judicial Watch, Inc.

Epi and indicators

Testing

Case investigation and tracing

Upcoming data sources

Appendix

Obtained via MI FOIA by Judicial Watch, Inc.

Michigan testing capacity and utilization overview

Where Michigan is today

15,631

Daily samples tested
(average past 7 days)

2.6%

Percent positive
(average past 7 days)

19,000+

Daily ready-to-go lab capacity
(current reported)

Daily **PCR testing** numbers increased over the past week, averaging 15.6K, with a high of 19.4K on 6/26

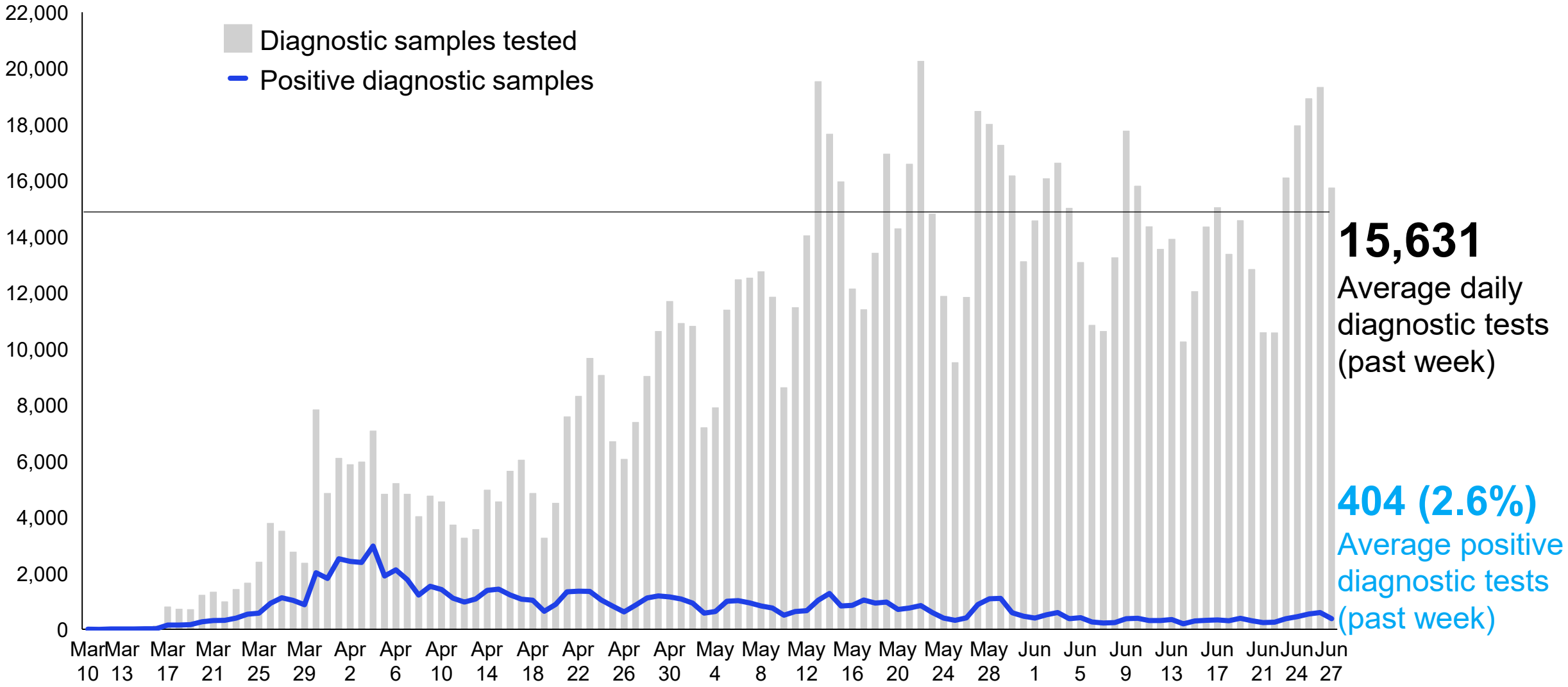
Labs are reporting ~19K daily ready-to-go-capacity, with additional ~15K non-commercial capacity available (but additional supplies needed); further commercial lab capacity available

Team is working to solve known constraints:

- **Demand and access:**
  - Announcing new test finder and hotline (211) scheduling partnership
  - Promoting pop-up testing sites
- **Collections capacity:**
  - 3 month plan in development for sample collection and testing across all populations
  - Finalizing contract this week for mobile testing vendor to conduct sample collection for vulnerable populations
- **Supply chain:**
  - Partnering with Dow to produce VTM; test batch in planning phase
  - Shipment of VTM received from FEMA
  - 3D-printed swab validation work complete, to inform future procurement efforts

Daily diagnostic tests and positive diagnostic tests, by message date

Obtained via MIFOIA by Judicial Watch, Inc.



Source: MDSS/Michigan Medical Advantage Group, MDHHS, testing labs

Obtained via MI FOIA by Judicial Watch, Inc.

Daily tests

State	Avg. daily tests
1. California	89.7K
2. New York	61.0K
3. Florida	38.3K
4. Texas	37.1K
5. Illinois	26.3K
6. New Jersey	21.2K
7. North Carolina	17.7K
8. Ohio	16.4K
9. Michigan	15.6K
10. Georgia	13.6K
11. Arizona	12.8K
12. Virginia	12.4K
13. Minnesota	11.0K
14. Tennessee	10.5K
15. Louisiana	10.5K
16. Pennsylvania	10.2K
17. Wisconsin	9.1K
18. Massachusetts	8.8K
19. Indiana	8.7K
20. South Carolina	7.8K
21. Maryland	7.4K
22. Washington	6.9K
23. Alabama	6.4K
24. Missouri	6.3K
25. Oklahoma	6.2K
26. Arkansas	6.0K
27. Iowa	5.6K
28. Mississippi	5.5K

Daily % of pop. tested

State	Avg. daily % tested
1. Alaska	0.4%
2. New York	0.3%
3. New Mexico	0.2%
4. New Jersey	0.2%
5. District of Columbia	0.2%
6. California	0.2%
7. Louisiana	0.2%
8. Rhode Island	0.2%
9. Illinois	0.2%
10. Arkansas	0.2%
11. Minnesota	0.2%
12. Mississippi	0.2%
13. Iowa	0.2%
14. Florida	0.2%
15. Arizona	0.2%
16. Delaware	0.2%
17. North Carolina	0.2%
18. Oklahoma	0.2%
19. Wisconsin	0.2%
20. Montana	0.2%
21. Michigan	0.2%
22. North Dakota	0.2%
23. Tennessee	0.2%
24. South Carolina	0.2%
25. Connecticut	0.2%
26. Virginia	0.1%
27. Ohio	0.1%
28. Utah	0.1%

Percent positive

State	% positive
1. Alaska	0.6%
2. Vermont	0.9%
3. Hawaii	1.0%
4. New York	1.1%
5. Connecticut	1.3%
6. Montana	1.3%
7. New Jersey	1.4%
8. West Virginia	1.7%
9. Maine	1.7%
10. New Hampshire	2.0%
11. Rhode Island	2.0%
12. District of Columbia	2.0%
13. Massachusetts	2.5%
14. North Dakota	2.5%
15. Michigan	2.6%
16. Illinois	2.7%
17. New Mexico	3.2%
18. Minnesota	3.3%
19. Delaware	3.5%
20. Kentucky	3.7%
21. Indiana	4.1%
22. Pennsylvania	4.4%
23. Virginia	4.4%
24. Ohio	4.5%
25. Wisconsin	4.5%
26. Colorado	4.7%
27. Oregon	4.7%
28. Wyoming	4.8%

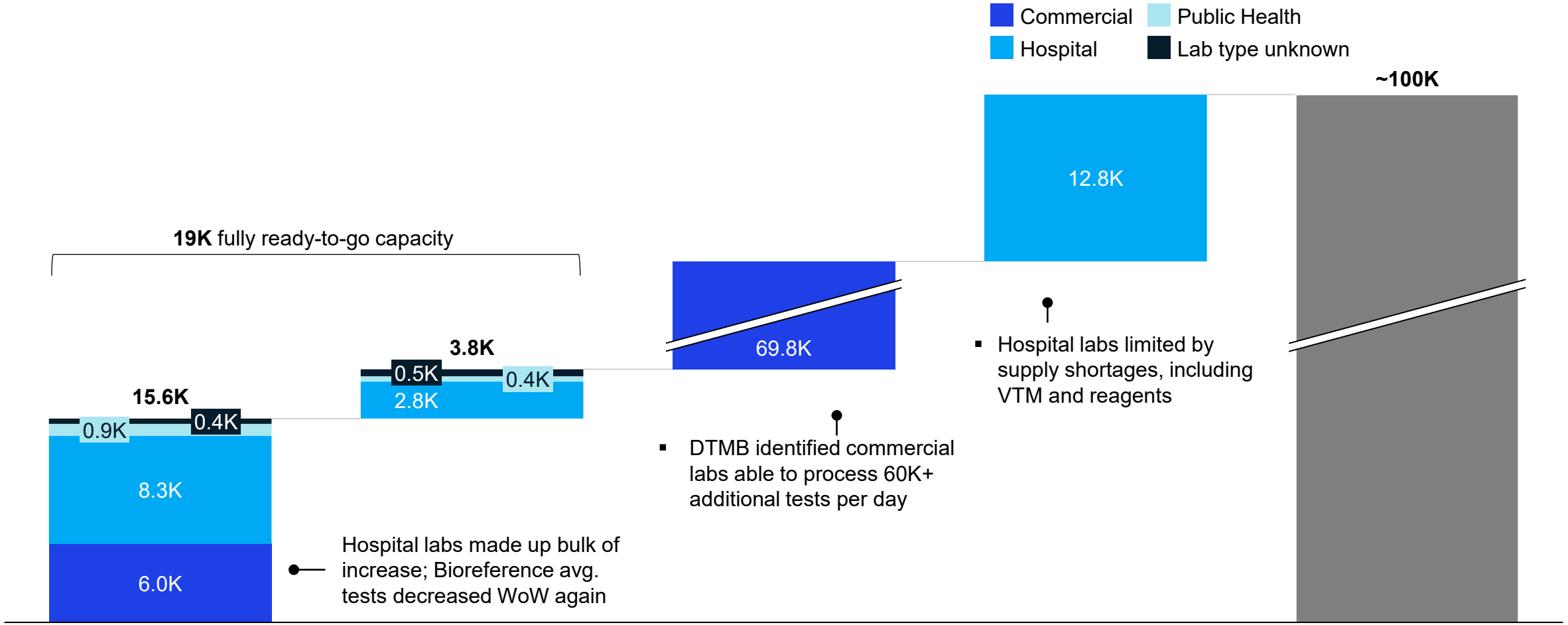
Averaged over June 21-June 27, 2020 (Michigan average uses most recent MAG data)

SOURCE: Numerical Data – MDSS, COVID Tracking Project, U.S. Census Bureau.

Obtained via MI FOIA by Judicial Watch, Inc.

Labs shown may have adjustments as capacity estimates are validated and new supply constraints arise

Labs: Michigan daily capacity snapshot



In-use capacity[1]
(averaged 6/21-6/27)

Additional ready-to-go capacity[2]
(supplies available today, non-commercial)

Additional commercial capacity[3]
- Out-of-state labs
- New labs / capital investment

Additional requiring constrained supplies

Total potential capacity

Sources:
1. MDSS/Michigan Medical Advantage Group, MDHHS for all lab types
2. Hospitals - lab director reported. Pub. Health, Commercial, Other - calculated as average tests conducted during top seven days of past thirty days
3. DTMB
4. Lab director reported

Obtained via MI FOIA by Judicial Watch, Inc.

Epi and indicators

Testing

Case investigation and tracing

Upcoming data sources

Appendix

Obtained via MI FOIA by Judicial Watch, Inc.

Case investigation and contact tracing: Current state

	Case investigation and contact acquisition			Initial contact tracing		Ongoing contact monitoring		
Goal	**90% calls attempted** in one day	**75% calls completed** in one day	**50% with contacts** in one day	**90% calls attempted** in one day	**75% calls completed** in one day	Successful ongoing daily outreach	Low cases lost to follow-up	Contacts with symptoms identified
Performance	81%[1]	63%[2]	59%[3]	91%[4]	62%[5]	49%[6]	4%[7]	4.1%[8]
Trend since last week	↑	↑	↑	→	↓	↓	↓	↓

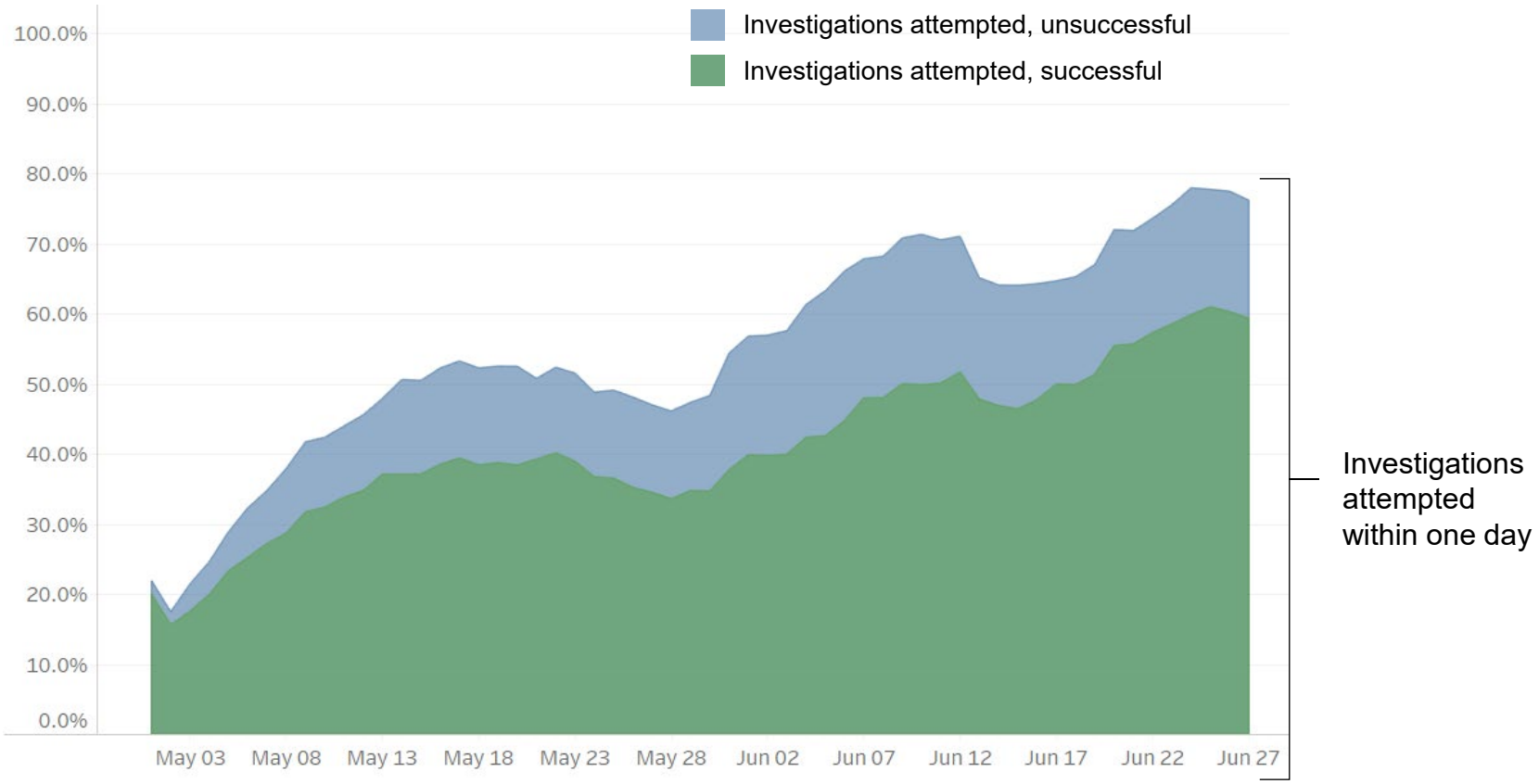
1. % of cases documented as "attempted" within one day; 2 % of cases documented as "successful" within one day; 3 % of cases with at least one contact documented within one day; 4 Weighted average of % of cases documented as "attempted" within one day in OMS, LHD survey, and Traceforce; 5 Weighted average of % of cases documented as "successful" within one day in OMS and Traceforce; 6 Traceforce only - % of non-first day contacts reached; 7 Traceforce only - % of contacts lost to follow-up (lost / total); 8 Traceforce only - Of contacts reached, % later reporting symptoms –Case investigation and initial contact tracing metrics exclude weekends on this page

Source: MDSS and OMS summary statistics. Traceforce summary statistics. LHD Sitrep survey.

Obtained via MI FOIA by Judicial Watch, Inc.

Case Investigation: Performance within 24 hours

% of cases investigated within 24 hours, seven day rolling average



In past week, LHDs hit new records for percent of contacts reached within 24 hours of referral

When expanding time dimension to represent completion within two days, LHDs attempted 88% of calls and completed 72%

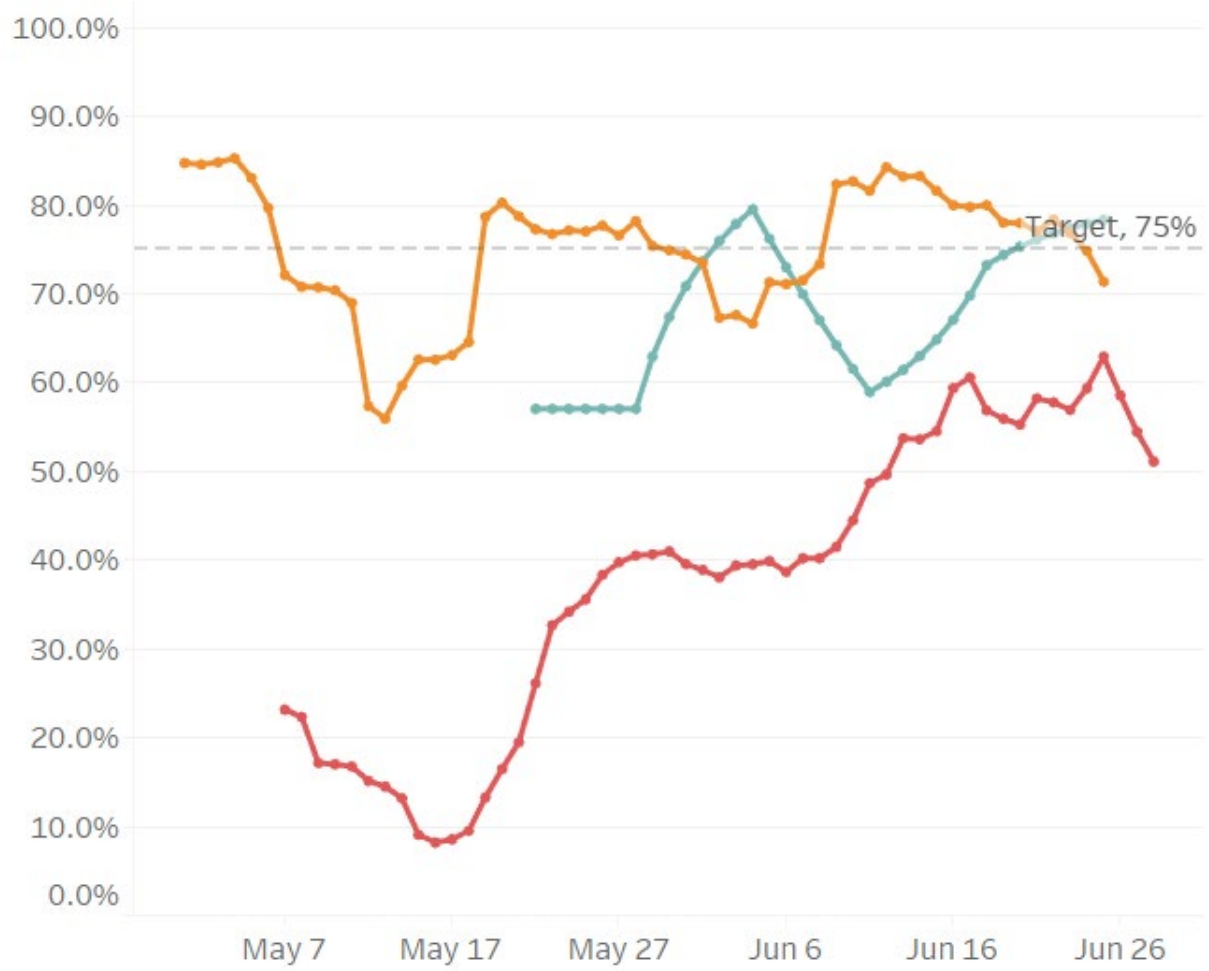
To identify how to help reach the remaining cases, the Technical Assistance process is including more active follow-up with LHDs after the initial technical assistance call

Source: MDSS summary statistics, 6/15

Obtained via MI FOIA by Judicial Watch, Inc.

Contact Tracing: Successful outreach within one day

Percent of contacts successfully reached within 24 hours (7 day rolling avg.)



LHD tracers, homegrown system, ~28% of cases[3]

LHD tracers, legacy system, ~24% of cases[1]

Central Contact Tracers, ~48% of cases[2]

- The TraceForce system saw several system issues over the past week, leading to a slight decrease in performance
- Additionally, pilot departments onboarded to perform their own contact tracing in TraceForce did not appear to conduct outreach over the weekend, lowering recent completion percentage

1. Excludes departments that indicated that they do not use OMS
2. State currently supports Detroit City, Wayne, Ionia, Ingham, Saginaw, Genesee, Delta-Menominee, Kalamazoo, Van-Buren Cass, Marquette, Huron, and Branch-Hillsdale-St. Joseph. Initial self-use pilot departments (Washtenaw and Livingston) have also been included in % of cases.
3. Data obtained through weekly LHD SITREPs starting on 5/28; only contains a weekly average

Source: MDSS and OMS summary statistics. Traceforce summary statistics, LHD SITREP. % of cases represents recent cases.

Obtained via MI FOIA by Judicial Watch, Inc.

Epi and indicators

Testing

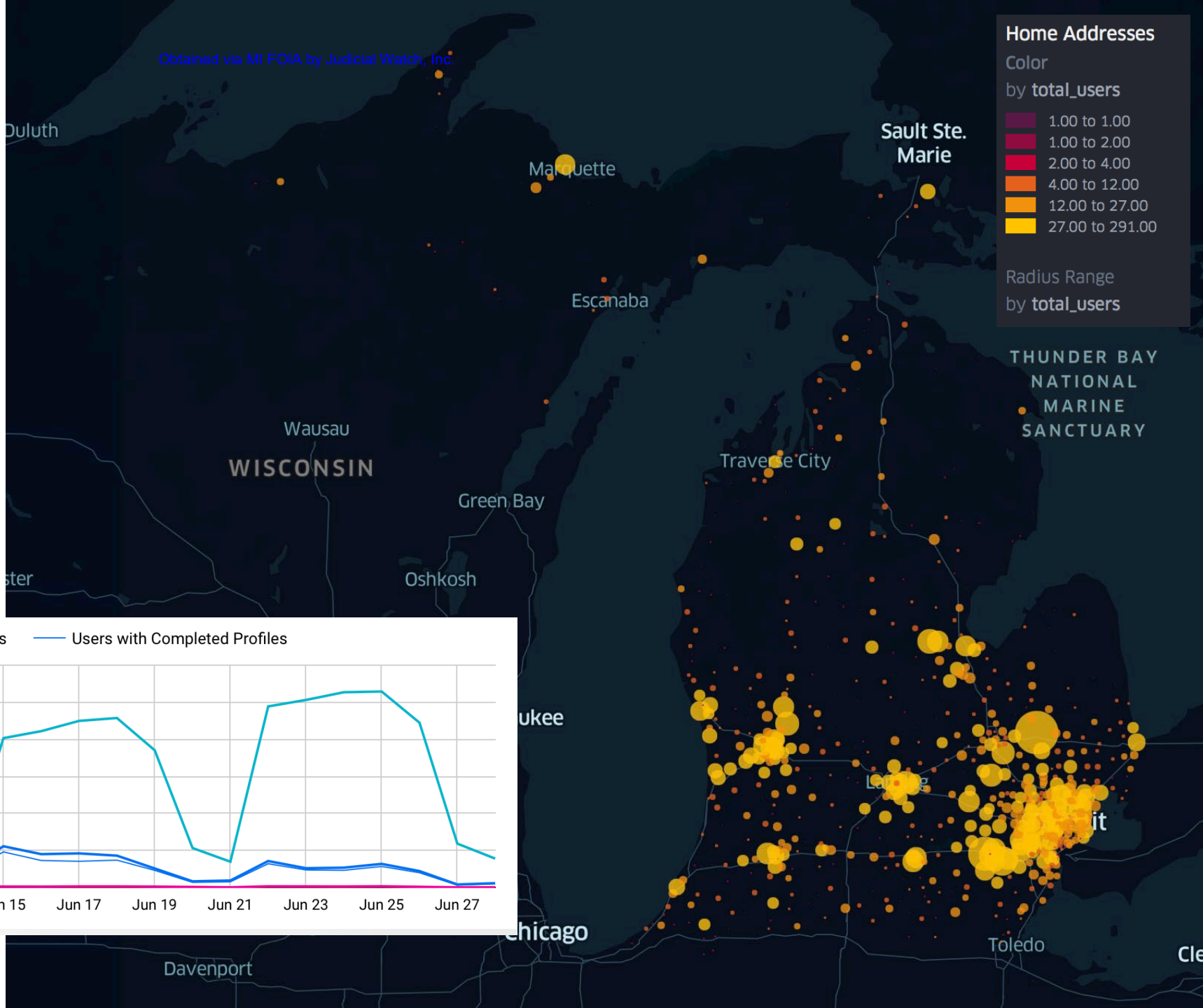
Case investigation and tracing

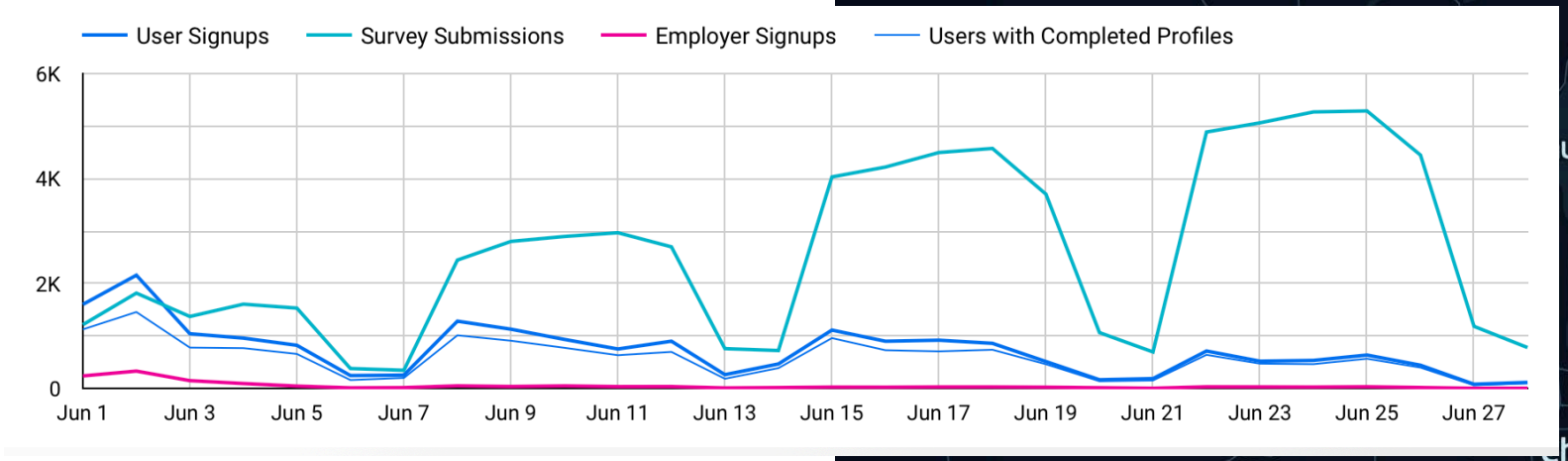
Upcoming data sources

Appendix

MI Symptoms

- >23K users signed up (~18K completed profiles)
- ~1600 employers





Obtained via MI FOIA by Judicial Watch, Inc.

Epi and indicators

Testing

Case investigation and tracing

Upcoming data sources

Appendix

Confirmed & Probable Cases

Obtained via MI FOIA by Judicial Watch, Inc.

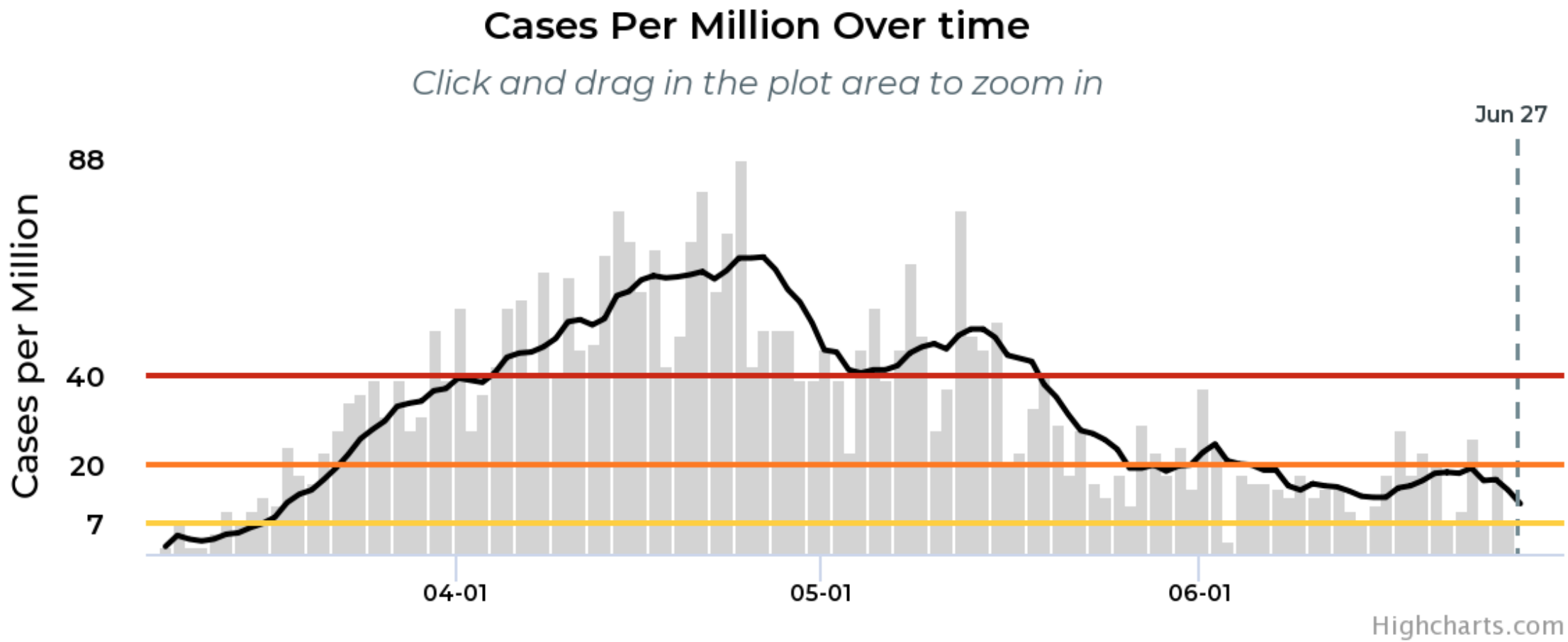
Note: data excludes MDOC

DATE: 2020-06-27	MERC Region Number	Public Health Region	Absolute cases (per million)	Case trend	Cases, 3-day surge	Absolute deaths (per million)	Death trend	Average percent positivity	Positivity trend	Tests per million
Detroit	1	2N + 2S	21.4	Increase - 1wk	No	0.4	Decrease - 10wk	2.7	Daily Avg < 3%	1353.4
Grand Rapids	2	6	29.0	Increase - 2wk	No	0.4	<20 wkly deaths	3.4	Increase - 1wk	1773.8
Kalamazoo	3	5	24.9	Increase - 1wk	No	0.3	<20 wkly deaths	2.6	Daily Avg < 3%	1421.7
Saginaw	4	3	15.6	Increase - 1wk	No	0.9	<20 wkly deaths	3.2	Decrease - 1wk	1391.7
Lansing	5	1	48.0	Increase - 1wk	No	0.2	<20 wkly deaths	2.8	Daily Avg < 3%	1753.0
Traverse City	6	7	6.5	Increase - 1wk	No	0.0	<20 wkly deaths	0.8	Daily Avg < 3%	889.6
Jackson	7	1	12.2	Decrease - 1wk *	No	0.0	<20 wkly deaths	1.1	Daily Avg < 3%	1476.5
Upper Peninsula	8	8	5.6	Increase - 2wk *	No	0.5	<20 wkly deaths	0.4	Daily Avg < 3%	1064.6

PUBLIC HEALTH

Obtained via MI FOIA by Judicial Watch, Inc.

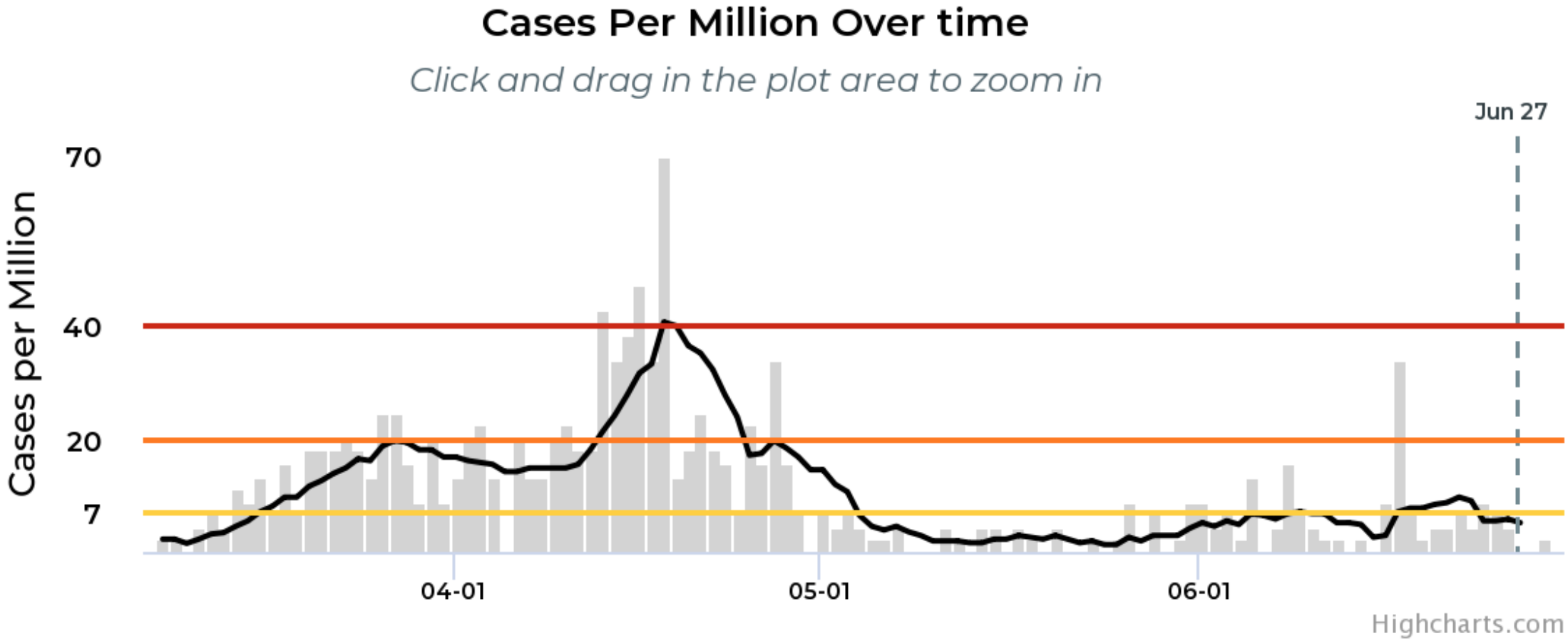
Saginaw



PUBLIC HEALTH

Obtained via MI FOIA by Judicial Watch, Inc.

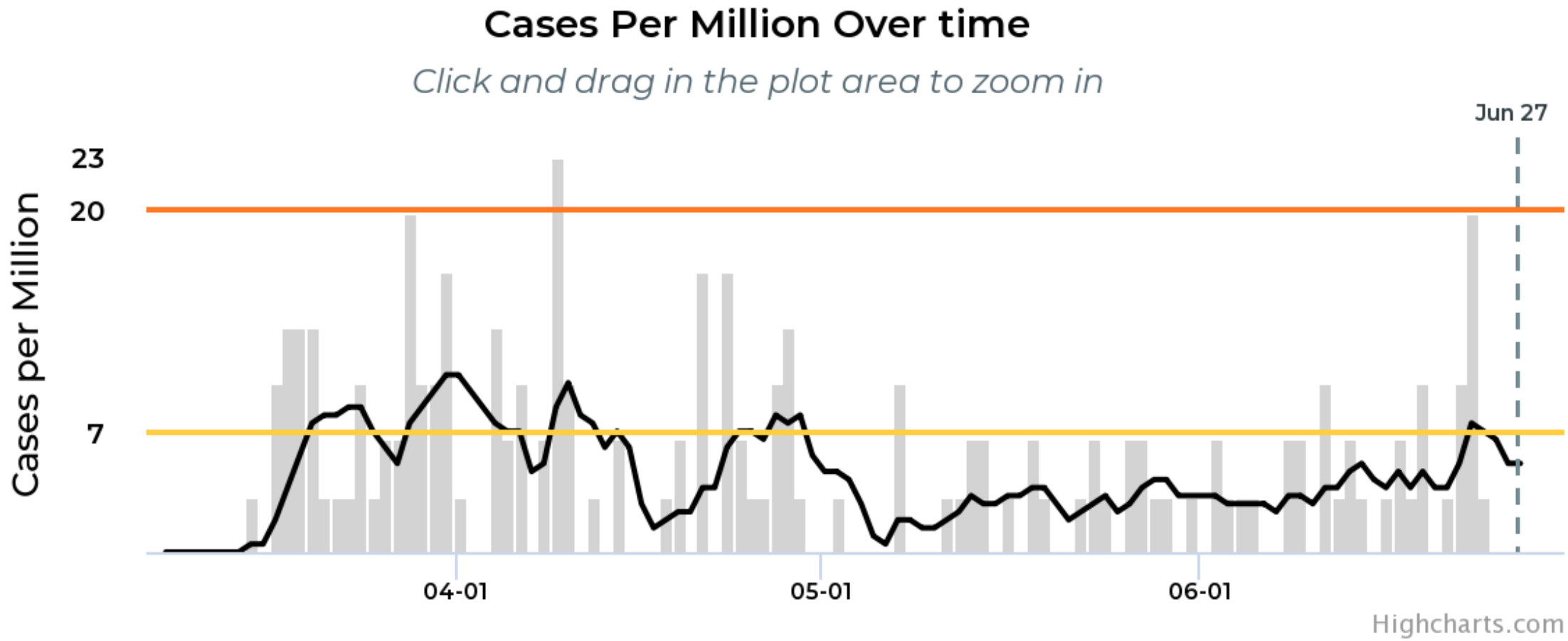
Traverse City Region



PUBLIC HEALTH

Obtained via MI FOIA by Judicial Watch, Inc.

Upper Peninsula



PUBLIC HEALTH

Health System Indicators

Obtained via MI FOIA by Judicial Watch, Inc.

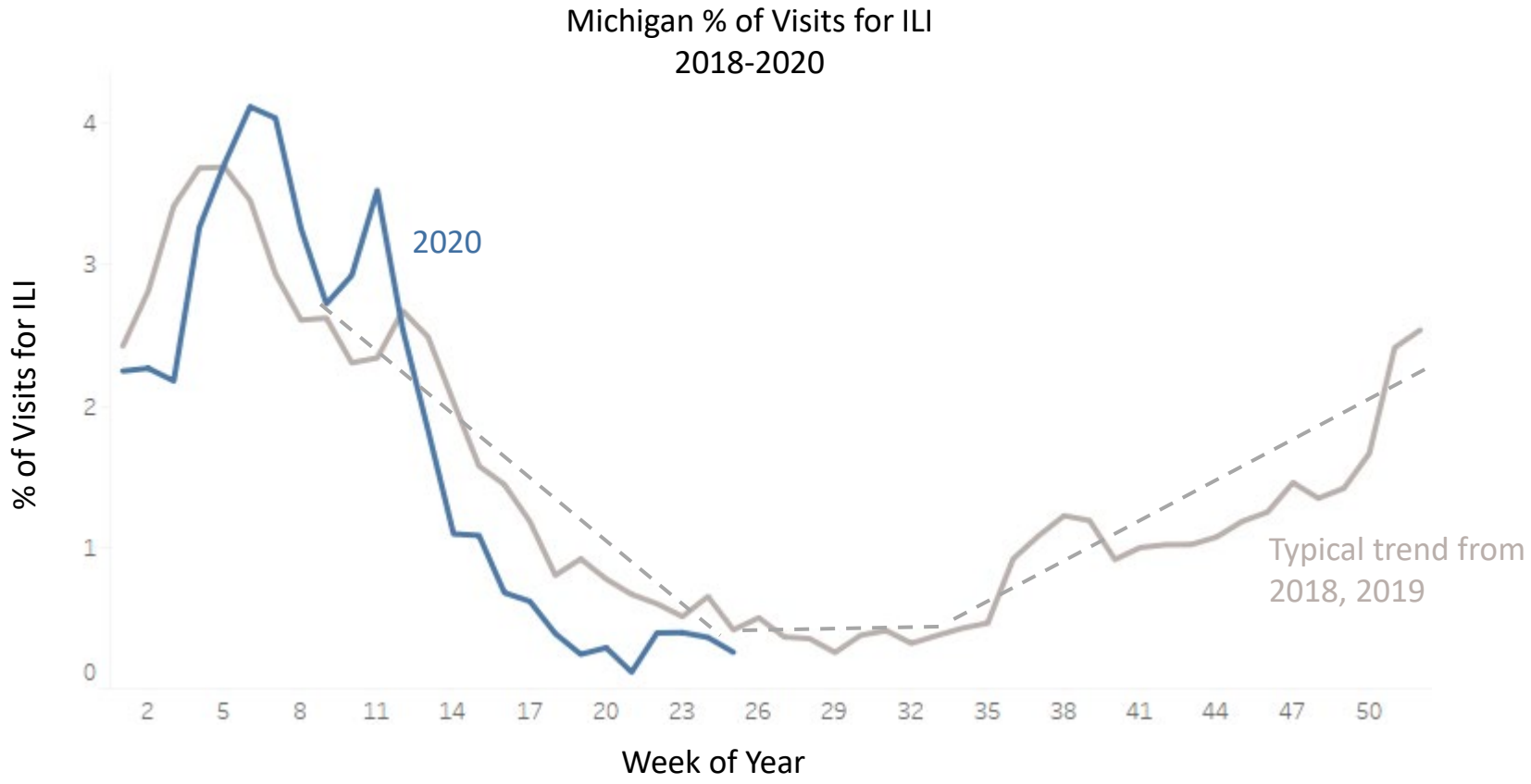
	DATE:2020-06-29 Public Health Region	Available IP Beds (per million)	Inpatient Beds Occupied	IP Beds Occupied by COVID	IP Beds Occupied by Cases and PUI	Inpatient COVID Cases (per million)	Inpatient Cases and PUI (per million)	Available ICU Beds (per million)	ICU Beds Occupied	Available Ventilators (per million)	Ventilators Used
Lansing	Region 1	412.8	69.9%	0.8%	3.7%	7.4	35.3	25.0	85.9%	143.8	20.5%
Detroit (N)	Region 2N	688.0	68.2%	2.3%	3.3%	34.2	48.3	50.0	77.4%	180.3	28%
Detroit (S)	Region 2S	695.2	75.5%	2.4%	3.8%	50.9	81.7	115.1	72.1%	346.5	36.3%
Saginaw	Region 3	633.4	72.4%	2.1%	4%	34.2	66.7	98.2	72.5%	198.2	27.9%
Kalamazoo	Region 5	403.2	74%	2.4%	3.4%	27.2	38.6	66.8	64.8%	193.2	18.5%
Grand Rapids	Region 6	656.0	58.1%	3.3%	4.5%	30.4	41.0	86.1	68.4%	242.3	16.1%
Traverse City	Region 7	1134.4	49.1%	0.4%	1.2%	4.5	13.6	178.9	60.1%	172.1	23.2%
Upper Peninsula	Region 8	885.4	52.2%	0.7%	1.7%	6.6	16.5	98.7	62.5%	296.2	6.2%

PUBLIC HEALTH

Obtained via MI FOIA by Judicial Watch, Inc.

ILI: Influenza Like Illness Surveillance and predicted COVID waves

Information on patient visits to health care providers for influenza-like illness (ILI) is collected through the U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet). % of visits for ILI is tracked and reportable for most states.



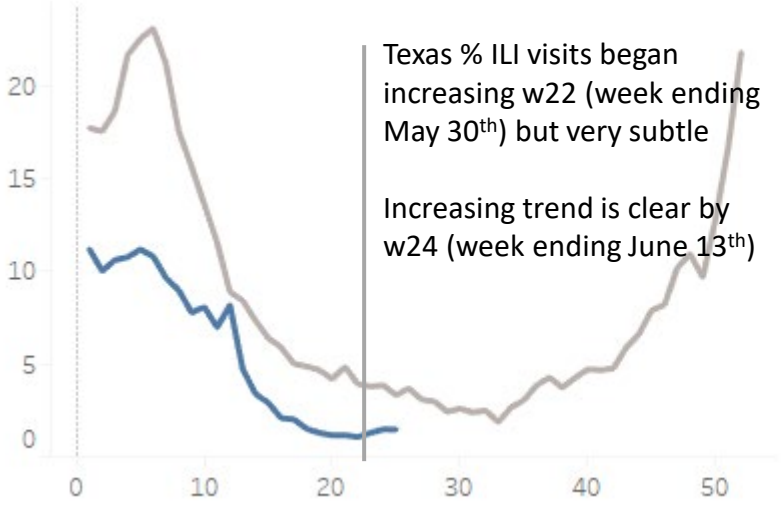
Percentage of Visits for ILI have consistent seasonal patterns. After influenza season peak, the metric decreases in most states until approximately week 23 (early June). Then flattens until ~week 35 (late August), when it begins to increase.

Source https://gis.cdc.gov/grasp/fluview/fluportaldashboard.html

Obtained via MI FOIA by Judicial Watch, Inc.

ILI and Confirmed Cases: Not entirely reliable to detect coming waves

Texas



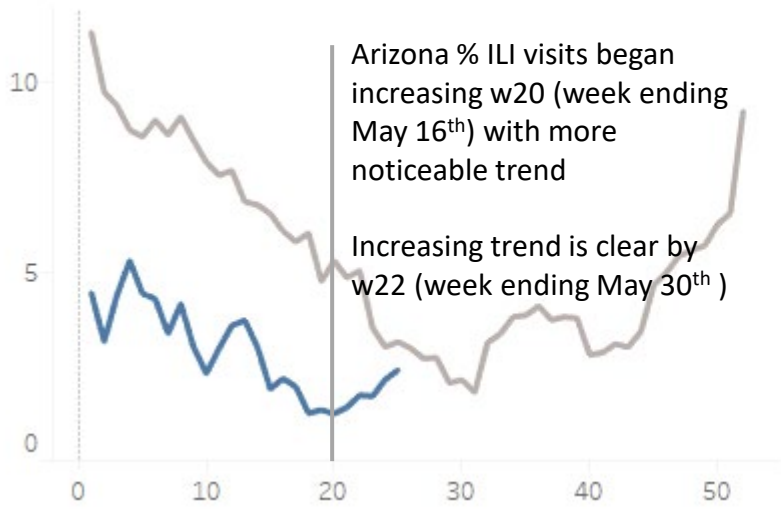
Texas % ILI visits began increasing w22 (week ending May 30th) but very subtle

Increasing trend is clear by w24 (week ending June 13th)



Sharp increase in confirmed cases begins June 15th

Arizona



Arizona % ILI visits began increasing w20 (week ending May 16th) with more noticeable trend

Increasing trend is clear by w22 (week ending May 30th)

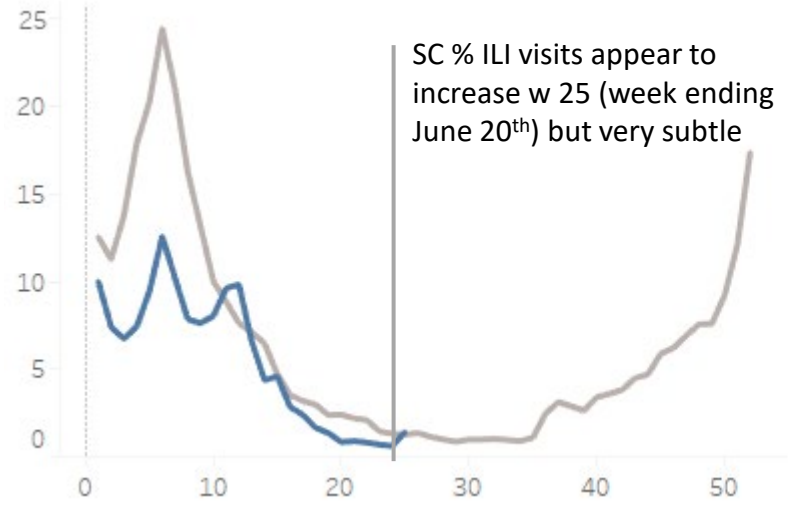


Sharp increase in confirmed cases begins June 1st

Obtained via MI FOIA by Judicial Watch, Inc.

ILI and Confirmed Cases: Not entirely reliable to detect coming waves

South Carolina

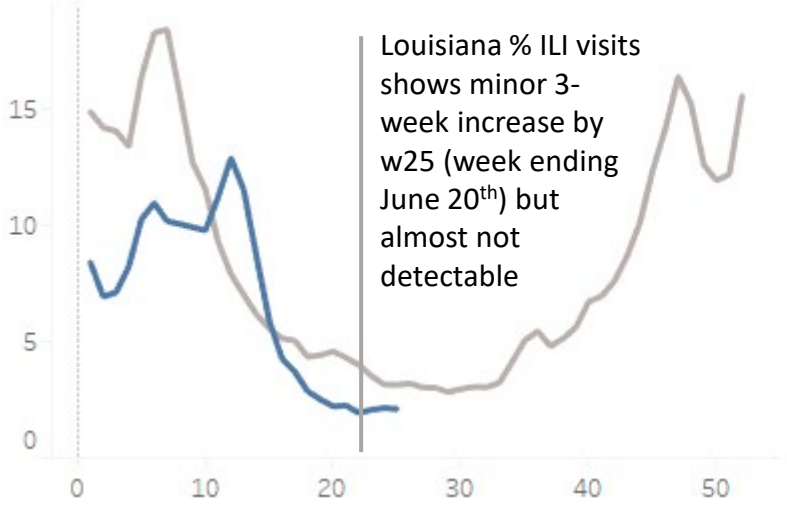


SC % ILI visits appear to increase w 25 (week ending June 20th) but very subtle

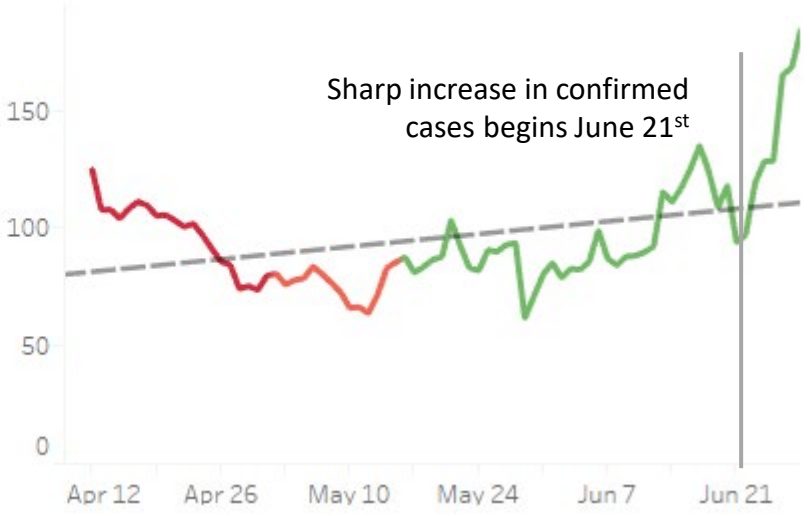


Sharp increase in confirmed cases begins June 5th

Louisiana



Louisiana % ILI visits shows minor 3-week increase by w25 (week ending June 20th) but almost not detectable



Sharp increase in confirmed cases begins June 21st

Obtained via MI FOIA by Judicial Watch, Inc.

ILI Summary

Monitoring % of Visits for ILI as a sentinel/preliminary indicator of resurgence maybe be helpful when taken with other indicators and in context of:

- Typical seasonal trend of ILI
- # of providers in state which participate in ILI reporting
- Identification of trend may be delayed given weekly reporting cadence

Obtained via MI FOIA by Judicial Watch, Inc.

MI COVID response

Data and modeling update

June 29, 2020

NOTE: all data as of June 27 unless otherwise noted

Draft and pre-decisional

DRAFT

Obtained via MI FOIA by Judicial Watch, Inc.

Executive summary

Indicators are increasing across MI, with varied risk across the state

Lansing region has seen an increase in new cases to >40 per mm, which puts them in a “high” risk level.

Grand Rapids region has also increased in number of cases over the last 2 weeks, raising the region above the 20 cases per mm threshold (medium-high risk). Also concerning is the increase in percent positivity during a time of increased testing

The Detroit, Kalamazoo, Saginaw, and Jackson regions have seen increases in cases over the past week however have remained under the 20 cases per mm level (medium risk). Additionally percent positivity remains below 3%

The Traverse City and UP regions have had increased case counts in the past week, however continue to have low overall case levels and low percent positivity (low risk)

Daily diagnostic (PCR) testing increased to 15.6K per day in the last week, driven primarily by increases by hospital labs

Percent positivity increased to 2.6% (up from 2.3% last week)

Case investigation rates reached new highs over the past week, but contact tracing slightly decreased after some system errors that have since been resolved

Of the ~1850 cases referred over the past week (including weekends), Local Health Departments are reaching 59% within the first day and 67% within two days, allowing for fast elicitation of contacts and communication about available resources

After obtaining contacts from these cases, LHDs and Central Tracers are reaching ~62% of contacts within one day. This number will fluctuate in the coming weeks as more Local Health Departments shift their workflows and acclimate to the new central Traceforce system

Obtained via MI FOIA by Judicial Watch, Inc.

Epi and indicators

- **State-level indicators**
- Regional and county indicators
- State comparison

Testing

Case investigation and tracing

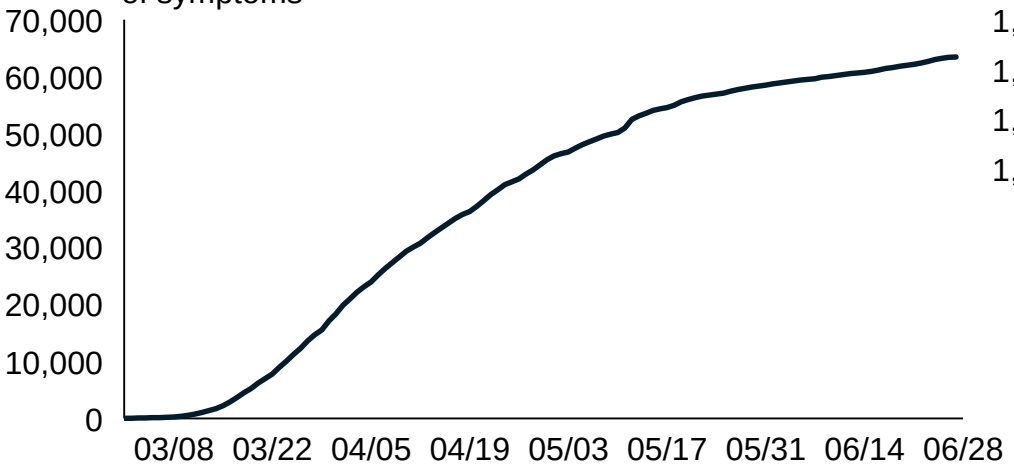
Upcoming data sources

Appendix

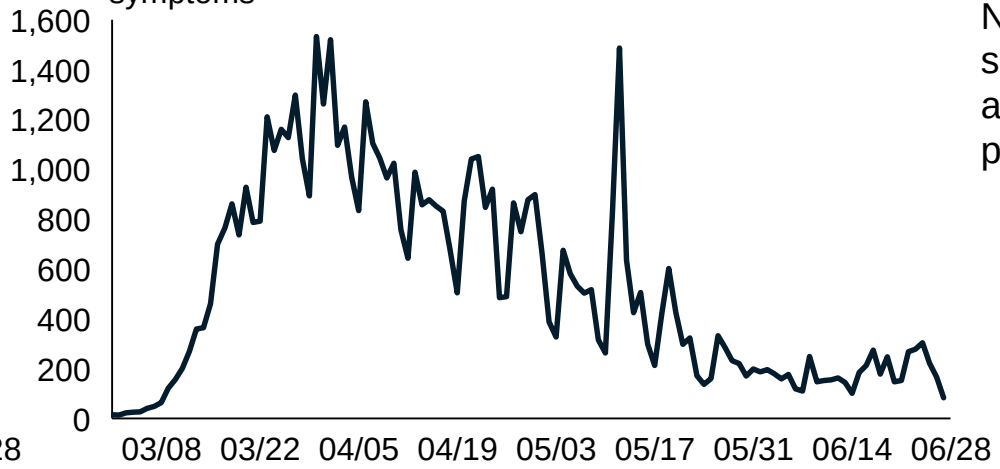
Obtained via MI FOIA by Judicial Watch, Inc.

COVID-19 cases and deaths: State of Michigan

Cumulative lab confirmed cases, by date of onset of symptoms



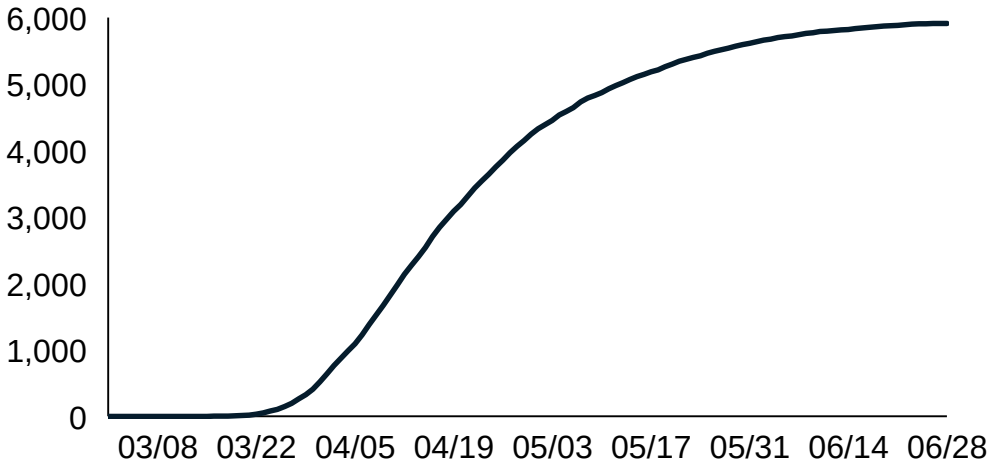
New lab confirmed cases, by date of onset of symptoms



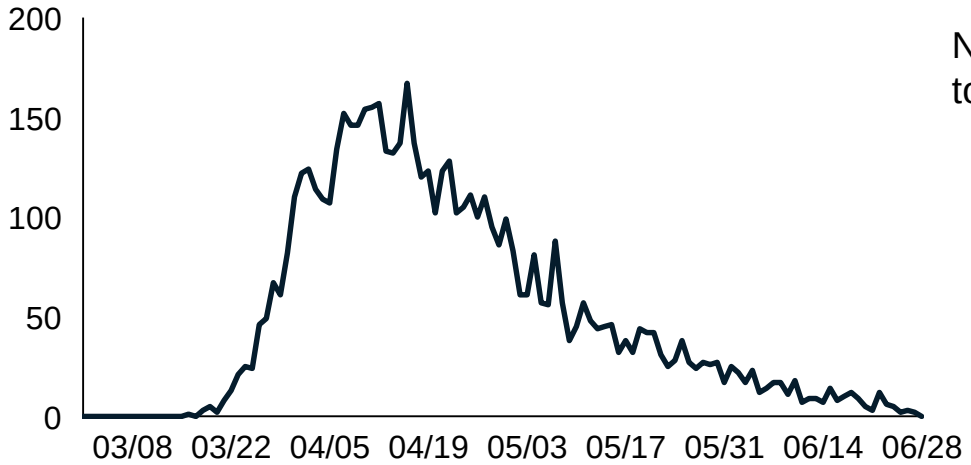
Updates since last week:

New cases per day rose slightly over the past week, after the recent period of plateau

Cumulative deaths, by reported date



New deaths, by reported date



Updates since last week:

New deaths per day continue to decrease

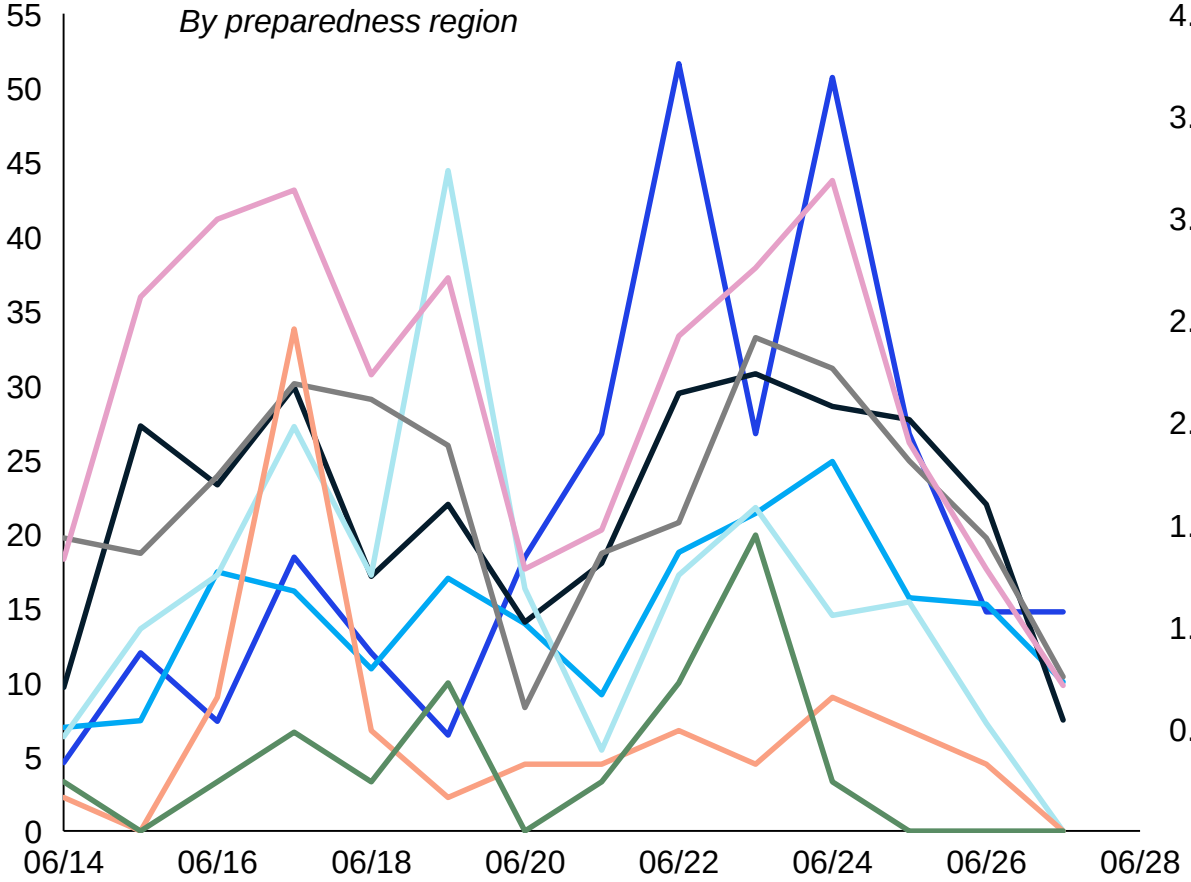
Note: Cases information sourced from MDHHS and reflects date of onset of symptoms (refers to lab-confirmed cases). Case spike on 5/12 is a result of batch of test results, not all of which have onset date of symptoms completed yet
Source: MDHHS – Michigan Disease Surveillance System

Obtained via MI FOIA by Judicial Watch, Inc.

COVID-19 cases and deaths: regional comparison PAST TWO WEEKS

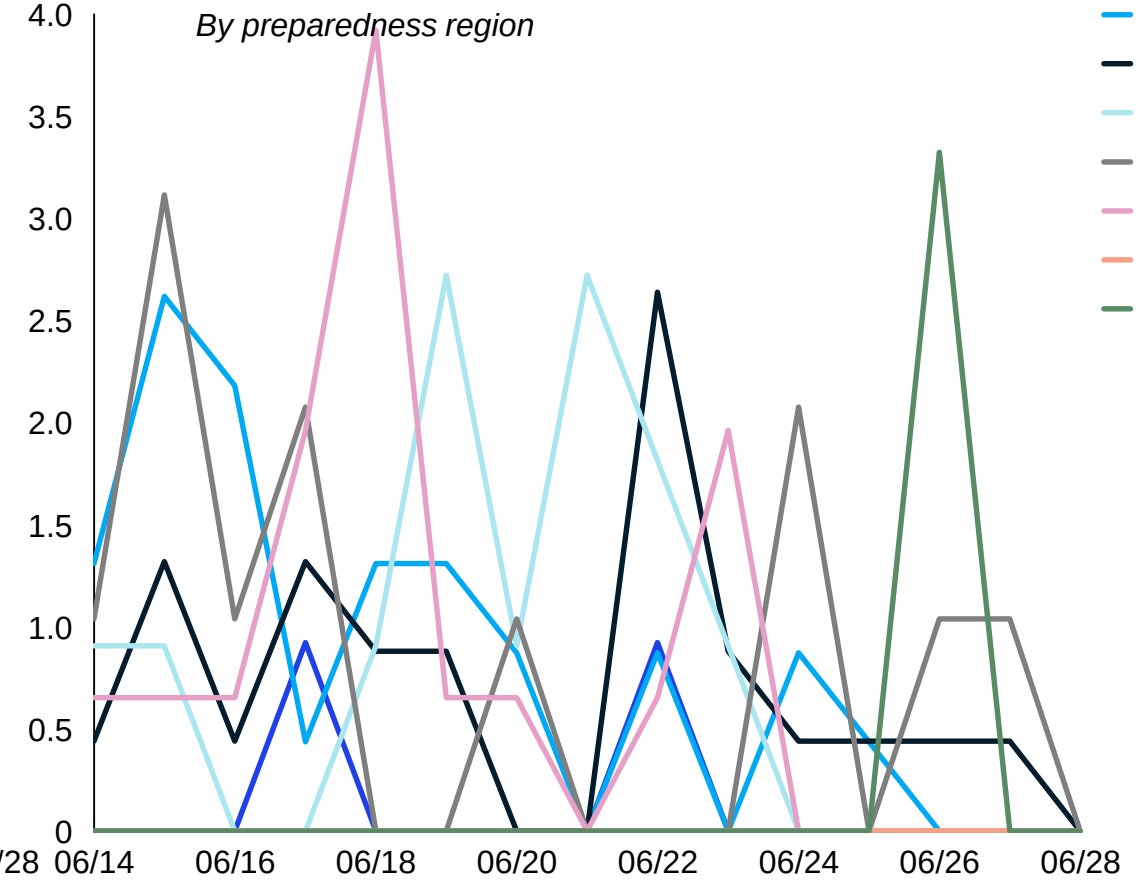
New cases per million, by date of onset of symptoms

By preparedness region



New deaths per million, by reported date

By preparedness region





Updates since last week:

Region one experienced several days of high case growth over the past week

Updates since last week:

Deaths continue to remain low across the state

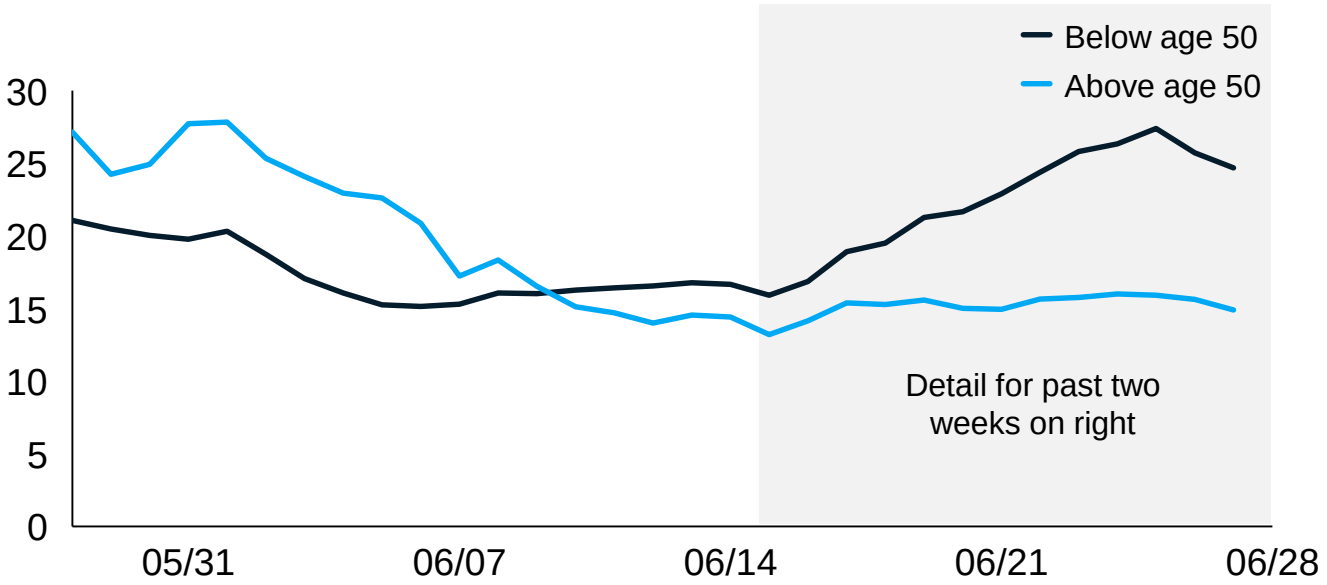
Note: “Cases” refers to lab-confirmed cases. Note: By preparedness region
Source: MDHHS – Michigan Disease Surveillance System

Draft

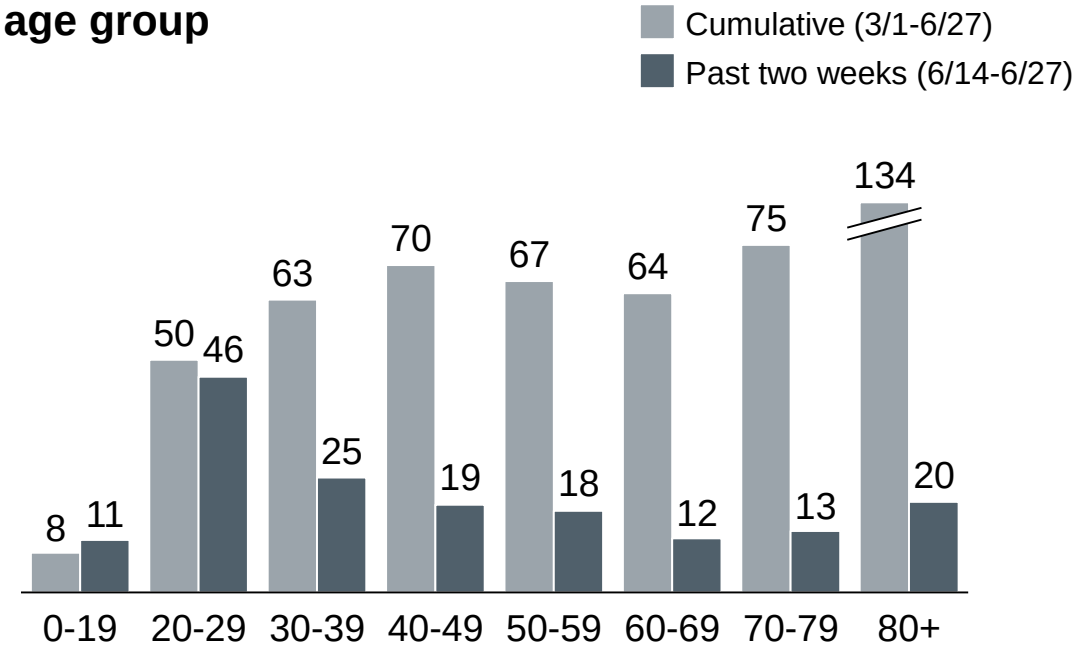
Obtained via MI FOIA by Judicial Watch, Inc.

Average daily new cases per million residents, by age group

Daily new cases per million by age group (7 day rolling average)



Average daily new cases per million by age group



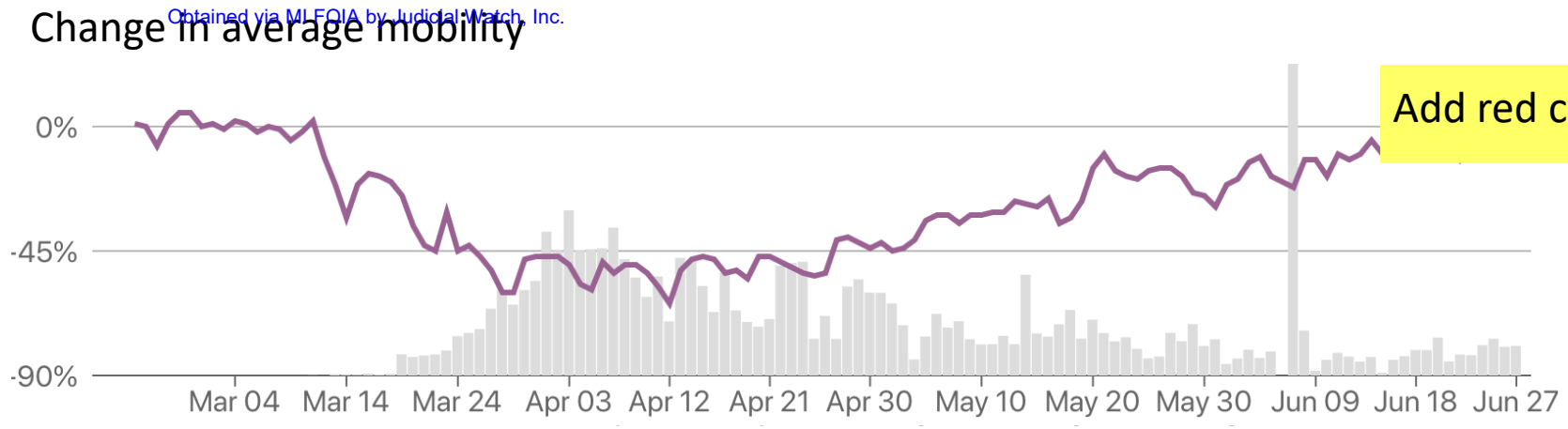
Recent increase in cases from young people could be driven by a recent outbreak in East Lansing and other gatherings, as well as by younger individuals returning to work

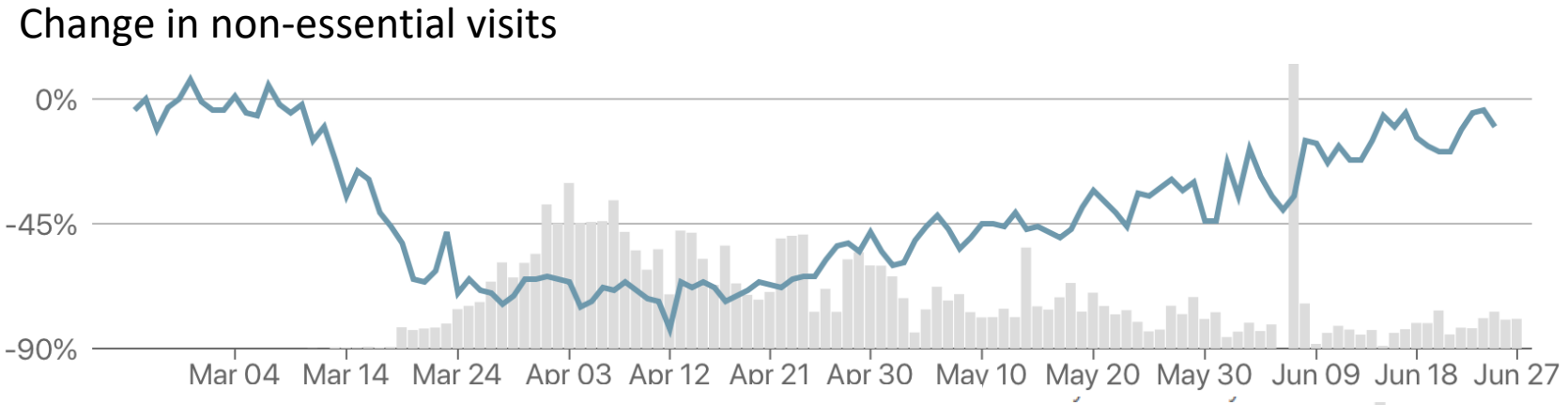
However, this data does not display percent positivity by age group, which is typically considered when analyzing outbreaks

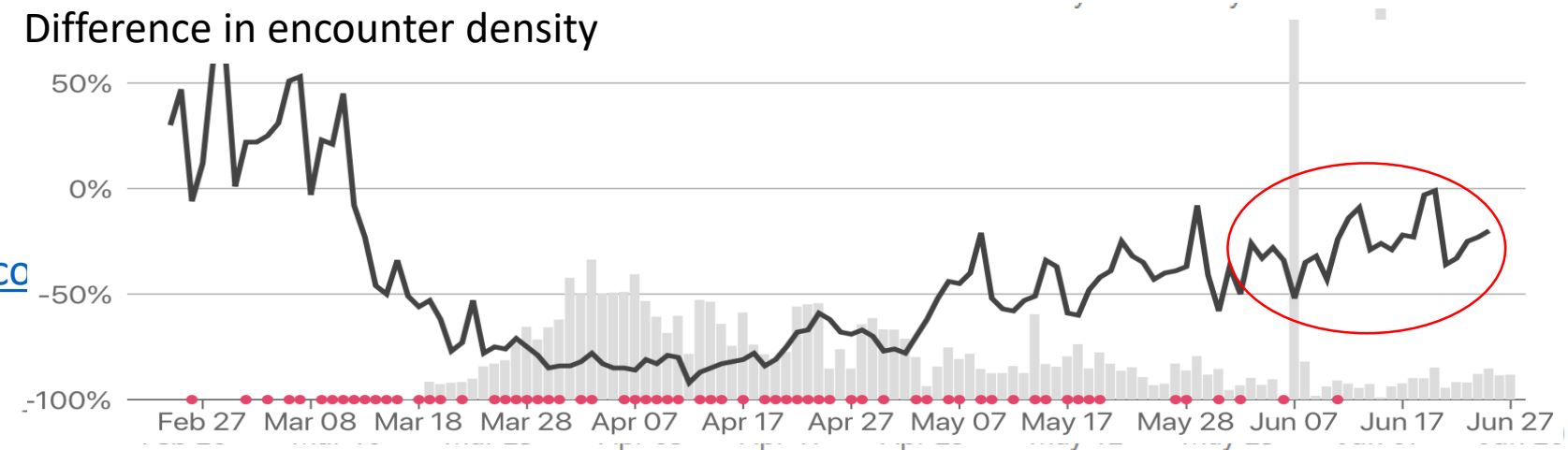
Note: Cases information sourced from MDHHS and reflects date of onset of symptoms (refers to lab-confirmed cases).
Source: MDHHS – Michigan Disease Surveillance System

Obtained via MLFOIA by Judicial Watch, Inc.

- Metrics indicate social distancing fatigue has been setting in since late April.
- These average mobility and non-essential visits have increased
- Encounter density has plateaued (potentially now increasing again also)







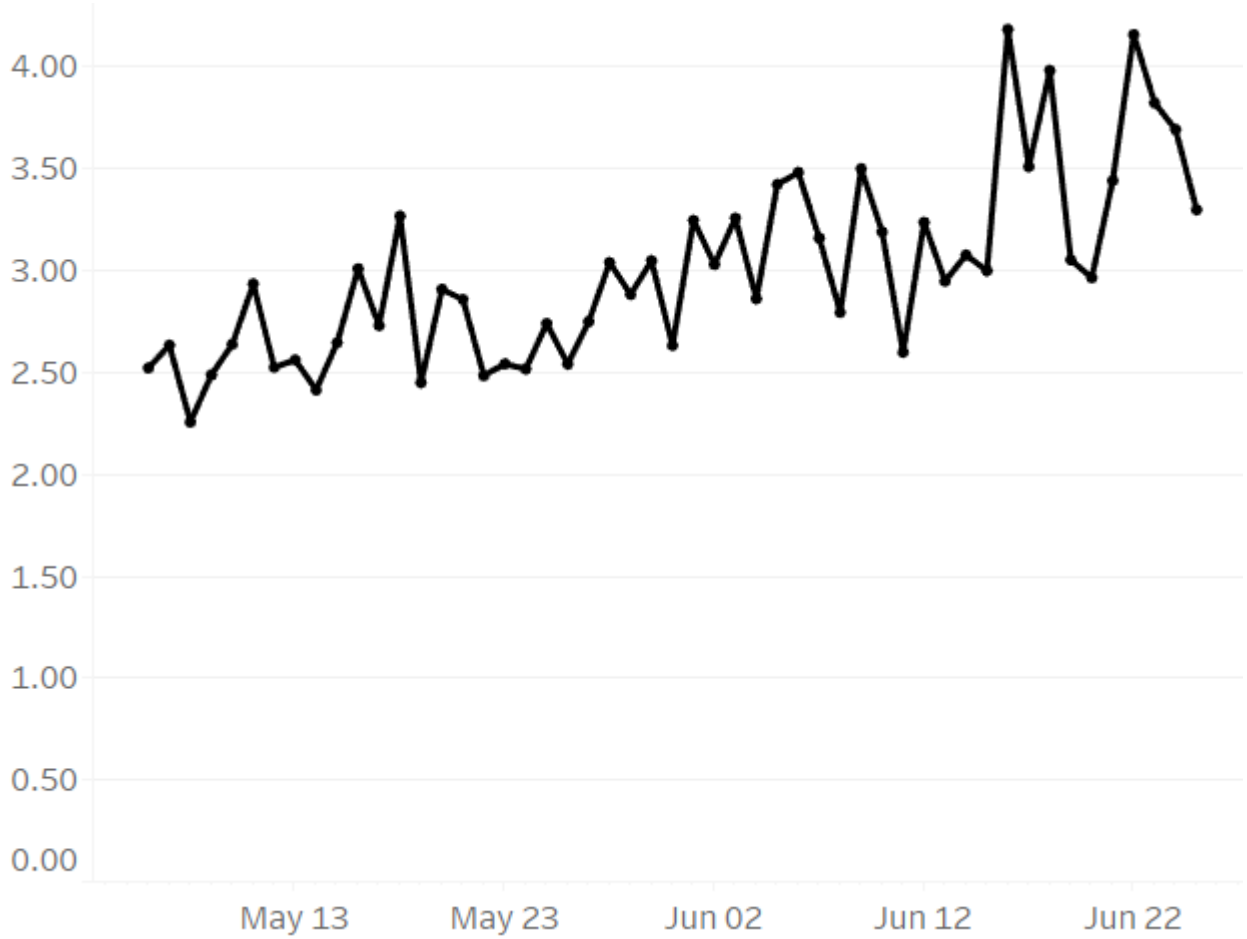
PUBLIC HEALTH

unacast social distancing scoreboard https://www.unacast.com/covid19/social-distancing-scoreboard

Contacts per case: State of Michigan

Obtained via MI FOIA by Judicial Watch, Inc.

Contacts per case, for cases with at least one contact (State of Michigan)



Contacts per case continues to rise, with several days after June 8th where the state averaged 4+ contacts per case

This number of contacts per case depends on actual encounter density, as well as the ability of case investigators to successfully elicit contacts

Source: Michigan Disease Surveillance System

Obtained via MI FOIA by Judicial Watch, Inc.

Epi and indicators

- State-level indicators
- **Regional and county indicators**
- State comparison

Testing

Case investigation and tracing

Upcoming data sources

Appendix

Confirmed Cases

Obtained via MI FOIA by Judicial Watch, Inc.

Note: data excludes MDOC

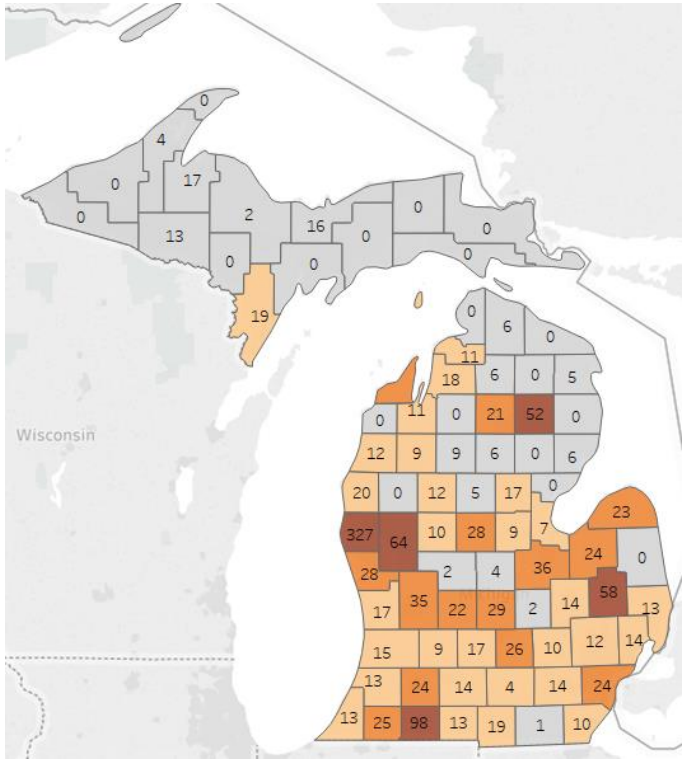
DATE: 2020-06-27	MERC Region Number	Public Health Region	Absolute cases (per million)	Case trend	Cases, 3-day surge	Absolute deaths (per million)	Death trend	Average percent positivity	Positivity trend	Tests per million
Detroit	1	2N + 2S	18.6	Increase - 2wk	No	0.4	Decrease - 10wk	2.7	Daily Avg < 3%	1353.4
Grand Rapids	2	6	27.2	Increase - 2wk	No	0.4	<20 wkly deaths	3.4	Increase - 1wk	1773.8
Kalamazoo	3	5	22.7	Increase - 1wk	No	0.3	<20 wkly deaths	2.6	Daily Avg < 3%	1421.7
Saginaw	4	3	11.2	Increase - 1wk	No	0.9	<20 wkly deaths	3.2	Decrease - 1wk	1391.7
Lansing	5	1	45.6	Increase - 1wk	No	0.2	<20 wkly deaths	2.8	Daily Avg < 3%	1753.0
Traverse City	6	7	5.2	Increase - 1wk	No	0.0	<20 wkly deaths	0.8	Daily Avg < 3%	889.6
Jackson	7	1	12.2	Increase - 2wk *	No	0.0	<20 wkly deaths	1.1	Daily Avg < 3%	1476.5
Upper Peninsula	8	8	5.2	Increase - 4wk *	No	0.5	<20 wkly deaths	0.4	Daily Avg < 3%	1064.6

PUBLIC HEALTH

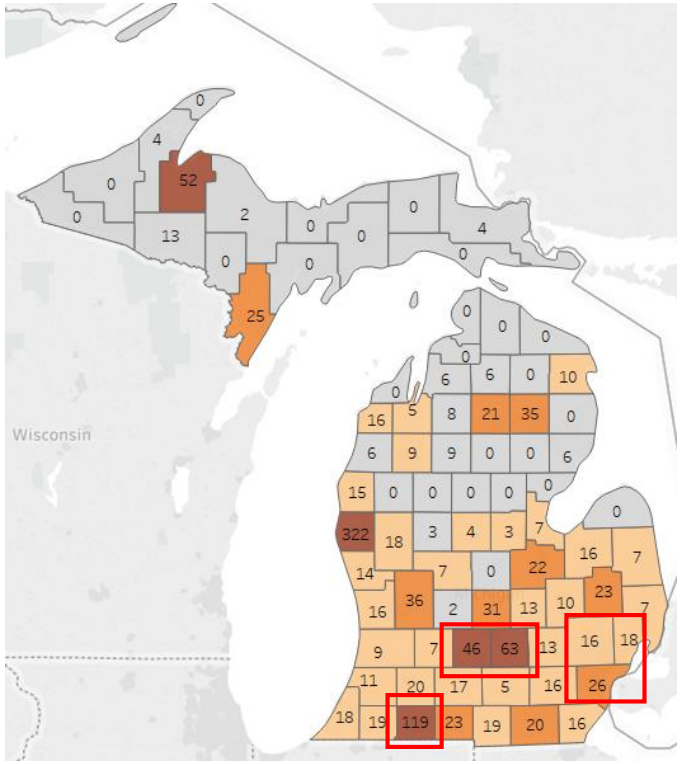
Obtained via MI FOIA by Judicial Watch, Inc.

Average daily new cases per million residents

6/15-6/21



6/21-6/27



Insufficient sample size; county has fewer than 2 new cases during the week

Fewer than 20 average daily new cases per million

20-40 average daily new cases per million

More than 40 average daily new cases per million

Updates since last week:

Overall, outbreaks continue to occur in pockets across the state

Some counties with increases include (not exhaustive):

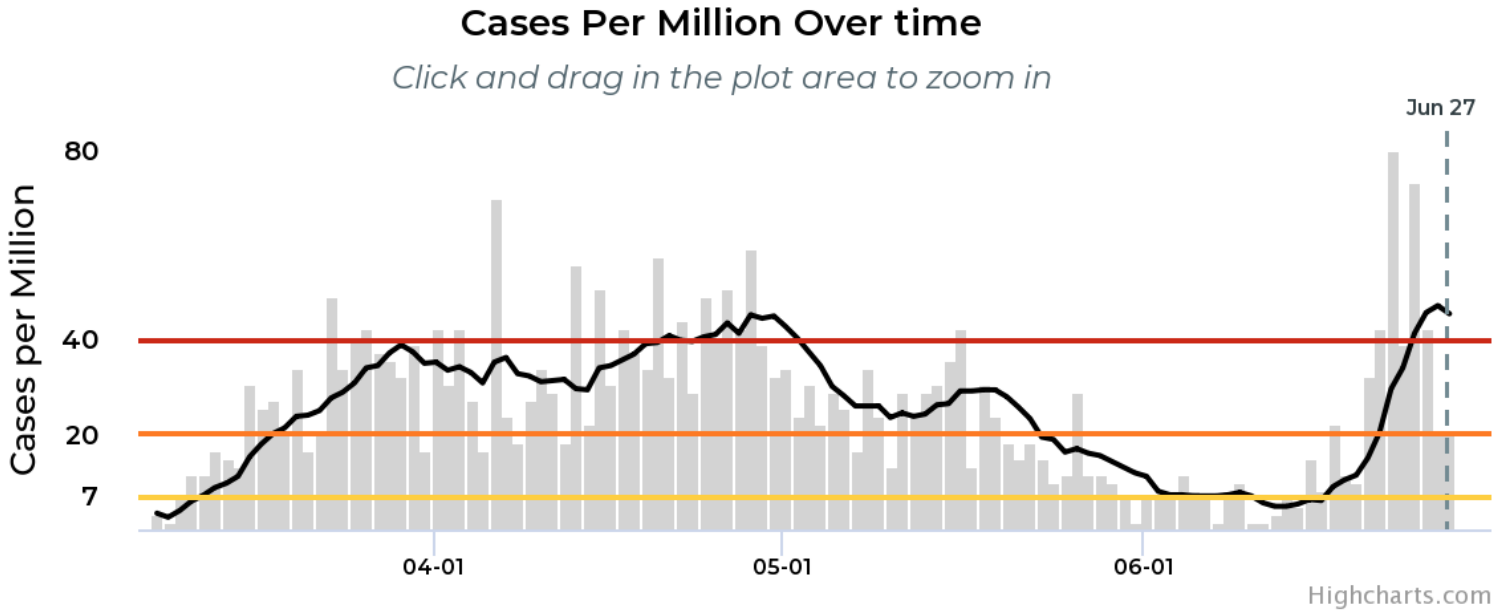
- Ingham, Eaton, St. Joseph, Macomb, Wayne, Oakland

Note: Cases information sourced from MDHHS and reflects date of onset of symptoms (refers to lab-confirmed cases).
Source: MDHHS – Michigan Disease Surveillance System

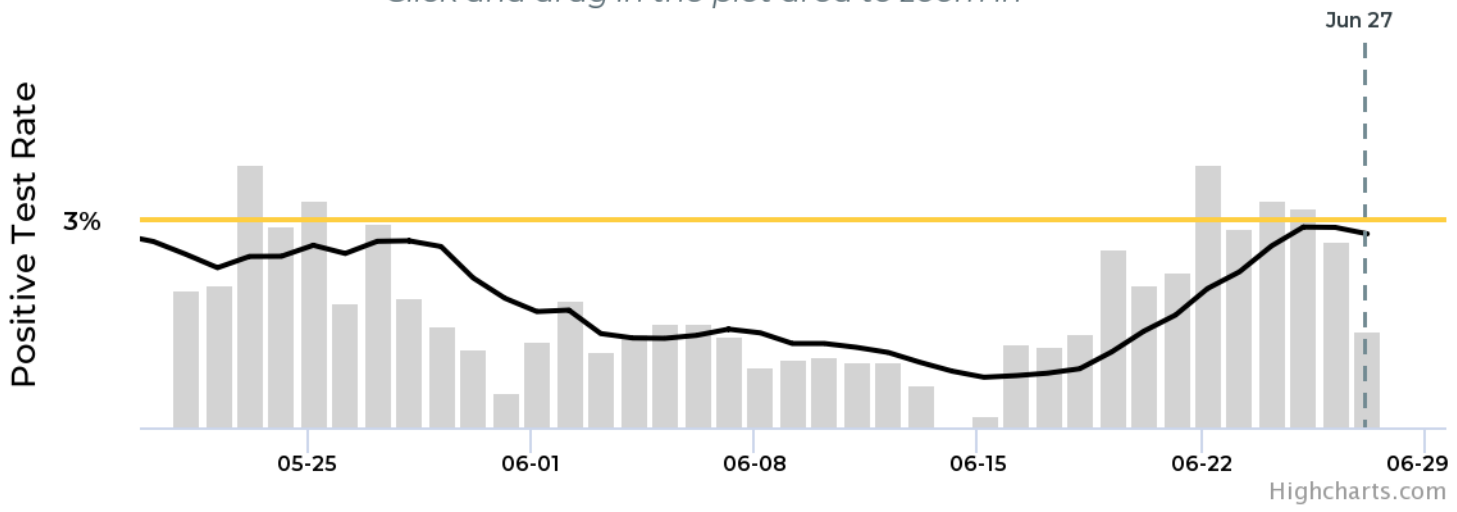
Lansing Region

Obtained via MI FOIA by Judicial Watch, Inc.

Cases Increasing & Above 40 new cases per million per day.



Percent positive increasing. (Want to see decrease here)

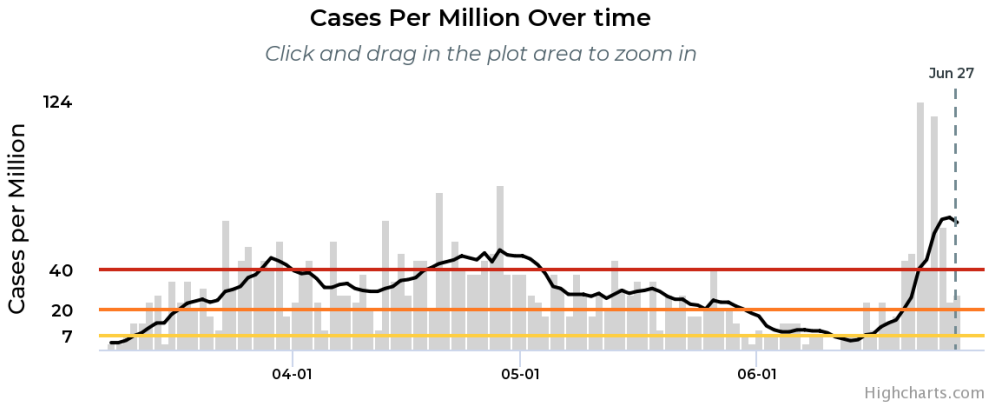


PUBLIC HEALTH

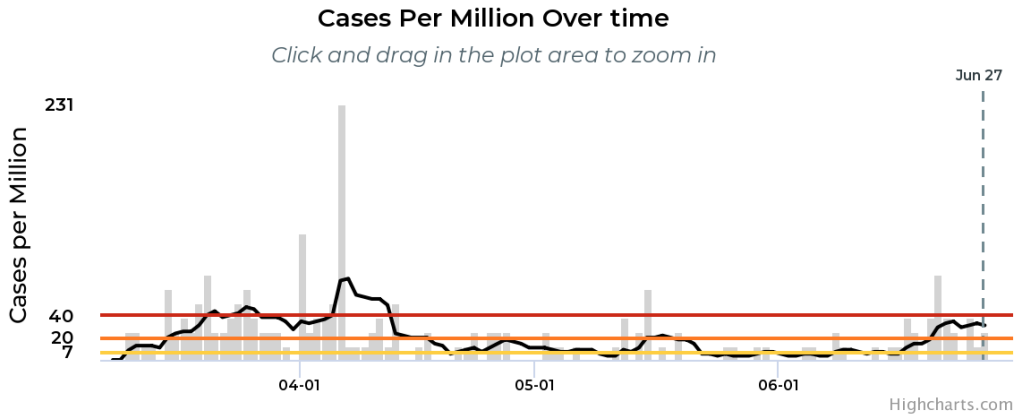
Lansing Region - Counties

Obtained via MI FOIA by Judicial Watch, Inc.

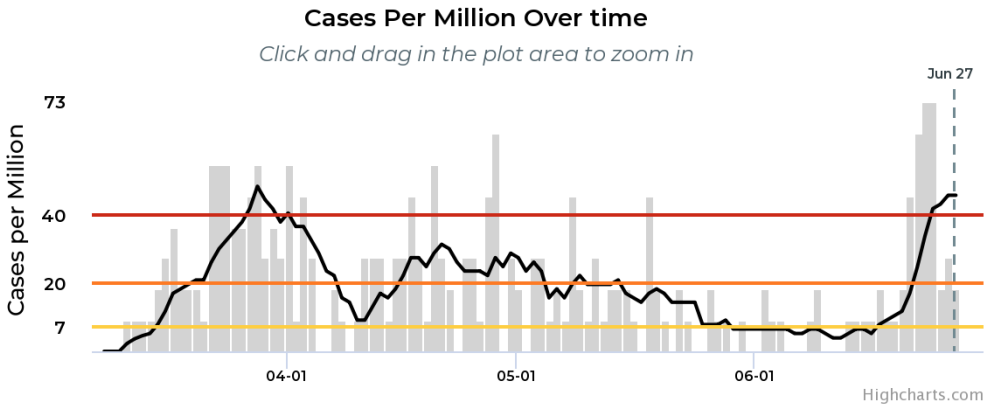
Ingham



Clinton



Eaton

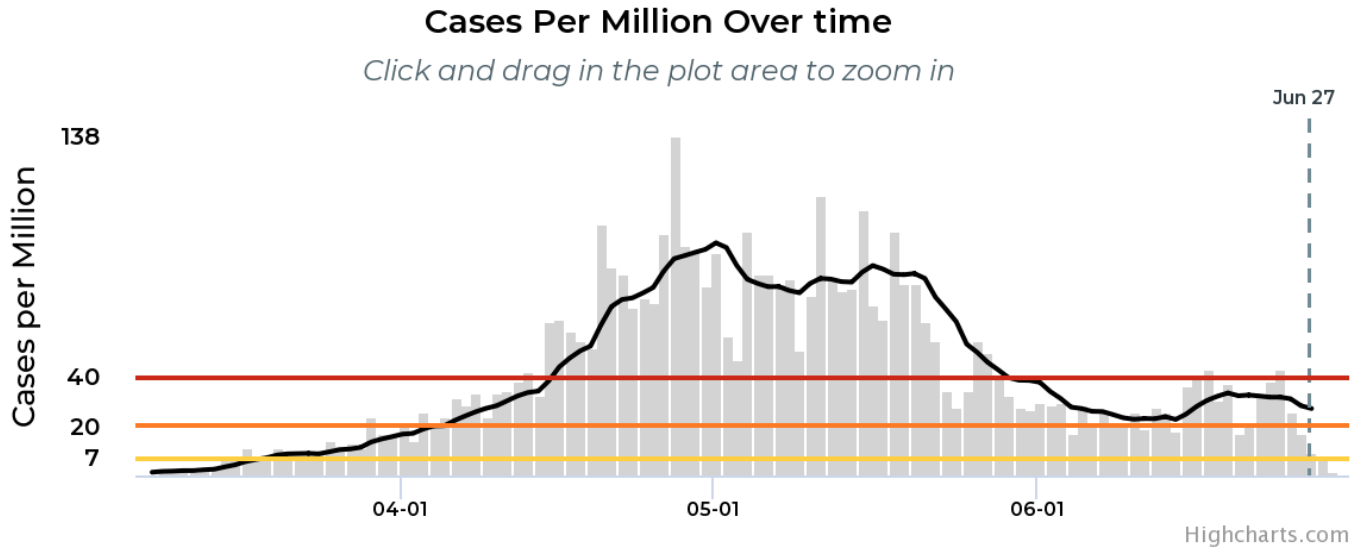


PUBLIC HEALTH

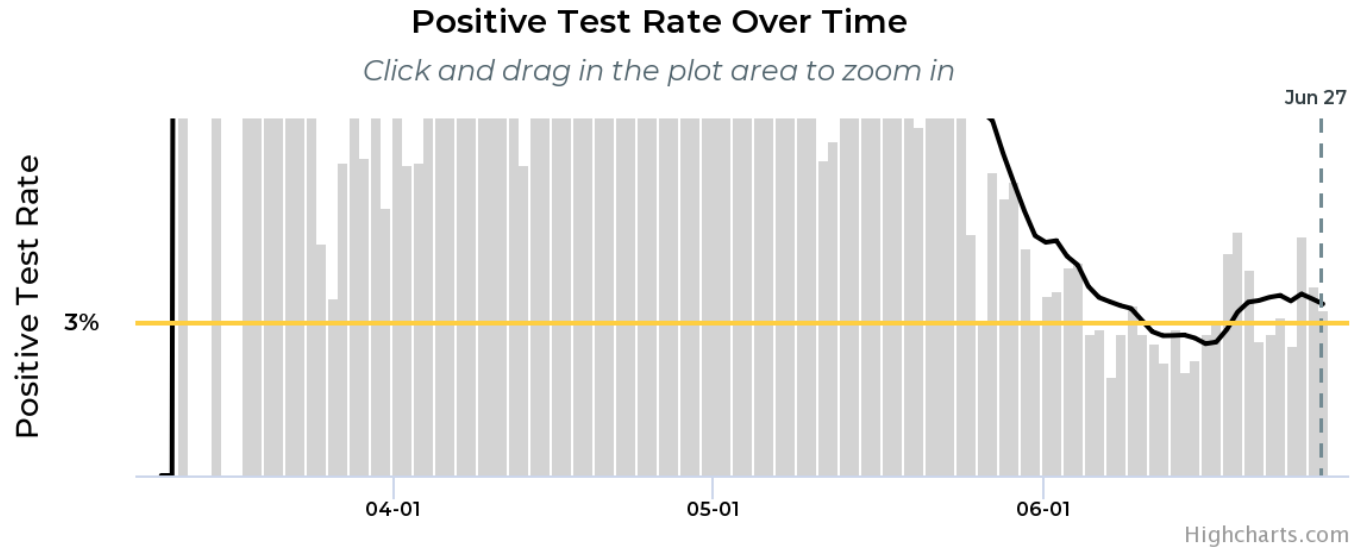
Grand Rapids Region

Obtained via MI FOIA by Judicial Watch, Inc.

Cases Increasing & Above 20 new cases per million per day.



Percent positive increasing, in the scenario of increased testing.

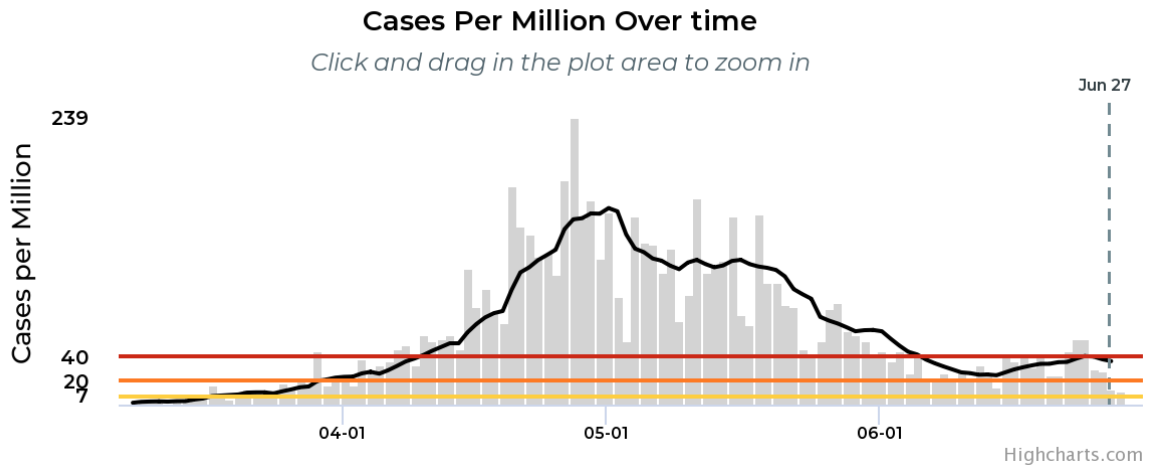


PUBLIC HEALTH

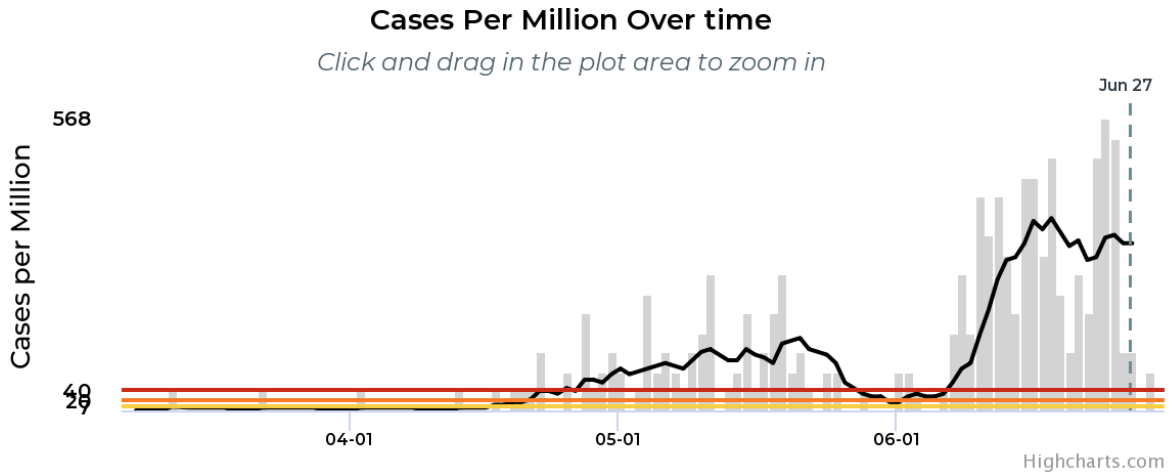
Grand Rapids Region - Counties

Obtained via MI FOIA by Judicial Watch, Inc.

Kent



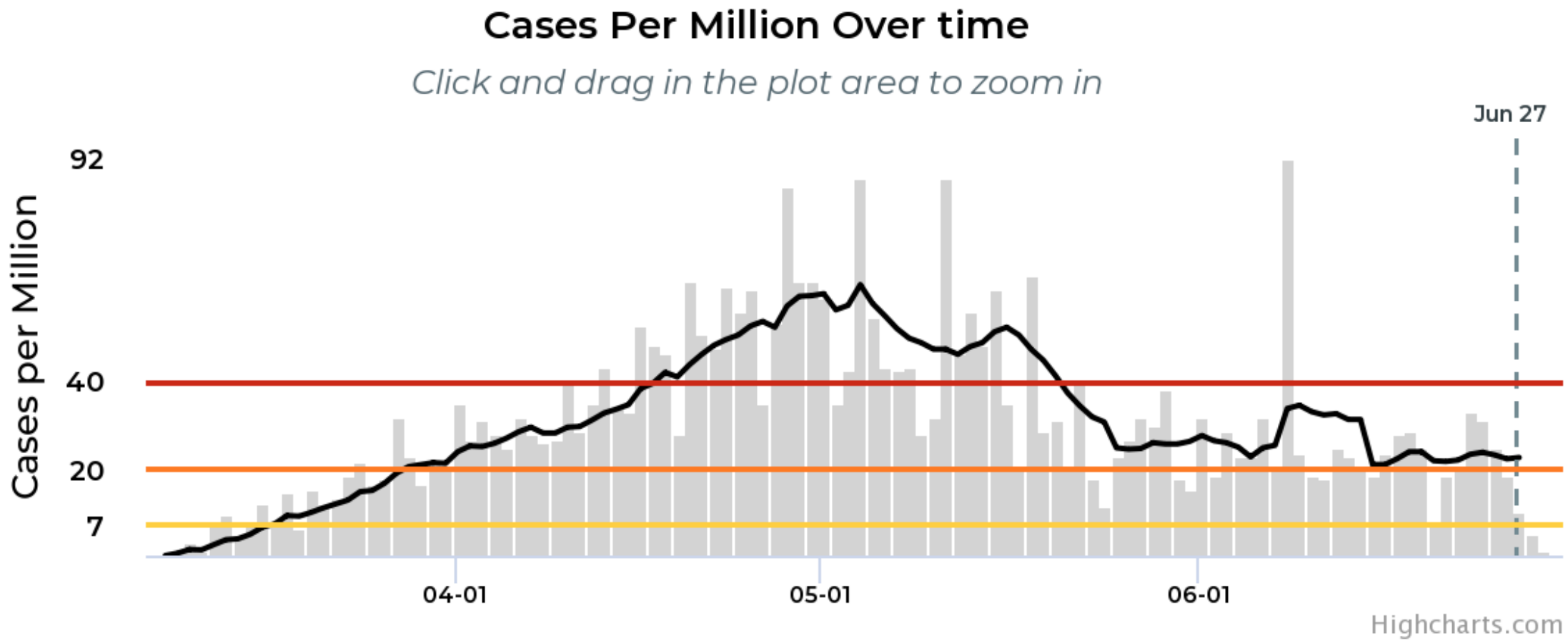
Oceana



PUBLIC HEALTH

Obtained via MI FOIA by Judicial Watch, Inc.

Kalamazoo Region



PUBLIC HEALTH

Obtained via MI FOIA by Judicial Watch, Inc.

Potential schedule for phase changes – **IF indicators continue to improve and meet requirements**

On Radar	Watch	Warning
Traverse City UP	Detroit Jackson Saginaw Kalamazoo	Lansing Grand Rapids

Obtained via MI FOIA by Judicial Watch, Inc.

Epi and indicators

- State-level indicators
- Regional and county indicators
- **State comparison**

Testing

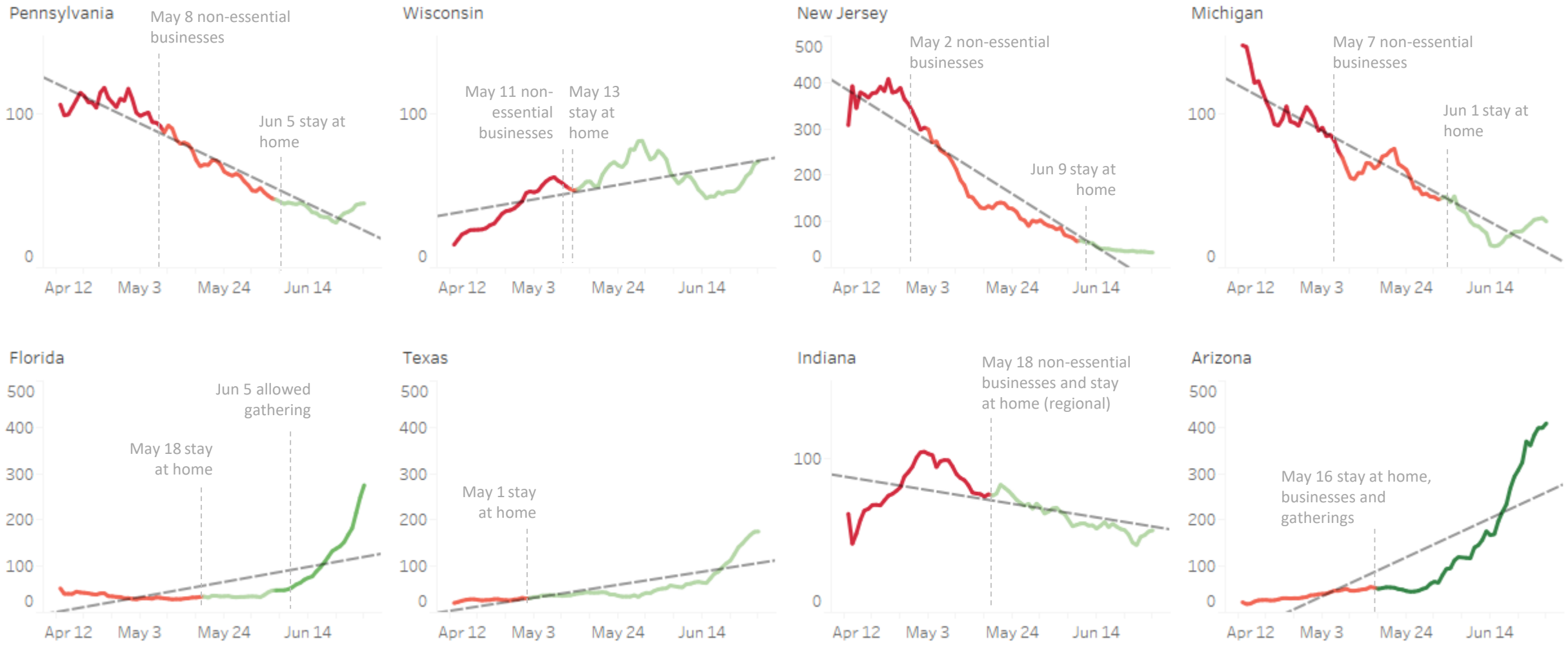
Case investigation and tracing

Upcoming data sources

Appendix

Obtained via MI FOIA by Judicial Watch, Inc.

State Comparisons: 7 day avg. of daily new cases per 1M population

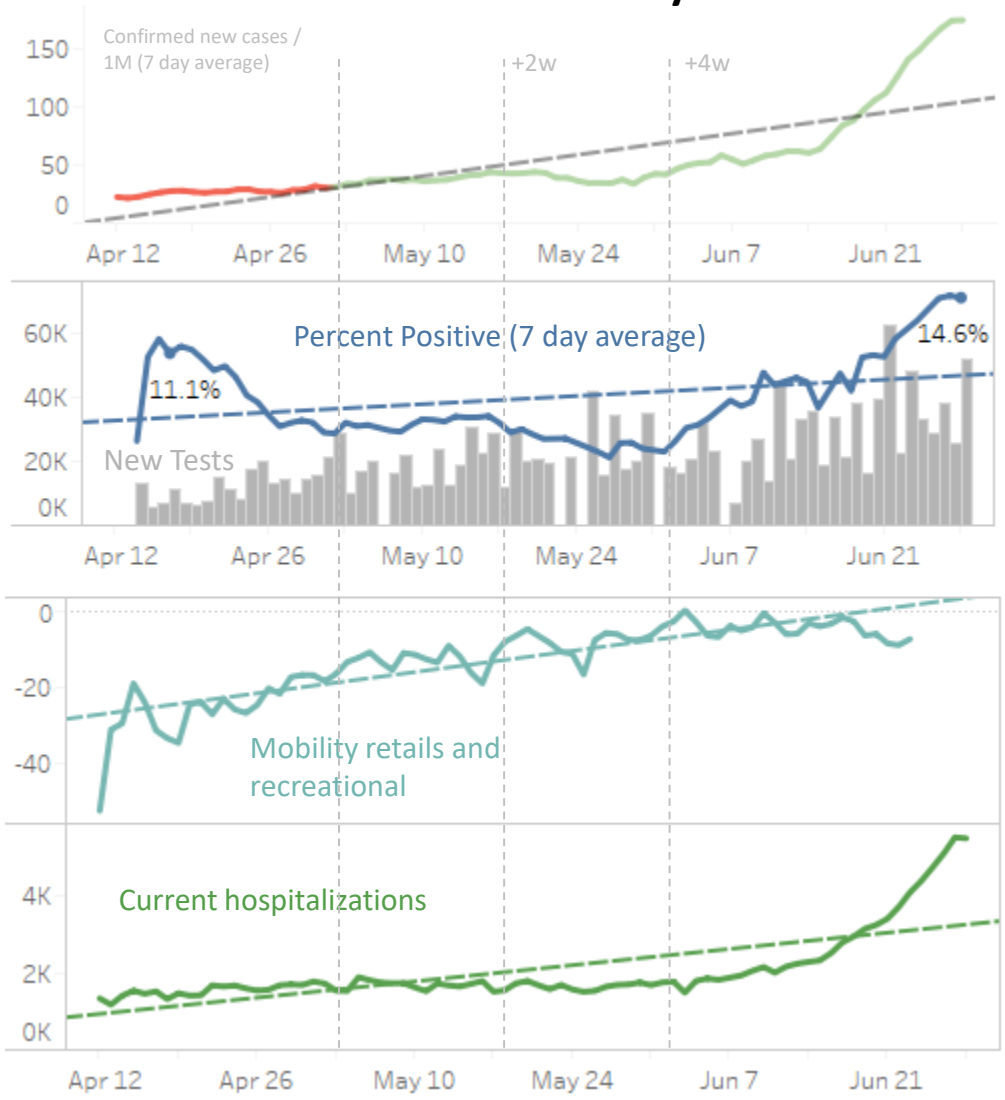


More interventions Less interventions

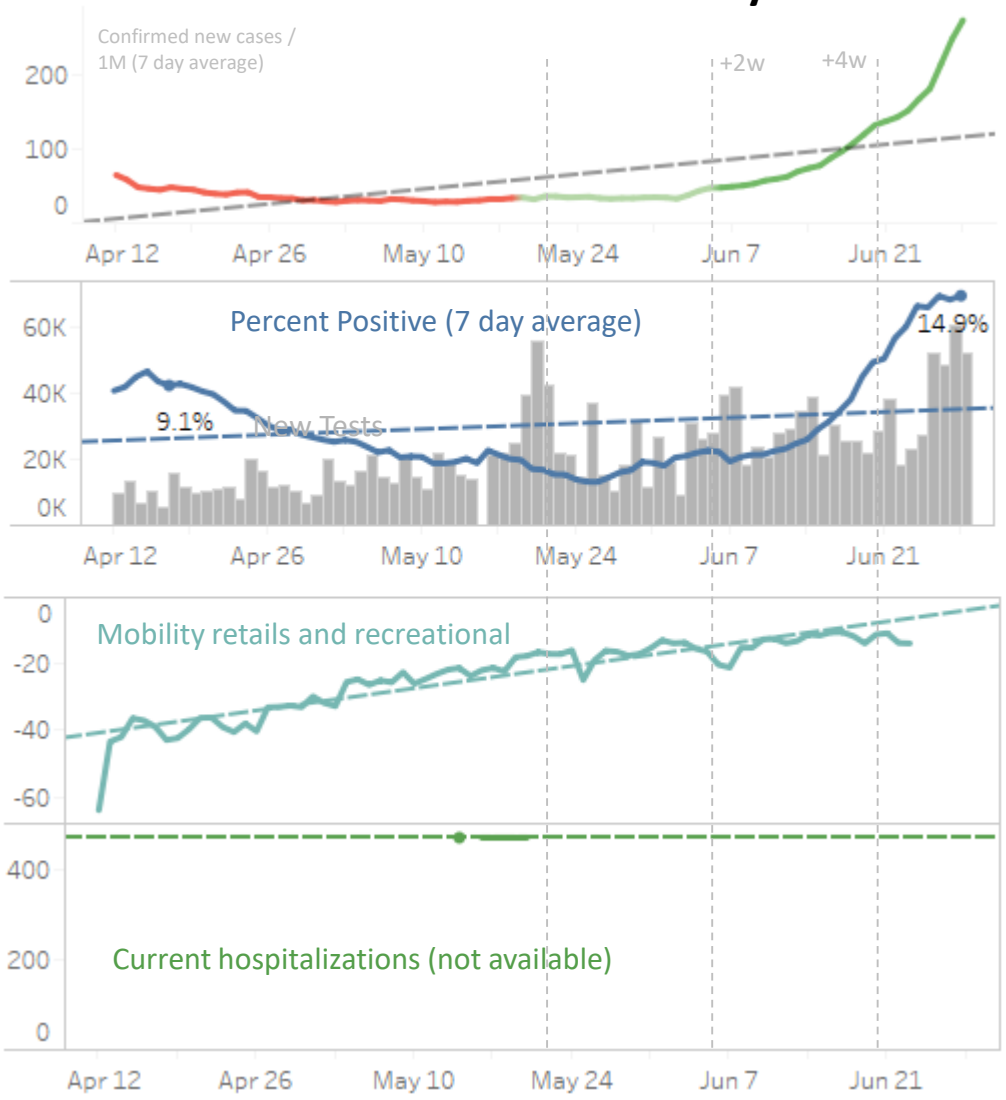
Obtained via MI FOIA by Judicial Watch, Inc.

Texas and Florida: Detailed examination

Texas: relaxed on May 1st



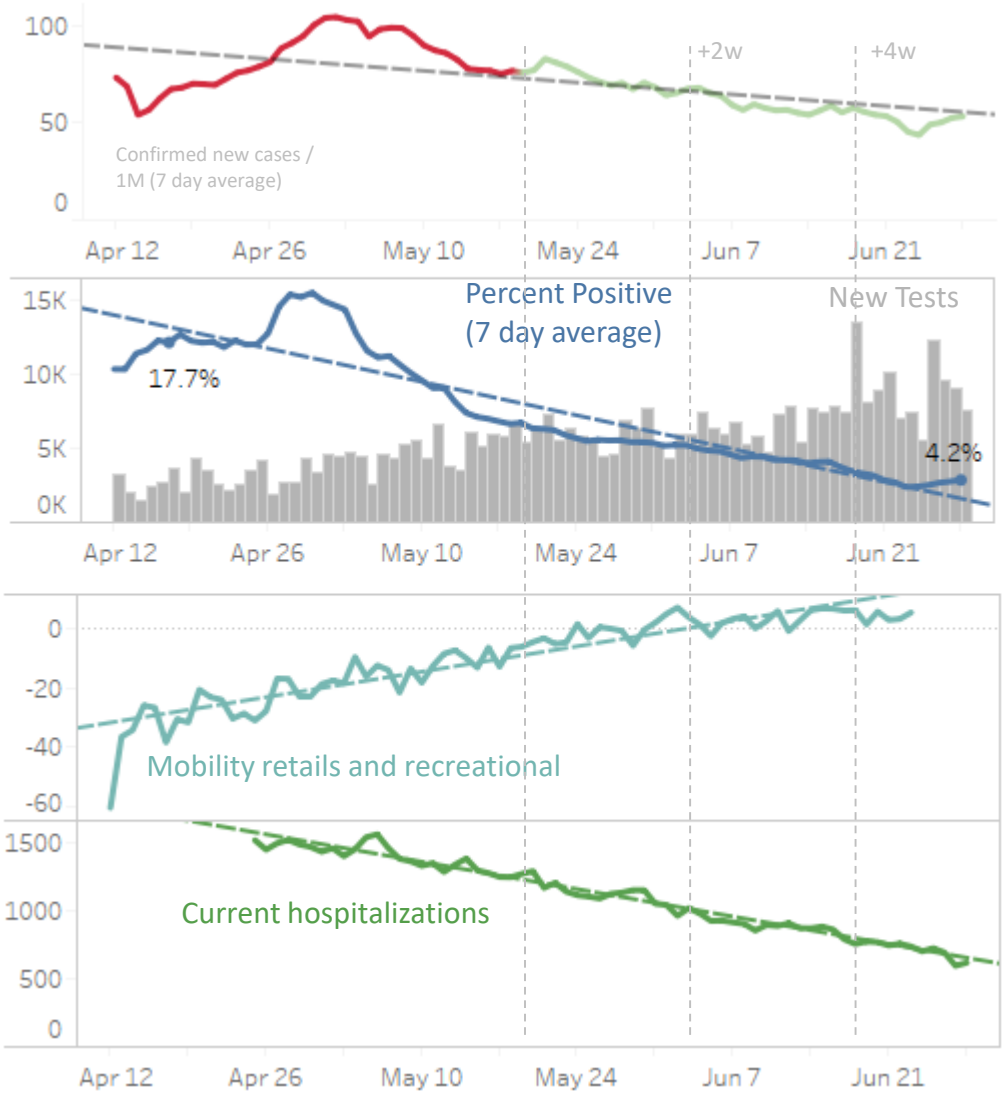
Florida: relaxed on May 4



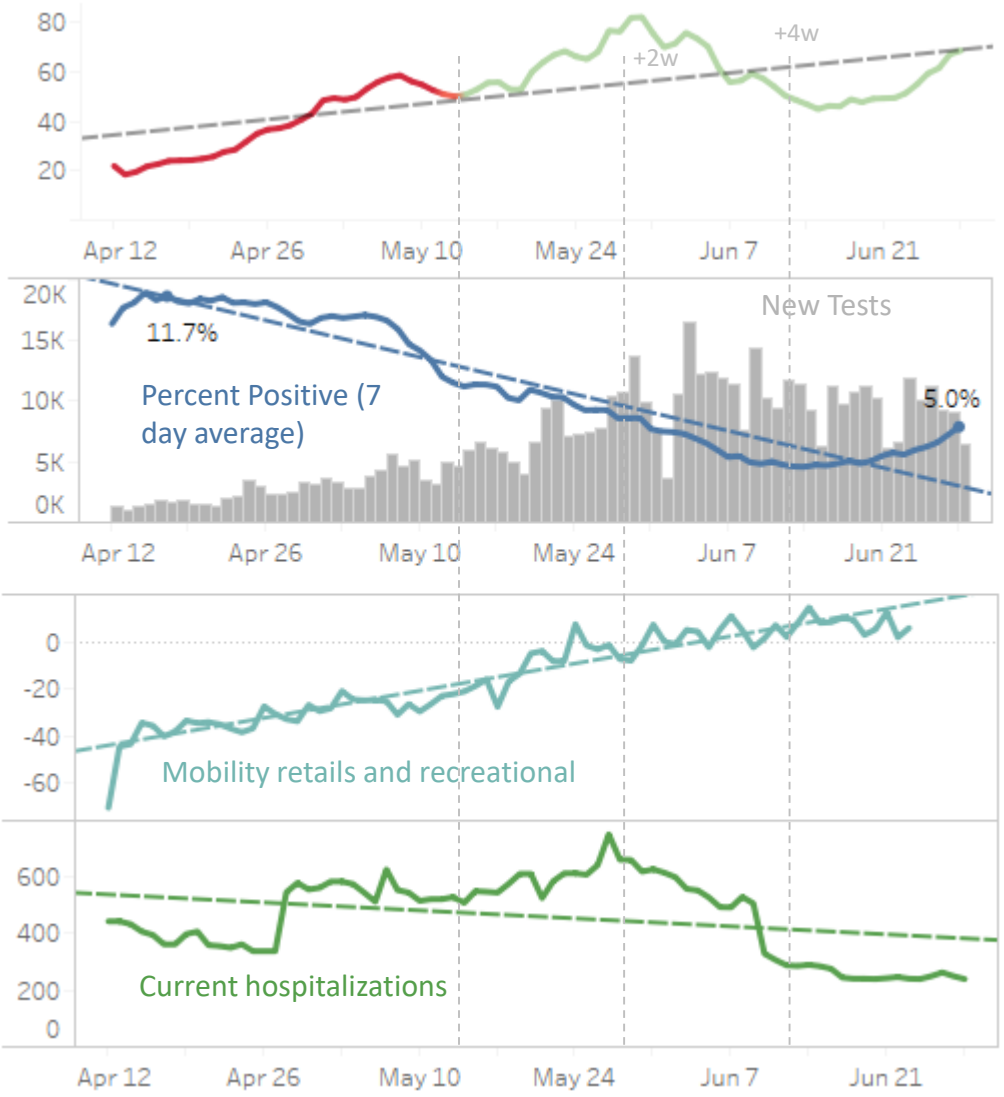
Obtained via MI FOIA by Judicial Watch, Inc.

Indiana and Wisconsin: Detailed examination

Indiana: relaxed on May 4th



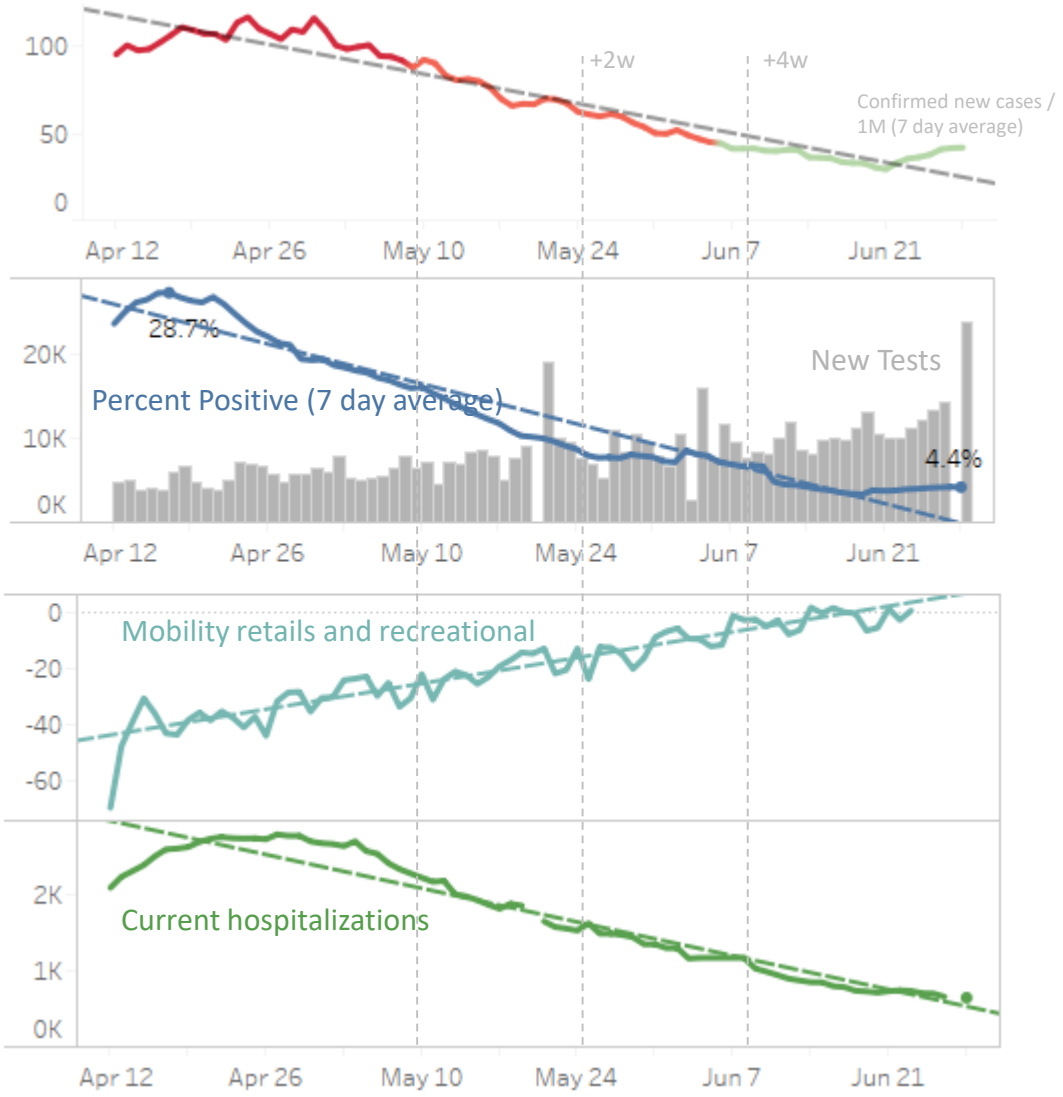
Wisconsin: Relaxed on May 11th



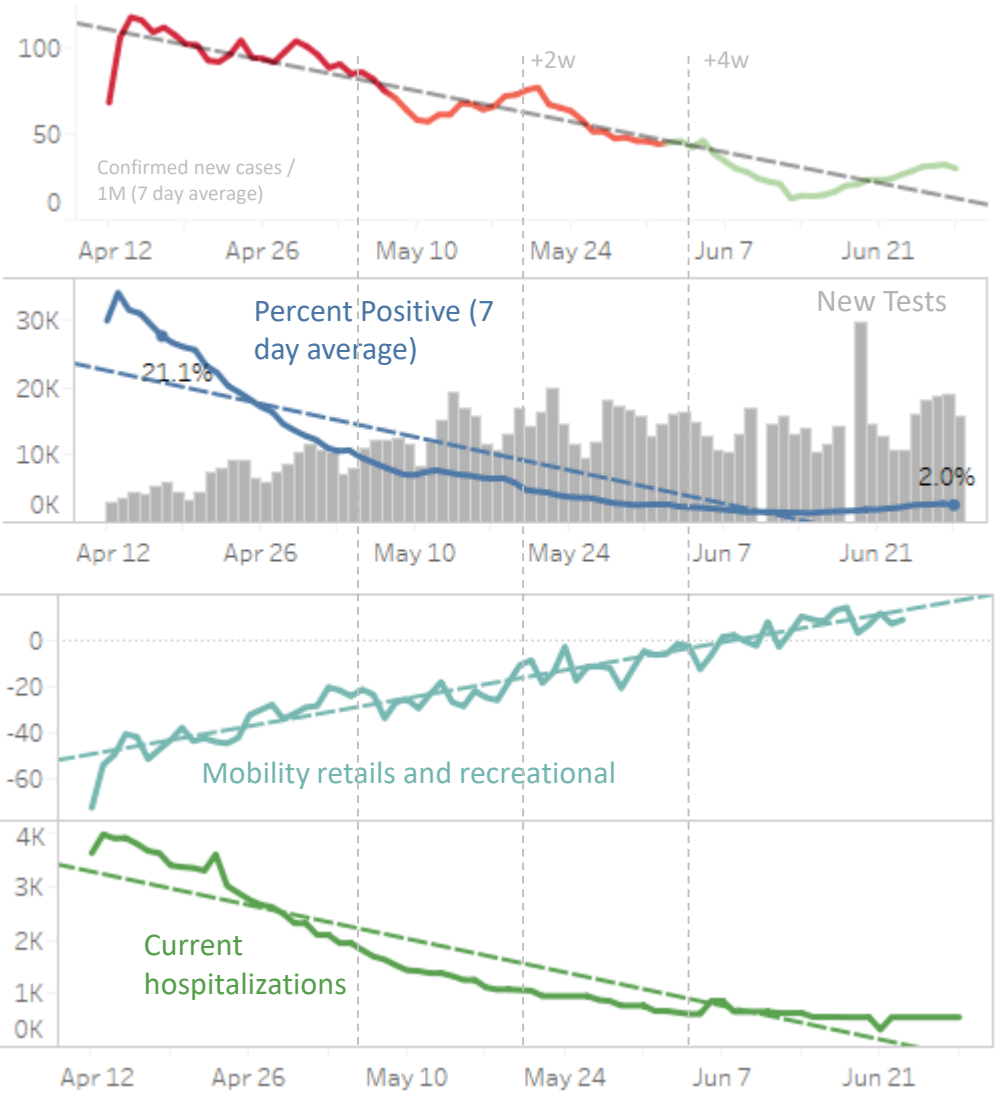
Obtained via MI FOIA by Judicial Watch, Inc.

Pennsylvania and Michigan: Detailed Examination

Pennsylvania: relaxed on May 8th



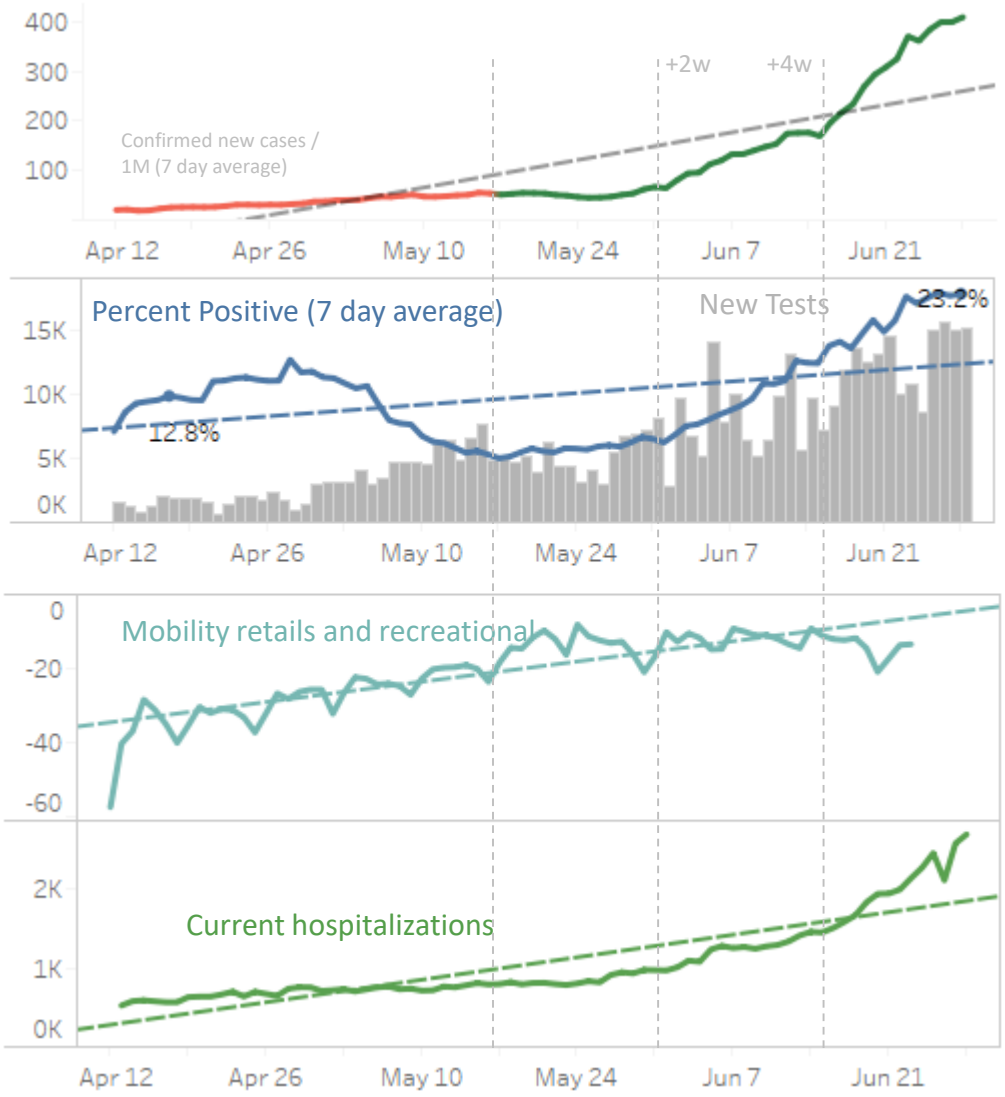
Michigan: Non-essential May 7th, Stay-at-home Jun 1st



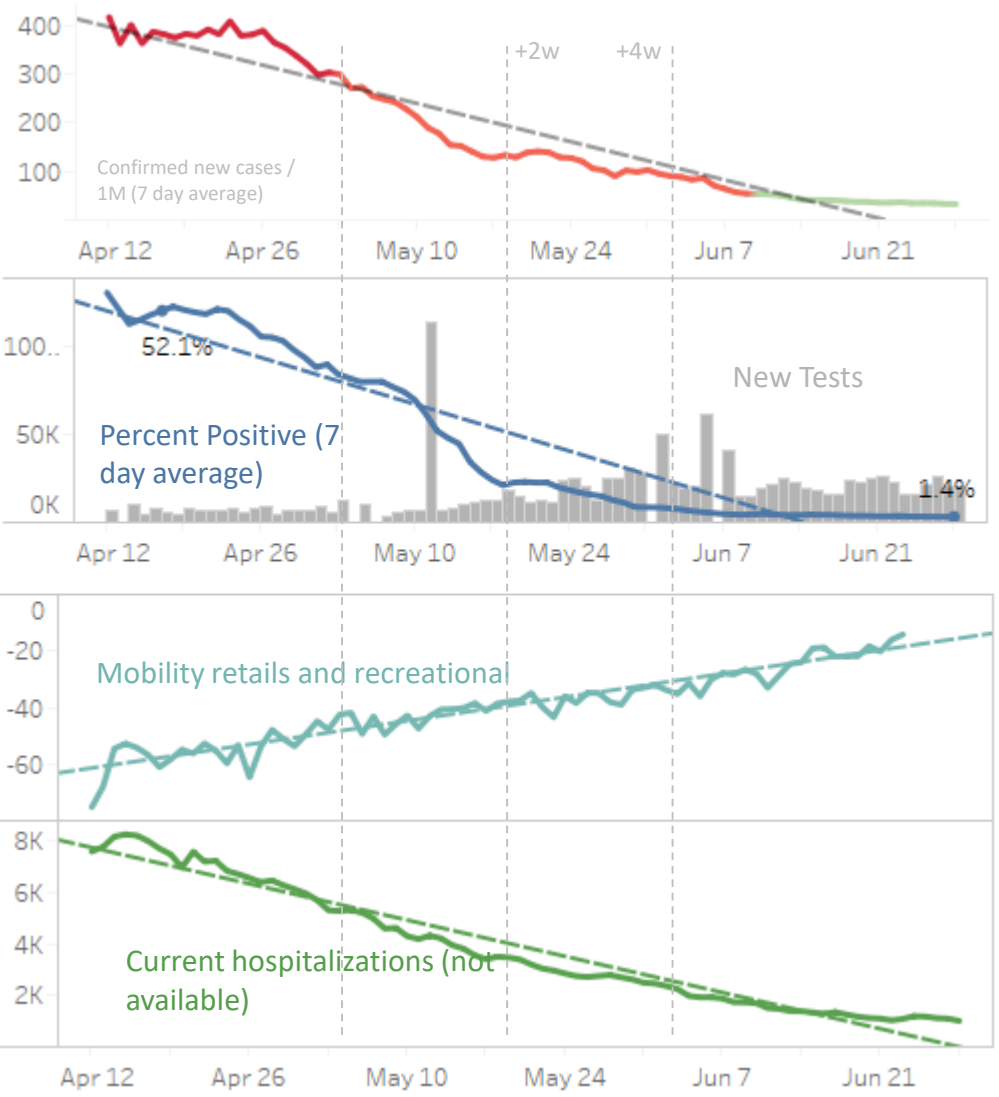
Obtained via MI FOIA by Judicial Watch, Inc.

Arizona and New Jersey: Detailed Examination

Arizona: relaxed all on May 16th



New Jersey: Non-essential May 2nd, Stay-at-home Jun 9th



Obtained via MI FOIA by Judicial Watch, Inc.

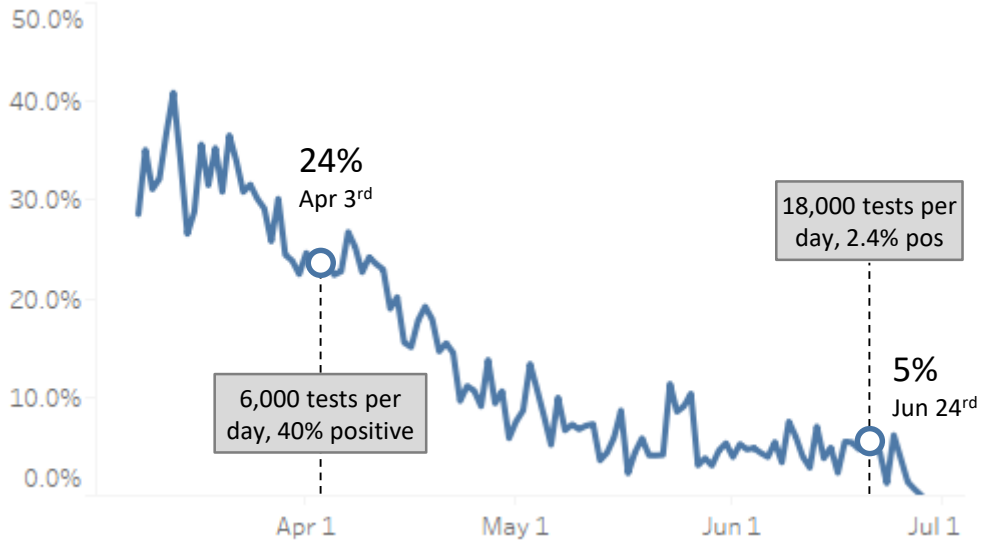
Observations/Learnings

- States which opened on a declining trajectory with % positive below 5% are maintaining stable trends although showing shift to stable/plateau vs. a decline
- Increase in percent positivity continues to be a good predictor of increasing cases in the future
- Some States stayed on a stable or declining trajectory after opening up:
  - Pennsylvania, recent change, cases per 1M stable, % positive stable
  - Indiana, lifted regionally right after peak, case per 1M stable, % positive stable
  - New Jersey, cases per 1M stable/decrease, % positive stable/decrease
- Some bear watching due to trend:
  - Texas, cases per 1M increase, % positive increase, hospitalizations increase
  - Arizona, cases per 1M increase, % positive increase, hospitalizations increase
  - Florida, cases per 1M increase, % positive increase, hospitalizations increase but data not clean
  - Wisconsin, case per 1M increase, % positive increase, hospitalizations stable

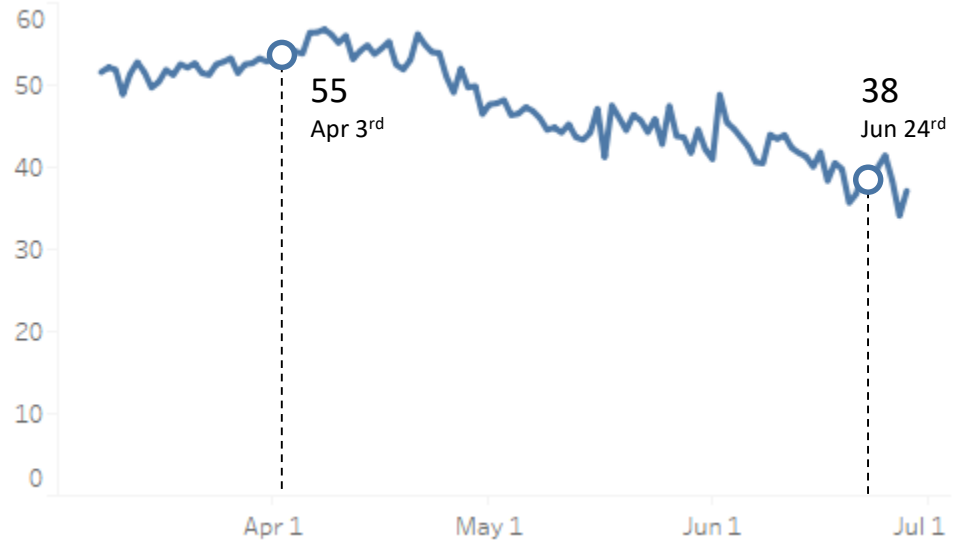
Obtained via MI FOIA by Judicial Watch, Inc.

What an average confirmed case in MI means now vs. April

Percent Admissions for Positive Cases



Average Age for Positive Cases



Date	Testing	Percent Positive	Admit Rate	Admits /day	Positive tests : Admits	Tests : Admits
Apr 3rd	6,000	40%	24%	576	4 positive tests to 1 admit	10 tests to 1 admit
Jun 24th	18,000	2.4%	5%	22	20 positive tests to 1 admit	833 tests to 1 admit

~6x lower ratio of admits for each positive case we find

Obtained via MI FOIA by Judicial Watch, Inc.

Epi and indicators

Testing

Case investigation and tracing

Upcoming data sources

Appendix

Obtained via MI FOIA by Judicial Watch, Inc.

Michigan testing capacity and utilization overview

Where Michigan is today

15,631

Daily samples tested
(average past 7 days)

2.6%

Percent positive
(average past 7 days)

19,000+

Daily ready-to-go lab capacity
(current reported)

Daily **PCR testing** numbers increased over the past week, averaging 15.6K, with a high of 19.4K on 6/26

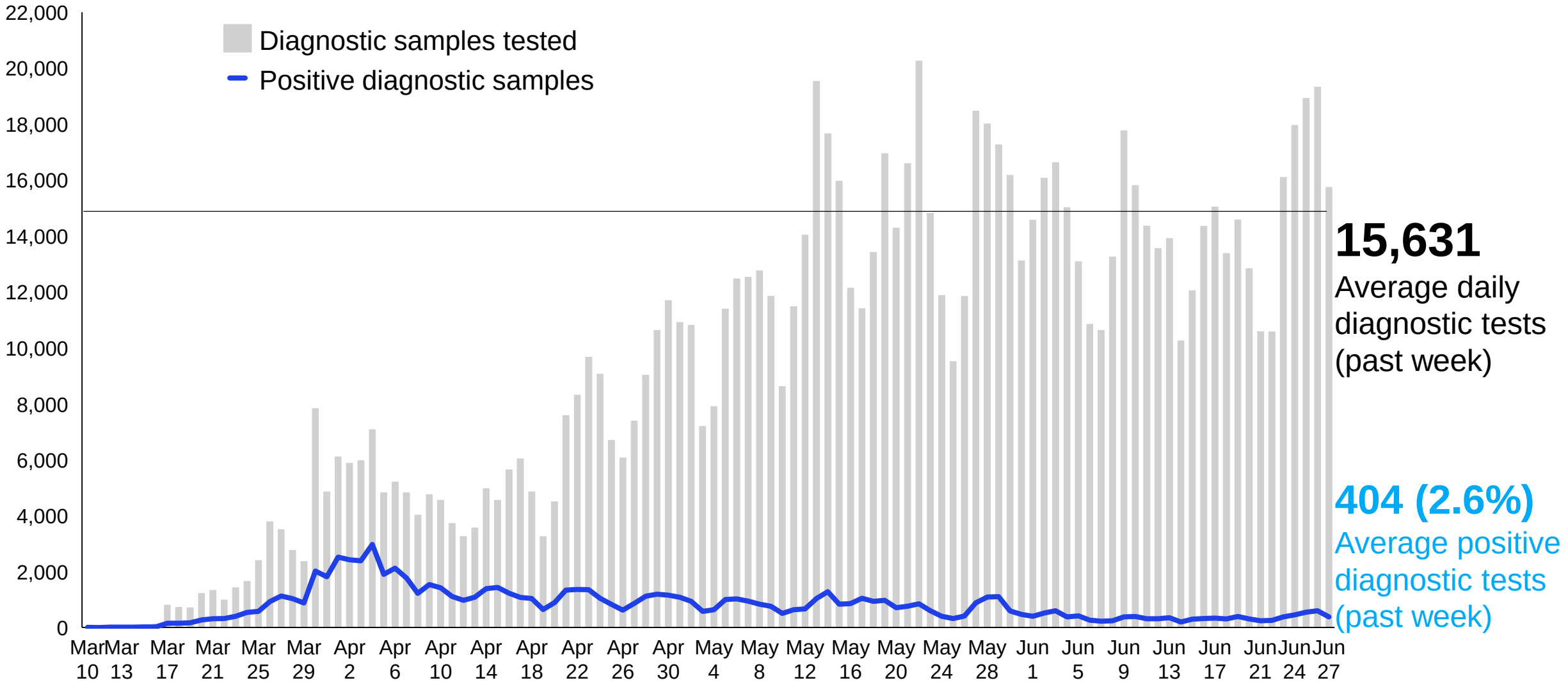
Labs are reporting ~19K daily ready-to-go-capacity, with additional ~15K non-commercial capacity available (but additional supplies needed); further commercial lab capacity available

Team is working to solve known constraints:

- **Demand and access:**
  - Announcing new test finder and hotline (211) scheduling partnership
  - Promoting pop-up testing sites
- **Collections capacity:**
  - 3 month plan in development for sample collection and testing across all populations
  - Finalizing contract this week for mobile testing vendor to conduct sample collection for vulnerable populations
- **Supply chain:**
  - Partnering with Dow to produce VTM; test batch in planning phase
  - Shipment of VTM received from FEMA
  - 3D-printed swab validation work complete, to inform future procurement efforts

Daily diagnostic tests and positive diagnostic tests, by message date

Obtained via MIFOIA by Judicial Watch, Inc.



Source: MDSS/Michigan Medical Advantage Group, MDHHS, testing labs

Obtained via MI FOIA by Judicial Watch, Inc.

Daily tests

State	Avg. daily tests
1. California	89.7K
2. New York	61.0K
3. Florida	38.3K
4. Texas	37.1K
5. Illinois	26.3K
6. New Jersey	21.2K
7. North Carolina	17.7K
8. Ohio	16.4K
9. Michigan	15.6K
10. Georgia	13.6K
11. Arizona	12.8K
12. Virginia	12.4K
13. Minnesota	11.0K
14. Tennessee	10.5K
15. Louisiana	10.5K
16. Pennsylvania	10.2K
17. Wisconsin	9.1K
18. Massachusetts	8.8K
19. Indiana	8.7K
20. South Carolina	7.8K
21. Maryland	7.4K
22. Washington	6.9K
23. Alabama	6.4K
24. Missouri	6.3K
25. Oklahoma	6.2K
26. Arkansas	6.0K
27. Iowa	5.6K
28. Mississippi	5.5K

Daily % of pop. tested

State	Avg. daily % tested
1. Alaska	0.4%
2. New York	0.3%
3. New Mexico	0.2%
4. New Jersey	0.2%
5. District of Columbia	0.2%
6. California	0.2%
7. Louisiana	0.2%
8. Rhode Island	0.2%
9. Illinois	0.2%
10. Arkansas	0.2%
11. Minnesota	0.2%
12. Mississippi	0.2%
13. Iowa	0.2%
14. Florida	0.2%
15. Arizona	0.2%
16. Delaware	0.2%
17. North Carolina	0.2%
18. Oklahoma	0.2%
19. Wisconsin	0.2%
20. Montana	0.2%
21. Michigan	0.2%
22. North Dakota	0.2%
23. Tennessee	0.2%
24. South Carolina	0.2%
25. Connecticut	0.2%
26. Virginia	0.1%
27. Ohio	0.1%
28. Utah	0.1%

Percent positive

State	% positive
1. Alaska	0.6%
2. Vermont	0.9%
3. Hawaii	1.0%
4. New York	1.1%
5. Connecticut	1.3%
6. Montana	1.3%
7. New Jersey	1.4%
8. West Virginia	1.7%
9. Maine	1.7%
10. New Hampshire	2.0%
11. Rhode Island	2.0%
12. District of Columbia	2.0%
13. Massachusetts	2.5%
14. North Dakota	2.5%
15. Michigan	2.6%
16. Illinois	2.7%
17. New Mexico	3.2%
18. Minnesota	3.3%
19. Delaware	3.5%
20. Kentucky	3.7%
21. Indiana	4.1%
22. Pennsylvania	4.4%
23. Virginia	4.4%
24. Ohio	4.5%
25. Wisconsin	4.5%
26. Colorado	4.7%
27. Oregon	4.7%
28. Wyoming	4.8%

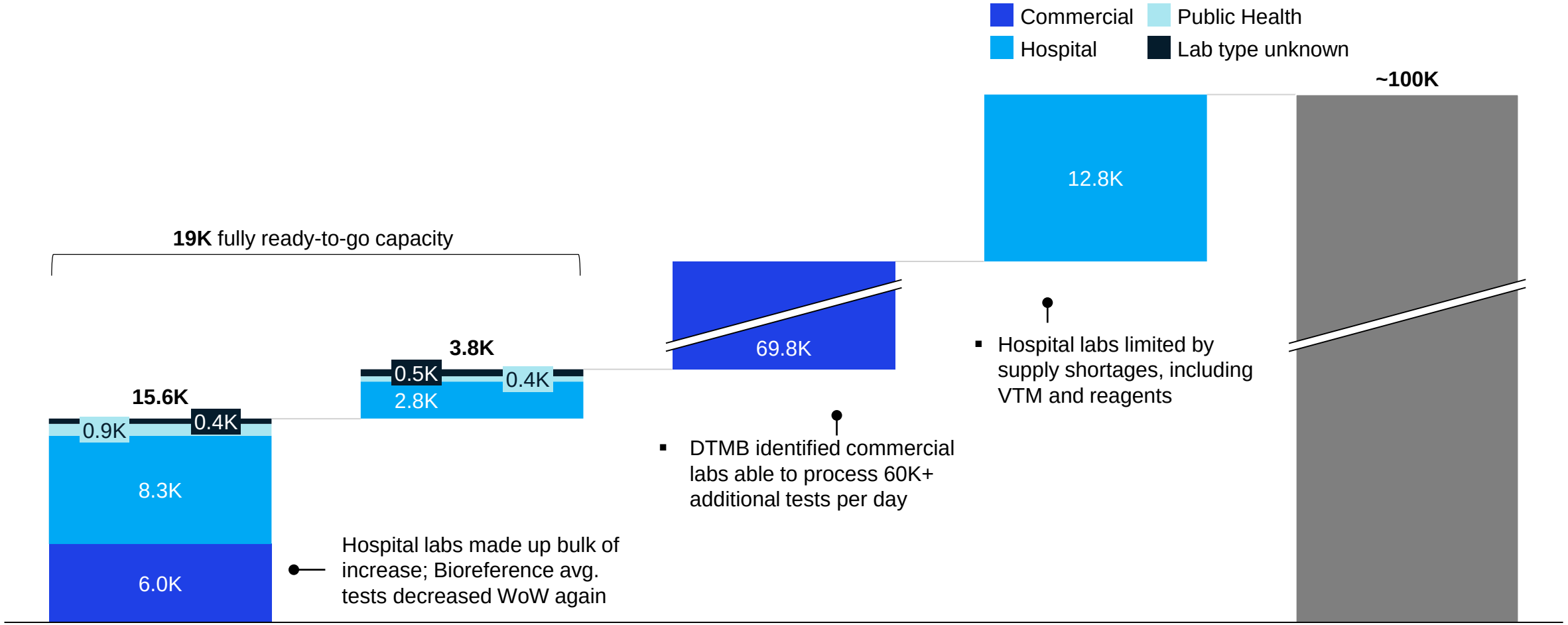
Averaged over June 21-June 27, 2020 (Michigan average uses most recent MAG data)

SOURCE: Numerical Data – MDSS, COVID Tracking Project, U.S. Census Bureau.

Obtained via MI FOIA by Judicial Watch, Inc.

Labs: Michigan daily capacity snapshot

Labs shown may have adjustments as capacity estimates are validated and new supply constraints arise



Sources:
1. MDSS/Michigan Medical Advantage Group, MDHHS for all lab types
2. Hospitals - lab director reported. Pub. Health, Commercial, Other - calculated as average tests conducted during top seven days of past thirty days
3. DTMB
4. Lab director reported

Obtained via MI FOIA by Judicial Watch, Inc.

Epi and indicators

Testing

Case investigation and tracing

Upcoming data sources

Appendix

Obtained via MI FOIA by Judicial Watch, Inc.

Case investigation and contact tracing: Current state

	Case investigation and contact acquisition			Initial contact tracing		Ongoing contact monitoring		
Goal	**90% calls attempted** in one day	**75% calls completed** in one day	**50% with contacts** in one day	**90% calls attempted** in one day	**75% calls completed** in one day	Successful ongoing daily outreach	Low cases lost to follow-up	Contacts with symptoms identified
Performance	81%[1]	63%[2]	59%[3]	91%[4]	62%[5]	49%[6]	4%[7]	4.1%[8]
Trend since last week	↑	↑	↑	→	↓	↓	↓	↓

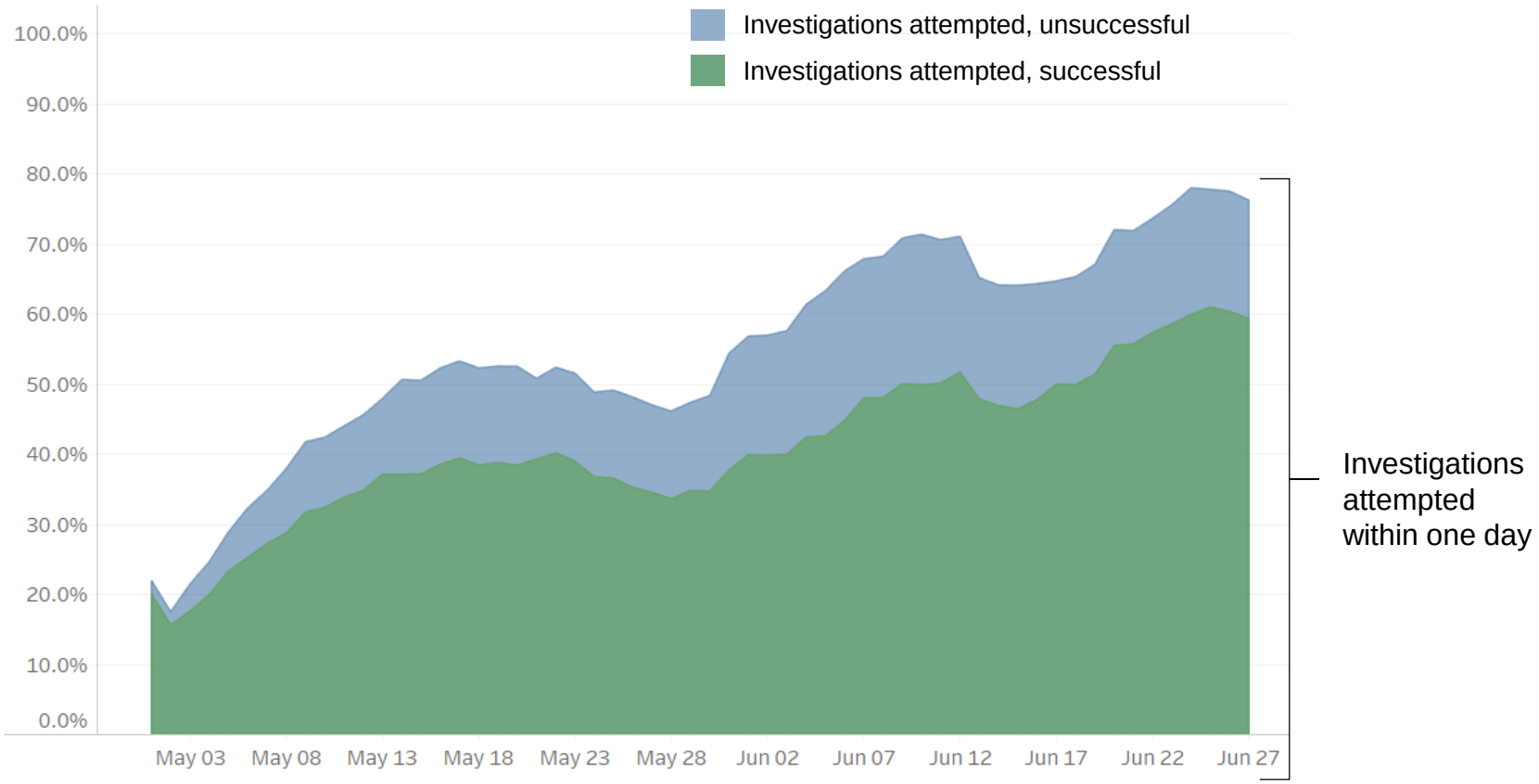
1. % of cases documented as "attempted" within one day; 2 % of cases documented as "successful" within one day; 3 % of cases with at least one contact documented within one day; 4 Weighted average of % of cases documented as "attempted" within one day in OMS, LHD survey, and Traceforce; 5 Weighted average of % of cases documented as "successful" within one day in OMS and Traceforce; 6 Traceforce only - % of non-first day contacts reached; 7 Traceforce only - % of contacts lost to follow-up (lost / total); 8 Traceforce only - Of contacts reached, % later reporting symptoms –Case investigation and initial contact tracing metrics exclude weekends on this page

Source: MDSS and OMS summary statistics. Traceforce summary statistics. LHD Sitrep survey.

Obtained via MI FOIA by Judicial Watch, Inc.

Case Investigation: Performance within 24 hours

% of cases investigated within 24 hours, seven day rolling average



In past week, LHDs hit new records for percent of contacts reached within 24 hours of referral

When expanding time dimension to represent completion within two days, LHDs attempted 88% of calls and completed 72%

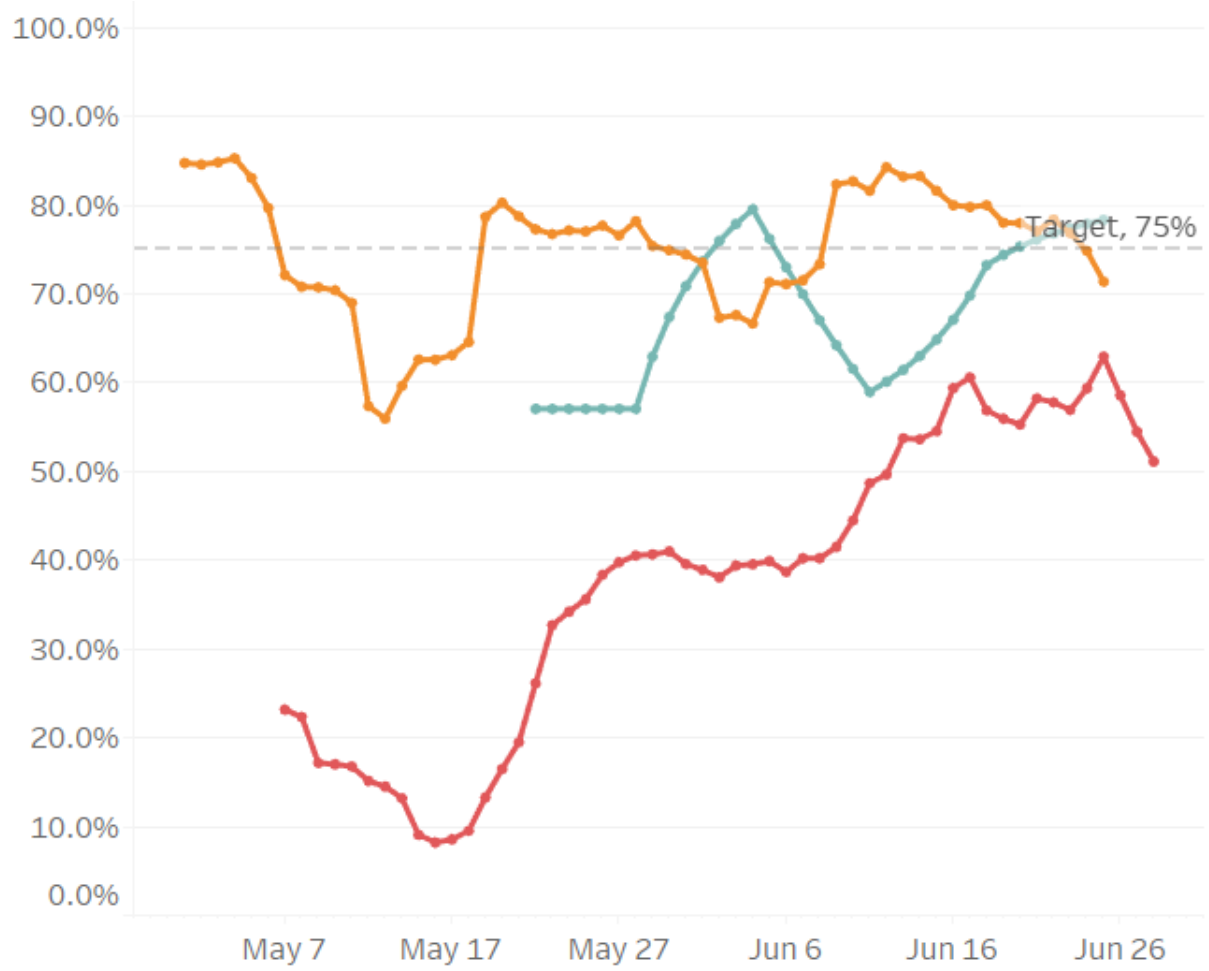
To identify how to help reach the remaining cases, the Technical Assistance process is including more active follow-up with LHDs after the initial technical assistance call

Source: MDSS summary statistics, 6/15

Obtained via MI FOIA by Judicial Watch, Inc.

Contact Tracing: Successful outreach within one day

Percent of contacts successfully reached within 24 hours (7 day rolling avg.)



LHD tracers, homegrown system, ~28% of cases[3]

LHD tracers, legacy system, ~24% of cases[1]

Central Contact Tracers, ~48% of cases[2]

- The TraceForce system saw several system issues over the past week, leading to a slight decrease in performance
- Additionally, pilot departments onboarded to perform their own contact tracing in TraceForce did not appear to conduct outreach over the weekend, lowering recent completion percentage

1. Excludes departments that indicated that they do not use OMS
2. State currently supports Detroit City, Wayne, Ionia, Ingham, Saginaw, Genesee, Delta-Menominee, Kalamazoo, Van-Buren Cass, Marquette, Huron, and Branch-Hillsdale-St. Joseph. Initial self-use pilot departments (Washtenaw and Livingston) have also been included in % of cases.
3. Data obtained through weekly LHD SITREPs starting on 5/28; only contains a weekly average

Source: MDSS and OMS summary statistics. Traceforce summary statistics, LHD SITREP. % of cases represents recent cases.

Obtained via MI FOIA by Judicial Watch, Inc.

Epi and indicators

Testing

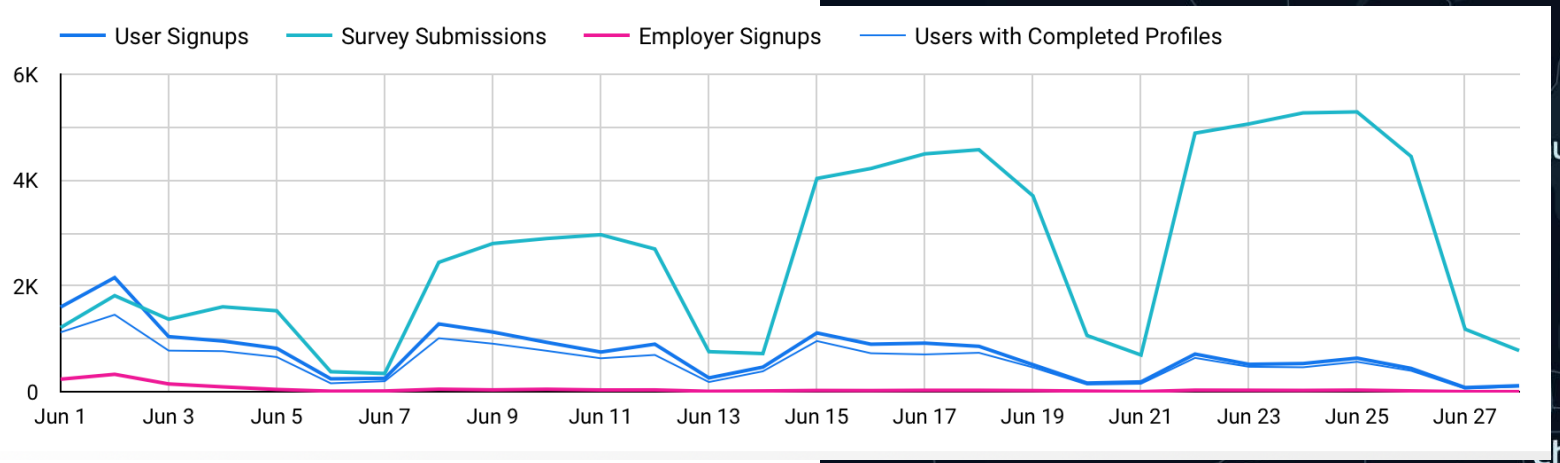
Case investigation and tracing

Upcoming data sources

Appendix

MI Symptoms

- >23K users signed up (~18K completed profiles)
- ~1600 employers



Obtained via MI FOIA by Judicial Watch, Inc.

Obtained via MI FOIA by Judicial Watch, Inc.

Epi and indicators

Testing

Case investigation and tracing

Upcoming data sources

Appendix

Confirmed & Probable Cases

Obtained via MI FOIA by Judicial Watch, Inc.

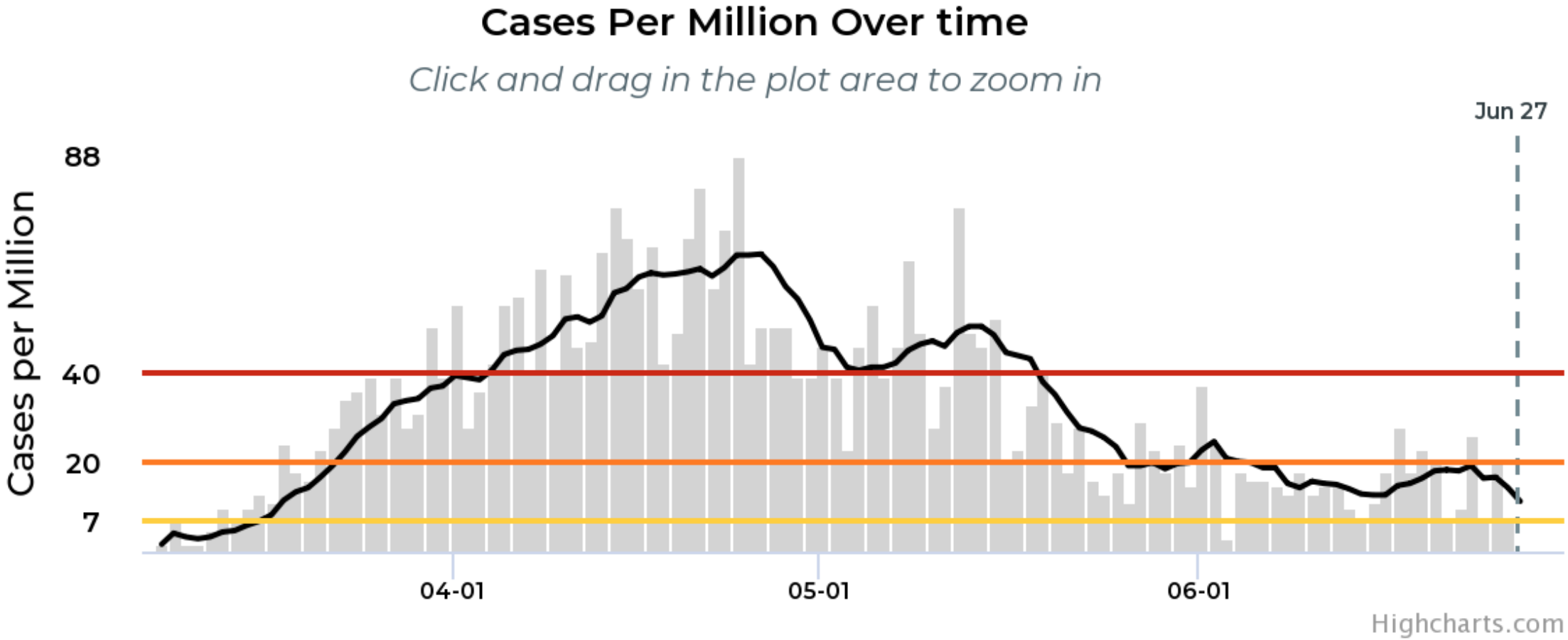
Note: data excludes MDOC

DATE: 2020-06-27	MERC Region Number	Public Health Region	Absolute cases (per million)	Case trend	Cases, 3-day surge	Absolute deaths (per million)	Death trend	Average percent positivity	Positivity trend	Tests per million
Detroit	1	2N + 2S	21.4	Increase - 1wk	No	0.4	Decrease - 10wk	2.7	Daily Avg < 3%	1353.4
Grand Rapids	2	6	29.0	Increase - 2wk	No	0.4	<20 wkly deaths	3.4	Increase - 1wk	1773.8
Kalamazoo	3	5	24.9	Increase - 1wk	No	0.3	<20 wkly deaths	2.6	Daily Avg < 3%	1421.7
Saginaw	4	3	15.6	Increase - 1wk	No	0.9	<20 wkly deaths	3.2	Decrease - 1wk	1391.7
Lansing	5	1	48.0	Increase - 1wk	No	0.2	<20 wkly deaths	2.8	Daily Avg < 3%	1753.0
Traverse City	6	7	6.5	Increase - 1wk	No	0.0	<20 wkly deaths	0.8	Daily Avg < 3%	889.6
Jackson	7	1	12.2	Decrease - 1wk *	No	0.0	<20 wkly deaths	1.1	Daily Avg < 3%	1476.5
Upper Peninsula	8	8	5.6	Increase - 2wk *	No	0.5	<20 wkly deaths	0.4	Daily Avg < 3%	1064.6

PUBLIC HEALTH

Obtained via MI FOIA by Judicial Watch, Inc.

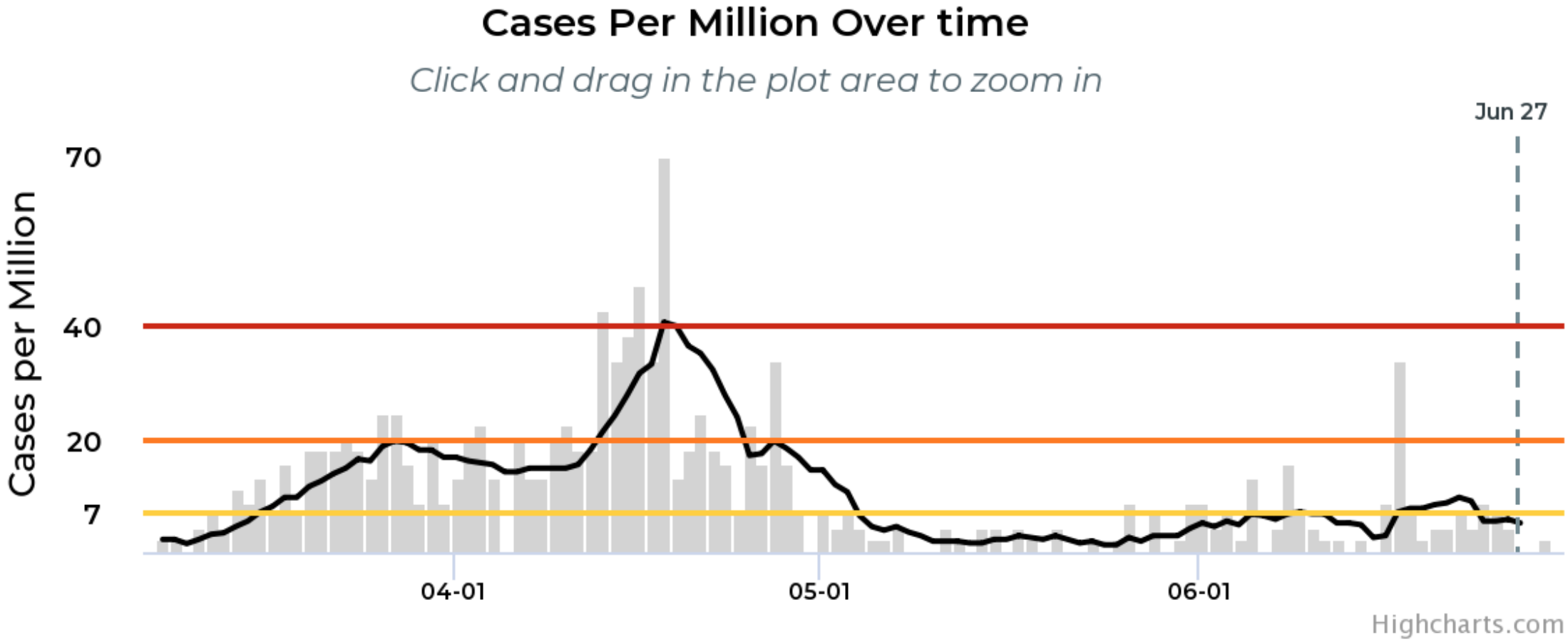
Saginaw



PUBLIC HEALTH

Obtained via MI FOIA by Judicial Watch, Inc.

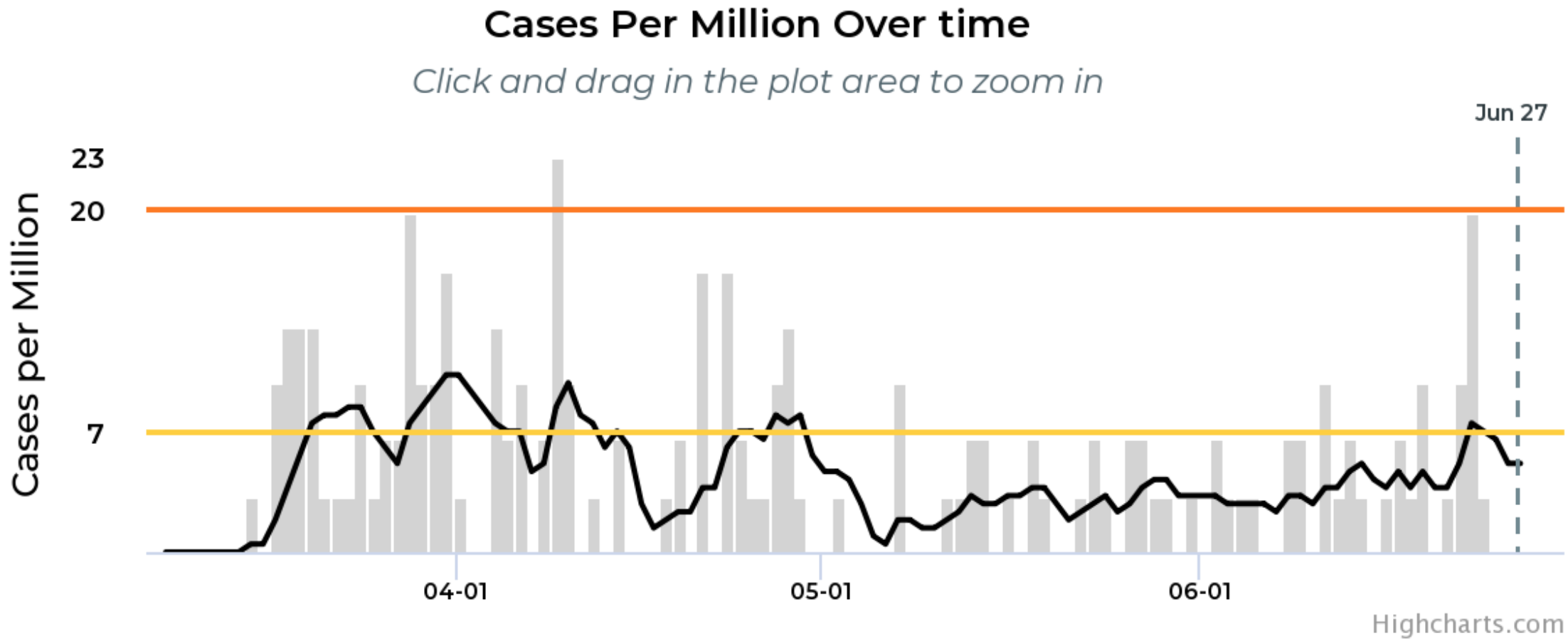
Traverse City Region



PUBLIC HEALTH

Obtained via MI FOIA by Judicial Watch, Inc.

Upper Peninsula



PUBLIC HEALTH

Health System Indicators

Obtained via MI FOIA by Judicial Watch, Inc.

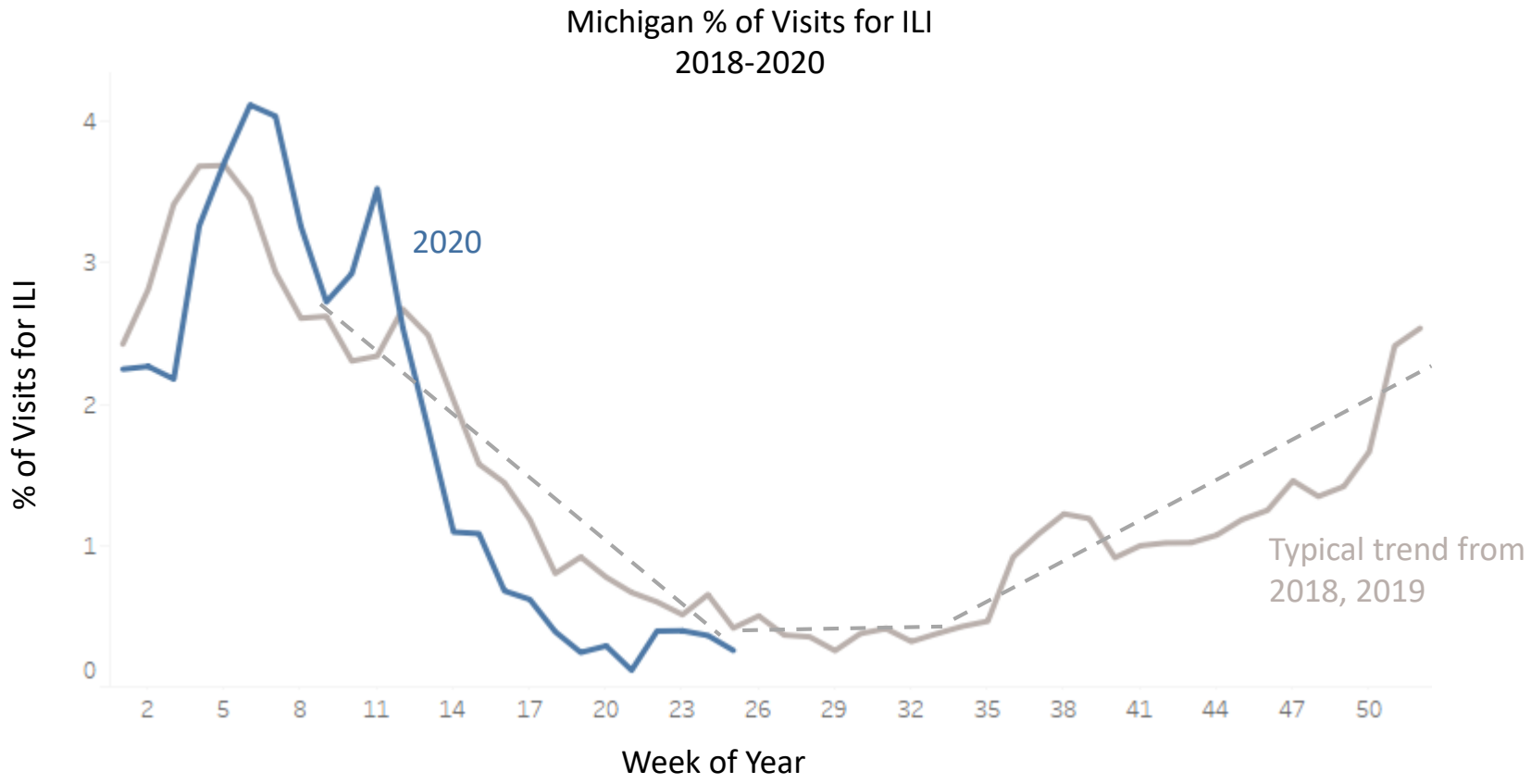
	DATE:2020-06-29 Public Health Region	Available IP Beds (per million)	Inpatient Beds Occupied	IP Beds Occupied by COVID	IP Beds Occupied by Cases and PUI	Inpatient COVID Cases (per million)	Inpatient Cases and PUI (per million)	Available ICU Beds (per million)	ICU Beds Occupied	Available Ventilators (per million)	Ventilators Used
Lansing	Region 1	412.8	69.9%	0.8%	3.7%	7.4	35.3	25.0	85.9%	143.8	20.5%
Detroit (N)	Region 2N	688.0	68.2%	2.3%	3.3%	34.2	48.3	50.0	77.4%	180.3	28%
Detroit (S)	Region 2S	695.2	75.5%	2.4%	3.8%	50.9	81.7	115.1	72.1%	346.5	36.3%
Saginaw	Region 3	633.4	72.4%	2.1%	4%	34.2	66.7	98.2	72.5%	198.2	27.9%
Kalamazoo	Region 5	403.2	74%	2.4%	3.4%	27.2	38.6	66.8	64.8%	193.2	18.5%
Grand Rapids	Region 6	656.0	58.1%	3.3%	4.5%	30.4	41.0	86.1	68.4%	242.3	16.1%
Traverse City	Region 7	1134.4	49.1%	0.4%	1.2%	4.5	13.6	178.9	60.1%	172.1	23.2%
Upper Peninsula	Region 8	885.4	52.2%	0.7%	1.7%	6.6	16.5	98.7	62.5%	296.2	6.2%

PUBLIC HEALTH

Obtained via MI FOIA by Judicial Watch, Inc.

ILI: Influenza Like Illness Surveillance and predicted COVID waves

Information on patient visits to health care providers for influenza-like illness (ILI) is collected through the U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet). % of visits for ILI is tracked and reportable for most states.



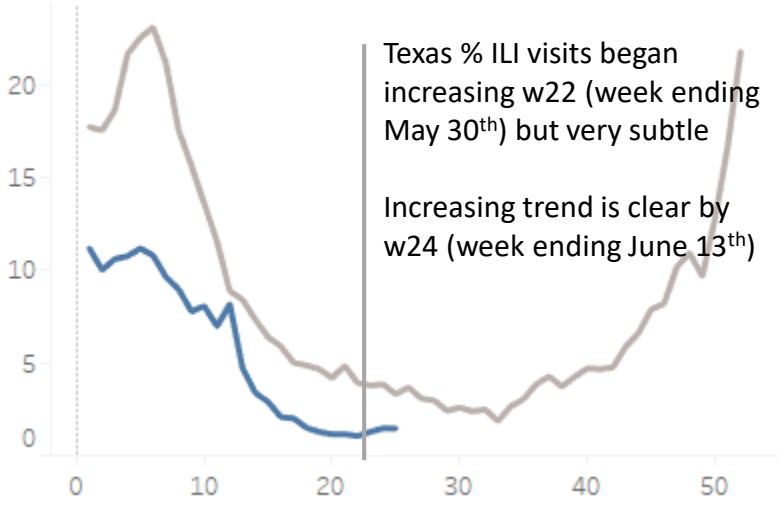
Percentage of Visits for ILI have consistent seasonal patterns. After influenza season peak, the metric decreases in most states until approximately week 23 (early June). Then flattens until ~week 35 (late August), when it begins to increase.

Source https://gis.cdc.gov/grasp/fluview/fluportaldashboard.html

Obtained via MI FOIA by Judicial Watch, Inc.

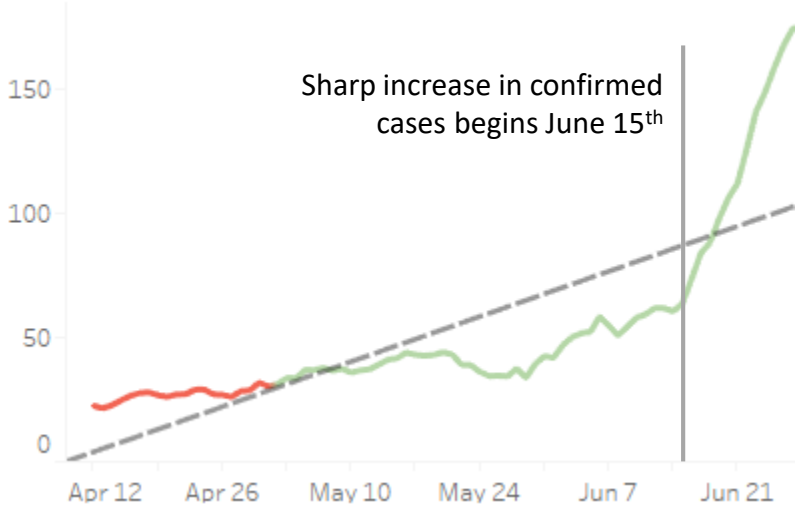
ILI and Confirmed Cases: Not entirely reliable to detect coming waves

Texas



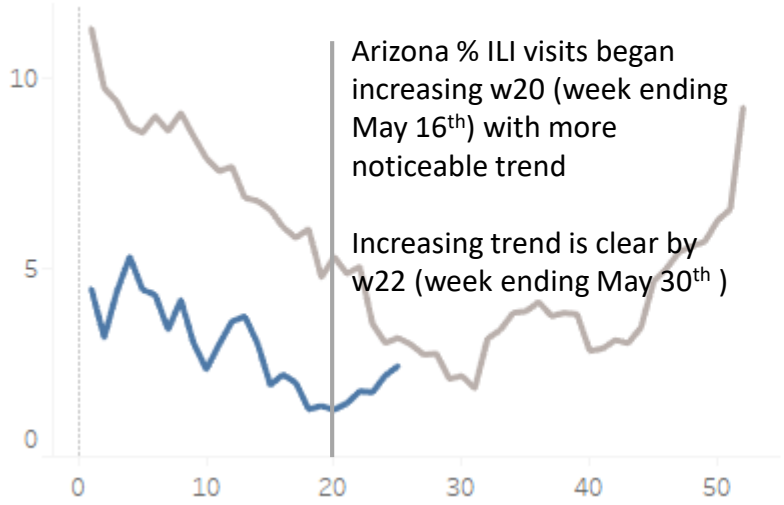
Texas % ILI visits began increasing w22 (week ending May 30th) but very subtle

Increasing trend is clear by w24 (week ending June 13th)



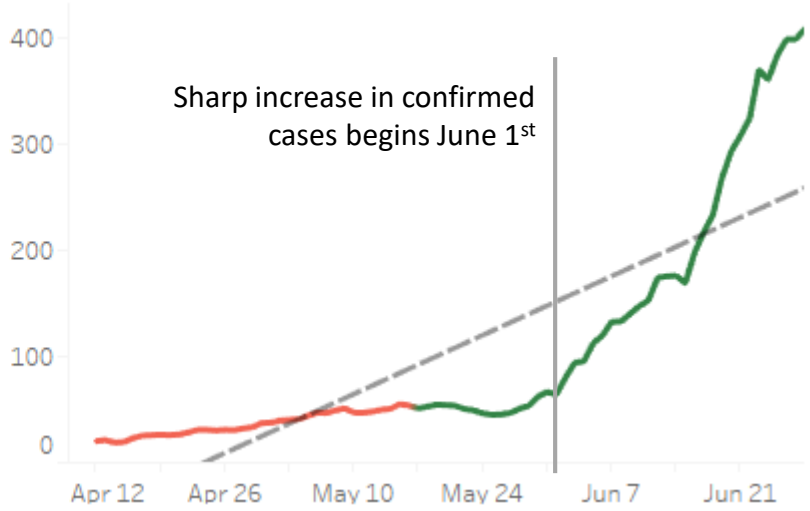
Sharp increase in confirmed cases begins June 15th

Arizona



Arizona % ILI visits began increasing w20 (week ending May 16th) with more noticeable trend

Increasing trend is clear by w22 (week ending May 30th)

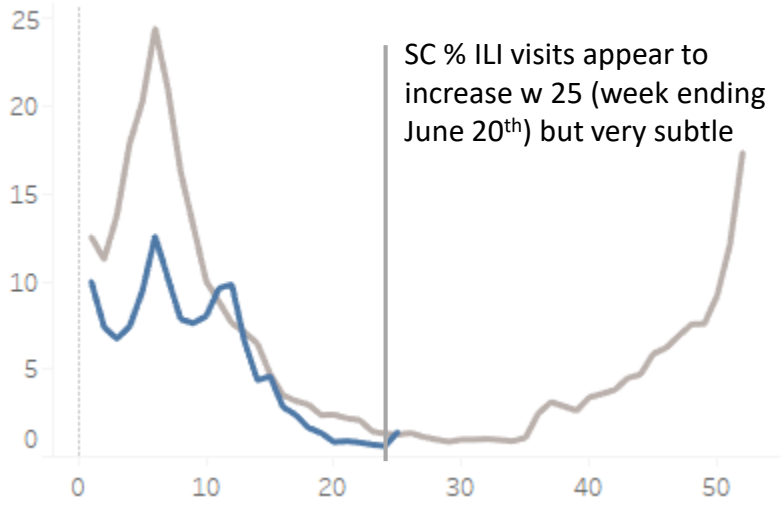


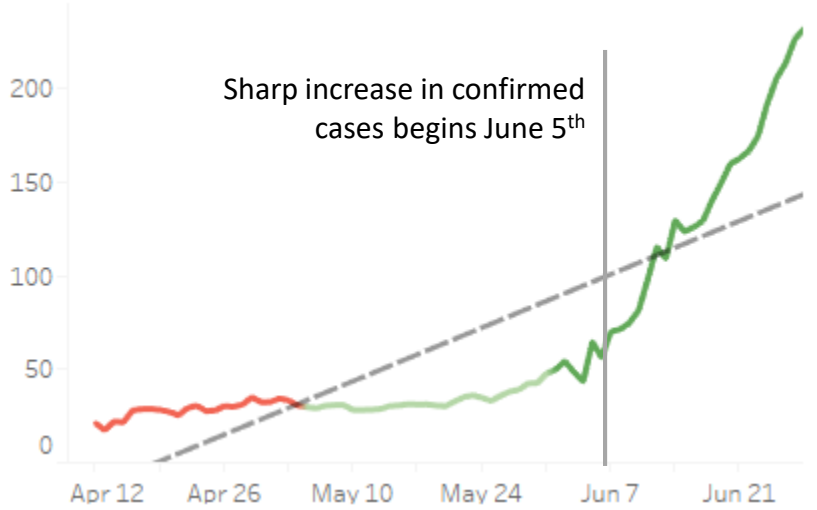
Sharp increase in confirmed cases begins June 1st

Obtained via MI FOIA by Judicial Watch, Inc.

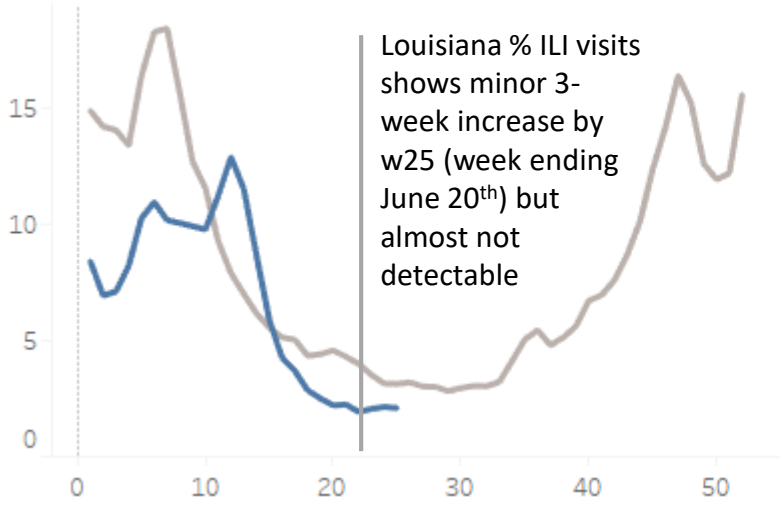
ILI and Confirmed Cases: Not entirely reliable to detect coming waves

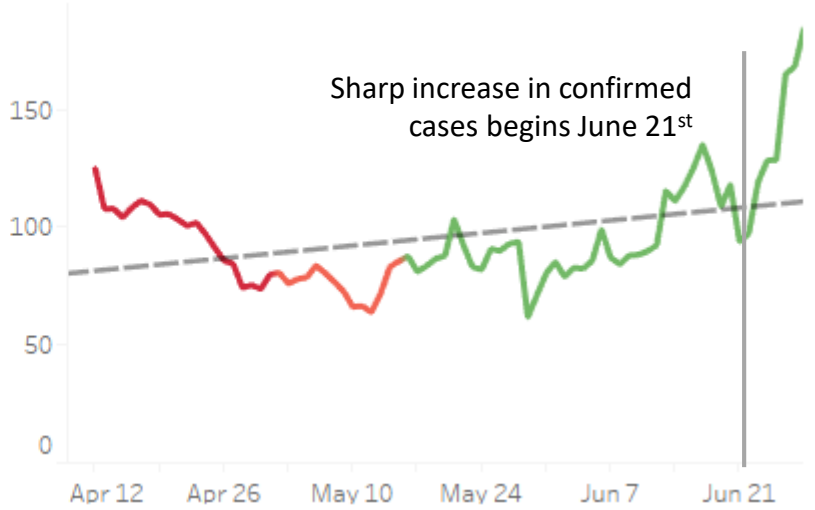
South Carolina





Louisiana





Obtained via MI FOIA by Judicial Watch, Inc.

ILI Summary

Monitoring % of Visits for ILI as a sentinel/preliminary indicator of resurgence maybe be helpful when taken with other indicators and in context of:

- Typical seasonal trend of ILI
- # of providers in state which participate in ILI reporting
- Identification of trend may be delayed given weekly reporting cadence

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Bouknight, Rey (DHHS); Khaldun, Joneigh (DHHS); LyonCallo, Sarah (DHHS); Hertel, Elizabeth (DHHS); Schwarzkopf, Emily (DHHS); Totten, Mark; Pohl, Zack; Flood, Jennifer
Subject: FW: letter to Senator Shirkey
Date: Monday, October 12, 2020 8:31:00 AM
Attachments: Sen.Shirkey.10.12.2020.pdf

Please see attached.

By way of background, I shared the Saturday article with Senator Shirkey's remarks with Dr. Sharfstein. He came up with the idea for, wrote, and collected signatures on the attached.

He told me he has shared it with reporters. I do not have information about their response. If thoughts on useful follow-up, let us know. We'll discuss some ideas within DHHS and potentially loop back.

Thanks,
Robert

From: Josh Sharfstein <joshua.sharfstein@jhu.edu>
Sent: Monday, October 12, 2020 7:52 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: letter to Senator Shirkey

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Dear Robert,

Attached is the letter that I and several other public health experts – including the President of the Infectious Disease Society of America and a former CDC director – sent to Senator Mike Shirkey this morning.

Please let me know if you have any questions.

Thank you,
Josh

Joshua M. Sharfstein, M.D.
Johns Hopkins Bloomberg School of Public Health

Obtained via MI FOIA by Judicial Watch, Inc.

October 12, 2020

The Honorable Mike Shirkey
Senate Majority Leader
S-102 Capitol Building
Lansing, MI 48933

Dear Majority Leader Shirkey,

As experts in public health and medicine, we read with concern your comments about "herd immunity" and the coronavirus pandemic in an October 10, 2020 article on mlive.com.

With cases of COVID-19 rising significantly in Michigan and across the country, we are writing to ask you to clarify these comments. We also suggest that the Michigan Senate convene a hearing of experts who are recommended by deans of Michigan schools of public health and medicine, so they can share current evidence about what can be done to reduce the spread of the coronavirus and save lives.

Comments Reported on October 10

In the mlive.com article, published this weekend, you reportedly stated of the virus, "**Nobody should be misled here or of the opinion that you can keep it from spreading -- it's going to spread, so we just do the best we can.**"

We certainly agree that the coronavirus will not disappear on its own. However, how much the virus spreads is not a matter of fate; it is very much up to us. There is strong evidence of specific steps that individuals can take in their own lives to reduce the chance of coronavirus infection for themselves and others. There is also strong evidence of steps that the states can take through policy to protect state residents from serious illness and death and contribute to a successful rebound of the economy.

Individuals can wash their hands, wear masks, and keep at least six feet of distance from others. States can take such steps as closing bars and limiting large indoor gatherings, because these settings in areas with substantial community transmission pose a high risk of contagion. Moreover, there is strong evidence supporting state-directed mask mandates.

For example, one study published in *Health Affairs* found a consistent reduction in viral spread among states that mandated mask-wearing compared to those that did not. Another

Obtained via MI FOIA by Judicial Watch, Inc.

study published this month in the *Journal of General Internal Medicine* found that states that reopened restaurants before a mask mandate experienced ten times the number of excess cases compared to those that had a mask mandate in place prior to reopening. This study found that "over 50,000 excess deaths were prevented within 6 weeks in 13 states that implemented mask mandates prior to reopening." Other studies have also found benefits.

You also stated, "**I'm also a big believer that there's an element of herd immunity that needs to take place**."

There is a mistaken view held by some that the solution to the pandemic is to wait for enough people to fall ill that the spread of the virus naturally slows down. One problem with this approach is that many people will need to fal lill before this level of herd immunity can be achieved. As of October 9, about 150,000 Michiganders have been diagnosed with coronavirus infection. The number of total infections may be as much as 10 times greater, which would mean that about 1.5 million people have been infected.

If "herd immunity" were to begin after about 80% of the state's population has been infected, as some believe, then 6.5 million more Michiganders would still need to contract COVID-19. At the current mortality rate, this would mean **more than 30,000 additional deaths** -- more than four times the number of deaths to date.

Another problem with waiting for "herd immunity" is that even if herd immunity is achieved, the coronavirus can still infect people. This means that even after a tremendous loss of life, there would still be an ongoing risk, leaving many understandably wary about returning to their previous levels of activity.

A much better alternative would be to control the spread of the coronavirus through policies based on evidence, followed by broad use of a safe and effective vaccine when available. We ask that you clarify your remarks about herd immunity to avoid leaving the impression that a leader of your stature is supporting greater spread of coronavirus as public policy.

Recommendation for a Hearing on the Science

Now nearly 10 months into the pandemic, there is much known about the novel coronavirus and how to reduce its spread. Many nations of the world have found success by following recommendations on hand washing, mask wearing, isolation, quarantine, and contact tracing, as well as other public health measures. To date, Michigan has been a national leader in using evidence to guide its response, accounting for a relatively low rate of infection for much of the late spring and summer.

However, cases are on the rise significantly in many places around the country, including Michigan. To understand the current situation and how best to respond, we suggest that the Senate convene a hearing with recognized experts in public health and medicine with expertise

Obtained via MI FOIA by Judicial Watch, Inc.

in COVID-19 who are recommended by the deans of public health and medicine in the State of Michigan.

Such a hearing would give experts the opportunity to share evidence, as well as provide Senators the chance to ask questions about the virus, its spread, and what can be done to save more lives.

Thank you very much for your consideration.

Sincerely,

Joshua M. Sharfstein, M.D.
Professor of the Practice in Health Policy and Management
Johns Hopkins Bloomberg School of Public Health

Thomas M. File, Jr., MD, MSc, FIDSA
President, Infectious Diseases Society of America

Tom Frieden, M.D., M.P.H.
President and Chief Executive Officer
Resolve to Save Lives, an Initiative of Vital Strategies
Former Director, U.S. Centers for Disease Control and Prevention

Ashish K. Jha, M.D., M.P.H.
Dean
Brown University School of Public Health

Carlos Del Rio, M.D.
Distinguished Professor
Department of Medicine, Division of Infectious Diseases
Emory University School of Medicine

This letter represents the views of the signatories and not necessarily their institutions.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Huls, JoAnne
Subject: FW: Meijer MI Covid Alert promo
Date: Wednesday, December 23, 2020 1:34:00 PM
Attachments: Partnership Proposal_Meijer_FOR PLANNING PURPOSES.docx

---

You may have already, but as originally drafted, the proposal to Meijer included both vaccines and the Mi Covid Alert promo $. Vaccines is a bigger deal, but I think the promo is worth doing too if we can. Thanks.

From: Darling, Darice (DHHS) <DarlingD1@michigan.gov>
Sent: Tuesday, December 22, 2020 12:01 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Simmons, Kirsten (DHHS) <SimmonsK7@michigan.gov>
Cc: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>
Subject: RE: Meijer MI Covid Alert promo

Hi Robert,

We finalized the proposal and sent to Sarah Triplett and Ron Owens for FYI/review. We sent over to John Van Fossen this morning and will follow up with him later today or early tomorrow morning.

Darice Darling
Acting Director
MDHHS External Affairs and Communications

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Tuesday, December 22, 2020 11:32 AM
To: Darling, Darice (DHHS) <DarlingD1@michigan.gov>; Simmons, Kirsten (DHHS) <SimmonsK7@michigan.gov>
Cc: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>
Subject: Meijer MI Covid Alert promo

Hi Darice and Kirsten,
Where do things stand re the promo $? Many of us are talking with Meijer re vaccinations and might raise.
Best,
Robert

Robert Gordon
Director, Michigan Department of Health & Human Services
gordonr3@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

Obtained via MI FOIA by Judicial Watch, Inc.

Michigan Department of Health & Human Services

Meijer-MDHHS
Partnership Opportunity Proposal

MI COVID Alert In-App Incentive
(Now through Spring 2021)

Background:

MI COVID Alert was launched statewide in November 2020 after a successful pilot program in partnership with Michigan State University and the Ingham County Health Department.

This no cost, easy-to-use app allows people to anonymously share a positive test result using a randomly generated PIN issued by the local health department or MDHHS. Anyone who was potentially exposed to COVID-19 receives an anonymous notification that they may have been exposed and the number of days ago that the exposure took place.

This has the potential to notify people faster than traditional contact tracing and still protects the privacy of the person who tested positive. Since traditional contact tracing relies on knowing your close contacts' contact information, MI COVID Alert has the added benefit of notifying anyone who may have been exposed, even if the person is unknown to the individual (i.e., as is often the nature of contact in public settings such as doctor's office waiting rooms, gyms, salons, retail and other public settings).

Because MI COVID Alert uses Bluetooth vs. GPS technology, the app doesn't track a user's exact location. Instead it uses random, frequently changing codes to recognize other phones with the app and gauge proximity to those phones. This is another feature that preserves anonymity.

Researchers have found that use of an app like this can reduce spread and have meaningful impact on infections when just 15% of a population downloads the app. As of Dec. 18, MI COVID Alert has been downloaded 465,736 times—a number equal to nearly 9.5% of Michigan's 18- to 64-year-olds (i.e., a large portion of the population likely to have cell phones).

Proposed Partnership:

To reach 15% of the target population, we must continue to encourage downloads of this app, which serves as an important supplement to the state's manual contact tracing efforts.

The centerpiece of this partnership would be an in-app incentive. MDHHS would like to partner with Meijer to provide a one-time coupon for money off a shopping visit or another incentive with broad appeal. App users would have exclusive access to the coupon, which could be scanned or entered using the same process cashiers already use to process coupons.

Obtained via MI FOIA by Judicial Watch, Inc.

The incentive would be promoted through MDHHS and Meijer communication channels ("Put your phone in the fight. Download MI COVID Alert between now and Feb. 28 to access a one-time use coupon for [INSERT INCENTIVE OFFER]"), thereby incurring no additional cost to Meijer.

Meijer would provide the coupon content, which would be embedded in the app by the State of Michigan and its app vendor.

Tactics now through February or March 2021 could include:

- MDHHS to partner with Meijer on a release to announce the incentive.
- Meijer to develop the content for the coupon and State of Michigan to add incentive to the app.
- MDHHS to promote via organic and paid social and digital ads approved by both MDHHS and Meijer.
- Meijer to potentially amplify MDHHS paid and earned promotion of the incentive (MDHHS can provide or work with Meijer on creative assets) through:
    - Social/digital
        - Meijer social channels (organic posts, tweets, etc.)
        - MPerks app (i.e., mention or ad with link to app web page)
        - Leveraging existing national or statewide (e.g., MSU and UM) sports team and athlete brand partnerships (e.g. "I (or we) put our phone(s) in the fight. You can, too. Download MI COVID Alert to be anonymously notified if you've been exposed to COVID-19.")
    - In-store marketing
        - Meijer in-store signage
        - In-store PSAs over speaker system (Voiceover in-kind by MSU figure, MDHHS or another partner)
        - CTA to download the app on backs of receipts and/or through coupon printer
    - Community education and outreach
        - Flier with QR code for the app in Simply Give-Meijer community food pantry packages

COVID-19 Vaccines
(Spring 2021-Winter 2021)

Background:

With two vaccines approved and the potential for more on the horizon, MDHHS has begun educating residents on the vaccine, approval process and expectations for distribution. Given some of the dialogue around vaccine development and the historical and polarized skepticism

Obtained via MI FOIA by Judicial Watch, Inc.

about these new vaccines– even as evidence of their safety and effectiveness exists—MDHHS and partners are providing communication and educational materials that serve to educate and address myths or misinformation.

Progress on this front plus successful distribution to critical infrastructure and the general public in early- and mid-2021 will also require partnerships with trusted community stakeholders. This includes respected individuals and brands across and within communities.

Third-party support from trusted brands or people to which others can relate play a key role in perceptions.

Proposed Partnership:

MDHHS is interested in partnering to both educate workers and the public on the COVID-19 vaccines and encourage vaccinations that will protect the health of individuals, families and communities and protect our economy. This could include a combination of communication tactics and efforts such as vaccine clinics at various stages in the rollout next year.

The phases for communication about the vaccine will follow these approximate timeframes (subject to change):

- Now and ongoing: Education about the vaccine approval process, safety and efficacy for all Michiganders
- Early 2021: Information and call-to-action to vaccinate frontline/critical infrastructure workers
- Mid-Spring 2021: Information and call-to-action to vaccinate people ages 65+ and with underlying conditions
- Late-Spring and ongoing: Information and call-to-action to vaccinate the broader population

Tactics in January through Fall 2021 could include (MDHHS can provide or work with Meijer on creative assets):

- Community education and outreach
    - Flier with vaccine basics and, later with information on how to get the vaccine, in Simply Give-Meijer community food pantry packages
- Social/digital
    - Meijer social channels for organic posts, tweets, etc. about the vaccine starting with ways to find more information in early 2021
    - MPerks app (i.e., ad with link to vaccine information and, later, to locations offering vaccines)
    - Leveraging existing national or statewide (e.g., MSU and UM) sports team and athlete brand partnerships (e.g. “I got my vaccine. Did you? Get one at no cost today at [INSERT LOCATION].”)

Obtained via MI FOIA by Judicial Watch, Inc.

- In-store marketing
  - Meijer in-store signage encouraging the vaccine
  - In-store PSAs over speaker system (Voiceover in-kind by MDHHS or another partner)
  - CTA to find out more or visit a vaccine clinic at Meijer on backs of receipts or through the coupon machine
- Internal communications
  - Share vaccine education information with workers (e.g., vaccine approval process graphics, basic information about the vaccines available and why it is important to get the vaccine when it is available) including e-news or periodic e-mails to employees
  - Share information about where and when to get vaccinated

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Pohl, Zack
Cc: Huls, JoAnne; Bouknight, Rey (DHHS)
Subject: FW: Michigan Apex Clarification
Date: Sunday, April 5, 2020 2:05:28 PM

Please advise, thanks.

From: LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>
Sent: Sunday, April 5, 2020 1:59 PM
To: Sutfin, Lynn (DHHS) <SutfinL1@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Razili Lewis <razili_lewis@mckinsey.com>
Subject: RE: Michigan Apex Clarification

I am good but want to make sure it is ok to mention McKinsey group? Dir Gordon and Raz?

From: Sutfin, Lynn (DHHS) <SutfinL1@michigan.gov>
Sent: Sunday, April 05, 2020 1:55 PM
To: LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>
Cc: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Razili Lewis <razili_lewis@mckinsey.com>
Subject: Re: Michigan Apex Clarification

Thanks to the edits. Are we good with this being the response?

Sent from my iPhone

> On Apr 5, 2020, at 12:48 PM, LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov> wrote:
>
> ---
>
> **From:** Sutfin, Lynn (DHHS) <SutfinL1@michigan.gov>
> **Sent:** Sunday, April 05, 2020 12:44 PM
> **To:** LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Razili Lewis <razili_lewis@mckinsey.com>
> **Subject:** FW: Michigan Apex Clarification
> **Importance:** High
>
> Making sure this is still my response to this question before responding. The highlighted yellow addresses his last question and I welcome feedback.

Obtained via MI FOIA by Judicial Watch, Inc.

Hi Brian,

We are making use of multiple sources of modeling including work from University of Michigan, IHME's https://covid19.healthdata.org/projections, the COVIDACTNOW.ORG site, running rough projections using assumptions in a paper from Imperial College, and working with McKinsey Group.

Each model is dependent on the data used to develop it including how timely and specific the data are to geography, onset date of illness, case count, community spread data, observance of shelter in place orders/social distancing, death data, etc.

We continue to urge Michiganders to follow Governor Whitmer's Stay Home, Stay Safe Order and to practice social distancing to help slow the spread of COVID-19 in our state.

From: Brown, Tiffany <BrownT56@michigan.gov>
Sent: Sunday, April 5, 2020 12:26 PM
To: Abel, Brian <Brian.Abel@WXYZ.COM>; Sutfin, Lynn (DHHS) <SutfinL1@michigan.gov>; Wheaton, Bob (DHHS) <WheatonB@michigan.gov>
Cc: Leddy, Robert <LeddyR@michigan.gov>; Lewis, Chelsea <LewisC23@michigan.gov>
Subject: Re: Michigan Apex Clarification

Hi Brian,

Looping in my colleagues with MDHHS to help with your inquiry.

—Tiff

From: Abel, Brian <Brian.Abel@WXYZ.COM>
Sent: Sunday, April 5, 2020 12:18 PM
To: Brown, Tiffany
Cc: Leddy, Robert; Lewis, Chelsea
Subject: Michigan Apex Clarification

Good afternoon,
Dr. Birx with the White House Coronavirus Task Force yesterday said the multiple hotspots (including Detroit) could apex at the same time in the next 6-7 days, citing predictions from healthdata.org
However on Thursday, Gov. Whitmer suggested Michigan is probably a month away from the apex.
Reaching out to see where the discrepancy is and if it is a difference in modeling, which modeling the Governor is using for her prediction.
Also reaching out for comment on what Michiganders should consider a more accurate assessment to prepare for considering a 3 week difference in those

Obtained via MI FOIA by Judicial Watch, Inc.

predictions.

Thank you.
Sincerely,
Brian

Brian Abel | **Anchor/Reporter**

248-763-6719

@BrianAbelTV



Scripps Media, Inc., certifies that its advertising sales agreements do not discriminate on the basis of race or ethnicity. All advertising sales agreements contain nondiscrimination clauses.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Totten, Mark
To: Gordon, Robert (DHHS); Khaldun, Joneigh (DHHS)
Subject: FW: Michigan's Need for Non-Discriminatory Guidance on Medical Rationing in the Event of Scarcity
Date: Saturday, April 25, 2020 7:28:41 AM
Attachments: Ltr to Gov Whitmer 4-24-20.pdf

Director Gordon and Dr. Khaldun,

I am not sure if you received this email – you were not included among others who were copied on the email I received, but you are mentioned as being cc'd on the attached letter.

We're giving this letter a close review in our office. As you'll see, among other concerns, MPAS discusses the *COVID-19 Practice Management Guide*. Let's find time to discuss your evaluation of that concern by phone in the next few days.

Your department and our office have been actively discussing the issue of protections for people with disabilities and I know we're jointly committed to making sure those protections are in place. This letter should help us focus our efforts and determine our next steps.

Thanks, Mark

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

From: KYLE WILLIAMS <KWilliams@mpas.org>
Sent: Friday, April 24, 2020 5:07 PM
To: Whitmer, Gretchen (MIEOG) <Gretchen.Whitmer@michigan.gov>; Michigan Attorney General <miag@michigan.gov>
Cc: Gilchrist, Garlin (MIEOG) <Garlin.Gilchrist@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>; Laidlaw, Emily <LaidlawE@michigan.gov>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Engelman, Mary (MDCR) <EngelmanM@michigan.gov>
Subject: Michigan's Need for Non-Discriminatory Guidance on Medical Rationing in the Event of Scarcity

Obtained via MI FOIA by Judicial Watch, Inc.

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Hon. Governor Whitmer and Hon. Attorney General Nessel,

Attached please find a letter representing the collective voices of disability rights organizations and individuals that wish to present concerns regarding the State of Michigan's current guidance on medical rationing in the event of scarcity.

While we all hope medical rationing does not occur in Michigan and commend you for your actions to ensure adequate healthcare infrastructure, we believe the State should have more appropriate guidance regarding medical rationing.

We all hope you will take our concerns into account and provide additional guidance to protect people with disabilities in this State.

Please feel free to reach out to me directly if any of the organizations or individuals who have signed this letter can be helpful in providing clarification or assistance regarding this issue.

Thank you for your attention to this matter. We all wish you the best in your efforts to fight this pandemic.

Regards,

Kyle Williams, Attorney
Director of Litigation Strategies
Michigan Protection & Advocacy Services, Inc.
4095 Legacy Parkway, Suite 500
Lansing, Michigan 48911
Phone: (517) 487-1755
Fax: (517) 487-0827

CONFIDENTIALITY NOTICE: The transmitted material is intended only for the use of the addressee. It may contain confidential, proprietary and/or legally privileged information. If you are not the intended recipient, please be aware that any review, use, dissemination, distribution, or copying of this communication, in whole or in part, is prohibited. If you received this communication in error, please notify us immediately by e-mail reply or by phone (800-288-5923), delete the communication and destroy any copies.

Obtained via MI FOIA by Judicial Watch, Inc.

MICHIGAN
MP&AS
"PROTECTING THE RIGHTS OF PERSONS WITH DISABILITIES"
PROTECTION & ADVOCACY SERVICE, INC.

Michelle Roberts, Executive Director

John McCulloch
President
Royal Oak

Hansen Clarke
1st Vice President
Detroit

Jane Shank, MSW
2nd Vice President
Interlochen

Mark Stephenson
Treasurer
Troy

Paul Palmer
Secretary
Lansing

Thomas H. Landry
Immediate Past President
Highland

Melody Arabo
West Bloomfield

Pamela Bellamy, Ph. D.
Lansing

Alethea Brinkerhoff
Bloomfield Hills

Davin Hemmila
Negaunee

Selena M. Schmidt
Shelby Township

Mark Wiedelman
Troy

April 24, 2020

Sent Via Email to: Gretchen.Whitmer@michigan.gov and miag@michigan.gov

Hon. Gretchen Whitmer
Governor, State of Michigan
P.O. Box 30013
Lansing, MI 48909

Hon. Dana Nessel
Attorney General, State of Michigan
G. Mennen Williams Building
525 W. Ottawa Street
P.O. Box 30212
Lansing, MI 48909

RE: Michigan's Need for Non-Discriminatory Guidance on Rationing Scarce Medical Resources in the COVID-19 Pandemic

Dear Governor Whitmer and Attorney General Nessel:

At the outset, we do want to take this opportunity to commend and thank you for your overall efforts to fight this crisis to protect the health and welfare of the residents of the State of Michigan.

This letter represents the collective voice of 19 disability rights organizations/individuals that desire to present concerns about the guidance from the State of Michigan regarding appropriate and ethical actions that healthcare providers are to take when making decisions about medical treatment during the COVID-19 pandemic.

We wish to inform you of serious concerns on behalf of people with disabilities in Michigan regarding their civil rights and equal access to potentially scarce resources in this pandemic crisis, including

Obtained via MI FOIA by Judicial Watch, Inc.

ventilators. **Current guidance adopted by the State will have a discriminatory effect on people with disabilities and pre-existing conditions which must be rescinded.** Michigan has implemented the *COVID-19 Practice Management Guide*, adapted from the Department of Defense and Minnesota Department of Health, which provides guidance to health care infrastructure that is discriminatory against people with disabilities.[1] This document guides healthcare infrastructure on what to do in the event medical resources become scarce.[2] The most notable example of discriminatory guidance is found in Appendix H, which details "strategies for scarce resource situations."[3] Most concerning is the guidance related to mechanical ventilation which includes prioritizing reallocation of life saving ventilation equipment based on disability, rather than an individualized assessment of whether the patient can benefit from treatment.[4] Under the current guidance, in order to be designated as having a "low potential for death" a patient cannot have a "severe underlying disease."[5] While consideration of underlying conditions is permissible as part of an objective, individualized assessment; de-prioritization based solely on an underlying diagnosis is discriminatory. As an example, an individual "requiring continuous oxygen use prior to the onset of acute illness" would be immediately de-prioritized under this guidance without requiring an individual assessment as to their ability to benefit from treatment.[6]

Additionally, those individuals who may require a greater duration of need are given lower priority in the determination of who receives a ventilator, which disproportionately affects people with disabilities.[7] Treatment allocation decisions should not be made based on the perception that a person's disability will require the use of greater treatment resources and should be based on an objective, individualized assessment. Further, the *COVID-19 Practice Management Guide* references the *Fair Allocation of Scarce Medical Resources in the Time of Covid-19* published in *The New England Journal of Medicine*.[8] This article encourages making scare medical resource allocation decisions that save the most life-years in allocating scarce medical resources.[9] Prioritization based on life-years disproportionately affects people with disabilities due to stereotypes and subjective assumptions about certain diagnoses. Medical resource allocation decisions should be made based on how to save as many people that can benefit from treatment rather than, for example, prioritizing the younger over the older.

The Office for Civil Rights of the Department of Health and Human Services has declared that "persons with disabilities should not be denied medical care on the basis of stereotypes, assessments of quality of life, or judgements about a person's relative 'worth' based on the presence or absence of disabilities." The *COVID-19 Practice Management Guide* violates this mandate.

---

[1] https://www.michigan.gov/documents/coronavirus/COVID19_Practice_Management_Guide_Final_685523_7.pdf
[2] *Id*. at 33-34, 38-39, 58, and 71.
[3] *Id*. at 58.
[4] *Id*. at 71.
[5] *Id*.
[6] *Id*.
[7] *Id*.
[8] *Id*. at 34, 39, and 44.
[9] *See* Recommendation 1 and 4.

Obtained via MI FOIA by Judicial Watch, Inc.

Disability rights advocates have written letters to the State as early as March 23, 2020 and as recently as April 10, 2020 regarding medical rationing issues.[10] Still, Michigan has failed to address the March 28, 2020 Bulletin from the HHS Office of Civil Rights; therefore, we believe it is our obligation, on behalf of all persons with disabilities in Michigan, to urgently request the inappropriate policy guidance contained in the *COVID-19 Practice Management Guide* be rescinded with notice provided to all healthcare entities and new guidance be issued that clearly advises hospitals to perform an individualized assessment of all patients when making resource reallocation decisions. Upon rescinding the problematic language, Michigan should work towards releasing additional guidance that complies with the principles and values outlined by Michigan Protection & Advocacy Service, Inc.'s correspondence to MDHHS' Department of Legal Affairs on March 29, 2020[11] and HHS' March 23, 2020 Bulletin.

From our perspective, having appropriate policy guidance on medical rationing is long overdue and critically necessary in order to prevent people with disabilities from unnecessarily being denied access to life-saving medical treatment by virtue of having a disability.

Even if we have reached the apex of hospital admissions and new cases, the State's response and action is urgently needed to save the lives of people with disabilities going forward. As we all know, the models are based on incomplete testing and the down-slope of the curve will likely have just as many or more deaths as the up-slope.

The guidance issued in Michigan will have a discriminatory impact on people with disabilities when determining how to provide and withdraw scarce life-saving resources.

This letter reiterates the request for a policy that protects the rights of persons with disabilities seeking medical care and treatment under any circumstance. Michigan ranks third in total deaths ***2,977*** and fourth in total cases of ***35,291*** nationwide as of April 24, 2020. This issue requires a formal response in the form of an Executive Order that explicitly states that civil rights are non-negotiable, rescinds the problematic aspects of *COVID-19 Practice Management Guide* identified above, and creates a policy in compliance with guidance issued by the United States Department of Health and Human Services.

Additionally, data shows that there is a disproportionate impact of COVID-19 upon older individuals, the African American community, and other communities of color. For people of color with disabilities, in particular, the risk of contracting COVID-19 and then facing challenges accessing healthcare and treatment are increased. People at the intersection of these identities are rightfully fearful of discrimination, stereotypes, and assumptions by medical providers based on one or several of their marginalized identities.

Disability is a key social characteristic that cuts across race, ethnicity, gender, national origin, sexual orientation, and religious affiliation, but it does not appear to be tracked by the state as

[10] April 1 and April 10, letters from Dessa Cosma, Detroit Disability Power and March 23, 2020 letter from Sam Bagenstos.
[11] *See* Exhibit 1.

Obtained via MI FOIA by Judicial Watch, Inc.

part of the COVID-19 response. It should be. Hospitals record comorbidities and pre-existing conditions, and if we track disability, we can explore correlations across social characteristics as well as solutions.

The signatories to this letter request immediate action and a response detailing the steps Michigan will take to ensure people with disabilities have equal access to healthcare in the event of scarcity.

We are looking forward to your response and working with you in any way we can to achieve these goals.

Thank you for your attention and consideration.

Sincerely,

Michigan Protection and Advocacy Service, Inc.

Autism Alliance of Michigan

Michigan Disability Rights Coalition

Michigan Developmental Disabilities Council

National Alliance on Mental Illness – Michigan

Samaritas

Nadia Vann, Disability Rights Attorney

Christine Caswell, Disability Rights Attorney

Sam Bagenstos, Attorney

Jan Lampman

Mental Health Association in Michigan

MHAM

The Arc of Michigan

Detroit Disability Power

American Civil Liberties Union of Michigan

Shannon DeWall, Disability Rights Attorney

Michael Bartnik, Disability Rights Attorney

Jill Babcock, Disability Rights Attorney

Jenny Thomas

cc: Lt. Governor: Garlin.Gilchrist@michigan.gov
Gov's Lawyer, Mark Totten: TottenM1@michigan.gov
Gov's Policy Director, Emily Laidlaw: LaidlawE@michigan.gov
MDHHS Director, Robert Gordon: gordonr3@michigan.gov
MDCR Interim Director, Mary Engleman: EngelmanM@michigan.gov
Dr. Khaldun: KhaldunJ@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

EXHIBIT

1

Obtained via MI FOIA by Judicial Watch, Inc.

From: KYLE WILLIAMS
Sent: Tuesday, March 31, 2020 9:33 PM
To: AsmanL@michigan.gov
Cc: Samuel Bagenstos <sbagen@gmail.com>; Merissa Kovach <mkovach@aclumich.org>; MARK MCWILLIAMS <mmcwilliams@mpas.org>
Subject: Joint Document Regarding Medical Rationing

Leslie,

Thanks for taking the time to discuss this matter with me. As you know, MPAS has been working with the ACLU and Sam Bagenstos to create guiding principles and values for addressing the event of medical rationing in Michigan. While we all feel there is a need for much greater guidance regarding the protocols for ensuing these principles and values are implemented, we have an opportunity to communicate our position on medical rationing jointly with the State. We are hopeful the State's principles and values are the same as ours and would like to work on a joint document reflecting the following principles:

- No life is more precious than another. All people in Michigan are worth saving.
- The ADA, PWDCRA, ACA, and Section 504 of the Rehab Act all provide that a person with a disability cannot be discriminated against on the basis of disability.
- Individuals with disabilities are entitled to reasonable accommodations in order to allow access to care.
- Should medical treatment need to be rationed, it will be done in the most equitable way possible. Specific protocol must be developed to diminish implicit bias in medical decision making including:
    - Prohibiting treatment allocation decisions based on the assumption that people with disabilities experience a lower quality of life, have a lower prospect of survival, and/or will require the use of greater treatment resources;
- The State must provide guiding principles for the development of protocols for medical rationing consistent with the following:
    - Decisions regarding the allocation of treatment/life-saving resources should be made on an individual basis, using objective medical evidence and not generalized assumptions about a person's disability;
    - A person is qualified to receive COVID-19 treatment if they can benefit from treatment (can recover) and the treatment is not contraindicated.
    - The protocol should avoid judgments about quality of life. "Quality of life" is a relative judgement prone to a number of biases, including but not limited to disability, income, race, gender identity, and more.
    - The protocol should also avoid judgments about "health status." Many persons with disabilities are healthy but live with ongoing conditions that could be construed as "unhealthy." For example, in Alabama, its current triage system chillingly denies life-saving services to those with a diagnosis of AIDS, with severe developmental disability, and those with renal failure requiring dialysis. Similarly, in Tennessee, its system wrongly excludes individuals from treatment if they experience advanced untreatable neuromuscular disease (such as ALS, end-stage MS, spinal muscular atrophy) and require assistance with activities of daily

Obtained via MI FOIA by Judicial Watch, Inc.

living or chronic ventilator support. Finally, the State of Washington is considering a reliance on "health" factors among other criteria in its triage system.

- The State of Michigan should instead establish an emergency triage treatment protocol for the entire state whose guiding principle would be an individualized assessment of each person's likelihood to survive if offered whatever medical services are in limited supply. This assessment would be based on an individual's specific functioning, and not upon assumptions based on a person's pre-existing condition or specific diagnosis. If a person is likely to survive with available treatment, he/she would receive treatment. If not, he/she would not receive treatment. This standard would enable the system to deflect limited available treatment away from: (a) people who are expected to recover without such treatment, and (b) people who are not expected to recover with such treatment.

As mentioned above, we all feel there is a need to develop more specific guidance on protocols that will implement these principles. We also request a work group be formed to create protocols with representation from the State, hospitals and doctors, people with disabilities, and advocacy organizations.

Thank You for your attention to this important matter. I hope to hear from you soon with MDHHS' response.

Regards,

Kyle Williams, Attorney
Director of Litigation Strategies
Michigan Protection & Advocacy Services, Inc.
4095 Legacy Parkway, Suite 500
Lansing, Michigan 48911
Phone: (517) 487-1755
Fax: (517) 487-0827

CONFIDENTIALITY NOTICE: The transmitted material is intended only for the use of the addressee. It may contain confidential, proprietary and/or legally privileged information. If you are not the intended recipient, please be aware that any review, use, dissemination, distribution, or copying of this communication, in whole or in part, is prohibited. If you received this communication in error, please notify us immediately by e-mail reply or by phone (800-288-5923), delete the communication and destroy any copies.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark
Subject: FW: Monday night document
Date: Tuesday, June 23, 2020 7:52:17 AM
Attachments: 20200622 Data and modeling update.pdf

Timeline a bit different than I'd said.

From: Erin McGovern <Erin_McGovern@mckinsey.com>
Sent: Tuesday, June 23, 2020 7:46 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: Monday night document

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Good morning Robert, here's the doc from last night.

Best,
Erin

Erin McGovern
McKinsey & Company
Mobile: +1.313.898.1718

+==+
This email is confidential and may be privileged. If you have received it
in error, please notify us immediately and then delete it. Please do not
copy it, disclose its contents or use it for any purpose.
+==+

Obtained via MI FOIA by Judicial Watch, Inc.

MI COVID response

Data and modeling update

June 22, 2020

NOTE: all data as of June 20 unless otherwise noted

Draft and pre-decisional

DRAFT

Obtained via MI FOIA by Judicial Watch, Inc.

Executive summary

Indicators declines are plateauing across MI, with most regions pointing to medium or low risk

The Grand Rapids region has risen slightly since last week, with new daily cases per mm the 20 threshold (medium-high risk), with percent positivity and deaths still declining

The Detroit region has had a small increase in cases since last week, but continues its decline in new daily cases and percent positivity

Kalamazoo, Lansing, and Saginaw Regions have declining case numbers and positivity

The Traverse City, Jackson, and UP regions continue to have low case levels with most indicators pointing to a low risk level, but the lowest testing numbers in the state

Daily diagnostic (PCR) testing remains around 13K per day in the last week, representing a slight drop from the previous week

Percent positivity continues to remain steady at 2.3% (slight increase from 2.2% last week, but still well-below 3% threshold)

Case investigation and contact tracing metrics are improving, but the group is continuing to examine ways to improve rates

The group is launching Traceforce 3.0 this week, which allows three pilot departments the ability to perform their own contact tracing in the new State system, a fundamental part of future state

In addition to making improvements to the system based on LHD feedback, the group is continuing to work with large departments to improve case investigation attempt percentages

Obtained via MI FOIA by Judicial Watch, Inc.

Epi and indicators

- **Epi overview**
- Latest indicators
- State comparison

Testing

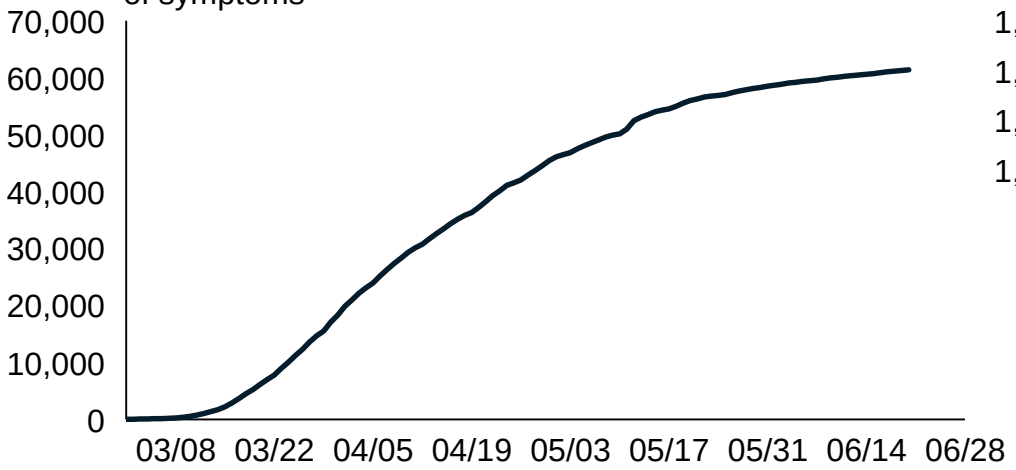
Case investigation and tracing

Appendix

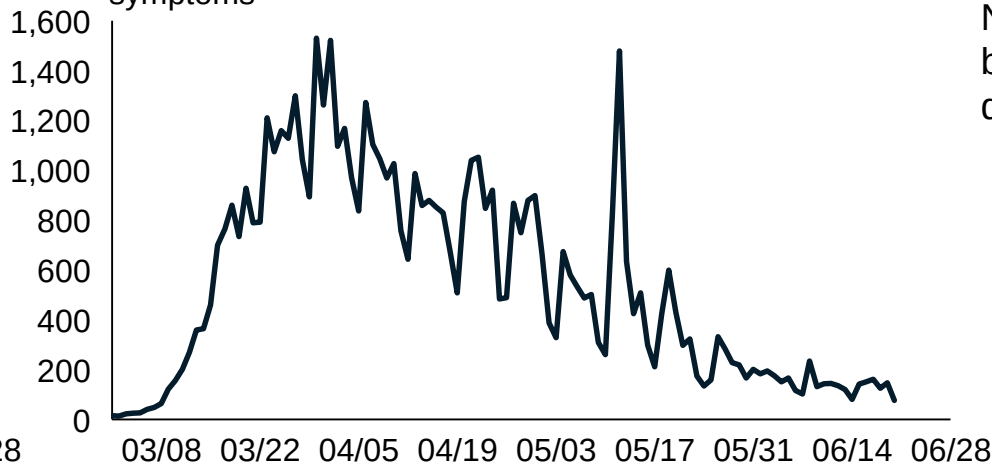
Obtained via MI FOIA by Judicial Watch, Inc.

COVID-19 cases and deaths: State of Michigan

Cumulative lab confirmed cases, by date of onset of symptoms



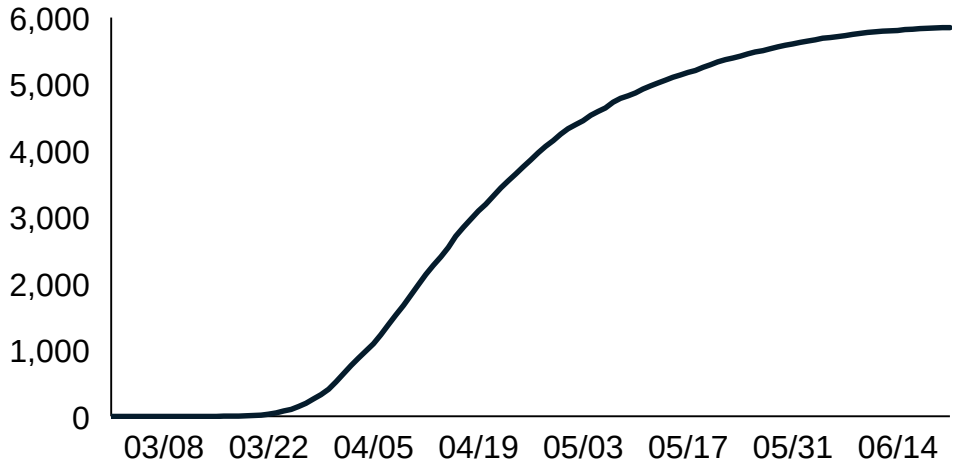
New lab confirmed cases, by date of onset of symptoms



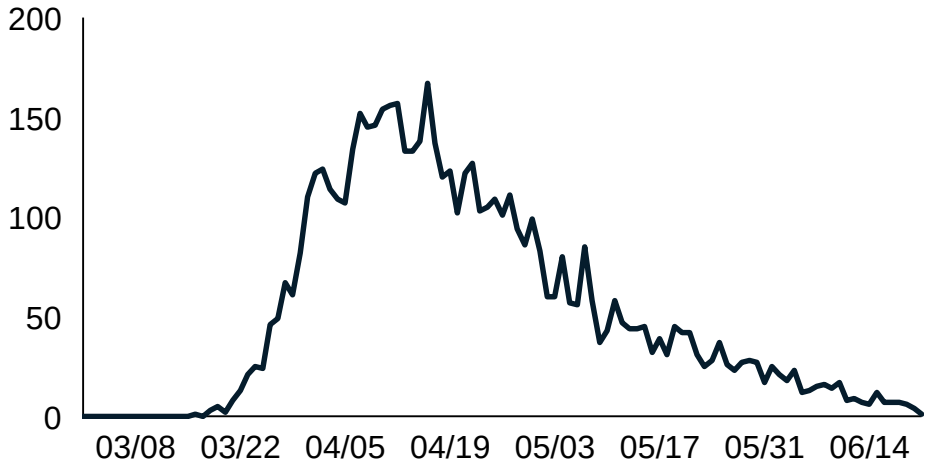
Updates since last week:

New cases per day appear to be flattening, rather than decreasing at same rate

Cumulative deaths, by reported date



New deaths, by reported date



Updates since last week:

New deaths per day continue to decrease

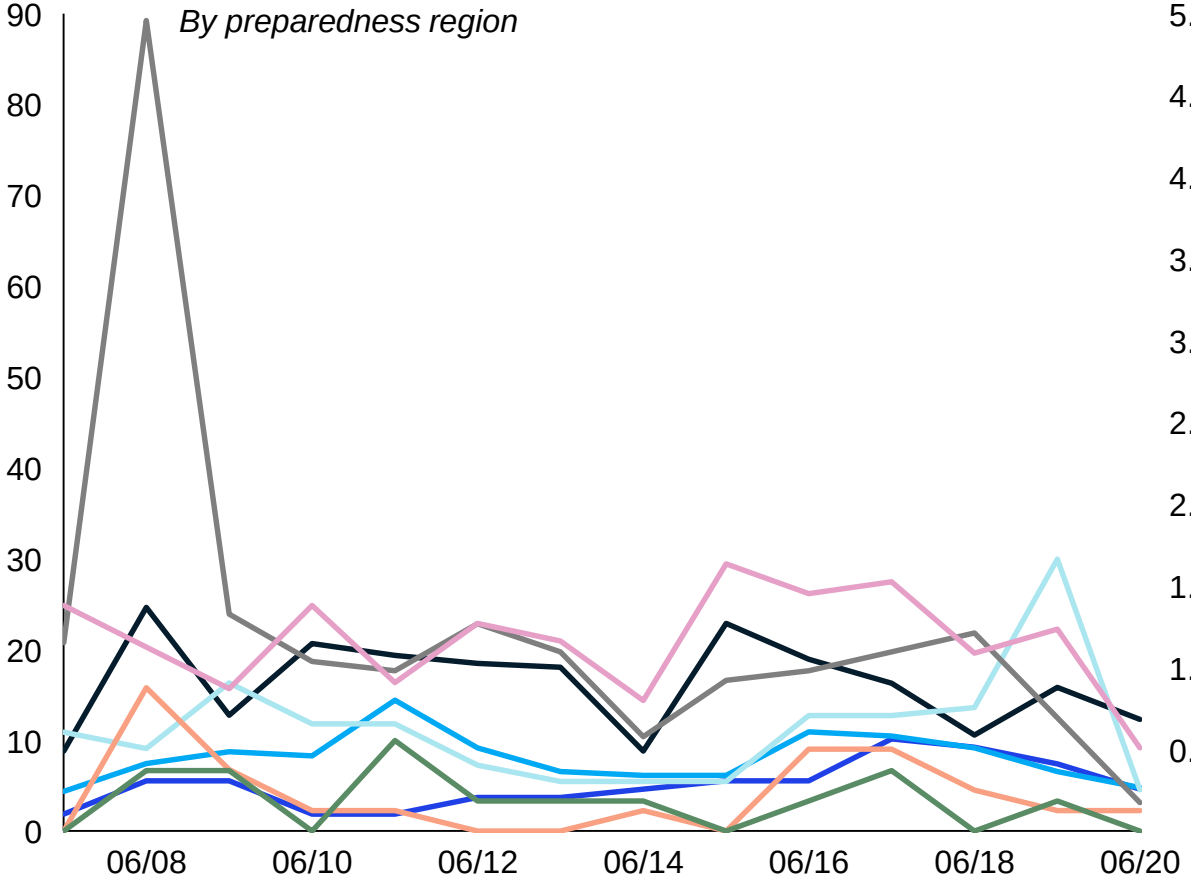
Note: Cases information sourced from MDHHS and reflects date of onset of symptoms (refers to lab-confirmed cases). Case spike on 5/12 is a result of batch of test results, not all of which have onset date of symptoms completed yet
Source: MDHHS – Michigan Disease Surveillance System

Obtained via MI FOIA by Judicial Watch, Inc.

COVID-19 cases and deaths: regional comparison PAST TWO WEEKS

New cases per million, by date of onset of symptoms

By preparedness region

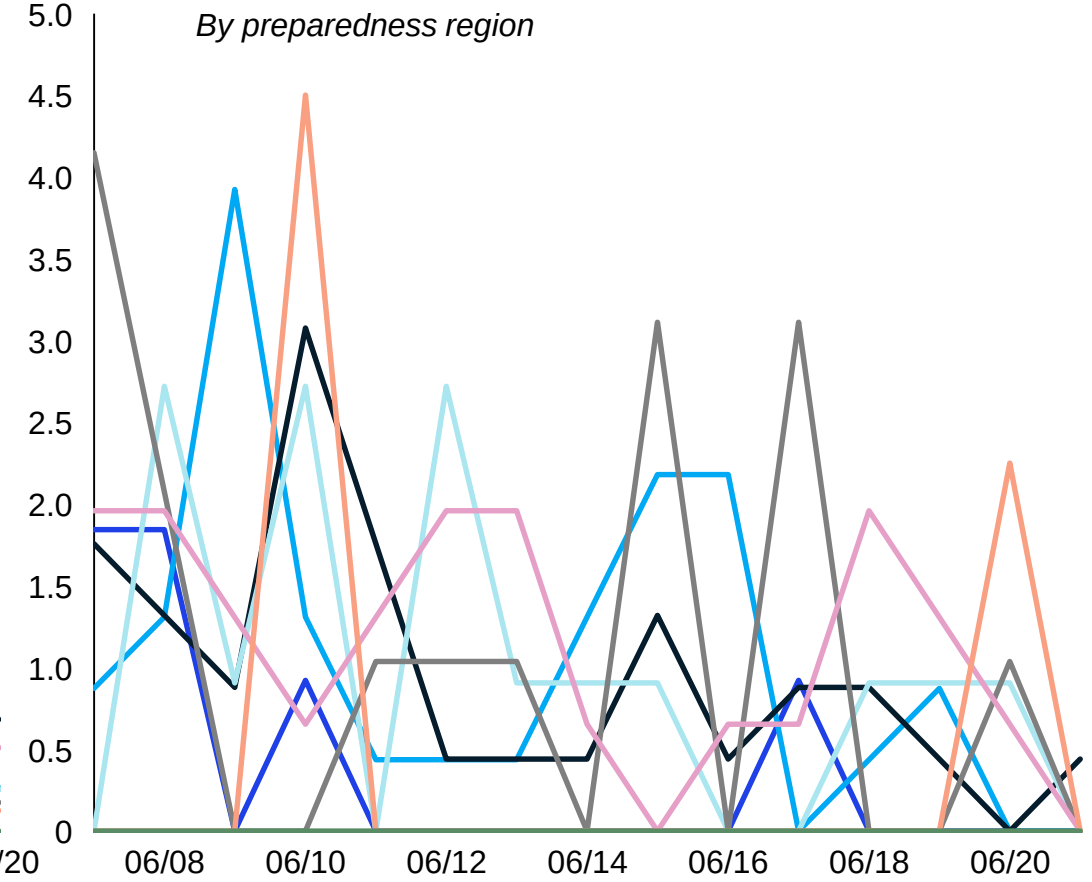


Updates since last week:

Most regions remained relatively flat week over week

New deaths per million, by reported date

By preparedness region





Updates since last week:

Deaths continue to remain low across the state

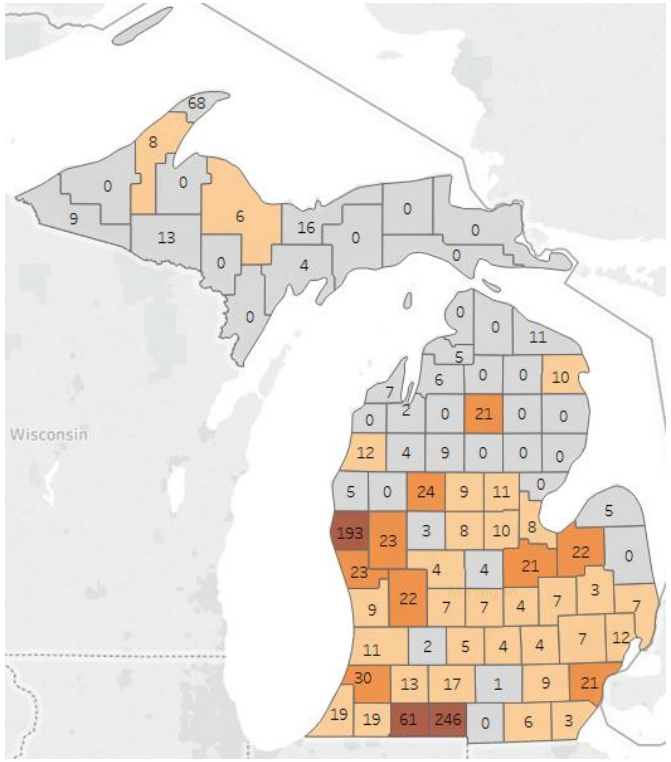
Note: “Cases” refers to lab-confirmed cases. Note: By preparedness region
Source: MDHHS – Michigan Disease Surveillance System

Draft

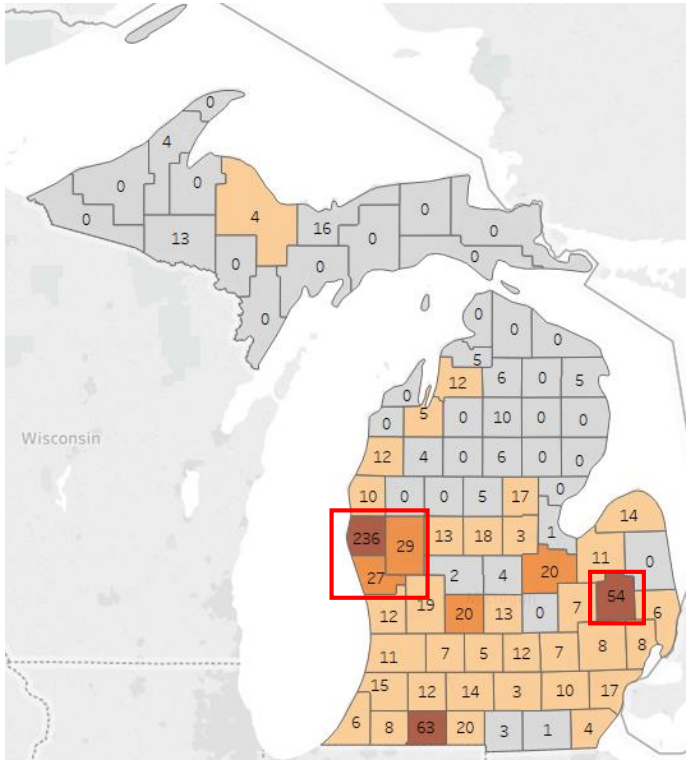
Obtained via MI FOIA by Judicial Watch, Inc.

Average daily new cases per million residents

6/8-6/14



6/14-6/20



Insufficient sample size; county has fewer than 2 new cases during the week

Fewer than 20 average daily new cases per million

20-40 average daily new cases per million

More than 40 average daily new cases per million

Updates since last week:

Overall, state continues to see cases per million drop week over week, with nearly all counties seeing fewer than 20 average daily new cases per million

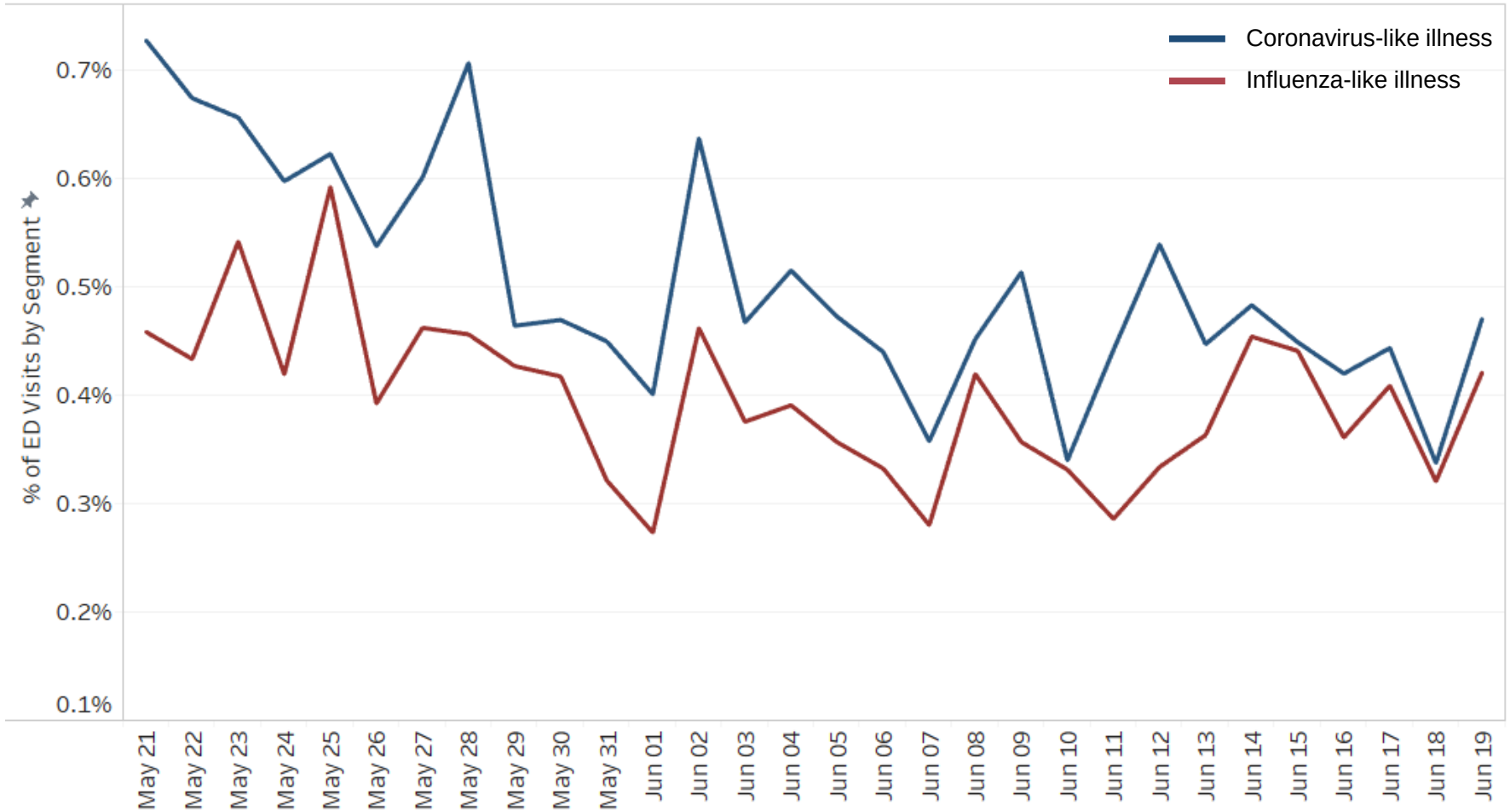
However, some counties saw increases (not exhaustive):

- Lapeer, Muskegon, Newaygo, Oceana

Note: Cases information sourced from MDHHS and reflects date of onset of symptoms (refers to lab-confirmed cases).
Source: MDHHS – Michigan Disease Surveillance System

Obtained via MI FOIA by Judicial Watch, Inc.

Coronavirus-like illness and influenza-like illness



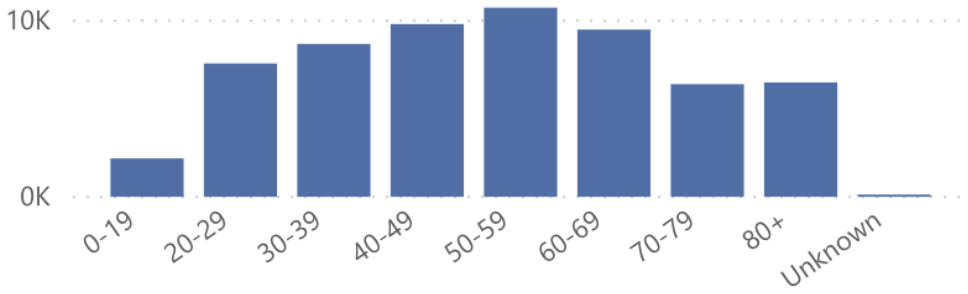
CLI and ILI as a percent of ED encounters has decreased overall since Memorial Day weekend, but has remained flat for the past two weeks

Source: Michigan Syndromic Surveillance System

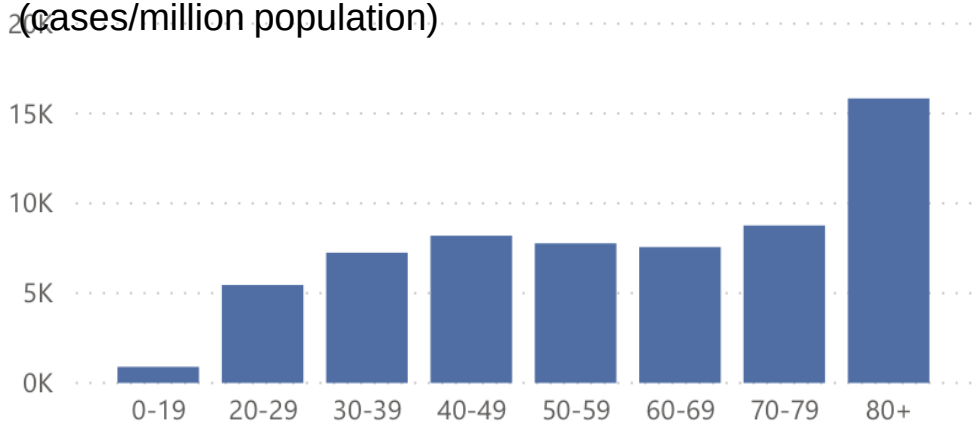
Obtained via MI FOIA by Judicial Watch, Inc.

Cases by age in Michigan

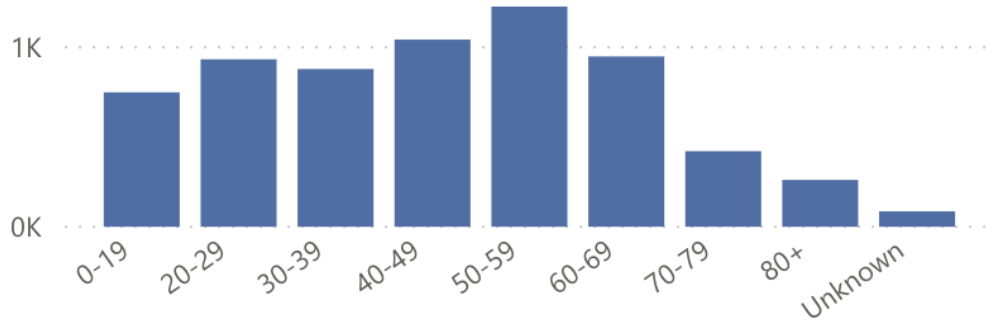
Confirmed Cases
(# cases)



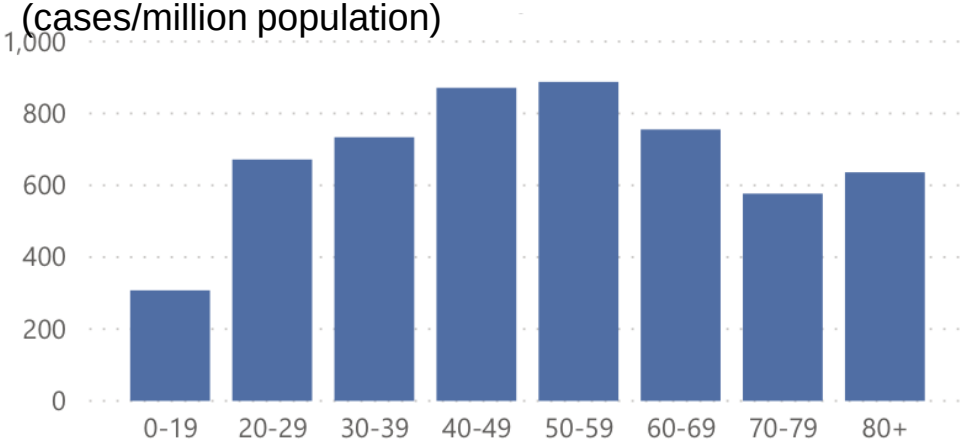
Confirmed Cases
(cases/million population)



Probable Cases
(# cases)



Probable cases
(cases/million population)

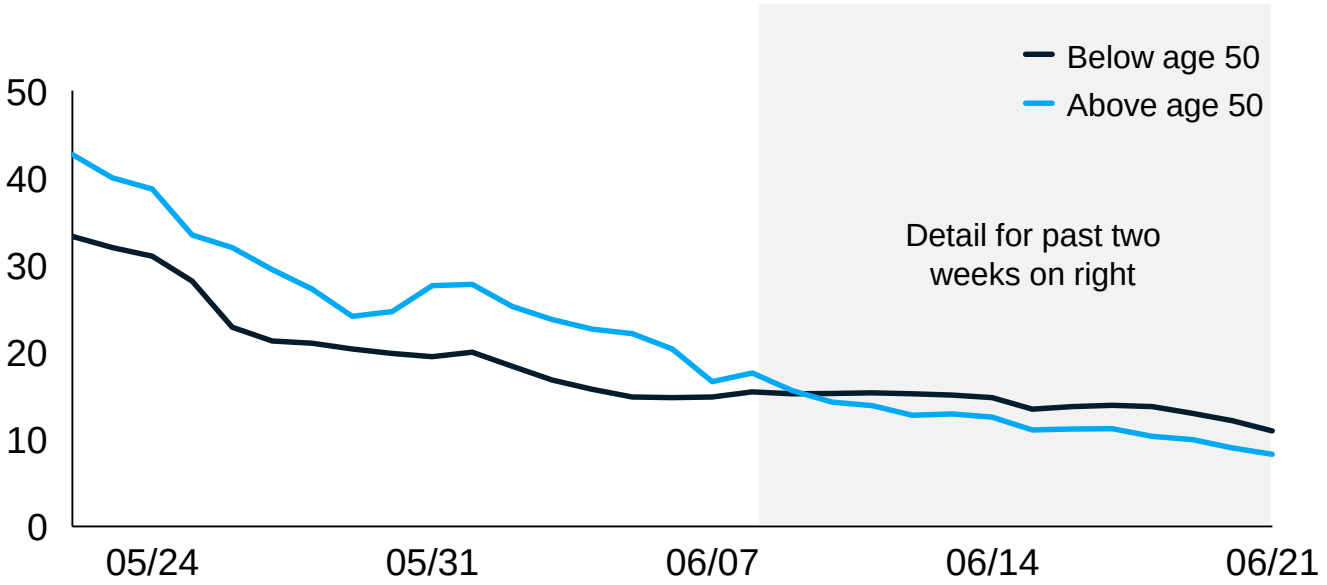


Draft

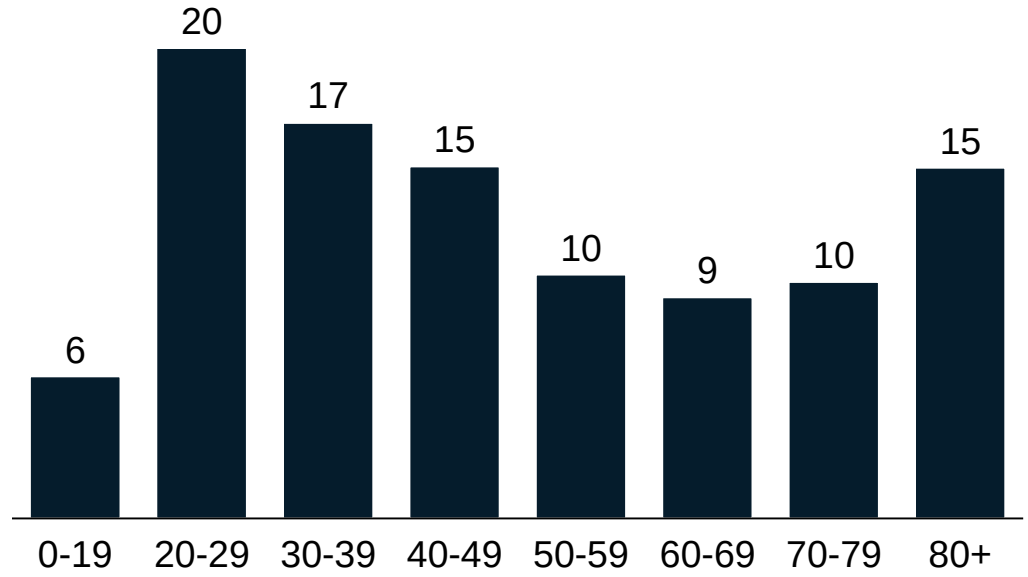
Obtained via MI FOIA by Judicial Watch, Inc.

Average daily new cases per million residents, by age group

Daily new cases per million by age group (7 day rolling average)



Average daily new cases per million by age group, 6/8-6/21



News from other states indicates that younger people are driving recent case increases around the country

In Michigan, though cases are not increasing, young people make up a higher proportion of recent cases than older individuals

Note: Cases information sourced from MDHHS and reflects date of onset of symptoms (refers to lab-confirmed cases).
Source: MDHHS – Michigan Disease Surveillance System

Obtained via MI FOIA by Judicial Watch, Inc.

Epi and indicators

- Epi overview
- **Latest indicators**
- State comparison

Testing

Case investigation and tracing

Appendix

Obtained via MI FOIA by Judicial Watch Inc.

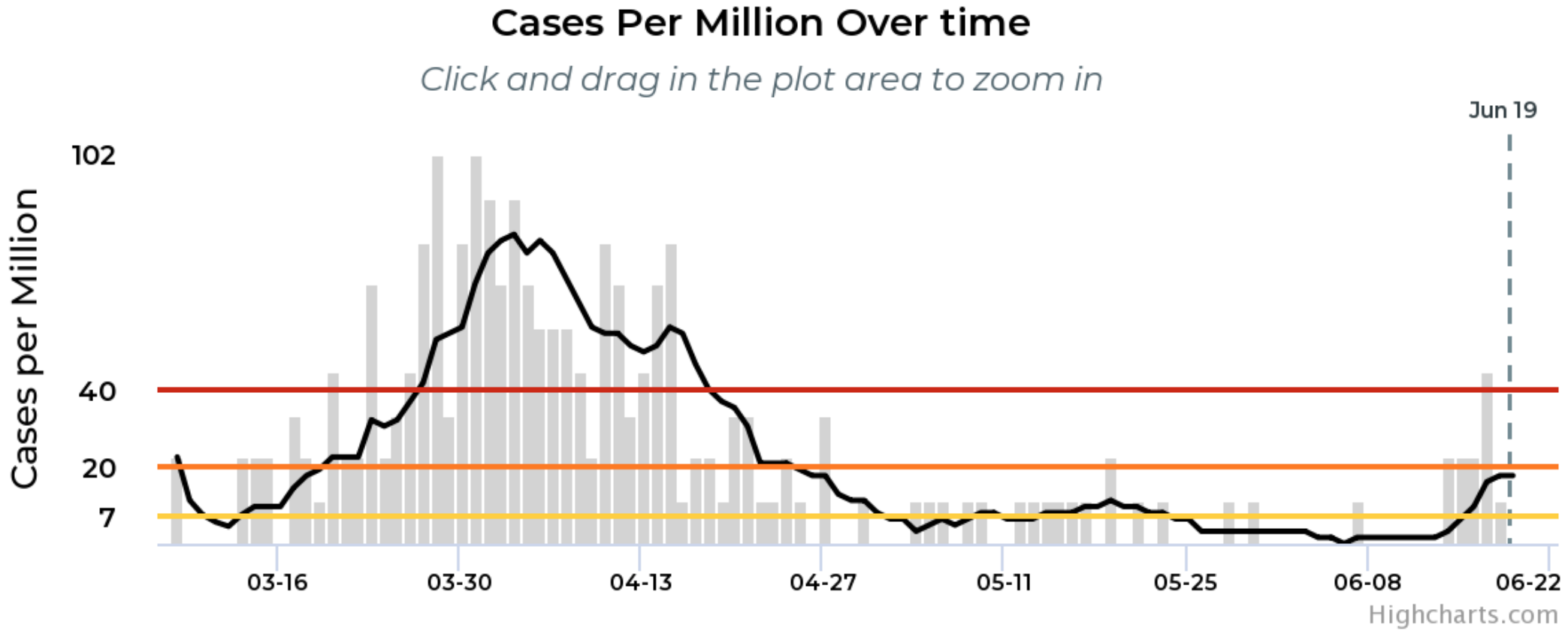
DATE: 2020-06-20	MERC Region Number	Public Health Region	Absolute cases (per million)	Case trend	3-day surge	Absolute deaths (per million)	Death trend	Average percent positivity	Positivity trend	Tests per million
Detroit	1	2N + 2S	11.5	Increase - 1wk	No	0.6	Decrease - 9wk	2.3	Daily Avg < 3%	1147.4
Grand Rapids	2	6	21.5	Increase - 1wk	No	0.8	<20 wkly deaths	3.4	Decrease - 4wk	1331.0
Kalamazoo	3	5	14.3	Decrease - 1wk	No	0.7	<20 wkly deaths	2.9	Daily Avg < 3%	1140.9
Saginaw	4	3	9.1	Decrease - 2wk	No	0.7	<20 wkly deaths	2.9	Daily Avg < 3%	1127.9
Lansing	5	1	9.0	Decrease - 4wk *	No	0.2	<20 wkly deaths	1.4	Daily Avg < 3%	1138.4
Traverse City	6	7	4.2	Decrease - 1wk *	No	0.3	<20 wkly deaths	0.8	Daily Avg < 3%	707.1
Jackson	7	1	2.4	Decrease - 8wk *	No	0.0	<20 wkly deaths	0.6	Daily Avg < 3%	1182.1
Upper Peninsula	8	8	2.4	Increase – 1wk *	No	0.0	<20 wkly deaths	0.3	Daily Avg < 3%	1064.6

Note: data excludes MDOC

PUBLIC HEALTH

Obtained via MI FOIA by Judicial Watch, Inc.

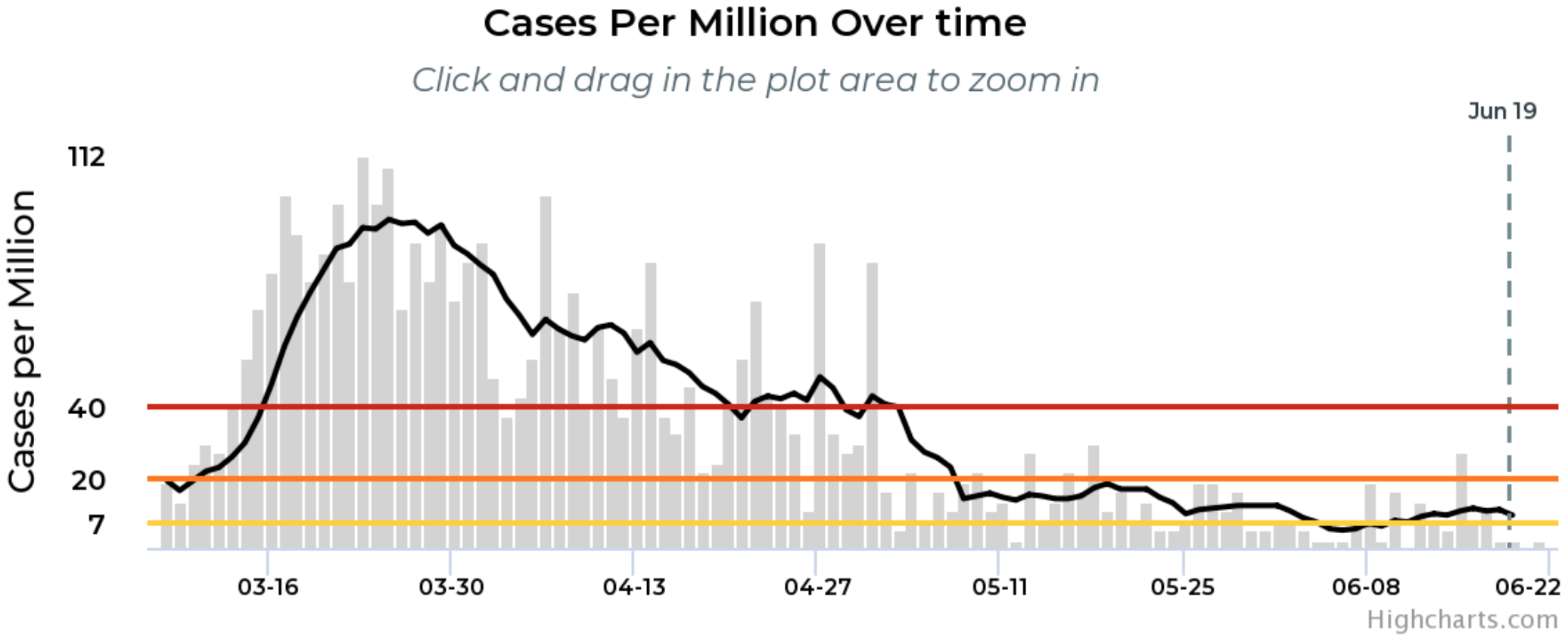
Detroit Region - Lapeer



PUBLIC HEALTH

Obtained via MI FOIA by Judicial Watch, Inc.

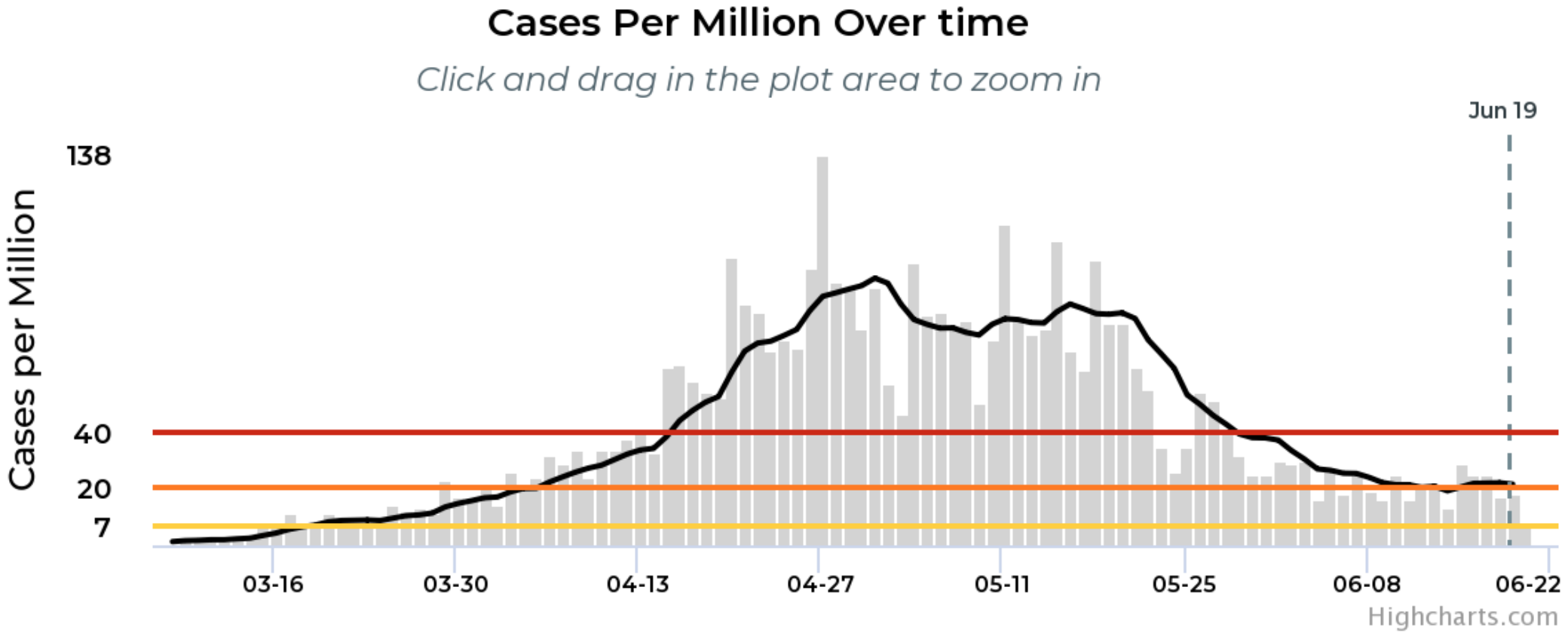
Detroit Region - Washtenaw



PUBLIC HEALTH

Obtained via MI FOIA by Judicial Watch, Inc.

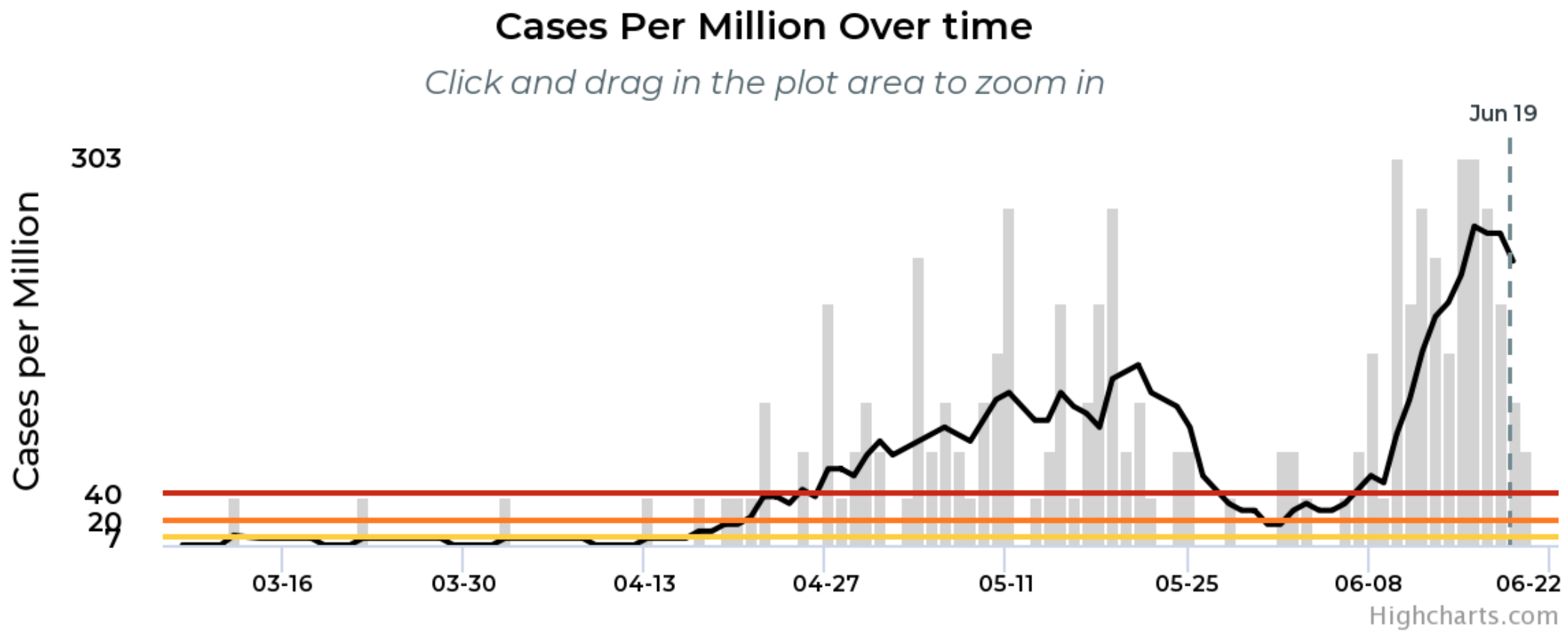
Grand Rapids Region - Overall



PUBLIC HEALTH

Obtained via MI FOIA by Judicial Watch, Inc.

Grand Rapids Region - Oceana



PUBLIC HEALTH

Obtained via MI FOIA by Judicial Watch, Inc.

Potential schedule for phase changes – **IF indicators continue to improve and meet requirements**

	June 15 to 21	June 22 to 28	June 29 - July 5	July 6 – July 12
Group 1: Traverse City UP	Moved to Low Risk **Requirements:** 1. No increases 2. <7 cases/million			
Group 2: Lansing Jackson Saginaw		**June 26:** **Review requirements, no new outbreaks**	Best-case enter Low Risk **Requirements:** 1. No increases 2. <7 cases/million	
Group 3: Kalamazoo Grand Rapids Detroit	For continued monitoring			

PUBLIC HEALTH

Obtained via MI FOIA by Judicial Watch, Inc.

Epi and indicators

- Epi overview
- Latest indicators
- **State comparison**

Testing

Case investigation and tracing

Appendix

Obtained via MI FOIA by Judicial Watch, Inc.

Comparison across states as they begin re-opening

What we see today:

Several states have seen spikes in case counts and hospitalizations in the past week

Other states continue on a downward trend of case counts and hospitalizations

What we plan to track going forward:

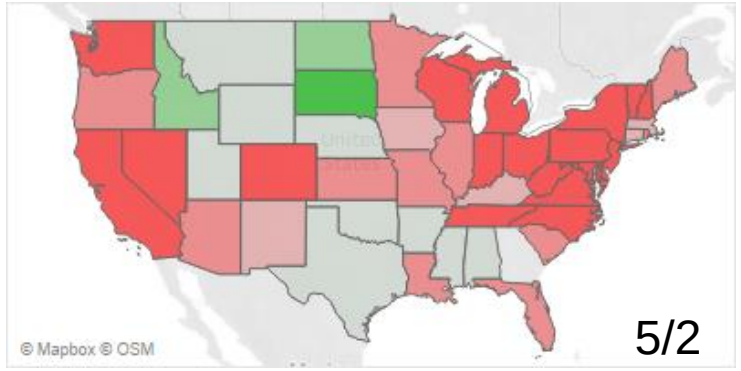
How changes in restrictions correlates with social distancing as well as new cases

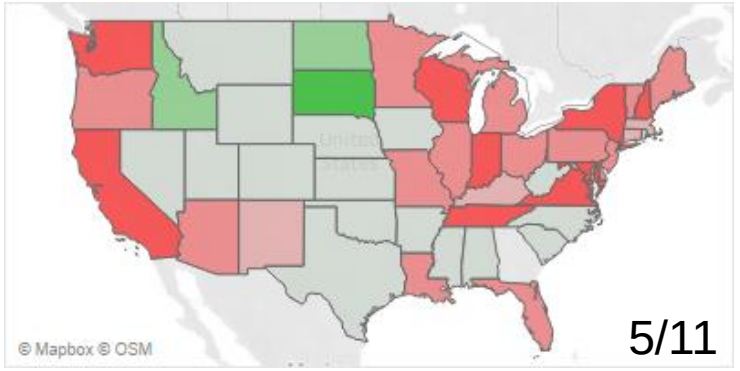
States' population-relative testing volume and positive percentage rates

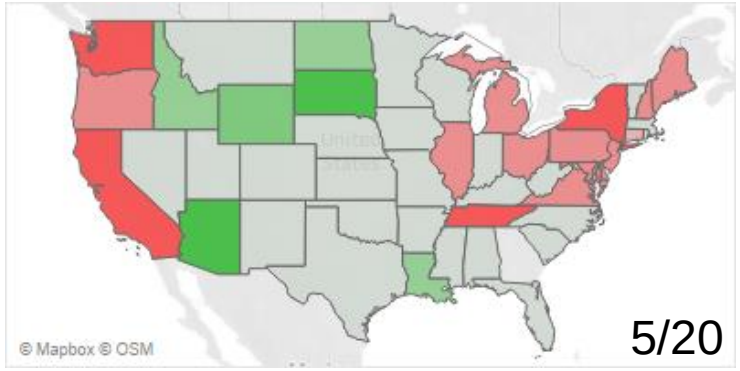
MICHIGAN MEDICINE

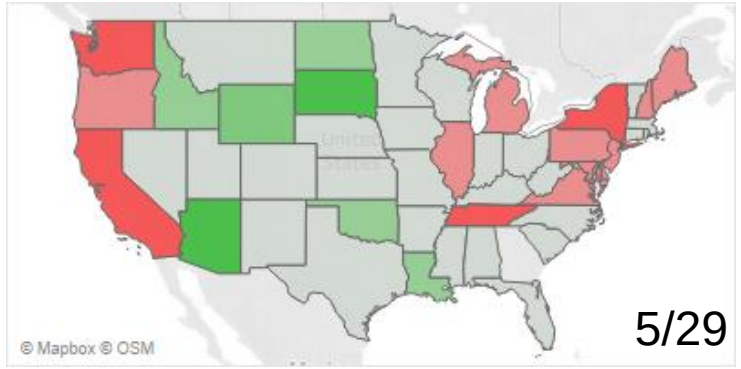
Obtained via MI FOIA by Judicial Watch, Inc.

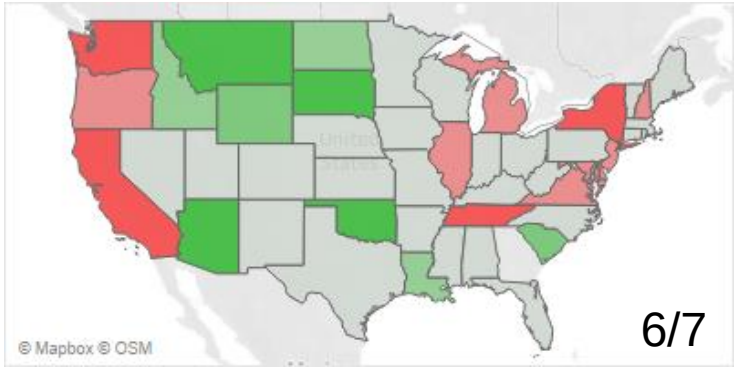
Over Time the Number of States Relaxing Restrictions is Increasing

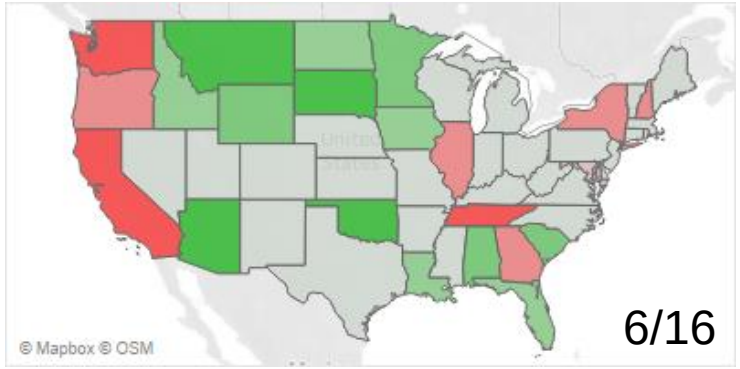












Less interventions

More interventions

Source data for interventions: The Institute for Health Metrics and Evaluation data and classification based on the New Zealand Government 4-level alert system. Score is calculated as interventions active on a date. Max score of 460 corresponds to red, reverse to green.

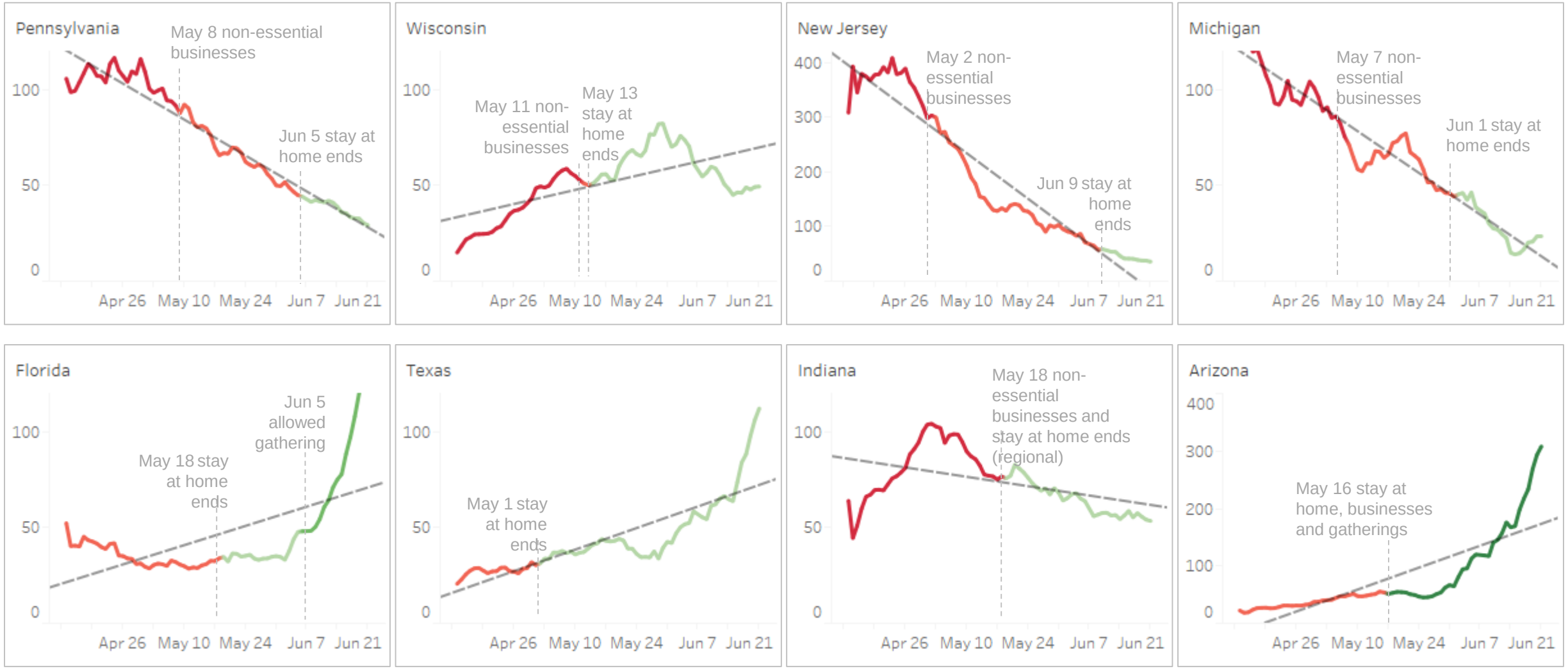
INTERVENTION	Score
Non-essential businesses ordered to close	70
Any business closures	100
Any gathering restrictions	70

INTERVENTION	Score
Educational facilities closed	50
People ordered to stay at home	120
Severe travel restrictions	50

MICHIGAN MEDICINE

Obtained via MI FOIA by Judicial Watch, Inc.

State Comparisons: 7 day avg. of daily new cases per 1M population



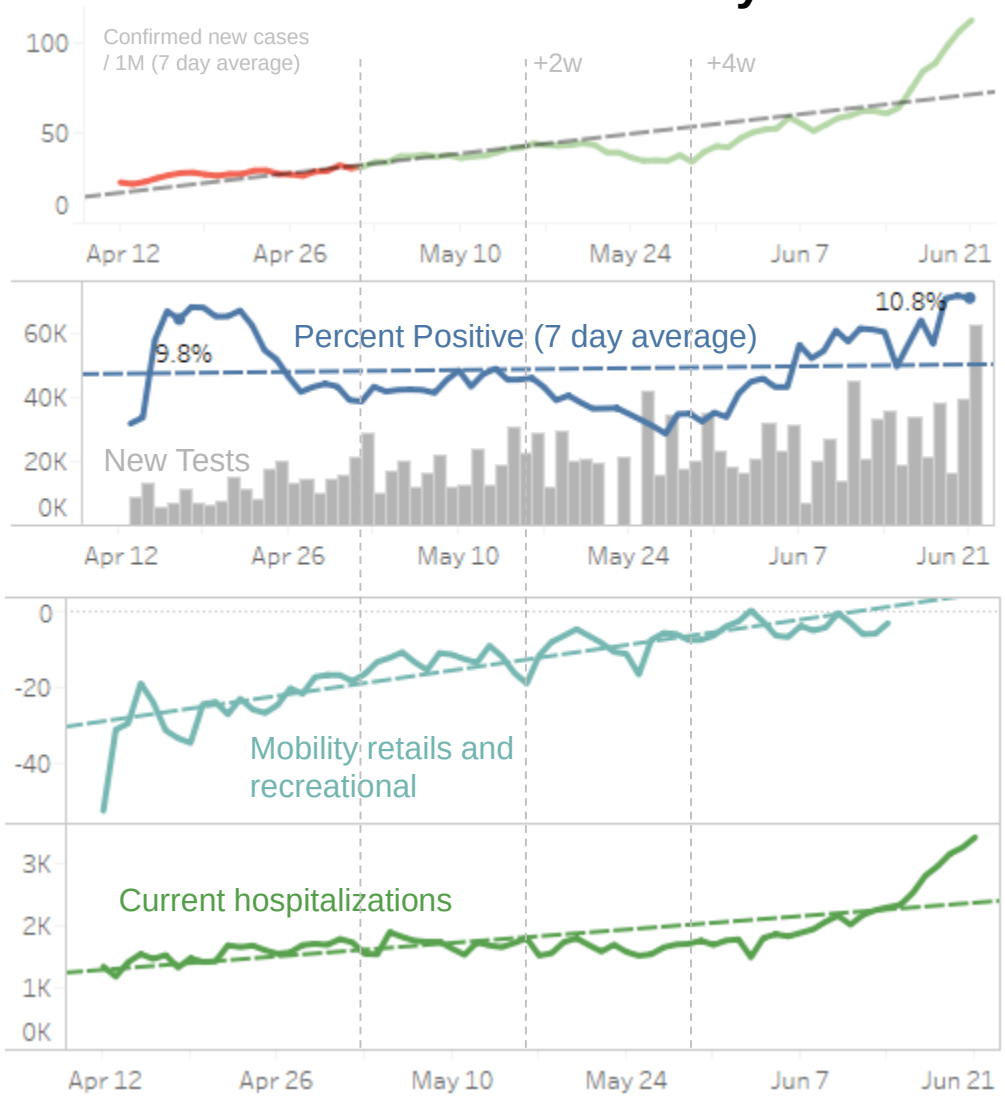
More interventions Less interventions

MICHIGAN MEDICINE

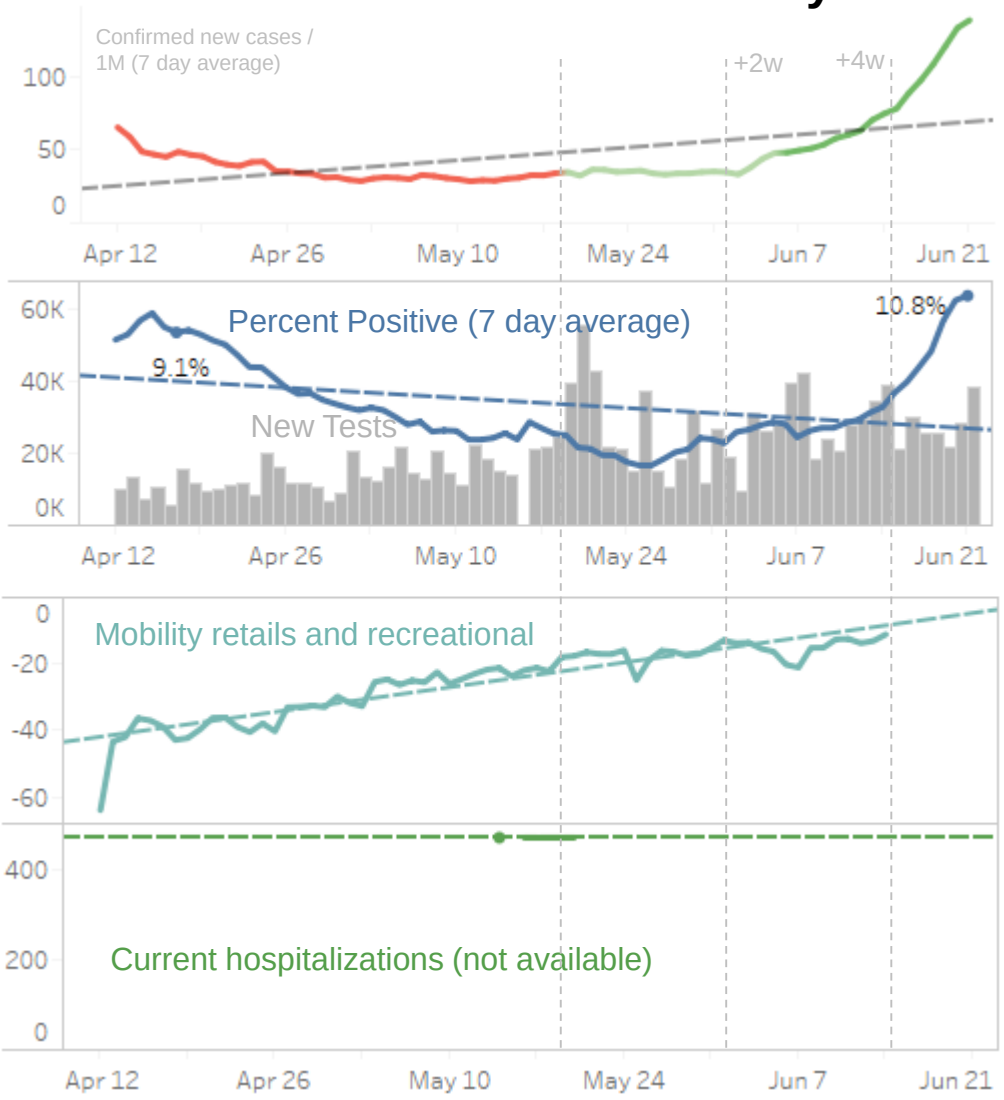
Obtained via MI FOIA by Judicial Watch, Inc.

Texas and Florida: Detailed examination

Texas: relaxed on May 1st



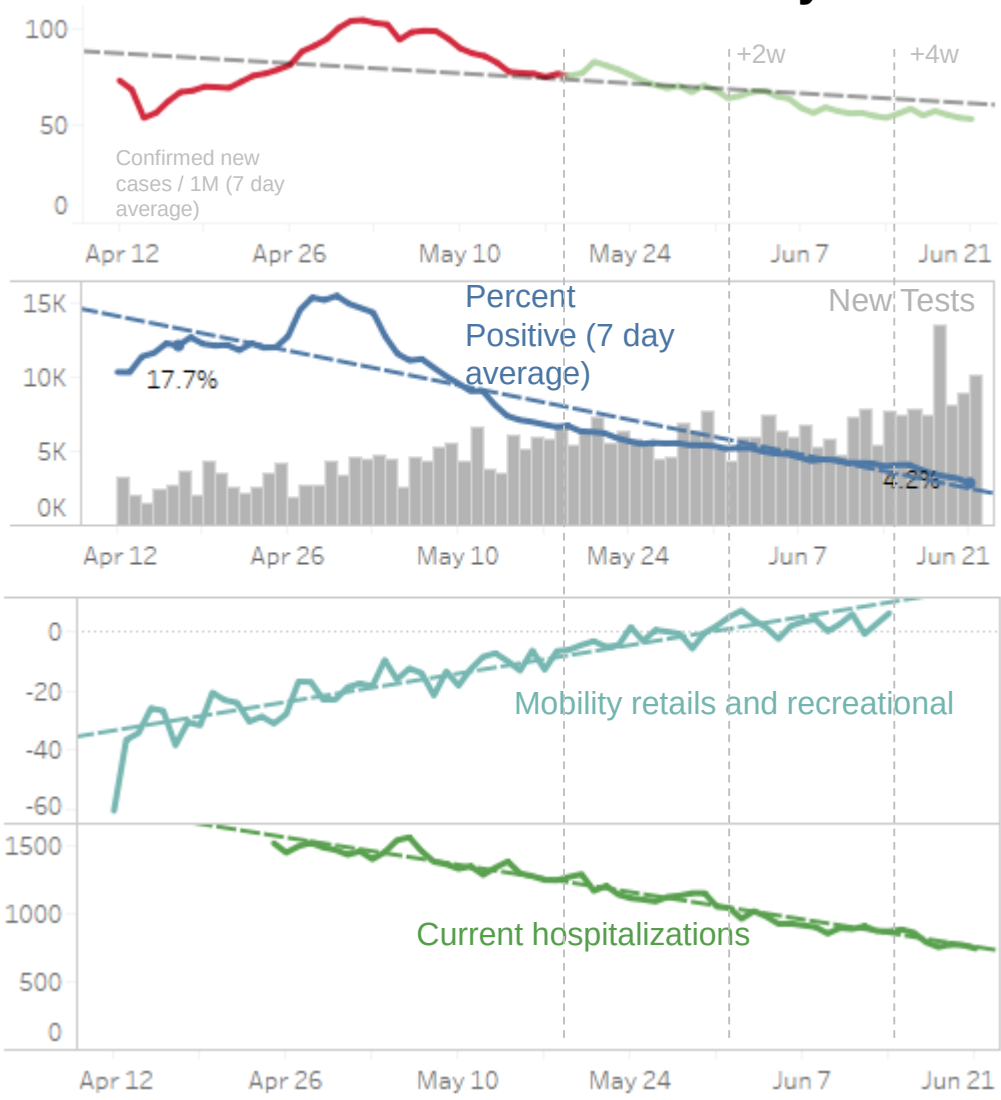
Florida: relaxed on May 4



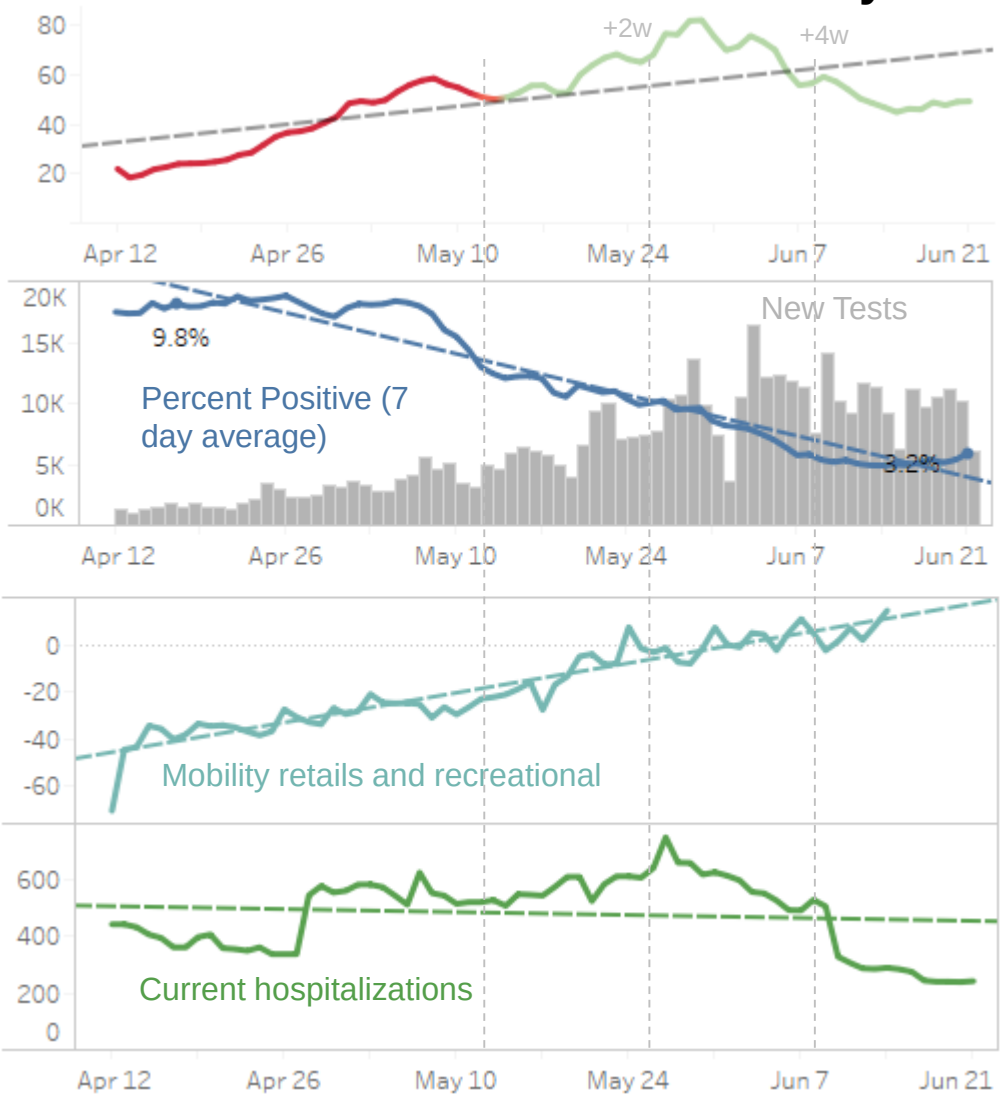
Obtained via MI FOIA by Judicial Watch, Inc.

Indiana and Wisconsin: Detailed examination

Indiana: relaxed on May 4th



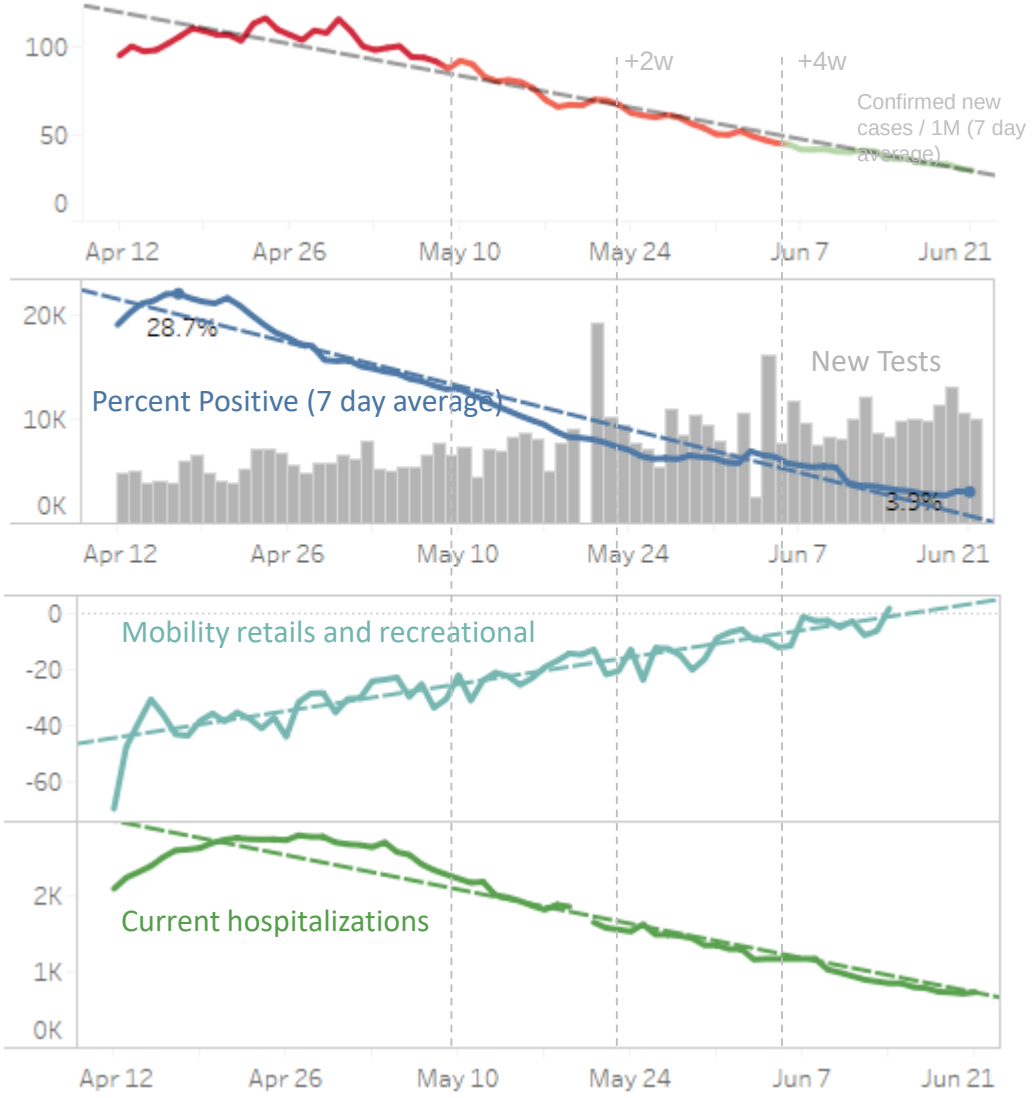
Wisconsin: Relaxed on May 11th



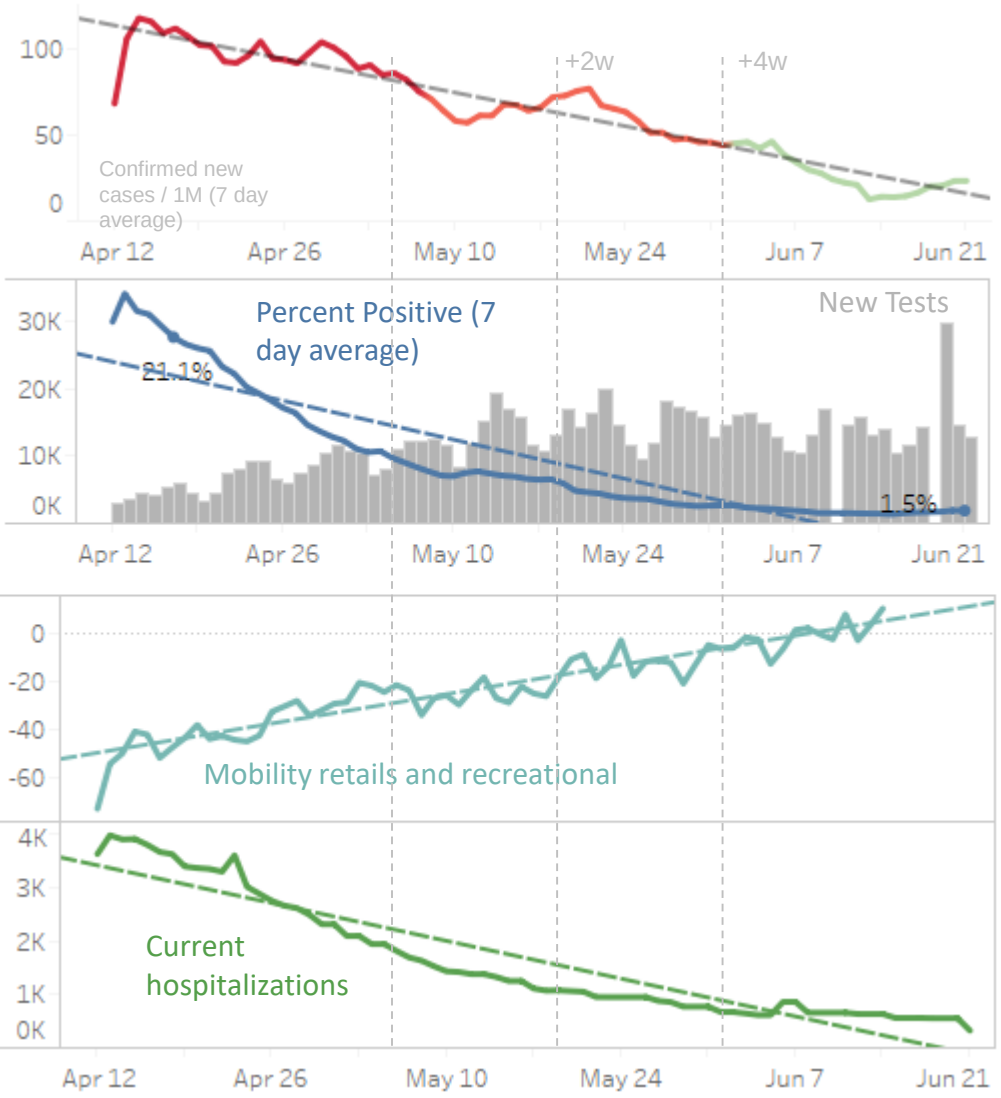
Obtained via MI FOIA by Judicial Watch, Inc.

Pennsylvania and Michigan: Detailed Examination

Pennsylvania: relaxed on May 8th



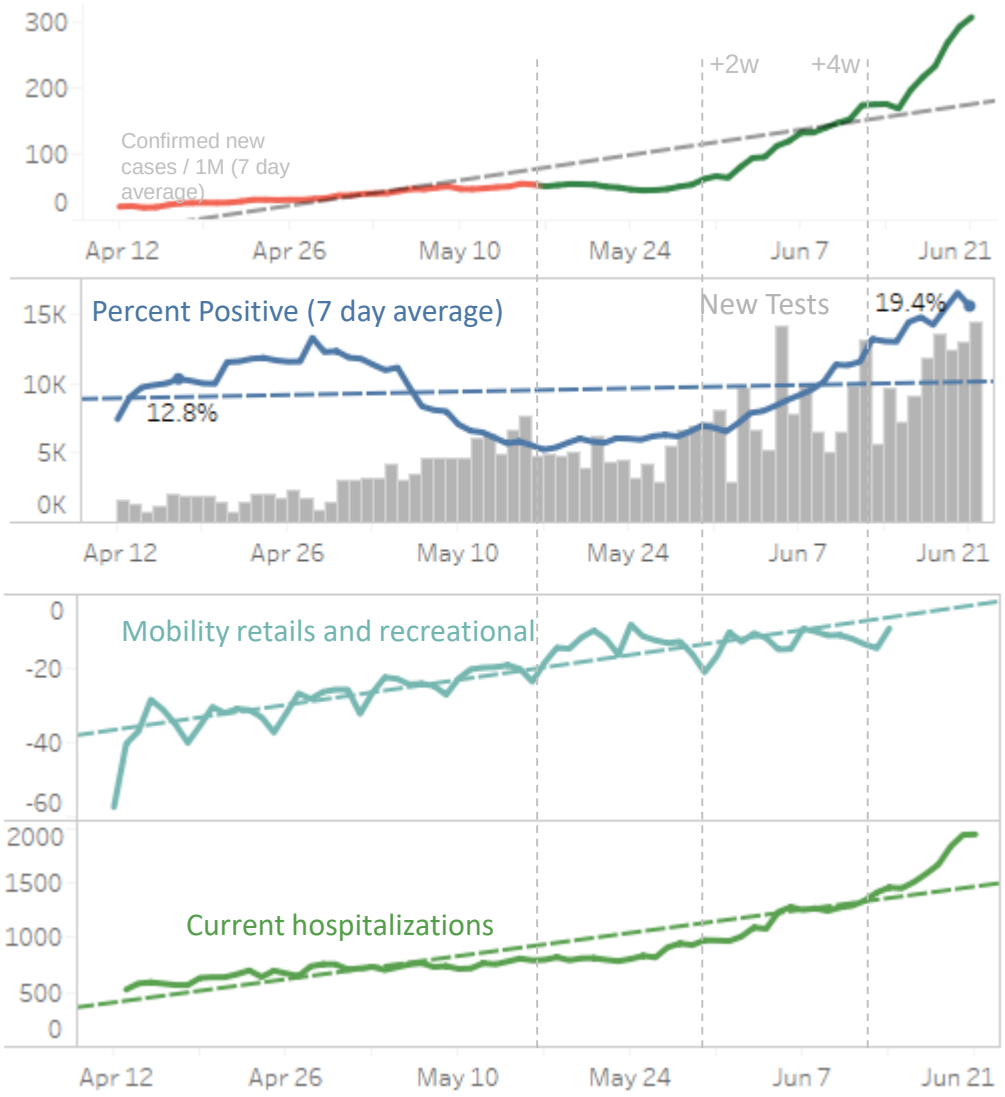
Michigan: Non-essential May 7th, Stay-at-home Jun 1st



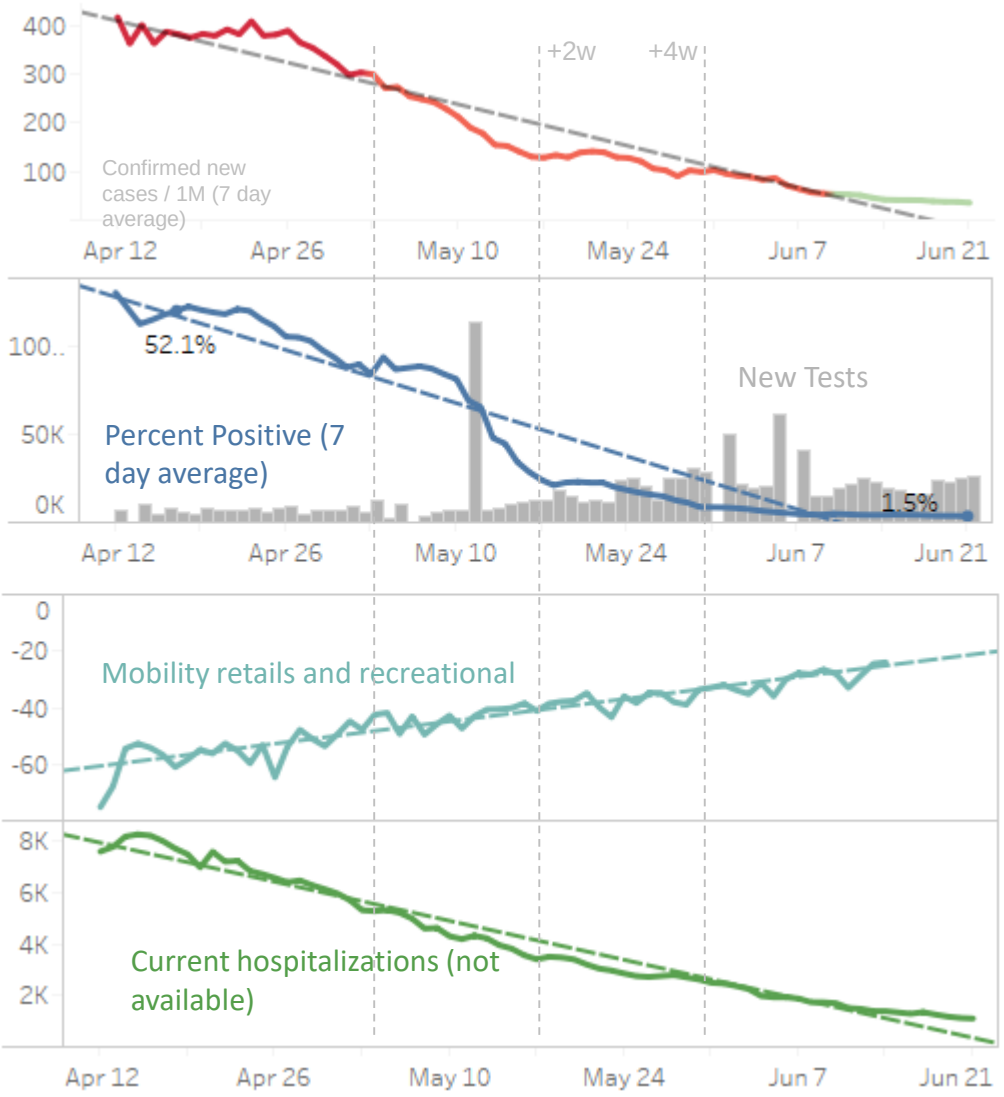
Obtained via MI FOIA by Judicial Watch, Inc.

Arizona and New Jersey: Detailed Examination

Arizona: relaxed all on May 16th



New Jersey: Non-essential May 2nd, Stay-at-home Jun 9th



Obtained via MI FOIA by Judicial Watch, Inc.

Observations/Learnings

Continue to monitor trends as states ease further restriction, with attention to the types of relaxation of restrictions and timing of any impact to measures.

Some States stayed on a declining trajectory after opening up:

- Pennsylvania, recent change, cases per 1M decrease, % positive decrease
- Indiana, lifted regionally right after peak, case per 1M decrease, % positive decrease
- Wisconsin, lifted before cases fell, case per 1M stable/decrease, % positive decrease, hospitalizations decrease
- New Jersey, recently lifted Stay at Home order with % positive well below 5%, cases per 1M decrease, % positive stable/decrease

Some bear watching due to trend:

- Texas, lifted early while cases rising, cases per 1M increase, % positive increase, hospitalizations increase
- Arizona, lifted before getting % positive below 5%, cases per 1M increase, % positive increase, hospitalizations increase
- Florida, regional approach, recent increase, cases per 1M increase, % positive increase

Obtained via MI FOIA by Judicial Watch, Inc.

Epi and indicators

Testing

Case investigation and tracing

Appendix

Obtained via MI FOIA by Judicial Watch, Inc.

Michigan testing capacity and utilization overview

Where Michigan is today

13,240

Daily samples tested
(average past 7 days)

2.3%

Percent positive
(average past 7 days)

19,000+

Daily ready-to-go lab capacity
(current reported)

Daily **PCR testing** numbers fell slightly in the past week, but continue to remain relatively **steady in recent weeks at around 13-14K/day** (13.2k average this week and 14.2K last week)

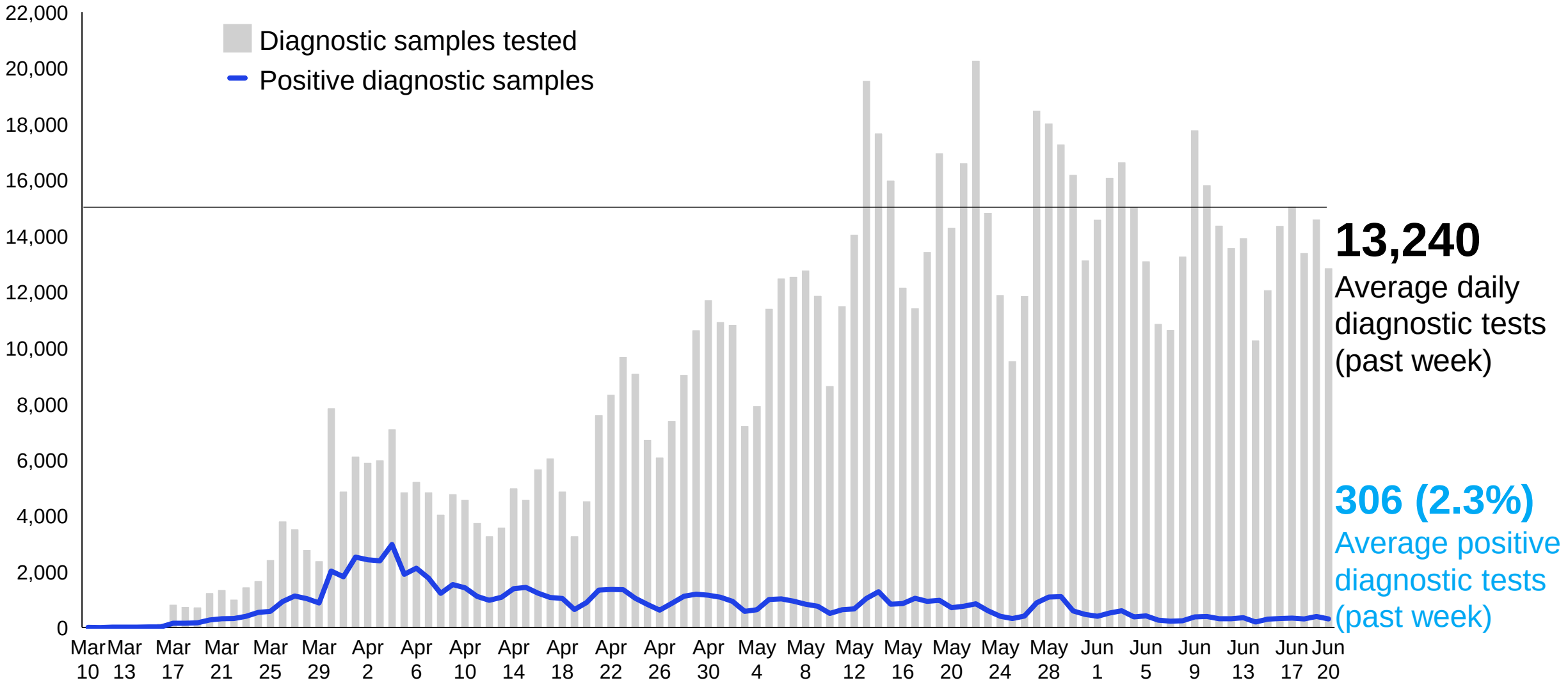
Labs are reporting ~19K daily ready-to-go-capacity, with additional ~15K non-commercial capacity available (but additional supplies needed); further commercial lab capacity available

Team is working to solve known constraints:

- Phase 1 community testing **walk-up sites opening doors** this week in Detroit and Flint
- Decision on **field testing contractor** to be finalized this week
- **LHD testing plans** have been submitted and consolidated; resources will be allocated this week
- National guard continuing to support **temporary pop-up testing and testing of vulnerable populations** in residential facilities
- Soft start this week for **211 testing site navigation hotline and scheduling services**
- Identified **new source** of inexpensive swabs and viral transport media to be purchased; Continuing to develop **alternative supply chain** solutions for viral transport media

Daily diagnostic tests and positive diagnostic tests, by message date

Obtained via MIFOIA by Judicial Watch, Inc.



Source: MDSS/Michigan Medical Advantage Group, MDHHS, testing labs

Obtained via MI FOIA by Judicial Watch, Inc.

Daily tests

State	Avg. daily tests
1. California	73.9K
2. New York	65.8K
3. Texas	32.9K
4. Florida	27.2K
5. Illinois	24.3K
6. New Jersey	21.1K
7. North Carolina	16.9K
8. Louisiana	14.5K
9. Ohio	13.9K
10. Michigan	13.2K
11. Minnesota	12.4K
12. Arizona	11.7K
13. Virginia	11K
14. Pennsylvania	10.6K
15. Georgia	10.5K
16. Tennessee	10.1K
17. Wisconsin	9.3K
18. Indiana	9.1K
19. Massachusetts	8.7K
20. South Carolina	7.8K
21. Maryland	7.7K
22. Alabama	6.7K
23. Connecticut	6.6K
24. Arkansas	6.5K
25. Missouri	5.7K
26. Oregon	5.2K
27. New Mexico	4.9K
28. Colorado	4.8K

Daily tests / M

State	Avg. daily tests / M
1. New York	3.4K
2. Louisiana	3.1K
3. Rhode Island	3.1K
4. District of Columbia	3.0K
5. Alaska	2.8K
6. New Jersey	2.4K
7. New Mexico	2.3K
8. Minnesota	2.2K
9. Arkansas	2.1K
10. Delaware	1.9K
11. Illinois	1.9K
12. California	1.9K
13. Connecticut	1.9K
14. North Dakota	1.7K
15. North Carolina	1.6K
16. Arizona	1.6K
17. Wisconsin	1.6K
18. Vermont	1.6K
19. West Virginia	1.5K
20. Montana	1.5K
21. South Carolina	1.5K
22. Tennessee	1.5K
23. Iowa	1.5K
24. Nevada	1.4K
25. Alabama	1.4K
26. Indiana	1.3K
27. Nebraska	1.3K
28. Michigan	1.3K

Percent positive

State	% positive
1. Vermont	0.5%
2. Alaska	0.6%
3. New York	1.0%
4. Montana	1.0%
5. Hawaii	1.1%
6. West Virginia	1.3%
7. Connecticut	1.4%
8. Maine	1.5%
9. New Jersey	1.5%
10. District of Columbia	1.7%
11. Rhode Island	1.7%
12. North Dakota	2.2%
13. Michigan	2.3%
14. New Hampshire	2.3%
15. Massachusetts	2.4%
16. Illinois	2.6%
17. New Mexico	2.7%
18. Minnesota	2.8%
19. Louisiana	3.1%
20. Wisconsin	3.2%
21. Ohio	3.8%
22. Delaware	3.9%
23. Pennsylvania	3.9%
24. Colorado	3.9%
25. Indiana	4.0%
26. Oregon	4.3%
27. Virginia	4.5%
28. Mississippi	4.6%

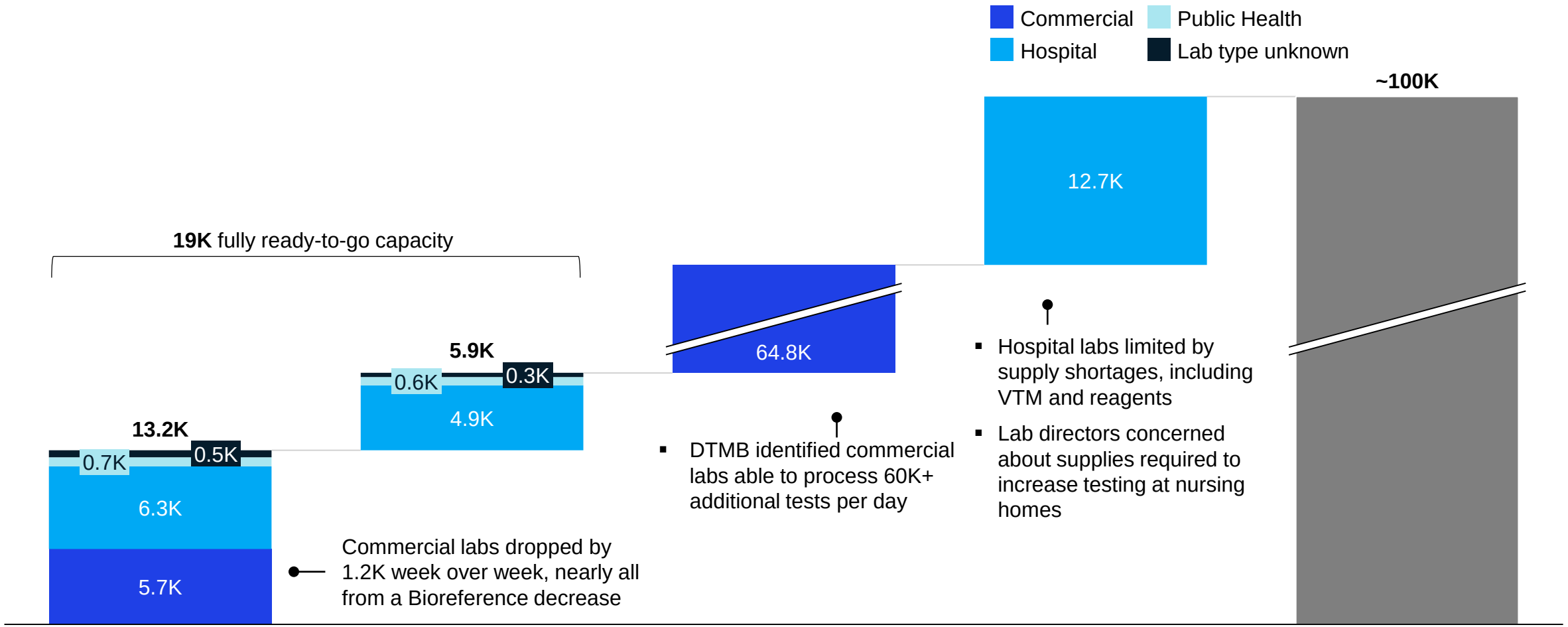
Averaged over June 14-June 20, 2020 (Michigan average uses most recent MAG data); Several states might display data errors from COVID Tracking Project; the website displays Michigan at 1.8% even though Michigan data shows 2.3%

SOURCE: Numerical Data – MDSS, COVID Tracking Project, U.S. Census Bureau. Test Types – State websites

Obtained via MI FOIA by Judicial Watch, Inc.

Labs: Michigan daily capacity snapshot

Labs shown may have adjustments as capacity estimates are validated and new supply constraints arise



Sources:
1. MDSS/Michigan Medical Advantage Group, MDHHS for all lab types
2. Hospitals - lab director reported. Pub. Health, Commercial, Other - calculated as average tests conducted during top seven days of past thirty days
3. DTMB
4. Lab director reported

Obtained via MI FOIA by Judicial Watch, Inc.

Epi and indicators

Testing

Case investigation and tracing

Appendix

Obtained via MI FOIA by Judicial Watch, Inc.

Case investigation and contact tracing: Current state

	Case investigation and contact acquisition			Initial contact tracing		Ongoing contact monitoring		
Goal	**90% calls attempted** in one day	**75% calls completed** in one day	**50% with contacts** in one day	**90% calls attempted** in one day	**75% calls completed** in one day	Successful ongoing daily outreach	Low cases lost to follow-up	Contacts with symptoms identified
Performance	75%[1]	59%[2]	52%[3]	91%[4]	69%[5]	54%[6]	5%[7]	4.6%[8]
Trend since last week								

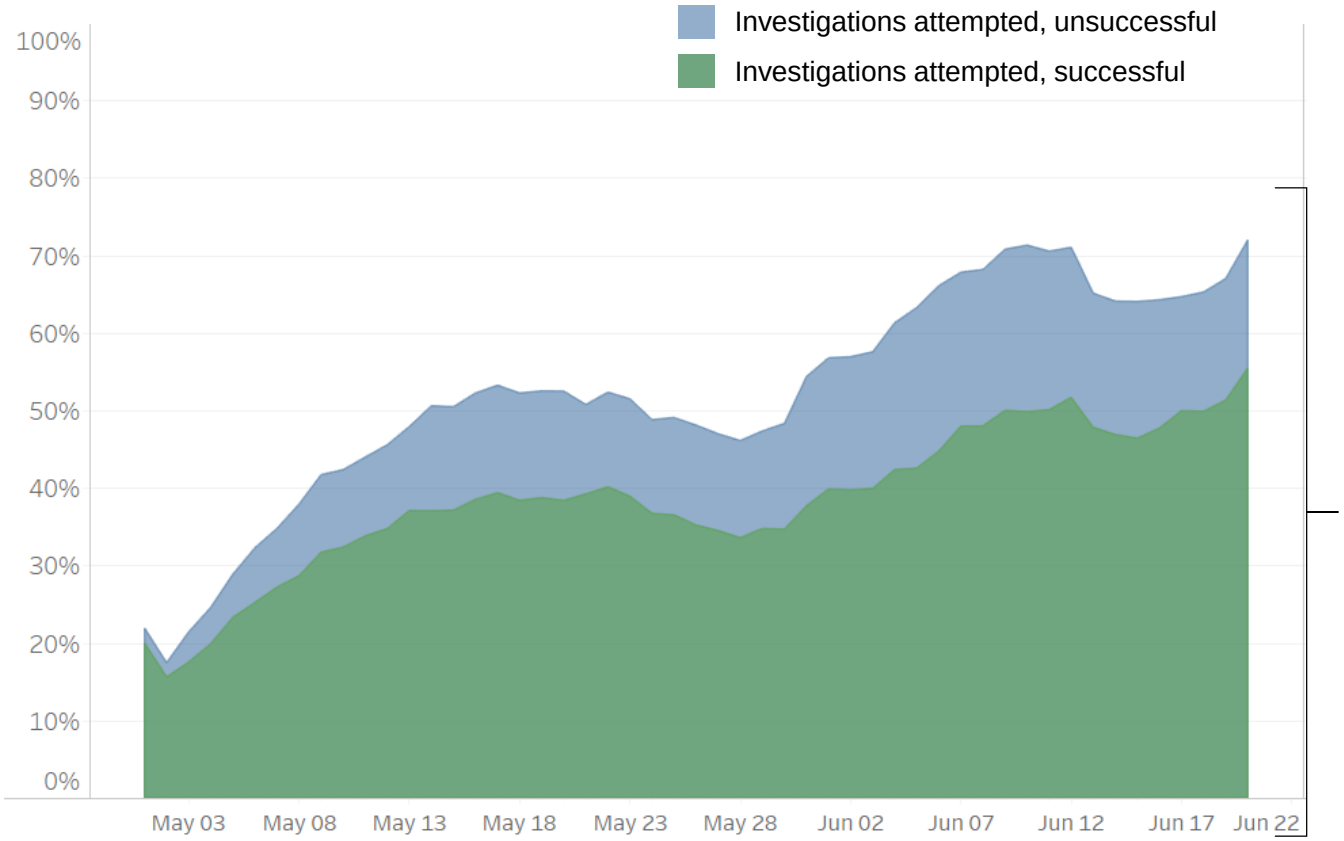
1. % of cases documented as "attempted" within one day; 2 % of cases documented as "successful" within one day; 3 % of cases with at least one contact documented within one day; 4 Weighted average of % of cases documented as "attempted" within one day in OMS, LHD survey, and Traceforce; 5 Weighted average of % of cases documented as "successful" within one day in OMS and Traceforce; 6 Traceforce only - % of non-first day contacts reached; 7 Traceforce only - % of contacts lost to follow-up (lost / total); 8 Traceforce only - Of contacts reached, % later reporting symptoms;

Source: MDSS and OMS summary statistics, 6/13. Traceforce summary statistics, 6/13. LHD Sitrep survey.

Obtained via MI FOIA by Judicial Watch, Inc.

Case Investigation: Performance within 24 hours

% of cases investigated within 24 hours, seven day rolling average



Investigations attempted within one day

In past week, LHDs maintained recent case investigation improvements

Select large departments have not continued improving, which has caused the state to plateau

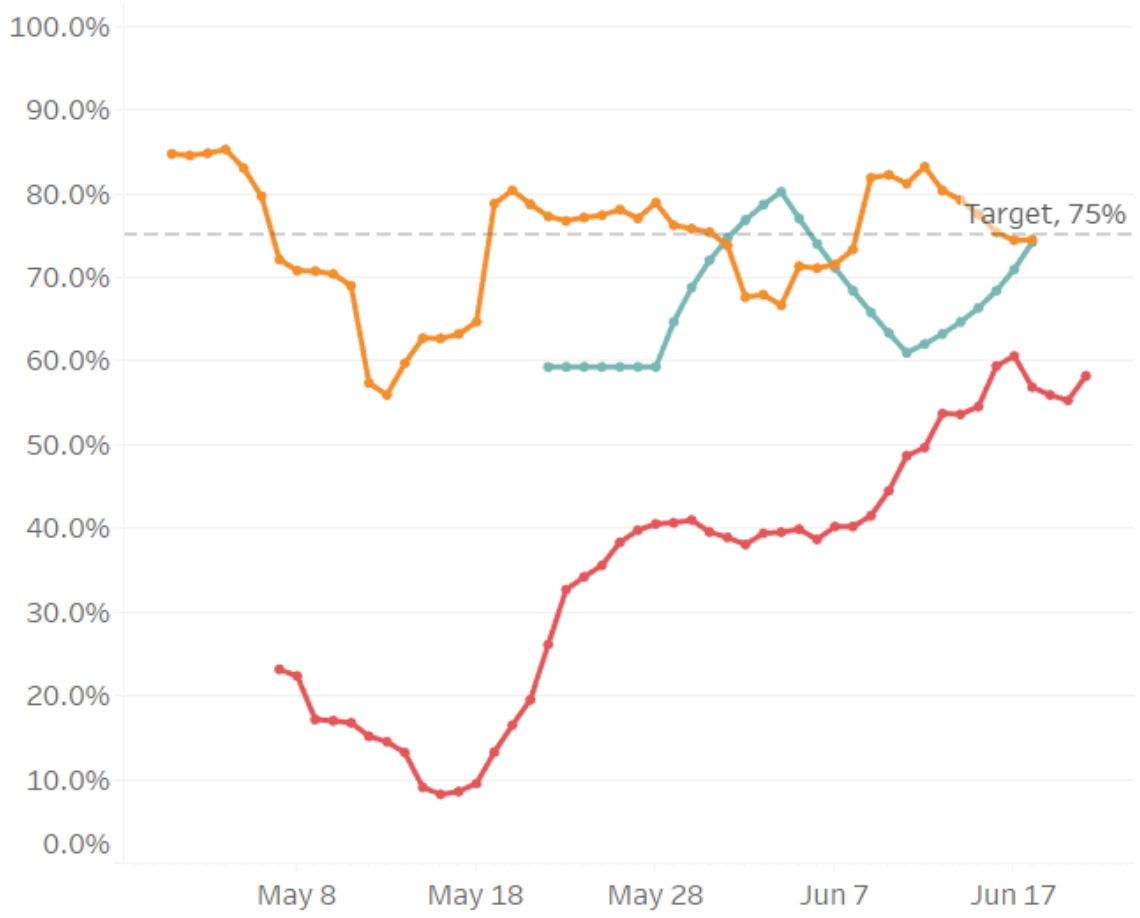
The workgroup is attempting to determine why this outreach has plateaued, as departments have indicated that capacity is not the issue

Source: MDSS summary statistics, 6/15

Obtained via MI FOIA by Judicial Watch, Inc.

Contact Tracing: Successful outreach within one day

Percent of contacts successfully reached within 24 hours (7 day rolling avg.)



LHD tracers, legacy system, ~20% of cases[1]

LHD tracers, homegrown system, ~40% of cases[3]

Central Contact Tracers, ~40% of cases[2]

- Central Tracers saw continued improvement over the past week, possibly due to new callback functionality
- The workgroup is focusing on launching department user roles to allow three pilot LHDs to use the system themselves

1. Excludes departments that indicated that they do not use OMS
2. State currently supports Detroit City, Wayne, Ionia, Ingham, Saginaw, Genesee, Delta-Menominee, Kalamazoo, and Van Buren-Cass.
3. Data obtained through weekly LHD SITREPs starting on 5/28; only contains a weekly average

Source: MDSS and OMS summary statistics. Traceforce summary statistics, LHD SITREP. % of cases represents recent cases.

Obtained via MI FOIA by Judicial Watch, Inc.

Epi and indicators

Testing

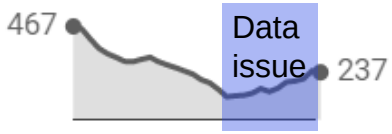
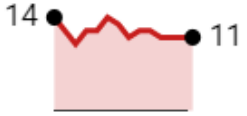
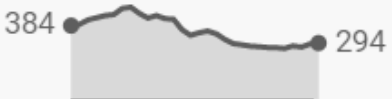
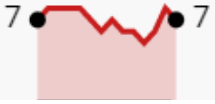
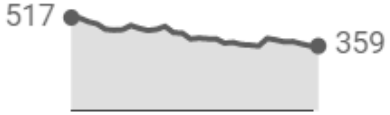
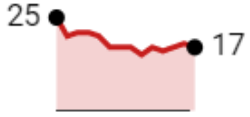
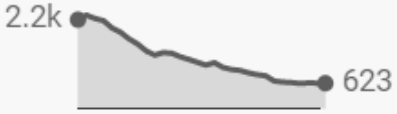
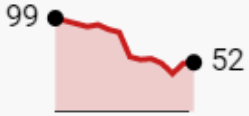
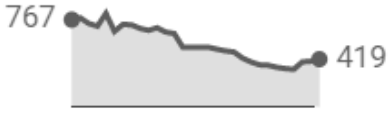
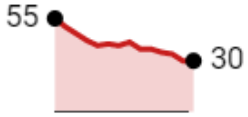
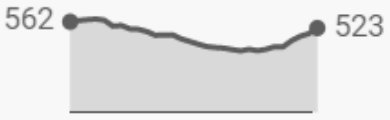
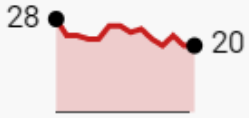
Case investigation and tracing

Appendix

State-by-state comparison

Obtained via MI FOIA by Judicial Watch, Inc.

Approximate date of re-open

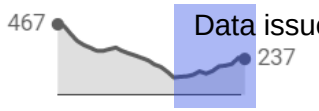
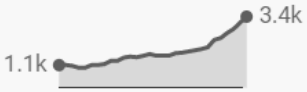
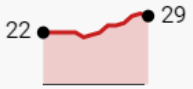
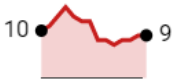
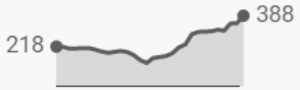
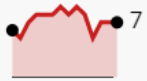
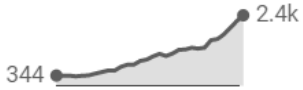
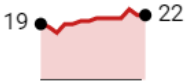
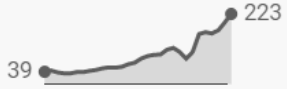
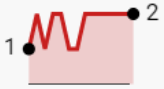
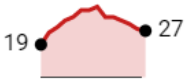
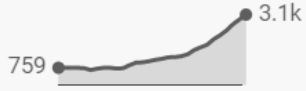
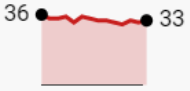
STATE	14-DAY CHANGE IN COVID+	TOTAL COVID+	LAST 30 DAYS OF COVID+ (ROLLING)	RT RANGE (90% CI)	DOUBLING TIME (DAYS)	LAST 14 DAYS OF DEATHS (ROLLING)	INFLUENZA-LIKE ILLNESS
Michigan	28%	67,711		0.9 - 1.3	196		Minimal *Level 1*
Wisconsin	-17%	24,819		0.7 - 1.1	56		Minimal *Level 1*
Indiana	-10%	42,423		0.6 - 1.0	79		Minimal *Level 1*
Illinois	-45%	137,762		0.6 - 0.9	151		Minimal *Level 1*
Pennsylvania	-20%	81,730		0.6 - 1.0	133		Minimal *Level 1*
Ohio	28%	44,808		0.7 - 1.1	57		Minimal *Level 1*

SOURCE: covidexitstrategy.org; COVID+ means COVID cases, but could vary based on state reporting whether it includes probable cases or not. Michigan cases include probable cases. Re-open dates gathered from New York Times (refer to Stay-At-Home lifted)

State-by-state comparison

Obtained via MI FOIA by Judicial Watch, Inc.

Approximate date of re-open

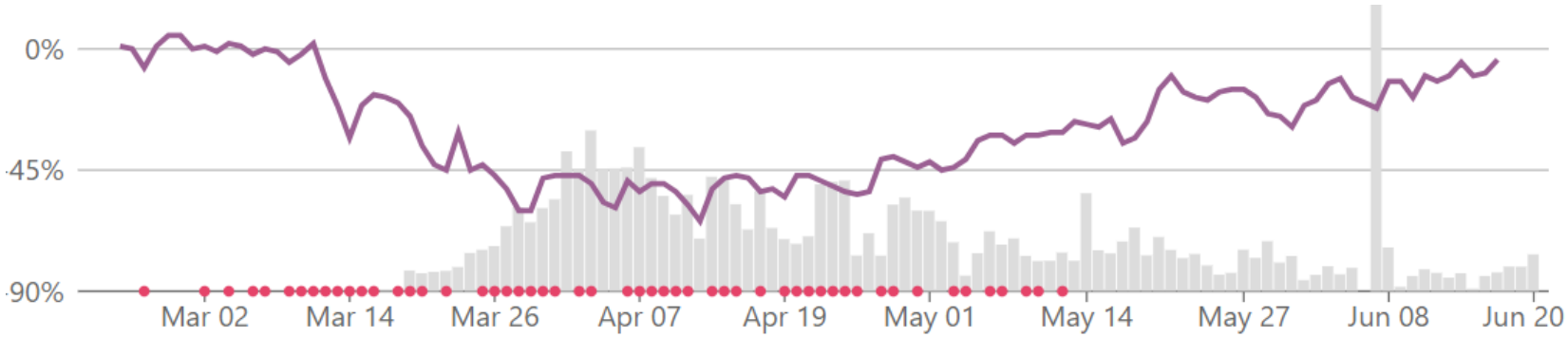
STATE	14-DAY CHANGE IN COVID+	TOTAL COVID+	LAST 30 DAYS OF COVID+ (ROLLING)	RT RANGE (90% CI)	DOUBLING TIME (DAYS)	LAST 14 DAYS OF DEATHS (ROLLING)
Michigan	28%	67,711	 Data issue	0.9 - 1.3	196	 Minimal *Level 1*
Texas	121%	111,601		0.9 - 1.4	20	 Minimal *Level 1*
Alabama	72%	30,021		0.8 - 1.2	31	 Minimal *Level 1*
Washington	141%	28,255		0.8 - 1.1	48	 Minimal *Level 1*
Arizona	121%	52,390		1.0 - 1.5	13	 Minimal *Level 1*
Oregon	152%	6,937		1.2 - 1.7	19	 Minimal *Level 1*
Georgia	26%	63,809		0.9 - 1.3	48	 Minimal *Level 1*
Florida	169%	97,291		1.1 - 1.6	19	 Minimal *Level 1*

SOURCE: covidexitstrategy.org; COVID+ means COVID cases, but could vary based on state reporting whether it includes probable cases or not. Michigan cases include probable cases. Re-open dates gathered from New York Times (refer to Stay-At-Home lifted). Oregon paused re-open policies on 6/12.

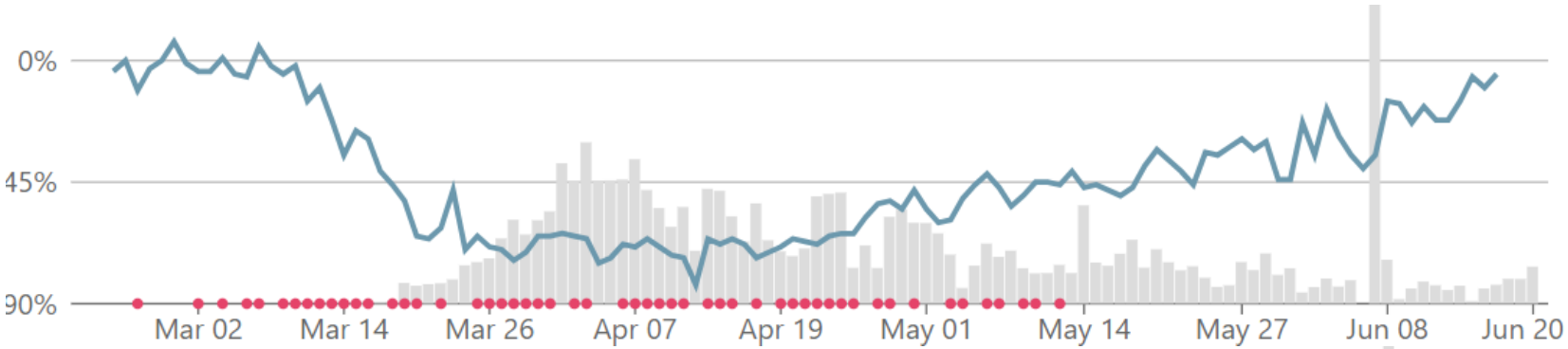
Obtained via MI FOIA by Judicial Watch Inc.

- Metrics indicate social distancing fatigue has been setting in since late April.
- These average mobility and non-essential visits have increased, but encounter density has plateaued.

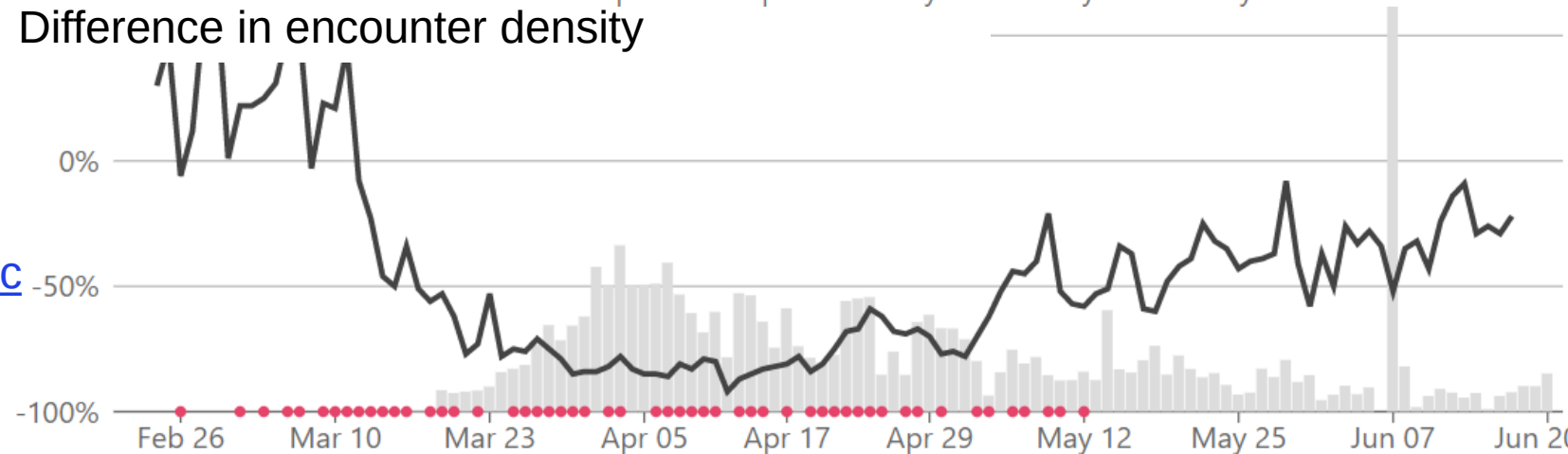
Change in average mobility



Change in non-essential visits



Difference in encounter density



PUBLIC HEALTH

unacast social distancing scoreboard https://www.unacast.com/covid19/social-distancing-scoreboard

Obtained via MI FOIA by Judicial Watch, Inc.

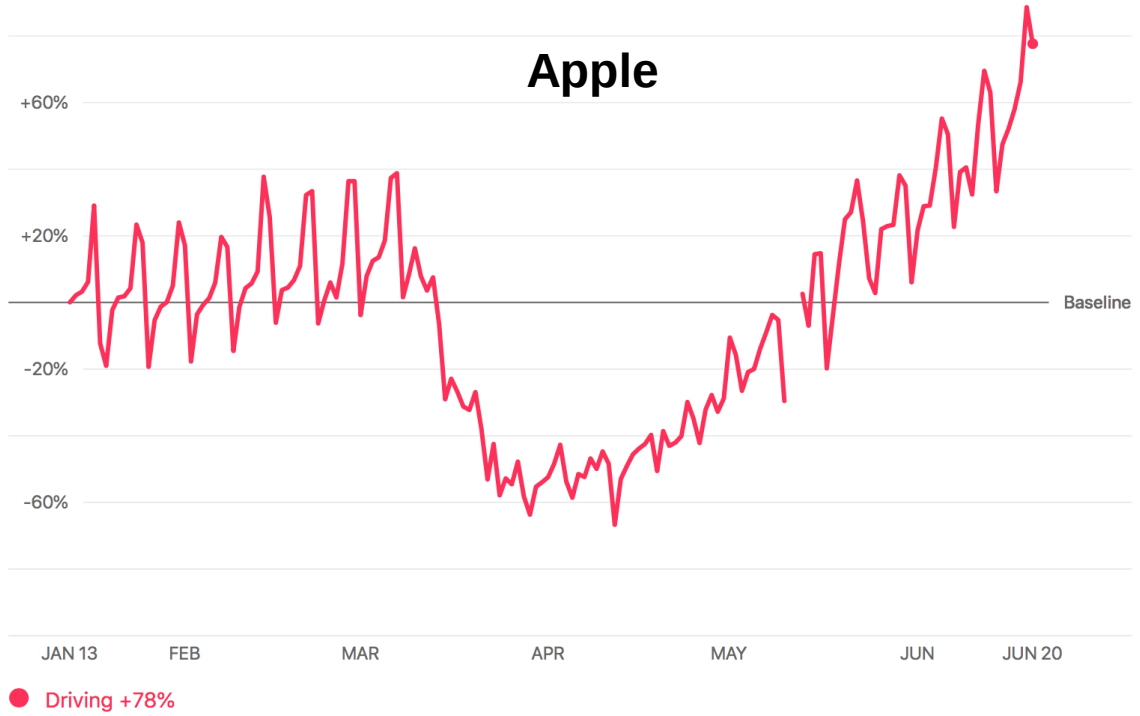
Similar increases in mobility seen in other data sources

Google – Retail & recreation

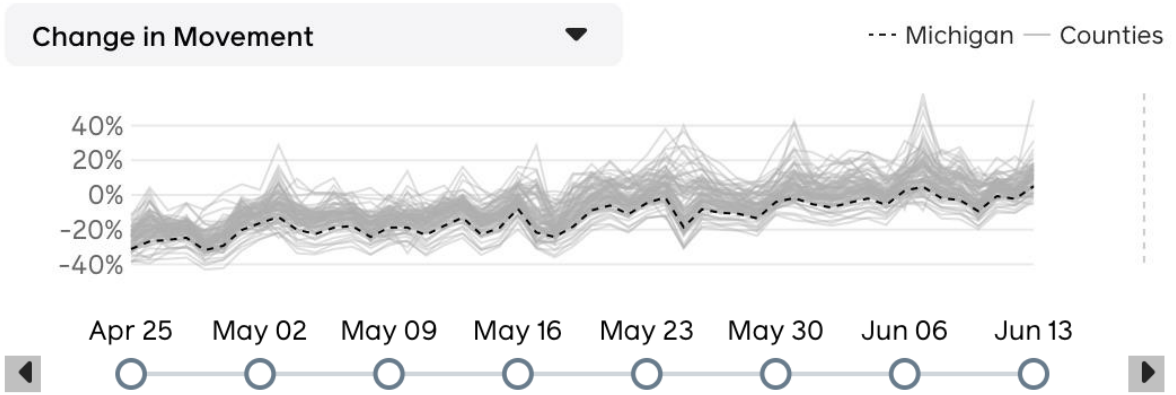


Retail & recreation	Grocery & pharmacy	Parks
-5%	+4%	+314%
compared to baseline	compared to baseline	compared to baseline

Apple

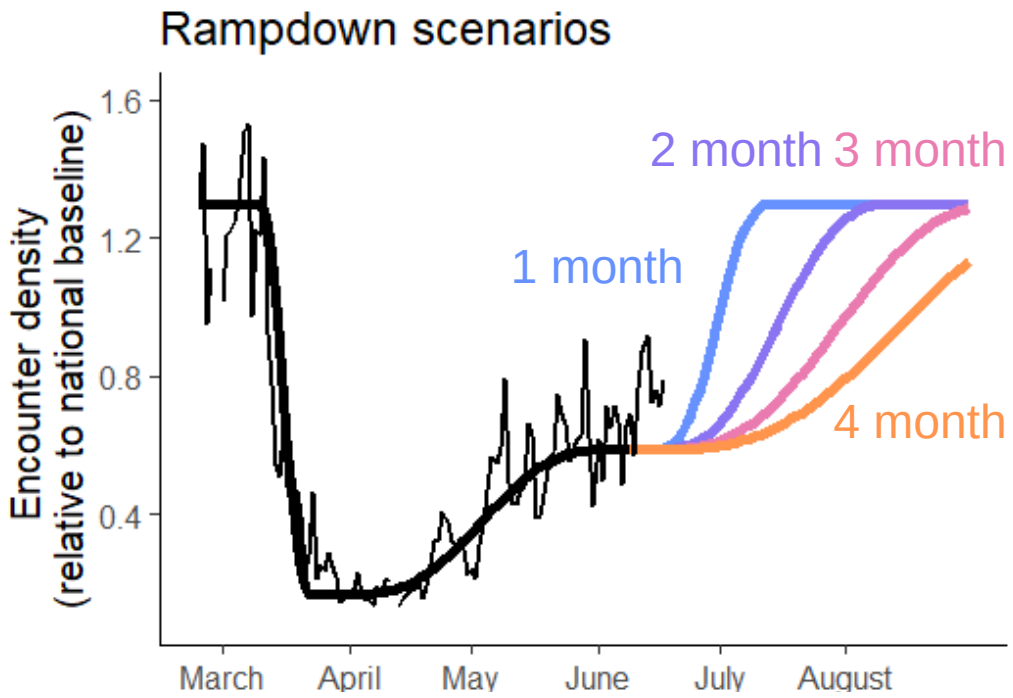


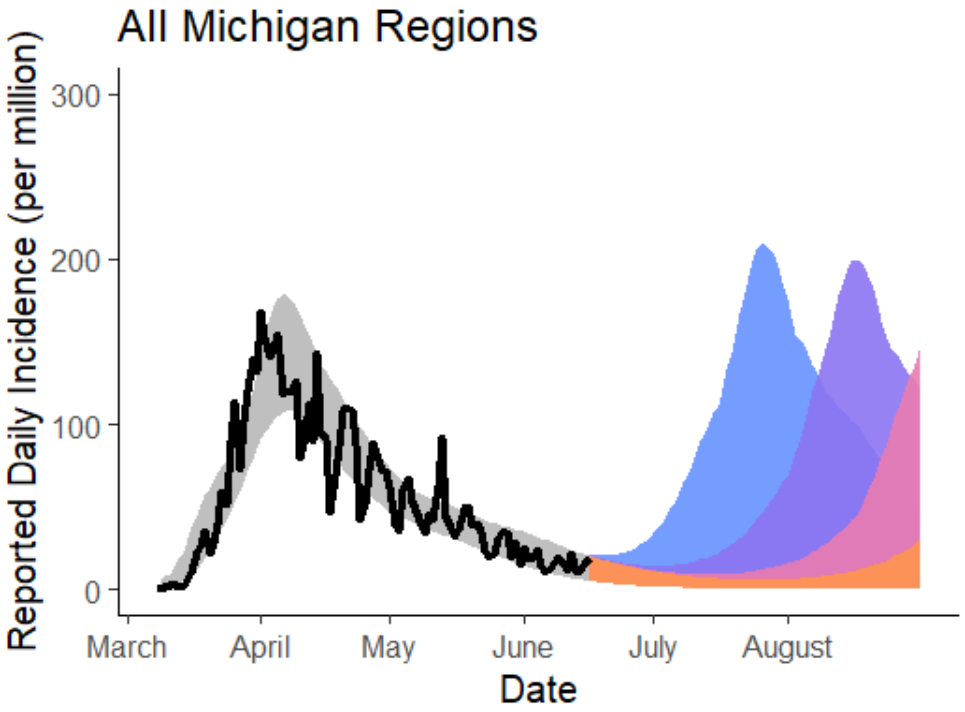
Facebook



Obtained via MI FOIA by Judicial Watch, Inc.

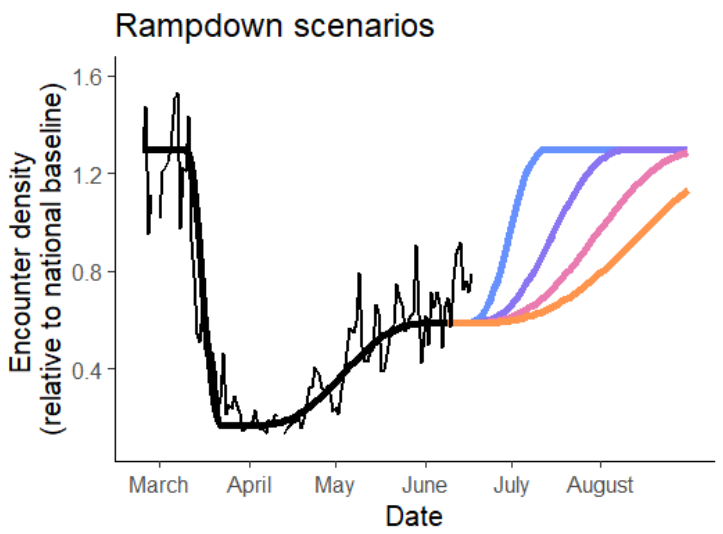
- We don't know how social distancing metrics correspond to effective contacts. We model 1,000 different scenarios to see which are the most consistent.
- Slowing of the decrease in reported cases is consistent with social distancing fatigue and reopening.
- New scenarios project range of outcomes with behavior change starting June 15.

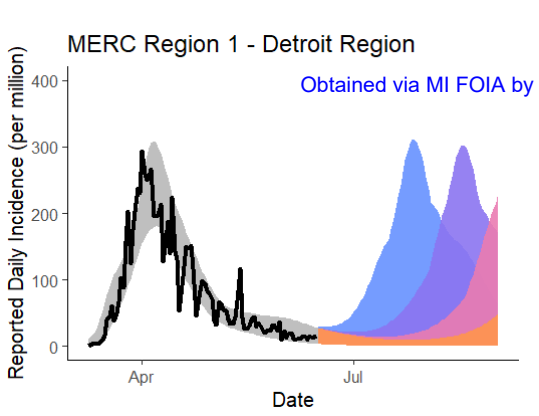




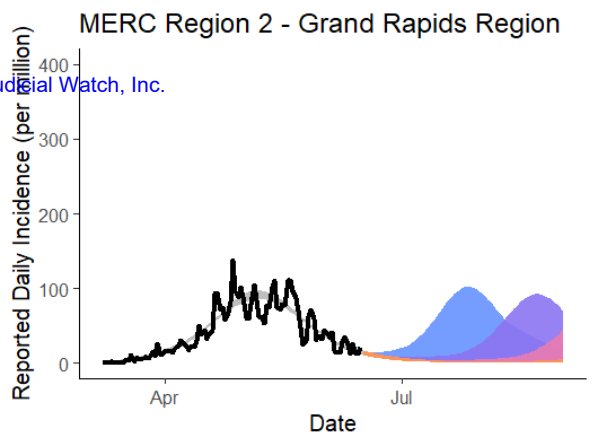
PUBLIC HEALTH

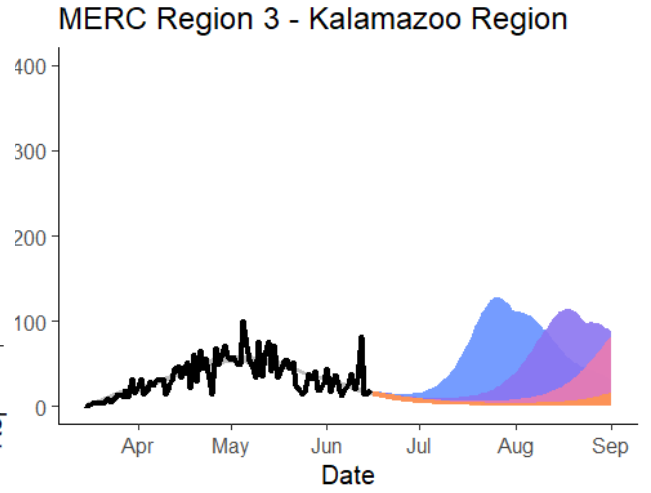
- We are showing scenarios rather than forecasts.
- We assume that the rampdown impacts both effective average number of contacts and the fraction of the population with no contacts.
- Uncertainty: top 10% of simulations.
- Excludes MDOC cases

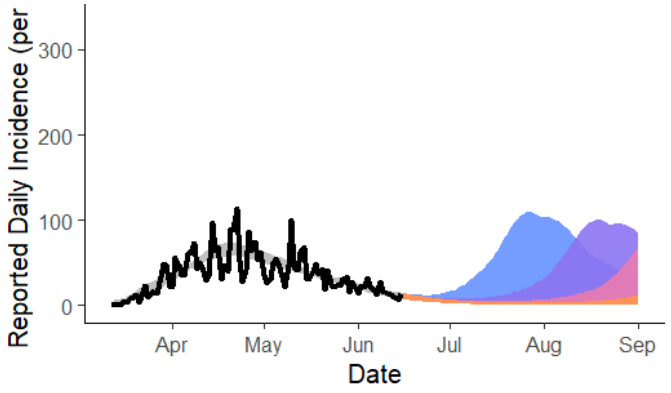


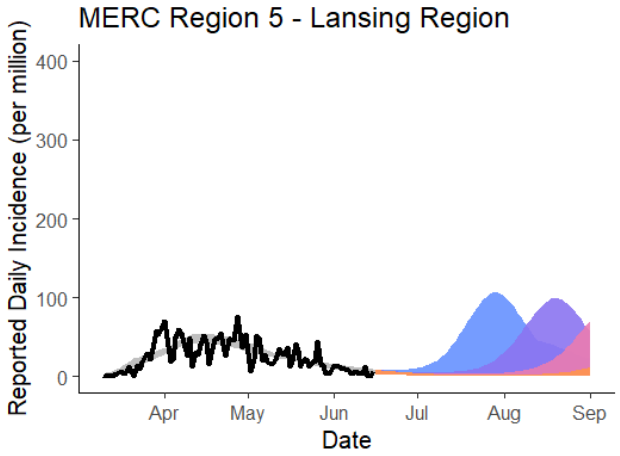


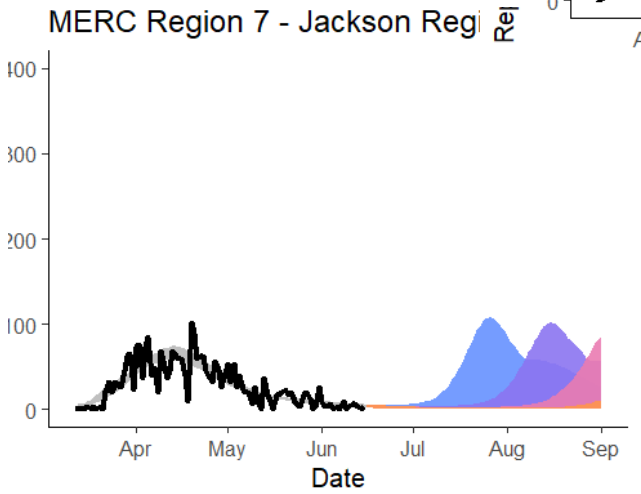
Obtained via MI FOIA by Judicial Watch, Inc.

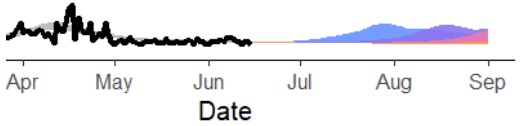












range from no 2nd peak to 2nd peaks higher to the first.

- Does not account for region-level differences in temporal patterns of social distancing.
- Uncertainty: top 10% of simulations.
- Excludes MDOC cases

PUBLIC HEALTH

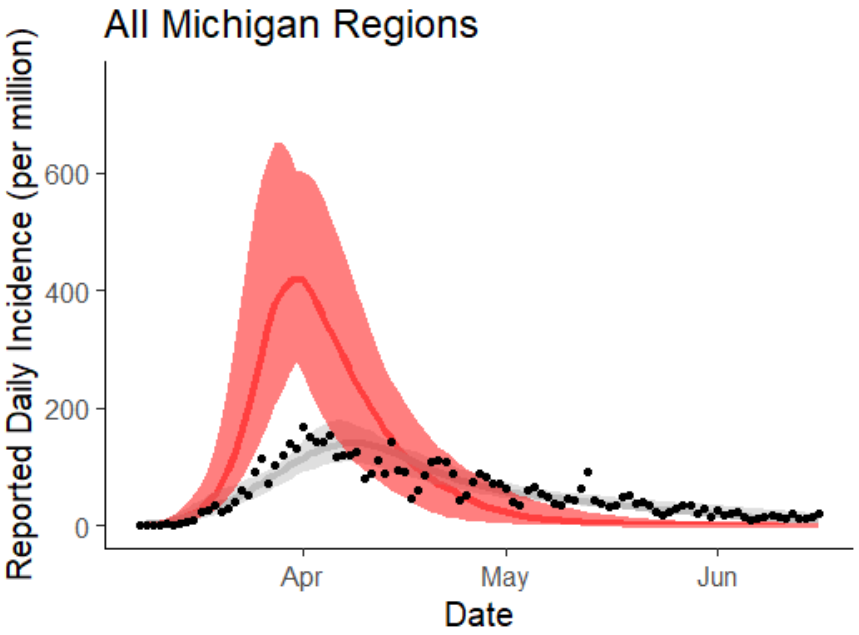
Counterfactual: what would have happened without social distancing?

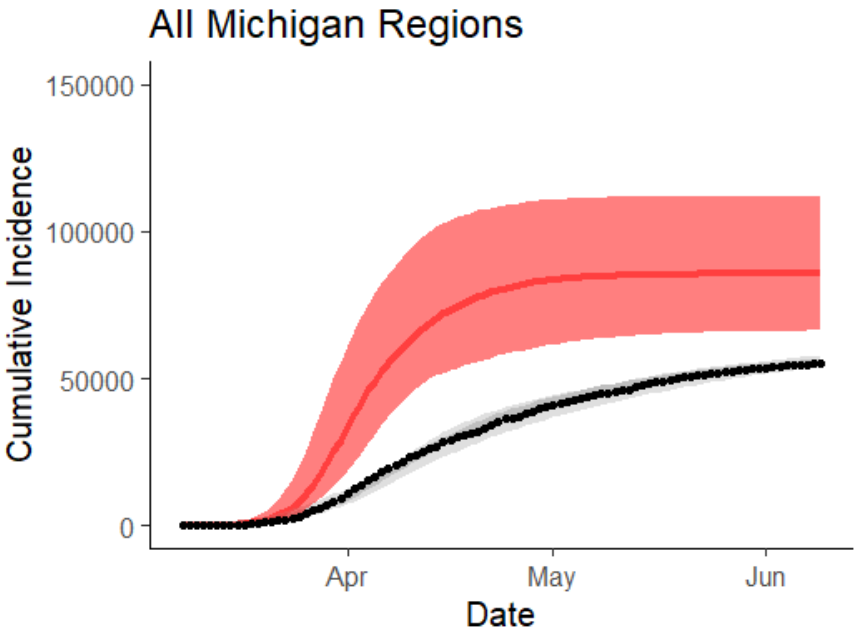
Obtained via MI FOIA by Judicial Watch, Inc.

Uncertainty: top 10% of simulations.

With Stay Home, Stay Safe

Without Stay Home, Stay Safe





Median estimate: without interventions, peak incidence would have been about 2.8 times the observed peak

Median estimate: without intervention, we would expect to have seen 31,400 more cases by June 1.

PUBLIC HEALTH

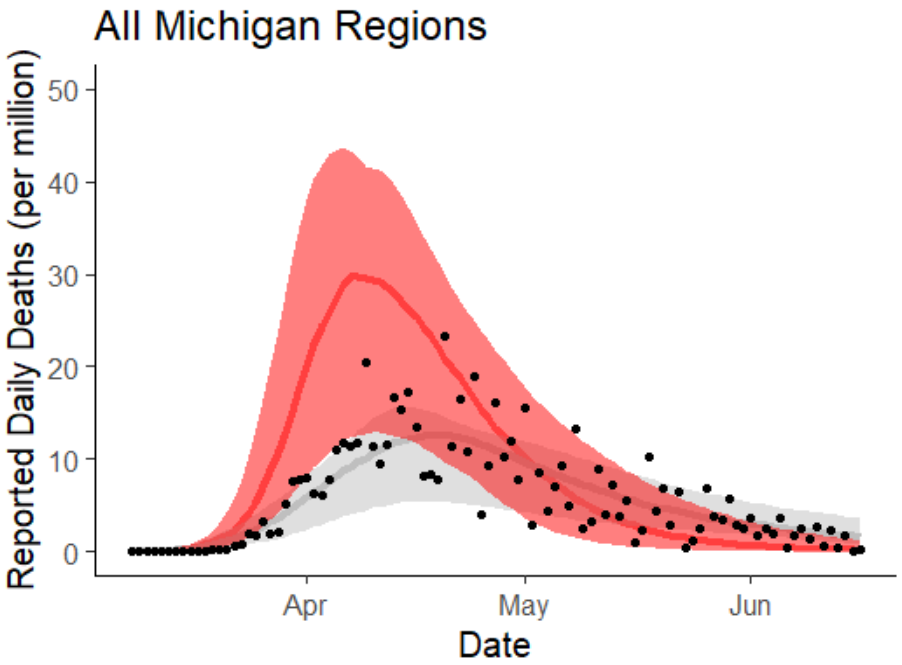
Counterfactual: what would have happened without social distancing?

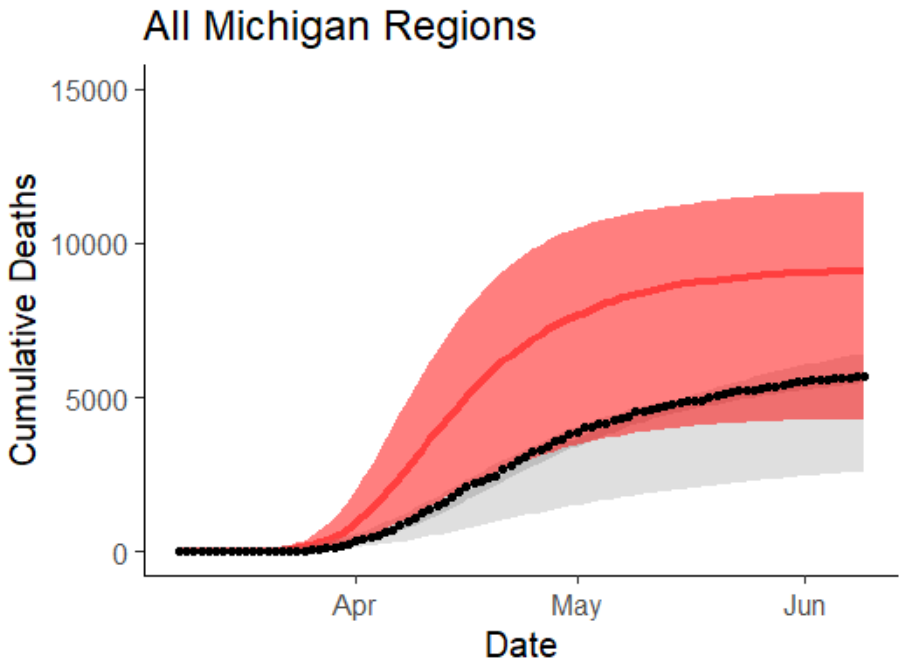
Obtained via MI FOIA by Judicial Watch, Inc.

Uncertainty: top 10% of simulations.

With Stay Home, Stay Safe

Without Stay Home, Stay Safe





Median estimate: without interventions, peak deaths would have been about 2.3 times the observed peak

Median estimate: without intervention, we would expect to have seen 3,650 more deaths by June 1. This estimate does not take into account excess mortality from exceeding

PUBLIC HEALTH

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark
Subject: FW: MSU COVID-19 Test
Date: Sunday, April 12, 2020 1:23:14 PM

Here's one more turn on your MSU inquiry.

From: Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>
Sent: Sunday, April 12, 2020 12:52 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: FW: MSU COVID-19 Test

From: Soehnlen, Marty (DHHS) <SoehnlenM@michigan.gov>
Sent: Saturday, April 11, 2020 10:54 AM
To: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Shah, Sandip (DHHS) <shahs@michigan.gov>
Cc: Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>
Subject: RE: MSU COVID-19 Test

I am happy to help as well. This is a group I had spoken to early on and explained the steps of what they needed to do to get to that FDA EUA stage so that they could get rolling.

I will only raise the caution that there is a very specific reason why research labs have a really hard time getting CLIA high-complexity and it generally has to do with a difference in the quality assurance processes. Having worked in both types of labs before I am aware that even the best of research labs are pretty much never in the same ballpark of quality, traceability, and proficiency testing requirements. Research labs are very, very important, but even at this stage where they have done so much work it may take a herculean effort to get them through LARA if they've not already accounted for it (perhaps they have). Not trying to be a naysayer in any way, only a realist.

Marty

From: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
Sent: Saturday, April 11, 2020 10:42 AM
To: Shah, Sandip (DHHS) <shahs@michigan.gov>
Cc: Soehnlen, Marty (DHHS) <SoehnlenM@michigan.gov>; Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>
Subject: Re: MSU COVID-19 Test

Obtained via MI FOIA by Judicial Watch, Inc.

Thanks. I'll loop you into email.

> On Apr 11, 2020, at 10:41 AM, Shah, Sandip (DHHS) <shahs@michigan.gov> wrote:
>
> I am fine speaking with them anytime this afternoon or tomorrow. MDHHS is not really involved in CLIA certifications. It lies with LARA so they need to decide what assay platform they want to Pick up (several available now) and contact LARA for appropriate level of certification. We can certainly talk to them as to how to pursue this path.... Sandip.
>
> ---
>
> **From:** Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>
> **Sent:** Saturday, April 11, 2020 9:00:52 AM
> **To:** Soehnlen, Marty (DHHS) <SoehnlenM@michigan.gov>; Shah, Sandip (DHHS) <shahs@michigan.gov>; Taverna, Andrea (DHHS-Contractor) <TavernaA1@michigan.gov>; LyonCallo, Sarah (DHHS) <lyoncallos@michigan.gov>
> **Subject:** Fwd: MSU COVID-19 Test
>
> Good morning team,
>
> See below. Marty and Sandip, I actually think you would be the best/knowledgeable people to speak with MSU about their testing questions. I'm happy to join the call as well. Let me know if you have some availability today; otherwise we can shoot for Monday.
> Thank you!
>
> Begin forwarded message:
>
> > **From:** "Totten, Mark" <TottenM1@michigan.gov>
> > **Date:** April 11, 2020 at 5:58:20 AM EDT
> > **To:** "Beauchamp, Norman" <beauch66@msu.edu>
> > **Cc:** "Sherman, Ann (AG)" <ShermanA@michigan.gov>, "Readinger, Patricia" <ReadingerP@michigan.gov>, "Taverna, Andrea (DHHS-Contractor)" <TavernaA1@michigan.gov>, "Khaldun, Joneigh (DHHS)" <KhaldunJ@michigan.gov>, "Bagley, Nick" <BagleyN@michigan.gov>
> > **Subject: RE: MSU COVID-19 Test**
> >
> > Norm,
> >
> > Thanks for your note. We want to be as helpful as we can with the EUA process. The governor has been taking our asks directly to Vice President Pence, and we've been working with the FDA as well. In addition, thanks for your thoughts on using research labs for testing. Let's explore what

Obtained via MI FOIA by Judicial Watch, Inc.

possibilities there may be there.

I'm adding several people to this email who can help. For background for everyone I'm adding, I contacted Norm about this post on MSUToday regarding a new COVID-19 test awaiting FDA approval.

FDA Process

1. *Ann Sherman* is the Deputy Solicitor General at the Michigan Department of Attorney General, and has been leading a legal team to help with the FDA approval process for other devices in the state for which we are pursuing EUA.

2. *Patty Readinger* is the Governor's Director of Federal Affairs and has been serving as our primary liaison to the Office of the Vice President and FDA.

Research labs for testing

3. *Dr. Joneigh Khaldun* is the state's Chief Medical Executive and oversees all the state's public health operations.

4. *Andie Taverna* is a Senior Advisor at the Michigan Department of Health and Human Services and has focused on building out our testing infrastructure.

For awareness, I've also copied Nick Bagley, who works in my office.

Ann and Patty – I want to ask if you can work with Norm to see how we can help shepherd the EUA process for the new test.

Dr. J and Andie – I want to ask if you all can follow-up with Norm about his testing questions below.

Thanks, Mark

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

Obtained via MI FOIA by Judicial Watch, Inc.

This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.

From: Beauchamp, Norman <beauch66@msu.edu>
Sent: Friday, April 10, 2020 5:16 PM
To: Totten, Mark <TottenM1@michigan.gov>
Subject: FW: MSU COVID-19 Test

> Hi Mark,
> Sam Stanley forwarded your offer to help regarding this post .
> Yes we can use your help! (and thank you for the extraordinary leadership out of the Governor's Office. We are very fortunate).
> We could use your help to advance this project and then second… there may be a way to ramp up universities statewide in the effort to do more testing. I know the Governor is interested in broadest reach.
> Some background first:
>
> An Emergency Use Authorization for a slightly different version of our protocol was submitted to the FDA by Bio-Rad, the company that makes the droplet digital PCR. We are deferring to Bio-Rad to get their version approved. They had a WSJ reporter reach out to me and we are hoping to connect Monday. They are also getting us a report oon the method in the trade journal, Clinical Lab Protocols.
>
> We have two big hurdles before offering actual diagnostic testing:
>
> One is the FDA approval of the test, and that's FDA and hopefully that will be done in a week. The application was in preEUA phase. Once feedback from FDA is incorporated and they submit the EUA, anyone can begin testing with the Bio Rad assay for patients.
>
> Second, and more state-based, would be getting CLIA accredited through MDHHS. If the governor's office could get someone from MDHHS to help us figure out a quick way to get research labs like ours CLIA accredited to run high complexity tests, we could quickly

Obtained via MI FOIA by Judicial Watch, Inc.

post that process in collaboration with MDHHS and thereby develop a pathway to certification for many research labs across the state to increase testing. Since it is pretty burdensome, without some hand holding, it will be difficult for labs like ours to do more than offer research level testing.

If we had someone dedicated to that from MDHHS, that would be incredibly helpful and a model for converting research labs into clinical diagnostic labs for the pandemic."
Be well.

Norm

Norman J. Beauchamp Jr., MD MHS
Executive Vice President for Health Sciences
Michigan State University

From: Samuel Stanley <samstanleyjr@gmail.com>
Date: Friday, April 10, 2020 at 3:15 PM
To: "Beauchamp, Norman" <beauch66@msu.edu>
Subject: Fwd: MSU COVID-19 Test

Help needed?

Sent from my iPhone

Begin forwarded message:

> **From:** "Totten, Mark" <TottenM1@michigan.gov>
> **Date:** April 10, 2020 at 1:26:08 PM EDT
> **To:** "Stanley, Samuel" <sstan55@pres.msu.edu>
> **Cc:** "samstanleyjr@gmail.com" <samstanleyjr@gmail.com>
> **Subject: MSU COVID-19 Test**
>
> President Stanley,
>
> I saw this post on the MSU website about the new COVID-19 test that MSU researchers have submitted for FDA

Obtained via MI FOIA by Judicial Watch, Inc.

approval. I would like to know if we can be helpful moving the test through the FDA process. Thanks for all the important work MSU is doing in this area.

Mark

Mark Totten
Chief Legal Counsel
Office of the Governor, State of Michigan
George W. Romney Building
111 S. Capitol Avenue
Lansing, Michigan 48909
tottenm1@michigan.gov
(517) 241-0061

****This email is CONFIDENTIAL AND PRIVILEGED – do not produce in response to FOIA or discovery requests. It is intended for use only by the person to whom it is addressed. If you have received this in error, please (1) do not forward or use this information in any way; and (2) contact me immediately.**

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Huls, JoAnne; Foster, Tricia; Khaldun, Joneigh (DHHS); Warsh, Jonathan (DHHS)
Subject: FW: Offer of help
Date: Thursday, March 19, 2020 11:22:34 PM
Attachments: MI U.S. Digital Response Memo 3.19.20 - Google Docs.pdf

---

From Andy Slavitt's org, these are more potential volunteers with IT and logistics skills. I know a couple of them—one great, one eh. If you see a serious gap we are struggling to fill locally, we could reach out.

From: Joanna Dornfeld <jdornfeld@usofcare.org>
Sent: Thursday, March 19, 2020 10:47 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Warsh, Jonathan (DHHS) <WarshJ1@michigan.gov>
Cc: Em Burnett <em@sylvanstrategies.com>; Robin Carnahan <robin@carnahan.org>; Raylene Yung <rayleney@gmail.com>; Ashley Meyers <ashleymmeyers@gmail.com>; Cori Zarek <cori.zarek@georgetown.edu>; Jennifer Pahlka <jen@codeforamerica.org>
Subject: Re: Offer of help

Bob and Jonathan,

As I mentioned, USofCare is partnering with the US Digital Service to match incredibly smart tech, logistics and data people to address state needs. The USDS effort already has 364 fantastic people with their hands raised to help government, and we're looking to assign them where needed. The group includes a variety of talent, mostly with a tech bent, but including some supply chain management people and even a few epidemiologists. Many with data skills. Attached is a memo with a formal offer of help. Our website is here.

Thank you for everything you are doing for Michiganders. We look forward to partnering with you to support your work.

Best,
Joanna

Joanna Dornfeld
Senior Director of State Affairs
651 343 8216
jdornfeld@usofcare.org
@USofCare | unitedstatesofcare.org

This email from United States of Care (and any attachments) is confidential and is meant only for the individual(s) or entity to whom it is addressed. If you are not the designated recipient of this message, you are not authorized to read, print, retain, copy or disseminate this message or any part of it. If you have received this message in error, please destroy and/or delete all copies of it and notify the sender of the error by return e-mail.

Obtained via MI FOIA by Judicial Watch, Inc.

Link to Bios

U.S. Digital Response Offer to State of Michigan

To: Bob Gordon and Jonathan Warsh, MI DHHS
From: Joanna Dornfeld, United States of Care, US Digital Response Team
Date: March 19, 2020
Re: Highly qualified volunteers to help during COVID-19 crisis

We write to offer help from the 350+ (and growing) highly qualified technology, data, and operations professionals who have registered with U.S. Digital Response to support state and local governments during this public health crisis. COVID-19 is already overwhelming the data and digital capacities of government in a myriad of ways, slowing the ability for states to respond to and stem the spread of the virus. We can match these highly qualified professionals to your needs during this unprecedented time. **To sign up to request these professionals go to:** www.usdigitalresponse.org**.**

U.S. Digital Response is an ad hoc group started by three former U.S. Deputy Chief Technology Officers (one who was a leader on the healthcare.gov rescue effort, one who founded Code for America, and one who leads the Digital Service Collaborative at the Georgetown Beeck Center) and a technical executive formerly with Facebook and Stripe. We are operating on a voluntary basis outside of our current roles because the need is clear and we can help. More about the organizing team is attached below and here: www.usdigitalresponse.org

Together we have sourced qualified people willing to help and skilled in technology, data, design, and operations. Many of our volunteers have worked at the U.S. Digital Service, 18F, Code for America, or in federal, state or local government and are already well aware of the constraints of working within a bureaucracy. Respect for public service and public servants is a baseline requirement for all our volunteers, in addition to a drive to help and a sensitivity to the nature of this work. **Many of these people are known to us from prior relevant projects (including the healthcare.gov rescue effort) and we will vet those who are not known to us to ensure that everyone we send is able to be immediately productive.**

We have identified volunteers all over the US. That said, much work is happening remotely now, so you may be able to use someone from anywhere in the country.

We are eager to understand your specific needs. We have heard from other state and local governments that their needs include:

- Help making it easier to collect and collate data from private and public testing facilities

Obtained via MI FOIA by Judicial Watch, Inc.

- Help keeping websites and systems that are under unprecedented strain from going down (i.e., benefit application systems for unemployment insurance, etc.)
- Help from data scientists with modeling and mapping infection data
- Help with an online tool for the public to self-assess before going to a testing center
- Help with appointment scheduling for tests
- Help building/implementing a system to better collect and track data from hospitals about their bed and ventilator capacity
- Help re-imaging and distributing laptops to EOCs
- Help with project & general operational management, as well as supply chain and procurement expertise
- Help managing logistics and personnel shortages

Because we are working with many states and counties, we also have the ability to coordinate tools and approaches across common needs. We will shortly be sharing some tools from one of the states we are working with that your state is free to use.

Our volunteers have a variety of skills:

- Data Science
- Front-End Engineering
- Back-End Engineering
- Product Management
- Site Reliability Engineering and Operations
- Procurement
- Logistics & Supply Chain (including for healthcare)
- Manufacturing & Production (including for healthcare)
- General Manager
- User Research / Design
- Healthcare
- Public Health / Epidemiologist
- Health Diagnostics
- Disaster Relief and Response

We have provided a list of sample volunteers attached to this memo.

Highly skilled volunteers are being used in a wide variety of government contexts right now. For example, there is a “SWAT” team led by the White House and the Department of Health & Human Services that’s working to accelerate access to testing and resources, and some of our volunteers are being tapped to join this.

Please let us know how we can help.

Obtained via MI FOIA by Judicial Watch, Inc.

Sample volunteers

Michael Pritchard
CTO of Onward Financial
https://www.linkedin.com/in/pipster/

Stephanie Hannon
Chief Product Officer at Strava // Director of Product at Google // CTO for Hillary for America
https://www.linkedin.com/in/skhannon/

Clara Tsao
Former Presidential Innovation Fellow @ Department of Homeland Security
https://www.linkedin.com/in/claratsao

Patrick Higgins
Software Engineer at Gremlin
https://www.linkedin.com/in/pat-higgins/

Ashley Grant
Associate Product Manager at Schmidt Futures // Lead Biotechnologist at Mitre
https://www.linkedin.com/in/kara-holinski-77b673b6/

Andrew Stroup
Founder & CTO of LVRG
https://www.linkedin.com/in/andrewstroup/

Alicia Rouault
Product Team Lead @ 18F, formerly of Code for America
https://www.linkedin.com/in/alicia-rouault/

Mark Lerner (Part-Time)
Former Deputy Executive Director of USDS at the Department of Homeland Security
https://www.linkedin.com/in/markjlerner/

Ben Balter
Senior Product Manager, GitHub // Former Presidential Innovation Fellow
https://linkedin.com/in/benbalter

Cory Eaves
Operating Partner at General Atlantic // Former CIO and CTO of AllScripts
https://www.linkedin.com/in/ceaves/

Obtained via MI FOIA by Judicial Watch, Inc.

US Digital Response Team

Jennifer Pahlka is the founder and former executive director of Code for America. She served as the U.S. Deputy Chief Technology Officer in the White House Office of Science and Technology Policy from 2013–2014, where she founded the United States Digital Service. She received the Skoll Award for Social Entrepreneurship, and was named by Wired as one of the 25 people who has most shaped the past 25 years. She serves on the Defense Innovation Board and the board of the Tech Talent Project. She holds fellowships with Ashoka, the National Academy of Public Administration, and the Volcker Alliance. Jennifer is a graduate of Yale University and lives in Oakland, California with her daughter, husband, and six chickens.

Cori Zarek works on technology and policy projects with a goal of helping governments better serve the public. She is the Director of the Digital Service Collaborative at the Georgetown Beeck Center for Social Impact + Innovation and previously served as the Deputy U.S. Chief Technology Officer. Before launching this project, Cori led the principles and practices work for Code for America and was a Mozilla fellow. From 2013-2017 at the White House, Cori advised the U.S. Chief Technology Officer and led the team's work to build a more digital, open, and collaborative government including helping to stand up and support the U.S. Digital Service, 18F and the Presidential Innovation Fellows. Cori also led the U.S. government's development and implementation of commitments to the Open Government Partnership.

Ryan Panchadsaram joined Kleiner Perkins in 2016 to focus on venture-stage companies across the firm and serve as technical advisor to John Doerr, Chair of Kleiner Perkins. Ryan was the Deputy Chief Technology Officer for the United States. At the White House, Ryan helped shape how an $80 billion budget can be used by federal agencies to deliver on their missions in a more effective, design-centric, and data-driven way. In 2014, Ryan was featured on the cover of Time Magazine as part of the crisis response team that rescued the rollout of Healthcare.gov. After the successful turnaround, Ryan helped launch the U.S. Digital Service. Ryan also represented the United States as a delegate to the United Nations, promoting increased connectivity and entrepreneurship around the world. Prior to public service, Ryan co-founded Pipette, a digital health startup that was acquired by Ginger.io, a MIT Media Lab spin-off using big data and machine-learning to improve the world's health. Ryan worked at Microsoft and Salesforce.com in product and engineering roles. Ryan graduated with a degree in Industrial Engineering and Operations Research from the University of California, Berkeley.

Raylene Yung is a recent fellow with the Aspen Institute's Tech Policy Hub. She was an engineering leader at Stripe where she led Payments, Product, and global expansion in Asia-Pacific. Prior to Stripe, she was an engineering director at Facebook and led efforts on privacy, content creation, and News Feed. She has authored multiple guides on management

Obtained via MI FOIA by Judicial Watch, Inc.

and scaling engineering organizations, as featured in First Round Review and Stripe Guides. She holds a BS and MS in Computer Science from Stanford University.

Robin Carnahan is the former secretary of state of Missouri and leader at 18F within the General Services Administration. Since she was first elected in 2004, Ms. Carnahan has focused on protecting consumers, cracking down on financial fraud, cutting costs and red-tape for businesses, and ensuring fair elections. She has modernized and improved Missouri's elections system by implementing its first statewide voter registration system, creating the Missouri Voting Rights Center, and launching a new interactive election results website. In the historic 2008 election cycle, she served as co-chair of the Elections Committee for the bi-partisan National Association of Secretaries of State. Prior to entering politics, Ms. Carnahan served at the Export-Import Bank of the United States where she explored innovative ways to help American companies increase their sale of goods and services abroad.

Joanna Dornfeld is the Senior Director of State Affairs for United States of Care. She served as Minnesota Governor Mark Dayton's Chief of Staff, where she managed the daily operation of state government – a $46 billion enterprise with more than 34,000 employees serving 5.5 million people. With more than a decade of legislative, policy, and leadership experience, Joanna served in multiple roles in the Dayton Administration including Deputy Chief of Staff for Legislative and Cabinet Affairs where she oversaw development of the Governor's biennial and capital budgets and managed legislative strategy. Joanna worked closely with stakeholders and legislators of both parties to build consensus and achieve results. She was instrumental in passing a health insurance premium rebate program to blunt the dramatic premium increases. Minnesota passed a reinsurance law that is credited with lowering insurance premiums. She also advocated for the Minnesota Care Buy-In which would expand access to Minnesota's Basic Health Care program to more Minnesotans.

Jennifer Anastasoff, former Head of People for USDS.
Jennifer was a founding member of U.S. Digital Service at the White House and served as Head of People from 2014 until 2017, increasing the team from three to over 200 and created a diverse, cross-functional pipeline of digital talent from around America into our federal government. She focuses on bringing together talent, innovation, and social change and loves building awesome teams.

She served as founding CEO of Fuse Corps, the nation's top executive fellowship bringing mid-career leaders from the private sector to serve as senior advisors to public executives, largely mayors and governors. Prior to starting Fuse Corps, Jennifer founded social enterprises focused on bringing technical and operational skills to the public sector, served as a consultant on the Higher Education Committee of the California State Assembly, and was a proud 6th grade teacher.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: whitmerg1@michigan.gov
Subject: FW: Op-Ed Submission/Michigan"s Public Health
Date: Thursday, November 12, 2020 6:43:00 AM

I will ask your office if you do these! He's a U of M expert on the history of pandemics, just wrote a great op-ed about the broad legal authority that remains at DHHS.

From: Howard Markel <howardmarkel@icloud.com>
Sent: Wednesday, November 11, 2020 7:51 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: Fwd: Op-Ed Submission/Michigan's Public Health

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

SUCCESS!!!!!! See below. The piece will run tomorrow morning. If you can get me an autographed picture of the Governor, I'd be most appreciative—I am a huge fan! H

Begin forwarded message:

From: "Gopwani, Jewel" <jgopwani@freepress.com>
Subject: Re: Op-Ed Submission/Michigan's Public Health
Date: November 11, 2020 at 7:42:49 PM EST
To: Howard Markel <howardmarkel@icloud.com>

This will run online in the morning. And I used a Detroit photo of Red Cross workers credited to the National Archives. That should be safe.

My fingers are crossed for print. I know there's a lot to get into the paper in the next couple of days, but your message will certainly be relevant next week, too.

Thanks for sharing your expertise with Free Press readers.

From: Howard Markel <howardmarkel@icloud.com>
Sent: Wednesday, November 11, 2020 7:05 PM
To: Gopwani, Jewel <jgopwani@freepress.com>
Subject: Re: Op-Ed Submission/Michigan's Public Health

Hi Jewel,

I just re-sent the headshots. Please let me know if you get them.

All of the Detroit photos on our website are pre-1918 and, hence, considered to be in the public domain by US copyright law. But I'll trust your judgment on that and am sure the Free Press archives has much better shots.

Thanks for helping us get this important word out. We are now in the worst wave of the pandemic—far worse than both of the previous ones combined—and I am certain the Free Press readers will appreciate learning about the points we make in our essay. As a former Free Press delivery boy [in the early 1970s] and someone who's first official publication was a letter to the editor of the Free Press—I hope it sees print as well as electrons.

All best,
Howard

On Nov 11, 2020, at 6:58 PM, Gopwani, Jewel <jgopwani@freepress.com> wrote:

Hi Dr. Markel,

This looks good. The only thing we're missing is your headshots. My apologies if you've sent those already but I can't seem to find them in my inbox.

As for photos from your site, I'm hesitant to use anything that was first published in a different publication as those copyrights may still hold, so we'll use something more recent that's in our archive.

I'll be out of the office tomorrow and Friday, but after you send the photos, I'll set this to publish online first thing Friday morning and leave it with Brian Dickerson and Nancy Kaffer for print publication. Print is always dependent on space and other news but I'll convey the urgency.

Jewel

From: Howard Markel <howardmarkel@icloud.com>
Sent: Wednesday, November 11, 2020 11:53 AM
To: Gopwani, Jewel <jgopwani@freepress.com>
Cc: Alex Navarro <jnavarro@umich.edu>
Subject: Re: Op-Ed Submission/Michigan's Public Health

Hi Jewel—we got it down to 895—we are ready to work with you to get his out as soon as possible!!!

———

Free Press Op-Ed
By J. Alex Navarro and Howard Markel

On October 2, 2020, the Michigan Supreme Court struck down Democratic Governor Gretchen Whitmer's authority to declare or extend states of emergency in response to the COVID-19 pandemic without the consent of the predominantly Republican legislature, based upon the so-called non-delegation doctrine. In these charged times, where public health has become too politicized for our own good, the ruling was hailed as a major victory by some and by others as a defeat. Despite recent good news about a potentially effective vaccine, as historical epidemiologists, we feel obliged to tell all Michiganders to settle down and pay attention to the clear and present danger.

To many Michiganders, Governor Whitmer's orders were seen as overreaching and unjustified. They were not, however, without historical precedent. Over a century ago, in the fall of 1918, the nation found itself in the midst of an influenza pandemic, the deadliest contagious crisis in human history. Then, as now, there was much debate on how best to halt the spread of the pandemic, or whether the disease could be controlled at all. Hesitant to take statewide action, Albert Sleeper, Michigan's Republican Governor, and Richard Olin, M.D., the State Board of Health's Executive Officer, initially left the public health response to local authorities. Many communities leapt into action, quickly issuing gathering bans and closure orders. Other cities, such as Detroit, Flint, and Grand Rapids were slower to respond.

The lack of consistent action allowed the pandemic to accelerate like an out of control forest fire. On October 18, 1918, Governor Sleeper called a special meeting of mayors and local and state health officers. The debate was contentious to say the least. Detroit health officials argued that closure orders and gathering bans were useless unless absolute, and if absolute would cripple the state's economy. The Grand Rapids health officer incorrectly assumed that influenza was not much worse than the common cold, and argued that closure orders were unnecessary. Other health officers disagreed. The Flint health officer, for example, lamented that he had not acted sooner: "We can reduce the chances for infection by reducing the opportunities of the people to congregate."

The next morning, Governor Sleeper issued a sweeping statewide order, "by virtue of the authority vested in [him] as governor of the state," closing places of public amusement and prohibiting all public gatherings and instructing local health officers to enforce the order.

Naturally, there were grumblings over the order especially among the business community. Despite these objections, local officials across Michigan worked quickly to put the governor's order into effect. In Detroit, Mayor Oscar Marx and health officer James Inches informed residents that the governor's order would be strictly enforced. Several weeks later, when Detroit's epidemic appeared to be waning, Inches asked Sleeper to lift the closure order. The governor refused because the epidemic was still raging across the state. Inches acquiesced and told Detroiters, "We have no right to demand favors that might cause trouble in other communities."

His proclamation to the contrary notwithstanding, Governor Sleeper's orders rested on shaky legal ground. Michigan law did not yet grant either the governor or the state health officer the authority to enact such sweeping public health measures.

To rectify this omission, the following year the Michigan legislature passed Public Act 146 of 1919, explicitly granting the Director of the Department of Health the authority to declare an epidemic and to issue closure orders and gathering bans. Some six decades later, the legislature again revised the state's public health laws, passing the Public Health Code, Act 368 of 1978. Like its predecessor, this act grants sweeping authority to the Director of the Michigan Department of Health and Human Services (MDHHS) to enact and enforce epidemic control measures. Moreover, it also grants such powers to local and county health departments. And remember, these measures are only used when combatting an easily spread and deadly microbial enemy like the influenza of 1918 or today's CoVID-19.

These statutes grant the state broad powers to protect the public's health. Indeed, the Michigan Supreme Court's recent decision specifically cites the 1919 law. In the aftermath of that decision, the Director of MDHHS has used this authority to issue numerous COVID-19 control measures. Such public health orders rest on overwhelming scientific evidence as well as the solid ground of over a century of legal authority.

To be sure, living under such orders is difficult. They are socially and economically restrictive. Masks are uncomfortable to wear. Seven months into this pandemic, we are eager to return to our normal routines. This is especially so as the holiday season is upon us. From the rising number of cases in Michigan, it looks to be a very lonely Thanksgiving and Christmas.

Still, these measures are not an unconstitutional infringement on our civil liberties, as some would have us believe. Rather, they are legally valid codifications of our collective obligation to our fellow Michiganders. We should not view them as burdensome orders, but rather as reminders that we must all do our part to better control the pandemic.

As we look down the barrel of CoVID's third surge, we must continue our social distancing measures to prevent disease and save lives until a vaccine is safe and widely distributed. Michigan's proud history tells us that we can rise to the occasion by making these necessary sacrifices, just as our forebears did a century ago.

[Dr Markel is the Director of the University of Michigan's Center for the History of Medicine and Dr. Navarro is its assistant director; they are co-editors of *The 1918-1919 American Influenza Pandemic: A Digital Encyclopedia and Archive at: www.influenzaarchives.org*]

Obtained via MI FOIA by Judicial Watch, Inc.

On Nov 11, 2020, at 11:02 AM, Gopwani, Jewel <jgopwani@freepress.com> wrote:

Hi Dr. Markel,

I want to apologize. I had started writing a response to you earlier this week but it got lost in the massive post-election coma that we're all in this week.

We are interested. Could you shave about 250 words off of the column? Our word limit is 600 words, but we make exceptions with an upper limit of about 900 words. When we have a shorter version we'll prepare it for publication. These days we're publishing everything online first and getting whatever we can into print as space and new allow.

Jewel

From: Howard Markel <howardmarkel@icloud.com>
Sent: Tuesday, November 10, 2020 8:04 AM
To: Gopwani, Jewel <jgopwani@freepress.com>
Subject: Re: Op-Ed Submission/Michigan's Public Health

Hi—has there been any movement on our op-Ed?

Howard Markel, MD, PhD
George E. Wantz Distinguished Professor of the History of Medicine and Director
Center for the History of Medicine
The University of Michigan
734-647-6914

Sent from my iPhone

> On Nov 2, 2020, at 7:29 AM, Howard Markel <howardmarkel@icloud.com> wrote:
>
> Dear Jewel,
> Thanks for this note. We are delighted by your interest.
> All of the photos on our digital encyclopedia, at www.influenzaarchives.org, including the ones from Detroit are in public domain [pre-1923], so you are free to use them.
> I will get you the headshots of me and Dr. Navarro shortly.
> Howard Markel
>
> > On Nov 2, 2020, at 6:37 AM, Gopwani, Jewel <jgopwani@freepress.com> wrote:
> >
> > Hello Dr. Markel,
> >
> > Thanks so much for sending this our way. We are interested, so please don't send your column elsewhere. I'll be albe to take a closer look later this week. In the meantime, do you have the rights to any archive photos that might go well with your column? Also, please send me headshots of you and Dr. Navarro.
> >
> > Thank you,
> >
> > Jewel
> >
> > ---
> >
> > **From:** Howard Markel <howardmarkel@icloud.com>
> > **Sent:** Sunday, November 1, 2020 8:02 PM
> > **To:** Kaffer, Nancy <nkaffer@freepress.com>; Gopwani, Jewel <jgopwani@freepress.com>
> > **Cc:** oped <dfpoped@freepress.com>
> > **Subject:** Op-Ed Submission/Michigan's Public Health
> >
> > Dear Ms. Kaffer and associates:
> >
> > As concerned historical epidemiologists at the U-Michigan Center for the History of Medicine, we would like to submit the following Op-Ed on the history of the state of Michigan's legal authority to combat an easily spread epidemic disease using social distancing measures.
> > Sincerely ,
> > Howard Markel, MD, PhD
> > George E. Wantz Distinguished Professor of the History of Medicine and Director
> > Center for the History of Medicine
> > The University of Michigan
> > 734-845-1220
> >
> > **How Michigan Battled a Pandemic a Century Ago**
> > **By:**
> > **J. Alexander Navarro, PhD**
> > **Howard Markel, MD, PhD**
> > **The Center for the History of Medicine**
> > **The University of Michigan**
> >
> > On October 2, 2020, the Michigan Supreme Court struck down Democratic Governor Gretchen Whitmer's authority to declare or extend states of emergency in response to the COVID-19 pandemic without the consent of the predominantly Republican legislature, based upon the so-called non-delegation doctrine. In these charged times, where public health has become too politicized for our own good, the ruling was hailed as a major victory by some and as a defeat by those who wish to see a strong, coordinated response to the ongoing pandemic. As historical epidemiologists, we feel obliged to tell those celebrating this outrageous usurpation of public health powers to settle down and pay close attention to the real threat before us.
> > To many Michiganders, Governor Whitmer's orders were seen as onerous, overreaching, and unjustified. They were not, however, without historical precedent. Over a century ago, in the fall of 1918, the nation found itself in the midst of an influenza pandemic, the deadliest contagious crisis in human history. Then, as now, there was much debate on how best to halt the spread of the pandemic, or whether the disease could be controlled at all. Hesitant to take statewide action, Albert Sleeper, Michigan's Republican Governor, and Richard Olin, M.D., the State Board of Health's Executive Officer, initially left the public health response to local authorities. Many communities leapt into action, quickly issuing gathering bans and closure orders. Other cities, such as Detroit, Flint, and Grand Rapids, however, were slower to respond.
> > The lack of consistent action allowed the pandemic to accelerate like an out of control forest fire. On October 18, 1918, Governor Sleeper called a special meeting of mayors and local and state health officers. The debate was contentious to say the least. Detroit health officials argued that closure orders and gathering bans were useless unless absolute, and if absolute would cripple the state's economy. The Grand Rapids health officer incorrectly assumed that influenza was not much worse than the common cold, and that a closure order was unnecessary. Other local officials, however, insisted that an immediate statewide action was necessary in order to save lives. Witness to the rapid rise in cases and deaths in his city, Flint health officer William DeKleine had a change of heart and lamented that he had not acted sooner. "We can reduce the chances for infection by reducing the opportunities of the people to congregate," he said.
> > The next morning, Governor Sleeper issued a sweeping statewide order, "by virtue of the authority vested in [him] as governor of the state," closing places of public amusement and prohibiting all public gatherings and instructing local health officers to enforce the order.
> > Naturally, there were grumblings over the order. Prominent citizens such as Henry Leland, who created the Cadillac automobile line, the *Detroit News* publisher George Booth, and Alfred McMeans, the corporate secretary of the Dodge Brothers Company, declared that the closure order would only increase public hysteria. In Grand Rapids, numerous residents asked for special economic dispensation from Sleeper's order. Yet despite the objections, local officials across Michigan worked quickly to put the governor's order into effect. Grand Rapids health officer Clyde Slemmons told the public that they "should not ask favors when lives are at stake." In Detroit, Mayor Oscar Marx and health officer James Inches informed residents that the governor's order would be strictly enforced. Several weeks later, when Detroit's epidemic appeared to be waning, Inches asked Sleeper to lift the closure order. The governor refused. The epidemic was still raging in other parts of the state, he replied. Inches, although disappointed, realized that controlling the pandemic required vigilance by

Obtained via MI FOIA by Judicial Watch, Inc.

every Michigan resident. "We have no right to demand favors that might cause trouble in other communities," he told Detroiters.

His proclamation to the contrary notwithstanding, Governor Sleeper's orders rested on shaky legal ground. Michigan law did not yet grant either the governor or the state health officer the authority to enact such sweeping public health measures.

To rectify this omission, the following year the Michigan legislature passed Public Act 146 of 1919, explicitly granting the Director of the Department of Health the authority to declare an epidemic and to issue closure orders and gathering bans. Some six decades later, the legislature once again revised the state's public health laws, passing the Public Health Code, Act 368 of 1978. Like its predecessor, this act grants sweeping authority to the Director of the Michigan Department of Health and Human Services (MDHHS) to enact and enforce epidemic control measures. Moreover, it also grants such powers to local and county health departments. And remember, these measures represent the nuclear option in a public health officer's tool box. They are only used when combatting an extremely contagious, deadly, and easily spread microbial enemy like the influenza of 1918 or today's CoVID-19.

It is under these statutes that the state retains broad powers to issue orders to protect the public's health during an epidemic. Indeed, the Michigan Supreme Court's recent decision specifically cites the 1919 law. In the immediate aftermath of that decision, the Director of MDHHS has used this authority to issue several sets of COVID-19 control measures, including limiting the size of public and private gatherings, face mask requirements, capacity restrictions in retail stores, restaurants, bars, and other public accommodations, and data collection requirements to make contact tracing easier. Such public health orders rest on overwhelming scientific evidence as well as the solid ground of over a century of legal authority.

To be sure, living under such orders is difficult if not annoying. They are socially and economically restrictive. Masks can be uncomfortable to wear. Seven months into this pandemic and with no clear end in sight, all Michiganders are eager to return to a life of normalcy, where we can freely go out to dine, meet with friends for drinks, and gather with family for celebrations. This is especially so as the holiday season is upon us. Already, Halloween has been cancelled and, from the rising number of cases across the nation and in our state, it looks to be a very lonely Thanksgiving and Christmas.

Still, these measures are not an unconstitutional infringement on our civil liberties, as some would have us believe. Rather, they are legally valid codifications of our collective obligation to our fellow Michiganders. We should not view them as burdensome orders, but rather as reminders that we must all do our part to control the contagion of COVID-19 and prevent its spread to others.

As we look down the barrel of a third surge of this scourge, we must continue our social distancing measures to prevent disease and save lives. Michigan's proud history tells us that we can all rise to the occasion by making these necessary sacrifices, just as our forebears did a century ago.

[Dr Markel is the Director of the University of Michigan's Center for the History of Medicine and Dr. Navarro is its assistant director; they are co-editors of *The 1918-1919 American Influenza Pandemic: A Digital Encyclopedia and Archive at: www.influenzaarchives.org*]

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Huls, JoAnne
Subject: FW: Project 100 Overview / Matching Fund Opportunity for Detroit
Date: Sunday, April 19, 2020 9:34:38 AM

FYI—don't know who is referenced below. I'm supportive of the substance

---

From: Shaefer Luke <lshaefer@umich.edu>
Sent: Sunday, April 19, 2020 9:24 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: Fwd: Project 100 Overview / Matching Fund Opportunity for Detroit

Just keeping you updated.

Luke

Begin forwarded message:

From: Jonah Edelman <JEdelman@stand.org>
Subject: RE: Project 100 Overview / Matching Fund Opportunity for Detroit
Date: April 18, 2020 at 5:21:07 PM EDT
To: Shaefer Luke <lshaefer@umich.edu>

Luke
Just circling back. Spoke to Whitmer's chief fundraiser and Serena from the City today. They all seem to be motivated to unlock national $$ and are on the case.

Separate question: did you explore Chris Hughes/Economic Security Project's interest in funding?

-----Original Message-----
From: Shaefer Luke <lshaefer@umich.edu>
Sent: Friday, April 17, 2020 12:07 PM
To: Jonah Edelman <JEdelman@stand.org>
Subject: Re: Project 100 Overview / Matching Fund Opportunity for Detroit

Hi Jonah-

I get the sense the state administration won't pursue the match funding. I could connect you with the head of development for the City of Detroit? I don't know how interested they would be, but seems like a more obvious choice. She's a really solid person and directly connected to the Mayor.

The Mayor is a democrat, but fairly conservative. But he likes bringing money into the city. Shall I introduce you to her?

Luke

On Apr 15, 2020, at 7:42 PM, Jonah Edelman <jedelman@stand.org> wrote:

Obtained via MI FOIA by Judicial Watch, Inc.

Robert,

Following up on our conversation, here is background on Project 100.

As noted below, given how incredibly hard hit Detroit has been, we are able and willing to match local gifts made prior to our Tuesday launch up to a total of $15 million (I can't guarantee that match beyond Tuesday because of the interest the launch will generate).

If Detroit donors drew down the whole $15 million in national matching money, that would enable direct payments non-profit GiveDirectly to efficiently provide $30 million in $1000 direct payments to help 30,000 Detroit Fresh EBT user/SNAP recipient families in dire economic circumstances to stay afloat during this terrible time.

Feel free to call me at 503-997-5355 if you have questions after reviewing the information below and to put interested donors in touch with me.

Many thanks for your tremendous leadership.

Jonah

PROJECT 100
Next Tuesday, pathbreaking software company Propel<https://www.joinpropel.com/>, whose Fresh EBT<https://www.freshebt.com/> app helps more than two million verified SNAP recipients each month, innovative direct payments non-profit Give Directly<https://www.givedirectly.org/>, and leading education non-profit Stand for Children<http://www.stand.org/> will launch Project 100.
Project 100's goal is to provide $1,000 digital cash transfers within the next 100 days to 100,000 SNAP recipient families in cities hard hit by the COVID-19 pandemic.
Given how deeply impacted Detroit has been, we are open to matching every dollar contributed specifically to provide direct cash payments to Detroit area SNAP recipient families up to $15 million.
Note: there are 90,000 Fresh EBT app user / SNAP recipient families in the Detroit area, making it readily possible to effectively and efficiently target $30 million in direct cash payments to 30,000 Detroit area families with demonstrated need who can access to Give Directly's digital payments platform.
Project 100 is the most ambitious COVID-19 response direct payments initiative to date, by far, and the largest private cash assistance campaign in U.S. history.

A pilot effort covered in Washington Post<https://www.washingtonpost.com/news/powerpost/paloma/powerup/2020/04/02/powerup-nonprofits-step-up-as-treasury-department-scrambles-to-deliver-coronavirus-stimulus-payments/5e85086f602ff10d49ada8d4/>, Vox<https://www.vox.com/future-perfect/2020/3/20/21186007/coronavirus-pandemic-donate-help-cash-benefits>, Fast Company<https://www.fastcompany.com/90479868/givedirectly-will-start-giving-away-1000-to-people-most-effect-by-the-coronavirus-shutdown> and supported by Ariana Grande, Google and many others laid the groundwork for Project 100. In the

Obtained via MI FOIA by Judicial Watch, Inc.

last two weeks, GiveDirectly used Hyperwallet to provide $1,000 digital cash transfers to more than 1,500 Fresh EBT user families who completed an app survey about the pandemic's impact.
Here are three actual responses from families who received payments:

"GiveDirectly just provided a way for my family to stay afloat during this crisis we are able to get much needed household items, pay an over due bill, have money for gas in case we need to transport."
"I brought my children laptops so they can do remote learning... I also was able to go food shopping ... feeding three children is a lot of food and this took such a weight off of me so I'm extremely grateful."

"I plan on using the funds from give directly by paying my rent and other bills while my kids are out of school. I bought some groceries and diapers and wipes for my youngest child. So all this helped me out tremendously."

Here are two powerful video testimonials from recipients of those timely cash payments: Video Testimonial 1<https://drive.google.com/file/d/1xMnsWbZqmUHFLgWHbhzCuI5V7_kIUZQU/view> Video Testimonial 2<2.%09https:/drive.google.com/file/d/1LtKsHQKjS0a7EobhYIm4ITGDoIYC3hos/view>

Project 100 has already surpassed $40 million in funding thanks to generous support from Stacy Schusterman, Blue Meridian Partners, James Walton, Rihanna, Google.org, Flourish, The Late Show with Stephen Colbert, and many others. Our goal is to secure at least $80M in commitments before the April 21st public launch.
Jonah Edelman | Chief Executive Officer | Stand for Children | M 503-997-5355 | jedelman@stand.org<mailto:jedelman@stand.org> | www.stand.org<http://www.stand.org/>

<winmail.dat>

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Huls, JoAnne; Foster, Tricia; Totten, Mark
Cc: Hertel, Elizabeth (DHHS)
Subject: FW: Protocols Workgroup Update
Date: Thursday, April 2, 2020 8:32:49 AM
Attachments: Relief Hospital and ACS Guidance (002).pdf
MDHHS PPE Optimization Final 4-1-202.pdf
COVID19 Practice Management Guide Final.pdf
2020.03.29 PPE Allocation Guidance vF.docx

Here is latest from Protocols:

- Important recent documents attached, which have gone out widely to key stakeholders
- Process going forward, which is streamlined and ensures SEOC has visibility.

In the interest of speed, we are not including EOG in approvals except where we see particular sensitivity. Happy to discuss.

From: Esty, Sarah (DHHS) <EstyS@michigan.gov>
Sent: Wednesday, April 1, 2020 7:39 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Cc: Ingersoll, Jean (DHHS) <IngersollJ2@michigan.gov>; Scott, Linda (DHHS) <ScottL12@michigan.gov>; Hudson, Nicole (DHHS) <HudsonN2@michigan.gov>; Bell, James (DHHS) <BellJ10@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>
Subject: Protocols Workgroup Update

Hi Robert,

As requested, pasted at the bottom of this email and continuously updated on sharepoint is our list of priority guidance issued and in progress (including newly identified guidance needed). All of the completed and issued documents are attached.

Codifying our process going forward:

- When a need for new guidance is identified (e.g., protocols around ventilator optimization), that need will be sent to James and Nicole to update the master document tracker and the priority guidance tracker, assign a document owner, and ensure appropriate SMEs have been identified and are working on it
- When a document is finalized, James/Nicole will send to the CHECC, Dr. J, and Elizabeth for review and approval
- When a document is approved to send out, the CHECC will return to James/Nicole. Nicole/James will distribute that document by:
    - Sending out through the HAN
    - Sending to DHHS senior deputies for awareness and encouraging Deputies to share with their own stakeholders
    - Sending to Sarah to share with relevant P-groups
    - Sending to Jason to put on the main Coronavirus website
    - Sending to Rachel and Phil to update the statewide FAQ master and share with hotline/inbox teams (as appropriate)
    - Sending to Comms for awareness and to share with the JIC (Comms will decide if further distribution/public messaging needed)
- Daily/as requested by EOG, Robert will send Joann the latest updated Priority Guidance Tracker and copies of new docs sent out since the last update

Topic	Project manager	Lead expert/SME	Est. release date	Status (title of final doc)
Initial set of allocation decisions for distribution of state-sourced PPE	Sarah Esty	Jean, Linda, Jay	3/29	Done (2020.03.29 PPE Allocation Guidance)
Guidance for PPE optimization/ conservation	Nicole Hudson	Linda Scott & Kathy Wahl	4/1	Done (PPE Optimization Final 4-1-2020)
Standards of care for providers/hospitals treating COVID patients during surge	James Bell	Dr. Khaldun, Dr. Martin, Dr. Strong	4/1	Done (Practice Management Guide Final)
Decision criteria and plans to address major outbreaks in residential facilities	Nicole Hudson	Kate Massey & Dr. McFadden	4/2	In progress
Criteria for load balancing between hospitals and other facilities	James Bell	Dr. Fales, Jay Fiedler, Linda Scott	4/1	Done (Relief Hospitals and ACS guidance)
Guidelines on decisionmaking around constructing/repurposing new facilities	James Bell	Elizabeth Hertel / Places workgroup	4/1	Under CHECC final review
Ventilator supply chain and usage protocols	James Bell	Linda, Jay	TBD	Initial meeting 4/2

Obtained via MI FOIA by Judicial Watch, Inc.

PPE: Updated list of priority groups to receive PPE (replacing 3/22 guidance)	Nicole Hudson	Brenda Brennan, Dr. Khaldun	TBD	Being drafted
PPE: Finalized PPE allocation formula (emergency reserve size, priority groups eligible)	James Bell	Jason Smith, Jeannie Byrne, Amber Pitts	TBD	Standing subgroup under Products established

Sarah Esty
Senior Deputy Director, Policy and Planning
Michigan Department of Health and Human Services
O: 517-284-4995
M: 517-599-5841
EstyS@michigan.gov

Obtained via MI FOIA by Judicial Watch, Inc.

Patient and Operational Considerations for Michigan Relief Healthcare Facilities and Alternate Care Sites

Description: This document is intended to provide guidance in the use of Relief Healthcare Facilities (including Relief Hospitals and Relief Long-Term Acute Care Facilities and Relief Skilled Nursing Homes) and Alternate Care Sites (ACS). This guidance may change as resource availability and demands for healthcare services change. Please be alert for revisions.

Core Components

Relief Health Care Facility: This includes licensed hospitals, skilled nursing homes, long-term acute care facilities, and other appropriate licensed healthcare facilities. Relief hospitals are intended to provide a conventional standard of care using available resources without compromising their ability to meet reasonable additional potential institutional surge needs. In general, transfer of most patients to a relief healthcare facility is preferred over transfer to an alternate care site.

- **Relief Hospital:** This includes licensed hospitals able to accept transfers from highly impacted hospitals (and other healthcare facilities) without compromising their ability to meet reasonable additional potential hospital surge needs. No transfers should occur without physician-to-physician communication with an accurate clinical description of the patient(s) and with clear acceptance by the Relief Hospital. There are currently four types of Relief Hospital statuses that may be displayed in EMResource for statewide awareness.
    - *Critical Care Bed - COVID-19:* This status is indicated for hospitals willing to accept COVID-19 patients requiring critical care, including mechanical ventilation. If hospitals are able to provide this service but are in need of a ventilator, they should contact their healthcare coalition (HCC). These patients should be able to oxygenate and ventilate effectively, not be in circulatory shock, not have multisystem failure, and (ideally) be considered to have at least a 75% potential for survival.
    - *Critical Care Bed - Non-COVID-19:* This status is indicated for hospitals willing to accept non-COVID-19 patients requiring critical care, including mechanical ventilation. If hospitals are able to provide this service but are in need of a ventilator, they should contact their healthcare coalition (HCC). These patients should be able to oxygenate and ventilate effectively, not be in circulatory shock, not have multisystem failure, and (ideally) be considered to have at least a 75% potential for survival. Patients in this category should be considered to not have COVID-*19,* ideally confirmed with laboratory testing (but not required based on clinical presentation).
    - *Non-Critical Care Bed - COVID-19:* This status is indicated for hospitals willing to accept COVID-19 patients not currently requiring critical care services or mechanical ventilation. These patients may need low to intermediate flow supplemental oxygen and basic in-patient (non-critical care) services. Patients in

Obtained via MI FOIA by Judicial Watch, Inc.

this category have a potential to deteriorate quickly within the first few days of presentation. Such patients should be transferred to Relief Hospitals having critical care capability available on site or immediately nearby. Patients who have stabilized and are considered to be at low risk of acute decompensation may be considered for Relief Hospitals without critical care capability on site or immediately nearby.

- *Non-Critical Care Bed - Non-COVID-19:* This status is indicated for hospitals willing to accept non-COVID-19 patients not currently requiring critical care services or mechanical ventilation. These patients may need low to intermediate flow supplemental oxygen and basic in-patient (non-critical care) services. These patients should be appropriate for the level of care available at the Relief Hospital. This may include such things as acute chest pain, CHF exacerbation (non-COVID-19), dehydration, intractable pain, and other similar conditions. Patients in this category should be considered to not have COVID-*19*, ideally confirmed with laboratory testing (but not required based on clinical presentation).

Relief Skilled Nursing Home: This includes licensed skilled nursing facilities (SNF) able to accept transfers from highly impacted hospitals (and other healthcare facilities) without compromising their ability to meet reasonable additional potential hospital surge needs. No transfers should occur without physician-to-physician communication and clear acceptance by the Relief SNF. These facilities should declare through EMResource (as available) and/or their HCCs their willingness to accept both COVID-19 and non-COVID-19 patients and if they are willing to accept stable patients requiring long-term mechanical ventilation and considered appropriate for SNF level of care.

Relief Long Term Acute Care Facilities: This includes long-term acute care (LTAC) facilities able to accept transfers from highly impacted hospitals (and other healthcare facilities) without compromising their ability to meet reasonable additional potential hospital surge needs. No transfers should occur without physician-to-physician communication and clear acceptance by the Relief LTAC. These facilities should be willing to accept stable patients requiring mechanical ventilation considered appropriate for LTAC level of care.

Alternate Care Sites: These are typically non-clinical facilities that have been repurposed to provide healthcare services when traditional healthcare facilities have insufficient capacity and/or capability to provide these services. Alternate Care Sites should strive to provide a level of care as close to conventional care as possible. However, it understood that the ability to meet the conventional standard of care in an ACS may be limited by the resources available. The table below illustrates the four ACS Tiers and describes their purpose, patient type, and considerations for ACS locations.

Obtained via MI FOIA by Judicial Watch, Inc.

Alternate Care Site Tiers, Patient Types and Operational Considerations

Tier	Description	Types of Patients	Operational Considerations
1 **M** **E** **D** **I** **C** **A** **L** **S** **H** **E** **L** **T** **E** **R**	**Tier 1 ACS** houses a cohort of patients who need limited monitoring and can care for themselves (e.g., do not need assistance with medications or activities of daily living (ADLs)). These patients could be housed in a dedicated hotel or dormitory meant for this purpose (in their own rooms with their own bathroom).[1] **Tier 1-Behavioral Health** provides the same services as a standard Tier 1 but for patients with behavioral health conditions but not in need of close supervision (e.g., not considered at risk for harm to self or others).	**Patients in Need of Medical Sheltering** Patients with mild to moderate symptoms likely from COVID-19 (preferably with negative RIDP) who are able to care for themselves and would be dischargeable from an ED. • Includes homeless or live alone • Not (yet) in need of admission • Need reasonable observation and rechecks to identify early deterioration Patients who were admitted to a hospital for COVID-19 and are medically appropriate for discharge. • Includes homeless or live alone • Need reasonable observation and rechecks ED or admitted patients appropriate for discharge and not suspected to have COVID-19. • Includes homeless or live alone • Need reasonable observation and rechecks • Examples: Mild exacerbations of CHF, COPD, or exacerbation of other chronic condition	Potential Sites • Dedicated hotel • Dormitory It is always preferred for patients to have a bed over a cot. Medical Support • Dedicated home health nursing team and/or community paramedics
2	**Tier 2 ACS** houses a cohort of patients who require some level of	**Patients in Need of Medical Sheltering**	**Open Layout Sites** (preferred) • Low Capacity: 25-50 beds

[1] https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/alternative-care-sites.html

Obtained via MI FOIA by Judicial Watch, Inc.

Tier	Description	Types of Patients	Operational Considerations
MEDICAL SHELTER	assistance (e.g., help with ADLs or medications) and who need a closer level of monitoring than patients in tier one. These patients may be better suited in a facility that has an open layout (e.g., school gymnasium) to allow limited numbers of healthcare personnel to more easily monitor their status.[1] **Tier 2-Behavioral Health** provides the same services as a standard Tier 2 but for patients with serious behavioral health conditions and in need of close supervision (e.g., considered at risk for harm to self or others, psychotic).	Patients with mild to moderate symptoms likely from COVID-19 (preferably with negative RIDP) who would be dischargeable from an emergency department. • Require some level of assistance (e.g., help with ADLs or medications) and • Need a closer level of monitoring than patients in tier one These might include patients who normally reside in nursing homes, assisted care, and dementia facilities who are unable to return to these facilities or patients receiving care at home from a caregiver who becomes symptomatic and may not be able to provide continued care.	• Medium Capacity: 50-200 beds • Large Capacity: >200 beds* • Super Capacity: >500 beds* *May be appropriate for non-FMS section of TCF Center if positive for COVID-19 **Residential Sites** (Alternative) • Dedicated hotel • Dormitory It is always preferred for patients to have a bed over a cot. A hospital bed is preferred but not required. **Tier 2-Behavioral Health** • Small capacity only (<25) • Should have systems in place to maximize safety of patient and others • Residential sites not recommended unless one-on-one supervision/ observation available

Obtained via MI FOIA by Judicial Watch, Inc.

Tier	Description	Types of Patients	Operational Considerations
3 **B** **A** **S** **I** **C** **M** **E** **D** **I** **C** **A** **L** **C** **A** **R** **E**	**Tier 3 ACS** houses a cohort of patients who require basic medical care which may include low flow supplemental oxygen (≤6 LPM), intravenous fluids, nutritional support, medication administration, and care, as similar as possible, to what would be received in a medical (non-monitored, non-critical care) unit of a hospital. Emergency medical capabilities should be readily available on site. **Tier-3 Limited:** This is identical to a Tier 3 ACS except has limited abilities to provide sustained oxygen flow. **Tier-3 Non-COVID-19:** This is identical to a Tier 3 ACS or Tier-3 Limited ACS except it is limited to patients who do not have COVID-19, ideally testing negative. **Tier-3 Palliative Care:** This is identical to a Tier-3 ACS but is primarily intended to provide end of life care.	**Patients in Need of Basic Medical Care** • ED/Clinic patients with moderate symptoms of COVID-19[2] including associated hypoxia responsive to low flow oxygen but without evidence of impending respiratory failure, hemodynamic instability (e.g., circulatory shock), older age, or significant co-morbid conditions. These patients would ideally be admitted to a medical (non-critical care) unit of a hospital where they would receive supplemental oxygen, intravenous fluids, medications, nutritional support, and basic hospital-level care. • Patients with moderate symptoms of COVID-19[2] and hospitalized in a medical (non-critical care) unit in a hospital for suspected or confirmed COVID-19 and considered sufficiently stable for transfer to a Tier 3 ACS for continued care, likely involving continued low flow oxygen. • Patients with non-COVID-19 related condition who are in need of basic (non-critical care) services where there is insufficient capacity at the hospital for admission. Examples include patients with cellulitis requiring IV antibiotics and patients with dehydration requiring IV fluids. These patients would NOT be house with COVID-19 patients. [2]Patients should have negative RIDP when possible	**Open Layout Sites** • Low Capacity: <50 beds • Medium Capacity:50-200 beds • Large Capacity: >200-500 beds • Super Capacity: >500 beds A Tier 3 ACS facility would be appropriate for a Federal Medical Station (FMS), or equivalent, capable of providing supplemental oxygen. It is always preferred for patients to have a bed over a cot. A hospital bed is preferred for a Tier-3 ACS. A Tier 3 ACS facility would be appropriate for a hospital-sponsored, HCC-sponsored, or jurisdictional-sponsored ACS. A Tier-3 is not intended to serve as a free-standing ED or a COVID-19 intake center.

Obtained via MI FOIA by Judicial Watch, Inc.

Tier	Description	Types of Patients	Operational Considerations
4 **A** **D** **V** **A** **N** **C** **E** **D** **M** **E** **D** **I** **C** **A** **L** **C** **A** **R** **E**	**TIER-4 ACS** houses a cohort of patients requiring advanced medical care, including mechanical ventilation. It is always preferable for this type of care to be delivered in a hospital or other traditional healthcare facility (e.g., long term acute care, skilled nursing facility) accustomed to dealing with patients of this acuity and with mechanical ventilation. In addition to mechanical ventilation capabilities, a Tier 4 must have bedside (or potentially remote telemetry) monitoring, oxygen delivery systems, and the personnel needed to provide this level of care, including intensivisist/pulmonologists (may be available by telemedicine), physicians experienced in critical care (e.g., emergency medicine, internal medicine; including senior residents), nurses with critical care experience, respiratory therapists (augment by RT students), patient care technicians, and pharmacists and pharmacy technicians.	**It is always preferable for this type of care to be delivered in a hospital or other traditional health care facility (e.g., long term acute care, skilled nursing facility) accustomed to dealing with patients of this acuity and with mechanical ventilation.** Patients for a Tier-4 ACS should be patients requiring mechanical ventilation who are: • oxygenating and ventilating well (require FIO@ ≤50%, ≤12 PEEP) • are hemodynamically stable • not demonstrating signs of multi-system organ failure • not requiring (or expected to require dialysis) • expected to have at least a 75% probability of recovery Patients should be excluded from a Tier-4 ACS who are: • in circulatory shock (elevated lactate, hypotensive) • demonstrating difficulty in ventilating or oxygenating (e.g., FIO2 >50%, PEEP >12) • have multiple comorbid conditions • require (or expected to require dialysis • considered to have less than 50% survival probability	**Potential Sites** • Free-standing surgery endoscopy) center or similar healthcare facility (preferred) • Other facility with open design that can be adapted for this purpose **Patient Capacity:** Because of the high level of care that may be required at a Tier 4 ACS, these facilities should have low capacity, ideally 10-15 patients. If a site has the ability for 20 or more patients, they should consider dividing into two smaller units to allow more focus of effort. They should operate under a joint incident command system. A hospital bed is required for a Tier-4 ACS.

Obtained via MI FOIA by Judicial Watch, Inc.

Patient Considerations for Placement in Traditional Healthcare Facilities and Alternate Care Sites

1. **Low Acuity Patients Suspected/Confirmed COVID-19 Appropriate for Care at Home or at Tier-1 or Tier-2 ACS**

   A. Patients presenting to a clinical facility (e.g., ED, clinic, telemedicine) and are determined to likely be demonstrating clinical symptoms and signs of COViD-19 and are not in need of hospitalization (would be appropriate for discharge to home) but are at risk for rapid decompensation but in whom rapid decompensation is not anticipated within 24 hours.

   B. Patients who are hospitalized (including Tier-3 ACS) with COVID-19 and considered sufficiently stable for hospital (including Tier-3 ACS) discharge.

   Preferred Destination: Home with self (family) -care and isolation or return to residential care facility for isolation.

   Alternative Destination: Type-1 or Type 2 ACS

   - This would be appropriate for patients who are homeless, for elderly patients who live alone, for patients dependent upon others for care who do not have care providers

2. **Low or Intermediate Acuity COVID-19 Patients Requiring Basic Medical Care at Hospital or Tier-3 ACS**

   A. Patients presenting to a clinical facility (e.g., ED, clinic, telemedicine) and are determined to likely be demonstrating clinical symptoms and signs of COVID-19 and are in need of hospitalization to a non-critical care unit and require low flow oxygen, intravenous (or oral) hydration, medication administration, nutritional support, and/or management of co-morbid conditions.

   B. Patients who are currently hospitalized in non-critical care units with COVID-19 (confirmed or PUI) who are considered to be sufficiently stable for transfer to another healthcare facility (including a Tier-3 ACS) in order to create additional hospital capacity for more seriously ill patients (including expanding critical care services).

   Preferred Destination: Transfer to a Relief Hospital for continued conventional level of care. May be at a distant site.

   Alternative Destination: Type-3 ACS

   - This would be appropriate when transfer to a Relief Hospital is not feasible or for relatively more stable patients allowing for more

Obtained via MI FOIA by Judicial Watch, Inc.

seriously ill patients of this type to preferentially be transferred to a Relief Hospital.

3. **High Acuity COVID-19 patients (including those requiring mechanical ventilation) and Preferentially Cared for in a Hospital**

   A. Patients currently hospitalized with suspected or confirmed COVID-19 and require critical care services (including mechanical ventilation) who are determined to be sufficiently stable for transfer to a Relief Hospital (preferred) or to a Tier-4 ACS. These patients include those that are oxygenating and ventilating adequately (≤12 PEEP, FIO2<50%), not in circulatory shock, not in multi-organ system failure, and anticipated to have at least a 75% survival rate. See additional inclusions and exclusions in Table above.

   B. Patients presenting to the Emergency Department with suspected or confirmed COVID-19 and requiring critical care services (including mechanical ventilation) who are determined to be sufficiently stable for transfer to a Relief Hospital (preferred) or to a Tier-4 ACS (only as last resort). These patients include those that are oxygenating and ventilating adequately (≤12 PEEP, FIO2<50%), not in circulatory shock, not in multi-organ system failure, and anticipated to have at least a 75% survival rate. See additional inclusions and exclusions in Table above.

   Preferred Destination: Transfer to a Relief Hospital critical care unit for continued conventional level of care. May be at a distant site.

   Alternative Destination: Type-4 ACS

   - This would be appropriate when transfer to a Relief Hospital is not feasible or for relatively more stable patients allowing for other more seriously ill patients of this type to preferentially be transferred to a Relief Hospital critical care unit. Because of the potential for rapid deterioration in the acute period, ED patients should be transferred to a Tier-4 facility only as a last resort.

4. **Non-COVID Patients:** Non-COVID patients may be transferred to a Relief Hospital (preferred when medically indicated) or to an appropriate Tier ACS based on the above guidance. However, non-COVID-19 patients should never be cohorted with COVID-19 patients at the same ACS facility. When COVID-19 status is uncertain, high priority testing should be completed prior to transfer to a non-COVID-19 Relief Hospital unit or ACS.



Obtained via MI FOIA by Judicial Watch, Inc.

OPTIMIZING PERSONAL PROTECTIVE EQUIPMENT DURING CRISIS CAPACITY

Michigan.gov/Coronavirus

The Centers for Disease Control and Prevention (CDC) provides strategies that can be utilized by healthcare workers to optimize use of PPE during periods of known shortages. These strategies should only be used when there is limited supply that has exceeded the ability to provide conventional standards.

During severe resource limitations, consider excluding healthcare providers (HCP) at higher risk for severe illness from COVID-19 from contact with known or suspected COVID-19 patients (e.g., those of older age, those with chronic medical conditions, or those who may be pregnant).

N-95 Respirators:

- Consider use of respirators beyond the manufacturer-designated shelf life for healthcare delivery.
- Consider use of respirators approved under standards used in other countries similar to NIOSH-approved N-95 respirators.
- Consider limited re-use of N-95 respirators for COVID-19 patients according to CDC guidance.
- Decontamination and reuse of N-95 respirators according to CDC guidance may be considered. Only respirator manufacturers can reliably provide guidance on how to decontaminate their specific models of respirators. However, if absent, third parties may also provide guidance or procedures on how to decontaminate respirators without impacting respirator performance. Vaporous hydrogen peroxide, ultraviolet germicidal irradiation, and moist heat are the most promising decontamination methods. **No current data exists supporting the effectiveness of these decontamination methods specifically against SARS-CoV-2.** Therefore, even after decontamination, these N-95 respirators should be handled carefully.
- In settings where N-95 respirators are so limited that routinely practiced standards of care for wearing **N-95 respirators and equivalent or higher level of protection respirators are no longer possible, and surgical masks are not available**, as a last resort, it may be necessary for HCP to use masks that have never been evaluated or approved by NIOSH.
- Any respirator that becomes obviously damaged or difficult to breathe through should be discarded.

MDHHS Michigan Department of Health & Human Services

For more information, visit **Michigan.gov/Coronavirus.**

Obtained via MI FOIA by Judicial Watch, Inc.

Eye Protection:

- Consider extending use of eye protection without removing between patient contacts. This can be done with disposable and reusable devices.
- Eye protection should be removed and reprocessed if it becomes visibly soiled or difficult to see through.
- Face shields that are reprocessed should be dedicated to one healthcare provider and reprocessed whenever it is visibly soiled or removed prior to putting it back on.
- Eye protection should be discarded if damaged (e.g., face shield can no longer fasten securely to the provider, if visibility is obscured and reprocessing does not restore visibility).
- Note: Avoid touching eye protection. If touched, immediately perform hand hygiene. If there is a need to remove eye protection, leave the patient care area.
- During extreme shortages (crisis standards of care) consider using eye protection devices beyond the manufacturer-designated shelf life (visually inspect the product prior to use and if there are concerns such as degraded materials discard the product).
- Prioritize eye protection for selected activities such as where splashes and sprays are anticipated-includes aerosol generating procedures; during activities where prolonged face to face or close contact with a potentially infectious patient is unavoidable.
- Consider using safety glasses (trauma glasses) that have extensions to cover the side of the eyes.

Isolation Gowns:

- Consider shifting disposable gowns to cloth isolation gowns (this may require augmenting laundry operations personnel).
- Gowns must be routinely inspected and maintained and discarded when thin or ripped.
- Consider use of coveralls (requires training and practice prior to use)
- Consideration can be made to extend the use of isolation gowns (disposable or cloth) so that it is worn by the same healthcare provider when interacting with more than one patient known to be infected with the same infectious disease when the patients are cohorted in the same location. Only to be considered when there are no additional co-infectious diagnoses transmitted by contact.
- Any disposable gown that becomes visibly soiled should be disposed of. Cloth gowns that are visibly soiled should be removed and cleaned.
- During extreme shortages (crisis standards of care) gowns should be prioritized for activities where splashes and sprays are anticipated including aerosol generating procedures and during high-contact patient care activities such as dressing, bathing/showering, transferring, linen changes, assisting with toileting, device care or use and wound care.

Obtained via MI FOIA by Judicial Watch, Inc.

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

ROBERT GORDON
DIRECTOR

Michigan Department of Health and Human Services COVID-19 Practice Management Guide

(Adapted from Department of Defense and Minnesota Department of Health)

Obtained via MI FOIA by Judicial Watch, Inc.

This Document is appended as the Crisis Standards of Care for the State of Michigan. Clinical information is current as of 3/27/20.

Introduction: The novel coronavirus (COVID-19) has presented a daunting public health challenge across the world, United States, and Michigan, straining local and state health departments and the healthcare system. The Michigan Department of Health and Human Services (MDHHS) is working closely with healthcare providers, local health departments, and the Centers for Disease Control and Prevention (CDC) to actively monitor and provide guidance to address the outbreak. Crisis Standards of Care (CSC) address specific challenges of a pervasive or catastrophic public health event that has generated a change in standard of care by warranting a shift in focus from individual patients to the good of the community. In these situations, demand often exceeds available resources, warranting proactive steps to coordinate a statewide response for a prolonged period, assuring the best care possible despite resource limitations. In 2012, the National Academies of Sciences, Engineering and Medicine published national guidance documents for crisis standards of care planning (91). They recommend the incorporation of key elements into the development of crisis standards of care plans, including:

- Strong ethical grounding;
- Integrated and ongoing community and provider engagement, education, and communication;
- Assurances regarding legal authority and environment;
- Clear indicators, triggers, and lines of responsibility; and
- Evidenced-based clinical processes and operations.

In the event of a CSC situation, MDHHS will facilitate equitable access to care through public health recommendations, regulatory guidance, support of alternate care mechanisms (e.g., telephone hotlines, alternate care sites), and support public information dissemination in such an event.

This document serves only as guidance for clinicians providing care in Michigan during the COVID-19 outbreak. It is also a guide for hospital administrators who should be actively planning, or already implementing, Crisis Standards of Care in their facilities given the current status of the outbreak as of the date of this publication. References to Executive Orders and guidance documents from the State of Michigan are up to date as of the date of publication. Clinicians should always use their best clinical judgement when determining the care of their patients.

Obtained via MI FOIA by Judicial Watch, Inc.

This is a guide and does not supersede Laws within the state of Michigan or individual clinical judgment

It is based upon the best information available at the time of publication. It is designed to provide information and assist decision making. It is not intended to define a standard of care and should not be construed as one. Neither should it be interpreted as prescribing an exclusive course of management. It was developed by experts in this field. Variations in practice will inevitably and appropriately occur when clinicians take into account the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Every healthcare professional making use of this guideline is responsible for evaluating the appropriateness of applying it in the setting of any particular clinical situation.

Obtained via MI FOIA by Judicial Watch, Inc.

DoD COVID-19 PRACTICE MANAGEMENT GUIDE

Clinical Management of COVID-19

To consolidate resources and optimize the management for patients requiring clinical care during the global COVID-19 pandemic.

Contributors

Lt Col Renée I. Matos, MC, USAF
COL Kevin K. Chung, MC, USA
CDR John Benjamin, MC, USN
LTC Matthew A. Borgman, MC, USA
Laura R. Brosch, RN, PhD
Robert F. Browning, MD
CAPT Timothy H. Burgess, MC, USN
Col Francis R. Carandang, MC, USAF
LTC Jacob Collen, MC, USA
LTC Christopher Colombo, MC, USA
Ms. Polyxeni Combs, MS
CAPT Konrad L. Davis, MC, USN
COL Sean N. Dooley, MC, USA
COL Jeremy Edwards, MC, USA
CAPT Eric Elster, MC, USN
MAJ Emilio Fentanes, MC, USA
MAJ Brian Foster, MC, USA
Dr. James Giordano, PhD
Mr. Joshua Girton, JD, LLM, MBA
Mark Haigney, MD
LTC Mitchell Hamele, MC, USA
COL Bonnie H. Hartstein, MC, USA
Maj Alison Helfrich, MC, USAF COL
Mrs. Jennifer Hesch,JD
COL Patrick Hickey, MC, USA
Col David Hsieh, MC, USAF
CDR Ashley E. Humphries, MC, USN
Maj John Hunninghake, MC, USAF
MAJ Nikhil A. Huprikar, MC, USA
CDR Michael J. Kavanaugh, MC, USN
Lt Col Jeremy Kilburn, MC, USAF
Maj David A. Lindholm, MC, USAF COL
COL Frederick Lough, MC, USA
LCDR Donovan L Mabe, MC, USN
Col Leslie Matesick, MC, USAF
CAPT Ryan C. Maves, MC, USN
CDR Sean Mckay, MC, USN
Maj Krista Mehlhaff, MC, USAF
COL Clinton K. Murray, MC, USA
Lt Col Jason F. Okulicz, MC, USAF
COL Neil Page, MC, USA
COL Jeremy C. Pamplin, MC, USA
LTC Wylan C. Peterson, MC, USA
Mr. Joseph Procaccino, JD, MFS
Col James B. Sampson, MC, USAF
LCDR David C. Shih, MC, USN
Bich-Thuy T. Sim, MD
LCDR Scott Snyder, MC, USN
Col Barton C. Staat, MC, USAF
Mr. Randy W. Stone, JD
Col Deena E. Sutter, MC, USAF
Lt Col Bryan D. Szalwinski, MC, USAF
Maj Robert Walter, MC, USAF
Mr. Bryan T. Wheeler, JD
Col Leslie Wood, MC, USAF
CAPT Luke Zabrocki, MC, USN
Mr. Michael J. Zleit, JD

Draft Release Date: 20 March 2020

Publication Date: 23 March 2020

Table of Contents

BACKGROUND 7
CLINICAL PRESENTATION & CLINICAL COURSE 7
PLANNING AND PREPARATION 8
Preparing Critical Care Resources & Teams 10
Establishment Case Registry for Clinical Performance Improvement 12
SCREENING AND TRIAGE: EARLY RECOGNITION OF PATIENTS WITH COVID-19 12
IMMEDIATE IMPLEMENTATION OF APPROPRIATE Infection Prevention Control (IPC) MEASURES 13
COLLECTION OF SPECIMENS FOR LABORATORY DIAGNOSIS 14
MANAGEMENT OF MILD COVID-19: SYMPTOMATIC TREATMENT AND MONITORING 15
MANAGEMENT OF SEVERE COVID-19: OXYGEN THERAPY AND MONITORING 16
MANAGEMENT OF SEVERE COVID-19: TREATMENT OF CO-INFECTIONS 18
MANAGEMENT OF CRITICAL COVID-19: ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS) 18
Endotracheal Intubation 19
Management of ARDS 19
MANAGEMENT OF CRITICAL ILLNESS AND COVID-19: PREVENTION OF COMPLICATIONS 21
Cardiovascular Disease (CVD) 21

Obtained via MI FOIA by Judicial Watch, Inc.

Acute Kidney Injury 23
Nutrition 23
Other 23
MANAGEMENT OF CRITICAL ILLNESS AND COVID-19: SEPTIC SHOCK & CARDIAC ARREST 23
Recognition of Septic Shock 23
Septic Shock Resuscitation 24
Rapid Response or Code Blue 24
Patient Transport 26
ADJUNCTIVE THERAPIES FOR COVID-19: TREATMENTPROTOCOLS 26
Ethics of Clinical Research during a Pandemic 26
Steroids 27
Remdesivir 27
Chloroquine (CQ) and Hydroxychloroquine (HCQ) 28
Lopinavir/Ritonavir 28
Host-directed anti-inflammatory strategies 28
Anti-IL6 monoclonal antibodies 28
CARING FOR SPECIAL POPULATIONS: Pregnancy, Nursing Mothers, Infants, Children, and the Elderly 29
Caring for Pregnant Women with COVID-19 29
Caring for Infants and Mothers with COVID-19: IPC and Breastfeeding 30
Pumping / Expressed Breast Milk (83) 31
Infants 31
Neonatal Intensive Care Unit (84) 31
Visitation 32
Caring for Children with COVID-19 32
Caring for Older Persons with COVID-19 33
SURGICAL CONSIDERATIONS FOR PERSONS WITHCOVID-19 34
Perioperative Care of COVID-19+ Patients and PUIs 34
In the OR 34
Intubation 35
Surge Capacity, Staffing, and 'Elective Surgery' 35
TELEMEDICINE SUPPORT DURING THE COVID-19PANDEMIC 35
EMERGENCY MANAGEMENT SERVICES AND GROUND TRANSPORT OF PERSONS WITH COVID-19 36
Michigan Emergency EMS Protocols for COVID 19 include: 36
Strained EMS Response due to Increased 911 Calls/Requests 36
Personal Protective Equipment (PPE) for Emergency Medical Services Personnel 36
EMS Transport of PUIs or Patients with Confirmed COVID-19 to a Healthcare Facility 37

Obtained via MI FOIA by Judicial Watch, Inc.

EMS Personnel Precautions for Procedures 37
Cleaning EMS Transport Vehicles After Transporting a PUI or Patient with Confirmed COVID-19 38
Follow-up for EMS Personnel after Caring for a PUI or Patient with Confirmed COVID-19 38
ETHICAL CONSIDERATIONS WHEN CARING FOR PERSONS WITH COVID-19 38
REFERENCES 40
APPENDIX A : COVID-19 INTUBATION PRE-ENTRY CHECKLIST* 45
APPENDIX B: COVID-19 PRE-INTUBATIONPACK* 46
APPENDIX C : COVID-19 INTUBATION PROTOCOL 47
APPENDIX D : COVID-19 COGNITIVE AIDS FOR INTUBATION 48
APPENDIX E : ADULT PRONE POSITIONING PROTOCOL EXAMPLE* 51
APPENDIX F: Setup and Monitoring Instructions – Anesthesia Machine as an ICU Ventilator 54
APPENDIX G: SCCM | Joint Statement on Multiple Patients Per Ventilator 56
APPENDIX H: PATIENT CARE: *STRATEGIES FOR SCARCE RESOURCE SITUATIONS* 58

Obtained via MI FOIA by Judicial Watch, Inc.

BACKGROUND

Coronavirus disease 2019 (COVID-19) is a respiratory illness caused by a novel coronavirus (SARS-CoV-2). COVID-19 was first described in Wuhan, China in December 2019 and is now a global pandemic. Most of those affected have milder illness (80%), 15% will be severely ill (require oxygen) and 5% will require ICU care. (1) Of those who are critically ill, most require early intubation and mechanical ventilation. Other complications include septic shock and multi-organ failure, including acute kidney injury and cardiac injury.(2) Older age and comorbid diseases, such as COPD, hypertension and diabetes increase risk of death.(3, 4) The virus is highly contagious and spread via respiratory droplets, direct contact, and if aerosolized, airborne routes. The most common symptoms include fever, fatigue, dry cough, and shortness of breath.

The intent of this publication is to provide clinicians and medical treatment facilities (MTFs) with best practices based on latest evidence to optimize response to the current COVID-19 pandemic.

CLINICAL PRESENTATION & CLINICAL COURSE

1. Incubation period: ~4 days (interquartile range: 2 to 7 days).(5) Some studies have estimated a wider range for the incubation period; data for human infection with other coronaviruses (e.g. MERS-CoV, SARS-CoV) suggest that the incubation period may range from 2-14 days.
2. Frequently reported symptoms of patients admitted to the hospital: (3, 6-9)
    - Fever (77–98%)
    - Cough (46%–82%)
    - Myalgia or fatigue (11–52%)
    - Shortness of breath (3-31%)
    - GI symptoms, such as diarrhea and nausea (may approach 50%)
3. Among 1,099 hospitalized COVID-19 patients, fever was present in 44% at hospital admission, and developed in 89% during hospitalization. (10)
4. Less commonly reported symptoms: sore throat, headache, cough with sputum production and/or hemoptysis, and lower respiratory tract signs and symptoms.
5. Risk factors for severe illness are not yet clear, although older patients and those with chronic medical conditions may be at higher risk for severe illness. (11)
6. Children: Limited information is available about the clinical presentation, clinical course, and risk factors for severe COVID-19 in children. Of confirmed COVID-19 patients in China as of Feb 11, 2020, only 2.1% were aged <20 years, and no deaths were reported among those <10 years of age. From limited published reports, signs and symptoms among children with COVID-19 may be milder than adults, with most pediatric patients presenting with fever, cough, congestion, and rhinorrhea, and one report of primarily gastrointestinal symptoms (vomiting and diarrhea). Severe complications of acute respiratory distress syndrome and septic shock were reported in a 13-month old with COVID- 19 in China and another was reported in a 55-day old. (12-15)
7. Prolonged detection of SARS-CoV RNA has been reported in respiratory specimens (up to 22 days after illness onset) and stool specimens (at least 30 days after illness onset). (12,13)
8. Clinical presentation among reported cases of COVID-19 varies in severity from asymptomatic infection to mild illness to severe or fatal illness. Several reports suggest the potential for clinical deterioration during the second week of illness. In one report, among patients with confirmed COVID-19 and pneumonia, just over half of patients developed dyspnea a median of 8 days after illness onset (range: 5–13 days). In another report, the mean time from illness onset to hospital admission with pneumonia was 9 days. (3,8)
9. Acute respiratory distress syndrome (ARDS) developed in 17–29% of hospitalized patients, and secondary infection developed in 10%. In one report, the median time from symptom onset to ARDS was 8 days. (3, 6, 7) Approximately 20-30% of hospitalized patients with COVID-19 and pneumonia have

Obtained via MI FOIA by Judicial Watch, Inc.

required intensive care for respiratory support. Compared to patients not admitted to an intensive care unit, critically ill patients were older (median age 66 years versus 51 years) and were more likely to have underlying co-morbid conditions (72% versus 37%). (3, 7)

10. Among critically ill patients admitted to an intensive care unit, 11–64% received high-flow oxygen therapy and 47-71% received mechanical ventilation; some hospitalized patients have required advanced organ support with endotracheal intubation and mechanical ventilation (4–42%).(6, 7, 11)
11. A small proportion (3-12% of ICU patients) have also been supported with extracorporeal membrane oxygenation (ECMO).(6, 7, 11) Other reported complications include cardiac injury, sudden cardiac death, arrhythmia, septic shock, liver dysfunction, acute kidney injury, and multi-organ failure. Post-mortem biopsies in one patient who died of ARDS reported pulmonary findings of diffuse alveolar damage. (16)
12. A case fatality rate of 2.3% has been reported among confirmed cases of COVID-19 in China. (11) However, the majority of these cases were hospitalized patients, so this mortality estimate is likely biased upward. Among hospitalized patients with pneumonia, the case fatality proportion has been reported as 4–15%. (3, 6, 7) In a report from one Chinese hospital, 61.5% of critically ill patients with COVID-19 had died by day 28 of ICU admission. Among all critically ill COVID-19 patients in China, the reported case fatality proportion was49%. (2)

**Adapted from the Center for Disease Control: https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html*

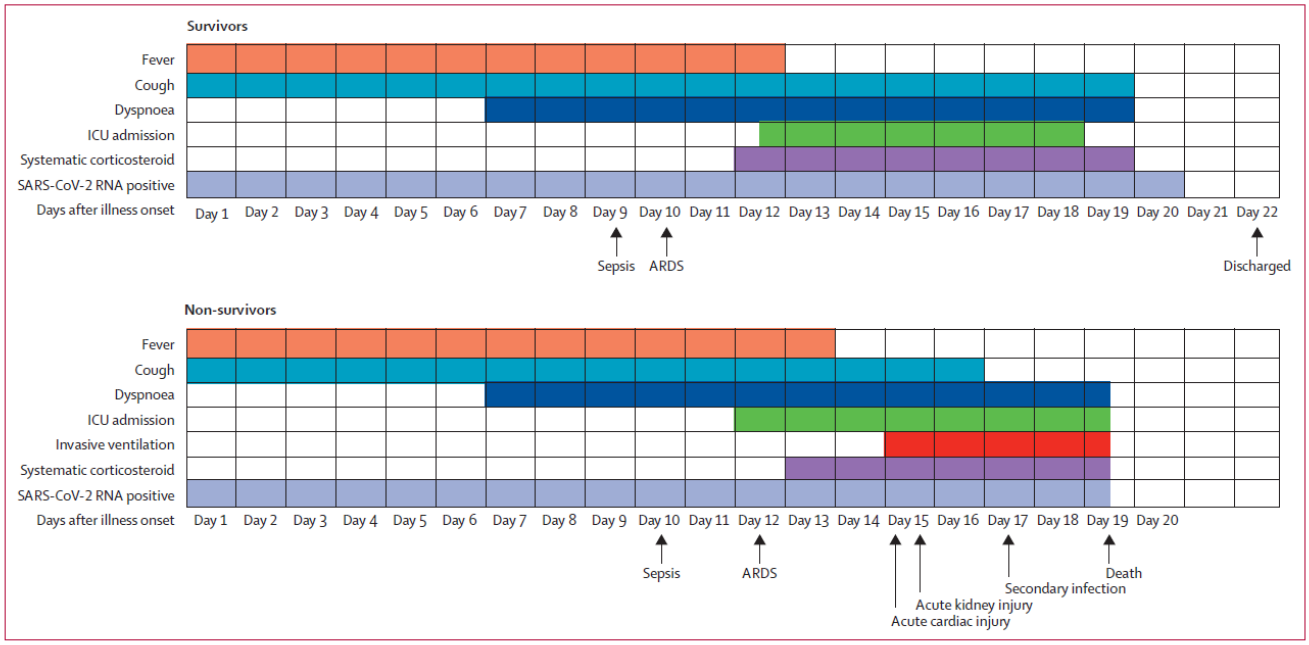


Figure 1: Clinical courses of major symptoms and outcomes and duration of viral shedding from illness onset in patients hospitalised with COVID-19
Figure shows median duration of symptoms and onset of complications and outcomes. ICU=intensive care unit. SARS-CoV-2=severe acute respiratory syndrome coronavirus 2. ARDS=acute respiratory distress syndrome. COVID-19=coronavirus disease 2019.

Figure 1. Clinical Courses of Major Symptoms and Outcomes and Duration of Viral Shedding [from Zhou, et al.; Lancet (2020)].(4)

PLANNING AND PREPARATION

Facility Incident Command and Systems.

1. A command structure with clearly defined roles and lines of communication should be established. These structures should have the ability to coordinate expansion or restriction of critical care resources through implementation of Contingency and Crisis Standards of Care (CSC) in conjunction with Unit medical directors, help coordinate "just in time" training as well as regional expert consultation (i.e. tele-consultation with critical care,

Obtained via MI FOIA by Judicial Watch, Inc.

infectious disease, or other specialists), facilitate the flow of critical equipment and patients, and communicate/coordinate CSC changes on both a local and regional level liaise with the community as transition depends on regional, not just local, healthcare utilization.

2. Establish and Manage Crisis/Contingency Standards of Care
    a. CSC are "a substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a pervasive (e.g., pandemic influenza) or catastrophic (e.g., earthquake, hurricane) disaster." (19)
    b. The establishment of the CSC should enable specific legal and regulatory protections for health care providers when having to operate under conditions of limited medical resources and alternate models of care. Executive Order 2020-30, effective March 29, 2020, relaxes scope of practice requirements and reinforces an existing law that protects hospitals and health-care workers from liability for taking necessary steps to protect Michiganders during an emergency.
    c. Design and implementation of these standards for each agency should remain flexible based on each situation and should be tiered (i.e. normal operations, contingency, crisis) and have specific triggers to engage. In general contingency when >120% typical capacity and crisis when >150-200% capacity though this may be revised down or up depending on availability of staff, supplies, and space.
    d. CSC should be developed by multi-disciplinary groups and should in some ways be individualized to a facility. A list of topics that should be included:
        - Authority and triggers for enacting escalating CSC
        - Emergency credentialing and scope of practice changes as CSC escalate (nursing, physician, etc.)
        - Alterations in practice allowed (limiting documentation, changes in work hours and locations, changes in location of patient care and monitoring requirements

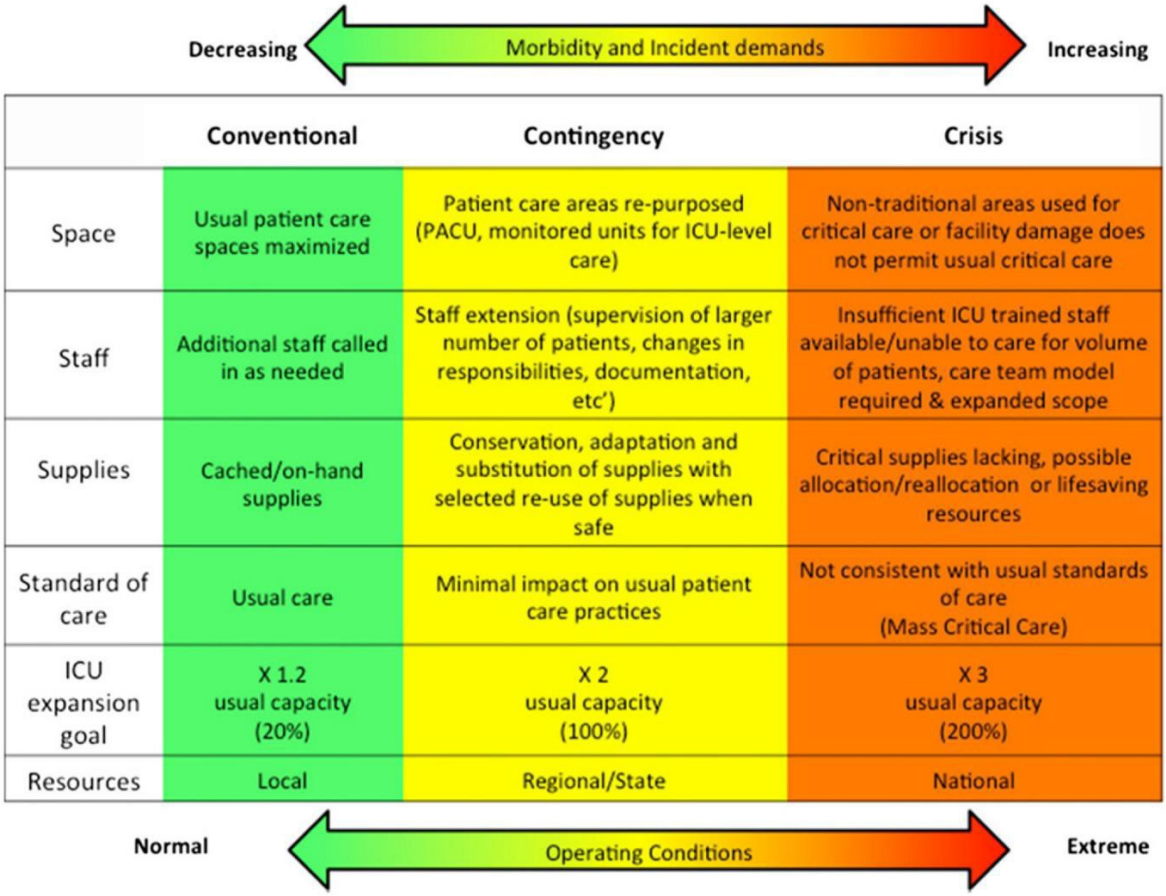


Figure 2. A framework outlining the conventional, contingency, and crisis surge responses. PACU: postanesthesia care unit. [from Christian, et al.; Chest (2014)].(20)

Obtained via MI FOIA by Judicial Watch, Inc.

3. Establish clear Lines of Communication (LOC) to ensure:
    a. The ability to maintain power, particularly at austere or atypical site of care.
    b. The ability to rapidly download a transferrable version of clinical information to follow patients through the system.
    c. That the systems exist to efficiently share this information with staff.
    d. That the communication be consistent, from designated sources, and the information be trusted by staff.
4. Establish Patient Tracking and Re-unification systems:
    a. Command centers should also help plan and coordinate a system for patient tracking, identification, and the ability to communicate with family members and next of kin regarding status and location of loved ones who may be restricted from visitation. (23)
5. Establish security, access points, and "clean" areas with access restricted:
    a. Given high levels of stress, limited resources, potentially crowded living conditions, and considerable anxiety surrounding pandemic disease, coordination with security both for a facility and the ICU should be included in the planning process.
    b. Establish "satellite" units in alternative locations to care for critically ill patients unaffected by the pandemic to group contagious patients, cohort staff, and protect non-infected patients. (24)
    c. Consider allocating "high risk" staff (underlying medical conditions, age >60) to these sections.
    d. Consider access to specialty care that may be needed in these sections with screening as patients enter.
6. Coordination of re-prioritization of clinical duties:
    a. Limitation of non-urgent care, well visits, routine visits or imaging
    b. If prolonged, give consideration to designating satellite sites to continue routine, but necessary care
    c. Coordinate re-allocation of assets off loaded by limitations to areas of need (Critical Care, Inpatient care, Initial triage, and Urgent/Emergency Care).
    d. Limit administrative, educational and academic duties to those necessary to directly support patient care
    e. Develop Recall Roster for all assets (nursing, physician, housekeeping, dietary, security, admin, etc.) and triggers for re-calling those who may be needed from remote work.
7. Consider logistic/ancillary support needs when determining "Essential Personnel" for tasks including:
    a. Disposal of PPE and cleaning both "dirty" rooms and shared spaces. These tasks should be prioritized and will be in very high demand.
    b. Allocation of adequate space for safe, respectful care of the deceased.
    c. Designating locations and facilities to shelter and feed families of ill patients, staff members, and even families of staff members to augment and limit the up to 40-50% absenteeism anticipated with illness, school/childcare closure, and fear.

Preparing Critical Care Resources & Teams

1. ***Staffing.*** Many facilities have reduced staffing capabilities to support their ICUs. However, in a global pandemic requiring care for a surge of critically ill patients, additional staffing models should be considered. Although tele critical care resources should be optimized, there may still be significant deficits in critical care trained healthcare workers.
    a. Staff Shortages:
        i. Preparation also needs to be made to compensate for reduced staffing. Illness, fatigue, fear, and care giver duties, particularly with school/daycare closure, limit staff availability with some estimates as high as 60% absenteeism. (24, 28)
        ii. Strategies listed above may mitigate (facility based child care, cohort care teams,

Obtained via MI FOIA by Judicial Watch, Inc.

etc.) but planning should consider at least a 25-40% reduction in staff availability. These guidelines are currently under review.

iii. The Society of Critical Care Medicine (SCCM) recommends the following staffing model to support expanded critical care bed capacity in the event of a global pandemic (https://www.sccm.org/Blog/March-2020/United-States-Resource-Availability-for-COVID-19), which includes use of multiple non-ICU trained healthcare workers (noted in red):(29)

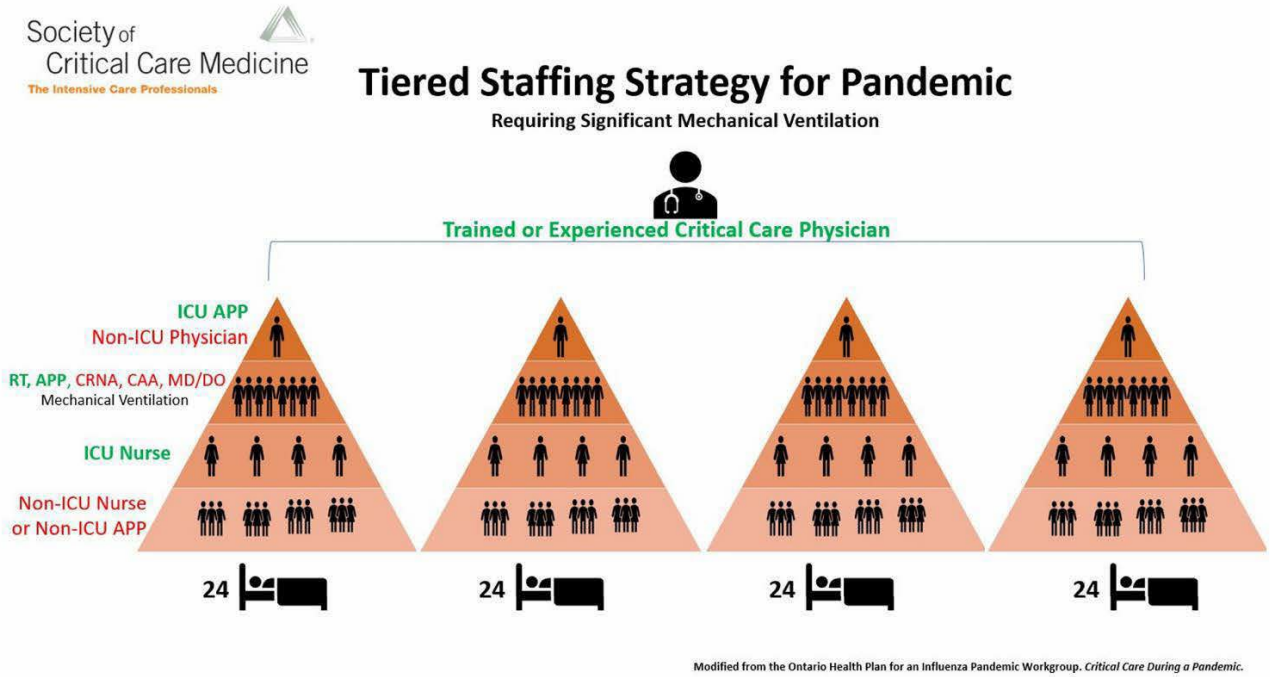


Figure 3. SCCM Tiered Staffing Strategy for Pandemic. APP: advanced practice provider; RT: respiratory therapist; CRNA: certified registered nurse anesthetist; MD/DO: physician [from SCCM link above].(29)

b. In accordance with Joint Commission regulations facilities and local leadership may cross-level providers as needed to provide any type of patient care, treatment and services necessary as a life saving measure- or to prevent serious harm, provided the care, treatment, and services provided are within the scope of the individual's license without modification of existing privileges. Privileging authorities may award disaster privileges on activation of their emergency management plans consistent with provisions established in DHA PM 6025.13, Volume 4.

2. ***Training of Staff.***
   a. ICU "Just in time training" for augmentees from other areas available at https://www.sccm.org/covid19 orhttps://www.sccm.org/disaster
      - Places with ICU care should develop brief local ICU orientation models focusing on safety practices, unit hierarchy, protocols, and consultative relationships but should be brief, no more than 4hrs.
   b. PPE; Donning and doffing officers should be assigned to train and monitor this.
      - These personnel could/should be pulled from non-clinical roles (administrators, support staff, etc.) and could fulfill a vital safety role after being trained. Training video: https://www.youtube.com/watch?v=bG6zISnenPg (30)
3. ***Equipment and Consumables.*** Daily assessment of ventilators, ventilator circuits, PPE, fluids, and sedating medication should be tracked with equipment burn rates estimated and updated as more information is available.
   a. Creation of intubation packs consisting of all necessary PPE (N95, hats, eye protection, gowns, shoe covers, disposable stethoscopes) to avoid providers assembling gear outside of treatment rooms should be considered and would augment ability to track supplies. This

Obtained via MI FOIA by Judicial Watch, Inc.

will both avoid delays in care and the potential for entering the room without proper PPE.

b. Consider alternative options to reduce and re-use critical items such as PPE and ventilator circuits. No current guidance but local policies and solutions should be shared as they become available.

c. When expanding into OR or PACU, the spaced utilization of anesthesia ventilators should be considered. Some should be held in reserve based on facility needs for acute, non- COVID needs.

4. ***Space:***

a. ***ICU Contingency Units.*** Non-emergency medical and dental surgeries and procedures were temporarily restricted under Executive Order 2020-17, which means that some operating room capacity, pre- or post-anesthesia recovery, and other monitored, ventilator capably areas may be available to use as alternative ICU rooms.

b. **Ward Cohorting:** Consideration should be given to establishing COVID wards. This includes regular as well as ICU care areas. Clean barriers on open units similar to chemical "hot lines" could be used. This includes cohorting staff to "COVID-positive" or "COVID- negative" teams based on which cohort they are caring for to reduce transmission. In particular, it is recommended that patients with non-COVID-19 coronavirus be separated from COVID-19 patients because of the risk of homologous recombination.

Establishment Case Registry for Clinical Performance Improvement

1. Systematic collection and iterative analysis of key data on risk factors and outcomes, coupled where possible with collection and repository storage of residual material from pertinent clinical diagnostic specimens, is essential to optimization of care delivery.
2. This should be executed urgently in the context of an approved, directed performance improvement initiative, in the setting of a learning health system.

SCREENING AND TRIAGE: EARLY RECOGNITION OF PATIENTS WITH COVID-19

1. **Screening:** Screen and isolate all patients with suspected COVID-19 at the first point of contact with the health care system (ER/clinic/drive-through screening).
2. **Triage:** Triage patients using standardized triage tools and initiate the appropriate disposition decision depending on the clinical setting.
3. **Initial treatment of hospitalized inpatients** consists of optimized supportive care in the ward or intensive care unit. Patients with increased risk of severe disease and mortality include:
   - Age >60
   - Diabetes mellitus
   - Hypertension
   - Immunosuppression
   - Cardiopulmonary disease
4. Patients may present with mild symptoms but have high risk of deterioration and should be admitted to a designated unit for close monitoring.
5. **Mild Illness.** For mild illness, hospitalization may not be required unless concern about rapid deterioration. Isolation to contain/mitigate virus transmission should be prioritized. Safe home care can be performed according to CDC guidance (https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/caring-for-yourself-at-home.html).

Obtained via MI FOIA by Judicial Watch, Inc.

6. **ICU Admission Criteria.** ICU admission and exclusion criteria may be a fluid decision based on the facility. Given that allocation of dedicated ICU beds and surge capabilities amongst individual hospitals are variable, each hospital should provide a specific plan regarding ICU admission/exclusion criteria. This could be based on the percentage of resources utilized (e.g., beds, ventilators). An example of a plan is provided below from the San Antonio VA:

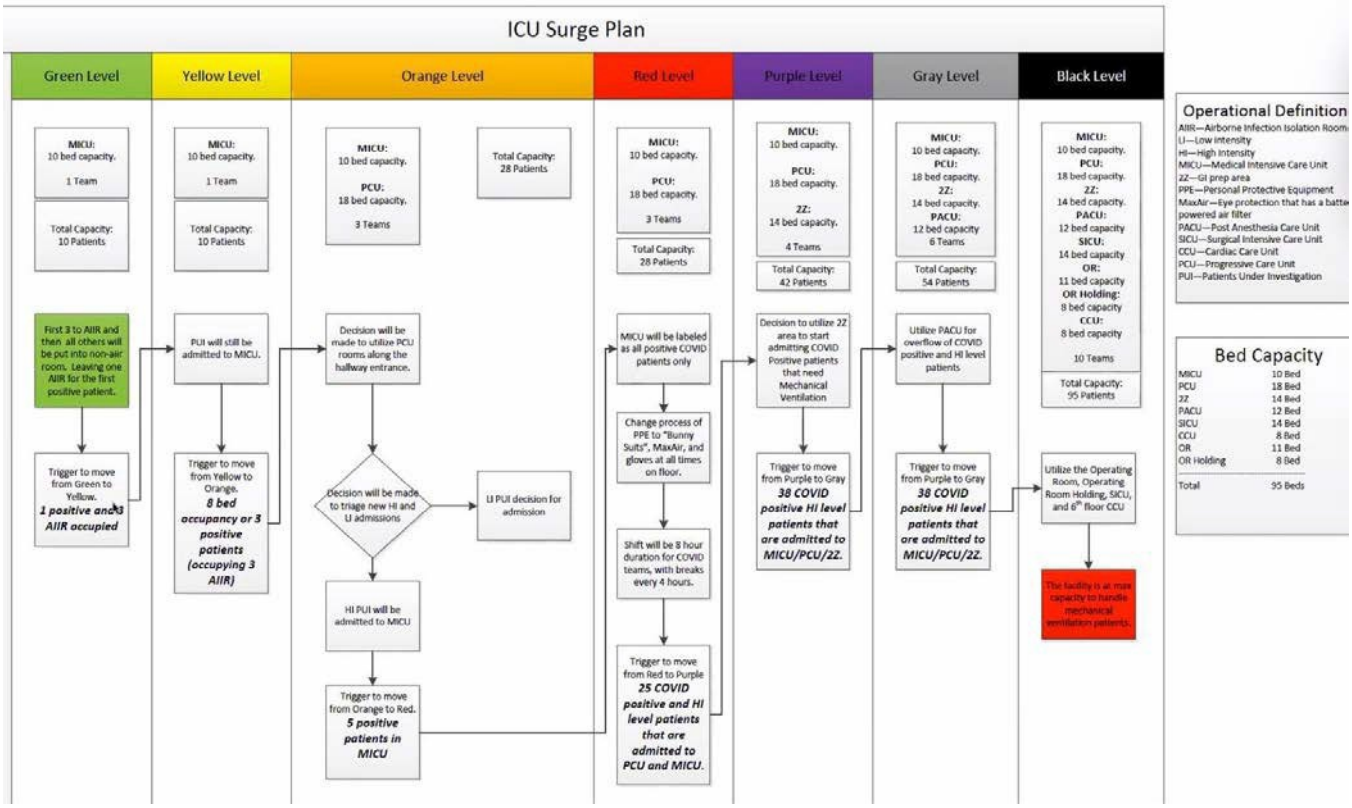


Figure 4. Example of an ICU Surge Plan (from the San Antonio Veteran's Affairs Hospital)

IMMEDIATE IMPLEMENTATION OF APPROPRIATE Infection Prevention Control (IPC) MEASURES

Prior to hospital admission, the patients should be actively separated such as through a tent outside the traditional confines of the hospital for testing purposes or a private room with the door closed within a facility as improved separation is ideal for infection control purposes.

Currently, the CDC's infection control guidance recommends standard and transmission based precautions. To protect health care workers and patients, Executive Order 2020-7 states that all health care facilities, residential care facilities, congregate care facilities, and juvenile justice facilities must prohibit from entering their facilities any visitors that:

- are not necessary for the provision of medical care, the support of activities of daily living, or the exercise of power of attorney or court-appointed guardianship for an individual under the facility's care;
- are not a parent, foster parent, or guardian of an individual who is 21 years of age or under and who is under the facility's care;
- are not visiting an individual under the facility's care that is in serious or critical condition or in hospice care;
- and are not visiting under exigent circumstances or for the purpose of performing official governmental functions.

Facilities must perform a health evaluation of all individuals that are not under the care of the facility each time the individual seeks to enter the facility, and must deny entry to those

Obtained via MI FOIA by Judicial Watch, Inc.

individuals who do not meet the evaluation criteria (symptoms of a respiratory infection, such as fever, cough, shortness of breath, or sore throat; and contact in the last 14 days with someone with a confirmed diagnosis of COVID-19). A partner and doula accompanying a laboring mother are allowed to accompany the mother, as labor qualifies as an exigent circumstance under this order, as long as they pass the health evaluation required.

COLLECTION OF SPECIMENS FOR LABORATORY DIAGNOSIS

1. **Triage:** Patients should be triaged according to testing algorithm and initial testing should optimally be performed in a manner separated from the general patient population such as in a tented environment or designated area within a facility. When determined appropriate to test, initial laboratory collection will include nasopharyngeal swab for COVID-19 testing and additional tests as indicated.
2. **Specimen Collection:** Collect specimens from the upper respiratory tract (URT; nasopharyngeal AND, where clinical suspicion remains and URT specimens are negative, collect specimens from the lower respiratory tract when readily available (LRT; expectorated sputum, endotracheal aspirate,) for COVID- 19 virus testing by RT-PCR and bacterial strains. Recent CDC guidance has granted the ability to utilize nasal swabs or mid-turbinate swabs, either clinical or self-collected, as long as they are transported in appropriate viral transport media (i.e. VTM, UTM, M4, Aimes, etc.). Additionally, testing for other viral infections such as influenza should be obtained or if available a respiratory viral panel (i.e. Biofire). Avoid bronchoscopy to minimize aerosolization unless critical therapeutic indication. (31)
3. **Critically Ill Patients:** If admitting a critically ill patient, collect blood cultures for bacteria associated with pneumonia and sepsis, ideally before antimicrobial therapy. If bacterial pneumonia is suspected, DO NOT delay antimicrobial therapy to collect blood cultures. If available, procalcitonin may be helpful as COVID-19 has been associated with low procalcitonin levels which can minimize antibiotic overuse. (32)
4. **Confirming COVID-19.** Per CDC, "for initial diagnostic testing for COVID-19, CDC recommends collecting and testing upper respiratory tract specimens (nasopharyngeal swab). CDC also recommends testing lower respiratory tract specimens, if available. For patients who develop a productive cough, sputum should be collected and tested for COVID-19. The induction of sputum is not recommended. For patients for whom it is clinically indicated (e.g., those receiving invasive mechanical ventilation), a lower respiratory tract aspirate or bronchoalveolar lavage sample should be collected and tested as a lower respiratory tract specimen."
5. **Hospitalized Patients:** In hospitalized patients with confirmed COVID-19, repeated URT and LRT samples can be collected to demonstrate viral clearance. The frequency of specimen collection will depend on local epidemic characteristics and resources. The CDC now recommends that patients with COVID-19 can be discharged from a healthcare facility whenever clinically indicated. The decision to discontinue Transmission-Based Precautions should be made using a test-based strategy or a non-test-based strategy (i.e., time-since-illness-onset and time-since-recovery strategy). Meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for discharge.
6. **Personal Protective Equipment (PPE):** For collection of URT specimens, HCP should an N-95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown. When collecting LRT specimens, HCP in the room should wear an N95 or higher-level respirator, eye protection, gloves, and a gown. LRT specimen collection generally involves aerosol-generating procedures and should ideally be performed in an airborne infection isolation room.
7. **For pregnant patients:** COVID-19 testing of symptomatic pregnant women may need to be prioritized to enable access to specialized care. Per the CDC, People who are pregnant should be monitored since they are known to be at risk with severe viral illness, however, to date data on COVID-19 has not shown increased risk.
8. **Co-infection:** Dual infections with other respiratory viral and bacterial infections have been found in

Obtained via MI FOIA by Judicial Watch, Inc.

SARS, MERS and COVID-19 patients. As a result, a positive test for a non-COVID-19 pathogen does not rule out COVID-19. At this stage, detailed microbiologic studies are needed in all suspected cases. Both URT and LRT specimens can be tested for other respiratory viruses, such as influenza A and B, respiratory syncytial virus, parainfluenza viruses, rhinoviruses, adenoviruses, enteroviruses (e.g. EVD68), human metapneumovirus and endemic human coronaviruses (i.e. HKU1, OC43, NL63, and 229E). LRT specimens can also be tested for bacterial pathogens, including Legionella pneumonia.

9. **Malaria-endemic areas:** If a patient recently returned from a malaria-endemic area, patients with fever should be tested for malaria or other co-infections with validated rapid diagnostic tests (RDTs) or thick and thin blood films and treated as appropriate. In endemic settings arbovirus infection (dengue/chikungunya) should also be considered in the differential diagnosis of undifferentiated febrile illness, particularly when thrombocytopenia is present. Co-infection with COVID-19 virus may also occur and a positive diagnostic test for dengue (e.g. dengue RDTs) does not exclude the testing for COVID-19.

MANAGEMENT OF MILD COVID-19: SYMPTOMATIC TREATMENT AND MONITORING

- The mainstay of treatment for mild cases of COVID-19 is supportive care.
- Those with mild disease may be managed as an outpatient, but the determination of outpatient vs inpatient care should be individualized based on consideration of symptom severity and risks for adverse outcomes (e.g., underlying illness and age), and the patient's social context:
    - Their access to resources such as food and other necessities for daily living
    - Their access to appropriate caregivers or ability to engage in self-care
    - Their ability to engage in symptom and public-health monitoring
    - The transmission risk within the home (e.g., the availability of a separate bedroom to minimize sharing of immediate living spaces with others, their access to appropriate personal protective equipment such as gloves and a facemask, their ability to adhere to home isolation, respiratory and hand hygiene, and environmental cleaning, and the presence of household members at increased risk for COVID-19 complications).(11, 33, 34)
- Although 81% of patients in a Chinese case series had mild symptoms, those who progressed to more severe disease were hospitalized a median of 7-11 days after the onset of illness.(4, 6, 35) Therefore, close monitoring for symptomatic progression through the second week of illness is important for non-hospitalized patients. Close monitoring should be emphasized in patients aged ≥ 60 years and/or with underlying medical comorbidities that may increase their risk for disease progression, to include: cardiovascular disease, cerebrovascular disease, chronic respiratory diseases, chronic kidney disease, chronic liver disease, diabetes, hypertension, cancer, immunocompromising conditions, and pregnancy. (6, 11, 35, 36)
- Monitoring for symptomatic improvement may be conducted by healthcare providers or public-health personnel.
- Clinicians should contact local public health and/or local/state health department regarding criteria for discontinuation of homeisolation.
    - Healthcare providers may provide patients or their caregivers access to available CDC guidance on home care: Preventing the Spread of Coronavirus Disease in Homes and Residential Communities
    - What to Do If You Are Sick
    - Caring for Someone at Home
    - Caring for Yourself at Home
    - MDHHS: COVID-19 Guidance for Healthcare Facilities for Discharge of Residents

Obtained via MI FOIA by Judicial Watch, Inc.



Figure 5. CDC Home Care Management Recommendations for COVID-19 Patients (website above). (34)

- Theoretical concern has been raised that the use of non-steroidal anti-inflammatory drugs (NSAIDs) may lead to complications of COVID-19 due to NSAID-induced upregulation of angiotensin-converting enzyme 2 (ACE2), which is the cellular binding target for SARS-COV-2. Although there is no clinical evidence of association between NSAIDs and outcomes for COVID-19, the French Health Minister cautioned that use of ibuprofen could be an aggravating factor in COVID-19. (39) Society of Critical Care Medicine's Guidelines on the Management of Critically Ill Adults with COVID-19 states that the use of non-steroidal anti-inflammatory drugs to treat fever in patients with COVID-19 continues to be debated. Until more evidence is available, we suggest using acetaminophen/paracetamol to treat fever.

MANAGEMENT OF SEVERE COVID-19: OXYGEN THERAPY AND MONITORING

1. Give supplemental oxygen therapy immediately to patients with respiratory distress, hypoxemia, or shock and target SpO2 92-96%. (40,41)

Obtained via MI FOIA by Judicial Watch, Inc.

2. Patients that have a persistent requirement for 5-6 L/min to maintain target SpO2 should be considered for early intubation/mechanical ventilation given risk of deterioration.
3. For adults, initiate oxygen therapy during resuscitation at 5-6 L/min and titrate flows to reach target SpO2 92-96% during resuscitation. If persistent requirement for 5-6 L/min and lacking resources for invasive ventilation, consider use high flow nasal oxygen (HFNC) or a face mask with a reservoir bag at 10-15 L/min if the patient is in critical condition.
4. Recommendations are evolving regarding risk: benefit, but favor HFNC over BIPAP/noninvasive ventilation (NIV) if early intubation and mechanical ventilation is not possible. HFNC is a more effective intervention for non-invasive management of ARDS that requires less staff intervention. HFNC is also potentially safer for staff than BIPAP/NIV. Avoid BIPAP, if HFNC is unsuccessful; early intubation is recommended. (31)
5. Recommend rapid sequence intubation (RSI) to minimize bagging for staff safety. Staff should have proper personal protective equipment for intubation including powered air purifying respirator (PAPR) if available or an N95 mask and face shield.
6. For children, use of nasal prongs or nasal cannula may be better tolerated, but the goal is to target SpO2 >94% during resuscitation, and >90% once stable.
7. Patients may deteriorate rapidly, so continuous monitoring is critical.
8. Aggressive fluid resuscitation may worsen oxygenation and outcomes in both children and adults, so in the absence of shock, fluid boluses should be minimized.
9. Avoid nebulizers, as metered dose inhalers are recommended for staff protection and avoidance of aerosol generation. (31)
10. Avoid routine steroids in patients without acute respiratory distress syndrome (ARDS) except under certain circumstances. However, consider steroids for intubated patients with ARDS per the Society of Critical Care Medicine's Guidelines on the Management of Critically Ill Adults with COVID-19.
11. For intubated patients with ARDS and a PaO2/FiO2 ratio<150, recommend early proning and consideration for transfer to an extracorporeal membrane oxygenation (ECMO) center. Prone patients may require paralysis with cisatricurium but resources may dictate per individual facility.
12. **Admission studies and labs**: Consider the following labs/studies for diagnosis, prognosis and risk stratification (and/or safety of agents) for all hospitalized patients with confirmed COVID-19/PUI:

Table 1. Laboratory and Study Considerations for Hospitalized Patients with COVID-19 (or PUI)

Recommended Daily Labs:

- Complete Blood Count (CBC) with diff (trend neutrophil-lymphocyte ratio, NLR)*
- Complete metabolic panel(CMP)
- CPK

Recommend on Admission (may repeat q2-3 days if abnormal or with clinical deterioration)

- D-dimer, PT/PTT,Fibrinogen
- Ferritin/CRP/ESR
- LDH
- IL-6
- Troponin (if suspect acute coronary syndrome or heart failure)
- SARS-CoV-2 test, Biofire rapid viraltesting
- Electrocardiogram (ECG) (daily withsevereinfection)
- Portable CXR

If Clinically Indicated

- Blood cultures
- Tracheal aspirates for intubated patients
- Viral serologies if LFTs are elevated if clinically indicated (HBV sAb/cAb/sAg, HCV Ab, HIV q/2 Ab/Ag)
- For acute kidney injury (i.e. serum creatinine >0.3 above baseline), send urinalysis and spot urine protein:creatinine)
- Procalcitonin

* https://emcrit.org/pulmcrit/nlr/

Obtained via MI FOIA by Judicial Watch, Inc.

13. Do not allow ICU visitors for Infection Prevention and Control (IPC) purpose during a pandemic except under exigent circumstances.
14. Facilities should assess daily operational status via huddle of equipment including ventilators, medications (e.g. induction agents and paralytics), and staffing (including respiratory therapists, physicians and nursing). In the event of more patients than ventilators, then patients requiring intubation can be intubated and bag valve mask ventilated until a lower acuity patient can be extubated. Current science does not recommend splitting ventilators for COVID-19 patients.(https://emcrit.org/pulmcrit/split-ventilators)

MANAGEMENT OF SEVERE COVID-19: TREATMENT OF CO-INFECTIONS

1. Clinical judgment and patient severity will dictate provider decision on early antibiotic therapy.
2. Data on the prevalence of bacterial superinfection in patients with COVID-19 are limited per the Society of Critical Care Medicine's Guidelines on the Management of Critically Ill Adults with COVID-19.
3. Consider empiric antimicrobials for intubated patients with COVID-19. Recommend antibiotic guidance as per ATS/IDSA Community Acquired Pneumonia (CAP) guidelines or as per critical care or infectious disease consultation. (42) However, as a starting point upon intubation, the following table can be used until consultation is available:

Table 2. Empiric Antimicrobial Considerations for Intubated COVID-19 Patients (or PUI)

	Starting Antibiotic Regimen
No comorbidities or immunosuppression or risk factors for MRSA or *Pseudomonas aeruginosa**	• Ceftriaxone† 2 g once daily, *and* Azithromycin† 500 mg once daily
With comorbidities‡	• Cefepime 1-2 g every 8-12 hours, *and* Azithromycin† 500 mg once daily *OR* • Piperacillin-Tazobactam 4.5 g every 6-8 hours, *and* Azithromycin† 500 mg once daily

Definition of abbreviations: MRSA = methicillin-resistant *Staphylococcus aureus*
*Risk factors include prior respiratory isolation of MRSA or *P. aeruginosa* or recent hospitalization AND receipt of parenteral antibiotics (in the last 90 d). If concern for MRSA, add **Vancomycin** 15-20 mg/kg q 8-12 hours (usually 2g/dose)
†If Ceftriaxone not available, replace with **Ampicillin/Sulbactam** 3 g q6h; If Azithromycin not available, replace with **Doxycycline** 100 mg q12h
‡Comorbidities include chronic heart, lung, liver, or renal disease; diabetes mellitus; alcoholism; malignancy; immunodeficiency/asplenia.

4. Recommend obtaining blood cultures and tracheal aspirate prior to initiation of antibiotics when feasible.
5. As noted in section on diagnostic testing, co-detection of other respiratory pathogens has been observed with SARS-CoV-2. For example, Stanford researchers recently provided rapid communication of experience with 562 SARS-CoV-2 tests; of 49 positive SARS-COV-2 results, 11 (22.4%) also had a co-infection, and of 127 positive for other viruses, 11 (8.66%) had a SARS-COV-2 co-infection. (https://medium.com/@nigam/higher-co-infection-rates-in-COVID-19-b24965088333)

MANAGEMENT OF CRITICAL COVID-19: ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS)

Development of Respiratory Failure

1. Recognize severe hypoxemic respiratory failure when a patient with respiratory distress is failing

Obtained via MI FOIA by Judicial Watch, Inc.

to respond to standard oxygen therapy. Prepare to provide advanced oxygen and ventilatory support.

2. All forms of respiratory therapy have a risk of aerosolization of the virus and risk to others. Comparison of non-invasive respiratory modalities continues to evolve, but presently use of HFNC should be favored over BIPAP. HFNC is more efficacious for non-invasive management of ARDS compared to BIPAP, is generally well tolerated, and requires less staff intervention (coming in and out of room for alarms and troubleshooting). If this therapy is attempted, it should ideally be confined to negative pressure isolation rooms and healthcare workers should have appropriate, to include N95 masks and PAPR.
3. Avoid use of nebulized medications when possible given the increased risk of aerosolization.
4. Non-invasive ventilation (e.g. CPAP, BiPAP) should in general be avoided given the rapid progression of respiratory failure in patients with ARDS from COVID-19 and the risks to staff. If escalation is required, early intubation should be performed. (41)

Endotracheal Intubation

1. Intubation should be performed early for a number of reasons, including the rapid disease progression, but also the additional time required to prepare for intubation in full PPE.
2. Intubation has the highest risk of aerosolization and exposure to COVID-19 of all procedures, and the person performing intubation is most at risk.(31) For this reason, the most experienced person should perform endotracheal intubation to reduce exposure to the healthcare team and all team members should be in appropriate PPE with fit-tested N95 and medical protected head hood or powered air purifying respirator (PAPR) during intubation. If PAPR is unavailable, N95, hair cover, protective coverall, gown, double gloves, face shields, goggles, and shoe covers should be used. Limit the number of staff members during airway manipulation to reduce the risk of unnecessary exposure. (https://www.apsf.org/news-updates/perioperative-considerations-for-the-2019-novel-coronavirus-covid-19/)
3. A pre-intubation checklist is strongly encouraged, which should include supplies to be brought inside the room by specific team members and others that should remain outside the room in case they are needed. **Appendix A** provides an example intubation checklist (adapted from University of Washington). *Note: a disposable stethoscope should be used to avoid transferring the virus and staff should touch as little as possible in the room to avoid fomites.*
4. For patients with a normal airway assessment, awake intubation should be avoided and modified rapid sequence intubation with sufficient muscle relaxation is strongly encouraged. For patients with difficult airways, good preparation of airway devices and detailed intubation plans should be made in advance. (43)
5. Some centers have advocated for further reducing exposure during pre-oxygenation and ventilation through preparing an additional COVID Intubation Pack (**Appendix B**), in addition to intubation medications, a video laryngoscope (if used, or direct laryngoscopy), and a non-vented BiPAP mask. The following video demonstrates the set-up:(https://youtu.be/C78VTEAHhWU).
6. **Appendix C** provides a framework for intubation with medications and doses, although this is not a substitute for clinical judgement.
7. Additional cognitive aids have been developed and might be useful. **Appendix D** provides examples.

Management of ARDS

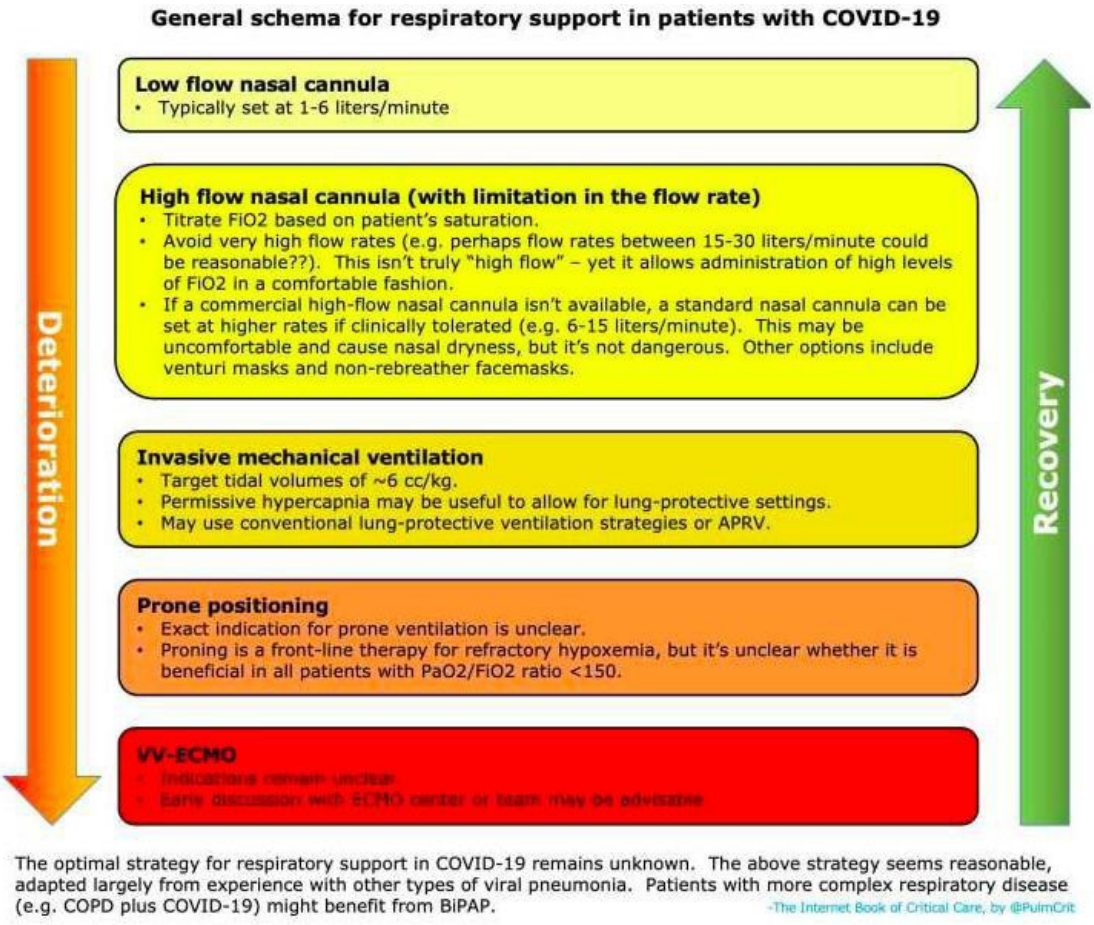
1. ***Non-invasive ventilation (NIV).*** It is recommended to avoid NIV because there is no exhalation filter. If there is an exception to this such as patients that chronically use NIV or DNI patients, these patients will require airborne isolation regardless of ICU/acute care status. *Note:* V60 ventilators are also highly aerosolizing and should be discouraged.
2. ***High-flow nasal cannula (HFNC).*** Although an area of controversy, early expert opinion favors HFNC

Obtained via MI FOIA by Judicial Watch, Inc.

over other non-invasive modalities (https://emcrit.org/ibcc/COVID-19/#high_flow_nasal_cannula) because it appears to be well tolerated, more efficacious than BIPAP and less provider intensive. There is presently no definitive evidence that HFNC augments transmission of virus.

3. ***Mechanical Ventilation.*** COVID-19 does not appear to cause substantially reduced lung compliance as is typical with ARDS, but rather atelectasis and interstitial pneumonia. Physicians in Italy have described severe hypoxia with decent pulmonary compliance. (http://www.ventilab.org/2020/02/29/ventilazione-meccanica-e-polmonite-da-coronavirus/)
   a. Target *high **PEEP**, lung-protective tidal volume* (**4-8 mL/kg ideal body weight**), and lower inspiratory pressures (**plateau pressure <30 cm H_2O**).(41,44)
      i. Start with 6 mL/kg ideal body weight tidal volume and titrate as needed
      ii. In patients with moderate to severe ARDS, suggest higher PEEP instead of lower PEEP. PEEP tables are available to guide titration: http://www.ardsnet.org/tools.shtml
      iii. In younger children, maximal PEEP setting is 15 cm H_2O as higher PEEP can result in decreased cardiac output.
   b. *Permissive hypercapnia* ensuring adequate hemodynamics and a pH >7.15 may be tolerated
4. ***Proning.*** Evidence has shown that patients who are unable to adequately ventilate in the supine position may benefit from being placed in the prone position to improve oxygen saturation (PaO2), pulmonary mechanics, and arterial blood gases (ABGs). (45-49) Anecdotal reports from Italy have found that patients with COVID-19 usually respond well to early pronation.
5. Prone positioning requires proper sedation/pain medications and paralytic agents if necessary.
   a. Length of pronation cycle should be a minimum of 16 hours in the prone position with a return to supine positioning at least once a day.
   b. Prone positioning should be performed as clinically indicated within the first 24 hours of the diagnosis of severe hypoxemia.
   c. Recommend use of a manual proning protocol with coordination if mechanical beds are not available. **Appendix E** provides an example protocol, which was adapted from University Medical Center in Las Vegas, NV. Additional protocols (including videos) are available. (50)
   d. Pregnancy is *not* a contraindication for proning or neuromuscular blockade. (51)
6. ***Neuromuscular Blockade.*** In patients with moderate-severe ARDS (PaO2/FiO2<150), neuromuscular blockade by continuous infusion should **not** be routinely used, but may be considered in the setting of worsening hypoxia or hypercapnia and in situations where the patient's respiratory drive cannot be managed with sedation alone resulting in ventilator dyssynchrony and lung decruitment.
7. ***Airway suctioning.*** Use in-line catheters for airway suctioning and clamp endotracheal tube when disconnection is required (for example, transfer to a transport ventilator). Avoid disconnecting the patient from the ventilator, which results in loss of PEEP and atelectasis.
8. ***Bronchoscopy.*** Routine diagnostic bronchoscopy is **not** recommended. It is not necessary for the diagnosis of viral pneumonia and should be avoided to minimize aerosolization. Tracheal aspirate samples for diagnosis of COVD-19 are usually sufficient. If bronchoscopy is required for another reason, it should be performed with the same level of PPE as recommended for intubation.
9. ***Inhaled nitric oxide and prostacyclin.*** There is no evidence for routine use of inhaled nitric oxide, prostacyclin or other selective pulmonary vasodilators in acute respiratory failure. However, during emerging infectious disease outbreaks when resources are exhausted, inhaled nitric oxide and prostacyclin may be considered as a temporizing measure when patients develop refractory hypoxemia despite prone ventilation, or in the presence of contraindications to proning or ECMO.
10. ***Extracorporeal Membrane Oxygenation (ECMO).*** In settings with access to expertise in ECMO, consider referral of patients who have refractory hypoxemia despite lung protective ventilation who are otherwise appropriate candidates. For more information: https://www.elso.org/COVID-19.

Obtained via MI FOIA by Judicial Watch, Inc.



https://emcrit.org/ibcc/COVID-19/#high_flow_nasal_cannula

https://i1.wp.com/emcrit.org/wp-content/uploads/2020/03/respsup.jpg?resize=713%2C600&ssl=1

MANAGEMENT OF CRITICAL ILLNESS AND COVID-19: PREVENTION OF COMPLICATIONS

Cardiovascular Disease (CVD)

Among 44,672 confirmed COVID-19 cases, those with cardiovascular disease (CVD), diabetes (DM) and hypertension (HTN) suffered from an increased case-fatality rate -10.5% for CVD, 7.3% for DM, 6.0% for HTN vs 2.3% overall. Furthermore, there several published reports suggesting SARS-CoV2 infection leading to exacerbation of CVD conditions, or CVD complications. (4, 35, 52)

1. ***Troponins and Basic Natriuretic Peptide (BNP) Evaluation.*** Elevated troponin is common (especially high sensitivity troponin), which is a strong predictor of mortality. Mild troponin elevation often does not represent a type-I (plaque rupture) myocardial infarction. Troponin value, velocity of change in troponin level, and echocardiographic imaging should guide the management of the elevated troponin, although current opinion advises that troponin and BNP should only be measured if clinical evaluation suggests acute coronary syndrome or heart failure. (53)
2. ***Electrocardiogram (ECG).*** Recommend ECG in suspected or acute coronary syndrome. May consider of obtaining from cardiac tele-monitoring screen.
3. ***Echocardiogram.*** An echocardiogram should only be ordered if it is likely to provide clinical benefit. Consider repeat echocardiograms only for clear change in clinical status. Point of Care Ultrasound (POCUS) exams may be used to screen/triage patients. Transesophageal

Obtained via MI FOIA by Judicial Watch, Inc.

echocardiogram (TEE) requests should only be considered when no other alternative imaging modalities are available as the procedure may be aerosol producing.

4. ***Acute Myocardial Injury.***
    a. *Definition*: An algorithm for the interpretation of myocardial injury is provided for reference and is based on the 4th Universal Definition of Myocardial Infarction (http://www.onlinejacc.org/content/72/18/2231).
    b. *Incidence and Prognosis*: Recent reports found that 7-17% of hospitalized patients with COVID-19, have a combination of elevated cardiac biomarkers, in addition to electrocardiographic and echocardiographic abnormalities.(3, 4, 6) This myocardial injury appears to be a late manifestation (up to 14 days from illness onset).(4)
5. ***Myocarditis.***
    a. *Incidence*: In a case series of 150 patients with COVID patients, nearly 10% of deaths were attributed to myocarditis with circulatory failure, and in 33% of cases it was believed to have contributed as a mechanism for multisystem organ failure.(52) Currently, pericarditis has not yet been reported.
    b. *Diagnosis*: There is currently no role for endocardial biopsy. POCUS at initial evaluation to help protocol TTE. Serial TTE/POCUS only if it will impact management.
    c. *Management*: Supportive care depending on hemodynamic status. Case reports on different treatment strategies (glucocorticoid and IVIG) but none are validated by clinical trials.
6. ***Acute Coronary Syndrome.***
    a. *Incidence*: Based on available published data, there is a potential symptom overlap between acute coronary syndrome and COVID-19infection. (2)
    b. *Evaluation*: Goal is to differentiate acute plaque rupture, demand related ischemia or myocarditis. Recommendation is for cardiology consultation when unable to determine etiology.
    c. *Management*: Once the diagnosis of acute coronary syndrome is made, medical management should be coordinated with cardiology. ST-Elevation Myocardial Infarction (STEMI) Fibrinolytics protocols should be reviewed at each institution with cardiology to discuss care plans in the event of strained resources.
7. ***Cardiac Arrhythmias.***
    a. *Incidence*: Common CV manifestation in COVID-19 patients. Current cases series report an occurrence of unspecified arrhythmias in 17% of hospitalized patients with COVID-19 (44% of ICU patients vs 7% non ICU patients).(4) The new onset of malignant tachyarrhythmias in combination with acute myocardial injury should raise suspicion for potential underlying myocarditis.(2)
    b. *Management*: Follow ACLS protocols. Cardiology consultation.
8. ***Heart Failure and Cardiomyopathy.***
    a. *Incidence*: In a recent report it was observed that 23% of patients with COVID-19 had presentations consistent with heart failure. More frequently observed in patients who did not survive the hospitalization (51.9% vs 11.7%). (4) Fulminant cardiomyopathy can occur and is thought to be a late feature described in patients recovering from respiratory failure. Cardiogenic shock and cardiac arrest contributes to 7-33% of deaths. (52)
    b. *Mechanism*: SARS-CoV-2 is thought to infect host cells through ACE2 to cause COVID-19, while also causing damage to the myocardium, although specific mechanisms are uncertain. (54)
    c. *Management*: In the absence of high-grade AV block or unstable bradycardia, cardiogenic shock, or acute kidney injury (AKI), guideline directed medical therapies should be continued in patients with heart failure. Assessment of continuation of these therapies should be determined on a frequent basis depending on the patient's clinical status. The American College of Cardiology, Heart failure Society of America, and American Heart association published a joint statement at the time of this writing that recommends continuation of ACE-I/ARB therapy in patients withCOVID-19. (55)

Obtained via MI FOIA by Judicial Watch, Inc.

Acute Kidney Injury

1. AKI requiring dialysis is reported in a subset of patients admitted to ICU.
2. The exact mechanism is unclear at this point, but AKI is present in ~7% of patients with pathology demonstrating acute tubular necrosis (a reflection of multiorgan failure). AKI correlates with an overall poor prognosis and seems to be the strongest predictor of mortality.

Nutrition

1. Oral and enteral routes of nutrition are preferred.
2. Post-pyloric feeding is preferred for critically ill and mechanically ventilated patients.
3. Energy supply should target. 25-30 kcal per kg body weight, the target protein content is 1.2-2.0 g/kg daily.
4. For elderly patients and/or those at high risk of aspiration or with abdominal distension, may give earlier consideration to parenteral nutrition.

Other

1. Implement the following interventions in Table 1 below to prevent complications associated with critical illness. These interventions are limited to feasible recommendations and are based on Surviving Sepsis or other guidelines and have been adapted from the WHO guidelines for COVID-19.

Table 3. Prevention of Complications

Anticipated outcome	Interventions
Reduce days of invasive mechanical ventilation	• Use weaning protocols that include daily assessment for readiness to breathe spontaneously • Minimize continuous or intermittent sedation, targeting specific titration endpoints (light sedation unless contraindicated) or with daily interruption of continuous sedative infusions
Reduce incidence of ventilator-associated pneumonia	• Oral intubation is preferable to nasal intubation in adolescents and adults • Keep patient in semi-recumbent position (head of bed elevation 30–45º) • Use a closed suctioning system; periodically drain and discard condensate in tubing • Use a new ventilator circuit for each patient; once patient is ventilated, change circuit if it is soiled or damaged, but notroutinely • Change heat moisture exchanger when it malfunctions, when soiled, or every 5–7 days
Reduce incidence of venous thromboembolism	• Use pharmacological prophylaxis (low molecular-weight heparin [preferred if available] or heparin 5000 units subcutaneously twice daily) in adolescents and adults without contraindications. For those with contraindications, use mechanical prophylaxis (intermittent pneumatic compression devices)
Reduce incidence of catheter-related bloodstream infection	• Use a checklist with completion verified by a real-time observer as reminder of each step needed for sterile insertion and as a daily reminder to remove catheter if no longer needed
Reduce incidence of pressure ulcers	• Turn patient every 2hours
Reduce incidence of stress ulcers and gastrointestinal (GI) bleeding	• Give early enteral nutrition (within 24–48 hours of admission) • Administer histamine-2 receptor blockers or proton-pump inhibitors in patients with risk factors for GI bleeding. Risk factors for GI bleeding include mechanical ventilation for ≥ 48 hours, coagulopathy, renal replacement therapy, liver disease, multiple comorbidities, and higher organ failure score
Reduce incidence of ICU-related weakness	• Actively mobilize the patient early in the course of illness when safe to do so

MANAGEMENT OF CRITICAL ILLNESS AND COVID-19: SEPTIC SHOCK & CARDIAC ARREST

Recognition of Septic Shock

1. Recognize septic shock in adults when infection is suspected or confirmed AND vasopressors are needed to maintain mean arterial pressure (MAP) 60-65 mmHg AND lactate is ≥ 2 mmol/L, in absence of hypovolemia. (40,56)
2. Recognize septic shock in children with any hypotension (systolic blood pressure [SBP] < 5thcentile or > 2 SD below normal for age) or two or more of the following: altered mental state; bradycardia or tachycardia (HR < 90 bpm or > 160 bpm in infants and HR < 70 bpm or > 150

Obtained via MI FOIA by Judicial Watch, Inc.

bpm in children); prolonged capillary refill (> 2 sec) or feeble pulses; tachypnea; mottled or cold skin or petechial or purpuric rash; increased lactate; oliguria; hyperthermia or hypothermia.

3. Standard care includes early recognition and the following treatments within 1 hour of recognition: antimicrobial therapy, and initiation of fluid bolus and vasopressors for hypotension (Surviving Sepsis Guidelines). The use of central venous and arterial catheters should be based on resource availability and individual patient needs. Detailed guidelines from the Surviving Sepsis Campaign and WHO are available for the management of septic shock in adults and children.

Septic Shock Resuscitation

1. For septic shock in adults: give 250–500 mL crystalloid fluid as rapid bolus in first 15–30 minutes and reassess for signs of fluid overload after each bolus. (56)
2. For septic shock in children, give 10–20 mL/kg crystalloid fluid as a bolus as quickly as possible using a manual push and reassess for signs of fluid after each bolus. (57)
3. ***Avoid Excessive Fluid Resuscitation***. The cause of death from COVID-19 is most often ARDS and subsequent complications, which may be exacerbated by fluid administration. (2) Patients usually present with normal lactate and blood pressure, but some patients do suffer from superimposed bacterial septic shock. Conservative fluid therapy consistent with FACTT trial should be considered for patients with evidence of hypoperfusion and a history suggestive of total body hypovolemia (e.g. prolonged nausea/vomiting and diarrhea).(58) Consider use of point of care ultrasound (POCUS) to guide fluid resuscitation and prevent volume overload. If there is no response to fluid loading or signs of volume overload appear (e.g. jugular venous distension, crackles on lung auscultation, pulmonary edema on imaging, or hepatomegaly in children), then reduce or discontinue fluid administration. This step is particularly important in patients with hypoxemic respiratory failure.
4. Resuscitation endpoints include perfusion targets (e.g., MAP 60-65 mmHg in adults; urine output > 0.5 mL/kg/hr in adults or 1 mL/kg/hr in children; improved level of consciousness; and lactate).
5. In **pregnant women**, compression of the inferior vena cava can cause a decrease in venous return and cardiac preload and may result in hypotension. For this reason, pregnant women with sepsis and or septic shock may need to be placed in the left lateral decubitus position at 30 degrees to off-load the inferior vena cava.
6. Clinical trials conducted in resource-limited studies comparing aggressive versus conservative fluid regimens suggest higher mortality in patients treated with aggressive fluid regimens.
7. Do **not** use hypotonic crystalloids, starches, or gelatins for resuscitation.
8. Vasopressors should be administered when shock persists during or after fluid resuscitation to maintain MAP goal 60-65 mmHg.
9. If central venous catheters are not available, vasopressors can be given through a peripheral IV, but use a large vein and closely monitor for signs of extravasation and local tissue necrosis. If extravasation occurs, stop infusion. Vasopressors can also be administered through intraosseous needles.
10. If signs of poor perfusion and cardiac dysfunction persist despite achieving MAP target with fluids and vasopressors, consider an inotrope such as dobutamine.
11. Norepinephrine is considered first-line treatment in adult patients; epinephrine or vasopressin can be added to achieve the MAP target.
12. Angiotensin II (Giapreza) is a vasopressor that may provide benefit in vasodilatory refractory shock as a third-line agent. However, in a resource-constrained environment, this is an unproven costly therapy.
13. In children, epinephrine is considered first-line treatment, while norepinephrine can be added if shock persists despite optimal dose of epinephrine.

Rapid Response or Code Blue

1. A local Protected Code Blue Protocol should be developed for resuscitating COVID-19 patients that is peer-reviewed and based on the best available data and evidence. It should be updated based

Obtained via MI FOIA by Judicial Watch, Inc.

on performance improvement data and experience.

2. Staff should be trained appropriately using high-fidelity simulation where possible.
3. Where it is necessary that the Rapid Response or Code Blue team attends, the following is recommended:
   a. PPE must be available that is equivalent to that used in ICU, therefore airborne precautions including an N95 mask.
   b. Entry to a patient's room should be limited to vital staff, which may mean a reduction in the Code Blue Team respondents.
   c. The patient should be assessed by the most senior medical staff available to determine appropriate management and disposition.
   d. If aerosol generating procedures (AGP) are required, these should ideally be performed in a negative pressure room, however, this needs to be balanced with the safety of transporting the patient.
   e. CPR is an AGP and we recommend all staff should wear airborne PPE including an N95 mask before commencing chest compressions. If available, an automated compressor device should be used to minimize required staff and exposure.
   f. If the patient is on a ventilator, keep the patient on a ventilator with an adjusted rate of 10 during CPR unless airway obstruction is suspected. If not intubated, consider placing a laryngeal mask airway (LMA) with a self-inflating bag, appropriate viral filter, and PEEP valve as intubation during an arrest will increase aerosolization of viral particles and increase the risk of spread.
   g. Avoid a prolonged code in patients that experience cardiac arrest who demonstrate signs of progressive cardiogenic shock or hypoxic respiratory failure.
   h. Focus on potentially reversible conditions (H's and T's): DOPE pneumonic for sudden hypoxia, identification and treatment of shockable rhythm, identification/treatment of tension pneumothorax. Consider use of portable ultrasound and obtain a blood gas.
   i. Equipment/medications that are needed in the room should be handled with attention to infection control best practices. If a specialized kit is not available, consider placing them through a crack in the door onto a bedside table in the room, but avoid physically handing it to code team personnel.
4. The following table identifies best practices based on a "Minimum, Better, Best" model, as the COVID-19 outbreak could ultimately result in limited resources based on observational data from other countries. The goal is to achieve all elements of each category, as "Good" equates with the minimum standard-of-care while "Best" equates with the most ideal condition.

Minimum-Better-Best Paradigm for Limited Code Blue

	Minimum	Better	Best
Advance Directives	Discuss & document with every patient's medical power of attorney (MPOA) if patient unable to speak for self	Discuss & document with every patient; Involvement of Palliative Care for high risk	Develop a script for clinician that incorporates unique circumstances & ethical considerations if worsening pandemic. Ideally, there are DNRs for those who might code due to refractory cardiogenic shock or respiratory failure
Alert mechanism	Educate current Code Team members about who should respond to "Overhead Code Blue" to COVID patients	Early activation	Directed announcement ONLY to COVID Code Team
PPE / Precautions	Droplet for room; Minimize door opening	Airborne/Negative ISO; Infection Control Gatekeeper; Door remains closed	Use of PPE Checklist; PAPR
Communication (via PAPRs or individuals outside room)	Whiteboard for written instructions; Closed-loop	Speakerphone in room; Vocera; Gatekeeper	Personal communication devices; VA Video Connect (tablets)
CPR	Rotate 2 individuals who don't leave room	Rotate 2 individuals who don't leave room and accomplish multiple tasks based on pre-established priorities	Automated compressor device (e.g. LUCAS) (outside room) for high risk patients

Obtained via MI FOIA by Judicial Watch, Inc.

IV access	Two standard functioning PIVs for all COVID patients	Tibial IO (if needed)	Early placement of central access before potential arrest
ACLS Equipment	Dedicated Code Cart for COVID ICU and wards; Accounting for Code Carts to ensure appropriate backups	For high-risk patients: consider early placement of defib pads in room or on patient, or prepositioning the Code Cart outside patient room	Specialized cart/kit containing appropriate meds, modular packs of equipment, and designated defibrillator; Dedicated COVID ward: US, EKG machine, portable CXR
Airway	Non-rebreather mask immediately over patient mask *OR* BVM with viral filter and ETCO2	Place LMA for non-intubated patients. For intubated patients, either leave on vent (if good chest rise, +ETCO2) or troubleshoot with DOPE pneumonic	Early intubation BEFORE arrest occurs
Simulation/Practice	Ongoing review and regular familiarization with Protected Code Blue policy; Development of "Mock COVID Code Blue"	One-time practice with all members of the COVID response teams	Regular practice and policy updates to all members of the COVID response team

Patient Transport

1. If COVID-19 is widespread in the community, surgical masks should be considered for ALL patients irrespective of COVID-19 status.
2. The movement of patients with COVID-19 should be limited with all efforts made to ensure the patient is initially admitted to the appropriate location.
3. If patient transport is necessary:
   a. Non-intubated patients should be transferred wearing a surgical mask over their oxygen delivery device which may include nasal prongs or a non-rebreather mask up to 15 L/min.
   b. Staff should wear airborne PPE.
   c. Once a patient is admitted to the ICU, transport outside of the ICU should be limited. If transport is required, then coordination should occur to ensure safety standards are maintained.
   d. Hallways must be cleared where possible and only essential staff should accompany the patient. Staff not involved in the transfer should not come within 6 feet of the patient.
   e. Intubated patients should have closed circuits with a viral filter in situ.

ADJUNCTIVE THERAPIES FOR COVID-19: TREATMENT PROTOCOLS

Note: *All therapies are investigational and none are proven as the literature is evolving quickly.* ***There are no specific therapeutics approved by the FDA to treat people with COVID-19.*** None can be routinely recommended for use outside of a randomized clinical trial. Additionally, there is no evidence for use of the following medications for outpatients or mildly ill patients. Use of these resources for that purpose should be discouraged through prescribing restricted to critical care, infectious disease, or rheumatology physicians.

Ethics of Clinical Research during a Pandemic

There are no US Food and Drug Administration (FDA)-approved drugs specifically for the treatment of patients with COVID-19. There is genuine uncertainty in the expert medical community over whether proposed off-label and investigational treatments are beneficial. Randomized, placebo-controlled trials (RCT) are the gold standard for determining if an experimental treatment can benefit patients. Some may question whether it is ethical to deprive patients of an agent that could potentially prevent or treat COVID-19, given the high mortality rate among critically ill patients and lack of known and available treatment options. A Committee of National Academies of Science, Engineering, and Medicine reviewed and conducted an analysis of the clinical trials conducted during the 2014–2015 Ebola virus disease outbreak in West Africa and found the that the RCT was an ethical and appropriate design to use, even in the context of

Obtained via MI FOIA by Judicial Watch, Inc.

the Ebola epidemic. The position of "equipoise"—genuine uncertainty in the expert medical community over whether a treatment will be beneficial—"is the ethical basis for assigning only some participants to receive the agent. If the relative risks and benefits of an agent are unknown, participants who receive the experimental agent may receive a benefit or may be made worse off. Providing the experimental agent to all would expose all participants to potentially harmful effects." (59)

Steroids

1. There is a strong consideration to avoid routine steroids based on early data out of China as well as other studies related to Middle Eastern Respiratory Syndrome Coronavirus (MERS-CoV) which have shown that steroids actually delay viral clearance. (60)
2. However, new consensus guidelines recommend considering steroids for intubated COVID-19 patients with ARDS. (40)
3. Steroids may be indicated for vasopressor-refractory shock, asthma, COPD exacerbation, or for antenatal therapy at risk for preterm birth from 24-34 weeks of gestation.

Remdesivir

1. Remdesivir is an investigational intravenous drug with broad antiviral activity that inhibits viral replication through premature termination of RNA transcription and has in-vitro activity against SARS-CoV-2 and in- vitro and in-vivo activity against related betacoronaviruses. It has been tested in humans against Ebolavirus disease, where it was not found to be superior to other therapies in the PALM RCT. (61) It has shown promise in vitro and in animal models for coronavirus infection.(62-64)
2. National Institute of Allergy and Infectious Diseases (NIAID) is leading a multicenter adaptive design randomized placebo-controlled trial of candidate therapies for COVID-19, initially focused on comparing Remdesivir to placebo "A Multicenter, Adaptive, Randomized Blinded Controlled Trial of the Safety and Efficacy of Investigational Therapeutics for the Treatment of COVID-19 in Hospitalized Adults." MAMC, NMCSD, BAMC, NMCP and WRNMMC MTFs are participating sites through IDCRP. Potentially eligible candidates are adult DoD Health Care Beneficiaries meeting inclusion criteria (SARS-CoV-2 positive with evidence of pneumonia with oxygen saturation of ≤94% on room air or requiring supplemental oxygen or mechanical ventilation). Exclusion criteria include alanine aminotransaminase (ALT) or aspartate aminotransaminase (AST) levels >5 times the upper limit of normal, stage 4 severe chronic kidney disease or a requirement for dialysis [i.e., estimated glomerular filtration rate (eGFR) <30]. (https://clinicaltrials.gov/ct2/show/NCT04280705)
3. Gilead has two Phase 3 randomized open-label trials of remdesivir (5-days versus 10-days versus standard of care) open to enrollment for adults with COVID-19, radiographic evidence of pneumonia and oxygen saturation of ≤94% on room air (severe disease: https://clinicaltrials.gov/ct2/show/NCT04292899) or >94% on room air (moderate disease: https://clinicaltrials.gov/ct2/show/NCT04292730). Exclusion criteria include ALT or AST levels >5 times the upper limit of normal, participation in another clinical trial of an experimental treatment for COVID-19, requirement for mechanical ventilation, or creatinine clearance <50 mL/min..
4. Remdesivir is potentially available under compassionate use from Gilead for patients with clinical pneumonia: compassionateaccess@gilead.com. From Gilead's website; "Compassionate use requests must be submitted by a patient's treating physician. Gilead is currently assessing requests on an individual basis and require, at a minimum, that the patient be hospitalized with confirmed COVID-19 infection with significant clinical manifestations."
5. USAMMDA Force Health Protection Division has established an expanded access treatment IND with a limited number of treatment courses of Remdesivir for Active Duty Service Members CONUS/OCONUS (and Federal civilian and contract employees deployed OCONUS while in support of operational forces) meeting inclusion criteria. "Intermediate-Size Patient Population Expanded Access Protocol for Treatment of Coronavirus Disease 2019 (COVID-19) with Remdesivir." Clinicians should contact USAMMDA FHP Division to determine eligibility to receive product, 24-hour international telephone: +1-301-401-2768.

Obtained via MI FOIA by Judicial Watch, Inc.

Chloroquine (CQ) and Hydroxychloroquine (HCQ)

1. These drugs have been widely used as anti-malarial treatment and prophylaxis and to treat autoimmune conditions.
2. BLUF: No high-quality evidence exists to support use at present. *Potential toxicities include QTc prolongation and risk forarrhythmias*.
3. In vitro studies have reported antiviral activity against SARS-CoV and more recently against SARS-CoV-2. Mouse studies for SARS-CoV demonstrated improved lung pathology without reduction in viral titers; similar animal studies for SARS-CoV-2 have not yet been completed. Recent studies conducted in China indicate in vitro activity of these agents against SARS-CoV-2, and a small survey in French patients showed reductions in viral load. An additional preliminary report on chloroquine clinical activity was released by investigators in China, but detailed information is pending. (64-67) Both CQ and HCQ concentrate in the lung. Optimal dosing needed to reach adequate concentrations in lung tissue for treatment of COVID-19 are unknown; modeling has suggested high doses might be required.(67) Despite showing in vitro antiviral activity, prior clinical trials demonstrated no benefit of CQ against other viral infections such as dengue virus, chikungunya, influenza, and HIV, though none investigated the use of chloroquine for coronavirus infection.(68-71) In a non-human primate study, hydroxychloroquine appeared to paradoxically enhance chikungunya infection.(72)
4. A report of 20 treated COVID-19 patients who received HCQ alone and in combination with azithromycin suggested that treatment was associated with viral load reduction over 6 days, compared to a nonrandomized control group, and were more pronounced in patients who received the combination; clinical impact was not assessed and methodologic issues limit the strength of the observation.(73) A brief report of a Chinese study of 100 COVID-19 patients suggested clinical improvement ("improved lung images, time to viral negative conversion, and shortening of disease course") with CQ or HCQ treatment versus an unspecified control; methodologic details were absent from the report, limiting the strength of conclusions.(74) If these comparisons are substantiated after availability of adequate additional data, this would be the first time chloroquine or hydroxychloroquine was found to be effective for the clinical management of a viral infection.
5. Several clinical trials have been initiated or are planned to study CQ and HCQ for treating and preventing COVID-19. Significant off-label use is occurring overseas and in some US hospitals.
6. A variety of dosing regimens have been reported in use, including: Hydroxychloroquine 400 mg PO BID x 1 days, then 200 mg PO BID x4 days.

Lopinavir/Ritonavir

1. Coronavirus cellular infectivity and replication are dependent on virally-encoded and cellular protease activity. Clinically used protease inhibitors effective for HIV and HCV infection have been examined for potential utility in treatment of SARS, MERS, andCOVID19.
2. Unconfirmed media reports from China suggested this combination to be effective for COVID-19 treatment. However, on 18 March 2020, RCT results were reported that found no benefit in patients who received lopinavir/ritonavir compared to standard care for treatment of severe disease. (75-77)
3. Do not use in combination with amiodarone (fatal arrhythmia), quetiapine (severe coma), or simvastatin (rhabdomyolysis).

Host-directed anti-inflammatory strategies

ARDS and sepsis, life-threatening downstream complications of COVID-19, and many other infectious and non-infectious conditions, remain significant unmet therapeutic gaps. Historically, numerous anti-inflammatory and anti-cytokine agents, as well as many other drug candidates, have been tested and failed to meaningfully affect morbidity and mortality in ARDS, sepsis and/or septic shock.

Anti-IL6 monoclonal antibodies

1. A variety of therapies are being administered to severely ill patients in China and elsewhere. One that is

Obtained via MI FOIA by Judicial Watch, Inc.

receiving substantial attention currently is an anti-IL6 receptor humanized monoclonal antibody, tocilizumab (Actemra®), which was added to the treatment guidelines published by China's National Health Commission (4 Mar 20) to treat serious coronavirus patients with lung damage.

2. Tocilizumab and sarilumab are licensed in US for treatment of giant cell arteritis, rheumatoid arthritis, and cytokine release syndrome following CAR-T therapy. They carry a black box warning for risk of severe, potentially fatal, infections.
3. No high-quality evidence currently exists to support use. Some reports from China have suggested elevated IL6 levels are associated with severe disease in COVID19 infection, though other reports have not found the same association. Tocilizumab has been used in Italy according to anecdotal reports and an unpublished uncontrolled case series from China treated 21 hypoxemic patients with tocilizumab 400 mg IV x1 and reported improvement in respiratory parameters. (38, 78)
4. Manufacturer-supported US randomized controlled trials of tocilizumab and sarilumab are setto launch as of 20 March 2020.

Several additional agents are under investigation and information is expected to emerge rapidly. Discernment of benefits and harms from novel therapies will require diligent attention to quality of evidence reported. The American Society of Health-System Pharmacists last updated their Assessment of Evidence for COVID-19-Related Treatments on 21 March 2020, which can be found here: https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/Coronavirus/docs/ASHP-COVID-19-Evidence-Table.ashx?la=en&hash=B414CC64FD64E1AE8CA47AD753BA744EDF4FFB8C.

CARING FOR SPECIAL POPULATIONS: Pregnancy, Nursing Mothers, Infants, Children, and the Elderly

Caring for Pregnant Women with COVID-19

1. Limited information on the effects of COVID-19 for pregnant women exist in the current literature and limited to 2 case series including 18 pregnant women. This small series showed severe respiratory morbidity in 1/18 cases. Clinical findings were similar in cases of non-pregnant adults. Pregnant women experience immunologic and physiologic changes that make them more susceptible to viral respiratory infections. Pregnant women might be at greater risk for severe illness, morbidity, or mortality compared with the general population, as is observed with other related coronavirus infections. Pregnant women should receive the same care as those who are not pregnant in regard to screening, radiology studies, laboratory evaluations and critical care.
2. American College of Obstetricians and Gynecologists (ACOG) and Society for Maternal-Fetal Medicine (SMFM) algorithm for outpatient assessment and management for pregnant women with suspected or confirmed novel coronavirus (COVID-19). https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/clinical-guidance/practice-advisory/covid-19-algorithm.pdf?la=en&hash=2D9E7F62C97F8231561616FFDCA3B1A6
3. Case series suggest no evidence of vertical transmission, similar to other viral respiratory illnesses, such as influenza. (79)
4. Preterm delivery has been reported. Some cases were iatrogenic and not due to spontaneous preterm labor. No neonatal deaths have been reported. (79)
5. Patients confirmed with COVID-19 in pregnancy or deemed persons under investigation should be considered for enrollment in the Pregnancy Coronavirus Outcomes Registry (PRIORITY) (https://priority.ucsf.edu/).
6. **Admission**: Patients with suspected or confirmed COVID-19 should be admitted to a unit capable of caring for the respiratory needs of the patient as well as provide appropriate fetal monitoring as clinically indicated. Patient should be in isolation per hospital and CDC guidance.
7. **Guidance for treatment**: Aggressive infection control, testing for COVID-19, testing for co-infection, oxygen therapy as needed, avoidance of fluid overload, empiric antibiotics (due to risk

Obtained via MI FOIA by Judicial Watch, Inc.

of superimposed bacterial risk), fetal and uterine contraction monitoring, early mechanical ventilation for progressive respiratory failure, individualized delivery planning, Maternal Fetal Medicine consultation, Pulmonology, Critical Care and Infectious disease involvement as indicated. Team based management is recommended. Consider early transfer of care to higher level facility if unable to provide services at MTF. (80) If a pregnant patient is admitted to an ICU for worsening pulmonary status, a Maternal Fetal Medicine consultation should be made.

8. **Imaging**: With few exceptions, radiation exposure through radiography, computed tomography (CT) scan, or nuclear medicine imaging techniques is at a dose much lower than the exposure associated with fetal harm. If these techniques are necessary in addition to ultrasonography or MRI or are more readily available for the diagnosis in question, they should not be withheld from a pregnant patient. The use of gadolinium contrast with MRI should be limited; it may be used as a contrast agent in a pregnant woman only if it significantly improves diagnostic performance and is expected to improvefetal or maternal outcome. (81)
9. **Delivery**: Delivery should be reserved for maternal and fetal indications. Recommend health care team wear appropriate PPE during delivery and delivery should be in a negative pressure room. For women infected in the third trimester who recover, attempts to postpone delivery until a negative test result or quarantine status is lifted. This will minimize risk of transmission to the neonate.
10. **Cesarean section**: Cesarean section should be reserved for maternal and fetal indications. Recommend operating room with negative pressure isolation.
11. **Antenatal surveillance**: Gestational age appropriate fetal monitoring should be part of the initial assessment of any women with respiratory symptoms and continuous fetal monitoring should be provided for any critically ill pregnant woman.
12. **Ultrasound**: Given how little is known about the natural history of COVID-19, mid-trimester ultrasound assessment may be considered following first or second trimester infection exposure. Third trimester growth assessment is reasonable to consider for later second trimester and third trimester infections.
13. **Follow up after diagnosis of COVID-19**: Patients should be treated according to symptom severity and admitted to the hospital if vital signs are abnormal or symptomatic support is indicated. When patient is discharged from the hospital a plan for follow up should be established. In non-pregnant patients with COVID-19 pneumonia there is evidence that respiratory status can worsen up to a week after symptoms initially presented. For that reason close follow up with patients via phone triage should be performed. If patients symptoms worsen arrangements should be made for patient to be seen by a health care provider to assess clinical status.
14. **Postpartum care**: Postpartum patients with COVID-19 should be isolated from other patients in a postpartum isolation room. Breastfeeding is encouraged. CDC recommends that temporary separation of mother and newborn to avoid exposure of the newborn to COVID-19. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/inpatient-obstetric-healthcareguidance.html). Women who intend to breastfeed should be provided a dedicated breast pump to express breast milk. There is no evidence of virus transmission in breastmilk. (79) Discussions prior to delivery surrounding the possibility of early separation of mother and infant to avoid post-partum transmission. Considerations can be made to delay delivery to prevent unnecessary exposure to neonate but ultimately delivery timing should be made based on maternal and fetal indications.
15. Hospitals should develop a local plan for appropriate locations where COVID-19 positive patients can come to receive care to assure appropriate prenatal care is delivered to the patient and to minimize risk of exposure to the virus of other patients and health care workers. Pregnancy care should be considered non-elective.

Caring for Infants and Mothers with COVID-19: IPC and Breastfeeding

1. Vertical transmission does not appear to occur, but perinatal infection leading to severe manifestations has been documented. It is unknown whether newborns with COVID-19 are at increased risk for severe complications, but transmission after birth via contact with infectious respiratory secretions is aconcern. (82)

Obtained via MI FOIA by Judicial Watch, Inc.

2. In addition to face mask and hand hygiene, consider temporarily separating a symptomatic PUI or COVID-19 mothers from her baby (e.g. separate rooms) depending on clinician judgement and individual circumstances. This carries risks as well (e.g. delayed maternal-child bonding, poor breastfeeding relationship, etc.).
3. COVID-19 positive postpartum mothers as well as postpartum PUIs will be counseled about the risks and benefits of colocation vs. separation.
4. Postpartum patients who elect to co-locate (also referred to as 'rooming in') with their infants will be encouraged to wear a facemask and gloves and to practice hand hygiene before each feeding. They will also be encouraged to wash any skin that may come in contact with the infant (e.g. breasts, chest, arms, etc.). They will be encouraged to limit other close contact with the infant(s) and a separate non-infected caregiver should be present to help care for the infant. This separate non-infected caregiver should perform a majority of the infant's care. While not breastfeeding, infants should be kept greater than 6 feet away from the mother within the room, per CDC guidance.

Pumping / Expressed Breast Milk (83)

1. Mothers who wish to breastfeed should be provided with a dedicated breast pump. (https://consultqd.clevelandclinic.org/managing-pregnancy-during-the-covid-19-pandemic/)
2. Postpartum patients who are pumping should follow CDC guidelines on equipment use and feeding.
3. Collecting Milk:
    a. Wipe the surface where syringes/bottles will be placed after collection with a germicidal disposable wipe, and cover surface with clean paper towel or cloth.
    b. Mother will wash hands and breasts before use and cleaning equipment before and after use. Mother will wear a mask while pumping.
    c. Mother collects breast milk by hand or by pump into clean syringes or bottles then ensures syringe/bottle cap is secured. The outside of the container will be wiped with a germicidal disposable wipe. A label in then placed to identify date, time, and patient.
    d. Transport and storage of breast milk from isolation room to common refrigerated storage should follow strict infection control procedures per hospital policy.

Infants

1. Infants born to mothers with confirmed COVID-19 should be considered PUIs.
2. All infants born to mothers with suspected or confirmed COVID-19 should be bathed immediately following delivery.
3. These infants should be tested for COVID-19 before hospital discharge. Prior to discharge, inpatient providers will directly discuss care of the infant with the follow-up provider.

Neonatal Intensive Care Unit (84)

1. COVID-19 positive postpartum mothers and their household contacts should not be allowed to visit in the NICU.
2. Any infant who has symptoms that meet criteria for NICU admission will be assessed by the NICU team and admitted to a COVID-19 cohort pod or other segregated section of the unit.
3. COVID-19 positive postpartum mothers and their household contacts will not be allowed to visit in the NICU.
4. For care teams assigned to infants requiring CPAP, SiPAP or undergoing aerosolizing procedures such as intubation, full PPE including N95 (or PAPR), eye shields, gown, hair cover, and gloves should be worn when caring handling the infant.
5. Patients requiring nasal cannula or those who are intubated on mechanical ventilation (closed circuit) require contact/droplet precautions when handling to include surgical mask, gown, hair cover, and gloves.
    a. Per WHO guidance for clinical management of COVID-19, "newer high-flow nasal

Obtained via MI FOIA by Judicial Watch, Inc.

cannula (HFNC) and non-invasive ventilation (NIV) systems with food interface fitting do not create widespread dispersion of exhaled air and therefore should be associated with low risk of airborne transmission." These patients could be cared for with contact/droplet precautions only (to include facemask) but could consider N95 (or PAPR) if readily available.

Visitation

1. No visitors experiencing symptoms of a respiratory infection, such as fever, cough, shortness of breath, or sore throat; and contact in the last 14 days with someone with a confirmed diagnosis of COVID-19 is allowed in any health care facilities, residential care facilities, congregate care facilities, and juvenile justice facilities.
2. For NICU: A partner and doula may accompany the mother, if they pass the health evaluation
3. For Labor and Delivery: each laboring COVID-19 positive or PUI mother will be allowed to have a partner and doula with her who must remain with her throughout her admission (to include in post-partum recovery). The partner and doula should only be allowed in areas on the hospital necessary to support birth.
4. For post-partum / newborn nursery: each COVID-19 positive or PUI postpartum mother may be allowed to have a partner and doula with her who must remain with her throughout the admission. The partner should be isolated to the post-partum room and not be traveling elsewhere within the hospital.
    a. If the mother chooses to co-locate with the infant, her partner will be encouraged to help with the infant's care.
    b. If the mother chooses to be separated from her infant, the partner may help with the infant's care when they are brought to the room.
    c. Newborns who are PUIs are not eligible for elective circumcision.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/inpatient-obstetric-healthcare-guidance.html University of Washington Handling of Breast Milk of COVID-19 Mothers

Caring for Children with COVID-19

1. Children (0-18 years) with COVID-19 are more likely to remain asymptomatic or have mildly symptomatic disease. Severe symptoms requiring admission for supplemental oxygen have been described in up to 10% of symptomatic children, particularly those under the age of 5, with the highest risk in those under 12 months of age. The mortality rate appears to be extremely low: one study out of China reported only one death in 2,143 pediatrics patients. (85)
2. The intersection with chronic pediatric respiratory conditions such as asthma, cystic fibrosis, and chronic lung disease, and with the attendant increased risk of severe disease, is unknown.
3. Respiratory virus co-infections and secondary bacterial infections are possible.
4. During periods of community transmission and in the absence of targeted therapy for mild and moderate disease, the decision to test children for SARS-CoV-2 is driven by resource availability, infection prevention and control principles, and epidemiologic contact tracing or hot-spot case finding.
5. Pediatric symptoms, if present, are similar to common viral respiratory infections with a majority of symptoms affecting the upper airway. This differs from adults, who tend to have lower respiratory symptoms most prominent. (13,85)
    - Fever 80-95% – majority <24 hr duration
    - (Dry) cough 45-80%
    - Myalgias or fatigue 10-45%
    - Pharyngitis 10-40%
    - Rhinorrhea and/or congestion 10-30%
    - Diarrhea 10-20%
    - Dyspnea or hypoxemia 5-10%
6. Most labs are normal to include inflammatory markers (ESR, CRP, procalcitonin), chemistries, kidney

Obtained via MI FOIA by Judicial Watch, Inc.

and hepatic function. White blood cell count is typically normal but may be low.

7. If abnormal imaging, CXR will have non-specific increased lung markings or patchy infiltrates. Chest CT shows ground glass opacities.
8. Treatment of severe disease remains supportive, to include critical care interventions as required. Enrollment in clinical trials, or compassionate use of experimental therapies, should be considered for children with severe disease just as they would be for severely affected adults. There is no evidence to suggest that prophylaxis is necessary or effective for the majority of children.
9. Children appear to efficiently shed the virus, even if asymptomatic. Viral load is detectable in respiratory secretions for up to 2 weeks and in stool for up to 4 weeks. (86,87)
10. Given the prolonged duration of shedding of respiratory viruses in children, during periods of community transmission of SARS-CoV-2, it may be prudent to assume symptomatic children are infected, unless proven otherwise from an infection control standpoint - an issue particularly relevant to caregivers from vulnerable risk populations.

Caring for Older Persons with COVID-19

1. COVID-19 can result in severe disease and death among older adults. Early data from China suggest that a majority of deaths have occurred among adults aged ≥60 years especially those with underlying health conditions. In the United States, mortality rates in patients above age 85 have ranged 10-27%, and 3-11% among patients 65-84 years. (36)
2. Ensure that care for the older adult and severely ill is in keeping with their goals of care, advance directives and patient and family wishes.
3. Conversations regarding goals of care should continue to be part of routine care.
4. Patients should be informed about their condition, and, if desired, their prognosis, in a way that is easy to understand.
5. If the patient is unable to communicate meaningfully, ensure that a surrogate decision maker or health care agent has been identified in accordance with state law based on facility location.
6. Symptom management: Aggressive control of symptoms such as pain, dyspnea or other bothersome symptoms relieves unnecessary suffering and is therefore crucial for all patients regarding of age, function, comorbidities and prognosis.
    a. Pain
        - Acetaminophen should be used first, typically 500mg every 6 hours as needed.
        - If acetaminophen is insufficient, start an opiate (drug, dose, route, and frequency should be individualized and based on symptom severity, kidney/liver function and prior opiate exposure). Consider local supply in drug selection to mitigate risk of drug shortage.
        - Start a stimulant laxative, if prescribing an opiate to prevent constipation.
    b. Dyspnea
        - If providing supportive care and supplemental oxygen is ineffective for management of severe dyspnea, a low-dose opiate may be used to help alleviate symptoms.
    c. All providers should be able to provide basic symptom management, routine discussions about code status and goals of care in patients that are seriously ill.
    d. If complex symptom management, difficult discussions about code status, and care goals arise, consider consultation from a palliative medicine subspecialist if available at your institution.
7. Compassionate extubation in the setting of comfort oriented care or the actively dying patient should be considered a medical procedure similar to ventilator initiation and follow a specific plan as removal of the ventilator can cause discomfort.
8. When resources become scarce:
    a. Principles for guiding health care resource rationing during a pandemic has been

Obtained via MI FOIA by Judicial Watch, Inc.

described using the following values: maximize benefits, treat people equally, promote and reward instrumental value, and give priority to the worst off. Additional guidance is available in Fair Allocation of Scarce Medical Resources in the Time of Covid-19

b. Decisions regarding allocation of resources should be made at local, regional, state or federal levels.
c. Providers should avoid discussing rationing care at the bedside and should continue to provide compassionate care for the individual patient.
d. Age and comorbidities should not be a factor for provision of care for older adults.
e. Individual decisions and institutional policy regarding allocation of resources should be discussed in an interdisciplinary fashion and include input from stakeholders such as palliative medicine and healthcare ethics experts.
f. Institutional policy should be frequently reevaluated given the rapidly evolving nature of this crisis.
g. Institutional Clinical Ethics Committees should work closely with palliative medicine services to review process and decision making in resource scarce environments. (88)

SURGICAL CONSIDERATIONS FOR PERSONS WITH COVID-19

Perioperative Care of COVID-19+ Patients and PUIs

Overview.

1. For purposes of surgical care, patients will be treated as presumed COVID-19 positive if they have symptoms/exposure history that warrants testing or are unable to provide information (obtunded or unable to communicate for any reason, poor historians, etc.). Any surgical patients that fall into the PUI category should be medically managed to the greatest extent before proceeding with surgery in an attempt to delay until confirmatory testing. Optimally, an OR or cluster of ORs should be predesignated with a distinct antechamber to maintain separation from non COVID patients. If negative pressure ORs aren't available, consult with facilities to ensure air handling is routed through HEPA filters.
2. All patient interaction will be performed with enhanced droplet precautions:
    - N95 respirator or PAPR
    - Eye protection- goggles, face mask (OR face shields/masks worn over N95), or plastic disposable wrap-around glasses. Eyeglasses are not adequate.
    - Gown, gloves, hair cover, shoe covers
3. Remove all PPE and place in a biohazard bag before exiting the room EXCEPT N95 mask.
4. Patients on the ward should be transported directly to the OR by the anesthesia team, similarly to an ICU patient. If assistance is needed with transport, every attempt should be made to use someone from the care team (nurse, surgeon, tech) to minimize exposure.
5. When transporting a ventilated patient, ensure an HME/HEPA filter is placed between the endotracheal tube and the Ambu bag. Hook the Ambu bag up prior to opening the door in the negative pressure room and ensure the door is closed when returning the patient and switching to the ventilator. The same filter may also be used on the exhalation loop of the anesthesia machine- do not throw it away.

In the OR

1. Make every attempt to take out all necessary meds and equipment from the carts prior to bringing patient into the room. It's better to waste a few meds and equipment instead of contaminating the cart.
2. Routine breaks for anesthesia providers should be avoided to limit exposure and conserve supplies. Cell phones should be left outside the OR to eliminate accidental contamination. Ensure help may be obtained using the OR phone.
3. Continue to wear full PPE for the duration of the case.

Obtained via MI FOIA by Judicial Watch, Inc.

Intubation

1. If a negative pressure OR is unavailable, consider intubating the patient in a negative pressure room and transporting to the OR after intubation.
2. Consider video laryngoscopy.
3. Rapid Sequence Intubation should be performed when at all possible to avoid mask ventilation due to increased aerosolization of secretions.
4. Ensure HME/HEPA filter is on the exhalation limb or at the Y-piece (sampling line should be post filter).
5. Double glove and immediately remove outer glove after the airway is confirmed secure. Outer gloves may be used to wrap disposable portions of airway equipment after use. Consider, at a minimum, using hand sanitizer on inner gloves or exchange with new gloves.
6. Intubation and extubation generate a transient, significant droplet load for the room. Ensure all non-essential personnel are given the chance to leave the room if possible before performing the procedures.
7. Any external equipment (US machine, GlideScope, etc) needed for the case should be draped to the greatest extent possible and NOT REMOVED until the room is terminally cleaned.
8. ICU patients will recover in the ICU and floor patients should be taken to a negative pressure room in the PACU. If a negative pressure PACU room isn't available, use the ICU as a recovery room if bed space allows. Extubating in a PACU negative pressure or ICU room if necessary. If extubating in the OR, place a regular OR mask on the patient prior to transport to the PACU or ICU. If you elect to extubate a patient in the ICU rather than the OR, the anesthesia team should maintain responsibility for the patient until stable for routine handoff.
9. The ASA continues to update its website and has relevant links: https://www.asahq.org/in-the- spotlight/coronavirus-covid-19-information

Surge Capacity, Staffing, and 'Elective Surgery'

General guidelines to manage capacity, case mix, and staffing during a prolonged COVID response follow:

a. Executive Order 2020-17 temporarily restricts non-emergency medical and dental surgeries and procedures. When there are questions or controversies whether or not a surgical procedure is elective, the time sensitivity and/or medical necessity should be determined at the local level, preferably the Department of Surgery Chief.
b. ICU, inpatient ward, PACU and ambulatory capacity, staff availability, and OR supply chain capacity, need to be continuously assessed by perioperative leaders with the site-specific leadership. Classification of cases should be based on operative capacity (available, constrained, or none) as well as patient needs and adjusted based on the above assessment.
c. For emergency operation on a COVID-19 positive patients, treat these as aerosol generating procedures throughout the operative period (including intubation). Such cases should be performed with airborne precautions (N95 with face shield or PAPR) and preferably in a negative pressure room.

TELEMEDICINE SUPPORT DURING THE COVID-19 PANDEMIC

1. Telemedicine encompasses a set of tools that leverage information and communication technologies to most commonly extend medical care across geographic distances and boundaries. These same tools have a significant and unique potential to support care delivery during an infectious pandemic in order to decrease healthcare worker exposure to contagion (i.e. "clinical distancing"), reduce the usage of consumable PPE, while also enabling continued medical care delivery for non-infected patients while in their home. Accordingly, the CDC now

Obtained via MI FOIA by Judicial Watch, Inc.

recommends the liberal use of telemedicine during the COVID19 Pandemic (https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/guidance-hcf.html).

2. Telemedicine can be provided through two primary mechanisms
    a. Direct-to-patient where the health care provider examines the patient in real-time, interactive audio or visual (or both) telecommunication system and the patient interacts with the offsite health care professional at the time the services are provided.
    b. Tele-Consultation. Services delivered in this manner may occur using telephonic (audio) only service delivery.

EMERGENCY MANAGEMENT SERVICES AND GROUND TRANSPORT OF PERSONS WITH COVID-19

Michigan has developed specific Emergency Protocols related to Emergency Medical Services (EMS) to facilitate identification and safe treatment and transport of patients with suspected COVID-19 infection during the COVID-19 pandemic. Dispatch centers have incorporated COVID-19 screening questions into their Emergency Medical Dispatch (EMD), but it is acknowledged that EMS may encounter patients that have not been pre-screened. In addition to screening and treatment protocols, several other protocols have been developed to meet the challenges associated with the requirement for COVID-19 crisis standards of care.

Michigan Emergency EMS Protocols for COVID 19 include:

- Destination and transport of patients at risk for coronavirus disease (covid-19)
- Personal Protection During Treatment of Patients at Risk for Coronavirus Disease (COVID-19) and Decontamination of Equipment after Use
- Telemedicine and stationary treatment of low acuity patients during covid-19 outbreak
- Specimen Collection for COVID 19Privileging and participating facilities release during covid-19 response
- Clinical treatment for patient with suspected covid-19 crisis standards of care
- Cardiac arrest in a patient with suspected covid-19 crisis standards of care

Strained EMS Response due to Increased 911 Calls/Requests

1. EMS systems may be stressed due to an influx of 911 calls due to known or suspected COVID-19 transmission or infection. In areas with limited EMS resources overwhelmed by 911 call volumes, the following should be considered:
    a. EMS and/or Fire Dispatch should triage 911 calls and prioritize responses accordingly (e.g. if a patient calls reporting signs and symptoms consistent with COVID-19, but denies respiratory distress and other complaints suggestive of a life-threatening condition (i.e. chest pain, etc.), ambulance services should be directed to an alternative, higher-acuity call.
    b. The Telehealth protocol may be utilized as appropriate to obtain medical control guidance in taking patient to an alternate destination such as urgent care, or treating in place.
    c. If EMS arrives on scene and determines that a patient does not have a life-threatening complaint (relating to the potential exposure or signs and symptoms of COVID-19), and other 911 calls are pending a response, EMS crews should follow the Refusal of Care Protocol Refusal of transport is not appropriate when call volumes are low.

Personal Protective Equipment (PPE) for Emergency Medical Services Personnel

1. EMS personnel providing care for a patient with possible COVID-19 infection should utilize the following recommended PPE:
    a. N-95 or higher level respirator or facemask (if a respirator is not available). N-95 respirators

Obtained via MI FOIA by Judicial Watch, Inc.

or respirators that offer a higher level of protection should be used when performing an aerosol- generating procedure.

b. Eye protection: goggles or a disposable face shield that fully covers the front and sides of the face should be worn. Personal eyeglasses and contact lenses are not adequate eye protection.
c. A single pair of disposable patient examination gloves. Gloves should be changed if they tear or become heavily contaminated.
d. An isolation gown. If there are shortages of gowns, they should be prioritized for aerosol-generating procedures, and high-contact patient care activities that allow transfer of pathogens (e.g. moving the patient to the stretcher).

2. If providing patient care, EMS personnel should wear all recommended PPE. After completing patient care and before entering an isolated driver's compartment, drivers should remove and dispose of PPE and perform hand hygiene to avoid soiling the compartment. If the transport vehicle does not have an isolated driver's compartment, drivers should remove face shields or goggles, gowns and gloves, and perform hand hygiene. A respirator or facemask should continue to be used during transport.
3. On arrival, after the patient is released to the accepting facility, EMS personnel should remove and discard PPE and perform hand hygiene. Used PPE should be discarded in accordance with routine procedures**.**

EMS Transport of PUIs or Patients with Confirmed COVID-19 to a Healthcare Facility

1. A facemask should be worn by the patient for source control.
2. EMS personnel will notify the receiving healthcare facility that the patient has an exposure history and signs and symptoms suggestive of COVID-19 so that appropriate infection control precautions may be taken prior to arrival.
3. Family members and other contacts of patients with possible COVID-19 should not ride in the transport vehicle, if possible. If riding in the transport vehicle, they should wear a facemask. When possible, use vehicles that have isolated driver and patient compartments that can provide separate ventilation to each area.
    a. Close the door/window between these compartments before bringing the patient on board.
    b. During transport, vehicle ventilation in both compartments should be on non-recirculated mode to maximize air changes that reduce potentially infectious particles in the vehicle.
    c. If the vehicle is without an isolated driver compartment and ventilation must be used, open the outside air vents in the driver area and turn on the rear exhaust ventilation fans to the highest setting. This will create a negative pressure gradient in the patient compartment.
4. Follow facility procedures for transfer of the patient (e.g. wheel the patient directly into an examination room).

EMS Personnel Precautions for Procedures

1. Prior to the initiation of any patient care, all crew members must don appropriate PPE as outlined above.
2. If patient presentation allows, EMS personnel providing care to a patient suspected of having COVID-19 should contact Medical Direction before initiating an aerosol-generating procedure. These aerosolized procedures include:
    a. Nebulizer Treatments
    b. Bag Valve Mask (BVM) Ventilations
    c. Endotracheal Intubation
    d. Oropharyngeal Suctioning
    e. Continuous Positive Airway Pressure Ventilations (CPAP)
    f. Cardiopulmonary Resuscitation (CPR)

Obtained via MI FOIA by Judicial Watch, Inc.

3. If an aerosol-generating procedure is required/recommended, the doors to the patient compartment of the ambulance should remain open to allow ventilation of the area during these procedures if possible. If the ambulance is equipped with an HVAC system it should remain on during patient transport.
4. If used, BVMs should have a HEPA filter attached. If the EMS agency has access to ventilators, units should contact the specific ventilator manufacturer for additional guidelines and to obtain part numbers for compatible HEPA filters.

Cleaning EMS Transport Vehicles After Transporting a PUI or Patient with Confirmed COVID-19

1. After transporting the patient, leave the rear doors of the transport vehicle open to allow for sufficient air changes to remove potentially infectious particles. The time to complete transfer of the patient to the receiving facility and complete all documentation should suffice.
2. When cleaning the vehicle, EMS clinicians should wear a disposable gown and gloves. A face shield or facemask and goggles should be worn if splashes or sprays during cleaning are anticipated.
3. Clean and disinfect reusable patient-care equipment before use on another patient, according to manufacturer's instructions.
4. Routine cleaning and disinfection procedures (e.g. use of cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant for emerging viral pathogens) are appropriate for COVID-19.
5. Ensure disinfection procedures are followed consistently, to include the provision of adequate ventilation when chemicals are in use. Doors should remain open when cleaning the vehicle.

Follow-up for EMS Personnel after Caring for a PUI or Patient with Confirmed COVID-19

1. Local public health authorities should be notified about the patient so that appropriate follow-up monitoring can occur.
2. EMS personnel who have been exposed to a patient with suspected or confirmed COVID-19 should notify their chain of command to facilitate appropriate follow-up.
3. EMS agencies should develop local policies for assessing exposure risk and the management of EMS personnel potentially exposed to COVID-19. Decisions for monitoring and quarantine should be made in consultation with public health and infectious disease authorities.
4. EMS personnel should be alert for fever or respiratory symptoms (e.g. cough, shortness of breath, sore throat). If symptoms develop, it is recommended that they self-isolate and notify their public health authority to arrange for evaluation.

ETHICAL CONSIDERATIONS WHEN CARING FOR PERSONS WITH COVID-19

The COVID-19 pandemic outbreak is a global phenomenon that has impacted all countries and citizens, while straining public health systems to an unprecedented level in recent times. Some of the more challenging dilemmas encountered in the treatment of the disease center around the appropriate response procedures in triaging patients presenting with COVID-19 like symptoms, and the just and equitable distribution of scarce medical resources for those patients requiring more acute medical interventions in an inpatient hospital setting. Many of these challenges fall within the general considerations of justice as applied to medicine in regards to the process by which medical leaders decide to create and implement these treatment and allocation parameters.

Obtained via MI FOIA by Judicial Watch, Inc.

Conceding at the outset that no static guidance can anticipate all the myriad factors that might arise as crucial variables in the clinical environment to influence the final decisions of those medical professionals on the frontlines in caring for these afflicted patients, the intent of this section is to provide references and resources from highly reputable and thought-leading organizations who have published comprehensive guidance on the ethical considerations at the bedside.

To that end, listed below is the recently published Ethical Framework Guidance by The Hastings Center which identifies critical bioethical issues for consideration in the development of both institutional response policies and individual treatment decisions. The Ethical Framework Guidance also contains numerous collateral references to previous works on the subject, which have been informed by best practices and past lessons learned during the MERS, SARS, H1N1, and Ebola outbreaks.

The Hastings Center COVID-19 Ethical Framework Materials (88)
https://www.thehastingscenter.org/ethicalframeworkcovid19/

The Society of Critical Care Medicine (SCCM) has also published various COVID-19 Emergency Resources to assist frontline health care providers in establishing appropriate care and checklist procedures in their clinical treatment methods. Those materials have also been listed below for reference going forward, and the website link will be continuously updated as new guidance is created for distribution, including a forthcoming ethical framework to be published in the near future.

The Society of Critical Care Medicine (SCCM) COVID-19 Emergency Resources https://www.sccm.org/disaster

Other frameworks and recommendations for ethical considerations in the setting of scare resources have been described. (90)

The New England Journal of Medicine: Fair Allocation of Scarce Medical Resources in the Time of Covid-19
https://www.nejm.org/doi/full/10.1056/NEJMsb2005114

The COVID-19 pandemic is, and continues to be, an incredibly dynamic, fluid, and evolving global health emergency. Issues and procedures will evolve and require refinement as more information becomes available about the nature and breadth of the disease. However, being familiar with the most recent counsel and guidance from the experts in the field will assist all medical leaders in implementing the best possible policies and treatment decisions for both individual patients and society at large.

Obtained via MI FOIA by Judicial Watch, Inc.

REFERENCES

1. TeamNCPERE. Vital surveillances: the epidemiological characteristics of an outbreak of 2019 novel coronavirus diseases (COVID-19) – China. China CDC Weekly. 2020;2(8):113-22.
2. Yang X, Yu Y, Xu J, Shu H, Xia J, Liu H, et al. Clinical course and outcomes of critically ill patients with SARS- CoV-2 pneumonia in Wuhan, China: a single-centered, retrospective, observational study. Lancet Respir Med. 2020.
3. Huang C, Wang Y, Li X, Ren L, Zhao J, Hu Y, et al. Clinical features of patients infected with 2019 novel coronavirus in Wuhan, China. Lancet.2020;395(10223):497-506.
4. Zhou F, Yu T, Du R, Fan G, Liu Y, Liu Z, et al. Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study. Lancet. 2020.
5. Guan WJ, Ni ZY, Hu Y, Liang WH, Ou CQ, He JX, et al. Clinical Characteristics of Coronavirus Disease 2019 in China. N Engl J Med. 2020.
6. Wang D, Hu B, Hu C, Zhu F, Liu X, Zhang J, et al. Clinical Characteristics of 138 Hospitalized Patients With 2019 Novel Coronavirus-Infected Pneumonia in Wuhan, China. JAMA. 2020.
7. Chen N, Zhou M, Dong X, Qu J, Gong F, Han Y, et al. Epidemiological and clinical characteristics of 99 cases of 2019 novel coronavirus pneumonia in Wuhan, China: a descriptive study. Lancet. 2020;395(10223):507-13.
8. Holshue ML, DeBolt C, Lindquist S, Lofy KH, Wiesman J, Bruce H, et al. First Case of 2019 Novel Coronavirus in the United States. N Engl J Med. 2020;382(10):929-36.
9. Pan L, Mu M, Ren HG, Yang P, Sun Y, Wang R, et al. Clinical characteristics of COVID-19 patients with digestive symptoms in Hubei, China: a descriptive, cross-sectional, multicenter study. 2020.
10. Li Q, Guan X, Wu P, Wang X, Zhou L, Tong Y, et al. Early Transmission Dynamics in Wuhan, China, of Novel Coronavirus-Infected Pneumonia. N Engl J Med.2020.
11. Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19): Center for Disease Control (CDC); 2020 [updated March 7, 2020. Available from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html#foot09.
12. Kam KQ, Yung CF, Cui L, Lin Tzer Pin R, Mak TM, Maiwald M, et al. A Well Infant with Coronavirus Disease 2019 (COVID-19) with High Viral Load. Clin Infect Dis.2020.
13. Cai J, Xu J, Lin D, Yang Z, Xu L, Qu Z, et al. A Case Series of children with 2019 novel coronavirus infection: clinical and epidemiological features. Clin Infect Dis.2020.
14. Wei M, Yuan J, Liu Y, Fu T, Yu X, Zhang ZJ. Novel Coronavirus Infection in Hospitalized Infants Under 1 Year of Age in China. JAMA. 2020.
15. Cui Y, Tian M, Huang D, Wang X, Huang Y, Fan L, et al. A 55-Day-Old Female Infant infected with COVID 19: presenting with pneumonia, liver injury, and heart damage. J Infect Dis.2020.
16. Xu Z, Shi L, Wang Y, Zhang J, Huang L, Zhang C, et al. Pathological findings of COVID-19 associated with acute respiratory distress syndrome. Lancet Respir Med.2020.
17. Dichter JR, Kanter RK, Dries D, Luyckx V, Lim ML, Wilgis J, et al. System-level planning, coordination, and communication: care of the critically ill and injured during pandemics and disasters: CHEST consensus statement. Chest. 2014;146(4Suppl):e87S-e102S.
18. Sprung CL, Zimmerman JL, Christian MD, Joynt GM, Hick JL, Taylor B, et al. Recommendations for intensive care unit and hospital preparations for an influenza epidemic or mass disaster: summary report of the European Society of Intensive Care Medicine's Task Force for intensive care unit triage during an influenza epidemic or mass disaster. Intensive Care Med. 2010;36(3):428-43.
19. Stroud C, Altevogt B, Nadig L. Crisis Standards of Care: Summary of a Workshop Series. Washington DC; 2010.
20. Christian MD, Devereaux AV, Dichter JR, Rubinson L, Kissoon N, Task Force for Mass Critical C, et al. Introduction and executive summary: care of the critically ill and injured during pandemics and disasters: CHEST consensus statement. Chest. 2014;146(4 Suppl):8S-34S.
21. Devereaux AV, Tosh PK, Hick JL, Hanfling D, Geiling J, Reed MJ, et al. Engagement and education: careof the critically ill and injured during pandemics and disasters: CHEST consensus statement. Chest.

Obtained via MI FOIA by Judicial Watch, Inc.

2014;146(4 Suppl):e118S-33S.
22. Ratnapalan S, Martimianakis MA, Cohen-Silver JH, Minnes B, Macgregor D, Allen U, et al.Pandemic management in a pediatric hospital. Clin Pediatr (Phila).2013;52(4):322-8.
23. Tosh PK, Feldman H, Christian MD, Devereaux AV, Kissoon N, Dichter JR, et al. Business and continuity of operations: care of the critically ill and injured during pandemics and disasters: CHEST consensus statement. Chest. 2014;146(4Suppl):e103S-17S.
24. Hota S, Fried E, Burry L, Stewart TE, Christian MD. Preparing your intensive care unit for the second wave of H1N1 and future surges. Crit Care Med. 2010;38(4Suppl):e110-9.
25. Einav S, Hick JL, Hanfling D, Erstad BL, Toner ES, Branson RD, et al. Surge capacity logistics: care of the critically ill and injured during pandemics and disasters: CHEST consensus statement. Chest. 2014;146(4 Suppl):e17S-43S.
26. Lowe JJ, Gibbs SG, Schwedhelm SS, Nguyen J, Smith PW. Nebraska Biocontainment Unit perspective on disposal of Ebola medical waste. Am J Infect Control.2014;42(12):1256-7.
27. World Health Organization. WHO Checklist for Influenza Pandemic Preparedness Planning. Switzerland; 2005.
28. Wise RA. The creation of emergency health care standards for catastrophic events. Acad EmergMed. 2006;13(11):1150-2.
29. Halpern NA, Tan KS. United States Resource Availability for COVID-19: Society of Critical Care Medicine; 2020 [updated March 19, 2020. Version 2:[Available from: https://www.sccm.org/Blog/March-2020/United- States-Resource-Availability-for-COVID-19.
30. Wax RS, Christian MD. Practical recommendations for critical care and anesthesiology teams caringfor novel coronavirus (2019-nCoV) patients. Can J Anaesth.2020.
31. Tran K, Cimon K, Severn M, Pessoa-Silva CL, Conly J. Aerosol generating procedures and risk of transmission of acute respiratory infections to healthcare workers: a systematic review. PLoS One. 2012;7(4):e35797.
32. Lippi G, Plebani M. Procalcitonin in patients with severe coronavirus disease 2019 (COVID-19): A meta- analysis. Clin Chim Acta.2020;505:190-1.
33. WHO. Home care for patients with COVID-19 presenting with mild symptoms and management of their contacts: Interim Guidance, 17 Mar 2020. 2020 [Available from: https://www.who.int/publications-detail/home- care-for-patients-with-suspected-novel-coronavirus-(ncov)-infection-presenting-with-mild-symptoms-and- management-of-contacts.
34. CDC. Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization for Coronavirus Disease 2019 (COVID-19) 2020 [Available from: https://www.cdc.gov/coronavirus/2019- ncov/hcp/guidance-home-care.html.
35. Wu Z, McGoogan JM. Characteristics of and Important Lessons From the Coronavirus Disease 2019 (COVID-19) Outbreak in China: Summary of a Report of 72314 Cases From the Chinese Center for Disease Control and Prevention. JAMA. 2020.
36. Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) — United States, February 12–March 16, 2020: MMWR Morb Mortal Wkly Rep; 2020 [updated 18 March 2020. Available from: http://dx.doi.org/10.15585/mmwr.mm6912e2.
37. Day M. Covid-19: ibuprofen should not be used for managing symptoms, say doctors and scientists. BMJ. 2020;368:m1086.
38. Fang L, Karakiulakis G, Roth M. Are patients with hypertension and diabetes mellitus at increased risk for COVID-19 infection? Lancet Respir Med.2020.
39. Véran O. 2020 [updated March 17, 2020. Availablefrom: https://twitter.com/olivierveran/status/1239931737549033472.
40. Alhazzani W, Møller MH, Arabi YM, Loeb M, Gong MN, Fan E, et al. Surviving Sepsis Campaign: Guidelines on the Management of Critically Ill Adults with Coronavirus Disease 2019 (COVID-19). Critical Care Medicine. 2020.
41. Clinical management of severe acute respiratory infection (SARI) when COVID-19 disease is suspected [press release]. World HealthOrganization2020.

Obtained via MI FOIA by Judicial Watch, Inc.

42. Metlay JP, Waterer GW, Long AC, Anzueto A, Brozek J, Crothers K, et al. Diagnosis and Treatment of Adults with Community-acquired Pneumonia. An Official Clinical Practice Guideline of the American Thoracic Society and Infectious Diseases Society of America. Am J Respir Crit Care Med.2019;200(7):e45-e67.
43. Zuo MZ, Huang YG, Ma WH, Xue ZG, Zhang JQ, Gong YH, et al. Expert Recommendations for Tracheal Intubation in Critically ill Patients with Noval Coronavirus Disease 2019. Chin Med Sci J.2020.
44. Acute Respiratory Distress Syndrome N, Brower RG, Matthay MA, Morris A, Schoenfeld D, Thompson BT, et al. Ventilation with lower tidal volumes as compared with traditional tidal volumes for acute lung injury and the acute respiratory distress syndrome. N Engl J Med.2000;342(18):1301-8.
45. Guerin C, Reignier J, Richard JC. Prone positioning in the acute respiratory distress syndrome. N Engl J Med. 2013;369(10):980-1.
46. Pan C, Zhang W, Du B, Qiu HB, Huang YZ. [Prone ventilation for novel coronavirus pneumonia: no time to delay]. Zhonghua Nei Ke Za Zhi. 2020;59(0):E007.
47. Albert RK, Hubmayr RD. The prone position eliminates compression of the lungs by the heart. Am JRespir Crit Care Med. 2000;161(5):1660-5.
48. Cornejo RA, Diaz JC, Tobar EA, Bruhn AR, Ramos CA, Gonzalez RA, et al. Effects of prone positioning on lung protection in patients with acute respiratory distress syndrome. Am J Respir Crit Care Med. 2013;188(4):440- 8.
49. Nyren S, Radell P, Lindahl SG, Mure M, Petersson J, Larsson SA, et al. Lung ventilation and perfusion in prone and supine postures with reference to anesthetized and mechanically ventilated healthy volunteers. Anesthesiology. 2010;112(3):682-7.
50. Guerin C, Reignier J, Richard JC, Beuret P, Gacouin A, Boulain T, et al. Prone positioning insevere acute respiratory distress syndrome. N Engl J Med. 2013;368(23):2159-68.
51. Samanta S, Samanta S, Wig J, Baronia AK. How safe is the prone position in acute respiratory distress syndrome at late pregnancy? Am J Emerg Med. 2014;32(6):687 e1-3.
52. Ruan Q, Yang K, Wang W, Jiang L, Song J. Clinical predictors of mortality due to COVID-19 based on an analysis of data of 150 patients from Wuhan, China. Intensive Care Med. 2020.
53. Jannuzzi J. Troponin and BNP Use in COVID-19 2020 [updated March 18, 2020; cited March 22 2020]. Available from:https://www.acc.org/latest-in-cardiology/articles/2020/03/18/15/25/troponin-and-bnp-use-in- covid19.
54. Zheng YY, Ma YT, Zhang JY, Xie X. COVID-19 and the cardiovascular system. Nat Rev Cardiol.2020.
55. Bozkurt B, Kovacs R, Harrington B. HFSA/ACC/AHA Statement Addresses Concerns Re: Using RAAS Antagonists in COVID-19. Mar 17, 2020 2020 [Available from: https://www.acc.org/sitecore/content/Sites/ACC/Home/Latest-in-Cardiology/Articles/2020/03/17/08/59/HFSA-ACC- AHA-Statement-Addresses-Concerns-Re-Using-RAAS-Antagonists-in-COVID-19
56. Rhodes A, Evans LE, Alhazzani W, Levy MM, Antonelli M, Ferrer R, et al. Surviving Sepsis Campaign: International Guidelines for Management of Sepsis and Septic Shock: 2016. Intensive Care Med. 2017;43(3):304- 77.
57. Weiss SL, Peters MJ, Alhazzani W, Agus MSD, Flori HR, Inwald DP, et al. Surviving Sepsis Campaign International Guidelines for the Management of Septic Shock and Sepsis-Associated Organ Dysfunction in Children. Pediatr Crit Care Med.2020;21(2):e52-e106.
58. Comparison of Two Fluid-Management Strategies in Acute Lung Injury. New England Journal ofMedicine. 2006;354(24):2564-75.
59. National Academies of Sciences, Engineering, and Medicine. Integrating clinical research intoepidemic response: The Ebola experience. Washington DC: The National Academies Press;2017.
60. Lee N, Allen Chan KC, Hui DS, Ng EK, Wu A, Chiu RW, et al. Effects of early corticosteroid treatment on plasma SARS-associated Coronavirus RNA concentrations in adult patients. J Clin Virol. 2004;31(4):304-9.
61. Mulangu S, Dodd LE, Davey RT, Jr., Tshiani Mbaya O, Proschan M, Mukadi D, et al. A Randomized, Controlled Trial of Ebola Virus Disease Therapeutics. N Engl J Med. 2019;381(24):2293-303.
62. de Wit E, Feldmann F, Cronin J, Jordan R, Okumura A, Thomas T, et al. Prophylactic and therapeutic remdesivir (GS-5734) treatment in the rhesus macaque model of MERS-CoV infection. Proceedings of the National

Obtained via MI FOIA by Judicial Watch, Inc.

Academy of Sciences. 2020:201922083.
63. Sheahan TP, Sims AC, Leist SR, Schafer A, Won J, Brown AJ, et al. Comparative therapeutic efficacy of remdesivir and combination lopinavir, ritonavir, and interferon beta against MERS-CoV. Nat Commun. 2020;11(1):222.
64. Wang M, Cao R, Zhang L, Yang X, Liu J, Xu M, et al. Remdesivir and chloroquine effectively inhibit the recently emerged novel coronavirus (2019-nCoV) in vitro. Cell Res.2020;30(3):269-71.
65. Dong L, Hu S, Gao J. Discovering drugs to treat coronavirus disease 2019 (COVID-19). Drug Discov Ther. 2020;14(1):58-60.
66. Liu J, Cao R, Xu M, Wang X, Zhang H, Hu H, et al. Hydroxychloroquine, a less toxic derivative of chloroquine, is effective in inhibiting SARS-CoV-2 infection in vitro. Cell Discov. 2020;6:16.
67. Yao X, Ye F, Zhang M, Cui C, Huang B, Niu P, et al. In Vitro Antiviral Activity and Projection of Optimized Dosing Design of Hydroxychloroquine for the Treatment of Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2). Clin Infect Dis.2020.
68. De Lamballerie X, Boisson V, Reynier JC, Enault S, Charrel RN, Flahault A, et al. On chikungunya acute infection and chloroquine treatment. Vector Borne Zoonotic Dis.2008;8(6):837-9.
69. Paton NI, Lee L, Xu Y, Ooi EE, Cheung YB, Archuleta S, et al. Chloroquine for influenza prevention: a randomised, double-blind, placebo controlled trial. Lancet Infect Dis.2011;11(9):677-83.
70. Sperber K, Louie M, Kraus T, Proner J, Sapira E, Lin S, et al. Hydroxychloroquine treatment of patients with human immunodeficiency virus type 1. Clin Ther.1995;17(4):622-36.
71. Tricou V, Minh NN, Van TP, Lee SJ, Farrar J, Wills B, et al. A randomized controlled trial of chloroquine for the treatment of dengue in Vietnamese adults. PLoS Negl Trop Dis. 2010;4(8):e785.
72. Roques P, Thiberville SD, Dupuis-Maguiraga L, Lum FM, Labadie K, Martinon F, et al. Paradoxical Effect of Chloroquine Treatment in Enhancing Chikungunya Virus Infection. Viruses. 2018;10(5).
73. Gautret P, Lagier J-C, Parola P, Hoang VT, Meddeb L, Mailhe M, et al. Hydroxychloroquine and azithromycin as a treatment of COVID-19: results of an open-label non-randomized clinical trial.International Journal of Antimicrobial Agents. 2020.
74. Gao J, Tian Z, Yang X. Breakthrough: Chloroquine phosphate has shown apparent efficacy in treatment of COVID-19 associated pneumonia in clinical studies. Biosci Trends.2020;14(1):72-3.
75. Cao B, Wang Y, Wen D, Liu W, Wang J, Fan G, et al. A Trial of Lopinavir-Ritonavir in Adults Hospitalized with Severe Covid-19. N Engl J Med. 2020.
76. Liu F, Xu A, Zhang Y, Xuan W, Yan T, Pan K, et al. Patients of COVID-19 may benefit from sustained lopinavir-combined regimen and the increase of eosinophil may predict the outcome of COVID-19 progression. Int J Infect Dis. 2020.
77. Yao TT, Qian JD, Zhu WY, Wang Y, Wang GQ. A systematic review of lopinavir therapy for SARS coronavirus and MERS coronavirus-A possible reference for coronavirus disease-19 treatment option. J Med Virol. 2020.
78. Xu X, Han M, Li T, Sun W, Wang D, Fu B, et al. Effective Treatment of Severe COVID-19 Patients with Tocilizumab. 2020.
79. Chen H, Guo J, Wang C, Luo F, Yu X, Zhang W, et al. Clinical characteristics and intrauterine vertical transmission potential of COVID-19 infection in nine pregnant women: a retrospective review of medical records. Lancet.2020;395(10226):809-15.
80. Rasmussen SA, Smulian JC, Lednicky JA, Wen TS, Jamieson DJ. Coronavirus Disease 2019 (COVID-19) and Pregnancy: What obstetricians need to know. Am J Obstet Gynecol.2020.
81. Committee on Obstetric P. Committee Opinion No. 723: Guidelines for Diagnostic Imaging During Pregnancy and Lactation. Obstet Gynecol. 2017;130(4):e210-e6.
82. Fan C, Lei D, Fang C, Li C, Wang M, Liu Y, et al. Perinatal Transmission of COVID-19 Associated SARS-CoV-2: Should We Worry? Clin Infect Dis.2020.
83. Center for Disease Control and Prevention. Pregnancy & Breastfeeding: Information about Coronavirus Disease 2019 2020.
84. CDC. Interim Considerations for Infection Prevention and Control of Coronavirus Disease 2019 (COVID-19) in Inpatient Obstetric Healthcare Settings 2020 [Available from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/inpatient-obstetric-healthcare-guidance.html.

Obtained via MI FOIA by Judicial Watch, Inc.

85. Dong Y, Mo X, Hu Y, Qi X, Jiang F, Jiang Z, et al. Epidemiological Characteristics of 2143 PediatricPatients With 2019 Coronavirus Disease in China. Pediatrics. 2020.
86. To KK, Tsang OT, Chik-Yan Yip C, Chan KH, Wu TC, Chan JMC, et al. Consistent detection of 2019 novel coronavirus in saliva. Clin Infect Dis.2020.
87. Xu Y, Li X, Zhu B, Liang H, Fang C, Gong Y, et al. Characteristics of pediatric SARS-CoV-2 infection and potential evidence for persistent fecal viral shedding. Nature Medicine. 2020.
88. Berlinger N, Wynia M, Powell T, Hester M, Milliken A, Fabi R, et al. Ethical Framework for Health Care Institutions Responding to Novel Coronavirus SARS-CoV-2 (COVID-19) Guidelines for Institutional Ethics Services Responding to COVID-19. 2020 March 16, 2020.
89. CDC. Guidance on Air Medical Transport for SARS Patients [cited 2020. Available from: https://www.cdc.gov/sars/travel/airtransport.html.
90. Institutions Responding to Novel Coronavirus SARS-CoV-2 (COVID-19) Guidelines for Institutional Ethics Services Responding to COVID-19. 2020 March 16, 2020.
91. Emanuel E, Persad G, Upshur R Thome B, Parker M, Glickman A. Fair Allocation of Scarce Medical Resources in the Time of Covid-19. The New England Journal of Medicine. 2020. Available from: https://www.nejm.org/doi/full/10.1056/NEJMsb2005114
92. Institute of Medicine. 2012. Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response: Volume 1: Introduction and CSC Framework. Washington, DC: The National Academies Press. https://doi.org/10.17226/13351.93.
93. Alhazzani W, Moller M, Arabi Y, Loeb A, Gong M, Fan E, et al. Surviving Sepsis Campaign: Guidelines on the Management of Critically Ill Adults with Coronavirus Disease 2019 (COVID-19). Society of Critical Care Medicine, 2020. Available from: https://www.sccm.org/getattachment/Disaster/SSC-COVID19-Critical-Care-Guidelines.pdf.

Obtained via MI FOIA by Judicial Watch, Inc.

APPENDIX A : COVID-19 INTUBATION PRE-ENTRY CHECKLIST*

For Providers:

To bring inside room:

Place a priority on rapid airway placement with video laryngoscopy (ie Glidescope) to create distance between operator and patient's airway, avoidance of BVM and NIV due to risk of aerosolization:

☐Airway Supplies:
- ETT (7 & 7.5 for adults, appropriate size for children) with syringe forcuff
- Glidescope or C-MAC (facilitate intubation from adistance)
- Appropriate stylet
- Bougie
- OG tube with syringe, lube andtape
- OP/NP airway
- Colorimetric end-tidal CO2 detector
- Suction setup

☐Disposable stethoscope
☐Sani-wipes (should be located inside room)

Keep outside room (on standby):

☐Back up Airway Supplies:
- Appropriate size laryngoscope blades (Mac 3 & 4 for adults) and handle (disposable preferred)
- Stylet
- BVM (avoid if possible due to risk of aerosolization ofpathogen)

☐Airway cart (never bring in room)
☐EZ-IO

For Nursing:

☐RSI meds kit
☐Restraints
☐Foley
☐ABG syringe
☐Post-intubation meds:
- propofol
- fentanyl
- phenylephrine
- norepinephrine drip

For Respiratory Therapy:

☐Ventilator with appropriate filters
☐ET securing device
☐Waveform capnography adapter
☐Viral filter for Ambubag

*Adapted from University of Washington (https://covid-19.uwmedicine.org/)

Obtained via MI FOIA by Judicial Watch, Inc.

APPENDIX B: COVID-19 PRE-INTUBATIONPACK*

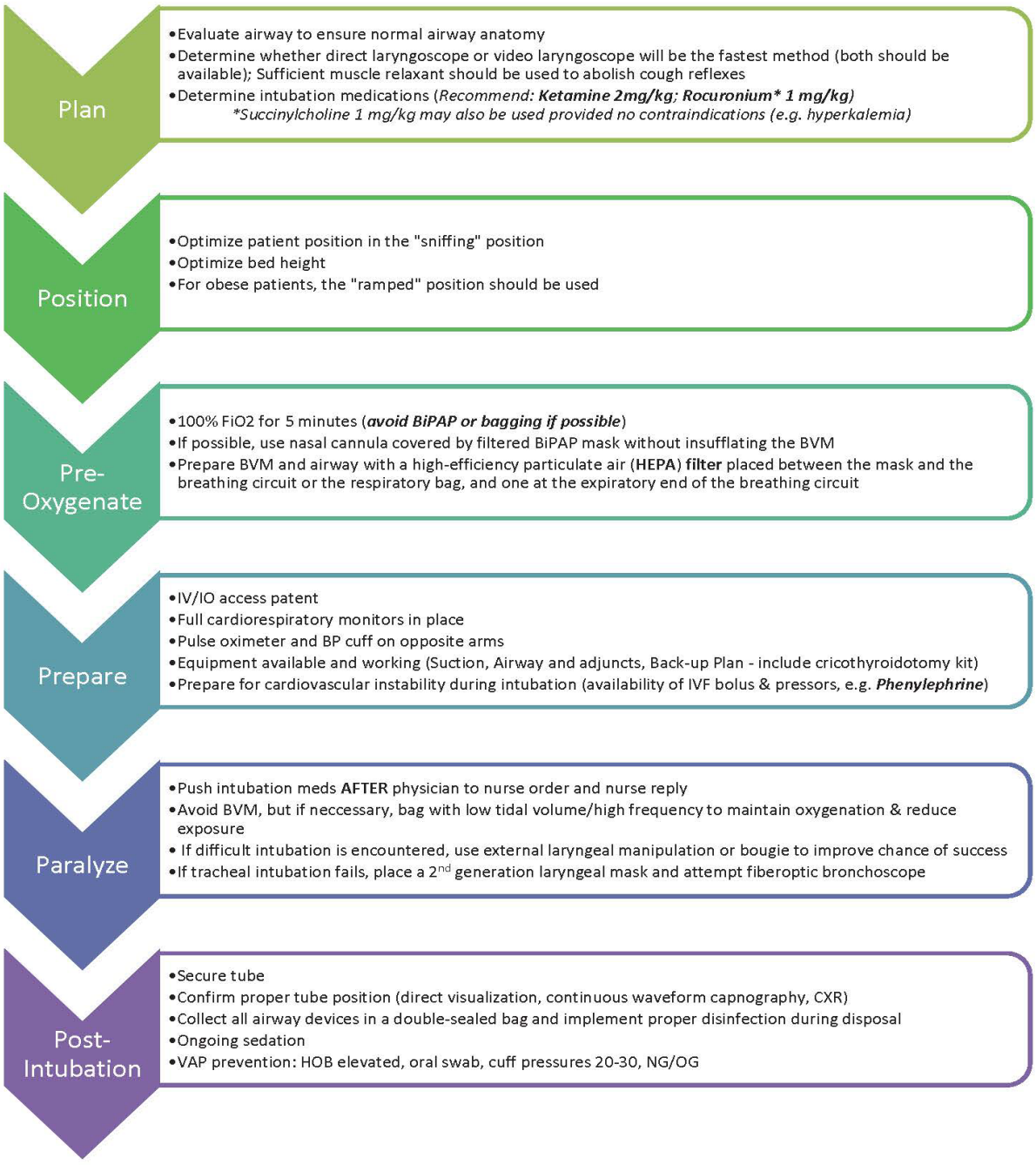
1. Adult BVM **
2. Nasal Cannula
3. Face Shield or Joint replacement Hood
4. End-tidal CO2 ETT Adaptor
5. End-tidal CO2 Tubing
6. Yellow Viral Filter
7. ETT Securement device
8. New, flexible tip bougie
9. PEEP Valve

*From: https://emcrit.org/emcrit/COVID-19-intubation-packs-and-preoxygenation-for-intubation/

** if possible, avoiding use of BVM is preferred to avoid spread of pathogen to providers performing airway interventions

Obtained via MI FOIA by Judicial Watch, Inc.

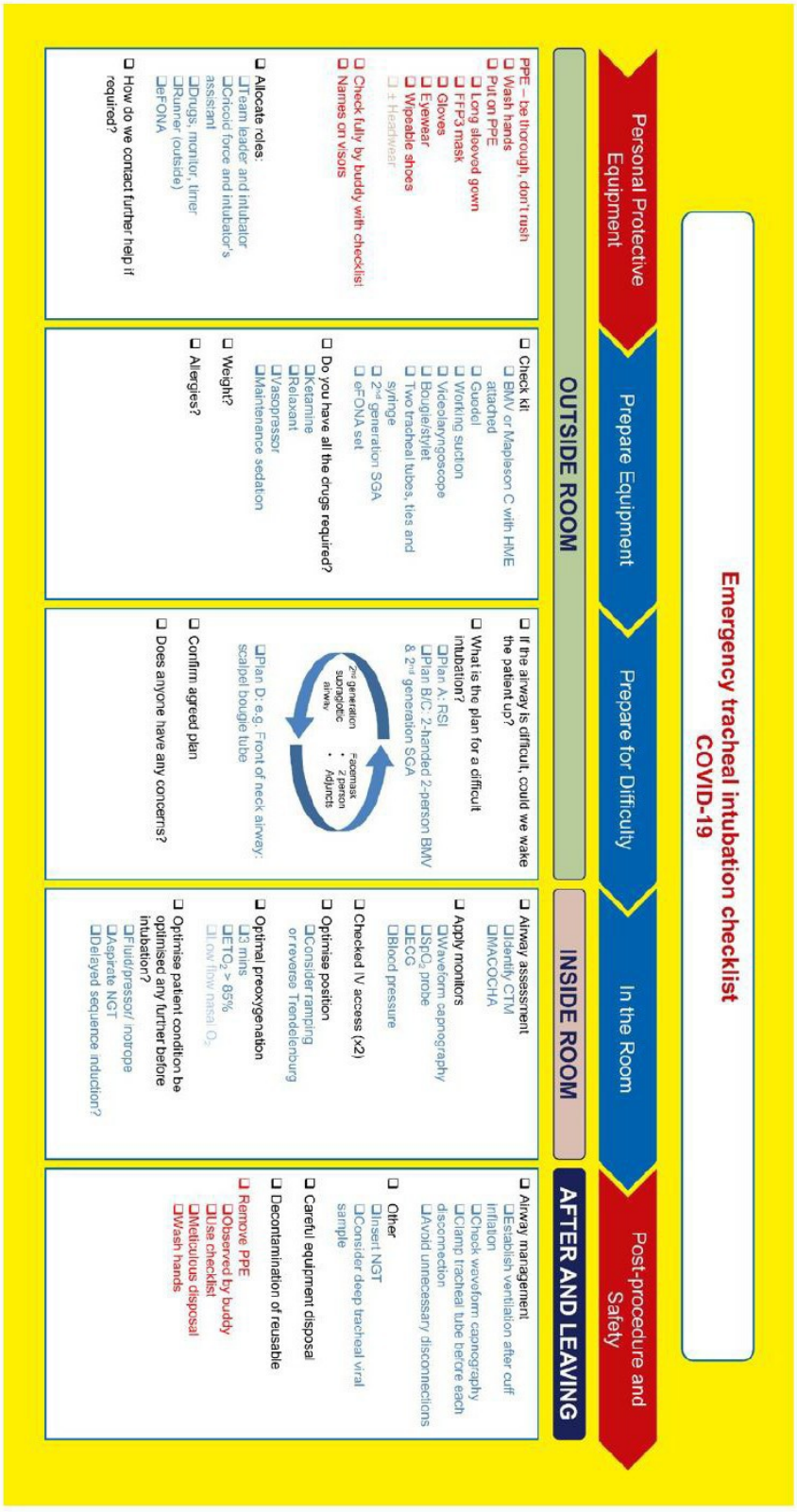
APPENDIX C : COVID-19 INTUBATION PROTOCOL



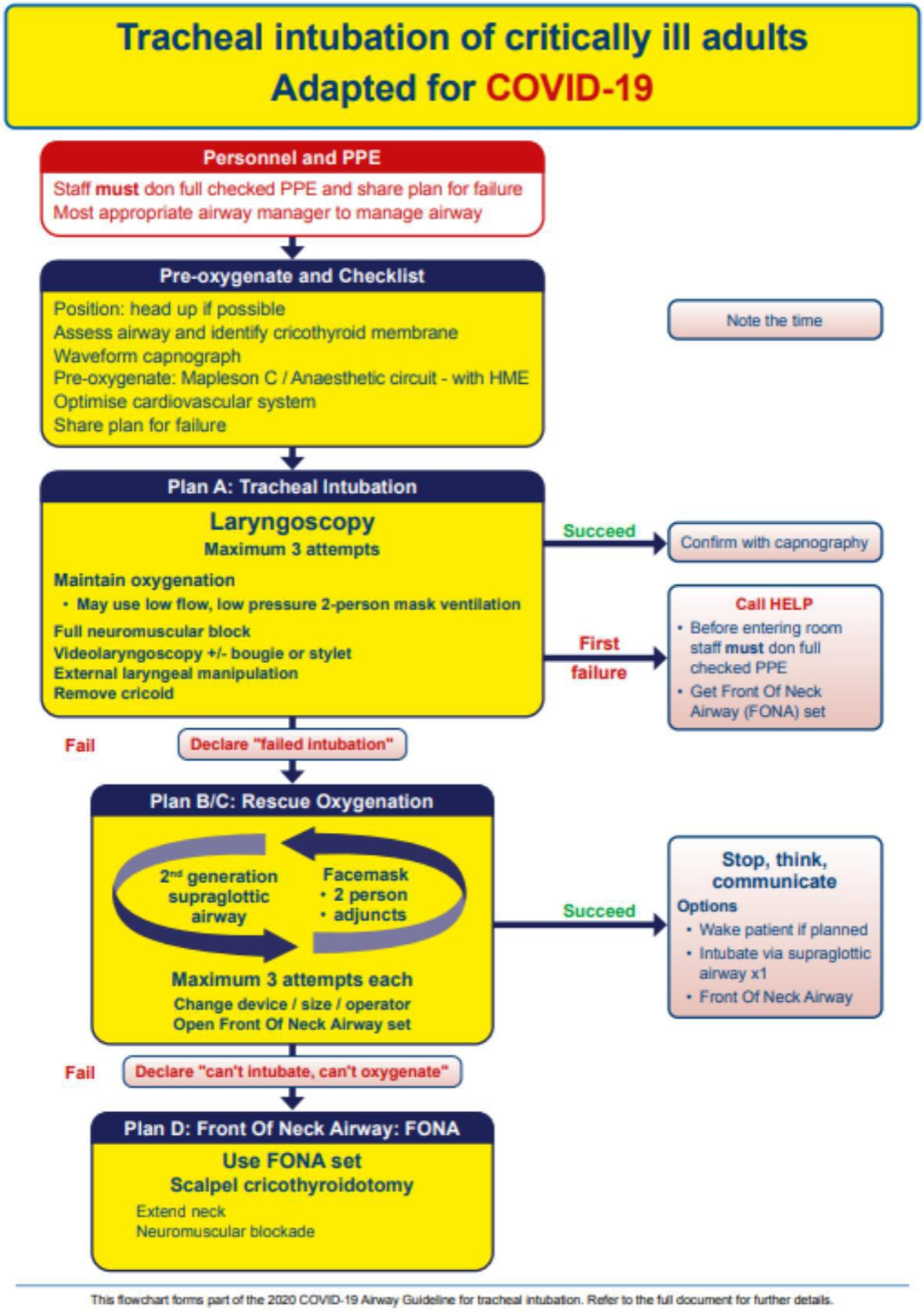
Guideline Only/Not a Substitute for Clinical Judgment

Obtained via MI FOIA by Judicial Watch, Inc.

APPENDIX D : COVID-19 COGNITIVE AIDS FOR INTUBATION



Obtained via MI FOIA by Judicial Watch, Inc.



Obtained via MI FOIA by Judicial Watch, Inc.

Can't Intubate, Can't Oxygenate (CICO) in critically ill adults

Adapted for COVID-19

CALL FOR HELP

↓ Declare "Can't Intubate, Can't Oxygenate"

Plan D: Front Of Neck Airway: FONA

Extend neck

Ensure neuromuscular blockade

Exclude oxygen failure and blocked circuit

Personnel and PPE

New staff **must** don full checked PPE

Most appropriate airway manager to perform FONA

Scalpel cricothyroidotomy

Equipment: 1. Scalpel (wide blade e.g. number 10 or 20)
2. Bougie (≤ 14 French gauge)
3. Tube (cuffed 5.0-6.0mm ID)

Laryngeal handshake to identify cricothyroid membrane

Palpable cricothyroid membrane

Transverse stab incision through cricothyroid membrane

Turn blade through 90° (sharp edge towards the feet)

Slide Coudé tip of bougie along blade into trachea

Railroad lubricated cuffed tube into trachea

Inflate cuff, ventilate and confirm position with capnography

Secure tube

Impalpable cricothyroid membrane

Make a large midline vertical incision

Blunt dissection with fingers to separate tissues

Identify and stabilise the larynx

Proceed with technique for palpable cricothyroid membrane as above

Post-FONA care and follow up

- Closed tracheal suction
- Recruitment manoeuvre (if haemodynamically stable)
- Chest X-ray
- Monitor for complications
- Surgical review of FONA site
- Agree airway plan with senior clinicians
- Document and complete airway alert

This flowchart forms part of the 2020 COVID-19 Airway Guideline for tracheal intubation. Refer to the full document for further details.

Obtained via MI FOIA by Judicial Watch, Inc.

APPENDIX E : ADULT PRONE POSITIONING PROTOCOL EXAMPLE*

*Adapted from University Medical Center (Las Vegas, NV)

Procedure for patient preparation prior to proning:

1. Obtain an order from the Fellow or Attending physician to place patient in the prone position. The order should include:
    a. Proper sedation/pain medications and paralytic agents ifnecessary.
    b. Length of time for each pronation cycle (patient should be in prone position a minimum of 16 hours, with a return to the supine position at least once aday).
    c. Prone positioning should be performed within the first 24 hours of the diagnosis of severe hypoxemia.
2. Explain proning procedure and benefits to patient and family members when present.
3. Prior to proning patient, make sure the following criteria have been met and necessary equipment is made available:
    a. Patient is mechanically ventilated via a secured endotracheal tube (ETT) with inlinesuction.
    b. RT is at bedside to evaluate securement of ETT with commercial tape and to place bite block as needed. Twill may be used in addition to the tape if additional securement is needed. Do not secure ETT with a commercial securement device (i.e.Hollister).
    c. Confirm patient intravenous access including central and arterial lines; verify lines are secure inplace.
    d. Remove ECG leads from anterior of torso; obtain new leads to place posteriorly once patient is prone. Electrocardiogram leads can be placed in the lateral limb position (left and right deltoid midaxillary line and left and right 12th intercostal space at the midaxillary line). The virtual lead (V1 or chest lead) can be placed on the dorsalsurface.
    e. Consider adhesive foam pads (i.e. Mepilex) to apply to boney prominences such as forehead, bilateral shoulders, chest, iliac crests and knees to preventpressureulcers.
    f. Obtain positioning pillows, blanket rolls or foam prone positioning kit from materials management or supply room.
    g. Continuous SpO2monitoring.
    h. Foley catheter and oral gastric tube secured inplace.
    i. Use fecal management system ifneeded.
    j. It is reasonable to provide enteral feedings while patient is in prone position. Elevation of head of bed in reverse Trendelenburg position helps reduce the risk of gastric aspiration. Post pyloric tubes are preferred.
    k. Lubricate patient's eyes prior to proning, then every six hours and as needed (Provider orderneeded).
    l. Assess and document pain and provide adequate sedation and pain management throughout the procedure.
    m. Patients may also require neuromuscular blocking agent duringproning.
    n. Remove head board and ensure bed brake is on.
    o. RT will perform and document a complete vent check including auscultation of bilateral lung sounds, ventilator settings, ETT positioning/depth, patient tidal volumes and ETT cuff pressures pre and post turn.

Procedure of manual pronation:

1. Assemble a minimum of a 5-person team consisting of at least on RT and the patient's RN. RT is to manage airway protection at the head of the bed and the other team members are positioned on either side of the bed to manually prone the patient. A fellow or attending physician should be present for the first turn.
2. Correctly position all tubes, taking into account the direction of theturn.
3. Lines inserted in the upper torso are aligned with either shoulder, exception is chest tubes or large bore tubes.
4. Tubes in the lower torso are aligned with either leg and extended off thebed.
5. Always initially turn the patient in the direction of theventilator.

Procedure for proper patient positioning (see diagram below):

1. Head and Neckpositioning:

    Place patient's head on a foam head positioner, which allows for the patient's head in a neutral position. Otherwise, support the patient's head in a rotated position paying attention to avoid pressure to the eyes and ears. Provide range of motion to the patient's head at least every hour, maintaining ETT tube alignment. Reposition head every two hours, head should be turned to the up are while in swimmer's pose, to avoid traction on the brachial plexus. Coordinate with RT to be present to maintain the airway while repositioning the head every two hours. This may require

Obtained via MI FOIA by Judicial Watch, Inc.

positioning the ventilator at the head of the bed rather than on one side of the bed to allow for the head reposition. Raise the head enough to provide for proper spinal alignment: avoid hyperextension or flexion of the cervical spine. Ensure that the eyes have no pressure on the orbits and ears are properly aligned, flat and not folded.

2. Armpositioning:

   If using foam prone positioning kit, place patient's arms in foam positioners. While the patient is in a side lying position, gently position the arms in a swimmer's pose. The simmers pose entails the up are is in a supported, flexed position at the level of the shoulder and the down arm is parallel to the body in a position of comfort. When the arm is in the up position, keep the shoulder in a neutral position, abducted to 90 degrees and the elbow flexed at 90 degrees. Utilize pillows or blanket rolls to prevent hyperextension of the shoulder and to ensure the weight of the arm is supported. Note: Head position should be turned to the up arm while in swimmer's pose, to avoid traction on the brachial plexus.

   a. Alternate the arm and head position every two hours with the patient in a side lying position and provide passive range of motion exercise to all joints of the upper and lower extremities.

3. Patientpositioning:
   a. Manually reposition the patient a minimum of every 2 hours with a slight right lateral-pillow support position (20-30°) to prone (flat) to a slight left lateral-pillow supported position (20-30°) and back to prone position. The use of automatic bed rotation is not a replacement formanualrepositioning.

      Note: When placing the patient in the lateral-pillow support position, coordinate head and arm in the up position toward the tilted side (Do not use foam wedges for lateral turns).

   b. During lateral turns inspect the skin and positioning of the tubes, lines and catheters (tubing and penis) and reposition accordingly, i.e. Foley catheters, chest tubes, IV lines, etc.

4. Legpositioning:

   While in prone and/or lateral prone position float the knees with a pillow (be careful not to cause hyperextension of the hip), and place a foam roller, pillow or blanket roll under the ankle area to elevate the toes and prevent tension on the tendons in the foot and ankle region.

5. Tilt the patient into reverseTrendelenburg:

   Goal is 30 degrees, as patienttolerates.

6. Alternative position of the arms for comfort or if swimmer's position is contraindicated.

   For example, the patient, family or PT/OT one-time evaluation report history of rotator cuff tear, stroke, nerve damage, osteoarthritis of shoulder complex, history of clavicle fracture, hyper flexible joints.

   a. Arms can be left in the side lying position aligned with the body and repositioned ever two hours to a slightly abducted positon.

Patient monitoring and care:

1. Time patient isprone/supine:

   a. It is recommended in the literature that patient is placed in the prone position for a minimum of 16 hours. The timing for prone cycling requires a physician order and is always situational. Patients should be returned to supine position for up to four hours, once per day preferably early AM to allow the interdisciplinary team time to assess while in supine position. While in supine position, reassessment of oxygenation, skin assessment and other relevant exam elements should occur. If the patient does not tolerate being supine (i.e. requiring increased ventilator settings, decreasing PaO2/FiO2 ration, hemodynamically unstable or decreasing SpO2/PaO2) return patient to the proneposition.
   b. Patients in prone position should receive the same standard of care as a patient that is supine (i.e. oral care,

Obtained via MI FOIA by Judicial Watch, Inc.

urinary catheter care, skin care, eye care, suctioning, etc.).

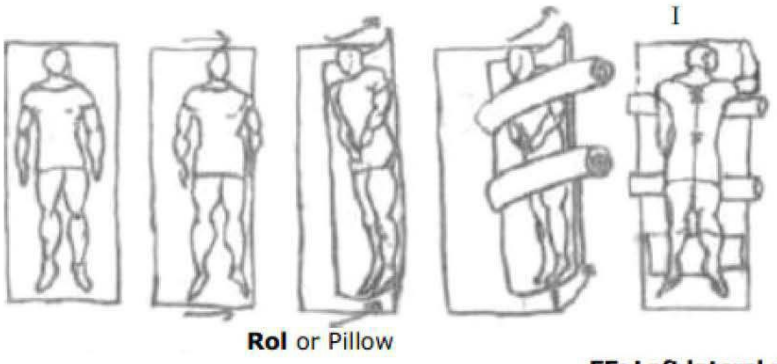
c. Discuss supine position tolerance and PaO2/FiO2 ratio in bedside report and during interdisciplinary rounds.
d. Ongoing assessment of how the patient is tolerating prone therapy and repositioning; documentation of all vital signs, capnography, patient and family education, length of time prone, patient's response to turning supine, any adverse events that occur and changes in the patient's condition.
e. Primary RN will coordinate with RT to re-secure ETT when the patient is supine and assist with turns, checking cuff pressures and tube placement before and after repositioning the patient; coordinate with radiology for chest x-ray when supine.
f. Monitor all tubes, lines, drains and catheters throughout the repositioning process and continue airway management, suctioning oral and ETT secretions.
g. Continue to evaluate enteral nutrition tolerance and maintain reverse Trendelenburg to help prevent ventilator associated pneumonia (VAP).
h. RT to change ETT tape at least once a day or more frequently if necessary due to facial swelling.
i. PaO2/FiO2 ratios should be calculated every day and when ventilator settings have been changed in order to identify candidates for returning to the supine position early.

Consider discontinuation of the prone position if:

1. The patient no longer shows a positive response to the position change or mechanical ventilation support has been optimized.
2. The patient's PaO2/FiO2 ratio is >200 on less than 50% FiO2 and PEEP ≤10 cm of water.

Complications related to prone positioning:

1. Unplanned extubation
   a. Lines pulled
   b. Tubes kinked
   c. Hemodynamic instability
   d. Facial edema
   e. Pressure ulcers
   f. Aspiration
   g. Cornea labrasions

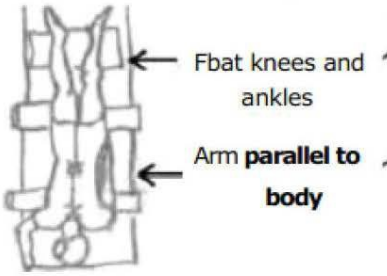


Face down position

Eg: Prone position-Arms side lying

Rol or Pillow

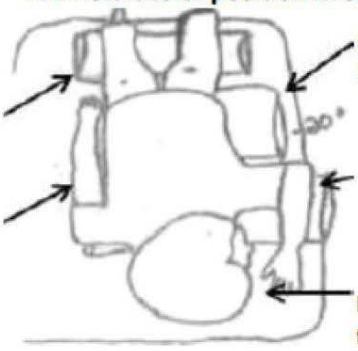
Eg: Prone position with arms swimmers pose



Fbat knees and ankles

Arm **parallel to body**

EE: Left lateral position in swimmers pose



Pillow at 20° for lateral turn

Snootier neutral-

***Ilya to 90' and elbow flexed at 90'**

Head turned towards arm in up position

Obtained via MI FOIA by Judicial Watch, Inc.

APPENDIX F: Setup and Monitoring Instructions – Anesthesia Machine as an ICU Ventilator

SETUP

- Insure manual ventilation device readily available
- Connect/Check Central Gas Supplies
  - Check Line pressure – 45 psi or better
  - Full E-cylinders of oxygen and air as backup
  - Remove nitrous oxide hoses and cylinders
  - Bellows ventilators configured for compressed air supply Biomed can do with manufacturer guidelines
- Scavenger
  - Connect to suction or allow to enter patient room
- Vaporizers
  - Remove or drain
- Configure machine with disposables
  - Breathing Circuit
  - Filters
    - HMEF on airway, gas sampling on machine side
    - Second filter on the expiratory limb if possible (required if no filter on airway)
  - **??** Active humidifiers NOT recommended but may be needed if no HME. Will require special monitoring if placed.
  - Large (3 Liter) Reservoir Bag
  - Gas analyzer for oxygen and carbon dioxide
- Perform Self Test
  - Compliance measurement essential – do not change disposables after this
  - Confirm no errors
- Check alarms, set limits, set to max volume
  NOTE: Defaults may not apply to ICU patients
  - Inspired CO2 alarm at 5 mmHg
  - Expired CO2 alarm for permissive hypercapnia
  - Pressure alarms – High and low if apnea pressure alarm
  - Volume/Minute Ventilation
- Set APL valve to 0 cmH20

INITIATE THERAPY

- Fresh Gas Flow Options
  - Option 1: Low fresh gas flow to conserve oxygen
    - Preserves humidity
    - **CO2 Absorbent must be available and maintained**
    - **Inspired CO2 Alarm must be set to 5 mmHg**
  - Option 2: Fresh gas flow => minute ventilation
    - No CO2 Absorbent needed (increase FGF if Inspired CO2 present)
    - Humidification is essential – consider active humidifier
- Setting Oxygen Concentration
  - Electronic Flowmeters – Set delivered concentration and monitor inspired oxygen that results
  - Mechanical Flowmeters
    - Air/oxygen mix needed for delivered O2 concentration (see table)
  - Inspired oxygen concentration will need to be monitored especially during low flows - it will be less than the set concentration
- Set Ventilator (See CCM guidance)
  - Ventilation Mode
  - Settings
    - Rate
    - Volume
    - I:E Ratio
    - PEEP
- Start Ventilator
  - **SET SPIROMETRY LOOP REFERENCE IF AVAILABLE WHEN VENTILATION STARTED**
  - **NOTE PRESSURE AND FLOW WAVEFORMS – CONSIDER PHOTO OF BASELINE SCREEN**
  - Record monitored values
    - Pressure – Volume relationships
    - Gas concentrations as expect

3/26/2020

asahq.org/ventilators

Obtained via MI FOIA by JudicialWatch, Inc.

MONITORING SCHEDULE (Record manually time and value if EMR not connected to machine)

Task	Continuous	Hourly	q 4 hours	q 24 hours
Alarms	X			
CO2 Absorbent		X		
Monitored Parameters • Insp Oxygen • Insp and Exp CO2 • Insp Pressure • Tidal Volume • Spirometry • *Agent concentration*		X		
Inspect for humidity and secretions • Filters • Water trap		X		
Check Vap Fill if Sedating				
Change Filter/HME			X	
Increase FGF to MV or above for 15 minutes			X	
Perform Self Test*				X

*Anesthesia machine WILL NOT provide ventilation during the self-test. An alternate ventilation strategy that can be maintained for several minutes is required. Consider transport ventilator if manual ventilation bag not likely to be successful. Power to the machine should be cycled between every patient and at least every 25 days.

3/26/2020

Obtained via MI FOIA by Judicial Watch, Inc.

Society of Critical Care Medicine
The Intensive Care Professionals

APPENDIX G: SCCM | Joint Statement on Multiple Patients Per Ventilator

Joint Statement on Multiple Patients Per Ventilator

March 26, 2020
12:00 p.m.

The Society of Critical Care Medicine (SCCM), American Association for Respiratory Care (AARC), American Society of Anesthesiologists (ASA), Anesthesia Patient Safety Foundation (ASPF), American Association of Critical-Care Nurses (AACN), and American College of Chest Physicians (CHEST) issue this consensus statement on the concept of placing multiple patients on a single mechanical ventilator.

The above-named organizations advise clinicians that sharing mechanical ventilators should not be attempted because it cannot be done safely with current equipment. The physiology of patients with COVID-19-onset acute respiratory distress syndrome (ARDS) is complex. Even in ideal circumstances, ventilating a single patient with ARDS and nonhomogenous lung disease is difficult and is associated with a 40%-60% mortality rate. Attempting to ventilate multiple patients with COVID-19, given the issues described here, could lead to poor outcomes and high mortality rates for all patients cohorted. In accordance with the exceedingly difficult, but not uncommon, triage decisions often made in medical crises, it is better to purpose the ventilator to the patient most likely to benefit than fail to prevent, or even cause, the demise of multiple patients.

Background: The interest in ventilating multiple patients on one ventilator has been piqued by those who would like to expand access to mechanical ventilators during the COVID-19 pandemic. The first modern descriptions of multiple patients per ventilator were advanced by Neyman et al in 2006[1] and Paladino et al in 2013.[2] However, in each instance, Branson, Rubinson, and others have cautioned against the use of this technique.[3-5] With current equipment designed for a single patient, we recommend that clinicians do not attempt to ventilate more than one patient with a single ventilator while any clinically proven, safe, and reliable therapy remains available (ie, in a dire, temporary emergency).

Attempting to ventilate multiple patients would likely require arranging the patients in a spoke-like fashion around the ventilator as a central hub. This positioning moves the patients away from the supplies of oxygen, air, and vacuum at the head of the bed. It also places the patients in proximity to each other, allowing for transfer of organisms. Spacing the patients farther apart would likely result in hypercarbia.

Spontaneous breathing by a single patient sensed by the ventilator would set the respiratory frequency for all the other patients. The added circuit volume could preclude triggering. Patients may also share gas between circuits in the absence of one-way valves. Pendelluft between patients is possible, resulting in both cross-infection and over-distension. Setting alarms can monitor only the total response of the patients' respiratory systems as a whole. This would hide changes occurring in only one patient. The reasons for avoiding ventilating multiple patients with a single ventilator are numerous.

Obtained via MI FOIA by Judicial Watch, Inc.

These reasons include:

- Volumes would go to the most compliant lung segments.
- Positive end-expiratory pressure, which is of critical importance in these patients, would be impossible to manage.
- Monitoring patients and measuring pulmonary mechanics would be challenging, if not impossible.
- Alarm monitoring and management would not be feasible.
- Individualized management for clinical improvement or deterioration would be impossible.
- In the case of a cardiac arrest, ventilation to all patients would need to be stopped to allow the change to bag ventilation without aerosolizing the virus and exposing healthcare workers. This circumstance also would alter breath delivery dynamics to the other patients.
- The added circuit volume defeats the operational self-test (the test fails). The clinician would be required to operate the ventilator without a successful test, adding to errors in the measurement.
- Additional external monitoring would be required. The ventilator monitors the average pressures and volumes.
- Even if all patients connected to a single ventilator have the same clinical features at initiation, they could deteriorate and recover at different rates, and distribution of gas to each patient would be unequal and unmonitored. The sickest patient would get the smallest tidal volume and the improving patient would get the largest tidal volume.
- The greatest risks occur with sudden deterioration of a single patient (e.g., pneumothorax, kinked endotracheal tube), with the balance of ventilation distributed to the other patients.
- Finally, there are ethical issues. If the ventilator can be lifesaving for a single individual, using it on more than one patient at a time risks life-threatening treatment failure for all of them.

References

1. Neyman G, Irvin CB. A single ventilator for multiple simulated patients to meet disaster surge. *Acad Emerg Med*. 2006 Nov;13(11):1246-1249.
2. Paladino L, Silverberg M, Charcaflieh JG, et al. Increasing ventilator surge capacity in disasters: ventilation of four adult-human-sized sheep on a single ventilator with a modified circuit. *Resuscitation*. 2008 Apr;77(1):121-126.
3. Branson RD, Rubinson L. One ventilator, multiple patients: what the data really supports. *Resuscitation*. 2008 Oct;79(1):171-172; author reply 172-173.
4. Branson RD, Rubinson L. A single ventilator for multiple simulated patients to meet disaster surge. *Acad Emerg Med*. 2006 Dec;13(12):1352-1353; author reply 1353-1354.

5. Branson RD, Blakeman TC, Robinson BR, Johannigman JA. Use of a single ventilator to support 4 patients: laboratory evaluation of a limited concept. *Respir Care*. 2012 Mar;57(3):399-403.

APPENDIX H: PATIENT CARE: *STRATEGIES FOR SCARCE RESOURCE SITUATIONS*

Obtained via MI FOIA by Judicial Watch, Inc.

Table of Contents

Core Clinical Strategies for Scarce Resource Situations Core clinical categories are practices and resources that form the basis for medical and critical care.		Resource Reference Cards Resource reference cards examine the demands of a specific subset of patients or a specific re- source likely to require specialised responses during a major incident. Resource reference cards in particular may contain content specific to the State of Minnesota that may not be applicable in other areas due to differences in resource availability or vulnerability.	
Summary Card	Page 2	Renal Replacement Therapy	Pages 14-16
Oxyen	Page 3	Burn Therapy	Page
Staffing	Page 4	Pediatrics	Page
Nutritional Support	Page 5	Palliative Care	Page
Medication Administration	Pages 6-7		
Hemodynamic Support and IV Fluids	Pages 8-9		
Mechanical Ventilation / External Oxygenation	Pages 10-11		
Blood Products	Pages 12-13		

Version 2.0 December 2011

MINNESOTA DEPAR TMENT OF HEALTH OFFICE OF EMERGENCY PREPAREDNESS
www.health.state.mn.us/oep/healthcare

Orville L. Freeman Building / PO Box 64975
625 Robert Street N. / St. Paul MN 55164
TEL: 651 201 . 5700 / TDD: 651 215 . 8980

Obtained via MI FOIA by Judicial Watch, Inc.

STRATEGIES FOR SCARCE RESOURCESITUATIONS Summary Card

Potential trigger events:	•Mass Casualty Incident (MCI) •Infrastructure damage/loss •Pandemic/Epidemic	•Supplier shortage •Recall/contamination of product •Isolation of facility due to access problems (flooding, etc)

How to use this card set:

1. Recognize or anticipate resource shortfall
2. Implement appropriate incident management system and plans; assign subject matter experts (technical specialists) toproblem
3. Determine degree of shortfall, expected demand, and duration; assess ability to obtain needed resources via local, regional, or national vendors or partners
4. Find category of resource on index
5. Refer to specific recommendations on card
6. Decide which strategies to implement and/or develop additional strategies appropriate for the facility andsituation
7. Assure consistent regional approach by informing public health authorities and other facilities if contingency or crisis strategies will continue beyond 24h and no regional options exist for re-supply or patient transfer; activate regional scarce resource coordination plans as appropriate

Core strategies to be employed (generally in order of preference) during, or in anticipation of a scarce resource situation are:

Prepare - pre-event actions taken to minimize resource scarcity (e.g., stockpiling of medications)
Substitute - use an essentially equivalent device, drug, or personnel for one that would usually be available (e.g., morphine for fentanyl)
Adapt – use a device, drug, or personnel that are not equivalent but that will provide sufficient care (e.g., anesthesia machine for mechanical ventilation) ***Conserve*** – use less of a resource by lowering dosage or changing utilization practices (e.g., minimizing use of oxygen driven nebulizers to conserve oxygen) ***Re-use*** – re-use (after appropriate disinfection / sterilization) items that would normally be single-use items
Re-allocate – restrict or prioritize use of resources to those patients with a better prognosis or greater need

Capacity

Conventional capacity – The spaces, staff, and supplies used are *consistent with daily practices* within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan.	**Contingency capacity** – The spaces, staff, and supplies used are not consistent with daily practices, but provide care to a standard that is *functionally equivalent* to usual patient care practices. These spaces or practices may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources).	**Crisis capacity** – Adaptive spaces, staff, and supplies are not consistent with usual standards of care, but provide *sufficiency* of care in the setting of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant ad- justment to standards of care (Hick et al, 2009).

Obtained via MI FOIA by Judicial Watch, Inc.

This card set is designed to facilitate a structured approach to resource shortfalls at a healthcare facility. It is a decision support tool and assumes that incident management is implemented and that key personnel are familiar with ethical frameworks and processes that underlie these decisions (for more information see Institute of Medicine 2009 Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report- *http://www.nap.edu/catalog/12749.html* and the Minnesota Pandemic Ethics Project - http://www.health.state.mn.us/divs/idepc/ethics/).
Each facility will have to determine the most appropriate steps to take to address specific shortages. Pre-event familiarization with the contents of this card set is recommended to aid with event preparedness and anticipation of specific resource shortfalls. The cards do not provide comprehensive guidance, addressing only basic common categories of medical care. Facility personnel may determine additional coping mechanisms for the specific situation in addition to those outlined on these cards.

The content of this card set was developed by the Minnesota Department of Health (MDH) Science Advisory Team in conjunction with many subject matter experts whose input is greatly ap- preciated. This guidance does not represent the policy of MDH. Facilities and personnel implementing these strategies in crisis situations should assure communication of this to their healthcare and public health partners to assure the invocation of appropriate legal and regulatory protections in accord with State and Federal laws. This guidance may be updated or changed during an incident by the Science Advisory Team and MDH. The weblinks and resources listed are examples, and may not be the best sources of information available. Their listing does not imply endorse- ment by MDH.

Version December

MINNESOTA DEPAR TMENT OF HEALTH OFFICE OF EMERGENCY PREPAREDNESS

Orville L. Freeman Building / PO Box 64975
625 Robert Street N. / St. Paul MN 55164
TEL: 651.201.5700 / TDD: 651.215.8980

OXYGEN

STRATEGIES FOR SCARCE RESOURCE

Obtained via MI FOIA by Judicial Watch, Inc.

RECOMMENDATIONS	*Strategy*	*Conventional*	*Contingency*	*Crisis*
Inhaled Medications • Restrict the use of Small Volume Nebulizers when inhaler substitutes areavailable. • Restrict continuous nebulization therapy. • Minimize frequency through medication substitution that results in fewer treatments (6h-12h instead of 4h-6h applications).	*Substitute & Conserve*			
High-Flow Applications • Restrict the use of high-flow cannula systems as these can demand 12 to 40 LPMflows. • Restrict the use of simple and partial rebreathing masks to 10 LPM maximum. • Restrict use of Gas Injection Nebulizers as they generally require oxygen flows between 10 LPM and 75 LPM. • Eliminate the use of oxygen-powered venturi suction systems as they may consume 15 to 50LPM.	*Conserve*			
Air-Oxygen Blenders • Eliminate the low-flow reference bleed occurring with any low-flow metered oxygen blender use. This can amount to an ad- ditional 12 LPM. Reserve air-oxygen blender use for mechanical ventilators using high-flow non-metered outlets. (These do not utilize reference bleeds). • Disconnect blenders when not in use.	*Conserve*			
Oxygen Conservation Devices • Use reservoir cannulas at 1/2 the flow setting of standard cannulas. • Replace simple and partial rebreather mask use with reservoir cannulas at flowrates of 6-10 LPM.	*Substitute & Adapt*			
Oxygen Concentrators if Electrical Power Is Present • Use hospital-based or independent home medical equipment supplier oxygen concentrators if available to provide low-flow cannula oxygen for patients and preserve the primary oxygen supply for more critical applications.	*Substitute &*			
Monitor Use and Revise Clinical Targets • Employ oxygen titration protocols to optimize flow or % to match targets for SPO2 or PaO2. • Minimize overall oxygen use by optimization of flow. • Discontinue oxygen at earliest possible time. **Starting Example** / **Initiate O2** / **O2** **Target** Normal Lung Adults: SPO2 <90% / SPO2 90% Infants & Peds: SPO2 <90% / SPO2 90-95% Severe COPD History: SPO2 <85% / SPO2 90% **Note**: Targets may be adjusted further downward depending on resources available, the patient'sclinical presentation, or measured PaO2 determination.	*Conserve*			
Expendable Oxygen Appliances • Use terminal sterilization or high-level disinfection procedures for oxygen appliances, small & large-bore tubing, and ventilator circuits. Bleach concentrations of 1:10, high-level chemical disinfection, or irradiation may be suitable. Ethylene oxide gas ster- ilization is optimal, but requires a 12-hour aeration cycle to prevent ethylene chlorohydrin formation with polyvinyl chloride plastics.	*Re-use*			
Oxygen Re-Allocation • Prioritize patients for oxygen administration during severe resource limitations.	*Re-Allocate*			

STAFFING

STRATEGIES FOR SCARCE RESOURCE

Obtained via MI FOIA by Judicial Watch, Inc.

RECOMMENDATIONS	***Strategy***	***Conventional***	***Contingency***	***Crisis***
Staff and Supply Planning • Assure facility has process and supporting policies for disaster credentialling and privileging - including degree of supervision required, clinical scope of practice, mentoring and orientation, and verification ofcredentials • Encourage employee preparedness planning (www.ready.gov and other resources). • Cache adequate personal protective equipment (PPE) and support supplies. • Educate staff on institutional disaster response. • Educate staff on community, regional and state disaster plans and resources. • Develop facility plans addressing staff's family / pets or staff shelter needs.	*Prepare*			
Focus Staff *Time* on Core Clinical Duties • Minimize meetings and relieve administrative responsibilities not related toevent. • Reduce documentation requirements. • Cohort patients to conserve PPE and reduce staff PPE donning/doffing time and frequency. • Restrict elective appointments and procedures.	*Conserve*			
Use Supplemental Staff • Bring in equally trained staff (burn or critical care nurses, Disaster Medical Assistance Team [DMAT], other health system or Federal sources). • Equally trained staff from administrative positions (nurse managers).	*Substitute*			
• Adjust personnel work schedules (longer but less frequent shifts, etc.) if this will not result in skill / PPE compliancedeterioration. • Use family members/lay volunteers to provide basic patient hygiene and feeding – releasing staff for other duties.	*Adapt*			
Focus Staff *Expertise* on Core Clinical Needs • Personnel with specific critical skills (ventilator, burn management) should concentrate on those skills; specify job duties that can be safely performed by other medical professionals. • Have specialty staff oversee larger numbers of less-specialized staff and patients (for example, a critical care nurse overseesthe intensive care issues of 9 patients while 3 medical/surgical nurses provide basic nursing care to 3 patientseach). • Limit use of laboratory, radiographic, and other studies, to allow staff reassignment and resource conservation. • Reduce availability of non-critical laboratory, radiographic, and other studies.	*Conserve*			
Use Alternative Personnel to Minimize Changes to Standard of Care • Use less trained personnel with appropriate mentoring and just-in-time education (e.g., healthcare trainees or otherhealth careworkers, Minnesota Responds Medical Reserve Corps, retirees). • Use less trained personnel to take over portions of skilled staff workload for which they have been trained. • Provide just-in-time training for specific skills. • Cancel most sub-specialty appointments, endoscopies, etc. and divert staff to emergency duties including in-hospital or assist- ing public health at external clinics/screening/dispensing sites.	*Adapt*			

NUTRITIONAL SUPPORT

STRATEGIES FOR SCARCE RESOURCE

Obtained via MI FOIA by Judicial Watch, Inc.

RECOMMENDATIONS	***Strategy***	***Conventional***	***Contingency***	***Crisis***
Food • Maintain hospital supply of inexpensive, simple to prepare, long-shelf life foodstuffs as contingency for at least 96 hours with- out resupply, with additional supplies according to hazard vulnerability analysis (e.g., grains, beans, powdered milk, powdered protein products, pasta, and rice). Access existing or devise new emergency/disaster menuplans. • Maintain hospital supply of at least 30 days of enteral and parenteral nutrition components and consider additional supplies based on institution-specific needs. Review vendor agreements and their contingencies for delivery and production, including alternate vendors. Note: A 30-day supply based on usual use may be significantly shortened by the demand of a disaster.	*Prepare*			
Water • Stock bottled water sufficient for drinking needs for at least 96 hours if feasible (for staff, patients and family/visitors), or assure access to drinking water apart from usual supply. Potential water sources include food and beverage distributors. • Ensure there is a mechanism in place to verify tap water is safe to drink. • Infants: assure adequate stocks of formula and encourage breastfeeding.	*Prepare*			
Staff/Family • Plan to feed additional staff, patients, and family members of staff/patients in select situations (ice storm as an example ofa short-term incident, an epidemic as an example of a long-term incident).	*Prepare*			
Planning • Work with stakeholders to encourage home users of enteral and parenteral nutrition to have contingency plans and alternate delivery options. Home users of enteral nutrition typically receive delivery of 30 days supply and home users of parenteral nutrition typically receive a weekly supply. Anticipate receiving supply requests from home users during periods of shortage. Work with vendors regarding their plans for continuity of services and delivery. • Identify alternate sources of food supplies for the facility should prime vendors be unavailable (including restaurants – which may be closed during epidemics). Consider additional food supplies at hospitals that do not have food service management accounts. • Determine if policy on family provision of food to patients is in place, and what modifications might be needed or permitted in a disaster.	*Prepare*			
• Liberalize diets and provide basic nutrients orally, if possible. Total parenteral nutrition (TPN) use should be limited and priori- tized for neonatal and critically ill patients.	*Substitut*			
• Non-clinical personnel serve meals and may assist preparation. • Follow or modify current facility guidelines for family donation of meals to patients. • Anticipate and have a plan for the receipt of food donations. If donated food is accepted, it should be non-perishable, prepack- aged, and in single serving portions.	*Adapt*			

Obtained via MI FOIA by Judicial Watch, Inc.

• Collaborate with pharmacy and nutrition services to identify patients appropriate to receive parenteral nutrition support vs. enteral nutrition. Access premixed TPN/PPN solutions from vendor if unable to compound. Refer to Centers for Disease Con- trol (CDC) Fact Sheets and American Society for Parenteral and Enteral Nutrition (ASPEN) Guidelines. Substitute oral supplements for enteral nutrition products if needed.	*Substitute & Adapt*			
• Eliminate or modify special diets temporarily. • Use blenderized food and fluids for enteral feedings rather than enteral nutrition products if shortages occur. Examples: 1. The Oley Foundation: Making Your Own Food for Tube Feeding, http://www.oley.org/lifeline/TubetalkSO07.html#Making%20your%20 own 2. Klein, Marsha Dunn, and Suzanne Evans Morris. Homemade Blended Formula Handbook. Tucson: Mealtime Notions LLC, 2007.	*Adapt*			

Obtained via MI FOIA by Judicial Watch, Inc.

RECOMMENDATIONS	Strategy	Conventional	Contingency	Crisis
Cache / Increase Supply Levels • Patients should have at least 30 days supply of home medications and obtain 90 day supply if pandemic, epidemic, or evacuation is imminent. • Examine formulary to determine commonly-used medications and classes that will be in immediate / high demand. • Increase supply levels or cache critical medications - particularly for low-cost items and analgesics. • Key examples include: **Analgesia** • morphine, other narcotic and non-narcotic (non-steroidals, acetaminephen) class - injectable and oral (narcotic conversion tool at http://www.globalrph.com/narcoticonv.htm) **Sedation** • particularly benzodiazepine (lorazepam, midazolam, diazepam) injectables **Anti-infective** • narrow and broad spectrum antibiotics for pneumonia, skin infections, open fractures, sepsis (e.g.: cephalosporins, quinolones, tetracyclines, macrolides, aminoglycosides, clindamycin, etc.), select antivirals **Pulmonary** • metered dose inhalers (albuterol, inhaled steroids), oral steroids (dexamethasone,prednisone) **Behavioral Health** • haloperidol, other injectable and oral anti-psychotics, common anti-depressants, anxiolytics **Other** • sodium bicarbonate, paralytics, induction agents (etomidate, propofol), proparacaine/tetracaine, atropine, pralidoxime, epinephrine, local anesthetics, antiemetics, insulin, common oral anti-hyper- tensive and diabetes medications	*Prepare*			
Use Equivalent Medications • Obtain medications from alternate supply sources (pharmaceutical representatives, pharmacycaches). **Pulmonary** • Metered dose inhalers instead of nebulized medications **Analgesia / Sedation** • Consider lorazepam for propofol substitution (and other agents in short supply) • ICU analgesia/sedation drips Morphine 4-10mg IV load then 2mg/h and titrate / re-bolus as needed usual 3-20mg/h); lorazepam 2-8mg or midazolam 1-5mg IV load then 2-8mg/h drip **Anti-infective** • Examples: cephalosporins, gentamicin, clindamycin substitute for unavailablebroad-spectrum antibiotic • Target therapy as soon as possible based upon organism identified. **Other** • Beta blockers, diuretics, calcium channel blockers, ace inhibitors, anti-depressants, anti-infectives	*Substitute* *Substitute*			
Reduce Use During High Demand • Restrict use of certain classes if limited stocks likely to run out (restrict use of prophylactic / empiric antibiotics after low risk wounds, etc.). • Decrease dose; consider using smaller doses of medications in high demand / likely to run out (reduce doses of medica- tions allowing blood pressure or glucose to run higher to ensure supply of medications adequate for anticipated duration of shortage). • Allow use of personal medications (inhalers, oral medications) in hospital	*Conserve*			
• Do without - consider impact if medications not taken during shortage (statins, etc.).	*Conserve*			

MEDICATION ADMINISTRATION

Obtained via MI FOIA by Judicial Watch, Inc.

STRATEGIES FOR SCARCE RESOURCE SITUATIONS

RECOMMENDATIONS	*Strategy*	*Conventional*	*Contingency*	*Crisis*
Modify Medication Administration • Emphasize oral, nasogastric, subcutaneous routes of medication administration. • Administer medications by gravity drip rather than IV pump if needed: *IV drip rate calculation - drops / minute = amount to be infused x drip set / time (minutes) (drip set = qtts / mL - 60, 10, etc.).* • Rule of 6: pt wgt (kg) x 6 = mg drug to add to 100ml fluid = 1mcg / kg / min for each 1	*Adapt*			
• Consider use of select medications beyond expiration date.* • Consider use of veterinary medications when alternative treatments are not available.*	*Adapt*			
Restrict Allocation of Select Medications • Allocate limited stocks of medications with consideration of regional/state guidance and available epidemiological informa- tion (e.g.: anti-viral medications such as olseltamivir)	*Re-Allocate*			
• Allocate limited stock to support other re-allocation decisions (ventilator use, etc.).	*Re-*			

*Legal protection such as Food and Drug Administration approval or waiver required.

HEMODYNAMIC SUPPORT AND IV FLUIDS

Obtained via MI FOIA by Judicial Watch, Inc.

RECOMMENDATIONS	Strategy	Conventional	Contingency	Crisis
Cache Additional Intravenous (IV) Cannulas, Tubing, Fluids, Medications, and Administration Supplies	*Prepare*			
Use Scheduled Dosing and Drip Dosing When Possible • Reserve IV pump use for critical medications such as sedatives and hemodynamic support.	*Conserve*			
Minimize Invasive Monitoring • Substitute other assessments (e.g., clinical signs, ultrasound) of central venous pressure (CVP). • When required, assess CVP intermittently via manual methods using bedside saline manometer or transducer moved be- tween multiple patients as needed, or by height of blood column in CVP line held vertically while patient supine.	*Conserve*			
Utilize appropriate oral rehydration solution: • Oral rehydration solution: 1 liter water (5 cups) + 1 tsp salt + 8 tsp sugar, add flavor (e.g., ½ cup orange juice, other) as needed. • Rehydration for moderate dehydration 50-100mL / kg over 2-4 hours Pediatric hydration: Pediatric maintenance fluids: • 4 mL/kg/h for first 10kg of body weight (40 mL/h for 1st 10 kg) • 2 mL/kg/h for second 10kg of body weight (20 mL/h for 2nd 10kg = 60 mL/h for 20kg child) • 1 mL/kg/h for each kg over 20kg (example - 40 kg child = 60 mL/h plus 20 mL/h = 80 mL/h) Supplement for each diarrhea or emesis NOTE: Clinical (urine output, etc.) and laboratory (BUN, urine specific gravity) assessments and electrolyte correction are key compo- nents of fluid therapy and are not specifically addressed by these recommendations. NOTE: For further information and examples, see http://rehydrate.org, http://www.bt.cdc.gov/disasters/hurricanes/pdf/dguidelines. pdf and http://www.ped.med.utah.edu/cai/howto/IntravenousFluidOrders.PDF.	*Substitute*			
Provide Nasogastric Hydration Instead of IV Hydration When Practical • Patients with impediments to oral hydration may be successfully hydrated and maintained with nasogastric (NG)tubes. • For fluid support, 8-12F (pediatric: infant 3.5F, < 2yrs 5F) tubes are better tolerated than standard size tubes.	*Substitute*			
Substitute Epinephrine for Other Vasopressor Agents • For hemodynamically unstable patients who are adequately volume-resuscitated, consider adding 6mg epinephrine (6mL of 1:1000) to 1000mL NS on minidrip tubing and titrate to target blood pressure. • Epinephrine 1:1000 (1mg/mL) multi-dose vials available for drip use.	*Substitute*			
Re-use CVP, NG, and Other Supplies After Appropriate Sterilization / Disinfection • Cleaning for all devices should precede high-level disinfection or sterilization. • High-level disinfection for at least twenty minutes for devices in contact with body surfaces (including mucous membranes);glutaraldehyde, hydrogen peroxide 6%, or bleach (5.25%) diluted 1:20 (2500 ppm) are acceptable solutions. NOTE: chlorine levels reduced if stored in polyethylene containers - double the bleach concentration to compensate). • Sterilize devices in contact with bloodstream (e.g., ethylene oxide sterilization for CVP catheters).	*Re-use*		(disinfection – NG, etc)	(steriliza - tion - central line, etc)

Obtained via MI FOIA by Judicial Watch, Inc.

RECOMMENDATIONS	Strategy	Conventional	Contingency	Crisis
Intraosseous / Subcutaneous (Hypodermoclysis) Replacement Fluids • Consider as an option when alternative routes of fluid administration areimpossible/unavailable • Intraosseous before percutaneous Intraosseous • Intraosseous infusion is not generally recommended for hydration purposes, but may be used until alternative routes are available. Intraosseous infusion requires pump or pressure bag. Rate of fluid delivery is often limited by pain of pressure within the marrow cavity. This may be reduced by pre-medication with lidocaine 0.5mg/kg slow IV push. Hypodermoclysis • Cannot correct more than moderate dehydration via thistechnique. • Many medications cannot be administered subcutaneously. • Common infusion sites: pectoral chest, abdomen, thighs, upper arms. • Common fluids: normal saline (NS), D5NS, D5 1/2 NS (Can add up to 20-40 mEq potassium if needed.) • Insert 21/24 gauge needle into subcutaneous tissue at a 45 degree angle, adjust drip rate to 1-2 mL per minute. (May use 2 sites simultaneously if needed.) • Maximal volume about 3 liters / day; requires site rotation. • Local swelling can be reduced with massage to area. • Hyaluronidase 150 units / liter facilitates fluid absorption but not required; may not decrease occurrence of localedema.	*Substitute*			
Consider Use of Veterinary and Other Alternative Sources for Intravenous Fluids and Administration Sets	*Adapt*			

MECHANICAL VENTILATION / EXTERNAL OXYGENATION

Obtained via MR CM by Judicial Watch, Inc.

RECOMMENDATIONS	*Strategy*	*Conventional*	*Contingency*	*Crisis*
Increase Hospital Stocks of Ventilators and Ventilator Circuits, ECMO or bypass circuits	*Prepare*			
Access Alternative Sources for Ventilators / specialized equipment • Obtain specialized equipment from vendors, healthcare partners, regional, state, or Federal stockpiles via usualemergency management processes and provide just-in-time training and quick reference materials for obtained equipment.	*Substitute*			
Decrease Demand for Ventilators • Increase threshold for intubation / ventilation. • Decrease elective procedures that require post-operative intubation. • Decrease elective procedures that utilize anesthesia machines. • Use non-invasive ventilatory support when possible.	*Conserve*			
Re-use Ventilator Circuits • Appropriate cleaning must precede sterilization. • If using gas (ethylene oxide) sterilization, allow full 12 hour aeration cycle to avoid accumulation of toxic byproducts on surface. • Use irradiation or other techniques as appropriate.	*Re-use*			
Use Alternative Respiratory Support Technologies • Use transport ventilators with appropriate alarms - especially for stable patients without complex ventilation requirements. • Use anesthesia machines for mechanical ventilation as appropriate / capable. • Use bi-level (BiPAP) equipment to provide mechanical ventilation.	*Adapt*			
• Consider bag-valve ventilation as temporary measure while awaiting definitive solution / equipment (as appropriate tosituation				

MECHANICAL VENTILATION / EXTERNAL OXYGENATION

Obtained via MR CHA by Judicial Watch, Inc.

Assign Limited Ventilators to Patients Most Likely to Benefit if No Other Options Are Available ***STEP ONE*:** assess patient acuity using SOFA (see next page+) scoring table and/or other parameters appropriate to the situation (agent-specific prognostic indicators, modifications based on agent involved).	*Re-allocate*			

ORGAN SYSTEM	SCORE =	1	2	3	4
RESPIRATORY Pa02 /	> 400	< 400	< 300	< 200 with resp.	< 100 with resp.
HEMATOLOGIC Platelets	> 150	< 150	< 100	< 50	< 20
HEPATIC Bilirubin (mg / dl)	< 1.2	1.2 – 1.9	2.0 – 5.9	6 – 11.9	> 12
CARDIOVASCULAR Hypotension	None	Mean Arterial Pressure	Dopamine < 5 or any	Dopamine > 5 or Epi < 0.1	Dopamine > 15 or Epi > 0.1
CENTRAL NERVOUS SYSTEM	15	13 - 14	10 - 12	6 - 9	<6
RENAL Creatinine	<1.2	1.2 - 1.9	2.0 - 3.4	3.5 - 4.9	>5.0

MECHANICAL VENTILATION / EXTERNAL OXYGENATION

Obtained via MR FOIA by Judicial Watch, Inc.

RECOMMENDATIONS				***Strategy***	***Crisis***
STEP TWO**:** Compared to other patient(s) requiring and awaiting external ventilation / oxygenation, does this patient have significant differences in prognosis or re-source utilization in one or more categories below that would justify re-allocation of the ventilator / unit? Factors listed in relative order of importance/weight. Injury/ epidemiologic factors may ha				*Re-allocate*	
Criteria	Patient keeps resource		Resource re-allocated		
1.Organ system function[a]	Low potential for death death (SOFA score ≤ 7)	Intermediate potential for death (SOFA score 8-11)	High potential for (SOFA score ≥12)		
2.Duration of benefit / prognosis	Good prognosis based upon epidemiology of specific disease/ injury.	Indeterminate / intermediate prognosis based upon epidemiology of specific dis-ease / injury	Poor prognosis based upon epidemiology of specific disease / injury (e g; pandemic influenza)		
	No severe underlying disease.[b]	Severe underlying disease with poor long-term prognosis and/or ongoing resource demand (e.g., home oxygen dependent, dialysis dependent) and unlikely to survive more than 1-2 years	Severe underlying disease with poor short-term (e.g., <1 year) prognosis		
3.Duration of need	Short duration – flash pulmonary edema, chest trauma, other conditions preexisting anticipating < 3 days on ventilator	Moderate duration – e.g., pneumonia in healthy patient (estimate 3-7days on	Long duration – e.g., ARDS, particularly in setting of ventilator) lung disease		
4.Response to mechanical ventila- tion	Improving ventilatory	Stable ventilatory parameters over time	Worsening ventilatory		
[a] The Sequential Organ Failure Assessment (SOFA) score is the currently preferred assessment tool but other predictive models may be used depending on the situation / epidemiol- ogy. Note: SOFA scores were not designed to forecast mortality, and thus single or a few point difference between patients may not represent a 'substantial difference' in mortality, but larger differences and trends can be extremely helpful in determining resource assignment					
[b] Examples of underlying diseases that predict poor short-term survival include (but are not limited to): 1. Congestive heart failure with ejection fraction < 25% (or persistent ischemia unresponsive to therapy or non-reversible ischemia with pulmonary edema) 2. Severe chronic lung disease including pulmonary fibrosis, cystic fibrosis, obstructive or restrictive diseases requiring continuous home oxygen use prior to onset of acuteillness 3. Central nervous system, solid organ, or hematopoietic malignancy with poor prognosis forrecovery 4. Cirrhosis with ascites, history of variceal bleeding, fixed coagulopathy orencephalopathy					
[c]Changes in Oxygenation Index over time may provide comparative data, though of uncertain prognostic significance. OI = MAWP x FiO2 / PaO2 where: OI = oxygenation index, MAWP= Mean Airway Pressure, FiO2 = inspired oxygen concentration, PaO2 = arterial oxygen pressure (May be estimated from oxygen dissociation curve if blood gas unavailable.)					
STEP THREE**:** Re-allocate ventilator / resource only if patient presenting with respiratory failure has significantly better chance of survival/benefit as compared to patient currently receiving ventilation. Follow additional regional and state/federal guidance and institutional processes for scarce					

BLOOD PRODUCTS

STRATEGIES FOR SCARCE RESOURCE

Obtained via MI FOIA by Judicial Watch, Inc.

MINNESOTA HEALTHCARE SYSTEM PREPAREDNESS

Category	*RECOMMENDATIONS*	*Healthcare*	*Blood Center*	*Strategy*	*Conventional*	*Contingency*	*Crisis*
All Blood	• Increase donations if required, and consider local increase in frozenreserves • Increase O positive levels • Consider maintaining a frozen blood reserve if severe shortage • Increase recruitment for specific product needs		√	*Prepare*			
	• Consider adjustments to donor HGB/HCT eligibility		√	*Adapt*			
	• Relax travel deferrals for possible malaria and BSE (bovine spongiformencephalitis)*		√	*Prepare*			
Packed Red Blood Cells	• Use cell-saver and auto-transfusion to degree possible	√		*Re-use*			
	• Limit O negative use to women of child-bearing age • Use O positive in emergent transfusion in males or non-child bearing females to conserve O nega- tive	√		*Conserve*			
	• Change donations from whole blood to 2x RBC apheresis collection if specific shortage of		√	*Adapt*			
	• More aggressive crystalloid resuscitation prior to transfusion in shortage situations (blood substi- tutes may play future role)	√		*Conserve*			
	• Long-term shortage, collect autologous blood pre-operatively and consider cross-over	√		*Conserve*			
	• Enforce lower hemoglobin triggers for transfusion (for example, HGB 7)	√		*Conserve*			
	• Consider limiting high-consumption elective surgeries (select cardiac, orthopedic, etc)	√		*Conserve*			
	• Consider use of erythropoietin (EPO) for chronic anemia in appropriate patients	√		*Adapt*			
	• Further limit PRBC use, if needed, to active bleeding states, consider subsequent restrictions includ- ing transfusion only for end-organ damage, then to shock states only	√		*Re-allocate*			
	• Consider Minimum Qualifications for Survival (MQS) limits on use of PRBCs (for example, only initi- ate for patients that will require < 6 units PRBCs and/or consider stopping transfusion when > 6 units utilized). Specific MQS limits should reflect available resources	√		*Re-allocate*			
	• Reduce or waive usual 56 day inter-donation period* based upon pre-donation hemoglobin		√	*Adapt*			
	• Reduce weight restrictions for 2x RBC apheresis donations according to instruments usedand medical director guidance*		√	*Adapt*			
Fresh Frozen	• Though not true substitute, consider use of fibrinolysis inhibitors or other modalities to reverseco- agulopathic states (tranexamic acid, aminocaproic acid, activated coagulation factor use, or other appropriate therapies)	√		*Substitute*			
	• Consider reduction in red cell : FFP ratios in massive transfusion protocols in consultation with blood bank medical staff	√		*Conserve*			
	• No anticipatory use of FFP in hemorrhage without documented coagulopathy	√		*Conserve*			
	• Obtain FDA variance to exceed 24 collections per year for critical types*		√	*Adapt*			

*FDA approval/variance required via American Association of Blood Banks (AABB)

BLOOD PRODUCTS

Obtained via MI FOIA by Judicial Watch, Inc.

STRATEGIES FOR SCARCE RESOURCE SITUATIONS

MINNESOTA HEALTHCARE SYSTEM PREPAREDNESS

Category	*RECOMMENDATIONS*	*Healthcare*	*Blood Center*	*Strategy*	*Conventional*	*Contingency*	*Crisis*
Platelets	• Though not true substitute, consider use of desmopressin (DDAVP) to stimulate improved platelet performance in renal and hepatic failure patients	√		*Substitut*			
	• May use leukoreduced whole blood pooled platelets (and, if required, consider non-leukore- duced whole blood pooled platelets)		√	*Adapt*	Leukoreduced		Non-leu-koreduce
	• Convert less needed ABO Whole Blood to Apheresis		√	*Adapt*			
	• Transfuse platelets only for active bleeding, further restrict to life-threatening bleedingif required by situation	√		*Conserve*			
	• No prophylactic use of platelets	√		*Conserve*			
	• Accept female platelet donors without HLA antibody screen		√	*Adapt*			
	• Accept female donors for pooled and stored platelets		√	*Adapt*			
	• Apply for variance of 7 day outdate requirement*		√	*Adapt*			
	• Consider a 24 hr hold until the culture is obtained and immediate release for both Pooland Apheresis		√	*Adapt*			
	• Obtain FDA variance to allow new Pool and Store sites to ship across state lines*		√	*Adapt*			
	• Reduce pool sizes to platelets from 3 whole blood donations		√	*Adapt*			

*FDA approval/variance required via American Association of Blood Banks (AABB)

RENAL REPLACEMENT THERAPY

Obtained via MI FOIA by Judicial Watch, Inc.

REGIONAL RESOURCE CARD

MINNESOTA HEALTHCARE SYSTEM PREPAREDNESS

Resource cards are intended to provide incident-specific tactics and planning information to supplement the general strategy cards. They are organized according to the'CO-S-TR' framework of incident response planning – http://www.dmphp.org/cgi/content/full/2/Supplement_1/S51.

Category	*RESOURCE and RECOMMENDATIONS*	*Strategy*	*Conventional*	*Contingency*	*Crisis*
Command, Control, Communication, Coordination	**General Preparedness Information** Compared to other critical care interventions, hemodialysis offers equipment availability, expansion capacity, and care coordination that greatly reduces the risk of contingency and crisis care, at least in our geographic area. Disaster dialysis challenges generally result from: 1. Lack of clean water sources (each hemodialysis requires about 160 liters ultra-clean water) 2. Relocation of dialysis-dependent patients to a new area (evacuation of nursing homes, flood zones, etc.) 3. Increase in patients requiring dialysis (crush syndrome, unusual infections) Outpatient • Primary providers are DaVita and Fresenius – both have extensive contingency plans to increasecapacity and relocate patients (including toll-free numbers to access dialysisservices) • Renal Network 11 (multi-state renal planning, quality, and emergency preparedness) has database of all di- alysis patients in the state/region and assists coordination activities (http://www.esrdnet11.org/resources/ disaster_prep_resources.asp) Inpatient • Most facilities lease inpatient services via contract with above or other agencies; some have own nurses and program – plans should account for contingency use of alternate services / leasing services	*Prepare*			
	Shortage of Renal Replacement Therapy (RRT) Resources • Affected facility should contact involved/affected dialysis provider companies and organizations asexpert consultants[1] (MDH OEP and the Renal Network 11 website maintain contact information)				
Space	**Relocated Patients Requiring Outpatient Dialysis** • Contact usual outpatient provider network to schedule at new facility – refer patients to'hotlines' as needed **Excess Patients Requiring Dialysis** • Transfer patients to other facilities capable of providingdialysis • Consider moving patients to facilities with in-house water purification if water quality is an issue formul- tiple inpatients requiring dialysis	*Substitute*			
	• Consider moving other inpatient or outpatient dialysis staff and equipment to facilities requiring increased dialysis capacity	*Adapt*			

RENAL REPLACEMENT THERAPY
REGIONAL RESOURCE CARD

Obtained via MI FOIA by Judicial Watch, Inc.

Category	RESOURCE and RECOMMENDATIONS	Strategy	Conventional	Contingency	Crisis
Supplies	**Water Supply** • Quantify water-purifying machines available for bedside dialysismachines • Identify facilities providing high-volume services purify their own water and pipe to specific rooms inthe dialysis unit, intensive care, etc. • Identify water-purifying and dialysis machines to be obtained through leaseagreements	*Prepare*			
	Water Contamination • Consider alternate sources ofwater	*Prepare*			
	• Consider transferring stable inpatients to outpatient dialysis centers for dialysis treatments and vice	*Substitute*			
	• Consider use of MN National Guard water reserves and purification equipment – but must assureadequate purity for dialysis (potable is NOT sufficiently clean)	*Adapt*			
	Power Outage or Shortage • Consider transferring stable inpatients to outpatient dialysis centers for dialysis treatments and vice versa • Consider transferring inpatients to other hospitals	*Substitute* *Adapt*			
	Dialysis Catheters, Machines, Reverse Osmosis Machines, and/or Other Supply Shortages ***Note:*** Dialysis catheters and tubing are inexpensive, relatively interchangeable, and supplied by several manufacturers				
	• Stock adequate dialysis tubing sets and venous access catheters (Quinton, etc.) for at least one month's usual use	*Prepare*			
	• Identify provider network and other sources of supplies and machines				
	• Transfer machines/supplies between outpatient centers and hospitals, or betweenhospitals	*Substitute*			
Staff	**Dialysis Staff Shortages**[2] • Non-dialysis nursing staff to take on "routine" elements of dialysis nursing (e.g., taking VS, monitoring respi- ratory and hemodynamic status, etc.)	*Substitute*			
	• Dialysis nursing staff to supervise non-dialysis nursing staff providing some dialysis functions • Outpatient dialysis techs may be used to supervise dialysis runs if provider deficit is critical issue (would be unlikely aside from potentially in pandemic or other situation affecting staff)	*Adapt*			
Special	**Community Planning** • Medical needs of re-located renal failure patients are substantial; planning on community level should incorporate their medication and dietary needs during evacuation and sheltering	*Prepare*			
	Insufficient Resources Available For All Patients Requiring Dialysis • Change dialysis from 'scheduled' to 'as needed' based on clinical and laboratory findings (particularly hyper- kalemia and impairment of respiration) – parameters may change based on demand for	*Conserve*			

Obtained via MI FOIA by Judicial Watch, Inc.

	• Conceivable (but extraordinary, given outpatient dialysis machine resources) situations may occur where resources are insufficient to the point that some patients may not be able to receive dialysis (for example, pandemic when demand nationwide exceeds available resources) – access to dialysis should be considered as part of critical care intervention prioritization (see Mechanical Ventilation Strategies for Scarce Resource Situations)	*Re-allocate*			

RENAL REPLACEMENT THERAPY
REGIONAL RESOURCE CARD

Obtained via MI FOIA by Judicial Watch, Inc.

Category	RESOURCE and RECOMMENDATIONS	Strategy	Conventional	Contingency	Crisis
Treatment	**Crush Syndrome** • Initiate IV hydration and acidosis prevention protocols "in the field" for crush injuries to prevent/treat rhab- domyolysis in hospital settings	*Conserve*			
	Mode of Dialysis • Restrict to hemodialysis only for inpatient care (avoid continuous renal replacement therapy(CRRT) and peritoneal dialysis (PD) due to duration of machine use (CRRT) and supply	*Substitute*			
	Increased Demand on Resources • Shorten duration of dialysis for patients that are more likely to tolerate itsafely • Patients to utilize their home "kits" of medication (Kayexalate) and follow dietary plans to help increase time between treatments, if necessary	*Conserve*			
Transportation	**Transportation Interruptions** • Dialysis patients may require alternate transportation to assure ongoing access to dialysis treatment. • Chronic patients should coordinate with their service providers / dialysis clinics first for transportation and other assistance during service/transportation interruptions. • Emergency management and/or the health and medical sector may have to supplement contingency transportation to dialysis during ice stroms or other interruptions to transportation.	*Prepar* *e*			

[1] The major national dialysis corporations have extensive experience contending with disasters; their input during any anticipated or actual incident is imperative to optimize the best patient care in Minnesota.

[2] See Staffing in the Core Clinical Strategies for Scarce Resource Situations cardset.

Obtained via MI FOIA by Judicial Watch, Inc.
DRAFT, PREDECISONAL, DELIBERATIVE, FOR INTERNAL USE ONLY
Updated 3.29.20

Draft PPE Allocation Formula Guidance

Purpose of this guidance: Provide clear, written decisions to guide future PPE allocation methodology to ensure consistency and adherence to our values and priorities.

Goals of our allocation formula: Distribute limited PPE fairly across the state to the workers at greatest risk, performing the most critical roles, in geographies and populations of greatest need, to minimize deaths of patients and staff, using the best available data. Maximize PPE flowing into the field to address urgent needs, while appropriately securing our ability to respond to greater emergencies that may arise.

Groups eligible to receive PPE*:* Using the categories defined in the *03/22/20 Prioritization Considerations for PPE Allocation During COVID-19 Outbreak* guidance, **recommendation that PPE goes only to Priority 1** (acute care hospital and EMS personnel), and a **limited supply for Priority 2** (congregate care facilities/shelters/state run facilities with COVID patients) **to address emerging outbreak clusters**. As more PPE becomes available, we could consider expanding to more groups.

Defining "need": The two major options are based on actual use (hospital-specific burn rates) or modeled need (based on patient counts). We do not yet have a hospital-specific burn rate baseline, so cannot tell if there are disparities across facilities, and therefore cannot yet make a recommendation. In general, we would **suggest adopting an actual use formula if burn rates appear to be comparable**/in line with CDC conservation guidelines. If there are disparities in the baseline burn rates, we would then consider using a modeled need formula instead.

Allocation when demand exceeds supply: In general, we would **adopt a proportional allocation approach** distributes the reductions across all requestors on a percentage basis. However, we would **require human oversight** over such decisions to address individual cases that might require adjustment (for example, the need to address an urgent facility-based outbreak).

Retention of PPE to smooth distribution over time/maintain a reserve: Given the critical shortages already existing, and the uncertainty of future supply and demand, we propose to **immediately distribute all supply** that arrives on a given day except for a **defined emergency reserve**. The Emergency Reserve size and conditions to access the reserve will still need to be defined. Critical inputs to the Emergency Reserve size include: supply chain conditions (frequency and certainty of shipments); disease burden/progression (where we are on the peak); demand signal (level of demand in the field, e.g., based on non-state supply chain access and disease conditions).

Requirement to adhere to specified equipment conservation guidance: We have already recommended facilities adopt the CDC equipment conservation guidelines at the crisis scenario level, but actual adherence to those guidelines is unknown. We will consider recommending additional practices as new evidence becomes available (e.g., recent studies on potential reuse of heat- or UV-treated N95 masks), based on the clinical judgment of the soundness of those practices and conditions on the ground. At this time, we do not recommend an absolute mandate, such as an executive order, requiring adherence to CDC conservation guidelines, but will continue evaluating the need for such an action as more data becomes available about local adherence.

Next step: Establishment an Allocation Team to (1) determine Emergency Reserve size; (2) finalize allocation formula; (3) serve on-call to address any shortfalls; (4) adjust all of the above as conditions on the ground shift

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark; Bagley, Nick
Cc: Taverna, Andrea (DHHS-Contractor)
Subject: FW: Re:
Date: Friday, March 27, 2020 7:15:07 AM
Attachments: Applecart - Coronavirus.pdf

Andie or I will talk to him before 9:30—I think the PR and ad partners could be key for raising our game

From: Sacha Samotin <sacha@applecart.co>
Sent: Friday, March 27, 2020 7:00 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Cc: Emanuel, Ezekiel J <zemanuel@upenn.edu>; Gayle Yelon <gayle@applecart.co>; Joe Shafer <joe@applecart.co>; Matthew Kalmans <matt@applecart.co>
Subject: Re: Re:

Robert, here's a short concept memo we put together about a week ago on COVID-related things we could do to help. This is by no means exhaustive. Separately, we have a whole network of partners in the PR and advertising worlds who we can bring in on short notice to help out depending on what direction(s) you want to go in.

On Fri, Mar 27, 2020 at 6:35 AM Gordon, Robert (DHHS) <GordonR3@michigan.gov> wrote:

> Hi, I'm up and free next hour or so; have a related call at 930. If you can, please give me a call, 517 242 0165. Or if you prefer conf life I can dial in. Robert
>
> **From:** Sacha Samotin <sacha@applecart.co>
> **Sent:** Friday, March 27, 2020 6:33 AM
> **To:** Emanuel, Ezekiel J <zemanuel@upenn.edu>
> **Cc:** Gayle Yelon <gayle@applecart.co>; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Joe Shafer <joe@applecart.co>; Matthew Kalmans <matt@applecart.co>
> **Subject:** Re:
>
> Thanks for everything you're doing Zeke, and thanks for everything you're doing Robert.
>
> Let me know when makes sense to chat, I'm available whenever works best for you and we're eager to help however we can.
>
> If there's a specific time that works best we can get a conference call line set up, otherwise feel free to reach me on my cell at any time. 239-272-6052.
>
> Sacha
>
> On Fri, Mar 27, 2020 at 5:40 AM Emanuel, Ezekiel J <zemanuel@upenn.edu> wrote:

Obtained via MI FOIA by Judicial Watch, Inc.

Robert meet Sacha,

Sacha is a former Penn student--the tops-- who runs a company that uses social media and behavioral economic technquies--prompts by people you know-- to get people to vote and do other socially positive things.

He has had some great ideas about how to do that for COVID-19. This might address your PR campaign issues.

In full disclosure, I have an investment in Sacha's company. But that is because it is super effective at what it does.

Ezekiel J. Emanuel, M.D., Ph.D.

Vice Provost of Global Initiatives
Chair, Department of Medical Ethics and Health Policy (on Leave 2019-2020)
Levy University Professor
Co-Director, Healthcare Transformation Institute
Perelman School of Medicine and The Wharton School
University of Pennsylvania

Phone: 215-898-7226 or 215-573-8104

Obtained via MI FOIA by Judicial Watch, Inc.

Applecart

Memorandum

From: Applecart March 17, 2020

To: Interested Parties

Re: Leveraging Applecart's Social Graph in the U.S. Response to COVID-19

Overview

Applecart is a leading data science company that uses publicly available data to map billions of real-world social relationships (e.g. friends, family members, work colleagues, neighbors, classmates, etc.) between over 250 million Americans.

Applecart's Social Graph helps major corporations, nonprofit organizations, and political campaigns to promote messaging to the trusted networks of friends, family, colleagues, classmates, and neighbors that surround key decision makers in government, business, and media.

Containing the spread of COVID-19 and mitigating its impact on global health and markets depends upon:

i) Convincing the public to stay home, particularly those members of the public that were likely exposed to someone who has since tested positive for COVID-19
ii) Public and private sector actors swiftly taking the necessary steps--recommended by public health officials--to contain the spread of COVID-19
iii) Media outlets accurately and responsibly disseminating the latest information about the steps the public needs to take to combat COVID-19

Applecart's platform offers a series of powerful applications to help public and private actors address the aforementioned challenges in limiting the spread of COVID-19. This memo outlines each of these major applications to address the COVID-19 crisis.

Use Cases

I. Identifying the Social Relationships of Positive COVID-19 Patients

As the medical community works to slow the spread of the Coronavirus, Applecart can help to quickly identify and inform those individuals who may have been exposed to infected persons so they can take immediate action to quarantine and seek appropriate medical care. Provided access to the names of individuals who have recently tested positive for COVID-19, Applecart can use its Social Graph to quickly and scalably identify first-and-second degree social relationships (friends, family members, colleagues, classmates, and neighbors, as well as those people's friends, family members, colleagues, etc.) of those who have tested positive. Applecart can provide names, addresses, and phone numbers for each of these

Obtained via MI FOIA by Judicial Watch, Inc.

individuals, so that they can be called, texted, or otherwise contacted to alert them to their potential exposure.[1] Applecart can return these lists within 72 hours of receiving the patients' names.

II. Urging Corporations and Local and State Governments To Take Action to Fight the Pandemic

One of the greatest public health risks associated with the COVID-19 crisis is the failure of major companies and local and state governments to take appropriate action. To assist in the efforts to combat COVID-19, Applecart can use its Social Graph to generate high-value custom advertising audiences comprised of people who have personal or professional relationships with major company executives or state and local government officials. These audiences can be targeted with either a) the latest information about the actions that companies and governments must take to prevent the spread of Coronavirus or b) negative news stories that criticize the companies and governments for their inaction, in order to spur action. For instance, you could target the networks surrounding high-level decision makers at companies like Amazon and Walgreens, urging them to crackdown on price-gouging and devote more resources to help medical facilities in need of supplies. Applecart can make it possible to promote content to these audiences across Facebook, Twitter, Google, Linkedin, OTT platforms, and more, in order to ensure that the messaging reaches those who matter most across their phones, computers, and televisions. These audiences will make it possible to cost-effectively deliver a high frequency of important content to those who have the most leverage to "flatten the curve".

III. Stopping the Spread of Misinformation

Credible and accurate information about the COVID-19 pandemic can quite literally mean the difference between life and death. Applecart can work to counter the threat of harmful misinformation by generating custom audiences comprised of the personal and professional networks surrounding key local and national reporters, editors, news producers, and other influential decision makers in media. Using these audiences, those fighting to stop the spread of Coronavirus can promote the latest public health information or pushback on widespread misinformation to the networks surrounding members of the media. This approach will ensure the high visibility of accurate information about how to prevent the spread of virus and will counter misinformation within the networks that surround and inform journalists. Ensuring that members of the media and those they trust are getting the latest, high quality information is the best way to ensure that the public at large receives the same.

IV. Correcting Inefficiencies in the Labor Market

As grocery stores, pharmacies, and other essential businesses are overwhelmed by demand, hourly and part-time employees of shuttered businesses like restaurants and bars are unemployed and in need of income. Applecart can mine its Social Graph to assemble lists of employees of restaurants, bars, movie theaters, and other businesses that have been mandated to close during the COVID-19 crisis and make these lists available to government agencies, as well as grocery stores, pharmacies, and other businesses, who may be in need of extra labor during a time of extraordinary demand. These lists will allow the government and essential businesses to market directly to a pool of qualified labor that may recently be in need of work, and can help to both address the immediate need for labor at essential businesses and put badly-needed income in the pockets of economically-vulnerable Americans.

[1] Note: Applecart would need to receive patient information in a HIPAA-compliant fashion. Additionally, in order to ensure compliance with state-level data privacy laws, Applecart cannot provide contact information on California and Nevada persons; however, Applecart can make an audience of those individuals advertisable on digital platforms or through an independent phone or text message provider.

Obtained via MI FOIA by Judicial Watch, Inc.

V. Providing Assistance to Americans 65+

COVID-19 mortality statistics suggest that Americans 65+ are at the most serious risk of adverse health outcomes as a result of contracting Coronavirus. Accordingly, while we hope that the overwhelming majority of Americans 65+ will shelter-in-place, many are having difficulty getting essential goods like medicines and foods. Applecart can mine its Social Graph to identify a list of Americans over the age of 65 and, for each, their closest neighbors under the age of 40. Public and private sector actors looking to combat COVID-19 can then call or text the neighbors, in order to enlist them as volunteers to procure and deliver food and medicine to their older neighbors, while they are sheltering-in-place. By instituting a volunteer network such as this, we can avoid exposing older Americans to the high risks associated with leaving their homes at this time.

About Applecart

Applecart is a leading NYC-based data science company that builds dense, accurate, and actionable maps of real-world relationships between individuals using publicly available data and a proprietary Social Graph platform. Applecart's Social Graph catalogues more than 25 billion social relationships between 250M+ Americans.

Applecart has powered some of the most sophisticated and successful political and commercial advertising campaigns in the country, ranging from Gov. John Kasich's 2016 U.S. presidential campaign and Rep. Conor Lamb's surprise 2018 special election victory to work for Boeing, Blackstone, KKR, and several of the largest bipartisan education reform organizations in the United States. Applecart's work has been featured by Bloomberg BusinessWeek, The Washington Post, The Associated Press, USA Today, Politico, and The Colbert Report.

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Gordon, Robert (DHHS)
To:	Huls, JoAnne; Totten, Mark; Khaldun, Joneigh (DHHS)
Subject:	FW: Request for Declaratory Ruling Filed with MDHHS Re. Water Shutoffs/CV-19
Date:	Wednesday, March 18, 2020 10:23:11 PM
Attachments:	2020_03_17COVID-19 DR REQUEST_Final.docx

[redacted]

From: Nicholas Leonard <nicholas.leonard@glelc.org>
Sent: Wednesday, March 18, 2020 5:12 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Cc: Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>
Subject: Request for Declaratory Ruling Filed with MDHHS Re. Water Shutoffs/CV-19

Good Afternoon Mr. Gordon,

I'm attaching a request for a declaratory ruling that I placed in the mail late yesterday afternoon. You should have received it today. In short, we believe the COVID-19 pandemic in conjunction with the widespread practice of public water systems to shutoff customers that have not paid their water bills presents an imminent danger to not only residents that have had their water shutoff, but all Michigan residents and that MDHHS must ensure this essential public health service is provided to all Michigan residents during the pandemic.

We request MDHHS to exercise its authority under the public health code to issue an order requiring public water systems to reconnect residents that have had water service shutoff, and to place a moratorium on shutoffs for the duration of the pandemic.

Nick Leonard
Executive Director
Great Lakes Environmental Law Center
4444 Second Avenue
Detroit, MI 48201
313-782-3372

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Schwarzkopf, Emily (DHHS); Hertel, Elizabeth (DHHS); Totten, Mark
Subject: FW: Request for Meeting - Michigan Legislature
Date: Tuesday, September 8, 2020 4:24:07 PM
Attachments: Formal Request to Meet.pdf

I talk to him periodically, most recently a couple weeks ago because we're partnering on a maternal-infant health initiative. I will plan to give him some context, including around discussion of Applecart, to which he referred us. If further thoughts, please let me know.

From: Emanuel, Ezekiel J <zemanuel@upenn.edu>
Sent: Tuesday, September 8, 2020 3:50 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Totten, Mark <TottenM1@michigan.gov>
Subject: FW: Request for Meeting - Michigan Legislature

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

I got this request.

Is it legitimate? What do you want me to do?

I don't know Michigan politics.

Ezekiel J. Emanuel, M.D., Ph.D.

Vice Provost for Global Initiatives
Chair, Department of Medical Ethics and Health Policy (On leave 2020-21)
Co-Director, Healthcare Transformation Institute
Levy University Professor
Perelman School of Medicine and The Wharton School
University of Pennsylvania

Tel: (215) 898-7226 or (215) 573-8104
@ZekeEmanuel
www.ezekielemanuel.com

From: Jeffrey Wiggins <JWiggins@senate.michigan.gov>
Date: Tuesday, September 8, 2020 at 2:31 PM
To: Zeke Emanuel <zemanuel@upenn.edu>
Subject: Request for Meeting - Michigan Legislature

Good afternoon, Dr. Emanuel.

Obtained via MI FOIA by Judicial Watch, Inc.

My names is Jeff Wiggins and I work in the Majority Policy Office of the Michigan Senate, while also serving as the Senate's lead policy advisor for the Joint Select Committee on the COVID-19 Pandemic. Attached is a letter from the committee's chair and vice chair, Representative Matt Hall and Senator Aric Nesbitt, inquiring as to your availability to talk with them and some of our staff about your efforts in advising Governor Whitmer's administration during the response to the pandemic, as well as in the areas of compiling and analyzing of data. Our schedules are flexible and we would be willing to accommodate whatever could work for you.

Please feel free to reach out if you have any questions and I thank you for your time and attention to the letter from Representative Hall and Senator Nesbitt.

Jeff Wiggins
Oversight Coordinator
Senate Majority Policy Office
Ph: 517-373-3330
M: 248-255-1052

Obtained via MI FOIA by Judicial Watch, Inc.

September 8, 2020

Dear Dr. Emanuel,

We have been selected by the Speaker of the House and the Senate Majority Leader to lead the Michigan Legislature's Joint Select Committee on the COVID-19 Pandemic. The goal of the committee is to examine the status and efficacy of governmental actions in response to the COVID-19 pandemic in Michigan, and report a summary of our findings and conclusions, as well as any other recommendations on further actions to address and prepare for future similar emergencies.

Pursuant to the stated goal, we are currently exploring the methodology and strategic decisions that determined Michigan's approach and response to the pandemic. In doing so, we were provided your name and credentials, as well as many other respected individuals in the health and medical professions, as someone who served a role in advising and providing insight to Governor Whitmer's administration during this crisis.

Acknowledging your role in working with our Governor and knowing of your extensive background and service in the health field, **we would like to extend an invitation to you to speak with us and our staff and provide details on your contribution to the current strategy in Michigan**. We would be willing to accommodate your schedule as is necessary.

Your service and counsel to our state has been much appreciated and we thank you for all you have done to assist the Governor's administration in their efforts. Please let us know the most accommodating way for you to share details of your efforts and contributions to the state of Michigan.

Sincerely,

Matt Hall
State Representative
Michigan House of Representatives

Aric Nesbitt
State Senator
Michigan Senate

Obtained via MI FOIA by Judicial Watch, Inc.

September 8, 2020

Dear Dr. Emanuel,

We have been selected by the Speaker of the House and the Senate Majority Leader to lead the Michigan Legislature's Joint Select Committee on the COVID-19 Pandemic. The goal of the committee is to examine the status and efficacy of governmental actions in response to the COVID-19 pandemic in Michigan, and report a summary of our findings and conclusions, as well as any other recommendations on further actions to address and prepare for future similar emergencies.

Pursuant to the stated goal, we are currently exploring the methodology and strategic decisions that determined Michigan's approach and response to the pandemic. In doing so, we were provided your name and credentials, as well as many other respected individuals in the health and medical professions, as someone who served a role in advising and providing insight to Governor Whitmer's administration during this crisis.

Acknowledging your role in working with our Governor and knowing of your extensive background and service in the health field, **we would like to extend an invitation to you to speak with us and our staff and provide details on your contribution to the current strategy in Michigan**. We would be willing to accommodate your schedule as is necessary.

Your service and counsel to our state has been much appreciated and we thank you for all you have done to assist the Governor's administration in their efforts. Please let us know the most accommodating way for you to share details of your efforts and contributions to the state of Michigan.

Sincerely,

Matt Hall
State Representative
Michigan House of Representatives

Aric Nesbitt
State Senator
Michigan Senate

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Huls, JoAnne; Readinger, Patricia; Groen, Meghan
Subject: FW: Request from Michigan around COVID-19
Date: Friday, March 20, 2020 6:33:31 AM
Attachments: MDHHS-FoodAssistanceProvisions-3-19-20 (003).docx

---

This began as an email to our FNS Regional Administrator (civil service) but drew a response from the FNS Administrator (political) re the new SNAP law. I would like for FNS to step up and for the complaint to go away. If it does not, I think the Gov could speak out.

Also attached is a partial list of actions we are planning. There is one more large one we will move to request, an increase for all existing SNAP beneficiaries, even those without school-age children.

From: Gordon, Robert (DHHS)
Sent: Friday, March 20, 2020 6:16 AM
To: Miller, Pam - FNS <pam.miller@usda.gov>; English, Tim - FNS <tim.english@usda.gov>
Subject: RE: Request from Michigan around COVID-19

Dear Pam,

Thanks for the quick and thoughtful response.

I urge you to get the information out today and to make clear that States have the full flexibility granted by the new law to be generous and to waive business-as-usual requirements. I would humbly suggest that anything less is going to lead to an outcry about footdragging and cruelty.

I look forward to saluting your success in this difficult time. Thank you for all you do.

Best,
Robert

From: Miller, Pam - FNS <pam.miller@usda.gov>
Sent: Friday, March 20, 2020 12:25 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; English, Tim - FNS <tim.english@usda.gov>
Subject: Re: Request from Michigan around COVID-19

Dear Director Gordon-
Thank you for your leadership during these challenging times and for providing input as FNS looks to implement the new law that will allow additional options and flexibilities in serving those in need. I can assure you that our team is working diligently to provide States additional information on these provisions as quickly as possible.

I know that Tim and his team will remain in close contact with you and your staff so that we can successfully serve our customers as we move forward. Thank you for all you are doing!

Obtained via MI FOIA by Judicial Watch, Inc.

Pam
USDA FNS Administrator
571-429-2828

From: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Sent: Thursday, March 19, 2020 10:43 PM
To: English, Tim - FNS
Cc: Miller, Pam - FNS
Subject: Request from Michigan around COVID-19

Dear Mr. English,

I've appreciated your partnership in recent months. Thanks in part to your urging and support, our most recent reported SNAP error rate, for October, was down by about one third.

I write now to urge USDA to act with the necessary speed and boldness in responding to the COVID-19 crisis. A few hours ago, I received a report from my staff regarding conversations with FNS today. While the content of the recently enacted provisions has been public for nearly a week, we are awaiting guidance around basic questions under the new statute, including the amounts we may issue and the persons for whom we may issue them. While we are ready to begin programming our systems to deliver the aid that Congress intends, we need this information.

At the same time, the guidance we have gotten is troubling. We are being told to submit a waiver for ABAWD work requirements, even though this is specifically covered by the new law. (We will go ahead and suspend the ABAWD provisions based on exemptions we have, but it should not require this.) And we are being told that we will need a waiver to serve college students who lose their half-time jobs due to the pandemic, even though these students are at this point just like other Americans in losing income and facing crisis.

On behalf of Governor Whitmer, I urge you to move quickly and boldly, with the commitment to meeting human needs that this extraordinary moment demands. If you'd like to call me, I may be reached at 517-242-0165. Thank you.

Sincerely,

Robert Gordon
Director
Michigan Department of Health & Human Services

From:English, Tim - FNS <tim.english@usda.gov>
Sent: Wednesday, March 18, 2020 4:08 PM

Obtained via MI FOIA by Judicial Watch, Inc.

To: andrea.palm@wisconsin.gov; kgarcia@dhs.state.ia.us; Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Grace.Hou@illinois.gov; Jennifer.Sullivan@fssa.IN.gov; jodi.harpstead@state.mn.us; kimberly.hall@jfs.ohio.gov
Cc: Hundley, Amy (DHHS) <HundleyA@michigan.gov>; Ashley.Probst (Ashley.Probst@jfs.ohio.gov) <Ashley.Probst@jfs.ohio.gov>; Betsy.Suver@jfs.ohio.gov; tikki.brown@state.mn.us; Cully, Leslie K. (Leslie.K.Cully@Illinois.gov) <Leslie.K.Cully@Illinois.gov>; Sweeney, Dawn (DHHS) <SweeneyD1@michigan.gov>; Kara.Bertke-Wente@jfs.ohio.gov; Kathy Bruen <kathy.bruen@state.mn.us>; Lipscomb, Lori <LLIPSCO1@dhs.state.ia.us>; Marlia.Mattke (Marlia.Mattke@dhs.wisconsin.gov) <Marlia.Mattke@dhs.wisconsin.gov>; Melinda.Kowalski@jfs.ohio.gov; Rebecca McAtee (rebecca.McAtee@wisconsin.gov) <rebecca.McAtee@wisconsin.gov>; Shields, Adrienne M (Adrienne.Shields@fssa.IN.gov) <Adrienne.Shields@fssa.IN.gov>; Smalley, David D <David.Smalley@fssa.in.gov>; Tiffany Vasey (tvasey@dhs.state.ia.us) <tvasey@dhs.state.ia.us>; Verry, Tim (Tim.Verry@illinois.gov) <Tim.Verry@illinois.gov>; Waite, Deborah J - DHS <Deborah.Waite@dhs.wisconsin.gov>; Wanda.Ellis (Wanda.Ellis@jfs.ohio.gov) <Wanda.Ellis@jfs.ohio.gov>; Mikkelson, Julie - FNS <julie.mikkelson@usda.gov>; Solis, Patricia - FNS <patricia.solis@usda.gov>
Subject: USDA FNS Support for State and Tribal Partners

Dear Midwest Commissioners, Directors, and Secretaries,

I'm writing a quick email to check in with each of you and to thank you for the dedicated and thoughtful response to COVID-19 emergency and for working so closely in partnership with FNS as we explore ways to leverage the programs we administer together.

First, I'd like to share that my staff have been having daily conference calls with your program directors and staff to share information, brainstorm, and talk through ways to respond to this crisis. My staff have expressed that they are impressed and inspired by the commitment of staff in all seven of our states and involved in nearly every Food and Nutrition Program. On behalf of all of us in the Midwest Region and at USDA, thanks to you and your staff for your dedication and for working in close partnership with us.

In addition to expressing our gratitude, I would also like to clarify information that was recently provided to state governors. USDA recently announced that it is seeking ideas and suggestions for ways to feed children across the country. Interested businesses, citizens, or not-for-profit staff can email their suggestions or ideas to FeedingKids@usda.gov. However, we'd still like our state partners to provide ideas, waivers, and questions to staff in our regional office. We didn't intend to convey that this mailbox should be the way to contact us and apologize that we may have given that impression.

And speaking of ideas and suggestions, we continue to receive these from your staff. These are being handled as expeditiously as possible so that we can support your efforts and Midwesterners affected by our current emergency. We encourage your staff to continue to provide ideas, suggestions, and waivers to our program directors and staff. That said, if there's anything specific you'd like to discuss with me, please don't hesitate to contact me.

Obtained via MI FOIA by Judicial Watch, Inc.

I want to personally assure you that I and my staff will strive to continue to provide the same excellent customer service that we always have. We understand the uncertainty that recent circumstances may present our FNS partners in the Midwest Region and stand ready to continue to assist you.

In the event that you have any questions or concerns, my staff and I are available to you. Please feel free to call me directly at 312-353-6663 or on my cellphone at 312-208-0837.

Kind Regards,

Tim English
Regional Administrator
Midwest Region
Food and Nutrition Service
United States Department of Agriculture
Tim.English@USDA.gov
Office: 312-353-6664
Cell: 312-208-0837

This electronic message contains information generated by the USDA solely for the intended recipients. Any unauthorized interception of this message or the use or disclosure of the information it contains may violate the law and subject the violator to civil or criminal penalties. If you believe you have received this message in error, please notify the sender and delete the email immediately.

Obtained via MI FOIA by Judicial Watch, Inc.

Below is a list of food assistance provisions included in the Families First Coronavirus Response Act (H.R. 6201) that MDHHS will implement as soon as possible:

MDHHS will suspend the work requirement and time limit on the food assistance (via the Family Assistance Program, FAP) for able-bodied adults without children. Following confirmation of the provision by the USDA Food and Nutrition Service (FNS), adults facing this provision and in danger of loss of benefits will be approved for continued benefit issuance.

Implementation date: March 23, 2020

MDHHS will issue supplemental food assistance benefits to families with school-aged children already receiving FAP. This can be executed as soon as guidance on the benefit population (child ages) and supplemented benefit amount is defined by USDA FNS.

Implementation target date: March 25, 2020

MDHHS will partner with MDE to identify and issue additional food assistance benefits to families with school-aged children not receiving FAP, but who participate in School-based Free and Reduced Priced Meal Programs. MDE will provide a list of families enrolled in school meals programs and MDHHS will cross-reference to identify households not on FAP and then issue benefits to the eligible families.

Implementation target date: not later than May 1, 2020

MDHHS will request to defer all re-certification activities for families currently receiving food assistance through FAP during the course of the COVID-19 crisis. Families currently receiving food assistance will not be required to re-verify eligibility and instead continue to receive benefits until the Secretary of Agriculture lifts the public health emergency declaration. These provisions may also allow MDHHS to issue a supplemental benefit to all existing FAP recipient families, but further confirmation is necessary.

Implementation target date: April 1, 2020

MDHHS will request to defer all recertification and in-person clinical requirements for families current receiving assistance through WIC, the Special Supplemental Nutrition Program for Women, Infants, and Children. Families receiving WIC will not be required to re-verify eligibility and continue to receive benefits and will not be required to participant in in-person clinical visits or interviews.

Implementation target date: April 3, 2020

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark; Kolodin, Zach
Subject: FW: Requesting Update Re. MDHHS Declaratory Ruling Request
Date: Monday, March 23, 2020 10:12:33 PM

Appreciate chance to talk in am. Sally called me re power tonight but I didn't hear on this. Thanks.

From: Nicholas Leonard <nicholas.leonard@glelc.org>
Sent: Monday, March 23, 2020 10:10 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>; Khaldun, Joneigh (DHHS) <KhaldunJ@michigan.gov>; Hertel, Elizabeth (DHHS) <HertelE@michigan.gov>; Sasy, Ninah (EGLE) <SasyN@michigan.gov>; Strong, Regina (EGLE) <StrongR1@michigan.gov>; Oswald, Eric (EGLE) <OswaldE1@michigan.gov>; Clark, Liesl (EGLE) <ClarkL20@michigan.gov>; Keatley, Aaron (EGLE) <KeatleyA@michigan.gov>; Cook, Kara <CookK14@michigan.gov>
Cc: Monica Lewis-Patrick <monica@wethepeopleofdetroit.com>; Jill M. Ryan (jill@freshwaterfuture.org) <jill@freshwaterfuture.org>
Subject: Requesting Update Re. MDHHS Declaratory Ruling Request

Good Evening Mr. Gordon,

I'm emailing to request an update regarding the request for a declaratory ruling that we filed with MDHHS regarding access to drinking water during the COVID-19 pandemic. I've cc'd several people from EGLE, including Director Liesl Clark, as well as Kara Cook in hopes that we can move quickly towards a resolution.

Since our request, I'm aware of at least 7 additional states (Rhode Island, Kentucky, New Hampshire, California, South Carolina, North Carolina, and Illinois) that have issued orders to ensure all residents have water during the pandemic. As discussed in detail in our request, we believe it's imperative for Michigan to urgently follow suit.

Thank you,

Nick Leonard
Executive Director
Great Lakes Environmental Law Center
4444 Second Avenue
Detroit, MI 48201
313-782-3372

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Gordon, Robert (DHHS)
To:	Totten, Mark; Hertel, Elizabeth (DHHS); Khaldun, Joneigh (DHHS); Huls, JoAnne; Foster, Tricia; LyonCallo, Sarah (DHHS); Taverna, Andrea (DHHS-Contractor); Warsh, Jonathan (DHHS)
Subject:	FW: see attached
Date:	Monday, March 23, 2020 2:42:38 PM
Attachments:	Recommendations for COVID-19 response for a major metropolitan area .pdf

Johns Hopkins team wrote this for Baltimore but see it having more general application. Lots on testing. I will try to find a few minutes to read and see what we might be missing.

From: Josh Sharfstein <joshua.sharfstein@jhu.edu>
Sent: Monday, March 23, 2020 11:24 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: see attached

Joshua M. Sharfstein, M.D.
Vice Dean, Public Health Practice and Community Engagement
Director, Bloomberg American Health Initiative

Johns Hopkins Bloomberg School of Public Health
615 N. Wolfe Street, Baltimore, MD 21205
Phone: 443.424.8490
www.jhsph.edu |americanhealth.jhu.edu
The Public Health Crisis Survival Guide | The Opioid Epidemic: What Everyone Needs to Know | The Public Health On Call Podcast

Obtained via MI FOIA by Judicial Watch, Inc.

Recommendations for a Metropolitan COVID-19 response

Executive Summary

This document reflects recommendations for immediate and medium-term response to the COVID-19 pandemic in a metropolitan area. It should be seen as recommendations as of March 21, 2020, and in light of constantly changing circumstances. We recommend:

1. Convening a regional steering group at least twice a week to review the current local, regional, national and global situation and advice, and revise recommendations.
2. Developing a comprehensive internal and external communication plan that includes an assessment of existing communication messages and resources, provides daily status and guidance updates from trusted authorities, and draws on a community advisory group to ensure locally appropriate messages.
3. Instituting a robust testing approach, including specific instructions for those testing positive, contact tracing, utilizing a call center, multiple testing sites offered through a variety of approaches, and training and guidance on testing protocols, community messaging, and tracking. Until robust testing is possible, recommendations should be provided for isolation and quarantine based on signs and symptoms.
4. Establishing a system for automated text-based messages for follow-up of cases and contacts to provide accurate information related to their existing or emerging symptoms. There should be similar outreach for people without access to phones.
5. Developing and implementing a plan to make isolation and quarantine possible for special populations, including individuals who are homeless or living in long-term facilities and group homes, as well as healthcare workers. This is essential to minimize the spread of COVID-19 in the metropolitan area.
6. Implementing a clear and consistent plan for discharge of confirmed COVID-19 patients.
7. Identifying and providing information on existing resources that could assist home-bound individuals who may need assistance accessing food, medicines, or routine medical care.

Obtained via MI FOIA by Judicial Watch, Inc.

Communication

We recommend urgently setting up ongoing and proactive communication channels to inform and advise the public about the outbreak. Accurate and up-to-date information should be provided on an ongoing basis via information sites and from local leaders daily.

First, we recommend a daily data-driven press conference delivered by a trusted source including health officers and county leaders. These briefings should include information about the outbreak, particularly local case and mortality information, local prevention recommendations and mandates focusing on social distancing, and how and when to access testing and care. These messages need to be amplified by local community leaders who are convened and asked to convey these messages in their communities regularly. All available communication channels including television, radio, and social media should amplify these messages.

Additionally, we recommend urgent assessment and updating of existing and, if necessary, creation of new communication materials targeted for public consumption, including cases and contacts, high risk communities such as long term care facilities and group homes, and healthcare providers and hospitals. It is important to develop tailored approaches and materials and engage local advisory groups for community engagement and communication. Materials should be updated frequently, as informed by new evidence and continuous analysis of local data, disseminated through official websites and social media channels and press releases, and amplified by community groups. We recommend developing, employing, and regularly updating channel-specific daily update templates as soon as possible.

This plan will require official communication channels and resources; contacts for key entities; a mechanism to gather, solicit and respond to frequently asked questions from residents; and real-time access to COVID-19 data. This approach and these materials should be reviewed and adapted regularly to meet the needs of the evolving situation. It will be important to use these methods to convey such messages as the need for social distances for extended periods of time.

Increasing testing and messaging about testing to communities

Call Center. We recommend setting up a call center staffed by individuals with clinical training with one highly publicized phone number to triage public calls, make recommendations for testing based on symptoms reported, advise callers about the nearest testing sites, and make appointments at testing sites. The call center would enter patient data into a secure web-based platform accessible to testing sites and integrated with results retrieval, patient tracking and contact tracing and tracking capabilities. Patients would be alerted to results via the system, which would prompt further human and/or automated messaging depending on outbreak stage and capacity (described more fully in the contact tracing section below).

Multiple community testing sites. We recommend rapid access to testing for local populations, especially those at high risk of infection and severe outcomes. For those who cannot drive to testing sites, we recommend community-based testing outside the home at designated community sites to serve high-risk individuals who lack non-public transportation options.

Obtained via MI FOIA by Judicial Watch, Inc.

People who could have coronavirus infection should not be sent for testing via public transportation. High risk and need communities should be identified using existing data. Community advisory groups and local clinics/businesses should be contacted now to facilitate this process. Creative solutions may be needed for testing at home.

In sum, we recommend:

1. Hospitals expand and continue safe (with adequate PPE) screening and testing already being conducted in tents outside hospitals,

2. Partnering with existing health clinics such as urgent care centers to offer testing, and

3. Setting up static, stand-alone drive-through and walkup testing sites staffed by school nurses, clinicians from the state medical corps, or other available health providers.

We recommend, as testing platforms advance, that specimens could be collected by patients themselves to minimize risk to healthcare providers. We further recommend that messaging convey the strong preference to schedule testing through the call center to reduce contact with other patients and keep providers safe. However, if possible, drive-up and walk-in testing should be offered without an appointment to be able to identify as many positive cases as possible.

Requirements. Requirements for this strategy include plans for how to run testing at new sites, provision of sufficient PPE, and training for community sites on testing protocols and public health (isolation/quarantine) messaging, partnerships with private clinics, and a system for tracking results. Possible limitations include shortage of specimen collection supplies.

Scaling up. A question to consider is what to do until sufficient testing is fully available. We recommend that, until testing is widely available, patients who have compatible symptoms but do not meet criteria for testing be directed to self-isolate for 14 days and inform their close contacts that they should self-quarantine for the same period. We recommend that the call center issue a code to these individuals to track isolation compliance and symptom progression, and that based on their inputs they receive an automated text message when testing is available more widely in their area with a link to their closest testing site.

Another potential option, which depends on availability of specimen collection supplies, is collecting and storing samples now for testing as soon as testing is available on a more widespread basis. Even if delayed, results of tests conducted can be used to produce epidemic curves, maps and data summaries that reflect more accurately the course of the outbreak and the characteristics of confirmed cases. The knowledge of having been infected (or not) can help someone know whether they are released from isolation, their contacts are released from quarantine, and whether they might acquire some immunity to the virus following future exposures. It will further provide critical information at the city and state level to understand the risk of lifting social distancing measures in the future. We recommend that alternative specimen types be explored but believe fresh frozen saliva might work.

Contact Tracing

Even in the setting of widespread transmission of the novel coronavirus, there is value in as much contact tracing as is feasible. Traditional contact tracing involves calling all cases

Obtained via MI FOIA by Judicial Watch, Inc.

identified from the national electronic disease surveillance system (NEDSS; CDC) to provide isolation requirements, collect contact information, and to call contacts to inform them of their risk and need for quarantine. This practice should be implemented to the extent possible and monitored to ensure that it is functioning well enough to have an impact.

We recommend creating a system for automated text-based messages for follow-up as soon as possible. The conversations with cases would be followed by two text messages that would be automatically sent to each case. The first message would include isolation guidelines and quarantine measures for their household members and instructions to input status daily into a web-based platform, and instructions for forwarding a second text message that will be sent to close contacts outside the home with quarantine and reporting instructions. If cases have concerns about notifying contacts, instructions would be given for reporting contacts through the on-line system.

Once cases overwhelm calling capacity to notify contacts, we recommend responding only with text messages as above. The system would also generate automatic reminders to enter tracking data.

We are aware of two technology companies with the capabilities to launch such a system within approximately one week.

Isolation and Quarantine Options

Isolation of infected patients and quarantine of their close contacts is the key to reducing transmission and slowing the spread of COVID-19. There must be a strategy to assist people who are in need of isolation and quarantine but do not have the capacity to do so effectively.

Specifically, patients testing positive and people under quarantine without a place to isolate/quarantine because of homelessness, group housing or living with family need a way to avoid putting others at risk and to adhere to discharge and/or quarantine instructions. This group also includes health care workers.

Given reductions in travel, many cities are prioritizing the use of hotels and motels as the first line of alternative housing. With most universities now closed, now-vacant university dorms could be considered. As needs surge, we recommend considering community facilities such as churches and schools that could be staged and managed for this purpose. We recommend convening a high-level group of city and county planners to discuss, prioritize options and work to make them available.

Special Populations

Residents of long-term care facilities, nursing homes and group homes represent a major high-risk group for morbidity and mortality. Given the high risk associated with infection, a special focus to ensure best practices at these facilities is warranted. Compliance with stated guidance could be bolstered or tracked by regular reporting into a web-based system by these facilities of key metrics, such as: policies for sick staff, number of staff calling in sick in the past week, current stocks of key PPE (gowns, masks, gloves), number of hand-washing stations, number fully functioning stations, number of sanitizer dispensers, stock of sanitizer, and daily visitor counts. We recommend that there are automated summaries of these data and flags that

Obtained via MI FOIA by Judicial Watch, Inc.

prompt follow-up by the health department. Even though testing remains limited, testing patients in these facilities who develop compatible signs and symptoms in order to rapidly isolate them and quarantine contacts should be a priority to save lives in this high-risk group.

Discharge of Hospitalized Patients

We recommend that each hospital's plan to discharge confirmed COVID-19 patients from their facility be compiled and reviewed so that the city and counties can harmonize discharge protocols. To facilitate home care when clinically suitable, every hospital should include discharge instructions for home-isolation for the patient and quarantine protocol for household contacts, with follow up similar to what other case and contacts receive. Partnerships with funeral homes will be required to support the safe and humane management of the deceased.

Mitigating Adverse Outcomes due to Social Distancing

Recommendations for social support for individuals who are home-bound to protect themselves or because of isolation and quarantine will be needed. We recommend that the city and county departments of health identify existing resources that could assist home-bound individuals who may need assistance accessing food or medicines or routine medical care. Messages should be provided so that home-bound individuals who need assistance have a single number to call, such as 311 and 211, with phone operators able to link to a specific set of services that address critical needs.

Obtained via MI FOIA by Judicial Watch, Inc.

These recommendations were developed by:

Melissa A. Marx, PhD, MPH is an Assistant Professor at Johns Hopkins Bloomberg School of Public Health (JHSPH) in the International Health Department with nearly 20 years of applied public health experience. Dr. Marx was an Epidemic Intelligence Service officer at the New York City Department of Health and an epidemiologist with the Centers for Disease Control and Prevention. She has responded to SARS, H1N1, Ebola and other outbreaks.

Emily Gurley, PhD, MPH is an Associate Scientist at JHSPH in the Epidemiology Department. Dr. Gurley spent 12 years at the International Center for Diarrheal Diseases Research, Bangladesh where she led the Surveillance and Outbreak Investigation Unit, and served as Director of the Program on Emerging Infections. She led investigations of outbreaks of Nipah virus, cholera, influenza, and anthrax, among others.

Jennifer Nuzzo, DrPH, is an Associate Professor at JHSPH in the Department of Environmental Health and Engineering and is a Senior Scholar at the Johns Hopkins Center for Health Security. Dr. Nuzzo directs the Outbreak Observatory, which conducts, in partnership with front-line public health practitioners, operational research to improve outbreak preparedness and response.

Lauren Sauer, MS, is the director of Operations in the Johns Hopkins Office of Critical Event Preparedness and Response and an Assistant Professor of Emergency Medicine at Johns Hopkins School of Medicine. She also serves as the JHU focal point for their partnership with the WHO Global Outbreak and Alert Response Network. She has worked in the field of disaster and public health emergency research and education for almost two decades working on healthcare system preparedness in disasters and outbreaks.

Rupali J. Limaye, PhD, MPH is an Associate Scientist at JHSPH in the Department of International Health and also serves as the Associate Director for Behavioral Research at the Institute for Vaccine Safety and as the Prevention Core manager for the Center for AIDS Research. She has a background in marketing and communication, and has developed health communication campaigns and materials in more than 20 countries.

William Moss, MD, is a Professor at JHSPH in the Department of Epidemiology, is the Executive Director for the International Vaccine Access Center, and a Deputy Director at the Johns Hopkins Malaria Research Institute. He is a pediatrician with subspecialty training in infectious diseases.

Justin Lessler, PhD, is an Associate Professor at JHSPH in the Department of Epidemiology researching the dynamics and control of infectious disease, with particular focus in the spread of pandemics. He works on the development and application of statistics, dynamic models and novel study designs to better understand and control infectious disease.

Obtained via MI FOIA by Judicial Watch, Inc.

Supporting members include Molly Sauer (content), Diwakar Mohan (input), Alain Labrique (input), and Forrest Jones (support).

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Totten, Mark; Kolodin, Zach; Esty, Sarah (DHHS)
Subject: FW: Sick leave
Date: Friday, November 6, 2020 7:17:00 AM
Attachments: image003.jpg
image001.png
image002.png

FYI. We are working with Dr. Frieden on a framework.

From: Thomas R. Frieden <trfrieden@resolvetosavelives.org>
Sent: Friday, November 6, 2020 6:27 AM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Subject: Sick leave

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Would you have the authority to say to businesses, if the risk level is x, you can only open if you provide paid sick leave?

Tom Frieden, MD, MPH
President and CEO
https://preventepidemics.org/about/dr-tom-frieden-md-mph/
tfrieden@rtsl.org
Remember the 3 W's to reduce risk of COVID-19**: W**ear a mask. **W**ash your hands. **W**atch your distance.

signature_1201759456

RESOLVE TO SAVE LIVES
An initiative of Vital Strategies

STAY CONNECTED
www.resolvetosavelives.org facebook twitter

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Gordon, Robert (DHHS)
To:	Totten, Mark; Kolodin, Zach; Esty, Sarah (DHHS); Rick, Matthew (DHHS); Khaldun, Joneigh (DHHS); LyonCallo, Sarah (DHHS)
Subject:	FW: State-level stringency scores
Date:	Thursday, October 15, 2020 5:20:00 PM
Attachments:	20201015_State-level guideline stringencies.pptx

This is worth a look. I am not sure how accurate it is, for example it says masks are "recommended" in Michigan. But if overall accurate, it is striking how much room we have to toughen up relative to other states. I will ask for detail behind some of the sections.

From: Erin McGovern <Erin_McGovern@mckinsey.com>
Sent: Thursday, October 15, 2020 3:13 PM
To: Gordon, Robert (DHHS) <GordonR3@michigan.gov>
Cc: Razili Lewis <razili_lewis@mckinsey.com>; Brandon Carrus <brandon_carrus@mckinsey.com>
Subject: State-level stringency scores

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

Hi Robert,

See attached slide for the overview you requested on differences in stringency scores between Michigan and other states. For additional info, you can click through the links in the demo dashboard, or let us know if any specific areas where we can help summarize in more detail.

We'll also be sending along the second view we discussed earlier this week of how cases, containment guidance, and mobility have been moving over time for Michigan and a handful of other states. Look for that tomorrow.

And, we had talked about designing a new look for the State website that communicates the MDHHS EO guidance. We now have a draft ready to review. Looking at it with Rey at 1pm tomorrow, and happy to add you to that or schedule another time to review it together.

Finally, it would also be great to connect with you for a few minutes this week on (1) PMO progress update and (2) contract touchbase.

Do you mind if we work with Andee to find a timeslot that works?

Thanks!
Erin

Erin McGovern
McKinsey & Company
Mobile: +1.313.898.1718

Obtained via MI FOIA by Judicial Watch, Inc.

This email is confidential and may be privileged. If you have received it in error, please notify us immediately and then delete it. Please do not copy it, disclose its contents or use it for any purpose.
+==+

Examples of selected guidelines with varied stringencies

Draft

Obtained via MI FOIA by Judicial Watch, Inc.

Guideline[2]	Current guideline in MI	Higher stringency score states[1]	Guidelines from highlighted states
Domestic & international travel restrictions	• Domestic: Open, no addl. guidelines • International: Follows federal travel guidelines, with intl. screening required	• 13 total states (e.g., Illinois, New York)	• Some or significant adaptations imposed, with mandatory quarantine periods for out-of-state visitors or travel bans on visitors from high-risk regions
Personal services & entertainment	• Some adaptations imposed, with 25-50% capacity limitations • Standard masks & social distancing guidelines are recommended	• 22 total states (e.g., Illinois, Kentucky, Minn., New Jersey, New York, North Carolina, Wisconsin)	• Full closure of many businesses/services • Significant adaptations with <25% of total capacities and high reductions in schedule or type of available activities
Places of worship	• Some adaptations imposed, with 25-50% capacity limitations • Standard masks & social distancing guidelines are recommended	• 24 total states (e.g., Kentucky, Minn., New Jersey, New York, Virginia)	• Full closure of many places of worship • Significant adaptations imposed, with <25% of total capacities
Tourism, culture, & arts	• Some adaptations imposed, with 25-50% capacity limitations • Standard masks & social distancing guidelines are recommended	• 27 total states (e.g., Illinois, Indiana, New Jersey, New York, North Carolina, Virginia)	• Full closure of many businesses/services • Significant adaptations with <25% of total capacities or restrictions on out-of-state visitors and tourists
Transportation (airports, urban hubs)	• Some adaptations imposed, with standard masks & social distancing guidelines recommended	• 2 total states (Minnesota, D.C.)	• Temporary closures of certain areas (e.g., terminals, public spaces) • Capacity limits imposed on urban hubs
Mass public transit	• Mass & individual public transit is open, with no addl. guidelines • Masks & distancing still recommended	• 34 total states (e.g., Illinois, Indiana, Kentucky, New Jersey, New York, Ohio, Virginia, Wisconsin)	• Significant adaptations imposed, with <25% of total capacities • Reduced schedules and/or coverage
Primary & secondary schooling	• Standard guidelines with capacity limitations, though guidelines differ by county & school system	• 21 total states (e.g., Kentucky, Minn., New Jersey, North Carolina, Ohio, Virginia)	• Full closures of schools, with full-time virtual learning for all students • Reduced or part-time in-person capacities

1. Highlighted restricted states include IL, IN, KY, MN, NJ, NY, NC, OH, VA, WI based on regional proximity and/or political similarities
2. Guidelines selected from 40+ guidelines where Michigan is most lenient compared to national guidelines (scores 0-1 of 4 of C7 COVID scale)

Source: McKinsey COVID-19 Public Sector Analytics tool & C7 dashboard

Obtained via MI FOIA by Judicial Watch, Inc.

From:	Huls, JoAnne
To:	Khaldun, Joneigh (DHHS); Gordon, Robert (DHHS); Hawks, Orlene (LARA)
Cc:	Readinger, Patricia; Brousseau, Jessica; Totten, Mark; Foster, Tricia
Subject:	Fwd: 2ND E-Mail - HHS COVID-19 Guidance - Governor Whitmer.pdf with Both Enclosures
Date:	Tuesday, March 24, 2020 8:24:09 PM
Attachments:	HHS COVID-19 Guidance - Whitmer.pdf Enclosure in March 24 Letter from Secretary Azar to Governors with Recommendations for Maximizing Healthcare Workforce for COVID-19.pdf

Second email - please let us know response.
Thanks

From: Hunt, Gregorio (HHS/IEA) <Gregorio.Hunt@hhs.gov>
Sent: Tuesday, March 24, 2020 8:19:41 PM
To: Huls, JoAnne <HulsJ1@michigan.gov>
Cc: Johnston, Darcie (HHS/IEA) <Darcie.Johnston@hhs.gov>
Subject: 2ND E-Mail - HHS COVID-19 Guidance - Governor Whitmer.pdf with Both Enclosures

Dear Governor Whitmer,

Attached please find a letter from Secretary Azar and a guidance document regarding your healthcare workforce. Thank you for your attention to this important matter.

Best,
Darcie

Darcie Johnston, Director
Office of Intergovernmental Affairs
U.S. Department of Health and Human Services
(202) 853-0582

Obtained via MI FOIA by Judicial Watch, Inc.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 2 4 2020

The Honorable Gretchen Whitmer
Governor
State of Michigan
Lansing, MI 48901

Dear Governor Whitmer:

To carry out a whole-America response to the COVID-19 pandemic, I write to ask for your assistance to extend the capacity of the health care workforce to address the pandemic. Specifically, I ask that you take immediate action to:

(1) Allow health professionals licensed or certified in other states to practice their professions in your state, either in person or through telemedicine;
(2) Waive certain statutory and regulatory standards not necessary for the applicable standards of care to establish a patient-provider relationship, diagnose, and deliver treatment recommendations utilizing telehealth technologies;
(3) Relax scope of practice requirements for health care professionals, including allowing professionals to practice in all settings of care;
(4) Allow physicians to supervise a greater number of other health professionals and to do so using remote or telephonic means;
(5) Allow for rapid certification/licensure and recertification/relicensure of certain health care professionals;
(6) Develop a list of your state liability protections for in-state and out-of-state health professionals, including volunteers, during this national emergency, work with your state insurance commissioner to modify or temporarily rescind any provision in any medical malpractice policy issued in your state that may prevent insurance coverage of a health care professional's work responding to the COVID-19 emergency in another state, and work with insurers to have them waive such limitations in their policies;
(7) To the extent deemed appropriate by state health authorities, modify laws or regulations to allow medical students to conduct triage, diagnose, and treat patients under the supervision of licensed medical staff; and,
(8) Modify any laws or regulations that require a signature for deliveries of pharmaceuticals to allow signature-less deliveries, which can help prevent contact between recipients and delivery personnel.

Responsive health professionals will be vital to swiftly containing and eradicating COVID-19 cases in America, as well as treating our citizens during this critical time of need. Doctors and nurses serving on the front lines of this outbreak are at risk of infection and some may be unable to treat patients due to quarantine. They need backup. Your help is needed to ensure health professionals maximize their scopes of practice and are able to travel across state lines or provide telemedicine to communities where they are needed most.

Obtained via MI FOIA by Judicial Watch, Inc.

Non-federal health care professionals carry out health care activities under licensing laws specific to the states in which they provide care. During emergencies, many states have statutory and regulatory mechanisms which allow health care professionals licensed in one state to provide aid in another state without being licensed in that state. These may include mutual aid compacts (multi-state emergency management laws that provide for license reciprocity when the Governor has declared an emergency or public health emergency) and emergency powers that Governors may utilize to modify or temporarily suspend state licensing requirements to allow out-of-state professionals to practice in their states. I ask your assistance to immediately activate these and other health care professional licensure exceptions to the fullest extent appropriate, and to waive any state licensure or certification fees, in order to extend the capacity of health care professionals to fully assist in responding to the COVID-19 emergency. I encourage states to work with their state licensing boards to establish enforcement moratoria for scope of practice and licensure issues to ensure that health care professionals can quickly respond to the COVID-19 emergency without fear of penalty or license revocation. States without existing statutory mechanisms may want to consider working with their legislatures to enact such mechanisms.

Many states also have statutory authority during emergencies to allow for rapid certification and recertification of certain health care professionals. I ask that you use these authorities to the fullest extent possible, and to waive any fees to allow for rapid relicensure or recertification of certain retired health care professionals (especially physicians, nurse practitioners, other registered nurses, and physician assistants), to allow them to reenter the workforce quickly to provide care during the COVID-19 emergency.

States may also be able to modify scope of practice requirements through the Governor's emergency powers or in accordance with the state emergency management laws to temporarily suspend certain scope of practice requirements, including any requirements for written supervision or collaboration agreements in order to avoid significant delays in the provision of services. Alternatively, states may be able to waive geographic restrictions on physicians supervising nurse practitioners (NP) or physician assistants (PA) (i.e., temporarily waive any requirements that the supervising physician be physically co-located with or within a certain geographic distance to the NP or PA who he or she is supervising). This could permit supervising physicians from any state to supervise remote telemedicine services by electronic or telephonic means. To maximize the potential for telemedicine services to expand capacity, states may want to consider waiving certain statutory and regulatory standards not necessary for the applicable standards of care to establish a patient-provider relationship, diagnose, prescribe, and deliver treatment recommendations utilizing telehealth technologies. In addition, states may be able to temporarily expand the number of non-physician health care professionals that a physician may supervise to permit greater use of these non-physician health care professionals to respond to the COVID-19 emergency.

States should also eliminate restrictions on the settings of care where certain types of health care professionals can see patients. Due to recommendations to socially distance, the setting of care will move from clinics to the home or other alternative locations. States should eliminate any restrictions on the types of nurse practitioners, other registered nurses, physicians, and other caregivers that may furnish care in the home or other setting, including restrictions for these providers to be aligned with a home health agency. Finally, states should consider expanding allowable activities for certain health care professionals (such as EMTs and paramedics) to allow those professionals to provide additional health care services during this emergency.

Obtained via MI FOIA by Judicial Watch, Inc.

For health care professionals to feel comfortable serving in expanded capacities on the frontlines of the COVID-19 emergency, it is imperative that they feel shielded from medical tort liability. To prevent medical tort liability from deterring volunteer physicians, Congress passed two volunteer liability reform laws: the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (HIPAA), and the Volunteer Protection Act of 1997, Pub. L. No. 105-19, 111 Stat. 218 (VPA). HIPAA protects physicians who volunteer in free clinics, provided the clinic sponsors the physician by submitting an application to the government. Under the VPA, volunteer health care professionals of a nonprofit organization or governmental entity are not liable for economic damages caused by providing medical care within the scope of their volunteer responsibilities (although this exemption does not extend to non-economic damages). The VPA only protects volunteer health professionals practicing with a license in that state, unless state authorities allow for licensure exceptions. The VPA preempts state laws that are inconsistent with the VPA, unless those state laws provide additional liability protection for volunteers.

In addition, the Public Readiness and Emergency Preparedness (PREP) Act provides broad immunity to health care professionals who administer or use countermeasures covered by declarations issued by the Secretary. Under my COVID-19 - Medical Countermeasures PREP Act declaration (effective February 4, 2020), this protection can apply to health care professionals using countermeasures such as diagnostic or other devices (e.g., COVID-19 testing and respiratory therapy), antiviral medications, other drug therapies, biologics, or vaccines used to treat, diagnose, cure, prevent, or mitigate COVID-19, or the transmission of SARS-CoV-2 or a virus mutating therefrom, as well as devices used to administer such products.

All 50 states and the District of Columbia have enacted laws protecting health professionals under specified circumstances. States should issue guidance summarizing the statutory scope of protections offered under their laws and the process necessary to attach those protections to a health professional's service. Given variation in the scope of these state laws, it is particularly important for states to issue guidance publicly, outlining the available liability protections during the COVID-19 emergency. Further, as noted above, I ask you to analyze whether your state insurance commissioner can modify or temporarily rescind any provision in any medical malpractice policy issued in your state that may prevent coverage of a health care professional's work responding to the COVID-19 emergency in another state and work with insurers to have them waive such limitations in their policies.

I do not want state variations in liability protections to confuse or deter health professionals in this COVID-19 emergency. I ask that your office quickly develop a list of the relevant state liability protections and waivers for health professionals during a national or state emergency and provide public guidance for any steps that out-of-state professionals need to take to provide medical care in your state. I also ask that you take quick action to expand the flexibilities offered in this time of emergency by waiving restrictions such as state licensure, scope of practice, certification, and recertification requirements. In that regard, I thank the National Governors Association for their useful site tracking state declarations and other COVID-19 responses at https://www.nga.org/coronavirus/#states.

Obtained via MI FOIA by Judicial Watch, Inc.

We are all in this together. The U.S. government and the Department of Health and Human Services are committed to working with you and your state to contain and eradicate COVID-19.

Sincerely,

Alex M. Azar II

Enclosure

Obtained via MI FOIA by Judicial Watch, Inc.

GUIDANCE TO STATES

Lifting Restrictions to Extend the Capacity of the Health Care Workforce during the COVID-19 National Emergency

On March 13, 2020, the President declared a National Emergency under the Stafford Act and the National Emergencies Act,[1] and on January 31, 2020 the Secretary of HHS declared a public health emergency under section 319 of the Public Health Service Act. As a result of these declarations, on March 10, 2020, the Secretary of HHS authorized the temporary waiver or modification of certain requirements of the Medicare, Medicaid, and State Children's Health Insurance (CHIP) programs and of the Health Insurance Portability and Accountability Act Privacy Rule, under section 1135 of the Social Security Act (SSA), for the duration of the public health emergency declared in response to the COVID-19 outbreak.[2] This includes the authority to waive federal requirements based on state licensure and scope of practice. *See* SSA §1135(b)(1)-(2).[3]

However, while this allows the Secretary to waive these requirements for the purposes of the Medicare, Medicaid, and CHIP Programs, and reimbursement for services provided to beneficiaries of these programs, health care providers must still comply with various state laws and requirements. Therefore, we are calling on states, territories, and the District of Columbia to take immediate action, under applicable state laws, to waive restrictions on licensure, scope of practice, certification, and recertification/relicensure consistent with the changes announced for federal programs.[4]

These actions should apply to all health care services delivered within the scope of the practitioner's license, and not just for COVID-19-related services, so that health care workers can be deployed as needed.

---

[1] Authority: Sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 *et seq.*) and The Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5121-5207).

[2] Authority: Consistent with section 1135 of the Social Security Act (SSA), as amended (42 U.S.C. 1320b-5). Note that states may request federal approval of specific waivers under section 1135 for their state Medicaid programs, including those related to streamlining provider enrollment and allowing out-of-state licensed providers to practice in their state. See guidance at: https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/cms-1135-waivers/index.html

[3] Section 1135(b)(1)-(2): "(1) (A) conditions of participation or other certification requirements for an individual health care provider or types of providers, (B) program participation and similar requirements for an individual health care provider or types of providers, and (C) pre-approval requirements; (2) requirements that physicians and other health care professionals be licensed in the State in which they provide such services, if they have equivalent licensing in another State and are not affirmatively excluded from practice in that State or in any State a part of which is included in the emergency area."

[4] Unless otherwise noted, all references in this document to States should be understood as applying to the District of Columbia and the territories (American Samoa, Guam, Puerto Rico, the Virgin Islands, and the Commonwealth of the Northern Mariana Islands).

Obtained via MI FOIA by Judicial Watch, Inc.

While all 50 states, the District of Columbia, and all U.S. territories have now declared states of emergency, not all have taken action to minimize barriers to care during this critical time. State licensure, registration, and certification requirements for non-federal health care professionals are typically governed by the laws of the state in which a patient is located at the time of the service. In order to more efficiently distribute scarce provider services during the time of a widespread emergency, states should take action to waive such requirements to allow health care professionals holding an active license, registration, or certification from a state *other than the state in which the patient is located* to provide healthcare services. States should also allow health care professionals like nurse practitioners (NPs), other registered nurses, and physician assistants (PAs) to practice to the fullest extent of their license and without restrictive supervision requirements, and allow for rapid certification/licensure and recertification/relicensure of retired health professionals during this emergency. States may also want to consider allowing residents to practice with general supervision instead of direct supervision for certain types of care. Finally, states should eliminate restrictions on the settings where caregivers can furnish services, including requirements for nurses that are furnishing care in the home to be under the authority of a home health agency (vs. a hospital or other health care provider).

A complete list of recommended actions is included below. We also thank the National Governors Association for tracking state actions at https://www.nga.org/coronavirus/#states.

RECOMMENDED ACTIONS

The Administration specifically recommends that state authorities consider and incorporate appropriate waivers or permissions as part of their emergency declarations, including:

1. **Provider Licensure Exceptions:** Waive restrictions, on a temporary basis (during the emergency period), on health providers licensed, registered, or certified in good standing with another state. We also encourage states to consider ways to process these waivers on a rapid basis.
    - Consider utilizing flexibilities currently available in your state's emergency declaration laws to allow licensure exceptions during the emergency period and waive any licensing fees.
    - Consider utilizing the Uniform Emergency Volunteer Health Practitioner Act (if your state enacted this model law) or the Emergency Management Assistance Compact and other mutual aid compacts, and stating that all temporary licenses are free of charge and valid through the duration of the emergency declaration period.
    - Encourage your State Boards of Medicine, Nursing, and other healthcare professions to put in place an enforcement moratorium for the length of the public health emergency for such licensure violations, which would allow health care providers to begin treating patients without fear of penalty or revocation. This moratorium should apply to all services for which providers are licensed.

Obtained via MI FOIA by Judicial Watch, Inc.

2. **Telemedicine Modality and Practice Standard Waivers:** To the extent permissible, waive statutes and regulations mandating telehealth modalities and/or practice standards not necessary for the applicable standard of care to establish a patient-provider relationship, diagnose, and deliver treatment recommendations utilizing telehealth technologies.

3. **Waivers of Scope of Practice Requirements:** Temporarily suspend any requirements for written agreements to meet supervision or collaboration requirements, in order to avoid significant delays in the provision of services. States should also expand allowable provider activities for certain health care professionals, such as NPs, other registered nurses, PAs, emergency medical technicians (EMTs), and paramedics, and remove all restrictions on where these types of professionals can furnish care. States should also encourage their State Boards of Medicine, Nursing, and other health professions to put in place an enforcement moratorium, for the length of the public health emergency, for scope of practice violations to ensure all practitioners can deliver needed care during the crisis. This moratorium should apply to all services for which providers are licensed.

4. **Physician Extender Permissions (if unable or unwilling to waive Scope of Practice pursuant to Recommendation No. 3):**
    - Waive geographic restrictions on physicians supervising NPs or PAs (i.e., temporarily waive any requirements that the supervising physician be physically co-located with, or within a certain geographic distance of the NP or PA who he/she is supervising). This would permit supervising physicians from any state to supervise remote telemedicine services via electronic or telephonic means.
    - Temporarily expand the number of health care professionals who a physician may supervise, in order to permit greater use of all health care professionals.

5. **Rapid Certification/Licensure and Recertification/Relicensure:** Allow for rapid certification/licensure of new health care professionals and recertification/relicensure of certain retired health care professionals (physicians, NPs, other registered nurses, PAs) to allow them to reenter the workforce to provide care during the COVID emergency, and waive any applicable fees.

6. **Alleviate Medical Malpractice Liability for In-State Health Care Professionals, Including Volunteers, Working across State Lines:** Provide guidance on liability protections available to health care professionals in your state by developing a list of your state's liability protections for in-state and out-of-state professionals, including volunteers, relicensed or recently licensed medical professionals, services provided through telehealth, and services consistent with expanded scopes of practice, during this national emergency. Work with your state insurance commissioner to modify or temporarily rescind any provision in any medical malpractice policy issued in your state that may prevent insurance coverage of a health care professional's work responding to the COVID-19 emergency in another state, and work with insurers to have them waive such limitations in their policies.

Obtained via MI FOIA by Judicial Watch, Inc.

7. **Utilize Medical Students when Deemed Appropriate:** To the extent deemed appropriate by state health authorities, modify laws or regulations to allow medical students to conduct triage, diagnose, and treat patients under the supervision of licensed medical staff.

8. **Signature-less Pharmaceutical Deliveries:** Modify any laws or regulations that require a signature for deliveries of pharmaceuticals to allow signature-less deliveries, which can help prevent contact between recipients and delivery personnel.

EXAMPLES

The following are examples of state emergency declarations that include flexibilities such as those described above:

1. **California:** https://www.gov.ca.gov/wp-content/uploads/2020/03/3.4.20-Coronavirus-SOE-Proclamation.pdf
2. **Florida:** https://www.flgov.com/wp-content/uploads/orders/2020/EO_20-52.pdf and https://s33330.pcdn.co/wp-content/uploads/2020/03/filed-eo-doh-no.-20-002-medical-professionals-03.16.2020.pdf
3. **Iowa:** https://governor.iowa.gov/sites/default/files/documents/Public%20Health%20Proclamation%20-%202020.03.17.pdf

This situation is evolving quickly, and many states continue to update the flexibilities currently being offered. Please see the National Governors Association Website for a complete, updated list of state actions to date: https://www.nga.org/coronavirus/#states.

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Taverna, Andrea (DHHS-Contractor); Hertel, Elizabeth (DHHS)
Cc: Gordon, Robert (DHHS); Smith, Dana
Subject: Fwd: Attached -- Rockefeller COVID testing plan
Date: Monday, April 20, 2020 8:38:38 AM
Attachments: RF National COVID-19 Testing Action Plan_LAST FINAL_04.20.2020.docx

---

Feel free to join this call Dana can give you details.
Thanks

From: Myers, Michael <MMyers@rockfound.org>
Sent: Monday, April 20, 2020 8:36:06 AM
To: ann.oleary@gov.ca.gov <ann.oleary@gov.ca.gov>; paul.mounds@ct.gov <paul.mounds@ct.gov>; anne.caprara@illinois.gov <anne.caprara@illinois.gov>; mark.cooper@la.gov <mark.cooper@la.gov>; kristen.lepore@state.ma.us <kristen.lepore@state.ma.us>; Huls, JoAnne <HulsJ1@michigan.gov>; george.helmy@nj.gov <george.helmy@nj.gov>; jill.desrosiers@exec.ny.gov <jill.desrosiers@exec.ny.gov>; nik.blosser@oregon.gov <nik.blosser@oregon.gov>; laurel.dawson@governor.ohio.gov <laurel.dawson@governor.ohio.gov>; david.ortiz@governor.ri.gov <david.ortiz@governor.ri.gov>; david.postman@gov.wa.gov <david.postman@gov.wa.gov>; Brunelle, Michael <mbrunelle@pa.gov>; ANDREW Jennifer J * GOV <Jennifer.J.ANDREW@oregon.gov>; Allen Patrick <Patrick.Allen@dhsoha.state.or.us>; EDLUND Tina * GOV <Tina.EDLUND@oregon.gov>; Marcott Mikayla <MIKAYLA.MARCOTT@dhsoha.state.or.us>; Matthew Clark -GOV- <matthew.clark@maryland.gov>; O'Connor, Eileen <EOConnor@rockfound.org>; Diane Croghan -GOV- <diane.croghan@maryland.gov>; Ron Gunzburger -GOV- <ron.gunzburger@maryland.gov>; Linda A Lacewell (dfs.ny.gov) <linda.lacewell@dfs.ny.gov>; Jim Malatras <jim.malatras@esc.edu>; Timothy Blute - NGA Future (tblute@nga.org) <tblute@nga.org>; Gareth Rhodes (dfs.ny.gov) <gareth.rhodes@dfs.ny.gov>; charissa.fotinos@hca.wa.gov <charissa.fotinos@hca.wa.gov>; Chang, Ashley <AChang@rockfound.org>
Cc: Tucker Warren (HPS) <twarren@hamiltonps.com>
Subject: Attached -- Rockefeller COVID testing plan

Dear Governors' senior staff,

Attached please find our Rockefeller COVID testing plan that will be released tomorrow. Some of you are joining our briefing this morning at 11:30 Eastern and some are unable to do so, but thought you all would want it now.

Our briefers at 11:30 will be Rockefeller Foundation President Dr. Raj Shah, our managing director for epidemics, Dr. Jonathan Quick, and Eileen O'Connor, our Senior VP for Communications and Policy Advocacy.

With thanks.

Michael

Obtained via MI FOIA by Judicial Watch, Inc.

-----Original Appointment-----
From: Lancaster, Drina **On Behalf Of** Myers, Michael
Sent: Friday, April 17, 2020 4:22 PM
To: Myers, Michael; ann.oleary@gov.ca.gov; paul.mounds@ct.gov; anne.caprara@illinois.gov; mark.cooper@la.gov; kristen.lepore@state.ma.us; hulsj1@michigan.gov; george.helmy@nj.gov; jill.desrosiers@exec.ny.gov; nik.blosser@oregon.gov; laurel.dawson@governor.ohio.gov; david.ortiz@governor.ri.gov; david.postman@gov.wa.gov; Brunelle, Michael; ANDREW Jennifer J * GOV; Allen Patrick; EDLUND Tina * GOV; Marcott Mikayla; Matthew Clark -GOV-; O'Connor, Eileen; Diane Croghan -GOV-; Ron Gunzburger -GOV-; Linda A Lacewell (dfs.ny.gov); Jim Malatras; Gareth Rhodes (dfs.ny.gov); charissa.fotinos@hca.wa.gov; Chang, Ashley
Cc: Tucker Warren (HPS); Timothy Blute - NGA Future (tblute@nga.org); Quick, Jonathan; Shah, Rajiv; Sweet, Andrew (Consultant); Yee, Elizabeth
Subject: Rockefeller Foundation COVID Response
When: Monday, April 20, 2020 11:30 AM-12:30 PM (UTC-05:00) Eastern Time (US & Canada).
Where: https://bluejeans.com/906670550

I reached out to many of you earlier this week to alert you of The Rockefeller Plan for COVID testing, contact tracing, supply chain management and phased re-engagement of the economy. The plan is in final stages of review and will be released on Tuesday. We invite you to a briefing of governors' staff on our recommendations on Monday.

The plan was developed based both on our own experience with epidemics and the input of top health experts, epidemiologists and economists. I've attached an embargoed executive summary which is still in draft form so you have a sense of the options. I know that many of you are wrestling in real time with the questions that this plan seeks to address.

With thanks for all you're doing and the leadership of your governors at this urgent moment.

Michael

Michael Myers
Managing Director, Policy
The Rockefeller Foundation
Washington, DC
mmyers@rockfound.org | www.rockefellerfoundation.org
Assistant: Drina Lancaster | dlancaster@rockfound.org

.....

Obtained via MI FOIA by Judicial Watch, Inc.

To join the meeting on a computer or mobile phone: https://bluejeans.com/906670550?src=calendarLink

Phone Dial-in
+1.408.317.9253 (US (Primary))
+1.866.226.4650 (US Toll Free)
+1.408.317.9254 (US (San Jose))
0.800.000.0959 (Egypt (Toll Free))
+27.10.500.9256 (South Africa (Johannesburg))
+39.800.684.162 (Italy (Toll Free))
1.800.011.097 (Thailand (Toll Free))
Global Numbers: https://www.bluejeans.com/premium-numbers

Meeting ID: 906 670 550

Room System
199.48.152.152 or bjn.vc

Meeting ID: 906 670 550

Want to test your video connection?
https://bluejeans.com/111

Is this your meeting? Do you need your moderator passcode?
.....
_ << File: EXECUTIVE SUMMARY_National for U.S. COVID Testing_v3.17-Apr-2020 1426.docx >>

Obtained via MI FOIA by Judicial Watch, Inc.

National Covid-19 Testing Action Plan: Pragmatic steps to restart the economy

Action Plan Summary

Pandemics sicken and kill people in three ways: first by overwhelming patients' immune defenses, then by swamping hospital networks, and eventually by cutting off a community's economic lifeblood. Hence, "saving lives or saving the economy" is a false choice. As of April 19, Covid-19 had directly killed more than 163,000 people worldwide, including nearly 35,000 in the United States. But the indirect effects are still being counted. The Great Recession of 2008, for instance, killed people in the thousands by disrupting healthcare for mothers, children and those with chronic illnesses and increasing a host of deadly mental and social conditions like alcoholism, depression and domestic abuse.

With the first wave of infections from the Covid-19 pandemic cresting in much of the country, American political and business leaders rightly are considering plans to reopen the economy. This Action Plan is intended to serve as a resource guide for that all-important project.

The bad news is that the U.S. is not yet administering enough coronavirus tests each week to adequately monitor the entire U.S. workforce or rapidly detect recurrent Covid-19 outbreaks. Such outbreaks can be expected for the foreseeable future given the low level of population immunity[1] as well as the virus's contagiousness and wide geographic dispersion. The location and size of recurrent outbreaks are difficult to predict. Close monitoring of the medically vulnerable, institutionalized, poor and imprisoned is vital.

The good news is that in the coming weeks the country could have the tools needed to allow governors and other officials to lift the most severe lockdowns and begin a phased reopening of some businesses. The goal is to allow enough economic activity to forestall a full-blown depression while keeping Covid-19 infection rates low enough to prevent hospitals from being overwhelmed and thereby causing a wider and more deadly health crisis.

This will be a delicate balancing act. Adjustment inevitably will need to be made based on close monitoring of the pandemic. Reopening the economy will be most successful if we move decisively to both increase testing capacity and optimally deploy testing supplies.

The goal of the Action Plan is to build a state-led national program of Covid-19 testing that supports reopening the economy through: workforce monitoring, early detection of recurrent outbreaks, and diagnostic and home testing. This would be the largest public health testing program in American history. Success will depend on the active engagement of the government, business, philanthropy, and the public.

Obtained via MI FOIA by Judicial Watch, Inc.

The action plan has three major objectives: (1) Scale up Covid-19 testing production and supply; (2) launch a Covid Community Healthcare Corps to carry out vastly expanded testing and contact tracing; and (3) create a Covid-19 testing data commons and digital platform to support the first two objectives.

1. Scale Up Covid-19 Testing Capacity

The steady increase in U.S. testing that began in late February has now plateaued. During the first two weeks of April, the number of tests per day averaged 143,000 (~ 1 million tests per week) with no appreciable upward trend.[2] As of April 18, 2020, the U.S. had completed 3,698,534 tests of which 722,182 were positive (19.50%)

This undoubtedly reflects just the tip of the COVID-19 pandemic in the U.S. Current barriers to rapid increases in American test production, supply, distribution and administration include uncertainty over financing and payment; lack of coordination of local, state, and national purchases; uneven distribution of test kits; severe shortages of reagents; regulatory barriers; and a severe lack of staffing.

Based on considerations detailed in the Action Play, the following action steps are proposed to overcome the barriers to testing to progressively expand testing from the current one million to three million and then to 30 million tests per week.

Action Steps:

- Create an Emergency Network for Covid-19 Testing (ENCT) to coordinate and underwrite the testing market. To drive rapid scale-up of Covid-19 testing, the ENCT will engage with: producers of testing equipment, reagents, and other lab consumables; national, state and local purchasers; public and private healthcare funders; and financial institutions. The ENCT will also work to identify and resolve choke points in the test supply chain. The ENCT should convene a consensus group of national, state, business, and academic leaders on the use of testing for workplace monitoring and early detection of Covid recurrences. An overarching analysis of the testing supply chain both in the United States and globally should be undertaken immediately.

- Expand current U.S. testing from 1 million to 3 million per week within the next eight weeks. This will be achieved by maximizing the use and throughput of existing testing at national, university, and local labs. Most important, a crash program to bolster the capacities and resources of thousands of small laboratories around the country must be undertaken. Supply constraints must be identified and eliminated.

- Grow U.S. testing capacity from 3 million to 30 million per week within six months. Some of this increase can be achieved through process efficiencies, lab techniques such as batch sampling, and a broad rollout of point-of-care and home-testing. Given the commercial uncertainties inherent in this 10-fold increase in production, however, it is likely that the Defense Production Act will be needed.

Obtained via MI FOIA by Judicial Watch, Inc.

2. Launch a Covid Community Healthcare Corps for testing and contact tracing

The taking and preparation of samples, analysis of testing, and human-centered privacy-protected contact tracing will require a massive amount of manpower that can be stood up in the next few weeks by federal, state, and local hiring authorities with funding offered via block grants to states.

The number of tests needed to successfully prevent recurrent outbreaks while allowing some relaxation of social distancing will depend on the vigilance of contact tracing. With the kind of high-precision contact tracing used in South Korea, just 2.5 to 5 million tests per day would be required. With the imprecise tracing of a country like Taiwan, 30 million tests per day would be needed – a level far beyond present capacities.

Action Steps:

- A Covid Community Healthcare Corps (CCHC) should be launched at state public health departments, an effort that will involve massive investments in manpower and equipment. At least 100,000 people and perhaps as many as 300,000 must be hired to undertake a vigorous campaign of test administration and contact tracing, and they must be supported by computer systems networked with regional and national viral datasets and as many electronic health records from local hospital systems as can be provided. The CCHC should designate staff to distribute, administer and oversee testing.

- A national system to track Covid-19 status must be created. Policy makers and the public must find the balance between privacy concerns and infection control to allow the infection status of most Americans to be accessed and validated in a few required settings and many voluntary ones.

- Digital apps and privacy-protected tracking software should be widely adopted to enable more complete contact tracing. Whenever possible, incentives should be used to nudge the voluntary use of these apps rather than require them.

3. Create a Covid-19 Data Commons and Digital Platform

Real-time analyses of resource allocations, disease tracing results and patient medical records will enable policy makers and researchers to identify the most promising areas for surges in testing volumes to snuff out Covid-19 recurrent outbreaks and identify the most promising therapeutic treatments and algorithms. This platform can enhance procurement, distribution and deployment of tests as those tests evolve in quantity and function. It should also enable state and local authorities to track testing results and capacities to identify spot shortages.

Action Steps:

- Federal, state, and private data platforms must be expanded to cover the full range of required Covid-19 data. This will help identify any supply and demand constraints so that testing levels can be aligned at regional levels with illness burdens.

Obtained via MI FOIA by Judicial Watch, Inc.

- Innovative digital technologies can improve workforce monitoring and early detection of recurrent outbreaks. When integrated into national and state surveillance systems, such innovations may enable the same level of outbreak detection with fewer tests. Promising techniques include anonymous digital tracking of workforces or population-based resting heart-rate and smart thermometer trends; continually updated epidemiological data modeling; and artificial intelligence projections based on clinical and imaging data.

- Digital health records and insurance claims data of hospitalized Covid-19 patients should be used to improve Covid-19 diagnosis and treatment. This requires that such data be aggregated and examined, while anonymizing personal identification, to determine optimal treatment paradigms and give leads for structured clinical trials.

The Way Forward

Recent reports from the American Enterprise Institute[3], Center for American Progress[4], Duke Margolis Center[5], Harvard University Safra Center for Ethics[6], and Johns Hopkins University[7] each provide unique, complementary perspectives toward a comprehensive approach for relaxing social distancing and reopening our communities and our economy.

Monitoring the pandemic and adjusting social distancing measures will require launching the largest public health testing program in American history. Successful implementation of a national plan to fast-track Covid-19 testing should allow the country to reopen and respond to recurrent outbreaks. The effort will ultimately grow to billions of dollars per month although innovations in testing technology should eventually drop costs. But with widespread business closures costing the country $350 billion to $400 billion each month, the expense will be worth it. This testing infrastructure is intended to tide the country over until a vaccine or therapy is widely available.

Coordination of such a massive program should be treated as a wartime effort, with a public/private bipartisan Pandemic Testing Board established to assist and serve as a bridge between local, state, and federal officials with the logistical, investment and political challenges this operation will inevitably face. Harvard's Edmond J. Safra Center for Ethics has done an excellent job of outlining possible options (Appendix A). We recommend a combination of federal and state appointed members who would actively serve throughout the crisis.

Obtained via MI FOIA by Judicial Watch, Inc.

Contributors

The Rockefeller Foundation is grateful to the following people who have contributed to this Action Plan through their participation in the video-conference Roundtable on Fast-Track Testing to Restart the Economy (April 9, 2020), through exchanges following the video-conference, or through other collaborations. Some may differ with aspects of it, or have stressed other matters of primary focus. All have contributed with the greatest sense of share purpose at this time of national need.

Danielle Allen, James Bryant Conant University Professor, Harvard University and Director, Edmond J. Safra Center for Ethics

Caroline Buckee – Harvard School of Public Health, Associate Director of the Center for Communicable Disease Dynamics

Lisa A. Cooper – Director, Johns Hopkins Center for Health Equity

Zeke Emanuel, Perelman School of Medicine, Department of Medical Ethics and Health Policy, University of Pennsylvania

Robert Grossman – Frederick H. Rawson Professor in Medicine and Computer Science, University of Chicago

Peggy Hamburg – Chair of the Board of the American Association for the Advancement of Science

Zia Khan, SVP Chief/Sr Managing Direction, Innovation, The Rockefeller Foundation

Rick Klausner – Co-Founder and Executive Chairman, Mindstrong Health.

Mark McClellan - Director, Duke-Margolis Center for Health Policy at Duke University

Allyala Krishna Nandakumar – Professor of the Practice; Director, Institute for Global Health and Development; Director, MS Program in Global Health Policy and Management

Eileen O'Connor, JD, Senior Vice President, Communications, Policy and Advocacy

Michael Osterholm – University of Minnesota, Director, Center for Infectious Disease Research and Policy

Michael Pellini, M.D., managing partner of Section 32 and board member of the Personalized Medicine Coalition

Jonathan D Quick, Managing Director, Pandemic Response, Preparedness, and Prevention

Naveen Rao, Senior Vice President, Precision Public Health

Caitlin Rivers – Senior Scholar, Assistant Professor, Johns Hopkins Center for Health Security

Paul Romer – professor at New York University and a 2018 Nobel laureate in Economics

Obtained via MI FOIA by Judicial Watch, Inc.

Rajiv Shah, President, Rockefeller Foundation

Jeremy Sugarman – Professor of Bioethics and Medicine, Berman Institute of Bioethics and School of Medicine, Johns Hopkins University

Eric Topol – Scripps Translational Research Institute

Nana A. Y. Twum-Danso, Managing Director, Health, The Rockefeller Foundation

Obtained via MI FOIA by Judicial Watch, Inc.

[UNTITLED START OF REPORT]

The Covid-19 pandemic caught the United States unprepared, with inadequate emergency stockpiles of protective equipment, ventilators and vital medicines. In addition, the country has little of the industrial capacity needed to manufacture vaccines, antibiotics and other crucial supplies that may go wanting when international borders close.

In some ways, the complaisance that led to this unfortunate vulnerability may have arisen because of a window of viral calm unique in human history. The country's middle-aged leaders are the first generation ever whose parents did not face the bleak terror of polio outbreaks among their children's friends. They were the first to reach puberty without fear that mumps would render them sterile, the first to reach adulthood without fear that cervical cancer would end their or their partners' lives, the first to reach child-bearing age without fear that rubella would cause birth defects in their children and the last generation to be vaccinated against smallpox, history's great viral scourge.

The century-long interval since a viral respiratory pandemic circled the globe with just the right mix of lethality and infectiousness may have led many to stop believing in the inevitability of such a plague. And while HIV/AIDS struck just as many were becoming sexually active, the concentration of infections in the United States among men who have sex with men and people who inject drugs may have increased a sense of invulnerability among those not in those high-risk groups.

But the AIDS epidemic demonstrates why Covid-19's assault could be lengthy and appallingly lethal. Nearly six years passed between the identification of AIDS and the emergence of the first effective treatment, and no meaningfully effective HIV vaccine is on the horizon despite nearly 40 years of diligent scientific effort.

The need for action is urgent. The number of confirmed Covid-19 infections in the country is approaching 700,000, with deaths nearing 35,000. Social distancing measures have successfully slowed the epidemic's implacable march but have led more than 21 million people to lose their jobs. The monthly economic loss is projected to be between $350 billion and $400 billion, with the gross domestic product expected to decline by as much as 7 percent in 2020.

A growing number of Americans worry that lives are being spared in the immediate term at the cost of a long term economic slowdown rivaling that of the Great Depression. Indeed, what is sometimes lost in the debate between "saving lives" and "saving jobs" is that shutdowns increase alcoholism, depression, domestic abuse and a host of other social woes that together contribute to higher mortality -- particularly among the poor. After the market crash of 2008, the United States saw a measurable decline in life expectancy. Depending on the severity and length of the shut-down, we run the risk of losing more lives from the economic downturn than from Covid-19.

Something has to change and fast. But how?

ACTION PLAN

1. **Scale Up COVID-19 Testing Capacity**

Obtained via MI FOIA by Judicial Watch, Inc.

Until Americans feel they can return to work without risking their or their family members' lives, the national economy will remain somewhere between comatose and moribund. Routine Covid-19 diagnostic tests — amplifications of nucleic acid sequences that are signatures of the virus — offer the best chance short of a vaccine to provide that kind of reassurance.

According to some epidemiological analyses, halting the epidemic entirely while allowing nearly everyone to return to work requires testing between 20 million and 30 million people daily, And in most cases, the tests should offer nearly instant results — or at least information quickly enough to allow someone to be tested before re-entering the workplace.

Unfortunately, the country's present Covid-19 testing capacity is less than 1/100th of that goal, and with most results delivered days and sometimes more than a week after being taken. And almost no one with experience in the diagnostic industry believes the epidemiologists' goal is reachable in the next five months with present technologies and infrastructure.

But over the next eight weeks, the country could conceivably get to the point where 3 million people — roughly one percent of the population — are tested weekly. It is a level that, combined with vigorous contact tracing, would allow crucial parts of the economy to restart. After another six months of intensive supply-chain oversight and the roll-out of new testing paradigms, that number could increase 10-fold to 30 million people a week. At least a year will be needed before the nation's labs will be capable of testing 30 million people every day.

BOX Language: ***Coronavirus Tests:*** *There are two type of coronavirus tests: molecular tests for SARS-CoV-2 infection and serological blood tests for antibodies. Molecular tests are usually taken with a nasal swab. The focus right now is choosing the right mix of molecular tests: highly accurate high-end PCR (polymerase chain reaction), middle point-of-care diagnostics (POC) and low-end home tests. Finding the optimal mix is important, but will evolve over time as new tests come on the market, with different levels of accuracy and costs. Serological tests are appropriate for population-based surveillance and research projects. Currently available serological tests should not be used for individual assessment of protection from future infection or back-to-work decisions.* END BOX

Create an Emergency Network for Covid-19 Testing (ENCT) to coordinate and underwrite the testing market.

The Rockefeller Foundation and its finance partners will help create an emergency procurement network, the Emergency Network for Covid-19 Testing, that can leverage public-private credit guarantees, define pooled procurement requirements for critical testing and supplies and negotiate medium term (3-6 month) contracts with suppliers to make sure large volumes of critical supplies are accessible to purchasing cooperatives, health systems, state and local governments, working alone or together, and other buyers. The Foundation will also offer ongoing guidance to these networks.

The aim of the ENCT would be to support and complement the work of Federal and State agencies by engaging with producers of testing equipment, reagents, and other lab consumables; national, state and

Obtained via MI FOIA by Judicial Watch, Inc.

local purchasers; public and private healthcare funders; and financial institutions. The intent is to overcome market, government, logistical, and diagnostic industry challenges that have plagued the dramatic scale up in Covid-19 diagnostic testing required to reopen the economy.

The Emergency Network for Covid-19 Testing would partner with states to:

1. 1. Optimize the use of existing state and regional purchasing arrangements and, as needed, work to restructure such arrangements to secure urgently needed COVID-19 testing equipment and supplies.

2. Support financial guarantees to equipment manufacturers and lab purchasers
3. Create state or regional Covid Diagnostic Testing Control Centers to coordinate lab needs, capacities and financing tools, and to solve problems as they arise.
4. Offer computer equipment, interfacing, and expertise to any participating CLIA labs that are not yet able to immediately accept test orders (requisitions) and report test results digitally.
5. Guarantee a fair market reimbursement (e.g. $100) for all Covid-19 assays regardless of testing platform, previously established provider-lab contracts, payor relationships, and with no in-network or out-of-network payer distinctions.
6. Provide a platform to qualify vendors and then offer guarantees to labs that order from the approved list.

The Emergency Network for Covid-19 Testing would partner with laboratories to:

1. Report all Covid-19 test results to health care providers as well as to state digital platforms within 24 hours of receiving samples while ensuring HIPAA compliance.
2. Report daily test volumes and 5 day forward-looking capacity estimates.
3. Provide Covid-19 Diagnostic Testing Control Centers specific plans to increase present Covid-19 test volumes according to the estimated needs of each state.

Diagnostic tests have long been used almost exclusively to identify illnesses and help the sick. In a viral pandemic, testing is used to slow infections, benefiting society as much or more than the individual patient. In most cases, positive tests for Covid-19 do little to change treatment or life decisions for people suspected of having the virus, since treatments are symptom-specific and quarantine recommendations almost universal.

For these reasons, Covid-19 diagnostic tests when still in short supply must largely be reserved for front-line medical, municipal, grocery and other workers in vital sectors since presymptomatic people can become super-spreaders. As more tests become available, they should be distributed according to a detailed hierarchy of economic, medical and social need.

Mildly and moderately symptomatic patients should be next on the priority list, since positive results will lead them and many of their family members to self-quarantine. As a result, drive-through and clinic testing programs should be expanded. Among the last on the priority list should be hospitalized patients, since x-rays and other diagnostic tools can effectively suggest a Covid-19 infection and treatment decisions will not change with a test's confirmation until effective treatments become available.

Obtained via MI FOIA by Judicial Watch, Inc.

Refusing to test the most desperately ill will be difficult for family members and others to accept, but it is the right course.

ACTION: Scale Up Covid-19 Testing Capacity

- Create an Emergency Network for Covid-19 Testing (ENCT) to coordinate and underwrite the testing market. To drive rapid scale-up of Covid-19 testing, the ENCT will engage with: producers of testing equipment, reagents, and other lab consumables; national, state and local purchasers; public and private healthcare funders; and financial institutions. The ENCT will also work to identify and resolve choke points in the test supply chain. The ENCT should convene a consensus group of national, state, business, and academic leaders on the use of testing for workplace monitoring and early detection of Covid recurrences. An overarching analysis of the testing supply chain both in the United States and globally should be undertaken immediately.

- Expand current U.S. testing from 1 million to 3 million per week within the next eight weeks. This will be achieved by maximizing the use and throughput of existing testing at national, university, and local labs. Most important, a crash program to bolster the capacities and resources of thousands of small laboratories around the country must be undertaken. Supply constraints would be identified and eliminated.

- Grow U.S. testing capacity from 3 million to 30 million per week within six months. Some of this increase can be achieved through process efficiencies, lab techniques such as batch sampling, and a broad rollout of point-of-care and home-testing. Given the commercial uncertainties inherent in this 10-fold increase in production, however, it is likely that the Defense Production Act will be needed.

2. Establish a COVID Community Healthcare Corp

Testing millions of people per week will require hiring a large number of community health workers. The disease is so infectious that reaching and quarantining potential contacts quickly is an urgent priority and maximizes the effectiveness of testing. A human-centered approach to administering tests and contact tracing is labor intensive but does not require specialized skills training and protects privacy. A combination of shoe-leather contact tracing and new digital tools can help target relevant populations for testing while minimizing privacy risks.

Obtained via MI FOIA by Judicial Watch, Inc.

South Korea successfully used aggressive contact tracing to target and maximize its own testing capacity to avoid just the sort of rapid spread and subsequent lockdowns that have bedeviled the United States. So contact tracing would seem in order. But the United States has had only limited contact tracing because of constrained resources. There are also heightened concerns about the privacy and the liberty of the infected and their contacts in the U.S..

In addition, such a workforce can be used to provide other services, such as providing meals on wheels and other necessary assistance.

Action Steps:

1. **Rapidly hire an additional 100,000 to 300,000 people using existing hiring authorities:** Considering the asymptomatic nature of much of the viral spread, Johns Hopkins University School of Public Health and The Association of State and Territorial Health Officials (ASTHO) estimates that about 100,000 would be needed for contact tracing alone. That is less than half the rate deployed in Wuhan. Testing administration and other services for vulnerable populations who are at-risk or under home isolation or quarantine would require additional workers, with estimates ranging as high as 300,000 needed to provide all essential services. At $40,000 for wages and benefits per employee per year, the cost could range from $4 billion to $12 billion when training and administrative costs are included.[1]

2. **Direct hires, contractors and volunteers:** An "all of the above approach" must be taken to maximize the ease and speed of hiring. Peace Corps Volunteers forced to return from postings early, although limited in number to approximately 7,000, are prime candidates for rapid re-hiring. The Corporation for National and Community Service, the federal agency that oversees Americorps, the Senior Corps and the Volunteer Generation Fund, could be used. The National Guard can fill gaps, and nonprofits can provide volunteers. (See Box)

3. **Skills Training:** The skills needed for both test administration and contact tracing are not specialized, and training can be provided virtually through the CDC and their partner organizations such as the National Network of STD Clinical Prevention Training Centers, public health schools, and companies.

4. **Management and oversight:** Covid-19 responders should be under the management of state and local authorities, particularly for contact tracing. Federal responders should be deployed by invitation and under the authority of governors and mayors. For core public health functions such as contact tracing, there should be a single, coordinated system in each jurisdiction, managed by local authorities.

Some privacy concerns must be set aside for an infectious agent as virulent as Covid-19, allowing the infection status of most Americans to be accessed and validated in a few required settings and many voluntary ones. The loss of privacy engendered by such a system would come at too high of a price if the

[1] Johns Hopkins Bloomberg School of Public Health and ASTHO; A National Plan to Enable Covid 19 Case Finding and Contact Tracing in the U.S.;

Obtained via MI FOIA by Judicial Watch, Inc.

arrival of a vaccine early next year was a certainty. But vaccine development and manufacture could take years, and when it comes certain populations may be excluded from receiving it for health reasons. In the meantime, infection status must be known for people to participate in many societal functions. Legislation protecting people from being fired over infection status must be passed.

Those screened must be given a unique patient identification number that would link to information about a patient's viral, antibody and eventually vaccine status under a system that could easily handshake with other systems to speed the return of normal societal functions. Schools could link this to attendance lists, large office buildings to employee ID cards, TSA to passenger lists and concert and sports venues to ticket purchasers. Such connections should be made in a way that protects personally identifying information whenever possible. For example, accessing the viral and antibody status of an individual can be done by using a cryptographic hash of an individual's private information without actually sending any personally revealing details.

This infection database must easily interoperate with doctor, hospital and insurance health records in an essential and urgent national program to finally rationalize the disparate and sometimes deliberately isolated electronic medical records systems across the country. Analytics across myriad platforms must be operationalized so that population-level health information can be used to identify at-risk populations, perform contact tracing, facilitate decision support, and evaluate interventions for effectiveness.

Unfortunately, obtaining the necessary clinical data to bring these powerful analytic tools to bear has been difficult due to information-blocking tactics of electronic health records (EHR) vendors. Among the longtime tactics used by such vendors has been charging unreasonable fees for data access, requiring providers to sign restrictive contracts, and claiming patients' clinical data is proprietary.

On March 9, the Department of Health and Human Services (HHS) released two long-awaited final rules that would prohibit information blocking in health care and advance more seamless exchange of health care data. But publication in the Federal Register, necessary to activate the rules, has been inexplicably delayed. This delay must end.

BOX Language: *The Rockefeller Foundation's Equity and Economic Opportunity and Health Initiatives is piloting a Community Health Workers Corps (CHW's) in Baltimore as a dual response to the pandemic and as a way to create quality employment opportunities for up to 1,000 displaced workers. A public/private partnership composed of the City of Baltimore, State of Maryland, University of Maryland, Johns Hopkins and various private sector partners are all coordinating and collaborating in launching the CHW Corps. Investing in the launch of a health workers corps would allow every community to not only have testing and contact tracing capability but also have a "social distancing/public health workforce." CHW's could undertake everything from sanitizing spaces to enforcing separation to spraying sanitizer on people's hands regularly, particularly where crowds gather. As trusted members of their cities they would also have a close understanding of the community served. Pending some approvals, the target launch is June 1, 2020.*

Obtained via MI FOIA by Judicial Watch, Inc.

Similarly, The Rockefeller Foundation has been working with The Community Organized Relief Effort (CORE) in Los Angeles to scale up testing in LA County, statewide, and ultimately nationwide through the training of volunteers to administer tests and record results) END BOX

ACTION: Launch a Covid Community Healthcare Corps for testing and contact tracing

- A Covid Community Healthcare Corps (CCHC) should be launched at state public health departments, an effort that will involve massive investments in manpower and equipment. At least 100,000 people and perhaps as many as 300,000 must be hired to undertake a vigorous campaign of test administration and contact tracing, and they must be supported by computer systems networked with regional and national viral datasets and as many electronic health records from local hospital systems as can be provided. The CCHC should designate staff to distribute, administer and oversee testing.

- A national system to track Covid-19 status must be created. Policy makers and the public must find the balance between privacy concerns and infection control to allow the infection status of most Americans to be accessed and validated in a few required settings and many voluntary ones.

- Digital apps and privacy-protected tracking software should be widely adopted to enable more complete contact tracing. Whenever possible, incentives should be used to nudge the voluntary use of these apps rather than require them.

3. Create a Data Commons and Digital Platform

Federal, State, and Private Data Platforms

There is a need to develop a real-time common data-sharing platform to better understand available testing capacity. This could take the form of a state-by-state heat map of laboratories to help governors and other elected officials make informed decisions on how to allocate scarce resources. States should be encouraged to use a common platform, as there are multiple competing platforms in place, limiting the effectiveness of existing data. This should be in done in partnership with the National Governors Association. To further encourage the uptake of this data commons, a set of compelling use cases should be put forward for how certain states have optimized data and its impact on curtailing the impact of Covid-19.

Analytical tools can be developed to help anticipate shortages of lab materials and equipment and to ensure efficient ordering and distribution of supplies. And as epidemiological modeling is improved and married with digital tracking information, it can become more predictive and anticipate outbreaks or

Obtained via MI FOIA by Judicial Watch, Inc.

non-compliance with public health guidance to direct surges in testing capacity. This work will require careful attention to geographic and racial imbalances in existing data collection procedures so that bias is not baked into models. The integration of diverse data sets from public health systems, social media, and mobility data into a shared platform with open-source modelling tool development and appropriate security and compliance controls will accelerate the experimentation and development of prediction algorithms that power the monitoring and decision-making components of the digital platform.

Marrying much of this information into easy-to-understand dashboards to improve decision-making by both public and private sector leaders will be an ongoing challenge as a flood of data threatens to create a thickening fog of information. Such a platform should allow users to integrate multiple datasets on the fly, model interventions, and track disparate impact on minority communities.

Platforms and apps can be used not only to identify emerging hot spots but also for developing and operating back-to-work predictive models. Such models can help make decisions about which regions at which times should move from shelter-at-home to work, and, as necessary, back to shelter-at-home again.

Doing this quickly and ethically will require an unprecedented effort on the part of government, industry, and academia. The development of these tools should follow four principles:

1. **Whenever and wherever possible data should be open**. We know from prior crises that openness creates efficiency and enables collaboration. This will require marshalling not just an army of engineers and scientists but also an army of lawyers to negotiate data sharing agreements.

2. **Computer upgrades:** Local and state health departments are famously shoestring operations. These departments will need rapid computer upgrades so they can receive listings of the newly infected directly from laboratory uploads, with contact information included as part of the record.

3. **Focus relentlessly on user needs.** Now is not the time for fancy new features or sophisticated interfaces. Developers must do rapid user research to identify specific decisions and pain points where digital tools can help.

4. **Build for interoperability and modularity.** New tools must play well with existing systems. This means developers should build on existing interoperability standards from the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC).

5. **Earn public trust for new technologies through ethical action and transparency.** Companies like Apple and Google are leading the way by engaging directly with privacy advocates, allowing individuals to opt-in to new tools, and publishing extensive documentation. Others

Obtained via MI FOIA by Judicial Watch, Inc.

across the private and public sectors should follow their lead or risk losing buy-in from the populations at large.

Fitbits, smartphones, smart thermometers and other digital tools can be used to uncover clusters of infections before patients flood local emergency rooms, allowing public health officials to redirect testing resources and rapidly initiate contact tracing. Apple and Google are working on a contact-tracing app to alert people — on an opt-in basis — if they've been in touch with someone known to have the novel coronavirus. An active symptom-checker app is in development. Even data such as Google searches for "I can't smell" help to identify infection localities.

Connecting Clinical Research and Digital Technology

Fully controlling the Covid-19 epidemic requires that we test the majority of the population weekly. Since we are far from that kind of capacity, the United States must undertake immediate and intense efforts to invest in new tests and ways of providing near-immediate diagnostic results. We must also invest in research that analyzes the electronic medical records of hospitalized Covid-19 patients to determine best treatment strategies and pathways for clinical trials that must be undertaken immediately.

The reason for both is that this country's gravest test may arrive around Labor Day as students pile into school buses and classrooms with the beginning of the next school year. Children and teens are particularly efficient viral vectors for Covid-19, since they are often asymptomatic and tend to be less careful than adults about social distancing.

Another vital research target is determining whether people who were previously infected with Covid-19 can be infected again. Anecdotal reports from other countries suggest quick re-infection is possible. Research is needed to explore under what circumstances this troubling outcome could occur. This research should also confirm which antibodies and serological tests are truly predictive of past exposure as well as future immunity.

Additionally, much has been posited about the risk to healthy, young people. Therefore, this research program should also determine whether age or underlying health disorders mitigate immunity and complicate the predictive power of antibody assays.

Obtained via MI FOIA by Judicial Watch, Inc.

ACTION: Create a Covid-19 Data Commons and Digital Platform

- Federal, state, and private data platforms must be expanded to cover the full range of required Covid-19 data. This will help identify any supply and demand constraints so that testing levels can be aligned at regional levels with illness burdens.

- Innovative digital technologies can improve workforce monitoring and early detection of recurrent outbreaks. When integrated into national and state surveillance systems, such innovations may enable the same level of outbreak detection with fewer tests. Promising techniques include anonymous digital tracking of workforces or population-based resting heart-rate and smart thermometer trends; continually updated epidemiological data modeling; and artificial intelligence projections based on clinical and imaging data.

- Digital health records and insurance claims data of hospitalized Covid-19 patients should be used to improve Covid-19 diagnosis and treatment. This requires that such data be aggregated and examined, while anonymizing personal identification, to determine optimal treatment paradigms and give leads for structured clinical trials.

INTERNATIONAL AND U.S. COVID-19 TESTING EXPERIENCES

Experiences from countries that are making progress in containing the spread of Covid-19 point to the vital role of an early and aggressive public health response to SARS-CoV-2, the highly contagious virus that causes Covid-19. This includes administering testing on a large scale; isolating and monitoring infected people; and tracing recent contacts who may have been infected and testing them too. This public health response has also appeared to minimize the need for blunt, economically damaging restrictions such as lockdowns to reduce the spread of infections.

A detailed exploration of the exemplar countries and territories, notably South Korea, Singapore, Hong Kong, Iceland, Norway, South Africa, and Ghana, reveal emerging best practices for mounting an early and aggressive public health response to Covid-19: Start as early and quickly as possible, Scale diagnostic testing in at-risk populations, not just those with symptoms, invest in the health workforce, and leverage technology

South Korea is one of the few countries to experience a serious Covid-19 outbreak and successfully flatten its curve through widespread testing and intensive contact tracing without shuttering its economy or overwhelming the health care system.[8] South Korea offers a useful point of comparison with the United States, as both countries confirmed their first cases of Covid-19 within a day of each other. However, since then South Korea has registered a Covid-19 mortality rate that is half that of the United States, and South Korea has tested three times as many people for the virus per capita as the United States has.[9,10] A crucial reason is that the Koreans prioritized quick action on Covid-19 testing.

Obtained via MI FOIA by Judicial Watch, Inc.

Less than a week after the country detected its first case, health officials met with medical and pharmaceutical companies to discuss the production and approval of test kits. Within two weeks, even as confirmed cases remained below 100, thousands of test kits were shipping daily.[11] To spare hospitals and clinics from being overwhelmed by increased demand for testing, South Korean officials opened 600 testing centers. At drive-through stations, patients are tested without leaving their cars.[12] When people test positive for Covid-19 in South Korea, health workers retrace their recent movements to find, test and isolate anyone the person may have had contact with. People ordered into self-quarantine must download an app that alerts officials if a patient leaves isolation.[13]

In recent weeks, there have been encouraging signs of a more aggressive and coordinated approach to testing and contract tracing in Massachusetts, Utah and Washington State.[14,15,16] There have also been new efforts announced by major U.S. technology companies - Apple and Google have announced a joint effort to bolster contact tracing by building software into smartphones that relies on Bluetooth technology to track users' proximity to one another. Facebook is participating in a similar effort led by the Massachusetts Institute of Technology.[17]

References

[1] The estimated Covid-19 prevalence rate for herd immunity is 60 to 70% of the population. Based on a total of 673,000 confirmed cases as of April 17, 2016, the estimated seroprevalence of Covid-19 in the U.S. is 0.2%. The actual seroprevalence is probably closer to 3% (15 times confirmed cases) based on evidence from influenza, another respiratory virus with pandemic potential.

[2] https://Covidtracking.com/data/us-daily Accessed 19-Apr-2020

[3] https://www.aei.org/research-products/report/national-coronavirus-response-a-road-map-to-reopening/

[4] https://www.americanprogress.org/issues/healthcare/news/2020/04/03/482613/national-state-plan-end-coronavirus-crisis/

[5] https://healthpolicy.duke.edu/sites/default/files/atoms/files/covid-19_surveillance_roadmap_final.pdf

[6] https://ethics.harvard.edu/files/center-for-ethics/files/white_paper_6_testing_millions_final.pdf

[7] https://www.centerforhealthsecurity.org/our-work/pubs_archive/pubs-pdfs/2020/a-national-plan-to-enable-comprehensive-COVID-19-case-finding-and-contact-tracing-in-the-US.pdf

[8] https://www.economist.com/asia/2020/03/30/south-korea-keeps-Covid-19-at-bay-without-a-total-lockdown

[9] https://www.foreignaffairs.com/articles/united-states/2020-04-10/south-korea-offers-lesson-best-practices

[10] https://gisanddata.maps.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6 (accessed April 15, 2020)

[11] https://www.foreignaffairs.com/articles/united-states/2020-04-10/south-korea-offers-lesson-best-practices

[12] https://www.nytimes.com/2020/03/23/world/asia/coronavirus-south-korea-flatten-curve.html

[13] https://www.nytimes.com/2020/03/23/world/asia/coronavirus-south-korea-flatten-curve.html

[14] https://www.npr.org/sections/health-shots/2020/04/13/832027703/massachusetts-recruits-1-000-contact-tracers-to-battle-Covid-19

[15] https://www.fastcompany.com/90487654/utah-is-running-mass-Covid-tests-why-arent-other-states

[16] https://projects.seattletimes.com/2020/charting-coronavirus-outbreak-washington-state/#testing

[17] https://www.statnews.com/2020/04/15/coronavirus-digital-contact-tracing-tech-questions/

Obtained via MI FOIA by Judicial Watch, Inc.

From: Huls, JoAnne
To: Totten, Mark; Foster, Tricia; Gordon, Robert (DHHS); Hertel, Elizabeth (DHHS)
Cc: Readinger, Patricia; Sherry, Dana; Brousseau, Jessica
Subject: Fwd: contact tracing request for HHS
Date: Wednesday, April 22, 2020 11:02:24 AM

Please let us know who will provide the information and we can respond on behalf of the state.
jh

From: Urban, Lori (HHS/IEA) <Lori.Urban@hhs.gov>
Sent: Wednesday, April 22, 2020 11:00:15 AM
To: Huls, JoAnne <HulsJ1@michigan.gov>; Sherry, Dana <SherryD2@michigan.gov>; Brousseau, Jessica <BrousseauJ@michigan.gov>
Cc: Johnston, Darcie (HHS/IEA) <Darcie.Johnston@hhs.gov>
Subject: contact tracing request for HHS

CAUTION: This is an External email. Please send suspicious emails to abuse@michigan.gov

JoAnne, Dana or Jessica -
Darcie has asked that I collect the follow data, for the White House.
We are requesting the information by 2pm Eastern, if possible.
The Emergency Management Team should have this.

In order to help with contact tracing and COVID-19 numbers -
We are collecting data on your opening plans, for your state.....

A. What is your plan for potential increased need for contact tracing?
    a. What is your current strategy for conducting contact tracing?
    b. How many contact tracers did you have prior to COVID-19?
        i. Do you currently have now and how is this pool staffed?
        ii. How many contact tracers will you need to implement your plan?
    c. What is your definition of a close contact?
    d. Do you utilize digital application tools in your contact tracing?
        iii. If yes, what type and where is it in use?
    e. Do you need technical support for digital application tools?
    f. Do you currently have a data collection and transmission method identified?
        iv. If yes, please provide the details.
    g. What additional resources are needed to increase contact tracing in your state/territory?

Next, we'd like to ask about surveillance and testing efforts to address the needs of vulnerable populations:

Obtained via MI FOIA by Judicial Watch, Inc.

A. What is your current strategy to monitor surveillance and implement any proactive testing in:
    I. Nursing homes/long-term care sites – symptomatic and asymptomatic
    II. FQHCs
    III. IHS sites
    IV. Others?
A. What additional resources are needed to enhance surveillance and increase testing for vulnerable populations in your state/territory?

Finally, do you have any other pressing needs that will assist you in opening and keeping open your state?

Many Thanks!

- Lori

Lori Urban
Senior Advisor, Office of InterGovernmental Affairs
U.S. Department of Health and Human Services
202-578-3498 Lori.Urban@HHS.gov

Obtained via MI FOIA by Judicial Watch, Inc.

From: Gordon, Robert (DHHS)
To: Foster, Tricia; Totten, Mark; Pohl, Zack
Cc: Chang, Jooyeun (DHHS); Darling, Darice (DHHS)
Subject: Fwd: FOR IMMEDIATE RELEASE: MDHHS shares gains in reforming state's child welfare system to improve child safety, keep families together; Department's new leadership and team praised by federal judge for 'being devoted to moving this case forward in a ...
Date: Tuesday, November 10, 2020 12:11:47 PM

Federal judge had warm words today in 12-year old lawsuit. She said she is hoping to retire soon and would love to wrap this up before then.

From: Michigan Department of Health and Human Services <MDHHS@govsubscriptions.michigan.gov>
Sent: Tuesday, November 10, 2020 12:04 PM
To: Gordon, Robert (DHHS)
Subject: FOR IMMEDIATE RELEASE: MDHHS shares gains in reforming state's child welfare system to improve child safety, keep families together; Department's new leadership and team praised by federal judge for 'being devoted to moving this case forward in a way t...

MDHHS banner with logo no names

Press Release

FOR IMMEDIATE RELEASE: Nov. 10, 2020

CONTACT: Bob Wheaton, 517-241-2112, wheatonb@michigan.gov

MDHHS shares gains in reforming state's child welfare system to improve child safety, keep families together

Department's new leadership and team praised by federal judge for being 'devoted to moving this case forward in a way that no prior team has'

LANSING, Mich. – With new leadership in place, Michigan is making needed improvements to its child welfare system to keep children safer and families together. Michigan Department of Health and Human Services (MDHHS) officials today shared successes during the early stages of their reform efforts and promised even more significant progress as new plans are put into place.

MDHHS was in federal court virtually via Zoom to report on child welfare system improvements during the last six months of 2019 and listen to a report from court-appointed monitors. That monitoring period coincided with the beginning of JooYeun Chang's tenure as executive director of the department's Children's Services Agency.

"We are making good progress," said MDHHS Director Robert Gordon. "The improvements we shared today are modest but real. Our focus during the brief period covered by today's report was to develop strategies to set the stage for more rapid improvements in the months to come – particularly in the area of child safety. That progress is already occurring. We look forward to demonstrating greater improvements in outcomes for children and families during the months ahead."

Obtained via MI FOIA by Judicial Watch, Inc.

Chang took over as head of the Children's Services Agency in May 2019. Speaking to Judge Nancy G. Edmunds of the U.S. District Court for the Eastern District of Michigan, she highlighted progress MDHHS is making in three areas that demonstrates its commitment to improve critical child safety outcomes. She said MDHHS has:

- Eliminated a previous backlog of 1,300 Children's Protective Services investigations when Chang came to MDHHS. The department has taken swift action by sending additional staff to county field offices, improving policy to eliminate redundancies and outdated requirements, and problem-solving weekly with county offices that were behind. As a result, backlogs were eliminated within four months.
- Taken steps to reduce maltreatment of children in foster care. Among other things, the department has created a new unit that follows up on concerns that children in care are being abused or neglected.
- Provided increased support to relative caregivers so they can keep children safe. MDHHS – which believes children are better off when they are placed with appropriate family members – now provides financial support to relative foster families even if they are not licensed.

"We know there is much more work to do," Chang said. "We will persist in our efforts to transform our system until we are able to meet a child's safety needs before family problems become a crisis and we will dedicate the best evidence-informed programs to support the remaining children who need the temporary protection that foster care provides."

Michigan's child welfare system is under federal court oversight as a result of a lawsuit filed by the advocacy group Children's Rights in 2006. In June 2019 – five months after Gov. Gretchen Whitmer took office – Judge Edmunds approved a new agreement that streamlined the monitoring compliance process so MDHHS could devote more resources to getting results.

Tuesday she noted issues remain to be addressed, but she said she's been impressed by the department's new leadership based on what she's heard from court monitor Kevin Ryan.

"My information from Mr. Ryan is that this team that you have assembled is passionate, hardworking and really devoted to moving this case forward in a way that no prior team has," Judge Edmunds told Gordon. "And that's good news for the children and everyone in the state of Michigan."

In addition to working to meet the court's requirements, Chang said MDHHS in the last year has focused on transforming the child welfare system. She said that has included:

- Improving the process for handling reports of suspected child abuse and neglect to the state's toll-free hotline – 855-444-3911. That means decisions about whether complaints should be investigated are more consistent.
- Investing in early intervention and prevention so that families can be assisted before children are at risk of imminent harm or need to be removed from their families. MDHHS partnered with Chapin Hall at the University of Chicago to analyze data to determine which families are most at risk so the department can intervene.
- Ensuring that children are placed in family-like settings whenever possible and increased monitoring of child-caring institutions where some children in foster care are placed so they are safe from harm.

Gordon and Chang also informed the court how MDHHS has responded to a pair of crises during 2020 – the death of a child at a child-caring institution in Kalamazoo and the COVID-19 pandemic.

Obtained via MI FOIA by Judicial Watch, Inc.

A 16-year-old died May 1 after he was wrongfully restrained at Lakeside for Children. Since then, MDHHS has moved to revoke Lakeside's license, eliminate the use of dangerous restraints in child-caring facilities and support family-based settings for children in care rather than large institutional facilities.

During the pandemic, MDHHS initiated a rapid review and reunification process, resulting in 432 children in care being safely reunified with their parents. While families spent more time at home due to COVID-19, MDHHS successfully contacted more than 8,000 families beginning in April who had recent CPS cases and more than 5,300 families beginning in August to provide support and resources.

MDHHS also shared with the court significant progress the Children's Services Agency has made in improving its use of technology.

Since the last court hearing, MDHHS has developed and implemented a plan for a new information technology system that will improve the ability to track and analyze data related to cases. The department is close to awarding a contract to build the first part of the new system, which will be constructed in modules as MDHHS phases out the Michigan Statewide Automated Child Welfare Information System (MISACWIS) that has been plagued by problems. The first module is expected to be finished by the end of 2021, with the entire project being completed within three to five years.

To view the latest federal court monitor report and other information, go to www.michigan.gov/ChildWelfareAgreement.

# # #

- Federal Court Monitor Child Welfare Press Release 2020.pdf

Become a foster parent through Michigan Department of Health & Human Services foster care program.

Questions? Contact Us

SUBSCRIBER SERVICES:
Manage Subscriptions | Unsubscribe All | Subscriber Help

STAY CONNECTED:

This email was sent to gordonr3@michigan.gov using GovDelivery Communications Cloud on behalf of: Michigan Dept of Health & Human Services · 235 S. Grand Ave W. · Lansing, MI 48909 · 1-855-275-6424