COVID-19 Center Self-Assessment

**Purpose:** The purpose of the COVID-19 Center Self-Assessment is to determine a hospital’s capability to participate in the Mississippi COVID-19 System of Care. Participation in the COVID-19 System of Care is voluntary.

**Process and Instructions:**

1. Each participant hospital will complete the following COVID-19 Center Self-Assessment Survey (page 3) and return the survey via email to: David Hall, Director, Acute Care Systems, at david.hall@msdh.ms.gov

2. Based on information provided by the respective participant hospital on the COVID-19 Center Self-Assessment Survey (page 3 of this document), the Mississippi State Department of Health will acknowledge the Self-Assessment in one of two ways:
   a. If the Self-Assessment Survey is complete and contains accurate information, the respective participant hospital will be included on the updated list of Self-Designated COVID-19 Centers (posted on the MSDH Website) and MSDH will send a letter to the hospital communicating the same
   b. If the Self-Assessment Survey is incomplete or contains inaccurate information, MSDH will inform the respective participant hospital of the need to submit a complete and accurate survey; no further action will be taken until the respective participant hospital re-submits the survey
Required Resources for Each Respective Level of COVID-19 Center

☐ **Level I COVID-19 Center**, which requires the following resources:
  - Teaching and research institution
  - Telemedicine provider capabilities
  - Dedicated COVID-19 Negative Pressure Intensive Care Unit (ICU)
  - Dedicated COVID-19 negative pressure hospital beds
  - Pulmonologist
  - Intensivist
  - Infectious Diseases
  - Emergency Medicine
  - Anesthesia
  - Continuous Renal Replacement Therapy (CRRT)
  - Extracorporeal Membrane Oxygenation (ECMO)
  - Intra-Aortic Balloon Pump
  - Hospital-based critical care transport teams for COVID-19 patient transfers
  - Telemedicine consultation for COVID-19
  - Rapid turn-around-time testing (<12 hours)
  - Active in-patient COVID-19 clinical trials

☐ **Level II COVID-19 Center**, which requires the following resources:
  - Required components include Intensive Care Unit (ICU)
  - Negative Pressure Hospital Beds
  - Pulmonologist and/or Intensivist
  - Infectious Diseases
  - Emergency Medicine
  - Anesthesia
  - Continuous Renal Replacement Therapy (CRRT)
  - Telemedicine consultation for COVID-19
  - Intra-Aortic Balloon Pump

☐ **Level III COVID-19 Center**, which requires the following resources:
  - Intensive Care Unit (ICU)

☐ **Level IV COVID-19 Center**, which requires the following resources:
  - ED staffed by a physician, or an advanced practice provider

☐ **Level V COVID-19 Center**, which requires the following resources:
  - Alternate Care Site (ACS)
  - Resources for receiving convalescing COVID-19 patients from higher level centers
  - These facilities will be managed by the State of Mississippi for the purpose of convalescing COVID-19 patients
COVID-19 Center Self-Assessment Survey

1. Hospital name and mailing address:

_______________________________________
_______________________________________
_______________________________________
_______________________________________
_______________________________________

2. Current Chief Executive Officer:

_______________________________________
_______________________________________

3. Based on staff and resource requirements for COVID-19 Centers, as prescribed in the COVID-19 System of Care Plan, and as chief executive officer of the hospital noted above, I verify the governing authority of said hospital and the director of the medical staff herein make the commitment to participate in the statewide COVID-19 System of Care at the following level:

☐ Level I
☐ Level II
☐ Level III
☐ Level IV
☐ Level V

4. Moreover, the hospital agrees to adhere to the COVID-19 System of Care Plan, which is posted in current version to the Mississippi State Department of Health website.

_______________________________________________  
Chief Executive Officer – Printed Name  
__________________________________________________  
Chief Executive Officer – Signature & Date

_______________________________________________  
Chief of Medical Staff – Printed Name  
__________________________________________________  
Chief of Medical Staff – Signature & Date