THE RISK MANAGEMENT ASSOCIATION

SARS-COV-2

Principles of Workforce Return to Facilities

MARCH 2021 | VERSION 2

INTRODUCTION

The World Health Organization ("WHO") was first informed of pneumonia-like cases concentrated in Wuhan, China, which were soon determined to be caused by a novel coronavirus, on December 31, 2019. On January 30, 2020, the WHO declared the coronavirus a Public Health Emergency of International Concern due to the increase in number of cases and additional countries reporting confirmed cases. RMA engaged Stephany Head, Ph. D. to develop pandemic planning resources for RMA members on January 6, 2020. Head delivered a webinar on pandemic planning for RMA's members on February 11, 2020. Ultimately, the WHO declared a pandemic on March 11, 2020.

Following the designation of COVID-19 as a pandemic, all 50 states and many major cities issued shelter-in-place or stay-at-home orders which required non-essential services to close. While financial institutions are essential services and, as such, remained open for business, many financial institutions implemented work-from-home policies intended to safeguard the health of their employees and flatten the curve associated with the spread of COVID-19 cases.

As of August 22, 2020, the WHO reported 23,057,288 cases of the coronavirus worldwide, with 800,906 deaths[1] in 216 countries. According to the Centers for Disease Control and Prevention (CDC), the U.S. accounted for 24% of the world's confirmed cases, and 22% of deaths. The U.S. accounts for 4.25% of the total world population.[2]

Several public and private organizations are conducting COVID-19 clinical trials for medical protocols, and in various phases of developing a COVID-19 vaccine. The WHO provides an International Clinical Trials Registry Platform to ensure that a complete view of research is accessible to all those involved in health care decision making.[3] Federal funded clinical trials can be found on the National Institutes of Health's U.S. National Library of Medicine (clinicaltrials.gov). In addition, the WHO has established a COVID-19 vaccine global access facility designed to guarantee rapid, fair, and equitable access to COVID-19 vaccines for every country in the world, rich and poor, to make rapid progress towards slowing the pandemic.[4]

As of this date, the world is nearly eight (8) months into the global pandemic. In recent days, several states have begun opening businesses, schools, and communities and schools. As part of the CDC's enhanced response to this coming flu season, the CDC has purchased an additional 2 million doses of pediatric and 9.3 million doses of adult influenza vaccine. Groups with the lowest influenza vaccination coverage have also been disproportionately affected by COVID-19. These additional doses provide a safety net for the uninsured or underinsured that may be at higher risk from COVID-19.[5]

1 WHO Coronavirus Disease (COVID-19) Dashboard, Data last updated: 2020/8/23, 12:48pm CEST. Retrieved from: https://covid19.who.int.

2 The current population of the United States of America is 331,282,824 as of Sunday, August 23, 2020, based on Worldometer elaboration of the latest United Nations data. The United States population is equivalent to 4.25% of the total world population. Retrieved from: https://www.worldometers.info/world-population/us-population/.

3 International Clinical Trials Registry Platform (ICTRP). Retrieved from: https://www.who.int/ictrp/en/.

4 World Health Organization, News Release, More than 150 countries engaged in COVID-19 vaccine global access facility, 15 July 2020, Geneva/London. Retrieved from: https://www.who.int/news-room/detail/15-07-2020-more-than-150-countries-engaged-in-covid-19-vaccine-global-access-facility.

5 CDC Media Telebriefing Transcript: Update on COVID-19, Press Briefing Transcript Friday, August 21, 2020. Retrieved from: https://www.cdc.gov/media/releases/2020/t0821-telebriefing-covid.html.

In May of this year, the Risk Management Association ("RMA") convened a Working Group comprised of business continuity, HR, and operational risk practitioners from leading institutions to develop guidelines for financial institutions to consider in connection with re-entry to their facilities by their distributed workforces. The RMA Working Group considered the issue of facilities re-entry across three phases (the identification of triggers for re-entry; implementation considerations; and triggers for re-instating shelter-in-place) and identified 24 key principles for institutions to consider in connection with the return of their workforces to their usual and customary workspaces within their facilities. The Working Group is committed to providing guidelines throughout the pandemic. The Principles of Workforce Return to Facilities document will be updated regularly throughout the pandemic.

1.1 Acknowledgments

RMA would like to thank the industry leaders who came together in these unprecedented times to craft the following SARS-COV-2 Workforce Return to Facilities Plan. Despite pressing concerns and commitments to their financial institutions and families, these RMA members selflessly gave of their time and expertise to help guide the financial industry back to normalcy—and to ensure future resiliency.
Leaders from the following institutions were integral in this effort: Bank of America, Charles Schwab, Discover, Fannie Mae, Fifth Third, Huntington, Iberia, M&T Bank, PNC, Regions, Royal Bank of Canada, Synchrony, TD Bank, TD Ameritrade, U.S. Bank, and Zions Bancorporation. RMA also recognizes the critical roles of TD Ameritrade Managing Director and RMA Operational Risk Council Chair Joseph A. Iraci, who headed the Return to Facilities process, and Stephany Head, Ph. D., a renowned expert on pandemic planning and President of OpRisk Associates, who provided wise and knowledgeable analysis.

1.2 About RMA

RMA is a 501(c)(6) not-for-profit, member-driven professional association whose sole purpose is to advance the use of sound risk management principles in the financial services industry. RMA helps its members use sound risk management principles to improve institutional performance and financial stability and enhance the risk competency of individuals through information, education, peer-sharing, and networking. RMA has 1,900 institutional members that include banks of all sizes as well as nonbank financial institutions. They are represented in the Association by more than 18,500 risk management professionals who are chapter members in financial centers throughout North America, Europe, Asia/Pacific, and Australia.
One of the most important components of RMA's mission is to provide independent analysis on matters pertaining to risk management. In this regard, the guidelines contained herein are informed by subject matter experts from member institutions of the Association.

EXECUTIVE SUMMARY

The ability for a financial institution to effectively re-enter facilities in the midst of a pandemic requires an understanding of the state of transmission of COVID-19; an institution's critical infrastructure and business requirements; an appreciation for the human needs of the institution's employees; and the ability to integrate and use public resources to support re-entry to facilities. The RMA Working Group considered these factors across three phases and identified 24 principles based on the guidelines summarized below.

Phase 1: Identify required triggers before return to facilities

1. Centers for Disease Control and Prevention (CDC) guidance
2. Guidelines for Opening Up America Again (The White House)
3. Federal Government has lifted restriction on group gatherings
4. State, municipal, and local restrictions have expired or been lifted
5. Institution-defined health and safety metrics are met
6. Environmental support institutions and public transportation are open and available
7. Employee willingness to return to facilities
8. Institution-defined health and safety protocols
9. Organizational preparedness should be in place
10. Robust communication protocol
11. A sound business case (why)

Phase 2: Measures to have in place as the workforce begins to return to the workplace facilities

1. Communicate to all stakeholders
2. SARS-COV-2 response plan:
   A. What to do if employees or members of the public become unwell while on site at your institution and believe they have been exposed
   B. What to do if an employee or a member of the public with suspected SARS-COV-2 has recently been in your workplace
   C. Employees with sick family members
3. Your institution should have health and safety protocols to address expectations of the institution
4. Your institution should have health and safety protocols to address expectations of the employee
5. Your institution has communicated the health and safety expectations it has of its customers and other third parties
6. Your institution should implement an on-site/off-site work strategy
7. Your institution has a robust employee support system
8. Robust communication protocol
9. Incentives for returning to facilities

Phase 3: Triggers and measures for reinstating "shelter in place"

1. Your institution should have a risk tolerance to identify if and when it should return to a "shelter in place"
2. Crisis management plan
3. Identify technology and apps that will support leadership decisions and inform the workforce
5. Establish a robust communication strategy

2.1 Introduction

Pandemics exemplify the definition of fragility and resilience and require a capability for non-predictive decision-making under conditions fraught with uncertainty, randomness, and opacity. Coupled with this is the fact that pandemics require continuous responses, updates to strategy, and reactions that burden the institution's most precious resource: people.

Pandemics require risk management in the now, where risk knowledge is acquired and assumptions are made in real time, demanding risk agility in solutions, and processes necessary for continued operations. Pandemics create multiple human-related issues that evolve over time, requiring unique responses, flexibility in strategy, and interdependence between your institution and public resources on a local, state, and federal level. Managing our human resources during a pandemic requires pre-planning in policy and support.

The SARS-COV-2 Workforce Return to Facilities Guidelines are designed to support the creation of policies and procedures necessary for the successful re-entry of a workforce in a manner that is consistent, has efficacy (in the areas of health, prevention, and safety), and can be communicated fully across the institution.

The SARS-COV-2 Workforce Return to Facilities Plan is an operational document designed to complement the existing emergency plans of the institution and business continuity and resilience strategies, and to provide the leadership with a foundation for preparation, planning, and response for workforce return to the various facilities during the management and recovery stages of the SARS-COV-2 pandemic.

2.2 Current Knowns as of August 2020

COVID-19 is a disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-COV-2)[6]. SARS-COV-2[7] was first detected in the city of Wuhan, China, in December 2019, after a cluster of patients with pneumonia of unknown cause was reported to the World Health Organization (WHO). [8]

- On January 30, 2020, the International Health Regulations Emergency Committee of the WHO declared the outbreak a "Public Health Emergency of International Concern" (PHEIC).
- On January 31, 2020, U.S. Department of Health and Human Services (HHS) Secretary Alex M. Azar II declared a Public Health Emergency (PHE) for the United States to aid the U.S. healthcare community in responding to SARS-COV-2.
- On March 11, 2020, the WHO publicly characterized SARS-COV-2 as a pandemic. This meant that the disease had spread worldwide. It was the first time that a coronavirus has led to a pandemic.[9]
- On March 17, 2020, the Office of Management and Budget issued a memorandum requiring agencies to take appropriate steps to prioritize all resources to slow the transmission of SARS-COV-2. In order to achieve this posture, consistent with The President's Coronavirus Guidelines for America, the Government immediately adjusted operations and services to minimize face-to-face interactions, especially at those offices or sites where people may be gathering in close proximity or where highly vulnerable populations obtain services.[10]
- On April 27, 2020, it was reported that an experimental coronavirus vaccine developed by Oxford University has protected six monkeys from "heavy quantities" of the pathogen — a promising breakthrough in the worldwide race for a cure. The current status is that researchers have identified a vaccine candidate and are working towards the first clinical testing phase.
- On April 30, 2020, the Director-General declared that the outbreak of COVID-19 continued to constitute a public health emergency of international concern.
- On May 29, 2020, the CDC stated that the cumulative COVID-19 associated hospitalization rate was 73.3 per 100,000, with the highest rates in people 65 years of age and older (229.7 per 100,000) followed by people 50-64 years (113.4 per 100,000). Hospitalization rates are cumulative and will increase as the COVID-19 pandemic continues.[11]
- On August 24, 2020, the CDC stated that it is using multiple surveillance systems run in collaboration with state, local, and territorial health departments; public health, commercial, and clinical laboratories; vital statistics offices; health care providers, emergency departments; and academic partners to monitor COVID-19 disease in the United States.[12]

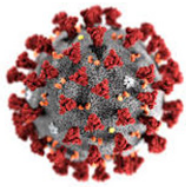


Figure 1 SARS-CoV-2, University of Arkansas for Medical Sciences

Phase 1: Identify required triggers before return to facilities

Institutions should have reliable mechanisms to develop policies and procedures based on sound, current scientific knowledge of how the disease

6 Coronaviruses are a family of viruses that infect birds and mammals (this includes humans!). Typically, they cause mild respiratory symptoms similar to the common cold, but can lead to death, often in those that are already immunocompromised.

7 Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) is the virus strain that causes coronavirus disease 2019 (COVID-19), a respiratory illness. It is colloquially known as the coronavirus and was previously referred to by its provisional name 2019 novel coronavirus (2019-nCoV). SARS-CoV-2 is a positive-sense single-stranded RNA virus. It is contagious in humans, and the World Health Organization (WHO) has designated the ongoing pandemic of COVID-19 a Public Health Emergency of International Concern.

8 Understanding the Novel Coronavirus (COVID-19), last updated 31 March 2020. Retrieved from: https://www.goinvo.com/vision/coronavirus/.

9 COVID-19 " the vaccine development, Oxford" " the Vaccine Group, Department of Pediatrics, Clinical " the Vaccine Research and Immunization Education, March 2020. Retrieved from: https://www.ovg.ox.ac.uk/news/covid-19-vaccine-development.

10 Veterans Health Administration - Office of Emergency Management, COVID-19 Response Plan Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan Version 1.6 March 23, 2020. Retrieved from: https://www." the Organization".gov/opa/docs/VHA_COVID_19_03232020_vF_1.pdf

11 COVIDView, A Weekly surveillance Summary of U.S. COVID-19 Activity, May 29, 2020. Retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/past-reports/05292020.html.

12 COVIDView, A Weekly surveillance Summary of U.S. COVID-19 Activity, May 29, 2020. Retrieved from: COVIDView, A Weekly surveillance Summary of U.S. COVID-19 Activity, May 29, 2020. Retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/past-reports/05292020.html.

spreads and impacts humans. Institutions should consider what sources of information they are dependent on and if they have appropriate expertise involved in policymaking.

The following triggers should be considered in determining when employees may begin returning to the office.

1. ***Centers for Disease Control and Prevention (CDC) guidance.***
   You should follow any current guidelines from the CDC to ensure adherence to national standards and best practices.
2. ***Guidelines for Opening Up America Again (The White House).***
   Opening Up America Again is a three-phased approach based on the advice of public health experts.[13] The proposed phased approach is based on up-to-date data and readiness, mitigates risk of resurgence, protects the most vulnerable, and is implementable on a statewide or county-by-county basis at governors' discretion.
3. ***Federal government has lifted or eased restrictions on group gatherings.***
   Shelter-in-place or stay-home orders have been lifted or relaxed. Limitations to the size of groups as well as occupancy limitations may still exist and drive prioritization of return to facilities.
4. ***State, municipal, and local restrictions expire or are lifted.***
   Group size limitations have been lifted. Shelter-in-place or stay-home orders have expired, been lifted, or relaxed. Shelter-in-place restrictions may vary across an institution's geography and physical locations of employees.
5. ***Institution-defined health and safety metrics are met.***
   Full consideration should be given to all applicable risk types, including operational, legal, strategic, and reputational risks. While federal, state/provincial, and local restrictions may be rescinded, in whole or in part, institutions should consider whether the criteria used to make such determinations satisfy the institution's risk appetite. Institutions should assess and consider the following:
   - The rate at which the virus is present in the geographies in which it operates. For example, an institution may consider adoption of a population-based metric to consider implementation of Phase 2, return to facilities:
     - Example: Fifty or fewer reported new cases per 100,000 people in each of the prior 14 days. In practice, an area with a population of 800,000 people would need to have fewer than 400 new confirmed cases reported in the past 14 days to meet the target.
   - Absence of mass outbreaks in the geographies in which the institution operates. Institutions should consider defining what constitutes a mass outbreak (e.g., 10 or more persons at a facility) and consider whether, and the extent to which, any mass outbreak has occurred over the prior 14-day period.
   - The extent to which hospitals located in the institution's geography have experienced a reduction in SARS-COV-2 cases, i.e., consider the extent to which area hospitals are operating at or near capacity.
   - Institutions should consider evaluating multiple return-to-office scenarios and conduct the appropriate corresponding analysis and risk assessments.
6. ***Environmental support institutions and public transportation are open and available.***
   These programs should be operating and supporting employees returning to work. Examples include but are not limited to:
   - Schools
   - Dependent care facilities
   - Afterschool programs and summer camps
   - Modes of transportation - if mass transit is not an option, consider providing an alternative to the workforce
   - Access and capacity of health care facilities
   - Restaurants which support an institution's facilities such as restaurants, coffee shops, and convenience stores
7. ***Employee willingness to return to facilities.***
   Employees should be surveyed to determine if they are willing and able to return to the office. Considerations should include but may not be limited to the following:
   - Whether the necessary social support institutions and transportation systems are open
   - Mental and emotional preparedness of the employees
   - Accessibility of mental and emotional support

13 Guidelines for Opening Up America Again, White House. Retrieved from: https://www.whitehouse.gov/openingamerica/#criteria.

8. ***Institution-Defined Health and Safety Protocols.***
   Physical locations should be able to support the institution's on-site/off-site work strategy (Phase 2).
   - Characteristics and geography of physical locations
   - Identify a unique "social distancing" metric based upon individuals being able to maintain a distance of at least six feet
   - Limit the number of individuals that may gather in a space
   - Determine the appropriate/maximum number of employees per square foot for each facility
   - Ability to successfully social distance
   - Accessibility of physical location while taking into consideration physical location restrictions of employees
   - Response protocols for situations in which an infected employee returns to the workplace
9. ***Organizational preparedness should be in place.***
   Your institution should consider the controls required to provide a safe and healthy environment for employees and customers.
   - Flow of traffic – entry and exit of locations
   - Ability to clean and disinfect all areas
   - Controls for multi-touch surfaces and group settings (restrooms, conference rooms, breakrooms, water fountains, elevators, stairwells, door handles, print and copy machines)
   - Ventilation systems – higher grade filters
   - Ability to provide personal protection equipment (PPE) and the PPE supply chain is able to meet the demand, including both the amount of equipment needed and over an appropriate extended duration
10. ***Robust communication protocol.***
    Communication with employees on all the above considerations is paramount to establishing a sense of order and safety as employees begin returning to the office. Additional communications will be required for regulatory agencies, and in response to media inquiries.
11. ***A sound business case (why).***
    Institutions should determine the motivation for returning employees to the office in a determined timeframe and order having due regard to the following considerations, among others:
    - Internal controls which are too expensive or difficult to sustain on a longer-term basis
    - The needs of customers and other stakeholders which are not being adequately met in a remote or work-from-home environment
    - The health and safety of the institution's employees and other stakeholders
    - The need for the institution to take a leadership role in its local communities in converting from shelter-in-place restrictions to returning to corporate facilities to sustain or positively impact local communities
    - The reputation of the institution
    - The impact to the institution's business strategy

Consider which roles require an on-site setting and which functions can continue to be effectively performed in a remote environment.

Phase 2: Measures to have in place as the workforce begins to return to the workplace facilities

Once employees are permitted to return to the office, what actions will the institution take to provide employees a high level of confidence that they are returning and working in a safe and healthy environment? In addition to the suggestions below, all relevant stakeholders should understand and embrace that health and safety requires a partnership between and shared responsibility among the employees and the institution.

General Principles

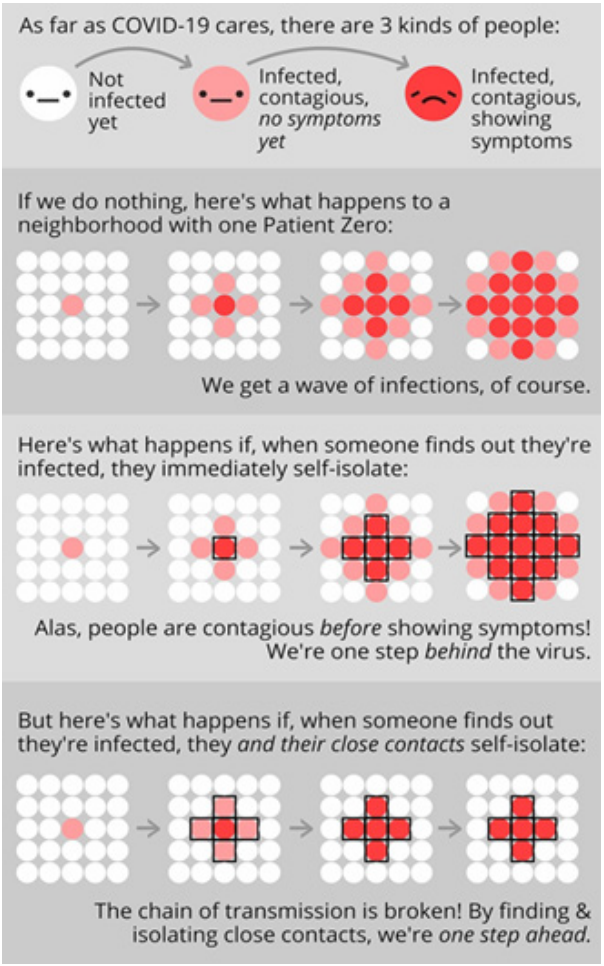
- Employee safety is of paramount importance
- Senior and executive management will lead by example
- Foster a "safe" work environment where employees are encouraged to abide by health and safety standards without fear of retaliation or job loss.

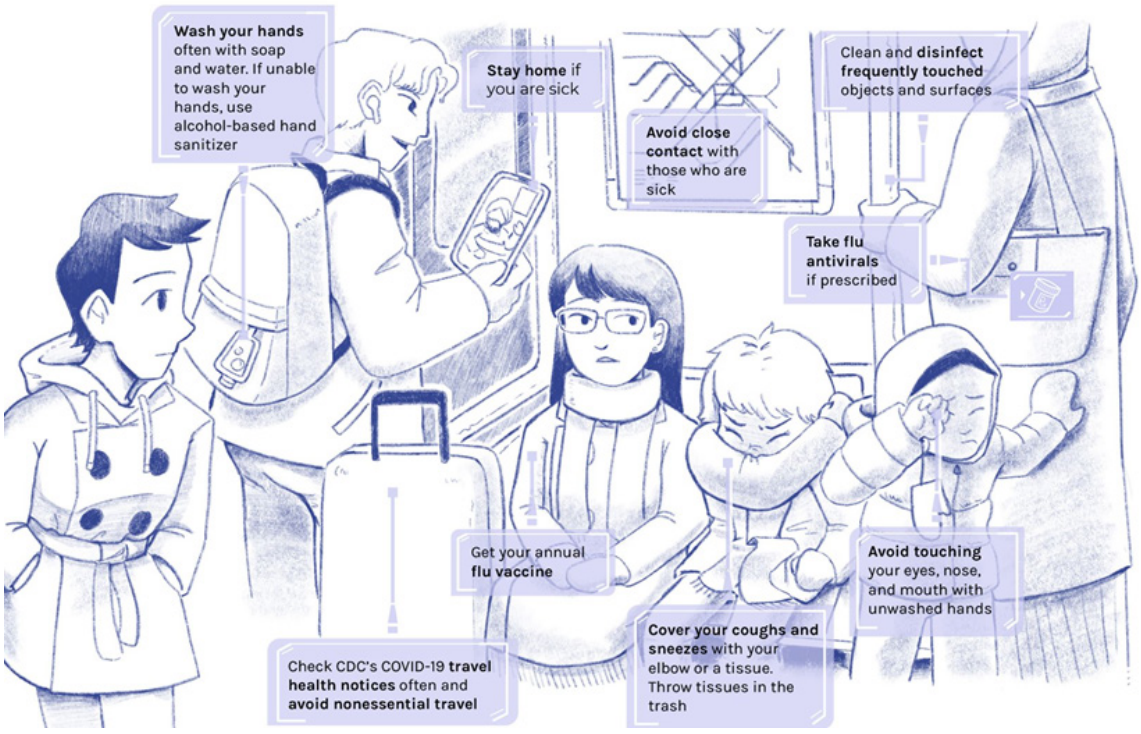
1. ***Communicate to all stakeholders.***
   The institution should be able to answer and support "why" and "who" as employees transition to an on-site environment. Consider which roles require an on-site setting and which functions can continue to be effectively performed in a remote environment. Considerations should include but may not be limited to:
   - Ability to most effectively service customers
   - Productivity impacts (e.g., some functions may be more productive in the office due to availability of technology, etc.)
   - Participation in the broader communities' efforts to re-start the local economy
2. ***SARS-COV-2 response plan.***

The institution should address steps that would be taken if an employee becomes SARS-COV-2 positive or has been in contact with someone with SARS-COV-2 while maintaining confidentiality.

- **What to do if employees or members of the public become unwell and believe they have been exposed**
  - If someone becomes unwell in the workplace and there is reason to suspect contact with SARS-COV-2, the person should be removed to an area which is at least six feet away from other people. If possible, find a room or area (temporary quarantine place) where isolation can occur behind a closed door, such as a staff office. If possible, open a window for ventilation. The affected person should remain at least six feet from other people. The person should avoid touching people, surfaces, and objects, and should cover both mouth and nose with a disposable tissue when coughing or sneezing. The tissue should be placed in a bag or pocket until it can be thrown in a trash bin. If tissues are unavailable, a person should cough and sneeze into the crook of the elbow.
- **What to do if an employee or a member of the public with suspected SARS-COV-2 has recently been in your workplace**
  - For contacts of a suspected case in the workplace, follow the guidance given by your local/state/federal authorities. Employees should contact the appropriate leadership or workplace about their status and identify staffers who have been in contact with them.
    - If a worker is confirmed to have SARS-COV-2, leadership should inform fellow workers of their possible exposure to SARS-COV-2 in the workplace but maintain confidentiality
    - Workers exposed to a co-worker with confirmed SARS-COV-2 should be given instructions on what to do according to organizational policies and the local/state/federal authorities´ guidance
    - Advice on cleaning of communal areas such as offices or toilets should be consistent with recommendations from the CDC, local health officials, etc.
- **Employees with sick family members**
  - Workers who are well but who have a sick family member at home with SARS-COV-2 should notify their leadership and refer to local/state/federal health services guidance as to how to assess their potential exposure and the measures to take.
  - If they develop new symptoms, or their existing symptoms worsen within the fourteen (14) day observation period, they should call their health services for reassessment.
  - If they are unwell at any time within their fourteen (14) day observation period and they test positive for SARS-COV-2, they will become a confirmed case. If testing is not available, but the symptoms are consistent with SARS-COV-2, they may nonetheless be considered as a confirmed case.
  - Staff who have not had close contact with the original confirmed case do not need to take any precautions other than monitoring their health for symptoms and can continue to attend work.
  - A confirmed case of SARS-COV-2 in the workplace will cause anxiety among co-workers and some may become stressed. Clear communication is important, as is directing workers to reliable sources of information about SARS-COV-2. Leadership should be supportive, understanding, and as flexible as possible on work arrangements.

3. ***Your institution should have health and safety protocols to address expectations of the institution.***
   - Communication protocol for potential exposure when an employee, an employee's social network, or customer has been confirmed with SARS-COV-2
   - Business travel policy and on-site visitor policy
   - Provide employee training if PPE is required. Training should follow and meet the CDC recommendations
   - Availability of personal hygiene supplies (e.g., hand sanitizer, wipes, etc.)
   - Frequently scheduled cleaning and disinfecting of the workplace
   - Dedicated disinfecting stations at all common touch areas (bathrooms, printers, breakrooms)
   - Close all areas of congregation and shared amenities, to include the following:
     - conference rooms – continue with virtual meetings
     - gyms
     - cafeterias, breakrooms, and shared coffee machines
     - water stations
     - vending machines
   - Standardized garbage collection and disposal – establish designated PPE disposal areas and strengthen management of collection and removal
     - Incorporate HR and employee relations to enforce health and safety protocols
   - Review and enhance HR employee privacy protocols to be inclusive of SARS-COV-2
   - Medical services - isolated areas for medical observation
   - Establish and communicate health and safety standards specific to customers who enter the workplace
4. ***Your institution should have health and safety protocols to address reasonable expectations of your employees.***





- Immediately notifying management if an employee feels unwell or has come in contact with anyone who has tested positive for SARS-COV-2
- Staying home if sick and immediately returning home if an employee begins to feel unwell during the day
- Complying with any PPE expectations of the employer (to include commute to and from workplace). Such recommendations are advised to reduce exposure
- Complying with social distancing guidelines and avoiding physical contact with others
- Adhering to social distancing guidelines and other protective measures when outside the office (e.g., PPE, hand washing, etc.)

5. ***Your institution has communicated the health and safety expectations it has of its customers and other third parties.***
   - PPE requirements – consider requiring and providing PPE to customers
   - Stagger and/or implement thresholds for customer and third-party access to the workplace – consider allowing workforce to enter workplace and establish routines before allowing customers on site

6. ***Your institution should implement an on-site/off-site work strategy.***
   Your institution should have a proactive approach to controlling access to workspaces and when they are accessed. Employees may be staggered into teams with each team working two weeks on site, and two weeks remotely. Teams should alternate schedules. Staggering teams may minimize on-site staff and permit the identification of non-symptomatic cases. This approach will allow automatic self-quarantine and allow time for regular cleaning and disinfecting of work areas.
   - Management identifies work groups and executes the strategy
   - Dedicated work groups have access and work in dedicated spaces/buildings
   - Alternate two weeks on site, two weeks remotely

7. ***Your institution has a robust employee support system.***
   Employees know where to turn when managing the mental/emotional aspects of returning to the office. Such systems should help address items including but not limited to the following:
   - Employee morale
   - Mental health
   - Work/home stress
   - Anxiety

8. ***Robust communication protocol.***
   Communication is the key to managing uncertainty and anxiety among employees and customers.

9. ***Incentives for returning to work.***
   Consider external scenarios/habits where employees may have contact or exposure off site. Create an environment where employees are able to stay on site.
   - Catering meals and drinks from a trusted vendor – meals should be individual meals, not buffet style
   - Transportation – prepaid parking, reimburse mass transit costs

Phase 3: Triggers and measures for reinstating "shelter in place"

Management of a pandemic, as with any urgent public health situation, requires certain decisions that balance potentially conflicting individual, organization, and public interests. It is recommended that the organization define a list of triggers that will reinstate the return to the original "shelter in place" mandates, regardless of the level of return to facilities achieved. These should include an institution's physical locations, and the geography of physical locations as well as employees.

The triggers should be defined and regularly updated based on three evolving medical constructs:

- CDC advancements in guidance is for clinicians caring for patients with confirmed infection with SARS-COV-2 (COVID-19).[14]
- COVID-19 testing is available to at least 15% of the U.S. population, and/or home testing is available on demand.[15]
- A COVID-19 vaccine is readily available to the U.S.[16]

1. ***Your institution should have a risk tolerance to identify if and when it should return to a "shelter in place."***
   Full consideration should be given to all applicable risk types, including operational, legal, strategic, and reputational risks. Some examples of a trigger may include, but not be limited to, the following:
   - The rate at which the virus is present in the geographies in which it operates. For example, an institution may consider adoption of a population-based metric to consider implementation of phase 3, return to shelter-in-place:
     - Example: If the number of reported new cases per 100,000 people in each of the prior 14 days exceeds 50. In practice, in an area with a population of 800,000 people, the recording of 400 or more new confirmed cases over a 14-day period may trigger a return to shelter-in-place.
   - Increase of mass outbreaks in the geographies in which the institution operates. Institutions should consider defining what constitutes a mass outbreak (e.g., 10 or more persons at a facility) and consider whether, and the extent to which, any mass outbreak has occurred over the prior 14-day period.
   - Trigger should be unique to the institution such as
   - Population density
   - Employee commuting plan (city to city, multi-state workforce)

2. ***Crisis management plan.***
   In the event your institution's risk appetite has been exceeded, determine the appropriate leaders needed to implement "stay home" protocols.
   - Emergency communication system in place to notify employees of "stay home" orders.

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14 Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19). Retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.

15 First at-home COVID-19 testing kit authorized by the FDA, LabCorp, which makes the test, is prioritizing health care workers and first responders, By Nicole Wetsman Apr 21, 2020, 9:35am EDT. The first FDA-authorized, at-home test to detect coronavirus, Pixel by LabCorp, is now available for $119. The test will not be billed directly through insurance and must be paid out of pocket Retrieved from: https://www.contagionlive.com/news/covid-19-vaccine-trial-england. https://www.theverge.com/2020/4/21/21229273/home-coronavirus-test-labcorp-fda-ppe-swab-pixel-health-care.

16 In Race for a Coronavirus Vaccine, an Oxford Group Leaps Ahead, New York Times, Published April 27, 2020, Updated April 30, 2020, 6:01 a.m. ET. Investigators from the University of Oxford have begun testing a potential vaccine for coronavirus 2019 (COVID-19) in 1100 volunteer patients, and are anticipating results may take 2-6 months. In addition, scientists at the Jenner Institute prepare for mass clinical trials, new tests show their vaccine to be effective in monkeys. Retrieved from: https://www.nytimes.com/2020/04/27/world/europe/coronavirus-vaccine-update-oxford.html.

3. ***Identify technology and apps that will support leadership decisions and inform the workforce.***
   Technology may provide a strategic advantage to decisions made during the pandemic. There are a number of applications for both Apple and Android that are entering the market to assist organizations in managing health and other information during the pandemic.[17]
   - The HIPAA-compliant, COVID-19 Response Management application[18]
   - COVID-19 Employee Safety and Business Continuity Tracker[19]
   - GetWellNetwork's apps connecting patients to a virtual physician[20]
   - HealthMap-Outbreaks Near Me (Apple and Android)[21]
   - Sickweather - Sickness Forecasting & Mapping (Apple and Android)[22]

4. ***Establish a robust communication strategy.***
   Communication with employees on all the above considerations is paramount to establishing a sense of order and safety in the event of an outbreak. Additional communications will be required for contractors, stakeholders, customers, external authorities, and regulatory agencies, and in response to media inquiries.
   - Prepare for the next wave, applying experience from previous phases.

17 Can Smart Phone Apps Help Beat Pandemics?, Posted on April 9th, 2020 by Dr. Francis Collins. Retrieved from: https://www.appian.com/covid19-response-management/. The Appian COVID-19 Response Management application is provided at no-cost for any private or public organization of 1000 employees or more. Appian customers also get no-cost access. The offer includes unlimited users and unlimited usage of the application for six months. There are no associated startup costs, hidden fees, etc.

18 The HIPAA-compliant, COVID-19 Response Management application. Retrieved from: https://www.appian.com/covid19-response-management/.

19 COVID-19 Employee Safety and Business Continuity Tracker. Retrieved from: https://www.pega.com/covid-19-tracker.

20 GetWellNetwork's connecting patients to a virtual physician. Retrieved from: https://www.getwellnetwork.com.

21 Outbreaks Near Me. Retrieved from: https://www.healthmap.org/outbreaksnearme/.

22 Sickweather - Sickness Forecasting & Mapping. Retrieved from: http://www.sickweather.com.