

# Hospital Preparedness Program Health Care Coalition Webinar

September 29, 2020

*Event Transcript*

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Jack Herrmann: I want to thank you all for joining us today. During today's meeting, we'll kick off with some updates from the COVID-19 Healthcare Resilience Working Group and ASPR TRACIE. Followed by those updates, Dr. John Hick will discuss the COVID-19 designated hospitals and followed by his presentation will be a presentation and discussion by Dr. Nimalie Stone related to the Nursing Home COVID-19 Federal Strike Teams. Finally, we'll have time for open discussion and some questions and answers. I want to thank all those who responded to the poll question in the event invite, which asks what topics are top of mind for you. We want to use your submissions to set the agenda for future calls. So, thank you again for submitting those. Many people provided information on or want information on COVID-19 testing, future vaccine dispensing strategies, as well as ways to address staff shortages. Another common topic that was submitted was related to the availability of PPE supply and PPE preservation strategies in the short term. Before we get to calls to address those topic areas, I'd recommend that you take a look at the PPE-related resources that are available through ASPR TRACIE's resource library including [a] recording for the COVID-19 Optimizing Health Therapy and PPE Supplies webinar, which took place on September 24. And then we look forward to covering some of these other topic areas in future webinars. I'd also like to provide another [unintelligible] familiar with. The health care and public health sector is seeing an increase of ransomware attacks across the sector. We encourage you to take all necessary precautions to mitigate the risk of being impacted. Ransomware attacks involve using a type of malware that encrypts the victim's data, making the system inaccessible until the ransom is paid. Oftentimes, the attacker will not bother to lock the user data even after a ransom is paid. We do encourage you to look at resources that have been developed by the HHS Health Sector Cybersecurity Coordination Center, DHS Cybersecurity and Infrastructure Security Agency, known as CISA, and from the FBI to get additional information about these recent attacks. We also encourage you to seek out information [audio cuts out for a few seconds]

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Angela Krutsinger: Jack, you're muted.

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Jack Herrmann: Sorry, electronic muting happening here for some reason, it must have been some kind of cyber issue. So, did folks hear my update on the ransomware attacks?

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Angela Krutsinger: Up to the FBI.

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Jack Herrmann: Okay, great. So those were the resources that we are encouraging you to take a look at as well as some ASPR TRACIE resources. Now before I hand it over to our first speaker, I want to thank

those who responded to the poll question in the invite again, and based on those poll responses, we'd like to conduct a short poll now which asks you to identify your biggest challenge related to some of the topics that that you submitted. You'll see it here in the polling question. If you do select "other", please type your answer in the chat box. Thank you for your participation and appreciate your responses to this polling question. And as I mentioned, we'll try to incorporate some of these topics into future Health Care Coalition calls. Now I want to hand it over to Matt Watson, who will share some updates from the COVID-19 Healthcare Resilience Working Group.

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Matt Watson: Great, thanks for that Jack. As Jack said, my name is Matt Watson, and I am a Senior Advisor and Hospital Team Lead for the COVID-19 Healthcare Resilience Working Group. Today, I'd like to give a few brief updates on some of the Working Group's recent efforts, the first being a pair of documents which were recently released. They are posted on ASPR TRACIE, and we'll make sure that you have links available to them. These documents directly support the Medical Operations Coordination Cell, or MOCC, concept. Briefly, the MOCC is a mechanism which aims to optimally distribute patients or balance the load of patients either in a region or state. And the two newly released documents are those which we've put out there to provide you with a little bit of extra guidance with respect to the initiation of load-balancing or load-leveling operations at the facility level as well as some principles on which that can be used to evaluate the effectiveness of those efforts. We'll make sure that you have links to both of those. Secondly, I'd like to provide an update on the Flu LEAD Project. Flu LEAD, or Linkages to End Access Disparities, is a joint initiative between the Healthcare Resilience Working Group, HRSA, and HUD and aims to increase site-wide influenza vaccination coverage in HUD-assisted communities during the 2020-2021 influenza season. The program will match HUD-assisted public housing authorities with HRSA-funded health centers to stand up flu vaccine clinics, provide technical guidance, conduct community outreach, and share best practices. On September 15, the Healthcare Resilience Working Group hosted a joint kickoff call for HUD and HRSA partners to learn more about the Flu LEAD initiative, which was well attended with over 115 attendees. So far, Flu LEAD has matched 13 public housing authorities and health centers and will continue to make matches on a rolling basis. Next, I'd like to move to the Telemedicine Hack, or TM Hack, Program. TM Hack is a 10-week learning community that aims to accelerate telemedicine implementation for ambulatory care providers. The goal of TM Hack is to have 90% of participants conducting and billing one or more video-based telemedicine visits by September 30, 2020. We completed the fifth and final TM Hack session on making telemedicine part of your permanent practice on September 16 with over 1,200 total participants from 50 states and 10 countries. The fifth and final office hour discussion occurred last Wednesday, September 23. Moving forward, the HRSA-funded Telemedicine— or sorry, Telehealth— Resources Center will continue to host sessions under the TM Hack banner. The first session to be held October 21 will hold focus on Telehealth technology trends. Next, I'd like to provide an update on the EMS Mental Health Webinar. That webinar entitled "Living Well and Leveraging Adversity and Stress Over the Long Haul" was held on August 20 and had 280 participants attend. This series is designed to deliver important information to those on the front lines, and to provide practical tools and best practices for EMS and 911 agencies so they can better protect and support their workforces. Finally, the last item I'd like to cover is related to the Rural Search Toolkit. As many of you know, the Rural Surge Readiness Web Portal is a collection of the most up-to-date and critical resources for rural health care systems preparing for and responding to surge events of COVID-19. This resource can be found on the Rural Health

Information Hub, or RHlhub. Recently, there were a series of listening sessions held with over 100 representatives from stakeholder organizations to further increase awareness of the toolkit. I will now pass it to Shayne Brannman to provide some ASPR TRACIE updates. Thanks, everyone.

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Shayne Brannman: Thank you, Matt, and good afternoon, health care coalition shipmates. First and foremost, I just want to thank you on behalf of a grateful nation for your sustained efforts to help advance the preparedness, response, and recovery activities within your coalitions. I have a few TRACIE updates. I'm sure you're kind of sick of hearing about TRACIE because [unintelligible] and you'll hear more about TRACIE from a couple other speakers. We're very honored to be able to support and post a wide array of virtual resources, so let me just highlight a few for you. But again, keep coming back to ASPR TRACIE. We're continually updating and adding new resources so please check it out and if you can't find exactly what you're looking for, simply email us, call us, or do an online form, and the ASPR TRACIE crew will get right to it. One new resource we recently added was collaborating with a COVID-19 Response Assistance Field Team, or CRAFT, to highlight relevant resources gathered from their engagements with local communities in supporting the COVID-19 response in a variety of efforts such as K-12 and institutes of higher education, critical infrastructure businesses, and outreach to at-risk populations. The CRAFT resource collections are now available on ASPR TRACIE. Secondly, we [worked] with Matt Watson and others from the Healthcare Resilience Working Group and AHRQ to [complete] a series of webinars with health care professionals focusing on the health care safety programs and lessons learned in their facilities during COVID-19. In particular, we highlight a short video by Dr. Vivek Prachand with the University of Chicago Medicine. He discusses how the health system developed and operationalized the medical-necessary, time-sensitive procedures scoring system. The scoring system allowed them to ethically and efficiently manage resource scarcity and minimize provider risk during COVID-19, so I highly recommend that for you to check that out. We are in the midst— and actually, we will begin tomorrow— of doing a series of Pediatric Center of Excellence webinars. The first one is tomorrow and will feature Dr. Kadlec [from] ASPR, kicking it off with a focus on child health and wellness, and will take place at 1:30-2:45 ET tomorrow. We have a few slots remaining if you want to still sign up for that webinar, but we have three additional webinars coming up and all that information is included in Jennifer Hannah's weekly outreach, so please check that out and register because those slots are filling up, and we look forward to having you participate on that. Last, have to do a little promoting here. ASPR TRACIE turned five years old this month, and we would like to take this opportunity to say we wouldn't have got there without your continued support, insightful technical assistance requests and recommendations, and many of you on the line today are part of the subject-matter expert cadre at ASPR TRACIE, so thank you for helping us. We're nearing 1 million visits to ASPR TRACIE, and we process more than 7,500 technical assistance requests. And actually just in the month of September alone, we've processed over 400 technical assistance requests, and we're working very hard, and I just want to remind you that we still have people on staff to assist you with the health care coalition estimator tool. This is a good segue for me now to introduce Dr. John Hick, who is your next speaker [and] who is at Hennepin Health, but most importantly, he's ASPR TRACIE's senior editor, and he works tirelessly to provide you tools and tip sheets and working with the TRACIE crew to meet your needs, but we only know what we know. So, if you have suggestions on how we can improve our services to you, please reach out to us. It's now my honor to pass it over to Dr. John Hick. Thank you.

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Dr. John Hick: Thanks so much, Shayne. It's an honor to receive that handoff from you. We wouldn't be where we are with ASPR TRACIE, except for the day in and day out attention that Shayne Brannman provides not only to our technical operations, but also to the work that we do and shaping the work that we do. She has been an absolute godsend to TRACIE, so just thanks Shayne for all your tireless hard work and also thanks to the support from the Working Group as well as the NHPP program for ASPR TRACIE and thanks to you, our SMEs, and those who provide questions and content and review for a lot of materials that we put out there. So one thing that I wanted to just take a few minutes to bring you up to speed on today is that we're putting together some resources and a hospital toolkit, and we hope to have this finalized within the next, you know, month or two in order to provide a ready resource on a variety of topics for hospitals doing planning for COVID-19. And as part of that, we were soliciting and I want to ask for some assistance today with identifying designated health care facilities for COVID-19 and I'll talk a little bit about what we've learned so far in the hopes that that will be of interest to you.

Dedicated hospitals for COVID-19 was a popular point of discussion very early on in the planning process for response. In some communities, there was consideration of designating acute care hospitals for care of COVID-19 patients only and, in fact, in some states, including New York— certain hospitals, including one on each borough— were designated for COVID-19 care. In reality, the designation of acute care hospitals did not necessarily work out well because people presented to the emergency department with conditions other than COVID-19. EMS, in many cases, continued to bring those hospitals' patients that were not a COVID-19, so it was very difficult to segregate those patient presentations. Many hospitals did institute a "two-entrance" policy where those with suspect COVID-19 symptoms, you know, were directed to one entrance and those who did not have symptoms of COVID-19 went to another. Certainly, precautions need to be taken across both of those departments and all of those areas because of the prevalence of asymptomatic patients with COVID-19 that were able to transmit the virus to health care providers and those around them. At the same time, this can allow the streamlining of sample collection screening, testing evaluation, and disposition when there's focused efforts to provide COVID-19 support and care. Examples of that include connection with home-based programs for monitoring, including provision of oxygen saturation monitors and other resources and materials. But suffice it to say the use of designated facilities and sub-parts facilities units and facilities that are used within health care systems for referral of COVID-19 patients has actually been somewhat successful and we're continuing to gather examples of that. And yet, we would like to know about any designated facilities that have been used that you are aware of. If you can send us an email to [askasprtracie@hhs.gov](mailto:askasprtracie@hhs.gov) or communicate with your field project officer or with NHPP staff, we can collect and further interview those locations. But what we've learned so far is that there's a couple of potential applications of this that have a lot of residents for health care systems in particular, so in one of those large systems, there was already a long-term acute care (LTAC) hospital that was functioning and provided some support for discharge from that hospital system as an intermediate step to discharge to skilled nursing or discharged to home, essentially a long-term rehabilitation center capable of providing acute care. That facility was essentially evacuated and was cleared of the patients in the facility to other rehab facilities. Modification and retrofitting of the HVAC system was conducted to provide additional air exchanges and enhance negative flow in some of the units and that facility was essentially created as a designated COVID-19 treatment facility for that health care system. So, any patient coming in with COVID after they were initially stabilized in an intensive care environment was transferred to this facility and the advantages to that were significant. There are a lot of patients with COVID-19, and especially early on that required protracted weaning from ventilators, and so this is a situation that when you have

dedicated pulmonology and surgical tracheostomy like ENT and other staff available, they can be very efficient and effective at taking care of these patients and weaning them long term from ventilators. Concentrating those patients in one facility for that larger health care system made a lot of sense. They were also able to conduct team-based interventions, whether that was airway or proning or other things that were facilitated by having a dedicated facility. They were able to control the entire facility from a PPE standpoint, expecting a very systematic, rigorous, and uniform application and PPE strategies throughout the facility, which was very beneficial to the staff because they knew every day they would be taking care of COVID patients and they knew that they had specific policies, processes, and standard work at that site that would be applied. Now, they also did leverage a lot of learning from that site to modify some of the existing care processes at their other locations and other hospitals with very good success so an interdisciplinary team worked very hard on quality assurance processes to make sure that patients and other facilities were benefiting from the lessons learned at that COVID-designated facility. We've also seen designated facilities within health care systems that were not designated as an overall facility but were designated as a referral facility within that system, especially again for long-term ventilatory management. In many cases, hospitals used existing ICUs and modified those intensive care architectures in order to accommodate sub-acute patients who were post-intensive care but required prolonged ventilatory support and weaning, and this was, again, very effective for a number of hospitals. They were able to really dedicate respiratory therapy, pulmonology, and then the rehab occupational therapy, physical therapy, and the discharge coordination services to those locations for these relatively complex patients that had significant ongoing needs. The ability to concentrate these patients in a location where those care teams could really focus their efforts on the unique needs of these patients worked out very well for those health care systems and they regarded them as a best practice. A number of hospitals that are standalone hospitals are not part of a large system that could support this kind of activity certainly wouldn't have this easily available, although they might have a resource like this in their region that they could refer to. What has been done in some of those locations in order to cope with some of the issues with prolonged to ICU bed occupancy for patients that require long-term ventilatory support is a program that originated in the upper Midwest actually, with a large tertiary center, that used their critical access hospitals, trained some of those staff and critical access hospitals to provide care for long-term ventilated patients, and set up telemedicine and telehealth consultations with pulmonology and the other support services needed to work on long-term ventilator weaning. The critical access hospitals were able to use their swing bed designations to accept those patients from the tertiary care center, who were stable but in need of continued ventilatory support that did not need ongoing dialysis or major acute interventions that were relatively stable and really required ventilator management over the long haul. So, they were able to take those patients from the tertiary center, unloading that tertiary center's ICUs, continuing inpatient care in their swing beds until such time as the reimbursement for that inpatient stay expired, and then transitioning to billing skilled nursing codes in those facilities with long-term respiratory support and then transition into skilled nursing, either at that facility or discharge to a skilled nursing facility. That was able to leverage some significant capacity within the critical access hospitals with appropriate training to provide support for those discharges from the ICU units in the tertiary care center. Having a designated or multiple designated critical access hospitals able to accept these sub-acute patients provided a significant outlet for the ICUs at the tertiary care centers. With that, I hope that provides a little bit of a summary of some of our issues that we recognize with designating COVID facilities that designate an acute care hospital for care only of COVID patients is unlikely to be successful. Although partitioning of the flow streams for

acute care of those locations can be highly beneficial in structuring the services provided but that focus consideration of the need for long-term acute care, especially in ventilator weaning in environments that may differ from a major tertiary care center and may allow concentration of these patients within a health care system, or actually dispersal of these patients from a tertiary center to smaller facilities that have been designated and with appropriately-trained staff to meet their ongoing care needs. This can be a very highly successful strategy for systems to unload the tertiary care centers, but also provide very focused COVID-specific care to a cohort of patients with ongoing respiratory needs, in particular. So some good learnings I think that we're happy to pass along, but we would look forward to hearing more about any COVID-specific facilities or strategies that you all are aware of out there that we can potentially conduct some ongoing interviews and include those materials in the upcoming hospital toolkits. Once again, thanks for your support of ASPR TRACIE, your engagement with us. ASPR TRACIE is only as good as the questions that we get, the materials our SMEs provide, and of course, our dedicated staff is always available to handle questions, try to get you to the right resources, and does an amazing job coming up with really great answers to the technical assistance questions in a short period of time. So, thank you for your service and thanks to the TRACIE team for all their diligence during COVID-19. As we've had drastic increase in our technical assistance requests, as you can imagine, and they have handled it with the adept skill of a catcher blocking down bad pitches and making sure everything stays under control and keeping the game moving, so thanks to all and would welcome any questions. Otherwise, I will turn it over to Dr. Namalie Stone from CDC to talk about the next presentation. Thank you.

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Maria Ramos: This is just a reminder that if you have any questions for Dr. Hick, you may submit a written question via the chat icon, or if you wish to ask a question verbally, please feel free to select the participants icon at the bottom of your screen and then select the raise hand icon on the right-hand side.

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Dr. John Hick: And certainly, if you do have questions down the line or comments or feedback we welcome those at any point, but in the interest of keeping our agenda moving along, over to Dr. Stone from CDC.

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Dr. Nimalie Stone: Thank you very much, Dr. Hick, and good afternoon to all of you. It's really a pleasure for me to be able to come and have a dialogue with you. I hope that we can talk through a little bit of what we're seeing with our response activities in long-term care and get some real feedback from all of you as far as how local efforts have really contributed meaningfully to this response. And I just want to thank my colleague, Abigail Viall, who is the long-term care lead for the Healthcare Resilience Working Group. I work at CDC at the Division of Healthcare Quality Promotion, and my team leads a lot of the prevention and outbreak response supports for nursing homes and assisted living, so we'll go through a little bit of what we've been seeing. I know it's a little different from the agenda, but I think a lot of the findings and things we'll talk about are universal for all the different deployments that have happened. Next slide. So briefly, I thought it would be helpful to talk through just a few of the gaps and solutions that we have seen evolving over the course of this pandemic. And again, I think our main goal today is to

get to know all of you and the work that you're doing locally and how your partnerships have really helped to contribute to the preparedness and response efforts in the COVID-19 pandemic, but also I think looking forward to the future. Next slide. As I mentioned, this is just a summary of several federal deployments that have gone out to support nursing homes and assisted living facilities throughout the pandemic. I just want to, in particular, call out the dark blue circles which are indicating where CDC has been in partnership with CMS and OS sending federal teams to work with nursing homes in the midst of their response to large outbreaks. A lot of the conversations— and what we'll talk about today— really stems out of those visits and those discussions with providers as they're sharing the contributing factors and some of the challenges that they faced when they were trying to contain and respond to this infection. Next slide. Our sort of structure when we go and talk with providers again, just either in terms of preparedness or responses, is to kind of go through some of the key strategies that we've been promoting for long-term care facilities throughout the pandemic, starting with the strategies that are evolving around visitation restriction, screening visitors and health care personnel, maintaining communication with families, and really keeping connectedness between residents and families all as part of strategies to try to prevent the introduction of COVID into the centers. A lot of discussion that I think relates very much in line with the support that the coalitions can offer these centers because of the increased need for clinical monitoring and physician services, the opportunities to increase capacity for testing, which I know is still a variable issue across the country. We heard a little bit about some of the issues related to setting up COVID-designated units or designated facilities in a community and I think there have been some interesting experiences looking at long-term care facilities in this way, I'd love to hear from you if that's something that your coalitions have also explored. With all infection outbreaks we look at sort of what is the infrastructure supporting implementation of infection prevention practices at the bedside? What are the supplies? What is the ongoing support to the health care staff? Then, finally, looking at the way that centers are networking with public health in incorporating infection surveillance and reporting through the National Healthcare Safety Network, and maintaining ongoing support for staff, which I think I've seen a few comments that have also recognized that there's a lot of fatigue among workers, there's a lot of challenges to keeping this particular group of caregivers buoyed and supported in this prolonged experience. Next slide. When we catalog different themes and findings from our visits to facilities and the conversations that we have with providers as well as other partners, I don't think that these challenge points will be of any surprise to all of you. The impact on staffing during outbreaks, but also because of anxiety and fear, driving shortages leading to “all hands on deck” where people who might have been given more time and resource for administrative or quality work are at the bedside delivering resident care. The long-standing challenges with maintaining infection prevention support in these centers is access to alcohol-based hand rubs, PPE— which of course has been a variable resource and continues to be vulnerable in certain places— and certain pieces of equipment like gowns and respirators. The infrastructure to support the use of the PPE was also pretty vulnerable and not well-established prior to the outbreaks happening in these centers, and there's a lot of catch-up trying to happen as the supply disruptions and the resource limitations are continuing to contribute to gaps in practices and lapses and then testing, which is another big area of focus and capacity has increased, but they're still maintaining supply concerns and an intermittent disruptions. There's still a lot we're trying to learn about the interpretation of different test platforms that are being used, and just understanding how the surge in testing is also impacting the access to testing and the turnaround times and other parts of the community as well. Then, the ongoing need to support both residents and staff who really have been suffering for months as a result of the

prolonged stress and isolation that's been occurring. So those are probably not uncommon or novel to you all. Next slide. I want to talk about a few of the successes we've seen at the center level, quite a few investments made with engaged facilities' leadership— bringing teams of support to really understand and address the front line staff with their concerns and their fears. There's been a lot of financial and also other supports like bringing dinners and lunches, bringing groceries to families, offering hoteling sometimes if individuals are afraid to go home. There's a tremendous array of different support that have gone into place to maintain the workforce, and I think we are seeing traction toward more centers being able to dedicate staff and resources as they realize just the critical importance of this program, their infection prevention program, really being strong and sustained. This used to be a job that one person was given who had five different roles, and we've been really encouraging a lot of centers to move toward dedicated staff and really giving them that capacity to do the education, the surveillance and the ongoing, just-in-time feedback to their to their colleagues on the unit. Next slide. The other piece that I think kind of sets the stage for our discussion a little bit is how we've seen partners come to the table and provide resources and really try to allay some of the challenges that the centers have had. I think what I what I have seen with local health departments have been a capacity to bring testing services to centers that have had challenges with their own access. They've been creating forums for shared learning and exchange of best practice ideas and the health departments working with groups like the coalitions are helping coordinate the community-level response. That includes long-term care facilities and several counties and districts that we worked in really did a nice job of bringing all these groups together early in their prevention and preparedness activities and its continued to be supported as the pandemic has evolved. So with that, the last slide just poses a few questions to all of you, hopefully to learn a little bit about how the pandemic may have changed the organization or the relationships that you had in your coalitions, especially related to nursing homes and assisted living facilities. Some of the specific examples that you've been able to do to provide resources and supports to these centers over time, and how is that continuing to be sustained from your perspective. What else could we do to help support you all in this effort? Let me stop there. Thank you very much for the opportunity to hopefully just be beginning a dialogue so we can continue to learn from you. I can hand it back over, or if you think there are some folks who may want to raise their hand and respond, I'd love to hear them.

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Maria Ramos: Sure, sounds great. For those of you on the phone, we do have a list of discussion questions here that can kind of get the conversation moving. We are always interested and willing to hear from you, on your needs, and how you're doing. If you all have any comments or questions related to the questions on the screen, please feel free to submit them via written chat, or if you wish to unmute yourself and ask your question verbally, you're more than welcome to click on the participants icon at the bottom of your screen and then there raise hand icon which is on the right-hand side.

00:40:31.980 --> 00:41:20.790

Dr. Nimalie Stone: I did want to note and share with the group, especially for those of you who are just joining by phone. Terry shared that in Los Angeles, they're using the provider association, the California Association for Healthcare Facilities, that is a conduit to getting engaged with their nursing homes in the area, which is a great recommendation and hopefully one that others have been able to tap into. I think

there may be a raised hand, I'm not entirely sure of the blue icon, and I don't know if I can unmute somebody's line.

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Maria Ramos: Yes, we do have one raised hand. It looks like Robert would like to ask a question, so Robert I'll go ahead and unmute you and feel free to ask your question.

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Robert Deede: Yes, this is Robert with North Central Wisconsin. Can you hear me?

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Maria Ramos: Yes, we can hear you.

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Robert Deede: All right, thank you. So, as you may be aware, our region is surging right now, and we have some questions that are really coming in perspective that we have not had before, particularly kind of circling back to what Dr. Hicks had mentioned. The need to transfer to a designated center or outside of network. To this point we've been able to stay with patients in network, and now they're moving out. The concern that we haven't really found the answer to is insurance considerations for these folks that are being transferred out of network not because there's a desire to, but because there's the necessity to, and how we're able to protect them so they're not left with a bigger problem post-infection with regards to debt. Thank you.

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Dr. Nimalie Stone: Thank you, Robert. I will admit that I'm really glad to hear this comment and know about some of those very practical local issues, especially for residents in circumstances where their transfer and transitions are not as you say just dictated by what is in network for them. I wonder if there's opportunity to engage the state Medicaid program or some of those resources to kind of understand how to navigate the complexity of that concern, and I'm certainly going to bring that issue back to colleagues of ours that we work with at CMS just to see if there's other waivers or any kind of solutions around dealing with how to provide funds for care when people have to move.

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Dr. John Hick: Hi, John Hick chiming in here. Robert, good to hear your voice and even though the Green Bay Packers are having a much better year than the Vikings, I'll definitely take a stab at that. You raise a very important issue, especially for private insurers and a lot of times this comes down to medical necessity and availability of in-network options. If there are no good in-network options, to my indirect knowledge, the insurers have been pretty good if there is documentation that those needs can be met in a specialized facility like LTAC or other facilities and wouldn't necessarily be covered in network or hospital transfers would not usually be a network, but during a surge situation because of the need for specialized care, that really is the patient's only viable alternative or the best viable alternative. Generally, there has been a good amount of flexibility. The state ombudsman often can be a really good resource in navigating any specific issues. Fortunately, that's rarely an issue with a true emergency transfer, but for more sub-acute transfers for patient-specific needs, it's definitely something that the

families and others should make sure that they have access to resources, whether that is the state ombudsman or others, if there are problems that crop up. In general, I have to say we've been gratified at the level of flexibility that a lot of the private insurers have exhibited regarding limitation or pre-existing networks during COVID-19.

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Maria Ramos: Thank you, everyone. Looks like we have another raised hand from Janine. Janine, would you like to unmute yourself and ask your question?

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Janine Wilson: Yes. Can you hear me?

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Maria Ramos: Yes, we can hear you.

00:45:27.060 --> 00:47:52.980

Janine Wilson: Okay, thank you. I wanted to just offer some comments to the open discussions in regards to the work that we've done in North Idaho with our long-term care and our critical access and trauma centers. We initiated, through our partnerships, weekly discipline-centric conversations directly with our level two trauma centers, our nursing homes, and our assisted living homes so that we could start the movement of medical surge when we needed to support our trauma center, which was a great effort, and we still continue to do that every other week now when we're in this lull, if you will, waiting for maybe that third event to happen. I see that New York City has done very similar work. I'm sure that there's a number of us across the nation that has done that. I will say that's probably one of the best communication devices that we have had here. In regards to establishing a COVID-exclusive or even a COVID wing of one of our long-term care facilities, we have had great hesitancy to take that step. Understanding that there's funding now available almost a little bit too late, if you will, to really have our long-term care partners, take that risk. I think that that needs to be attributed to some education that needs to come to our long-term care partners, but also maybe some forward thinking from your level, Ms. Stone, to how can we get our long-term partners to engage in that risk, if you will, to open up a COVID wing or facility and ensuring that we can support them, because that's without the proper PPE, without the staff, I mean, they're losing staff faster than they're losing N95s. It makes it challenging for them, and we're in rural America out here. Thank you.

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Dr. Nimalie Stone: Thanks for this comment. Janine. I couldn't agree more with you about the assurances that a lot of these providers would need in order to take that step and try to become a resource at the community level to care for residents as they're recovering from infection and needing to transfer out of hospitals or some nursing homes have taken residents from assisted living centers that are not capable of providing the same level of monitoring and clinical support and becoming a resource and there as well. However, the anxieties that you describe are very real. The pool of staff available in a lot of our rural communities right now is very thin, so it's hard to even find volunteers. It's hard to kind of get respite, if you will, for the staff that have been working in these centers and that's part of what needs to happen, I think, in order for them to be able to maintain that level of care. I'm wondering,

some hospitals have been able to provide additional infection prevention support, education, and sometimes even staffing to the network of nursing home providers in their community. I'm wondering if anybody has seen that happen in your local area or have been able to foster some of that? Well, I think that moving forward, where these relationships have become better established with your coalitions and the long-term care provider community I do hope that this will be one of those sustaining bridges that go beyond COVID and really becomes a better connection for the whole community and the health of your communities moving forward because I think you bring tremendous, robust resources to support these providers during outbreaks and even as they're recovering. Thank you very much again for the discussion.

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Jack Herrmann: Thank you, Dr. Nimalie, I also want to thank Dr. Hick again for his presentation on COVID-19 designated hospitals. We are tracking your questions and your comments in the group chat box and we'll be sharing those with Dr. Nimalie and Dr. Hick. If after this call you have additional questions about the COVID-19-designated hospitals or support to long-term care facilities, please email us at [hpp@hhs.gov](mailto:hpp@hhs.gov), and we'd be happy to pass those questions on to Dr. Hick and Dr. Nimalie. Also, before we end the call, a couple other things. We'd love to hear from you as to how you're using your cooperative agreement funds to make impacts on your community. I would ask you to submit any of your descriptions on how you're using their funds to the [hpp@hhs.gov](mailto:hpp@hhs.gov) mailbox and we use those in many different ways— in our reports to Congress, to senior federal officials. We use them in our social media and on our website and would love to hear how you're using your funding to help support your communities. And then lastly, what I'd like to do is have Maria, if she can, put the polling question back up and if you did not have a chance to respond to that poll, I would ask that you do so now. Only about a third of you on the call actually responded, so I'm not sure, some of you who are on via telephone and not on the link probably can't participate. If you do have access to the poll and in the chat box, if you would put what your biggest challenge is there: A. testing availability, B. surge planning, C. personal protective equipment supply, D. staffing capacity, or E. Other. And then identify in the chat box what that "other" challenge is, we'd appreciate it. We are nearing the end of the hour here and want to thank you all for your patience as we work through trying to give you responses to the areas of interest that you've submitted to us. I know that these hours, for some, go by quickly and you wish you had more time to ask questions. As we continue with these routine calls, we'll do our best to try to focus on the topics that are priority for you and are of most interest. I want to thank all of our presenters today and look forward to speaking with you all on a future call. Take care everybody, and have a great afternoon.