April 2022 Hospital Association Webinar Transcript
April 21, 2022
Call Transcript

**The first four minutes of this call were not recorded, and the audio has been transcribed for reference.*

Richard Hunt: Thank you all for joining us today. I am Dr. Richard Hunt, the Senior Medical Advisor of ASPR's National Health Care Preparedness Programs, or NHPP, Branch. Before I hand it over to our first presenter, I would like to provide a brief overview of what we will cover today. Next slide.

I will provide a few ASPR Health Care Readiness Programs updates. Next, Shayne Brannman will highlight some recently published and upcoming ASPR TRACIE resources and presentations. Afterwards, Dave Csernak will lead the first of our new monthly, Regional Hospital Association panels. Finally, we will leave some time at the end for questions from the audience. I'd like to begin today's webinar with a couple of administrative updates. Next slide.

First, I'm excited to announce that the HPP recipient fact sheets for 2021 are now available on the ASPR website. They can be found by going to the Health Care Readiness Near You webpage and clicking on each individual state. The fact sheets include key programmatic information such as funding levels, spotlights on preparedness and response activities, and COVID-19 response highlights for each of the 62 HPP annual cooperative agreement recipients. A member of our team will drop a link to the website with the 62 fact sheets for your reference. Next slide.

Next, I would like to take a moment and highlight two recently published Stories From the Field. Stories from the Field provide the opportunity to highlight the hard work and accomplishments of our recipients and sub-recipients. We have recently published two new Stories From the Field, highlighting efforts in Illinois and American Samoa. Both stories provide an example of the diversity of support that ASPR funding offers recipients and sub-recipients as they bolster emergency preparedness and response. To read these stories and others, head to the Stories From the Field page on aspr.hhs.gov. For your reference, a member of our team will share the Stories From the Field page link in the chat momentarily. I will now pass it over to Shayne Brannman to present ASPR TRACIE updates.

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Shayne Brannman: Thanks, Dr. Hunt. I'm going to start off today's updates with our Climate Change Resilience and Health care System Considerations document. It provides considerations for health care executives and emergency managers who are planning for the impacts of climate change on patient health and patient surge on their health system's resilience and ability to deliver care. The second resource I'd like to share is the Crisis Standards of Care (CSC) review. In Spring 2022, ASPR TRACIE conducted a review of open-source materials to determine crisis standards of care (CSC) actions taken by each state during the COVID-19 pandemic. This included review of relevant CSC declarations and media accounts of crisis conditions at health care facilities. The summary document provides key findings from the

review and recent literature, challenges, and suggestions for future work to help ensure a more equitable, uniform response in the future. I'd also like to share the Countries Experiencing Conflict page. This is designed to assist partners providing support to the conflict in Ukraine. We have also responded to requests on cybersecurity, the role of rehabilitation professionals in disaster preparedness and response and helped draft a Job Action Sheet for health equity, diversion, and inclusion roles under incident command. For your awareness, we updated our workplace violence topic collection and our emergency preparedness modules for nurses in acute care settings. We have also recorded webinars on climate change, workplace violence, and excess mortality and COVID-19 surges. We have used our speaker series to cover targeted topics, including blood supply issues and the impact of COVID-19 on solid organ donation and transplantation. During our AHEPP session, we even covered the role of supportive and allied health care during and beyond the pandemic. Finally, I'd like to specifically highlight the upcoming Disaster Available Supplies for Hospitals (DASH) Tool which we are developing in collaboration with Health Care Ready, RDHRS 7, HIDA, CIP, NHPP, and other subject matter experts. DASH will be a comprehensive, integrated tool for acute care hospitals to determine their needs and likely usage during an incident. It will provide a hospital with suggested supplies, equipment, and pharmaceuticals that they may need and may consider stockpiling for various incident types. I'd also like to point out another helpful resource, the Exchange Issue 15. It focuses on health care ethics, CSC, and patient load balancing during disasters. Currently, we are reviewing the significant role the military played in supporting the pandemic response. On the horizon, we've got several upcoming presentations to record which range from system sharing and how they used ASPR TRAICE's pediatric surge templates to enhance HCCs, to the impact of COVID-19 on the delivery of oral health care. We will also feature several health care coalitions sharing their recent lessons learned around fit testing, mental health, and creating a Regional dashboard to monitor the pandemic. As you can see, we have a lot going on. I invite you to visit our site to check out these and other resources. If you have any specific questions reach out to us and, most importantly, thank you thank you for your efforts daily and your support for ASPR TRACIE. Back to you, Megan.

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Megan Wassef: Thank you so much, Shayne. I will give a couple of minutes if anybody has any questions for Shayne or the ASPR TRACIE team. Feel free to put them in the chat or come off mute. We've also added to the chat a couple of links to the resources and, in addition, to these slides that we will share after the webinar. We'll give just a couple moments here for folks to ask any questions. Seeing no questions feel free at any time to put those questions in the chat and we will make sure to answer them or get those answered and reach back out to you. Thank you again, Shayne, for taking the time to share all of those and for curating all of these wonderful resources.

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Shayne Brannman: Thank you for the opportunity.

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Megan Wassef: Of course. I will now go ahead and pass it over to Dave Csernak who will introduce and moderate the Hospital Association Regional panel on load balancing.

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David Csernak: Thank you, Megan. Good afternoon. Thank you for joining us today. I am from the NHPP and one of the Regional staff supervisors as well as the Field Project Officer for Region 10. I am excited to be here with everyone today to help facilitate this, the first of what is hopefully going to be many monthly panels. During each one of our monthly webinars, moving forward, we're going to be asking health care representatives from one of the Regions to present. We're going to do our best to rotate throughout the entire country. We're going to participate in panel discussions, highlighting hot topics and lessons learned throughout the COVID-19 pandemic. This month will be health care representatives from across Region 10 that are going to be discussing how their states handled patient load balancing and managing hospital capacity throughout the multiple COVID-19 surges. Next slide.

It is my pleasure to be joined today by several representatives from across Region 10. From the state of Washington, I have Mr. Mark Taylor. He's the current Director of Operations for the Washington Medical Coordination Center and is based out of Harborview Medical Center in Seattle, Washington. From state of Oregon, I have Daniel Davis the Senior Director of Patient Flow from the St. Charles Medical Center. Also from Oregon, Dr. Carl Erickson who's an Associate Professor of the Pediatrics Division of Critical Care School of Medicine at the Children's Hospital, which is part of the Oregon Health Science University System. From the state of Idaho, Ms. Christine Newhoff who's the Senior Vice President and Chief Legal Officer at the St. Luke's Health Care System out of Boise, Idaho. These individuals have volunteered today to join our discussion panel. They are here to represent not only their health care systems, but they also all played a key role in their local communities, in their local health care coalition's as well as supporting the state and their respective states and Region 10 in managing the multiple COVID-19 surges and assisting and supporting patient flow and patient management across the entire Region. We're excited to have them on the call today and we're looking forward to hearing about their individual experiences, their challenges, accomplishments, and the way forward for each one of them. I'll start with a couple of logistics for the panels. I'm going to reach out with a discussion question and then I will pick one of you at random to start the conversation. And then feel free to add on to anything a previous panelist says said. For everyone in the audience, feel free to insert any questions you have in the chat throughout the panel discussion. We're going to have a Q and A session, following the discussion, in which turn we will turn to each of the panelists to answer.

My first question for the group today is going to focus on pre-pandemic. Could each of you tell us about what resources or capacities your state had in place prior to the COVID-19 pandemic, specifically for managing hospital capacity and patient load balancing? I'm going to start with Mr. Daniel Davis.

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Daniel Davis: Thank you. It's hard to think back about where we were pre-pandemic given everything that's transpired over the last couple of years, but if I can get my head back around that there were limited resources available for our state. We had our daily reporting measures that occurred in our health care system, which were situated within Oregon directly on the east side of the Cascade mountain range. It can make it feel like there's a physical barrier across that mountain path, so our central region feels like an island and we're going it alone. If we got ourselves in a position where we needed to move patients, our best resource at that time was the health care system. The challenge with that, though, was that it was a report that was as good as the information that was uploaded into it. It was uploaded at best once a day, so we get

ourselves halfway through and find ourselves in a difficult situation. We could use that as a resource, but as anybody that's involved in patient capacity management knows it is at best a snapshot in time and there's a lot that evolves. It was a real challenge for us on the get go. We started to run into these issues and there wasn't a lot of real time information available to us.

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David Csernak: Thank you, Daniel. I'm going to look to Dr. Carl Eriksson who is also from Oregon, but from a different part of the state.

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Carl Eriksson: Thank you. We were rudimentary in terms of systems or processes to support this. I'm a pediatric intensive just and for certain very limited resources. We had a little bit more awareness. The pediatric ICU us in the state, which are all concentrated in the Portland metro area. We would communicate when capacity was limited to ensure that we at least had some statewide capacity, but that was a completely ad hoc system that was purely driven by medical directors to ensure that we were maintaining access. There was no real system to support this work, certainly not at a statewide level.

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David Csernak: Thank you, Dr. Eriksson. Let's turn to Mr. Mark Taylor from the state of Washington. How are things in Washington?

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Mark Taylor: Yes, so very similar. I appreciate your comment regarding the geographic barrier of the mountains. We have that similar experience here and it does feel like almost an impenetrable wall in some circumstances. I would say that our planning around patient movement also suffered from that geographic barrier. We do have our population centers that are primarily focused in western Washington with the other large center at Spokane on the other side of the mountains. However, where the two meet is where we talk about load balancing across that mountain range. We also have in Washington state a similar program that we require hospitals update twice a day, so every 12 hours we get a sense of the status and current capabilities of our facilities in our state. Again, that's for actual real time planning of patient movement, so it's essentially completely unhelpful. The other thing I would add is that we have had a fair amount of conversation regarding the local and state disaster medical coordination center group to be activated during MCI planning, which was some level of coordinated patient movement. However, other than that, I would say two or three centers in western Washington and the Spokane area that the local disaster medical coordination center structure hadn't not been exercised. When you start talking about the assembly of multi-Regional movement beyond that is where we activated sort of an overarching state, MCC structure, that had not occurred. We had had some conversations about it, but no active practice.

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David Csernak: Excellent. Christine, your perspective from Idaho?

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Christine Neuhoff: Our pre-pandemic resources sound like they're consistent with both Oregon and Washington. We have a system for reporting data on hospitals, the Idaho resource tracking system. We've evolved it so many times in the last two years, that it's hard for me to recall what exactly it looks like pre-pandemic. I would say, one of the reasons we continue to evolve it over the course of the pandemic was discovering things that were less helpful because the way they were used or intended to be used wasn't providing information that was quite as helpful as we thought we needed. That resulted in changes over time, so the responsiveness was great during these last two years. We also have a lot of geographic barriers in terms of the ability to move patients great distances, so that's not something that I would say happened with any degree of frequency nor was it needed with much frequency prior to the pandemic. I think we had a lot of issues around patient movement that arose in the last two years that just had never surfaced prior to the pandemic.

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David Csernak: It sounds like while there are several similarities across each of the states pre-pandemic, there is variation in some of the plans, processes, and systems that we're currently in place prior to the to the pandemic response, which then potentially lead to some challenges within each of your states. My second question is going to be about the challenges as you began to identify, recognize, and began to strategize on how to overcome them as each of your started to experience multiple reoccurring surges. You know the hospitals began to experience challenges in in bed availability, workforce availability, and resource availability. Their ability to not only identify available beds, available resources, and transport assets, they were really struggling as well to communicate. Can you expand on these challenges presented within each of your state's surrounding the patient transport patient load balancing bed availability? And further, how you began to take some steps to overcome these challenges, as you began to experience these reoccurring surges? Let’s start with Mr. Taylor in Washington.

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Mark Taylor: Happy to talk about it. The unfortunate privilege of having the first major outbreak of COVID-19 occurring in a local nursing home that sent many patients to an adjacent suburban hospital, not a small hospital, but suburban. It essentially overwhelmed that facility. Identifying what was occurring there over the course of a few days, lead us to the immediate conclusion that we really needed to implore sort of that load balancing structure to be able to keep any of our local facilities, even though these are not small facilities within King county, the county that Seattle exists in. We need to be able to distribute patients more broadly to prevent a single facility from becoming overrun and running out of resources and having to start making treatment decisions or rationing health care doing that DMC structure that I referred to, we stood up our DMC. This wasn't a mass casualty from a bus crash, plane crashed, or a building falling, but this was, in essence, a single point of impact from many patients. We distributed those patients to the broader King county Regional hospitals to accommodate those patient needs. That worked very well, but, of course, is a kind of an off-label use of a structure that we had set up for an entirely different purpose. Immediate recognition ranged from not only how we would identify resources to accomplish this and a long-term strategy regarding care for something, such as during the pandemic here, but also facilities in and around our state. We had the knowledge of how to interact with some type of a coordination center to both recognize when they needed assistance, but also how they would assist when they had those capabilities. That became part of the structure. The education and training process that was needed for how to

utilize a load balancing structure. The primary concern was the ability to physically move the patients and how many transportation assets existed to accomplish that goal. From Washington state, the metro area is highly populated and is how we would resource Spokane in the same situation. There are lots of transportation assets, but 20 minutes outside of either of those areas and transportation assets immediately disappear. It becomes very difficult to find and identify resources to move patients around. Accomplishing that I think was through a variety of also different and very creative uses of nurses from facilitates for instance, that may ride along to provide enhanced care to patients during a transport or a very low threshold for utilization of flight programs. To move patients by air, instead of by ground, even though it might be technically possible there did seem to be capacity for air transport, when we didn't have it for ground transport. I guess that might be just some of the initial challenges that we face as we started thinking about regional load balancing within Washington.

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David Csernak: Thank you, Mark. I'm going to turn to Ms. Christine Neuhoff to tell us about what the challenges you began to face and how you initially started to address them.

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Christine Neuhoff: Our first experience with COVID-19 in Idaho really started in a small hospital in our resort community. That hospital became completely overwhelmed very quickly by not an enormous number of patients because it was a critical access hospital. We had to make fast decisions about how to handle the situation in that location because not only did we have patients who had come in through the emergency department, who had COVID-19 and it wasn't immediately recognized because their original their initial symptoms were GI and that wasn't yet on the list of symptoms we were watching for in March of 2020. We not only had those patients, but we also ended up having many of our staff out with COVID-19. Ultimately, we had to temporarily close that hospital and move the patients somewhere else. It did present an initial challenge. Fortunately, we have multiple hospitals in that same system. It's a system that I worked for and were able to transfer patients to another one of our facilities. Then that quickly ended up creating a significant, I'm going to use the word burden, but it's probably an overuse on critical care resources at this other facility. It had us thinking more about how to transport people, if there were to be an outbreak at a more remote facility like the one where it did start or at a facility that didn't have any sibling organizations who were standing ready and able to take on those patients. We did face that early. In terms of the transport needs, those initial needs, we were able to handle that. We were concerned about what was going to be coming down the road in the future and the state did initiate some statewide calls that included, not just the health systems, of course, but a county emergency management transportation agencies and public health officials statewide. It was a statewide incident command system that was set up early in the pandemic. In this meeting, we would fairly frequently to talk about what resources are needed, where and how we can redeploy those as needed, if our needs didn't reach a crisis level in those first few months, except in small needs for transport in more isolated instances. Those tend to be effectively addressed by county emergency and transport services as well as those that could be contributed to by private entities who weren't as overwhelmed with patients as some of the ones that aren't always first responders, but who are more typically transporting patients among facilities, were able to step up in those circumstances.

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David Csernak: Excellent. Dr Erickson, your perspective from the Portland metro area?

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Carl Eriksson: Thank you. I'll start by saying that Oregon may actually have the lowest number of hospital beds per capita. I know we're certainly in that bottom five, if we're not lowest, so that is a stressor even in some normal times. From my vantage point, we largely did okay through the early parts of the pandemic until the delta surge and then we had that point where we started noticing it, especially in the metro area where the majority of our tertiary critical care service are concentrated In Oregon it happens in the Portland metro area. We started noticing that the wait times were increasing. People were calling saying they called 50 centers. I think everybody has heard about how limited access was and that spurred us to take action. I think another significant component was when people were calling 50 centers, those 50 centers were all trying independently to get the patient. The amount of duplicate work that was happening was staggering. It's pretty deflating to spend a few hours trying to identify a plan for a patient to call back to the referring center and find out they got a better sign somewhere else 15 minutes earlier. Those were probably the major stressors that were really happening. We were fortunate in that we had pretty good coordination between our hospital systems, both in the Region and in the state. Some of that's because of our state trauma system and our Regional resource hospital system. I think it's fair to say we have six functional Regions, probably, or maybe seven in in the state with the Regional resource hospitals. They are meeting on a regular basis with our state public health leadership. We also had the CMOs of the major hospital systems in the Portland metro area meeting. I think what was important was that it established a way to communicate quickly when things were not going well. What we set up in the metro area was initially basically just text messaging back and forth between the transfer centers of the major health systems. At first, it was the health systems that offered ECMO and then it became the major health systems in the metro area. We never tried to change transfer patterns for many patients. We basically figured that anything that was working already, we weren't going to touch it. It was more based on an individual patient not being able to be served in a timely way. It was almost exclusively critical care, and, at the beginning, it was really more tertiary critical care. The attempt was to present a patient generically to the group because of HIPA constraints with text messaging. Anybody that could identify an appropriate bed within their health system would step up and say I could take it. We would connect the referring to that hospital system and it could be originated by any of the systems that were unable to place a patient in a timely manner. What we did subsequently was we expanded that to the rest of the state and the patients who didn't only need the ECMO kind of services, but who needed more critical care services in general. I think we found that even in the middle of what felt to us very much like an emergency, people held on to their usual patterns of behavior. It's not uncommon at all for a specific hospital in southern Oregon to call us for just about every transfer need regardless of whether it's a patient who benefits from our unique services or whether it's a patient who could potentially be served elsewhere. The Regional resource hospital system was a great way to try to identify a closer hospital that had both the capability and the capacity to take care of a patient. I can talk about this for a long time, but I'm going to break.

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David Csernak: Thanks Dr. Eriksson. Dan, your perspective?

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Daniel Davis: Dr. Eriksson did a great job of describing what was going on the state and how we worked together. It felt to me like when we expanded some of that coordination statewide that was where things started to ease up. I referenced that the mountain ranges were a barrier, but it seems to be less of a challenge and less of a barrier, as we got into things. I think, at the very beginning, one of the things that helped us was that regional resource collaboration where we were all getting on a call once a week or more frequently as needed. I think that became the forum for us to all start getting together and talking about what our challenges were. As we all started to hit these peaks in capacity there was recognition that there's more patients than we have beds across the state. We had extra work happening as they tried to find best option for the patient. That became the starting point and I give a lot of recognition and kudos to the team for the work they did within the Portland metro area to establish a model that can be expanded, to the rest of the state. Once we did expand to the rest of the state, we kept it simple. On the internal side, we had an extra cell phone that we pulled out and dedicated for this purpose and left it with our administrator on duty to help coordinate. They were monitoring calls 24/7 and our Regional resource partners all had access to it. We tried to keep it simple. It was saying that we have a patient needing critical and within minutes we would be getting responses from across the state. Another important point that Dr Eriksson already hit on is that we're not going to disrupt normal transfer patterns. The hospital will continue to work, but we're going to work together as regional resource hospitals that minimize the duplication of work and create more situational awareness amongst ourselves. We are going to connect those within our Region to understand capacity. I think the other key aspect was that we really called out that we weren't going to serve as transfer center for the state. We're really are just for coordination. With our teams, there was never that feeling of competition, but that we were all moving in the same direction. I have several examples where we were at capacity and we're able to quickly find a location for a patient. We're also on the receiving end of several of those, too. We were all able to set some of our own preconceived notions or agendas, or even biases aside, and just work together as a team. The big thing we did was keep it simple and try not to take the place of normal established patterns used.

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David Csernak: Thank you, Dan. I'm going to merge the final two questions together. We talked about your understanding of where each of your states started off pre-pandemic and then got into the challenges you began to experience and how you began to overcome those challenges by adapting your plans to modify your processes and procedures. Essentially, this started to evolve based on lessons that you learned and practices that you begin to develop and share amongst one another, I want to get your insight on what you feel are probably the most significant evolution and improvements within each of your perspective states or across the Region that has come out of the COVID-19 response as well as what you have on the horizon. I'm going to start back actually with Dr. Eriksson.

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Carl Eriksson: Thanks. The evolution has been staggering. I agree with what Daniel said at the beginning, where it's sort of hard to remember what it was like before the pandemic started in some ways. The state feels a lot smaller now. I think we've clearly solidified a lot of relationships and ways of communicating. We're working right now within the state to create something very similar to what Washington has developed, which is a statewide coordinating center for placing patients that will be more formal. We've also developed some data systems that are a version of

what we had before. We have real time reporting that automatically pulls information from each hospital electronic health record to give us a sense for what capacity is looking like in different parts of the state, which I think is valuable. I think it's important to mention that we have taken a soft approach in Oregon and I think it’s because even in the middle of disasters, people will often want to continue doing things rough largely the same way they have been doing them. In many ways, that makes sense. Those patterns often evolved for very good reasons and so our goal is not to build something to replace daily operations. It's to layer something on top of what generally works well. As an example, when different hospital systems report their census is, one hospital says they are at 120% of capacity and another hospital says they're at 150% of capacity. It's hard to know what that means if you're not in that hospital and seeing what happens. By keeping it about transfer of an individual patient that helped to ground everybody to what the clear need was regardless of what you were reporting in terms of capacity. It was a patient that you were unable to have and that helped galvanize support for the system. Last thing I'll say is it has been great to have conversations with both Idaho and Washington. Through the pandemic and I have personally called the Washington Medical Coordination System about patients in central Washington, who were requesting transfer whether the referring center was requesting transfer into Oregon and I know that Washington has done the same to us. A more Regional awareness of where capacity is and what the goals are for taking care of patients in the most logical way that ideally keep patients closest to home, has been valuable.

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David Csernak: Thank you Dr. Eriksson. Dan, do you have anything further to add for Oregon?

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Daniel Davis: As we move forward, something that is on my mind is what we’ve worked on within our four hospitals in the system. There is some statewide work that can be done as well to address how to keep patients closer to home versus skipping over other facilities. I've grown in my appreciation of the ordinary services that some of our other larger institutions in the Portland metro area have, if we're filling those beds with patients that can be served in other facilities closer to their home. We're preserving those beds for the patients that really need them and we're not bottling up the hospital. In this battle we have opportunity to continue to create awareness of what services are available across the state and make sure we are getting patients to the right level of care and not a higher level of care than what they need.

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David Csernak: Very good point. Christine, how is Idaho evolved and what's on the horizon?

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Christine Neuhoff: We have evolved a lot over the course of the COVID-19 surges. When we started off, we were far into a significant surge in the Fall of 2020. We became, of course, concerned about whether we had sufficient visibility to do load leveling across facilities and in the state or, at least in our Region. At that point in time, we started it just in part of the state because the need didn't seem to be quite enough to require at that point trying to coordinate patients all of Idaho at the same time. We started locally and learned about what capabilities the various hospitals have. I think we developed quite a strong level of collaboration. Facilities were

saying that they could take a number of surge patients from other facilities. We came to realize COVID-19 critical care patients needed to be in the hospital. Further, they needed to be in the hospitals where they were unless there was no way to expand that kind of capacity for those patients and move people who are more stable to other facilities, who potentially had or did have a room to take them. In that surge, we were able to do that effectively and didn't have to facilitate nearly as many patient transfers as we later did when we got to the delta surge, which was a strain on the facilities across the entire state. Last summer, we could see that surge starting. At the time we probably thought we were far into it, but it, as we know, continued. We started having our Idaho medical operations coordination center calls. I think it was probably late August that we started doing that and those scaled up and down over time. We were meeting every day certainly through the crisis standards of care and beyond. Through that process, there were over 200 calls, among other groups and the purpose there, of course, was to make sure that we had folks who could provide a more up to date point in time picture of what their capacity was, what they were expecting to see over the course of the day, what movements they might need to make if somebody has capacity, and to add some color to the data. Dr. Eriksson mentioned that you look at the numbers on the dashboard and one person says they are at 120% and someone else says they are at 150%. Having these conversations daily, we had a better sense of what someone means by. We tried to get a little bit more standard in the way we were all using that terminology, so that we could understand if someone had space or no space. We, of course, had to adapt over time to say what we have in terms of staff beds and what capacity. We would have to expand staff beds, to take on additional patients. Similar to Oregon, we continued to use the existing transfer center personnel and operations at the various facilities for you know when actual movement needed to occur. Patients weren't technically transferred through these calls, but people were connected to facilities through these calls with who might be able to help today. I believe our number was certainly dozens. I believe close to 70 patients were moved from the activities. In these calls, resources were shared across facilities such as if someone needed ventilators or another resource that they ran out of, without which they couldn't continue to expand the number of patients. I’d say it was a real success here in Idaho. Our implementation and the way we used this process resulted in no patient having to be denied a resource due to the crisis standards of care. We also didn't have to make any allocation decisions due to the crisis standards of care. I'll say there were circumstances where one or more facilities were close to it and another facility stepped up to relieve the pressure. I'd say among the lessons learned is we how capable we are of doing a lot when we put our heads together. We will continue to use this process under this kind of circumstance. We did also leverage another tool that the state had in place. It was an alert sense tool. If someone needed assistance between meetings, they could call a group together. Generally, the idea was that we pull together the tertiary facilities because they're likely to be the ones who could help in those circumstances. Those are the facilities we felt were more likely to be able to expand capacity, if necessary and take on additional patients. I'll stop there.

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David Csernak: Thank you, Christine. Mark, you're the anchor for the discussion.

00:49:01.650 --> 00:49:05.580

Mark Taylor: I do want to leave some time for questions. We did take this opportunity to expand that structure concept and really design or create a coordination center initially in western

Washington and then expand it rapidly across the state in in recognizing that we may not want to become the state transfer center. Part of the education and training is the collaboration that occurred with the Department of Health and the Washington state hospital association both health care coalition's here in Washington, to train the facilities regarding the workflow that needs to occur utilizing the WMCC as we refer to it, so utilize your own transfer center and your typical transfer process first. When that doesn't work call us. At that point in time, using the available knowledge that we have from situational awareness calls as well as the data platforms, which I do want to command Oregon on their data platform. It's significantly better than what we have. We've started to have collaborative talks and it's an area that we can learn more about here in Washington state from Oregon. Call us and we will utilize the data that we have available to find an available resource for you, whether that be, because you have too high of a capacity or the patient activity is beyond your capability to handle. I believe there have been 3,600 or so calls already. It's evolved to the status that we have now, which is a 24/7 operation that's scalable. At its baseline, we're available for hospitals to reach out and it's not done. It still needs work to develop. It gives us a good jumping off point for what I think the next step really is, which is that our Region or Oregon, Washington, and Idaho continue this sort of collaborative effort, so that we can build on the statewide coordination in each of these three states. I would include throughout Region 10 completely too and consider interstate patient movement as well through this type of a collaborative effort. Let me stop there, I know we're short on time.

00:51:52.710 --> 00:51:59.280

David Csernak: Thank you very much. Mark, appreciate the great summary. I want to thank everybody for your participation in the panel, for sharing your information, sharing your experiences and your strategies for moving forward. Thank you all very much for your time today. And with that said, I'm going to turn it back over to Megan to transition us into our final Q and A session for the panel.

00:52:23.130 --> 00:53:14.730

Megan Wassef: Thank you so much Dave. Thank you to our panelists and Dave for such a great panel. We're very excited to continue this in the coming months and really appreciate your great insight. For the last couple of minutes, we will give a couple more minutes for any questions. I know I saw one in the chat. And we will get back to you, Kathy, on your question. I will use the email you provided on the registration for them to reach back out to you. I did see another question in the chat. It looks like it's a grant questions, so we will also get back to you using the email you provided at registration. It looks like we're almost at the top of the hour and I'll leave the line open just for a second here if anybody has any quick questions or comments.

00:53:24.420 --> 00:55:12.570

Richard Hunt: Thanks for an extraordinary presentation. I'm not sure any of us would have known how important the work that you did and continue to do really is. Many of you probably have already seen it, but the study by NIH showing that one in four COVID-19 deaths was potentially attributable to hospital surge by certain caseloads reinforces the importance of the work they did. It was a study of data from 558 hospitals, so not a small study. A follow up study to try to figure out the transportation made a difference. It's ended and the outcome reinforced that transport works and it doesn't compromise outcomes. The work you did was masterful. A couple pf quick thanks beyond our presenters and panelists. To all those who participated today we absolutely invite you to share any stories regarding how you or your member hospitals are

using ASPR funding to make a positive impact on their communities. If you've got a story to share, please fill out the stories from the field submission form or reach out to your Field Project Officer for more information. We’re going to try to share the grant information in a separate communication because I want to make sure that Jennifer has a chance to weigh in on those responses. Megan, anything else?

00:55:13.200 --> 00:55:17.250

Megan Wassef: Thank you so much. Have a great rest of your day.