

August 2021 ASPR Health Care Readiness Cooperative Agreements All-Recipient Webinar

*August 11, 2021
Event Transcript*

00:00:06.480 - 00:00:12.570

Jennifer Hannah:

Thank you, Cat, and thank you all for joining us today. For those that may not know me and those that are new, I am Jennifer Hannah, the Deputy Director of ASPR's National Healthcare Preparedness Programs, or NHPP, Branch. It is my pleasure to be with all of you today to connect on a variety of topics related to ASPR's Health Care Readiness Programs.

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. First, we will provide an overview of some exciting ASPR Health Care Readiness Programs updates. Next, we will hear from Jackie Gatz & Kara Amann-Kale of the Missouri Hospital Association regarding the COVID-19 Lessons Learned Report. Then Dr. Lisa Villarreal from the Arizona Department of Health Services will facilitate a panel discussion on hospital load-balancing with several state public health officials. Finally, we will close the meeting with a panel Q&A to address any questions or comments you have.

I'd like to begin today's webinar by sharing a few ASPR Health Care Readiness updates. I wanted to make you aware that there are several ASPR Health Care Readiness resources that have recently been released. First, the ASPR Health Care Readiness individual state, territory, and major metropolitan area recipient web pages are now live on PHE.gov. These pages highlight how the ASPR Health Care Readiness Programs Portfolio engages health care stakeholders across all 50 states, U.S. territories and freely associated states, major metropolitan areas, and Washington, D.C., to strengthen the nation's emergency preparedness, response, and recovery capabilities. To access these pages, visit the Health Care Readiness Programs webpage on PHE.gov and select the Health Care Readiness Near You tile in the bottom left hand corner. You can also select the link provided in the chat to view the web pages directly.

In addition to these webpages, the ASPR Health Care Readiness Programs Portfolio has also released video resources, the newest of which is a video summarizing the role and impact of the National Special Pathogen System, or NSPS.

00:02:54.270 - 00:03:00.120

NSPS Video audio:

How do hospitals, health systems, and healthcare providers know how to respond during infectious disease outbreaks like COVID-19 or Ebola? In 2020 after the U.S. declared COVID-19 a public health emergency, ASPR established the National Special Pathogen System or NSPS to support infectious disease readiness through education, regional coordination, and surge activity funding. NSPS is a nationwide, system-based network that consists of four (4) components: The National Emerging Special Pathogens Training and Education Center or NETEC, 10 regional Ebola and other special pathogen treatment centers, 53 hospital associations, and 62 Hospital Preparedness Program recipients. NSPS has supported our frontline healthcare workers throughout the COVID-19 pandemic and will continue to shape our response for future special pathogens.

00:03:53.910 - 00:04:05.610

Jennifer Hannah:

Great. Thank you, Megan. As you can see, this video provides a clear, concise introduction to NSPS and its activities to help hospitals, health systems, and health care workers prepare for and respond to special pathogens, including COVID-19. If you'd like to access this video, you can find it at the link provided in the chat. The video is also posted to ASPR's YouTube page and will be shared on PHE.gov in the coming months. I will now pass it over to Jackie Gatz & Kara Amann-Kale to present on the Missouri Hospital Association COVID-19 Lessons Learned Report

00:04:32.700 - 00:04:33.690

Jackie Gatz:

Thank you, Jennifer. Good afternoon everyone and thank you for having us today. As Jennifer said, I am joined today by my colleague Kara Amann-Kale, our director of Hospital Preparedness Programs at the Missouri Hospital Association. I myself am the Vice President over safety and preparedness, and together, along with many others on our team, we've been working over the last two years to help our hospitals respond to the COVID-19 pandemic. Today we're going to talk a little bit about our evaluation and how we've continued to cultivate and refine resources to help our hospitals conduct rapid process improvement through COVID-19, despite continued response efforts.

I want to give a little bit of background to our role in Hospital Association preparedness. First, definitely need to give credit to 2 funding sources through ASPR. We are a subcontractor through our Department of Health with the Hospital Preparedness Program and have been since 2002. And then again just recently, as was referenced in that video, we became a contractor to ASPR as a state hospital association in 2020, specifically related to COVID-19. So these two funding sources have certainly supported a lot of the work that we have done, but our Board of Trustees has always played an active role and supported an active effort in hospital preparedness. And, as such, we've created many association specific initiatives over the course of the last two decades, both in preparedness (you'll see the plain language), emergency codes, hospital mutual aid agreement. We maintain our state's Juvare license for communication that's supported through the Hospital Preparedness Program. We do have a long-standing board recognized safety and preparedness advisory committee that informs all of the work that we'll be outlining today. And then all of that preparedness really positions us to be able to respond accordingly. Many of you will recall the efforts that we took forth in Missouri in 2011 in response to the EF5 tornado in Joplin. Certainly, many other large and small scale incidents that have impacted healthcare operations, and then, most recently, and for all of us, the COVID-19 pandemic. We do have 142 Member hospitals and all acute hospitals and critical access hospitals across the state are our Members, so we're really able to cultivate a substantial strategy when we're addressing many of these measures.

So, all of you know the story of COVID-19, so really what we're going to focus on today is how did we really align and bring together those evaluation activities through the surge that we experienced. So, for us in 2020, we experienced our first surge in spring around April, predominantly in the St Louis region. That was our first surge, but it really came after we learned from many of our colleagues across the country and on the coasts and what those metropolitan-based surges looked like. So in July of that year, we conducted a hospital assessment to really capture what we anticipated to be about the mid-response mark of COVID-19. We now know that that was not the case, and it really focused on activation, clinical strategies, certainly PPE and how that was sourced, and that initial surge in spring of 2020. From that we produced in September of that year, a mid-response assessment. When these slides are made available, all of these links are active, so you have access to this. And from that, we've gleaned through that assessment and through the development of that report, lessons learned that we could provide

as best practices for our members that we conducted through all of last fall. As we were producing the report last summer, we experienced our second surge and that really came on the heels of Memorial Day and fourth of July activities for many of our tourist areas. And unlike the spring surge, it was much more widespread. So many of these lessons learned series provided an established weekly touch point with our members, where we can bring real time resources, provide updates, and as we were beginning to cultivate a lot of the vaccine work we were doing, we can start to educate on that process as it was being developed throughout the fall.

So then in 2021, what we anticipated was that would that we would roll out the COVID-19 vaccine, we were very active in that space. Missouri adopted what was referred to as a “high throughput health care model” where many of our large hospitals and small hospitals in more rural areas stepped up to do a high efficiency, high volume, clinics in partnership, but separate, from mass vaccination sites that were managed predominantly through local public health and our Missouri National Guard. So we did quite a bit of effort in early 2021 rolling out the COVID-19 vaccine and what we anticipated is we would evaluate that process and really then conclude, if you will, much of the after action reporting so that we could get underway with true emergency preparedness process improvement cycles.

What we didn't anticipate were the variants, and certainly the delta variant, that really took a foothold in Missouri in spring of 2021. So, I will go back for just a moment and share our largest surge was in December of 2020 with around 2,900 hospitalizations. And again, we had anticipated we would identify how we managed staffing and that surge specifically, and then again how did that vaccine administration occur. But the variant has really changed the COVID-19 response across Missouri. We have been actively addressing it since June of this year. We are currently sitting around 2,200 hospitalizations and our cases continue to climb. We also are seeing that it first started in Southwest Missouri, which is a more rural area that had a lower vaccination rate. So, we're watching closely to see how this will impact our two metropolitan areas, St Louis and Kansas City, as we aren't entirely certain what those surges will look like. So that graphic on the bottom right really shows where we are today in our hospitalization curve.

So, despite these four surges that have occurred over the last 18 to 19 months, we have persisted to continue to conduct these evaluation opportunities. So again, I share we did the series last fall that really postured many of our hospitals to be more prepared for that winter surge, and then much of what delta has provided us. But now we're really looking at how do we continue to identify solid improvements and strengthen our plans so that we're prepared, not only for future COVID-19 surges, but other infectious diseases as well. So, utilizing an established hospital assessment that we've conducted for over 15 years, in spring of 2021 we started to ask those more detailed questions to inform an after-action report. We also hosted focus groups with our clinical and executive leaders to ensure that we not only had a preparedness and safety and operational lens through improvement, but we also incorporated all clinical and executive input. And on the right-hand side of your screen you'll see those key takeaways of really what were identified as successes and improvements. And then, as we brought this information to our advisory committee, we recognize that there's no good time to do this work, and they encouraged us to persist and continue through the summer with doing much of this activity because it's so challenging to address it all. And as more and more time and more surges are occurring, we recognize it would be harder to digest. So, we have been proceeding, and I'll walk through that process for you right now.

So what we have done, so the Spring assessment has informed a COVID-19 clinical operation, what we're now referring to as a “reflections report.” It is not summative, it's not culminating, we anticipate there will be a third report to this series post Delta. The format for this is a general

summary by focus area. Every focus area has a timeline to provide context to how we addressed and what those four surges looked like to date. Data insights that we've used throughout the COVID-19 response to inform decisions have been pulled in to provide perspective. We have all of the summative hospital data from that assessment, and then we've spotlighted members, specifically in each of the focus areas that you identify following. I will share, we are in final layout for the report. We had anticipated an early August release and pleased to report that we will be pushing it out next week, so happy to share it with ASPR, and everybody that's registered on today's webinar.

So, as we visited with our hospitals, I think it's important to highlight why are we conducting this. It's very simple, I think, for some, to say, do we really need to be doing this, can we be investing our time elsewhere. We know there is value to document these real-world events, it exempts them from other planned exercises in the future, specifically from a regulatory perspective. We certainly wanted to highlight that return on investment for them. We also know that surveyors are going to be seeking areas for improvement and how plans were improved. So, we knew we had an opportunity to cultivate good discussion and ensure that we really were developing stronger programs from the COVID-19 response. And then really just highlighting again for hospitals, the purpose of an after action and an improvement plan to summarize how you anticipated something to occur, how it did occur, what were those differences, what do we need to change, and then, what can we sustain that was a solid improvement going forward.

So, what we created were topic specific PDFs that were developed to help our hospital staff facilitate internal discussions. We know we can't do it for them, we don't have enough breadth and depth. We also know that every hospital is going to be conducting a little bit differently: some are doing it by calendar year quarter, others are doing it by topic. We thought it was most appropriate following the format of our report to develop these topic specific PDFs. Again, that would help facilitate those conversations internally, really capturing some key questions to consider and then, what were those key improvement planning activities, we have a matrix within each form. We also have if any of those findings were shared internally, how they were documented, if the plan has been updated. And we know not only that we can use this information more collectively as a state to drive improvement, but internally, they can also use that for any surveys that they have coming forward.

So, what I would share is every other week now for the next about four months, we're going to be hosting of topic specific webinar. So once those forms are completed internally, we want to reconvene those subject matter experts within the hospitals to share among one another. So, if they've missed something internally that they're hearing from a partner or a neighboring hospital, they can that bring that in before finalizing their documents.

I won't read these for you specifically, but these are really the early findings that we are identifying as next steps as we talk with our hospitals around these topics and release these after-action strategies going forward. Certainly, there are changes to our regulatory landscape, we know there's work to be done in a variety of ways to enhance our supply chains. We know that our clinical care teams have been exceptional. We see that they've been very agile, we want to sustain that, we want to see how we can use and leverage that in future work. Certainly, continue to evaluate the continuity of operations from an environment of care or physical environment perspective. There is a tremendous effort underway, I know nationally, and we certainly want to play a role in that in Missouri, so we're having very active discussions with local subject matter experts on that emergency response data strategy. What that looks like for Missouri, what that looks like nationally, making sure we can connect to that. And then, lastly, we would be remiss not to recognize the strain that COVID-19 response has had on our workforce. So, we really want to support their resiliency and their mental health, so that they can

be stronger coming forward. I believe that is our last formal slide, so I will provide our contact information. Certainly, you can reach out to us at any time, but certainly available for any questions that you might have as well.

00:18:56.970 - 00:19:05.220

Cat Fullerton:

Thank you Jackie and Kara. As a reminder, if you have a question feel free to insert into the chat or to raise your hand and I will unmute you.

00:19:10.920 - 00:19:15.060

Jackie Gatz:

Catherine, while we're waiting, I will just reiterate we've had an opportunity to use some of the staff time that was supported through those funding opportunities that I highlighted at the beginning of our presentation.

And so, all of the work that we've cultivated, we're very happy to share with anybody that wants to use that. So, I can make that available to ASPR leadership, but then I can also share it with anyone directly if they contact us.

00:19:47.400 - 00:19:51.720

Cat Fullerton:

It looks like we have a question from Ron Marshall. You should be unmuted now.

00:19:53.610 - 00:20:02.400

Ron Marshall:

Hey Jackie this is Ron. Thank you. I just dialed in, but on supply chain issues, we're hearing increasing concerns about food delivery from Cisco, one of our main food vendors. Have you experienced that in the Missouri side? I know a couple weeks ago Cisco cut off restaurants on short notice. And today, I heard a couple of nursing homes in western Kansas were notified they would longer get food delivery. So, it is due to staffing, they don't have enough drivers to deliver the food, maybe not a food shortage. Any idea what's happening with that on your side?

00:20:29.940 - 00:20:41.850

Jackie Gatz:

Ron I had not heard that, that's interesting. We have a call shortly with our members, I will raise that and see if it's something that they're hearing as well, and then I can connect with you to see if we can collaborate across state lines on that.

00:20:42.360 - 00:20:54.990

Ron Marshall:

Okay yeah. A couple of hospitals are getting food, but the deliveries are less predictable and being delayed, so we're worried that hospitals may be the next to be cut off from some food deliveries at all.

00:20:55.590 - 00:20:57.990

Jackie Gatz:

Understood. Thanks for the awareness.

00:21:14.010 - 00:21:15.570

Cat Fullerton:

Thanks Ron. Any other questions from the group?

Great, alright. Well, thank you very much Jackie and Kara. And again, their information is provided here and will be provided in follow-up materials following this webinar.

And so, I think with that we can move on to our next presenters, the State Hospital Load-Balancing Panel. So, I'll hand it off to Lisa Villarroel, who will be facilitating this session.

00:21:55.830 - 00:22:01.290

Lisa Villarroel:

Great. Hi, thank you. Good morning Western states, good afternoon Central, South and West. My name is Lisa Villarroel and I am the Medical Director of Public Health Preparedness at the Arizona Department of Health Services and I will be facilitating the panel discussion on statewide hospital load-balancing today. We're going to begin the panel discussion with a brief overview of what a centralized load leveling transfer service is, and then we're going to transition into a discussion with health care or public health representation from Arizona, Maryland, Minnesota, New Mexico, and Washington state. And we encourage you to participate in this discussion by submitting your questions or comments into the chat box, or by raising your hand if you would prefer to speak live.

For a brief overview of what a load leveling service is, basically, in preparation for an unbalanced hospital surge due to COVID-19, the representatives on this panel individually developed their own statewide approach to coordinating patient transfers and load leveling hospitals, including federal hospitals, county hospitals, private, public, critical access, and so on. And the concept for all of us is that we really wanted a coordinated, higher view, of the hospital bed availability, in order to target transfers and maximize bed utilization in order to save the maximum number of lives. Rather than what we saw in the early days in New York City, where one hospital was over one run and one was relatively empty, we wanted to keep all of our hospitals in our states balanced. Between all of us on the line, we have facilitated the transfer of around 10,000 patients to a higher level of care. Each one of our transfer lines is a little bit different, with different scope, structure and governance, but they have been critical to our state's response and just really want to share that with you all today. Furthermore, it looks like load leveling services are the way of the future, given the ethical approach to triage and really this driving need to postpone triage. And load leveling is thus a recommended strategy as put forward by the national academies of medicine and other academic journals.

It is my pleasure today to be joined by several state and healthcare representatives, including Dr. Theodore Delbridge from Maryland. Maryland's line has transferred around 1,100 patients to a higher level of care, then Dr. Karyn Baum and Walter James from Minnesota. Minnesota's line has transferred around 800 patients to higher level of care. Kyle Thornton from New Mexico. New Mexico has transferred around 600 patients to a higher level of care. Dr. Mitchel from Washington. Washington has transferred about 400 patients to a higher level of care. I and Teresa Ehnert will be the representatives from Arizona, and we've transferred around 6,000 patients to a higher level of care.

So honestly, everyone, all the panelists, it's great to have you on a on a national call today and we're looking forward to hearing about your experiences and challenges and accomplishments on your state's load leveling transfer services.

So my first question focuses on the steps and factors that contributed to the success of your load balancing activities. So first question, can you please describe the process that was followed to organize and implement load leveling activities in your state, and what factors or

regional partnerships do you believe were most critical for this. Why don't we start with Minnesota right now, Dr. Karyn Baum and Walter James.

00:25:38.100 - 00:25:48.390

Karyn Baum:

Hi, good day and thanks for having us. Hello from my hospital, which is certainly very busy. So I think in a very brief sentence, this was put together by several of us, most importantly, the State Healthcare Command Center, also known as the SHCC, which is a collaboration across our organizations and health systems. I think that's the key to this for us, is this was something that was done in collaboration between the Department of Health, the Hospital Association and the senior executive leadership of our largest health systems in the state, which I think was essential to have all of those folks really agree to come together and do this and not get caught up in finger pointing or whose job it may be, or may not be.

00:26:42.180 - 00:26:43.170

Lisa Villarroel:

Thank you, Dr. Baum.

How about could we hear from Washington state, Dr. Steve Mitchel?

00:26:50.100 - 00:27:00.420

Steve Mitchel:

Good morning everybody from Washington state. In in our state, we began by using our relationships and workflows as the Regional Disaster Medical Coordination Center, whose primary mission in a very similar way is to get the right patient to the right bed. And as we recognized that the surge was very much like a disaster scenario, we just expanded it over to a much larger region and are now doing and applying those efforts statewide. We quickly realized the need for key partners at, as Dr. Baum just mentioned, our healthcare coalitions (we have two of them in Washington state), our State Department of Health, our hospital and the executive leadership at all levels and across every health system. In the end, it was our Washington state hospital association working collaboratively that allowed us to reach an agreement because all of us we found very quickly were able to get behind the key concepts of cross health system data sharing and the need for that for decision making that is shared and openly available, and also shared governance. It was remarkably easy for all of those disparate players to get to come together behind the idea that we are all in this together and we are going to rise and fall together, and the primary goal is just to get the right patient into the right bed. It's easier than we thought it was going to be in the beginning to accomplish that.

00:28:38.730 - 00:28:44.370

Lisa Villarroel:

That was great, Dr. Mitchel. Thank you. Can we move to new Mexico, Mr. Kyle Thornton.

00:28:50.130 - 00:29:06.840

Kyle Thornton:

Hi, sorry for the delay there. You know, I hate to start sounding like a broken record. The successes here and the initiation really came out of the public and private partnership with the large health systems and particularly what we consider our metro hospitals where obviously a lot of the upper level critical patients tend to flow to. There was a desire and much has been described previously that on the part of all of the hospital systems to not engage in competition or any of those things that might exist in other situations to try to make sure that we were

utilizing the limited resources (we have the best) and use what infrastructure already existed, and call centers that might have existed, to work together to create a single call center that helped load level all of the facilities. Certainly the success that we've had so far isn't because of me, by any stretch it, it was truly the individuals from the hospitals working together to make this thing work. I'll be forever indebted to their work and how it's worked, so thank you.

00:30:20.520 - 00:30:30.870

Lisa Villarroel:

Thank you, Kyle, and thank you Minnesota, Washington, and New Mexico. At least speaking on behalf of Arizona, we've learned from all of you and it's helped make our surge line better here as well.

Let's move to the second question. This focuses on any best practices or lessons learned over the course of implementing this load leveling activity in your state. So, the question is, can you please describe what you have accomplished by performing hospital load leveling activities and anything that you've learned that you're going to carry forward in future responses. For this question, let's move to Maryland, Dr. Delbridge.

00:30:57.840 - 00:31:05.820

Theodore Delbridge:

Thank you and good afternoon or good morning, depending on where you are. I think the two lessons that we learned, things that we've been able to accomplish, are one, we're particularly focused on moving critical care patients. Every referring center consults with an on call central intensivist physician. What we've learned is that, by getting that consultation upfront and early with a very neutral physician, who is not at the time tied to any particular health care system, they're able to provide guidance that in many cases has obviated the need to transfer the patient at all. And so what we've learned is that patients who would otherwise be in the queue waiting for a bed, and all the logistical considerations that involves, we're able to keep right where they are oftentimes, and provide the care that's needed. I think that's thing one.

Thing two, the other lesson we learned that has really helped us, is we were considered a neutral broker of information before all this even began. By being very transparent with relatively limited data set and having frequent communications that were facilitated by the hospital association to get all the interested parties on conference calls frequently, we were able to reassure folks and answer their concerns if they were worried about how we were directing patients or not. That really created a huge buy in and we're at the stage now where people want us to actually do more than we're currently put up to do and are trying to fund us to do additional parts of the mission.

00:32:34.140 - 00:32:47.610

Lisa Villarroel:

Thank you, Dr. Delbridge. I'll give the Arizona answer as well. I will say with regards to all the other transfer lines of the states, Arizona's is probably most similar to Maryland's in terms of its governance structure. Our Arizona surge line is funded and administered by public health, but it's protocolized and the different algorithms are come up by a steering committee made up of hospital representation across the state.

Few key lessons that we've learned at ours. One, is really to consider public private partnerships. We bought an out of the box bed visibility system so that we can see 90% of the hospital beds in the state within 90 seconds if it's occupied or not. We also bought a phone

system called Revation, and that's what Minnesota's line uses as well and this helped us be up and running very quickly in Arizona.

Second lesson would probably be to have data transparency. It did help defuse most situations as this line was up and going and in particularly intense moments during peak surge, it really helped diffuse most situations to provide, within an hour, the percent of patients being sent to this system versus this system, turnaround times per system, who was sending patients from where to where. This was shared and was transparent with the steering committee every week.

And the third thing is, I think what Dr. Delbridge also hit at, is this need to be adaptable. Every surge, we're on surge three in Arizona, we are having to come up with new processes on the fly. Every time we think we have it totally down, and then we have to come up with something new. Right now, we're coming up with new procedures or protocols for ECMO as that's running into extreme short supply.

In general, for us, this has been an equity enhancing initiative. Here in Arizona, insurance is not a consideration when we're transporting COVID-19 patients between hospitals. We found that on the line over these thousands of patients that we've moved, that we've transferred mostly American Indian Alaska native. The majority of the patients that we're transferring are coming from socially vulnerable zip codes. Truthfully, this ended up being a really good source of truth for us at the health department on the health of the health care system. It has proven to be a cost-effective public health preparedness strategy. We do plan on keeping it going to utilize for hospital surges in the future, due to flu, due to wildfires, due to other pandemics that may come.

I will take a brief moment to see if Teresa Ehnert from Arizona, do you have anything else that you want to add about lessons learned?

If not, let's move to audience Q&A. We're going to transition into the open discussion portion of today's panel. Members of the partner community, please feel free to submit questions or comments via the chat or raise your hand if you would prefer to speak live.

Let me look in the chat here first.

I do see a question about bed visibility system. It's interesting, like we think that we, you know this group on the panel has discussed before about there's different approaches to bed visibility. We bought an out of the box kind of system, it's called central logic, we can give you our contract and you can see what we bought from them. But basically it has leads to 90% of our licensed hospital beds, and so it shows up on a bed board that we see for the whole state and it tells us how many beds are now open facility by facility in each region.

Would anyone else like to comment on what they do for bed visibility on the panel?

00:36:10.710 - 00:36:24.540

Theodore Delbridge:

Yeah, we were a lot less low tech than that. We were keeping surveillance of bed status and hospitals daily, which is how we sort of fell into this business. We had visibility on bed availability that the hospitals didn't have. We use essentially a spreadsheet tied to Tableau to get data visibility and we do it by just a lot of phone communication throughout the day to make sure that we have updated surveillance. So ours is much more about networking and communicating with the various hospital systems throughout the day then doing something automatic.

00:36:48.780 - 00:36:52.860

Steve Mitchel:

In Washington state, we worked in the earliest days to essentially built a novo with Microsoft, a platform that would cross systems, which I think is the most single important concept is that every hospital and system not used to sharing information needs to be openly and transparently available for these efforts. One product, in addition to what Arizona has been and others have been using is a product, now that has been built with Microsoft, that is able to track beds and different resources specific to these surges. It's publicly available and I'm happy to share that.

00:37:35.670 - 00:37:46.650

Karyn Baum:

And this is Dr. Baum for Minnesota. I will say, as you're probably all thinking about this, having a bed, having a staffed bed, and having the right staffed bed, are all very different things. This data can give you directionality, but when you're down to your last crash bed, it still has to be a phone call at the end of the day.

00:38:02.400 - 00:38:04.560

Lisa Villarroel:

Thank you. Are there any other questions? In the chat or live.

Okay, if not, I have a question for the panel. Do any of you have any advice for other jurisdictions, regions, or states that are hoping to incorporate this load leveling work into what they do in their region?

00:38:35.790 - 00:38:37.140

Steve Mitchel:

I would just say that, as has been mentioned earlier, that this is a key disaster preparedness opportunity for us, and I think is fast becoming the standard of care as we deal with different public health emergencies. I would add that it's actually probably easier than people think to operationalize, it just takes some focus and some collaboration across different sectors of your state in order to make things happen, but it is easier than we think that it is to pull off.

00:39:19.230 - 00:39:20.100

Kyle Thornton:

One of the things that was important for us, figure out what you want to do, the most rudimentary mission that you want to be successful at, and then add things that you have the capability and capacity to do instead of developing all these things you will like to do in your call center and find out the things that you can't do as you go. That was one thing I think was sort of important for us, to figure out what we could be successful at the outset, and then add to our capability. It's probably kind of silly, but it became rather important.

00:40:06.780 - 00:40:17.340

Lisa Villarroel:

Thanks Kyle. In Arizona, we had the same thing. We have four objectives, our first objective is to expedite transfer to a higher level of care, that is our number one priority. Then we have three others underneath it, which is expediting transfer to lower level of care, which is like discharge placement, and then providing backup transport, and then having consultation services for critical care and palliative care on the line. And we pulled off the first one first, right, the higher level of care, and then we added on as we could, two, three and four.

Can I just ask a brief question? This is a few word answer from each of you, can you please give a sense of the timeline of what it took to stand up your little leveling system in your state how many days, weeks, months.

00:40:47.520 - 00:40:48.210

Theodore Delbridge:

Two weeks.

00:40:50.760 - 00:40:54.180

Steve Mitchel:

Hours in western Washington, a few weeks for the entire state.

00:40:57.060 - 00:40:57.570

Lisa Villarroel:

Minnesota?

00:40:57.960 - 00:41:05.370

Karyn Baum:

About two weeks for version 1.0, and then as they transitioned over to our admission and transfer center, about another two weeks for that.

00:41:06.480 - 00:41:11.910

Lisa Villarroel:

New Mexico?

Kyle Thornton:

I'll say about a two-week period of time.

00:41:12.810 - 00:41:22.140

Lisa Villarroel:

And in Arizona, we are about three weeks. So that was also one of the messages that we wanted to get across, that this is doable, you're not probably going to get through this next surge before having this up and going. Did I say that right? You have time during this next surge to get this up and going.

Another question I have is about equity. So, I talked a little bit I guess about Arizona's experience with equity, but for the rest of the panel, what health equity considerations should a state or region account for when implementing this program? Could I start with Washington?

00:41:51.660 - 00:42:01.710

Steve Mitchel:

Sure. I'll just say that what's become very quickly apparent to us and our efforts in Washington state is that as delta surges significantly and our hospital system is now under more stress than at any other point in the pandemic and real in real time, that is increasingly becoming an equity issue between people who live in rural areas and people who live in more urban areas. As the rural areas have always moved patients to more urban areas for specialty care or critical care that increasingly is just unavailable while patients in urban areas, despite their hospitals being severely strained, are still providing specialty care for those people who arrived in their hospitals and their emergency departments, etc. Increasingly the challenge around equity is that our rural citizens are more and more challenged for getting the care that's always historically been

provided, and so our next focus is trying to implement every everything we can to serve those people knowing those issues, including things like tele consultation and tele health that has been discussed here a bit ago, thank you.

00:43:24.810 - 00:43:40.800

Theodore Delbridge:

Yeah, I'll springboard from that. I would say that in Maryland, one of the factors that isn't a consideration is the payer. Because of the way health care is financed in Maryland, payer source is an irrelevant factor for a hospital. But if you consider the disparity between rural and urban health care, that is really a problem. One of the things we've been able to accomplish is return who would normally be referring centers into accepting centers, so patients are traveling bidirectionally. Every hospital in the state has become a receiving center as well as a referring center at some point. As a matter of fact, there are a few hospitals that are in the top 10 hospitals for both. In other words, they're sending the patients that they're not capable of taking care of, and on a day when they have available space, they are accepting patients. It has really been not just a load leveling thing in terms of the numbers of patients in various facilities, but a care leveling thing in terms of our ability to match patients' needs with the available resources. Without this, what would be happening is patients standing in a long queue waiting for space at a particular place. It's not just that patient that's affected, but the patients who aren't being cared for by the rural physicians who are focused on caring for patients that they're inadequately prepared to by virtue of their expertise to their equipment. So it really is a huge win, win.

00:44:58.260 - 00:44:58.710

Lisa Villarroel:

Thank you. I will just put out another request, are there any more questions or resources that anyone on the call would like or that we can answer for people?

I then can close out this panel by saying thank you to all the panelists. Speaking on behalf of the panelists, we feel very strongly about this strategy and we see the impact that it's had on our state and on our hospitals and on our patients. All of us are more than willing to connect with any of you to talk about our model and how to pull this off in a couple weeks. All of us have our protocols and our algorithms, Arizona's are all posted online as well as on our website and with that.

00:45:45.390 - 00:45:51.300

Karyn Baum:

I will say one last thing Lisa, which is we have crossed state lines and I expect all of you have as well. We would accept patients from Western Wisconsin, and we had partners into North Dakota who would accept patients. Care doesn't stop at the border, and so I will say, you know, especially in certain parts of the country, it may be that this is a regional solution as well. So just to throw that out there.

00:46:16.380 - 00:46:28.680

Lisa Villarroel:

Thank you, Dr. Baum. I love that and I think this should be a regional approach. Arizona would have really benefited from partnering with California and New Mexico, I mean the four corners, that would have been a lot better and hopefully that's in the future.

00:46:36.360 - 00:46:47.430

Cat Fullerton:

Wonderful. Thank you, Lisa. Since we've concluded with the Q&A, I will hand it back to Jennifer who can answer any general questions the group may have and close out this webinar.

00:46:51.150 - 00:47:05.910

Jennifer Hannah:

Great. Thanks Cat. I believe that we had one comment or a question that came in a little bit earlier, and it was related to the annual FFR 425 reports. This is specific to the hospital associations and it was noted that in PMS the due date shows is July 9, 2021 and they show as delinquent, but they were not available for us to complete in the payment management system until recently. Kathy noted that she checked the system later and that the reports were unavailable at the time, but they did not receive an email that they were available. Unfortunately I can't speak to where the disconnect was with that, I will state within the funding opportunity announcement, or within the NOFO, for the hospital association awards that it was noted there that the requirement was an annual end of year federal financial report that would be due 90 days after the end of each 12 months budget period. As I said, I can't speak to where the disconnect was with the payment management system, I just wanted to let you know that you will not be penalized for anything that's showing as a delinquent report and that we will be following up with our colleagues and ASPR grants management to work to adjudicate this and to put out a message to all of the hospital associations. Most likely via Grants Solutions Grant Note. So, more information to come, but we will work to address this with our colleagues in ASPR grants.

I've got another question here from Prachee, is there an update on when FY21 HPP Ebola Part B awards will go out to recipients?

Great question, thanks for that Prachee. We're working through the process to get the funding decision memo approved by the new ASPR. Ideally, we would hope that those would go out by the end of this month. Please stay tuned and we will get a message out to everyone regarding that as well and apologize for the delay in getting out that award.

Okay, and Kathy had a follow-up question, should we just complete the FFR as soon as we can? Many other hospital associations may not know it is ready for completion. I would recommend that you go ahead and complete the FFR as soon as possible.

Then a follow up question was from Jennifer Mueller regarding when is the FFR due? Jennifer, we will follow up with ASPR grants management to identify the exact date. As I said, we have to coordinate and figure out where the disconnect was within the payment management system. As stated within the within the funding opportunity announcement, the end of year or annual FFR would have due 90 days after the end of the budget period, the budget period ended in April, so then that means that the due date would have been July 9th of this year. But again, we will follow up with ASPR grants management to work through this particular issue.

Okay I'm not seeing any additional questions in the in the chat but just wanted to say thank you to all of our speakers today, Jackie and Kara from the Missouri Hospital Association, and also our facilitator and panelists, Teresa, Dr. Delbridge, Dr. Baum, Mr. Thornton, Dr. Mitchel and Dr. Villarroel, and want to thank all of our participants or our attendees on today's call for joining us and for everyone for your questions and also the productive discussion.

Please reach out to HPP at [hhs.gov](https://www.hhs.gov) if you have any other questions or comments that you may have. As a follow up from this webinar, we will be providing the slides and the recording to anyone that may have missed today's call or anyone that just may want to replay and also see any of the of the slides. You can also stay in touch with ASPR by visiting our website at

www.PHE.gov or by following us on social media at the handles shown on this slide. And with that we'll give you about six minutes back on your calendar for today.

I just want to thank everyone for all of your hard work, we know that it is very difficult for you to really take time out of your very busy schedules, especially at this time, we know that everyone is exhausted, stressed, probably stretched very thin but again, really appreciate everyone's participation. With that, we'll say thank you and have a wonderful day. Thank you.