

September 2021 Monthly HPP Cooperative Agreement Recipient Webinar

September 8, 2021

Call Transcript

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Ramos, Maria: I will now pass it over to Jennifer Hannah, who will open today's call.

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Jennifer Hannah: Good afternoon, everyone, thank you for joining us today, I'm Jennifer Hannah, the Deputy Director of ASPR's National Preparedness Programs Branch. It is my pleasure to be with all of you today to connect on a variety of topics related to the management of your cooperative agreement and the ongoing COVID-19 response. 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 please.

First, I will spotlight a new resource recently posted to our ASPR Health Care Readiness Programs website, Next, we will hear from Meghan Treber, ASPR TRACIE's ICF Program Director, who will provide an overview of the crisis standards of care and patient surge management resources now available on or coming soon to ASPR TRACIE's website. Afterwards, Kate Gorbach of the NHPP Branch's Data and Evaluation Support Team, will share some guidance on how to report end-of-year Health Care Coalition member organization details. Then, Lauren Egbert of the NHPP Branch's Data and Evaluation Support Team will share updates on the Medical Response and Surge Exercise, or MRSE, which is formerly known as the coalition/hospital surge test, or CST/HST. Finally, we will hear from representatives from HHS' Office for Civil Rights, who will discuss health equity considerations related to crisis standards of care, planning, and implementation. Next slide please. And next slide please.

As I stated, I wanted to begin today's webinar by sharing an ASPR Health Care Readiness update. And here is a new release of our ASPR Preparedness and Response Capabilities fact sheet. The ASPR Preparedness and Response Capabilities Fact Sheet is now published on phe.gov. This fact sheet describes the high-level objectives that the health care delivery system and Health Care Coalition, including its core members, should undertake to prepare for, respond to, and recover from emergencies. To access this fact sheet and view the full 2017-2022 Health Care Preparedness and Response Capabilities, please visit the ASPR Health Care Readiness Programs web page, select the Performance Measures, Reports and Guidance tile, and navigate to the Other Guidance and Reports section. A member of our team will drop this direct link to the resources in the chat shortly. I will now pass it over to Meghan Treber to share information on some new or upcoming ASPR TRACIE resources. Meghan?

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Meghan Treber: Thanks, Jennifer. Go ahead and move to the next slide. So as Jennifer said, we did want to highlight some new TRACIE resources that we've released since the last time we spoke, highlighting a number of them that would be particularly helpful for meeting FOA requirements, including the Health Care Coalition radiation emergency surge annex template. This is to write the annex. The plan that is the annex to your overall response plan. And, along with that radiation surge annex template, we also updated our radiation and nuclear topic collections. So, that's very helpful for meeting those FOA requirements. We've also continued to

update our patients surge, scarce resources, and crisis standards of care resources with lessons learned from COVID-19. So those are updated. We've also updated our tip sheets on monoclonal antibody therapy for COVID-19, based again on feedback and information that we've gathered from others implementing these infusion centers and this kind of operation nationwide. And then, we also have a number of technical assistance request responses. So, many of you know that ASPR TRACIE is open to receive technical assistance requests all day long. And so, when we do get those requests, if they are the type of requests that generates a written response, we redact it with the requester's information, but we post all of those answers, because we firmly believe that just because you haven't asked the question, doesn't mean you don't have the questions. So, we post all of that information so that you can access it. But we've just highlighted a few of our recent technical assistance responses that we've developed on 1135 waivers, on MOCC resource assessments, MOCC being the "Medical Operations Coordination Center", or you know, it's a specific kind of operation, patient load balancing where MOCC is a solution, so we did a resource assessment. Exercise requirements for an intermediate care facility for individuals with intellectual disabilities, pediatric surgery sources for COVID-19. We know that that is an issue facing most, if not, many, if not most of you, and then also were able to provide some sample physician orders for monoclonal antibody infusion treatment for where you're using standing orders. We also encourage you to take a look at the EXPRESS messages that we sent. These are our e-newsletters. We sent two in August. They are hyperlinked here, but you can also find them on our website in our new resources, and then we do have a series of presentations that are geared towards pediatric lessons learned from COVID-19, and they're focusing on pediatric mental health and the issues that have arisen since COVID-19. And it's a series, it's one of our speaker series, so there's a number of presentations that cover different topics. And we did these in partnership with WRAP-EM, one of the ASPR Pediatric Centers of Excellence. So, next slide.

And so, we are working on a number of resources, as always. When we identify areas where we think we can contribute some resources, we work on developing them. So, we, as I mentioned, we just released the radiation surge annex template. You are also required to then exercise it, so we are developing the radiation emergency storage annex tabletop toolkit that should be released relatively soon in the next couple of weeks. We are developing a tip sheet on concerns and opportunities for health care leadership as a result of COVID-19. What are the things that we are hearing that are keeping up your health care executives at night? The effect of COVID-19 on health care incident command systems. Hospital and health care facility incident command systems have now been stood up for longer than they ever have before, and so that has caused- A: We have a lot of lessons learned about managing incident command in your facilities but also lots of lessons learned about things that are now maybe not part of incident command anymore. They've been moved into just daily operations. There are things that they that have been done so long and has improved the process of your day-to-day operations, but they're ingrained in your daily work. Updated active shooter and explosive topic collections. We are continuing to work on the HCC COVID-19 engagement assessment project. This is a long-term project that we've been doing since February on Health Care Coalition engagement during COVID-19. We will have that information and report and next steps available within the coming weeks. And our upcoming exchange issue, which is our newsletter on the impact of civil unrest and community violence on health care. We are currently working on compiling really, really impactful lessons from the field on how this is affecting health care. Working on some resources on health care resiliency and climate change and will be rounding out the surge annexes with

completing a chemical emergency surge annex template. And then, we're working on a number of upcoming presentations on blood supply and COVID-19 poison control centers, which have even more recently come in the limelight. They're in the spotlight now. And the impact of COVID-19 on women in health care. That speaker's presentation will be coming out soon. So, I'm happy to take any questions if you have any or certainly you can reach out to the Assistance Center at any time. Anybody have any questions? Okay, hearing none. I am turning this over to Kate.

00:09:05.490 --> 00:14:07.800

Gorbach, Kate: Hello, everyone. Good to see everyone. I see a lot of familiar faces. I'm gonna go ahead and share my screen. So, I'm going to talk about the end of your reporting in PERFORMS and how we're collecting that end of year data. So, I went ahead and opened up a random state in PERFORMS; not going to share necessarily. But yep, so I said, we have, so when you go into PERFORMS, you'll see this list of discrepancies here. These are all the things that need to be answered in order to submit the form. One piece of trouble we're running into is with the organizations. So, an update is that we will not be collecting the organizations through PERFORMS this year. We will be collecting through an Excel template. So, in order to submit the rest of your data through PERFORMS, you might see a lot of errors. You know there's no answer for this, so here's what you would do to bypass these performance discrepancies. You can go to Form 1.2: HCC Member Organization Details. You can delete all the member organizations here, except for one. It'll always ask for one. Alternatively, you could associate, to just get rid of the errors, associate at HCC over here, in this first column. This workaround will allow you to submit the end of your performance measure module at your earliest convenience while still keeping the reporting of the HCC member organizations through the Excel template. So I hope that makes sense, but the whole goal is just bypass the errors that you'll see on the homepage here so that you can still submit. We won't be asking for this information twice; we're only asking for it through Excel. So I can go ahead and share this, you should have received this in your email from the SHARPER mailbox. That's SHARPER@HHS.gov. Each of these is individual, it is tailored to each recipient. So here, I made this demo one example here, and these are the instructions. It's pretty straightforward. We prepopulated all of the member organizations that we know here. And the whole goal is to make this as easy as possible and reduce the burden here and allow for easier editing of information. So, as you can see, we put in all the information that we have, including addresses, if you keep scrolling to the right and if there's any information, it will be highlighted in yellow. So here, the HCC has not been assigned, so we just need to know which HCC these organizations belong to. If an organization belongs to more than one HCC, we would just ask that you put a semi-colon and then type the name of the second right next to it or put it in the next column as well. Either way, we'll know to associate more than one HCC, only in the case that there's more than one HCC associated to one organization. If you want to add more organizations, you can scroll to the very bottom. And just add any information at the end. So, you'll add the name of the HCC, the name of the organization. The type of organization has a drop-down menu, so you can select the type. If you do select "other", this year we are asking for a little bit more information. You know a little bit of a category to go with it. And then address; you only need to provide address for the core member organizations: that's acute care hospitals, public health agencies, EMS and emergency management agencies. Other than that, you don't need to provide any addresses. And the core member organizations do have that designation next to them, in the drop-down menu already. And then, my last point, I'm going to go ahead and stop sharing here and go back to the

instructions. The budget reporting in PERFORMS has changed to help the burden. The budget data will only be required at the object class level. So, for financial assistance, personnel, and contractual if you have any questions, please reach out to SPPR via the SHARPER mailbox. But, I can go ahead and open it up right now to any questions that I could answer. If anyone wants to come off mute or drop any questions in the chat, please feel free.

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Ramos, Maria: It does look like we had a couple questions come in. One of them is from Valerie. Can you repeat what you said about deleting all organizations, except for one?

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Gorbach, Kate: Sure, yes, that is one way to bypass those PERFORMS discrepancies. You can delete all of your member organizations except for one, and then associate that one organization with a coalition. That will get rid of all of the errors. Alternatively, you can just associate HCCs to each organization that has an arrow next to it. Again, the goal is just to clear out those errors. We're still working with our partners at PERFORMS to bypass that. If there is an update, we will let you know.

So, there's another question from the chat here. "Who is the email from?" I can drop the address in the chat as well. So that's who you should have gotten the email from. If you haven't received an email with that template, please reach out to that email or me directly and/or your project officer. Any of those avenues, we will get you those templates as soon as possible.

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Ramos, Maria: And I think I did see one other question or a comment from John, that he had already updated or uploaded all of the HCC data into PERFORMS, prior to the guidance being sent out to submit data via Excel. Do you have any suggestions on next steps there?

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Gorbach, Kate: Yes, so everything else, so all HCC information and budget and performance measures all of those are still being collected and PERFORMS. So, it's good to keep that there. Just the only the member organizations that are being collected via Excel. So, we've already prepopulated that information based on the PERFORMS submissions before. So, hopefully there won't be many changes. Just making sure that we've all crossed our t's and dot our i's. And again, hopefully, because it's in Excel, it'll be much easier to edit you don't have to go one by one. So, hope that helps.

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Ramos, Maria: Right, there's another question regarding, "what was in tab 2.1?"

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Gorbach, Kate: Yes, let me go ahead and share my screen again. Tab 2.1 is the member organization details but lists out all of the member organizations of that recipient, sorted by the HCC. As you can see. So you can either leave this alone or you can just fill in what you need to just associate the HCC where you need to in order to get those errors to go away on the summary page. To get some of these errors to go away, so you can submit. Yeah, or you could

delete all of the organizations here. Except for one, just to bypass the system for more information about filling in the performance measures in PERFORMS. There is a training webinar recording and guidance document in the PERFORMS library.

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Ramos, Maria: Great thanks, Kate. Looks like we also received a question from Jessica about “For those organizations that have already updated PERFORMS, can they download the data file from PERFORMS, and then match the formatting for the SHARPER email?”

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Gorbach, Kate: Great question, I don't see a way in order to download on this tab. That's unfortunate. There are some tabs you can export to Excel, directly from PERFORMS. I don't think this is one of those tabs. Right, I know for sure you can copy/paste and that's kind of the MacGyvered way to go about this. But you can copy this, and then paste contents into Excel. So, that could be a workaround, if you're trying to do a direct comparison from PERFORMS to the Excel template sent out. Again, the template sent out is based off of PERFORMS submissions in the past, so there really shouldn't be too many discrepancies. Unless you've made changes starting on the date that PERFORMS opened. Which was when? Well let me check my calendar here. Monday August 2nd. So, if you had if you did make those changes since Monday, August 2nd, those won't be reflected in the templates yet. But then again, you can copy, paste, and compare files that way.

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Ramos, Maria: Great thanks, Kate and I think we, in the interest of time, we have to move on to our next speaker. But would love to come back if we have extra time at the end of the webinar to answer any additional questions about this.

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Gorbach, Kate: Ooah actually, I'm so sorry, you can download your list of recipients from over here on the reports tab. Oh sorry, I paused sharing. Over here, on the reports tab, you can download your list of organizations; we can export that to Excel to them compare. It is required to fill in the Excel template from the SHARPER mailbox, just because we have identified areas that we just fill in some gaps. So sorry Maria, I'll go ahead and stop there.

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Ramos, Maria: No worries, sounds good. Thanks for clarifying that. Alright, well then, I will pass it over to Lauren Egbert.

00:20:35.850 --> 00:32:02.370

Lauren Egbert: Thank you very much. Hi everybody. Thanks for being here today, and thanks for your patience as NHPP has been developing and pilot testing the Medical Response and Surge Exercise, or the MRSE as we're calling it. And that's the new exercise that's replacing the previous coalition surge test and hospital surge test, starting in this budget period.

So, as I mentioned, we are currently pilot testing the MRSE, and we expect that the final and full exercise will be released in October. You're going to see additional updates and receive

additional information in advance of October, so that you're aware of the exact date of release, so you're able to access upcoming webinars that will orient you to the MRSE, and so you're able to access the tools that are going to support that exercise. So please, you know, stay tuned with your Bulletin for additional updates on the MRSE. But early on, we wanted to share some information with you, especially about the major changes in the exercise between MRSE and the previous CST HST exercises. So, as we said, as the exercises rolled out, we're going to be offering sessions to orient you and orient coalitions to the new exercise, but this is just a high-level overview, to give a little bit of information as where pilot testing, and everything is in its draft form.

So first, I just want to acknowledge the large team that's been responsible for developing this exercise. The core team has been led by staff from the National Health Care Programs Branch; including several of the fields project officers that you know. It's included ASPR's evaluation branch, long standing program partners at Deloitte and Gryphon Scientific, and then, a range of subject matter experts have also contributed to the development of the exercise. Including ASPR'S Exercise Branch, ASPR TRACIE has contributed, Hospital Associations have provided feedback, the office of EMS within the Department of Transportation, and of course we were receiving feedback and support from the Health Care Coalitions that are currently piloting the exercise. And so, all of those folks have contributed to the exercise. As it stands in its draft format today. We can move to the next slide.

Now this is to highlight some of the most significant changes of the exercise. The team has really taken the approach of trying to create a much more flexible and customizable exercise. So, it allows Health Care Coalitions to really create a surge scenario and test the things that they know that they need to test. And while there is additional flexibility, that creates additional responsibilities for HCCs during their exercise scenario, in advance of the exercise. And there are tools provided that will allow Health Care Coalitions to plan their particular search exercise that they'll conduct. Let's see, so basically what that means is that Health Care Coalitions don't just have to test a structured evacuation scenario anymore. Your Health Care Coalitions can test whatever they know they need to test from their HVA's, or their response planning. Any improvement planning that they've done in the past or after-action reports that have, you know highlighted areas in which additional testing and improvement would be helpful. HCCs will really pick that exercise that's right for them. And that also allows flexibilities for Health Care Coalitions to meet other exercise requirements, and they plan their surge scenario that way. So, it allows the exercise play to really also be structured around their own response plan and hopefully be a little bit more faithful to the way that the coalition would actually respond in any of these scenarios. The team has also really tried to expand engagement of other members of the coalition during this exercise so there's a greater role for EMS, for example, in the exercise. And additionally, the exercise is now going to use the same structure for all coalition's, rather than that differentiated CST and HST exercise in previous years. The final thing I'm going to highlight is that the 90-minute limit has been removed. So NHPP has heard from your agencies that it really creates a false limitation. It isn't helpful for them to test their medical surge capability and so NHPP has done away with that requirement for this exercise. All right, we can move to the next slide now.

All right, in the MRSE, the use of real-world events is still perfectly suitable to fulfill the exercise requirement, in a given budget period. And the criteria for using a world real world event are outlined here. And so, you know, we're really asking that Health Care Coalitions use their

judgments and try to identify if the real-world event that they have in mind, meets these criteria, in order for them to be able to use that real world event to satisfy their exercise requirement. And the ones that I would flag here as the most important are, you know that the real-world surge incident has like a pretty discrete beginning and end, right? So, you know when that surge begins, and you know in that search ends. And they're kind of book ends. That allows you to begin and end the exercise. I think that's a very important criterion. Another one to highlight is that the Health Care Coalition must be able to respond to the performance measures that are collected through the MRSE, and those are all highlighted in the tools and it will be, you know the Health Care Coalitions will be able to see what data they would need to provide from that real world exercise to be able to answer those MRSE performance measures. And, additionally, the Health Care Coalition must hold an after-action review and do improvement plan. And so, you know, certainly, we expect that some Health Care Coalitions are going to have questions and as the MRSE is rolled out, we will ask Health Care Coalitions and recipients to engage with your Field Project Officer when you know, you could use a little extra support thinking through whether or not your real-world event is suitable to use for the exercise.

All right, let's go to the next slide. We'll do this at a very high level, because you're going to get a lot more information about this as the exercise is finalized. But there are really three tools that are going to support the exercise. The first is the situation manual, and that helps all the participants at the exercise walk through all of the crucial exercise actions. There's an exercise planning and evaluation tool. And that's an Excel based tool that will again, just like the situation manual guide folks you're conducting the whole exercise, and it will also be one place that all exercise data can be recorded and documented. So, there isn't the need to kind of document information and a whole bunch of other places, and then calculate your performance measures. This tool is going to collect all your data, and then it will populate the performance measures for you, using the data that are that are entered by the coalition during the exercise. And then there's an evaluation plan that walks the exercise evaluator through collecting those data and that information during the exercise. And it also gives a really detailed performance measure implementation guidance we are able to really see for each of your performance measures. What is the operational intent of those performance measures and what is, you know for each of the performance measures what's the calculation "what's the denominator?" "what's the numerator?" and really feel that that folks understand those performance measures in detail. And we have one more piece of info to share and we can open it up for some questions.

Alright, so this is a very high-level overview of the exercise. The exercise is really going to happen in three phases. And that first phase is different from the CST/HST. This is phase one which is the plan and scope exercise and it's different because a Health Care Coalition is going to is going to really organized their own unique medical surge scenario. You're going to, you know gather exercise inputs from your HVA from your surge estimator tool, and other member requirements and sit down together and plan the surge scenario. And then, in phase two is when the exercise will actually be conducted. And in phase three, you'll have after action review and improvement planning, based on the outputs of the after-action review. Every phase of the exercise is supported by information in the situation manual, as well as all of the data collection from the beginning of phase one until the end of phase three. That is going to be collected in that exercise planning and evaluation tool, so there's one place to go through the full exercise and input all of the associated data.

Alright, great well I'm going to pause there. I think we have maybe one or two minutes if anybody has any questions that they'd like to submit before I hand it over to our colleague Scott Dafflitto.

If no one has questions at this time that's ok too. There will be many, many opportunities for learning and additional questions it's really just the primer. Okay wonderful we'll seeing no questions I will hand it over to Scott Dafflitto. Thanks so much.

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Scott Dafflitto: Thank you and good day everybody. My name is Scott Dafflitto I'm a senior public health advisor for the National Health Care Preparedness Programs branch, here in ASPR. And just as a couple of quick reminders before moving into our next presentation. The crisis standards of care concepts requirements have been extended to the end of this budget period. The ASPR wanted to provide additional time to make sure recipients are addressing specifically nondiscrimination issues. Additionally, recipients must conduct an annual exercise that specifically addresses the needs of people with disabilities and other high at-risk individuals or populations. NHPP recipients should consider the access and functional needs of at risk, individuals, and engage these populations as they plan HCC based exercises. During the past two budget periods, ASPR provided flexibility to allow recipients to use the COVID-19 response to meet the requirement, if there's verification of inclusion of vulnerable populations, based on COVID-19 parameter set by the CDC. And on this note- today, we have an opportunity to engage with the HHS Office of Civil Rights, specifically on issues of nondiscrimination and health equity in crisis standards of care. So, I'd like to introduce Robin Frohboese, the acting director and principal deputy for civil rights. Thanks to you and your team for joining us today.

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Robinsue Frohboese: Thank you Scott. Thank you so much for inviting us to join you today and thank you for the great collaboration that we have had with you, your team, and all of ASPR, throughout COVID-19, and in terms of overall preparedness and planning. And I also do want to thank all of the HPP participants because I really understand what is on your shoulders and in your hearts every day as you're both responding to the pandemic and its many twists and turns, but also thinking ahead about lessons learned best practices and the next potential emergency situation that might come. I am joined by two of my very key colleagues from the Office for Civil Rights, who also will be joining in on this presentation. I'd like to introduce them at the outset. Molly Bergdorf, who is a senior civil rights analyst. If you could wave Molly, I see you there. And, at least on my screen right below you is Ari Ne'eman, who is a contractor who has been invaluable to OCR throughout the COVID-19 pandemic and particularly around crisis standards of care. So, we like to save some time at the end for questions. Thank you to those who drafted questions ahead of time. And we have tried to weave them into our presentation, but if we could advance through the slides let's see the next one that may come up. There, we go.

And if we could go to the first slide, which is for those of you who may not be familiar with our office, it is the Office for Civil Rights, the acronym is OCR. We are part of the Secretary's office, and we are actually a law enforcement agency and also have a regulatory policy outreach technical assistance role. We do enforce a number of civil rights laws, and those civil rights laws are applicable, really to all of you it's anyone who receives funding from HHS but also HHS programs, as well as any public entity. We are located in Washington DC. As a matter of fact,

I'm directly one floor below the Secretary, in our main office and in Washington D.C., and we have regional offices throughout the country. On the next slide you'll just see the range of topics that we cover. So that will be the, there we go, the major laws that we enforce and, as you can see it's very broad ranging in terms of civil rights, it covers race, color, national origin, disability, age, sex nondiscrimination. And we have a very important role under the Affordable Care Act because there is a nondiscrimination provision, known as section 1557 that prohibits discrimination on all of the bases that are in the bullets above- health programs and activities and it includes insurance plans. We also, in addition to our civil rights responsibilities, are the law enforcement agency and regulatory agency for HIPPA privacy security and breaches.

The next slide really gets to the heart of what we're talking about today, which is COVID-19 and health equity. And we do know from firsthand experience as the pandemic unfolded, just the tragic disproportionate impact that it had on communities of color and other vulnerable populations, including individuals with disabilities and older adults. And so, health equity has been a principal throughout the government's response. It was formalized by President Biden on his first full day in office on January 21st, when he issued the executive order on ensuring an equitable pandemic response and recovery, and there's a hyperlink to that executive order right in this PowerPoint. And it also was a cornerstone of the entirety of the COVID-19 response national strategy that this administration also has issued. So, this executive order does address the disproportionate and severe impact of COVID-19 on communities of color and other populations, as I mentioned. And the President notes that it's really impossible to change the course of the pandemic without tackling it in the hardest hit, communities, and some of the underlying issues. So, the executive order does direct a government wide effort to address health equity. HHS including ASPR is at the lead of that effort and there also is this HHS COVID-19 Health Equity Task Force.

So, moving on to the next slide. Then you may wonder why the Office for Civil Rights is talking about the broader principles of equity and that's because equity. Of course, starts with nondiscrimination. And none of us intend to discriminate against individuals actively, intentionally, but it oftentimes, and we certainly found this in the COVID-19 response, would be that there would be policies and practices that unintentionally discriminated against certain communities and in civil rights parlance had what we call a disparate impact. So, right from the get-go in March of 2020 at the very first announcement from the Secretary of Public Health Emergency on COVID, we did make the announcement that through during public emergencies, including the COVID-19 pandemic that laws prohibiting discrimination remain in effect. And we then stood up a COVID-19 Civil Rights web page. We also have a separate COVID-19 HIPPA webpage because we've been active in that areas well. And each of them contains multiple guidance documents and technical assistance in terms of the civil rights guidance. It really covers a wide variety of areas from accessibility to vaccinations. We just very recently, in conjunction with the Department of Justice, issued guidance on long COVID-19, which is also a growing phenomenon. It covers hospital visitations in many other topics, including crisis standards of care.

So, on the next slide. We are turning to the principle that that we would like to focus on during this particular presentation and that's crisis standards of care. I know that we all had fervently hoped that states invoking their crisis standards of care was long past. We saw yesterday that Idaho had to invite invoke its crisis standards of care and there's word that there are number of other states that, tragically, are at the cusp of issuing their crisis standards of care. So, at the

beginning of the pandemics once lots of crisis standards of care, were in place, our office actually received a lot of complaints from stakeholders from a consumer coalition's, from advocacy groups, really concerned about their states crisis standards of care. So largest-

Can everyone hear me okay? Hopefully. All right, so we received a number of complaints about crisis standards of care, and we realized that we needed to address these complaints, but also address the topic of crisis standards of care in a way that would be very helpful to states to provide technical assistance and also to work with states to voluntarily revise their crisis standards of care, to eliminate this this inadvertent discrimination that could be built in one way or the other. And you see on this slide hyperlinked, we have examples of nine different situations states hospital and regions, then, and also an HHS Component, the Indian Health Service, where we worked side by side with the states to incorporate really best practices of how to apply basic civil rights principles.

On the next slide you'll see that we right now, and so this is very timely, are working on a civil rights toolkit that will bring together all of the work that we've been doing. The lessons that we have learned in working with states and hospitals and various regions. And to provide this toolkit for the as states are looking at their crisis standards of care. Now interestingly enough, at the beginning of COVID-19 we were seeing some very outdated crisis standards of care. We actually had some categorical exclusions, that, and by that, I mean that certain groups of individuals, either by age or type of disability, would just not be automatically not be considered for scarce resources that were available. So, we worked with some states to do early course correct on that got the word out about categorical exclusions and as we went on in working through our complaints and states reaching out to us for technical assistance. Both the types of situations are thinking about the best way to apply since civil rights principles really evolved over time. But they do focus around two very key concepts and the very first one is that medical care, of course, should never be denied based on stereotypes, assessments of quality of life, or judgment about a person's relative worth, or the presence or absence of disabilities, or age, or other protected characteristics. And the second really key principle is that decisions, whether an individual is a candidate for treatment over scarce resources, really do have to be based on the best available objective medical evidence, so the two go hand in hand.

On the next slide we are turning to a specific case and sample which is really our most recent work with the state and prices standards of care and Ari Ne'eman, who was essential in this crisis standards of care case resolution, is going to walk you through it, so that you can see the application of some of the principles that I've been talking about.

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Ari Ne'eman: Thank you so much, Robinsue. You know, as you mentioned, our most recent early case resolution was with the state of Arizona, which made a series of voluntary changes in the context of the ECR process ECR. The ECR is a non-adversarial process where covered entities work with OCR to resolve the complaint in a collaborative fashion. We provided Arizona with technical assistance, leading to the adoption of the following best practices, many of which are also reflected within OCR has other ECR's on crisis standards of care. This is, you know really only the most recent the number we've done, and we now have a series of standard best practices we look for in CSC policies when complaints or technical systems requests are brought to us. So, Arizona made the following changes within their CSC. First, they removed language that made use of long-term survival as an allocation factor Arizona's new CSC now

focuses on likelihood of short-term survival to hospital discharge. Arizona also, next slide please, avoids the use of categorical exclusions, incorporating instead individualized assessment based on the best available objective medical evidence. Arizona also avoids the use of resource intensity and duration of need, as a criterion for the allocation or reallocation of scarce medical resources. This protects patients who require additional treatment resources, due to their age or disability from being given a lower priority to receive lifesaving care due to those needs. Arizona incorporated reasonable modifications to the use of clinical instruments for assessing likelihood of short-term survival when necessary for accurate use the patients with underlying disabilities. And I want to highlight this because it responds to a question, we received from one of you during the registration process, asked specifically about prognostic scoring instruments. Like the sequential organ failure assessments, the modified sequential organ failure assessment, SOFA. And this is really an example that would apply to the SOFA and SOFA and other scoring instruments, where you have an instrument used to assess likelihood of short-term mortality risk that may need modifications when being used with people with disabilities, for example. The SOFA incorporates the Glasgow Coma Scale which gives patients and elevated score and less than elevated risk of mortality when they have difficulty with speech or motor movements. That may be appropriate and predictive in the case of certain acute injuries, but it wouldn't be appropriate if you're assessing someone say with cerebral palsy or an autistic person who has preexisting and stable challenges with motor movements or speech that have nothing to do with mortality risk. So, the example the kind of reasonable modification that Arizona incorporated within their CSC. And then next slide please.

Arizona also incorporated protections against providers steering patients into agreeing to the withdrawal or withholding life sustaining treatment. And the idea behind this you know which the CSC goes into more detail on this topic it's worth looking at. For specific language is really to ensure that as providers communicate with patients about advanced care planning and end of life options. You know, while those communications may become more frequent in the context of shortages, you know Arizona felt that it was very important to ensure that coercion did not figure into that process and that individuals were not required to consent to a particular advanced care planning decision or make a particular advanced care planning decision in order to continue to receive services. And then finally Arizona incorporated within their CSC language, ensuring that long term ventilator users would be protected from having a personal ventilator, a ventilator they bring with them into a hospital setting taken from them to be given to someone else. And this just reflects a concern that we've heard from the public with respect to, or rather than Arizona heard from the public with respect to fear of reallocation of personal ventilators from long term ventilator user. Arizona incorporated this protection within their ECR in order to alleviate that concern, excuse me, within their CSC in order to alleviate that pain. Thank you, I'll have things back to Robinsue

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Robinsue Frohboese: Thank you, Ari, I know we're almost at the end and I know some questions came in, so let me just say that of course you're well familiar with TRACIE, but I wanted to let you know that we work closely with the health care resilience task force to develop some specific documents that do incorporate these civil rights principles, both in hospitals long term care facilities and also with the national academies in their call to action on crisis standards of care. I also, these slides will definitely be available to everyone on this webinar and if we go to the next page, I definitely want to encourage each and every one of you to the questions that

we don't get to, to reach out to us individually or collectively, and we are happy to follow up and provide technical assistance.

And so do we have time for, I guess we just have a couple of minutes, I one of the questions that was asked, during the registration process that also came up by saw in the chat box, had to do with how do we engage consumers and stakeholders as we're putting together see a season of the plans. And I wanted to turn to Molly to just give a few best practices in that area.

00:55:14.370 --> 00:55:14.970

Molly Burgdorf: Can y'all hear me.

00:55:17.280 --> 00:55:18.450

Robinsue Frohboese: Yes, okay great.

00:55:18.660 --> 00:58:09.180

Molly Burgdorf: Thanks, Robinsue, and the question that Robinsue was referring to what was submitted in advance was "how do we get representatives on our CSC committee?" And I wanted to thank both the live question and the pre-submitted question asked here, because stakeholders, including people with lived experience, including informal support networks, including providers, and the broader community are invaluable to inform this process. And I first want to just emphasize that we are taking a close look at this and in the toolkit that you'll see referenced in the slides that we are working on developing for communities like you to develop crisis standards of care plans, we're looking at best practices for stakeholder engagement, and that includes community consultations with relevant stakeholders and sharing representation of communities of color people with disabilities, older adults, immigrants, people from low-income backgrounds, and other marginalized groups. Of course, alongside clinicians and administrators and other providers and relevant health care personnel. So that's the baseline and there'll be more to come, but nitty gritty and particularly focusing on people of people with disabilities and organizations that serve people with disabilities. We would suggest that you start with the existing federally funded entities such as and I'll give you a couple on aging area agencies on aging and aging and disability resource centers. The Disability Space specifically it's a great idea to start with your protection and advocacy system in your state, which are a network of congressionally mandated, legally based disability rights agencies. In a lot of states, they're called disability rights and then the name of the state, but not exclusively. And we can help connect you if you are looking for that information. And there's a number of other federally funded entities that you might want to start connecting with if you're not already, including the Center for Independent Living in your state, or the State Developmental Disability Councils, the University Centers on Excellence and Developmental Disabilities. And, finally, because I know taking a lot of time, it may behoove you to look at some of the resources that have been developed around vaccine access and vaccine outreach, because a lot of attention has been paid by the CDC, and by the Administration for Community Living, on how to develop systems partnerships collaboratively and, particularly, how to do equitable outreach surrounding vaccine access. But a lot of that particular suggestions on how to do it and actually who should be involved, is translatable to the some of the CSC work, and I know there's a lot more on that, but let me hand it back to Robinsue, thank you.

00:58:09.690 --> 00:59:24.780

Robinsue Frohboese: Thank you Molly. A lot of these resources and partners within HHS are listed on our website and there was one question about what is the disability law during public health emergencies with regard to evacuation and outreach? and just the simple answer to that is that disability law and the nondiscrimination principles and under the ADA under section 504, 1557 apply to every phase of preparedness response and recovery and outreach, as Molly just talked about in, as they're developing these plans. Again, we are happy to answer any follow up questions we are happy if ASPR would like to have us back at some point to talk about some additional issues when there might be more time and really have appreciated this opportunity to spend some time with you this afternoon. So, I think we're right at the three o'clock area and Maria, turn it back to you.

00:59:27.450 --> 00:59:47.920

Ramos, Maria: Good thanks Robinsue, Molly and Ari. Really appreciate your time and the discussion and I did want to pass it over to Jennifer to close this out for today.

00:59:47.940 --> 01:01:04.890

Jennifer Hannah: Thank you, Maria and I want to thank all of you for taking your time with us today want to especially thank our colleagues from the Office for Civil Rights and we certainly will invite you back to address this particular group, because we know that this crisis of care planning was really something that is a particular interest to all of our recipients. So, thank you again for participating. Also, thank you to all of our other speakers Meghan and Kate and Lauren as well, and we will, as was stated will make sure that all of these slides available to everyone, as well as the recording in a follow up email. As always, we want to hear from all of you, so if you'd like to share how you and your coalition's are using cooperative agreement funding to make an impact on your community you know, please fill out our story from the field submission form in a quick note to your project officer or email htp@HHS.gov.

Please stay in touch with ASPR by visiting our website www.phe.gov or by following us on social media at the handles shown on this slide and with that I'll say thank you and have a wonderful day. Thanks everyone.