

# December 2020 Hospital Association COVID-19 Preparedness and Response Activities Cooperative Agreement Monthly Discussion

December 17, 2020

Event Transcript

00:00:03.090 - 00:06:04.410

**Jack Herrmann:** Good afternoon and thank you all for joining us today. I'm Jack Herrmann, the Acting Director of ASPR's National Health Care Preparedness Program, and before I run through the agenda, I have a couple of brief announcements. As some of you may be aware, I stepped in as the Acting Director of the National Health Care Preparedness Program in August of 2019. While the COVID-19 response delayed the recruitment of the Director position, we have recently re-posted the position. The application process closes tomorrow. If you are interested in the position, or you know someone who is, we are happy to provide the link in the chat box. At the end of this month, I'll be rotating back to my other ASPR job as the Director of External Stakeholder Engagement. I'd like to take this opportunity to express my sincere appreciation to the NHPP team, and in particular Jennifer Hannah for all her support and collegiality over the last 16 to 17 months that I've been in this role. I'm looking forward to returning to my other position, but also look forward to seeing who the new director and the new leadership of this very important and critical federal program will be.

So let's move on to today's call. During today's meeting, Jennifer Hannah will first share a few programmatic updates, and then we will welcome Rover Severino, who is the Director of the HHS Office for Civil Rights. Mr. Severino will discuss crisis standards of care civil rights issues that have emerged in the context of COVID-19. As background, ASPR was invited to work with Johns Hopkins University Center for Health Security, The American Association of Medical Colleges, and the National Academies of Sciences, Engineering, and Medicine to identify ways to raise the visibility of the need for our state and local partners, as well as health care systems and other private sector partners to ensure they have crisis standards of care guidelines and processes in place to help clinicians make difficult decisions at the bedside when faced with a resource-constrained environment, such as what we're seeing now. Towards this effort, this group developed a call to action and a series of informational documents to help guide the healthcare and public health community in crisis standards of care decision-making. The HHS Office of Civil Rights has been instrumental in helping advise these resources and we expect the resources will become available tomorrow. They are slated to be released by the National Academies at noon, and we'll be sure to provide you with the links in our weekly updates that come from our office.

Finally, on today's call, we'll hear from Dr. Connie Price and Mara Prandi-Abrams, who will share insight into Denver Health's Virtual Hospital Concept and approaches to address patient surge management.

Before we begin the meeting, I want to take a quick poll of this group. As rates of COVID-19 infection and deaths escalate across the country, the resultant surge on the nation's health care facilities is having significant impacts on frontline health care workers, resulting in worker fatigue, burnout, and concerns of shortages, such as personal protective equipment. In addition to increasing the availability of PPE and addressing health care worker staffing shortages, what other actions or interventions may be taken by the U.S. government to reduce or mitigate these impacts. Some examples that have been raised to far include providing childcare, providing additional infection control training, expanding home health care options, or expanding eligible health care providers such as utilizing EMS professionals at the top of their scope of practice. We invite you now to type your responses in the chat box, or if you'd prefer to remain anonymous, feel free to click the link in the chat box or cut and paste the URL into your browser. Please note that this is the same link that we provided in the Health Care Readiness Bulletin. For those of you who received it, but it's different from the registration question we asked you related to crisis standards of care. This survey helps us better support your needs in regards to crisis standards of care. We are very

interested in trying to understanding what, if anything, the government can do to help relieve that pressure on the front lines and address some of the mental health issues and other challenges that frontline health care workers are dealing with.

So now let me pass it over to Jennifer Hannah and she'll share a few programmatic updates.

00:06:06.840 - 00:08:22.200

**Jennifer Hannah:** Thank you Jack. Before I begin, I would like to take a moment to thank Jack for his leadership during this time and during his time as the Acting NHPP Director. We greatly appreciate the time that he has spent in NHPP, and although he is leaving us, he's not going far and we look forward to continuing to work collaboratively with him.

I have just a few updates. You all should now be receiving the Health Care Readiness Bulletin, which generally comes out every Monday. It provides the latest information on upcoming meetings, Cooperative Agreement requirements, and health care specific trainings and webinars offered by ASPR and our partners.

As some of you may have seen, we sent a brief update to you recently regarding the rollout of the Cooperative Agreement Accountability and Management platform, or CAAMP, right before the Thanksgiving holiday. While we have you all on the phone, we wanted to provide you with a quick update. We are still working closely with the HHS Office of the Chief Information Officer to obtain necessary approvals to go live. This is a necessary step and although it has moved slower than we would have hoped, we are confident we will get there. Once we've been given the green light, we are essentially ready to roll out the platform to you, and we will start with training sessions and office hours to familiarize you with the functionality. Key to this platform, of course, is the ability to report on performance measures. Once the platform is open, please be assured that you will have ample time to complete the required reporting. Please let us know if you have any questions or concerns about CAAMP. You can send those questions to the HPP mailbox at [hpp@hhs.gov](mailto:hpp@hhs.gov). Again, I want to emphasize that you will have ample time to complete your mid-year reports once the platform is live.

I will now pass it over to Mr. Roger Severino from the HHS Office of Civil Rights.

00:08:27.480 - 00:17:33.180

**Roger Severino:** Thank you very much. It's my pleasure to be speaking with you today about one of the most important questions our country can be facing. What is life worth? Who decides who gets to live and who gets to die? At HHS, we've done everything in our power to make sure that hospitals have the resources they need so that they avoid having to face those tough questions, but we have to prepare for the worst in case it does happen. We encourage states and hospitals to adopt crisis standards of care that provide the guidelines for these "What If?" scenarios if the time does come where resource allocation decisions have to be made.

There's a lot of discretion where states operate in this area, but my office, the Office for Civil Rights, sets out the boundaries and the guidelines to make sure that nobody is left behind, and that everybody gets a fair shot, that discrimination never has any place in life and death decisions. Our civil rights are there to provide those guardrails because there's been an unfortunate history with the medical profession, especially on the topic of disability and age, that has not given full solicitude to the most vulnerable members of our community. Our office enforces Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, and the Age Discrimination Act, among others, to make sure that when the going gets tough, the most vulnerable do not get thrown overboard. Unfortunately, in some quarters, there is a utilitarian ethic and a temptation to try to reduce people to some composite measure of their worth, which will, by its very nature discriminate against people with disabilities and older persons, and we want to resist that temptation.

When we face a crisis such as this global pandemic, that is a time and we need to hold fast to our civil rights laws. Our civil rights laws are not suspended during a crisis. Whenever we forget our Constitution and our civil rights laws in times of emergency, things only go badly and we end up

regretting it as a county. So far, we've been working very hard with states to make sure that whenever these decisions are made to adopt crisis standards of care, that the people who need the protection are protected.

To give you one example, one state dusted off their crisis standards of care plans and we discovered that they had not updated it in quite some time. They had a categorical exclusion for persons with "profound mental retardation," so that they would be flatly ineligible for a ventilator in case of shortage. Now imagine that. What message does that send as a society to people with Down Syndrome, for example, that your life is not even worth attempting to save so they could get a ventilator to somebody who is "more worthwhile?"

Thankfully, after our intervention, the state quickly dispensed with that archaic standard and we've seen other states improve their standards, not just on categorical exclusions based on disability, but also the prioritization of persons based on disability and age. I'm going to walk through just a few of the standards that we've picked up on in review of the states who have been working collaboratively with us so that you can get a sense of where the trip wires are and how you can address them.

Whenever you specifically mention a particular disability as a basis for distinction and create a criterion for either exclusion from a particular life-saving care or reprioritization, you are running into dangerous territory. There are clinically relevant bases for determining who should be allocated a resource. Saving the maximum number of lives is a noble, laudable goal. You are not reduced to simple coin flips to determine who gets scarce resources. However, when you do make these choices, they have to be based on an individualized assessment, which means each person has an equal shot. You don't reduce them to a category and then exclude, you must take an equal individualized assessment based on the best objective medical evidence of that person in that circumstance, given the circumstances.

Second, do not rely on stereotypes. Do not rely on quality of life judgements, thinking: "What is this person's life going to be like before, during, and after treatment?" Even if a person will have a difficult life, that's their life. Medical professionals should not be in a position of weighing the relative value of one life versus another based on their condition or their ability.

So, what standards can be used? We focus on short-term survivability to discharge from the hospital. Whatever their treatment or allocation of resources, you're on safe ground if you focus on their odds and likelihood of survival to discharge. You could use all sorts of tools for that decision-making. We've seen use of the Modified Sequential Organ Failure Assessment (MSOFA) for sequential organ failure. My office does not comment on whether or not that is the best tool or an appropriate tool for medical indications or analysis or diagnostics of survival likelihoods, we are saying whatever tools are used cannot discriminate on the basis of age or disability. So if someone were to use an MSOFA, if it has a ranking order that includes something that has a disparate impact on disability, provide reasonable modification, auxiliary aids, and support for that person with a disability. So, if you're doing an exam of cognitive ability, it's very different when someone has difficulty with comprehension and eye tracking once they've had a traumatic head injury versus a person who has a long-term developmental disability. They're very different circumstances and you have to make sure their tools can take into account those differences, make the reasonable modifications, and take into account auxiliary aids and support.

There is a question of reallocation of resources. If somebody comes in with a ventilator that is a personal ventilator. They do not want to ever be in a position where they're afraid to go to the hospital because it might be taken away from them and given to somebody else from these impermissible measures. Being proactive and seeing that reallocation of somebody's personal ventilator is not allowed is something that we encourage states to adopt.

Additionally, resource intensity as well as duration of need. People with disabilities need auxiliary aids to support, or reasonable modifications. Older persons as well. People to assist them with communication. We want to make sure we don't discriminate because they have additional needs

even during times of scarcity. So there are clear boundary lines on doing what we can to modify our policies and make accommodations so that persons with disabilities are put on an equal plane with people without, and resource intensity and duration of need is one where you start getting into difficult territory.

And additionally, advanced directives. If medical providers are pressuring advanced directives or making it a condition before they do treatment, that's putting people in a very vulnerable state and an unfair position. We encourage states to specifically disavow pressuring people to accept advanced directives, especially as a way of triage, because that puts people in an imbalance.

We want transparency. It's far better to have plans out there, debated with the public, where we have competing ideas of the public good come together than to have it done under the table left to the discretion of somebody on the ground. My sister is a paramedic nurse in an emergency room. She's in the thick of the battle. It'd be unfair to her to not provide proper guidance in these difficult life and death circumstances. There's a way that we could fulfill the goals of maximizing the number of lives saved without using impermissible criteria that discriminate against older persons and persons with disability, using that individualized method that uses medically relevant information based on the likelihood of survival. Those are the touchstones that we've seen in so many states, and the National Academies will come out with a report touching on these things. If you're interested in any particular example, we recommend the State of Utah's Crisis Standards of Care and the State of Oregon's Principles of Crisis Standards of Care. They are fantastic models. My Office for Civil Rights is open to provide any technical assistance to you on the ground who need it. We are here to help to the extent we can as fast as we can, because we are all in it together.

00:17:43.980 - 00:18:31.620

**Maria Ramos:** Great. Thank you so much, Roger. To everyone on the phone, please feel free to submit questions via the written form in the chat. If you'd like to ask a question live, feel free to click on the participants icon at the bottom of your screen and the raise hand button on the right hand side.

00:18:41.970 - 00:20:39.900

**Jack Herrmann:** I just want to remind our State Hospital Association colleagues on the line that as we look at what we are currently faced with across the country and in the increasing escalation of stress on hospital systems as a result of the spread of the virus where ICU Capacity is surging and other care delivery systems are becoming more and more stretched, we do encourage you to make us aware of the particular challenges in your jurisdictions that are notable, and thinks that we should be monitoring here at ASPR as well as where there are implications around this issue of crisis standards of care as we're looking at it. Obviously we're looking at various first line defenses, such as the use of monoclonal antibody therapeutics as ways and methods to hopefully mitigate a community reaching that crisis standards of care line. We recognize that communities across the country are dealing with this in a variety of different ways, and many communities are already having to make critical decisions on care delivery. In order for us to maintain what is happening on the front line, we would just appreciate you letting us know if there are specific concerns or issues that are going on in your jurisdictions or thinks that you believe the federal government can be doing to support those jurisdictions.

00:20:40.650 - 00:20:49.950

**Maria Ramos:** I did see a couple come through the chat. The first question is: Can you please repeat the states with a good model for crisis care?

00:20:53.040 - 00:21:24.450

**Roger Severino:** Utah as well as Oregon. I think those are the two best we've seen. We've reached resolutions with four states and are on the verge of a fifth and sixth. I think those are the two best models. As we've gone through crisis standards of care and speaking a lot with hospitals and medical professionals and civil rights advocates, a lot of it was complaint-driven and the result

of this interactive process over time, we think that Utah and Oregon are the best. We can provide links for you as well. I'll try to track it down for the chat.

00:21:25.980 - 00:22:04.140

**Maria Ramos:** Wonderful, thank you. It looks like Utah has dropped a link to their crisis standards of care resources, and it was updated as recently as yesterday. That is available in the chat as well.

Thank you so much, Roger. I will pass it over to Dr. Price and Mara to begin their presentation.

00:22:04.530 - 00:23:40.650

**Connie Price:** Thank you. My name is Connie Savor Price. I am the Chief Medical Officer at Denver Health in Denver, Colorado, and I'm also an infectious diseases physician. Mara Prandi-Abrams and I wanted to present to you our approach to planning for the surge of COVID patients in our hospital. A lot of creative solutions were needed, including things like innovations, like Virtual Hospital at Home. We'll touch briefly on that. I found in my years of disaster planning that it's really nice to have a surge plan, but until you know exactly what you're in and what the special threat is with regard to emerging pathogens, it's really hard to do this up front. I hope that some of the principles that we describe here might be useful in informing future models and planning for future emerging infectious disease threats in hospitals going forward. With that, I will turn it over to the real brains of this duo, which is Mara Prandi-Abrams, who is our Operations Manager of Patient Flow at Denver Health.

00:23:41.760 - 00:32:15.270

**Mara Prandi-Abrams:** Thank you Connie. I'm here to talk a little but about how we've approached it and what we've seen and what was different in the first surge versus the second surge. I will talk a little bit about who we are, what we looked like before COVID, our Spring surge in that Virtual Hospital at Home, as well as our Fall surge and share our surge plan.

We're Denver's safety net hospital. We are about 550 licensed beds. We are actually a full system that includes our hospital, primary specialty care, multiple urgent cares, behavior health, Denver Public Health, school-based health centers, poison and drug safety, and we are also the 911 system. A high percentage of our patients are Medicaid, so we definitely treat that population as a majority.

Pre-COVID we had about 227 adult med surge and critical care, which was split about 47 ICU and 12 intermediate care. The rest of the licensed beds were things like psych, we have our correctional care facility, women and children, and various things like an eating disorder clinic and things of that nature. We did have frequent adult ED boarding and we did typically have capacity in our Women and Children Pavilion.

In the Spring, we definitely saw a large number of sick COVID patients as I imagined much of the country did. We did still have overall capacity in our hospital because we weren't seeing the typical patients that were coming into our hospital before that. People definitely took notice to stay home. As part of that surge, we took multiple of our existing med surge units and we added that ICU infrastructure so that we can actually increase our ICU capacity by quite a lot. We did also convert a unit that had been one-third immediate care and two-thirds med surge care, and we created a kind of flexible unit which allowed us to flex up and down based on what the need was, whether that was floor care, intermediate care, or critical care on that unit. We did consolidate some of our lower census pediatric units, which really gave us more beds that we could leverage for that adult population that we were seeing in quite high numbers.

We developed a surge plan specific to this crisis and we also created this Virtual Hospital at Home program. So let's talk about that Virtual Hospital at Home and ultimately our goal is: How do we not hospitalize patients that were higher risk that had COVID-19 to make sure we reserved our hospital capacity for those who really needed it and met criteria. In addition, we hoped to be able to discharge our patients with COVID so that they could reduce their length of stay and really open up

those hospital beds for other patients out of our hospital. It was an extra level of safety for those patients who are enrolled in the program to make sure that if they were decompensating, we could quickly catch that and get them to the next higher level of care that they needed.

The criteria for that program has really changed as we've not had as much hospital bed capacity. Initially, it was really just one or more risk factors for decompensation and now the criteria have increased to two or more risk factors. We can really monitor that mild hypoxia outside of the hospital. The program was focused on how to use our outpatient providers—providers, nurses, care navigators—to monitor patients at home? Patients were given a pulse oximeter, a blood pressure cuff, and a thermometer and they would receive two calls daily. Typically, one from the provider and one from the nurse to really check in on how those vital signs were going at home, any concerns in terms of what they were experiencing, and things of that nature. Patients would be monitored through that usual timeframe of decompensation and really monitor for that improvement or not. Patients were provided education, meal assistance, supplemental oxygen as needed, and then ultimately the patients experiencing decompensation, we could arrange for them to be transported to the hospital so that they didn't really have to worry about anything and we could focus on just getting them to the hospital to get well. As part of the second surge, we provide therapeutics for patients who meet that criteria as well.

Capacity in our Virtual Hospital at Home and the results, like I said before, really flex staffing to meet demand. It's been about 30 to 35 patients daily, but we've had as many as 45 and if we need to, we can actually increase even more. Because it's been such a popular program, we've had to downgrade some of those lower risk patients to less intensive monitoring to really allow our providers and nurses to focus on those that are a little bit higher risk. As of yesterday, we've seen 1,000 patients in the program for an average duration of the program for about four days. For the initial analysis that was done during that Spring surge of 288 patients, only about 13% required care escalation and those that did require it, about 34% of those were admitted to the hospital.

The patient feedback has been very, very positive and a huge shoutout to the folks down at the bottom there, Stacey Altman and Dr. Ryan, as well as Dr. Hanratty, who really put this program together. It's been a huge success at our hospital.

So, in the Fall, it's been a really different set of patients that we've seen. While we've seen that increase in COVID patients, we've also seen a pretty large increase in non-COVID patients. So overall, our hospital capacity has been much fuller. We did go ahead and permanently convert some of those units that we had capitalized on from our women and children's unit in the Spring to increase our adult capacity. In addition, we privileged pediatricians so that they could treat patients up to age 30, which really allowed us some flexibility when the hospital was fuller so that we can treat our older adults in our adult units. The availability of having heated high-flow oxygen has made it so that we can offload our ICU and allow our respiratory therapists to treat more patients in our floor units instead of in the ICU.

As always, with the greatest-laid plans, you have to change them oftentimes. Our surge plan tended to have larger increments in terms of how many beds we increased at each level, and we learned that that really was not feasible and ultimately, we didn't need to increase by 40 to 50 beds at a time. We work to really break down our surge into smaller levels both to make it easier to move up levels as well as allow for recruiting staff to keep up with a lot of that. Staff, as I imagine many people are experiencing, is hard to find, and so we're using a lot of that temporary staff.

After that, our surge plan was ready to go. When we received an order from the Colorado governor to increase capacity by 50%, we were able to quickly respond to that and use both our hospital capacity as well as our Virtual Hospital at Home capacity as part of that response to that executive order

This is our surge plan. You can see that level one was where we were pre-COVID and then level two is where we were in the Spring. Each level as we go up allows us to increase capacity, doubling beds in certain rooms, increasing both ICU and med surge capacity frequently at different

levels to make sure that we don't have too much of one versus the other. A lot of what we've learned is really that having hybrid units that can treat COVID positive and negative patients has been very helpful, depending on where we are within the particular surge. That's all I had, if there are any questions.

00:32:23.910 - 00:32:36.390

**Maria Ramos:** Thank you so much, Mara. I'm monitoring the chat to see if any questions come in. As a reminder, feel free to send us your written questions via the chat or you can also ask a question verbally by raising your hands.

00:32:57.480 0 00:33:08.220

**Connie Price:** Yes, I'll ask a question of the audience, I'm curious, how many of you also have a virtual hospital at home or similar construct? Are we pretty novel?

00:33:37.980 - 00:34:02.850

**Jack Herrmann:** Yeah, it looks like some in the chat box saying, not at this time, in Kansas they do, other folks may have slight variations of this. Feel free to raise your hands and we are happy to have you participate on the screen.

00:34:06.390 - 00:35:15.630

**Connie Price:** I think I have heard that some of the other Colorado hospitals have done something similar. Honestly, I think the barrier has been in reimbursement because it isn't well-reimbursed right now, so you do get paid better to put the patients in the hospital. That said, when we're in the middle of a pandemic and we are even talking about scary issues like crisis standards of care, because we don't have hospital beds available. I think as a health care system, we all need to get more creative and try to get around those barriers of reimbursement in just doing the right thing. So perhaps we'll see some movement on that in future health care models that this won't be a costly intervention for most, because it was very effective, both from a patient satisfaction issue as well as from a care issue.

00:35:17.250 - 00:37:42.090

**Jack Herrmann:** Thank you, Dr. Price. Just looking in the chat, now it looks like there may be some facilities like in Utah, Idaho, New Mexico, that may be looking at variations of this, but again, this is in the context of what we're currently dealing with and what we're projecting to see over the next weeks and months, and with regard to surge on hospitals. With concepts like these and models like these that I think are going to be instrumental to communities at being able to address patient care delivery services in the context of these constrained resources, we're going to see that likely continue for the next weeks and months given where we're at now with this pandemic. We encourage you all to be looking for these kinds of resources and make sure that you're connecting with us if there are things that we can be of assistance with or resources and tools that we can be sharing with you and in turn you are sharing with your members. Please do not hesitate to let us know.

I want to jump back to one issue. I'm not sure if Mr. Severino is still on the line, but you were promoting the Utah and Oregon crisis standards of care plans. When you describe them as exemplary plans, you're talking about the perspective of their inclusion of provisions to address civil rights as opposed to kind of looking at the whole plan and every element within the plan as an exemplar.

00:37:43.320 - 00:38:46.470

**Roger Severino:** Precisely. When I mentioned, for example, the discussion of MSOFA, it's not whether or not it's clinically appropriate, that's a judgment for the doctors to decide. It's whether or not it's used, is there are proper accommodations and taking into account civil rights laws. So, when I refer to Utah and Oregon, I've sent a link to Utah's in the chat box, it's for their civil rights compliance and best practices. They are great in saying that if you use X, Y, and Z tools, this is how you do it in a way that does not discriminate. It doesn't use age cutoffs, it doesn't use categorical calling out of disabilities, and it says you should not use things like reallocation or long-

term duration. So, it has green lights, yellow lights, and red lights. Green lights are what you should do. Yellow lights show if you apply it, how you should modify it and make accommodations. Red lights, you should not do it and here's why. So, from a civil rights perspective, and a civil rights perspective only, we think they are models.

00:38:46.830 - 00:39:46.320

**Jack Herrmann:** I appreciate that clarification because I think this is one of the issues we're going to be challenged with again over the coming months as states and jurisdictions and healthcare systems begin to either develop their plans or refine their plans because of what they're encountering in real time, they're going to need to be able to make real time changes and updates and they're going to need to know what subject matter experts they can reach out to for consultation or consideration and certainly from the perspective of civil rights, they can always reach out to the HHS Office for Civil Rights for any assistance or support, they may need in helping refine update modify those particular components of their plan to ensure that they are respecting civil rights, is that correct?

00:39:47.700 - 00:40:23.550

**Roger Severino:** Yes, that's right. For example, we say, there should be individualized assessments of each patient using the best available medical evidence. We don't advise as to what actually counts as the best. That's the expertise of you all to figure out what is the best evidence for the clinical presentation, and if you're going to use discharge, survivability to discharge. So that's, you know, there's different spheres of expertise and we're happy to provide any assistance for anybody on the line if you want to know more of how civil rights laws could apply with whatever tool you may be considering adopting

00:40:24.060 - 00:43:26.340

**Jack Herrmann:** Great, thank you. And also, as we try to connect with the patient surge management issues as well as is drawing people's attention to ASPR TRACIE for the many, many resources that ASPR TRACIE has available to you and your members in regards to resources to address search management issues and it will we have obviously great relationships with our partners, including our Denver partners, who can help you know answer questions or lead you to other particular resources that your, your members may need it, as you all begin to continue down this path of facing the very real challenges that this pandemic is bringing to the front line every day. Let me stop and see if Mara or Connie have any additional comments or feedback or would like to pose other questions to the group.

Let me open it up and take a few minutes to ask our State Hospital Association partners: Are there any other topic areas that you would like to either raise on this call or have us consider for future calls? What are the things that are most impacting your members throughout your states or you as a program office, if you will, in administering the COVID-19 supplemental funding that ASPR has provided you? Looking in the chat box here: staffing strategies for surge, delays in discharge for long-term care patients, staffing resources for critical care, more frequently asked questions for addressing vaccination, we'll add these to the list.

Anyone think that considerations for telemedicine in the vaccine implementation strategy or the role of telemedicine in vaccine implementation, which has been growing should be addressed?

00:43:26.400 - 00:44:40.320

**Roger Severino:** I have a pitch on telemedicine. So my office also regulates HIPAA which you all know and love, and we issued a notice of enforcement discretion earlier this year, allowing use of common telecommunication apps like FaceTime, Zoom, WebEx, and Skype can be used for telemedicine now, and we will not enforce any related HIPAA violation that comes from use of that particular device. Normally you would need a business associate agreement and a few other things, and I think that's helped revolutionize the shift towards telemedicine that will still continue through vaccination. You could use your phone to talk to your patients, if you weren't aware of that. Please take full advantage if your patients are comfortable using their iPhone to communicate



remotely, they should be able to with you, and don't worry about HIPAA enforcement and we're actually looking for ways to make that sort of communication permanent because we believe there's enough privacy with the end to end encryption that it may fall under the exception, but please be aware that you could use that right now.

00:44:42.420 - 00:48:37.320

**Jack Herrmann:** Great, thank you. So, you know, looking in the chat we see a number of responses related to staffing shortages and I'll challenge folks to try to be as in the weeds as possible. If there are specific areas to address within staff shortages, as specific as you can be, please let us know. You can submit any of these questions or refinements to your topic areas at our email address at [hpp@hhs.gov](mailto:hpp@hhs.gov). As I said, we can look at how to add these topic areas to future calls, or to set up ad hoc calls if we see there's enough interest in these topic areas. I'm taking away from this that there's obviously more discussion or information on the vaccine implementation strategy, how to address and resolve staffing shortages, and again, please give as much definition to that question as you can provide me would be appreciated. It looks like we've got a few others on here as well around risk communication, public messaging around mask mandates, and issues related to that.

Well, again, we appreciate your time today and I also want to thank our presenters for the great presentations that you provided to us this afternoon. As I mentioned, we will continue to monitor any challenges or other issues that you bring to our attention. We want to encourage you to share your stories or those of your members by emailing us at [hpp@hhs.gov](mailto:hpp@hhs.gov). I also want to remind you that if you've not taken any of the surveys that we sent you in the chat box, we would really appreciate your input and feedback. As I mentioned at the top of the call, our priorities right now are to look at ways we can help reduce the surge on healthcare systems and the stressors on health care systems that we're seeing related to the increasing pandemic. We want to make sure that we remain open to hearing what challenges you and your members are facing and are there opportunities for the U.S. government to help alleviate or mitigate some of those. Our efforts over the next couple weeks are going to be focused on raising the visibility on the use of monoclonal antibody therapeutics as a way to mitigate or prevent patients from needing hospitalization or reaching the ICU, as well as making sure the states and local jurisdictions and health care systems are putting together the necessary actions related to crisis standards of care. You'll see us emphasize that over the next few weeks and months as we deal with the stress on the front-line health care systems. Again, thank you all for joining us today and we appreciate your time. Take care everyone.