December 2020 Hospital Preparedness Program Cooperative Agreement Monthly All-Recipient Webinar

December 9, 2020
Event Transcript

00:00:03.840 --> 00:04:16.440
Jack Herrmann: Good afternoon, everyone, and welcome to the monthly Hospital Preparedness Program All-recipient Webinar. I'm Jack Herrmann, the acting director of ASPR's National Health Care Preparedness Program, and I want to thank you for being on today's call.

Before I run through the agenda, I have a brief announcement. As many of you know I joined the NHPP in August of 2019 while we were conducting a national search for a new director. Unfortunately, that search got a bit disrupted by COVID-19 but I'm happy to say that we have recently relaunched the search and the position now appears on USA jobs.gov as a supervisory public health advisor, more commonly known as the NHPP director. If you are interested in the position or would like to promote it to other colleagues who need additional information, please let me know. At the end of this month, I will be rotating back to my other ASPR job as the Director of the Division of External Stakeholder Engagement. I want to take this opportunity to extend my appreciation to the NHPP team, in particular, Jennifer Hannah, for all of her support and collegiality over these last 16 or 17 months that I've been in the role. It's hard to believe that time has flown by so quickly, but here we are. I'm looking forward to returning to my other position, but also looking forward to see who will be the new director and the new leadership of this very, very important and critical federal program.

So let me move on now to today's call. During our meeting today, Jennifer Hannah will share a few of the HPP programmatic updates. Then we'll welcome Dr. Fales who will share insights into how the MOCC concept has been successfully deployed in the state of Michigan and then hear from Dr. Thota on how the medical resorts program they have has accommodated COVID-19 patient surge in the Houston, Texas area.

But before we dive into the HPP updates, I wanted to first thank those of you who provided a response to the status of your crisis standards of care planning via the web form that we sent out in the same invite for this webinar. If you have not had the chance to reply to that survey, we encourage you to complete it, as this will be tremendously helpful as we move forward with understanding the impact that the current COVID-19 surge is having on jurisdictions across the country and the readiness of those jurisdictions in regards to the challenge of implementing crisis standards of care. We are going to send the link via the chat box now and if you could take a second to respond to that, that would be great. And I think we're looking to have you type your responses in the chat box. If you wish to remain anonymous, type the URL into your browser and select the link there and you can respond to it from that position as well. And again, this is the same link that we provided in this week's Health Care Readiness bulletin, so if you've already completed the question, we asked that you not complete it again. But if you have not, please do so. I'd like to now pass it over to Jennifer Hannah for a few other programmatic updates, Jennifer.

00:04:19.830 --> 00:09:05.850
Jennifer Hannah: Thank you, Jack. Good afternoon, everyone. As many of you know the HPP funding opportunity announcement, as well as the notice of funding opportunity requires that recipients meet the Emergency System for Advanced Registration of Volunteer Health Professionals, or ESAR-VHP, program compliance requirements. These compliance requirements

consist of capabilities and procedures that each state ESAR-VHP program must have in place to ensure effective management and enter jurisdictional movement of volunteer health professionals in emergencies. The compliance requirements are documented in the East RBS guidelines which were last updated in 2010. We are updating the compliance requirements and the guidelines over the coming months and would appreciate your and your service coordinators input and guidance along the way. In particular, we'll be interested in what about the guidelines should remain or change based on lessons learned from day to day operation and responses, such as hurricanes, floods, wildfires, COVID-19 etc. And also we'll be interested in your input regarding other recommendations you may have for the guidelines and how they should adapt to any volunteer staffing concerns in the near or medium-near term. This project is currently underway so please, be on the lookout for additional communications from us regarding your feedback and input.

Recent discussions have brought to light the increased burden for recipients to submit after coalition membership and member location data through the PERFORMS system, given the pandemic response. For the HPP cooperative agreement End of Year FY 2019 (Budget Period 1) data submission. NHPP and SHARPER are offering an alternate option for submission of the required member organization information to reduce time spent reporting on the mandatory performance measures. NHPP will allow recipients to submit a complete list of healthcare coalition members in your jurisdiction directly to the branch via email using Excel template with the same due date of January 8 for the completion of the performance module. We will send the instructions on this slide in an email in the coming days. Please keep in mind, NHPP and SHARPER will only accept one option from each recipient either via PERFORMS or Excel template. If you have any questions on the proposed solution for this budget period, please reach out to the SHARPER mailbox at SHARPER@hhs.gov, Chris Suzich, and/or Kate Gorbach at the email address listed on this slide.

Finally, I want to provide some insight into our recipient data collection for our recipient factsheets and how we hope to utilize a streamline in a year validation process to collect the qualitative data for those fact sheets. We'll be including a request to either validate or input in new response for each of the following: a preparedness or response story, COVID-19 response bullets, and general HPP highlights. Our team will use these inputs to update each of your public-facing recipient fact sheets. You can see the template of the recipient fact sheet on this slide. The highlighted sections are those that we are asking for your input on through this validation process. Please be aware that we will be gathering this qualitative data for recipient fact sheets in the upcoming month. Additional information will be forthcoming from the evaluation team, also known as SHARPER. I will now pass it over to Dr. Bill Fales.

00:09:06.510 --> 00:11:02
Jack Herrmann: And this is Jack. While Dr. Fales is preparing his presentation here let me add one more thing that I should have added earlier and my apologies, because the team did a great job giving me the talking point and I forgot to do it, but one of the things that our senior leadership, including all the way up to the Secretary of Health and Human Services has been interested in is addressing the growing burnout and fatigue of healthcare workers on the front line. And he has asked us to consider reaching out to our partners such as you to identify ways that the US government may be instrumental in helping mitigate or prevent continued burnout and fatigue amongst our healthcare workers. Now we know most of the responses we've been getting are that we need more messaging at the government level on non-pharmaceutical interventions like mask usage and handwashing and social distancing and even responses that we need more funding and address staff shortages. But what we'd like to ask you to do, and maybe in the polling question, and Maria just put this in the chat box, if you could kind of think more in the weeds about this. Are there things that the federal government can be doing besides some of the things I just mentioned that could really support health care workers on the front line and reducing/mitigating burnout and fatigue? Feel free to write those into the chat box or there's a URL in the box as well that you can

click on and provide your answers there. So thank you for indulging me and a little redirection here. I'm going to turn it over to Dr. Fales.

00:11:05.580 --> 00:34:08.310
Dr. William Fales: Good afternoon, everyone. Thanks Jack for the opportunity to speak today on Michigan's experience, particularly from last spring with the utilization of the Medical Operations Control Cells at the state level.

In addition to my position as the State Medical Director for Division of EMS and Trauma within the Department of Health and Human Services, my only other disclaimers are really professional relationships. My day job is with Western Michigan University School of Medicine and I've also served as a Kalamazoo County Medical Control Authority Medical Director. None of these, I believe, should be a conflict.

So, very briefly, just a quick overview of Michigan's healthcare preparedness program. And this is about as simplified as we get. It falls under our Bureau of EMS, Trauma, and Preparedness and since the very beginning of the old HRSA days in 2002 following the attacks of 9/11 we have organized into regional Health Care Coalitions. I don't believe we called them that in the beginning, but that really is how our program has been organizing this work service fairly well during that time, the hospitals, EMS, local public health emergency management, Long Term Care, tribal health, and others all come together into these eight regional Coalitions now. Because Michigan is special, if you look at that map, you'll notice we have two regions to the north and the south and we don't have a region Four for some strange reason. Our Health Care Coalition regions also align with our State Police emergency management districts and that seems to make some sense. Each Health Care Coalition has a full-time regional coordinator, an assistant coordinator, and a part time, typically 25% FTE, medical director. Each Health Care Coalition is also expected to provide a Regional Medical Coordination Center to function as a multi-agency coordination center under NIMS to help make all the stakeholders, work, and play well together during a response. And I guess we've never had a response like we've been dealing with now.

To go back to the spring, and I really would like to avoid going back to the spring, but Michigan started with COVID-19 in March when we identified our first two cases in Oakland County, which is a large suburban county just outside of Detroit. What was not particularly unique to Michigan was what I would describe as just asymmetric epidemiology where in southeast Michigan, we had truly extreme activity. In the rest of the state, it was quite sporadic and this was really comparable to other states. And this is just a map of New York State. New York was about 10 days ahead of us. I think their first case was on March 1. And you can see just the tremendous activity in the tri-state area around New York City, but in surrounding states and upstate New York, relatively sporadic activity. In Southeast Michigan, what we really saw was just what I would describe as really extreme conditions during this period of March, April, and kind of phasing out in May, early May. Our peak hospitalizations in Southeast Michigan alone for COVID-19 were over 4400. We had 12 days with over 1000 COVID patients on mechanical ventilation. I believe our peak was 1223 in one day and our peak number of patients intubated on one day was 176.

This is kind of a busy slide but it illustrates that asymmetry that I talked about. The two curves at the top of this slide are two Southeast Michigan regions. The city of Detroit is a region to South and you can just see the separation for hospitalizations per 1 million population between Southeast Michigan and the rest of the state. The only one that came close to that was Region 3 which is the kind of the south-central part of Michigan, Flint and Saginaw areas. And then this just shows the same thing with mechanical ventilation. Again, Southeast Michigan is just exponentially above the rest of the state.

This is a poor attempt to kind of compare New York City and Detroit as it relates to the COVID-19 outbreak and this is picking 21 days when both cities were experiencing extreme stress on her healthcare system and looking at COVID-19 daily hospital admissions in both cities. No question that just because of the size of the City, New York far surpassed Michigan and Detroit in terms of the hospital admissions. If you normalize this though per 1 million population, now you see a little bit of a different story. And you see that really, the orange and the blue bars are fairly similar. And a few days, Detroit actually exceeded the number of hospitalizations per 1 million. So I would just argue that the stress on the healthcare system in both cities was just unimaginable. When we look at mortality rates in both cities at 40 days after the initial Sentinel case, there were 646 deaths per million in New York City and 919 deaths per million in the city of Detroit.

This all required us to revisit rapidly and make some revisions to our state health care surge strategy. And very simply that the goal of the strategy is to save lives and reduce pain and suffering by optimizing the use of the state's healthcare resources. And with that, to extend conventional standards of care to as many patients as possible while minimizing the needs for crisis standards of care, especially while conventional capacity exists and that really becomes an important part of our strategy. Four components of our strategy were the use of relief hospitals, alternate care sites, homecare sites, and relief personnel. And you can see that EMS really plays a role in each of those. The Medical Operating Coordinating Center really primarily focused on the relief hospitals. Real briefly, I'm sure everyone is familiar, the term relief hospitals may be a little bit unique to Michigan, but the objective of the relief hospitals was basically to extend conventional standard of care to as many citizens that we could and minimize the need to move to the crisis standards of care. We view alternate care sites as typically reflecting crisis standards of care, and even if it involves moving patients of further distance, we believe that's preferable rather than to use a non-healthcare facility.

Fundamental to the use of relief hospitals and patient redistribution or load rebalancing [was] the movement of patients between facilities. And when we look at that we really can see kind of three patterns evolve. One is the movement of patients within a healthcare system and Michigan, like probably most states, has their healthcare networks out there, so that was often kind of the first point of relief to move patients from hospitals that were being heavily impacted to hospitals within the same system that had capacity. But beyond that, we saw the need for inter-regional transfers within any one of our eight regions, particularly in southeast Michigan. And these were coordinated by our regional medical operations coordinating centers, what we refer to as just Regional Medical Coordination centers. Yet at the state level for the first time we really saw a need to do coordination of extra-regional transfers through the S-MOCC or the state medical operation coordinating center.

When we went to create the S-MOCC what motivated us was just a fear that the health care system in southeast Michigan, in the Metro Detroit area particularly, was reaching the breaking point. And we would be forced to move emergency patients rapidly out of Detroit to hospitals in rest of the state that had capacity. The S-MOCC was felt to be appropriate to help facilities facilitate these intra-regional transfers. Then you're kind of forced to choose who is best to operate this S-MOCC. We started off by thinking about our own Bureau staff operating it, we talked about the state police, emergency management colleagues, as well as the National Guard. And we realized that none of these people were really best prepared to deal with regular interactions with hospitals and with EMS agencies. So we made a decision to approach one of our large regional EMS agencies in Western Michigan that was a relatively unaffected part of the state at the time, and to see if they would take on this role as a remote part of our overall Incident Management System [because] they can offer the ability of having familiarity with inter-facility transfers. They do that on a regular basis. They knew where most of the hospitals were in the state because it is a large agency and they do transfers statewide and they were also familiar with EMS agencies around the state. They also used, as most of our state did at the time but never like we do now, EMResource which is our proprietary state web-based patient or hospital tracking system and resource system. We

offered a single phone number to our hospitals that rang into this coordination center. And it would staff, obviously since it's an EMS dispatch center, staffed 24/7. We had dedicated generally supervisory level personnel in the in the control center there that were primarily handling the S-MOCC responsibilities and their job was to be sort of a matchmaker trying to connect hospitals that had, at times, a very desperate need for transferring patients to hospitals that had availability, what we refer to as our relief hospitals. And then whenever needed, they would help to broker EMS to execute the transfers by either ground or, on less frequent occasions, by air. Hospitals were responsible, though, to ultimately accept all transfers, the relief hospitals, and to ensure that physician to physician and nurse, a nurse communication took place. So it wasn't the S-MOCC deciding absolutely where one patient went and avoiding the usual communications that need to take place in a handing off a patient during a transfer.

I'm just going to show where we fall under NIMS. Our state of emergency operations center has a health branch, which would fall under the operations section and the medical operation coordinating cell would be underneath that. Remotely our department's community health emergency operation coordination Ccenter is a supporting multi agency coordination center to our state EOC. Underneath the S-MOCC, we did have a physician consultant that was typically me just helping on occasion to try and provide some guidance when we had some challenging transfer decisions.

These two columns here are really very analogous and they are just our Regional Medical Operations Coordinating Center compared to our State Operations Coordinating Center and the process was fairly similar. Real relief hospitals had to declare their status or availability to accept patients on EMResource. That was used by both the R-MOCC and the S-MOCC to identify where patients and beds might be patients might be able to be transferred and where beds might be available. R-MOCC would receive requests from transferring hospitals within their region just like S-MOCC would from outside of the hospital's region. The MOCCs would identify the relief hospitals that would be potentially available and make that information available to the hospitals. And the transferring hospital would contact the relief hospitals directly to secure an acceptance. The relief hospitals would accept the patients. The MOCCs would assist with coordinating EMS as needed and really rarely was it needed. Usually hospitals could find local EMS to execute the transfers.

This is just one screenshot of EMResource showing what this is one of what was going to be many different web based we refer to them as boards, the resource boards or cancer alerts.
We have hospitals declare their status: would you be willing to take COVID-19 patients and would you be willing to take non-COVID patients because that also could help offload badly burdened hospitals. And then, then they would specifically enter the application and declare, how many critical care and non-critical care patients, they would be able to take for both COVID and non-COVID patients.

While we stood up the MOCCs, both regionally and state MOCCs to help facilitate these transfers, we did so realizing that our preference was that hospitals would operate like they would normally do outside of disaster conditions and deal with direct transfers whenever possible. So the MOCCs were where they are to facilitate those transfers and play the role that we just described, but that we recognized that hospitals are good at doing these transfers. It was somewhat unusual to see large 901,000 bed hospitals transferring to a 100 bed hospital with a small ICU. But nonetheless, it was still an area that we felt was best to move the patients just using the normal mechanisms so these hospitals would bypass the regional or state MOCCs. They would identify potential hospital on EMResource that would be a relief hospital and then make the appropriate arrangements on the road. If needed, the MOCC would step in and help coordinate ambulance transfer.

So what are the five key elements you really need to make this patient redistribution or load balancing work? First, you obviously have to have hospitals that have a need to transfer patients

out that are being overly burdened. You have to have some kind of coordinating entity, enter the MOCCs. It's essential you have situational awareness and some kind of a platform to provide all the stakeholders at all echelons with the awareness of where bed availability is. And you have to have EMS to provide the entire facility transfer. Then the fifth thing is you have to have hospitals that are willing to accept the patients. And while we were successful with transferring an awful lot of patients, we also, I think, came short in being able to fully exploit some of the extra capacity in hospitals in our less impacted parts of the state.

It's not totally clear why that why we had those challenges, but I think probably the biggest thing, and remember, this was back in the spring when we weren't really sure [of the situation]. A saying that we use a lot in Michigan is “Look where the puck is going not where the puck is,” so many of our hospitals in the Western side and Central part of the state just felt that this was a calm before the storm. It was just a matter of time before Detroit just spread their COVID patients into their communities. They were really afraid of this, with some basis, to give up their abundant capacity to serve as relief hospitals with fear that it was coming to them very soon. And there was also some number of hospitals that expressed concern that they had not yet had any significant COVID activity in their community. They thought by accepting patients that would be bringing it into their hospital. We did our best to try and debunk that. I don't know how successful we were, but I think all this really points to the importance that during the public health emergency like this, we have to have really good, real time epidemiological intelligence to help inform policy decisions at all echelons.
This is an illustration of how we did during a 20-day period. We moved almost 1000 patients. And by saying we, that was not me. It was our hospitals in the system and with some facilitation by MOCCs. But again, as we kind of hoped, the majority, 85%, [of transfers] were done by direct inter-facility contacts. About a third of our inter-facility transfers were transfers within health systems and if we look at southeast Michigan, not surprisingly, that's where the bulk of the transfers occurred and typically moving from the badly impacted hospitals of the Metropolitan Detroit areas to other hospitals, such as in Ann Arbor, Michigan, a short distance away from Metro Detroit, that had capacity, and a far less amount number of transfers in the rest of the state.

What are the roles of MOCCs in Michigan? I think it's important [to know that] for Michigan we viewed the role as clearly a role of being a facilitator, not a controlling entity. We were helping to be that matchmaker role and helping to arrange EMS transport, but not pointing and saying patients in Hospital X go to Hospital Y. That really was kind of outside of the area we were functioning. Staffing at the state MOCC was, we think, very well accomplished by experienced paramedics and using an EMS control center that was removed from our state EOC, but was in regular communication with the rest of the emergency incident management system. The physician role was very much consultative and helped on occasion with problem solving and again, not that controlling role at all. And maybe perhaps providing a little bit of medical leadership to the process. And then the use of the statewide hospital web-based status application, like EMResource in our case, was absolutely essential to making this work and allowed a lot of hospitals to do those direct transfers, which were so successful.

So just to summarize, we believe the relief hospital and MOCC concepts work. Statewide MOCCs are successful in coordinating the transfers. [You have] to have something like a resource for that situational awareness and a decentralized approach empowering hospitals to do what they would do in non-COVID times and execute transfers. To facilities where there are resources available, it seems to be a good approach and then the state's role and regional role is just to help facilitate that. Relief hospital recruitment can be challenging, to say the least. And we also felt pretty comfortable that overall inter-facility ground and air transfers were safe and effective including some very sick patients that were transferred on mechanical ventilators. With that, I offer to address any questions that might’ve come up. Thank you.

00:34:09.060 --> 00:34:24.780
Maria Ramos: Thank you so much, Dr. Fales. It looks like we had a couple questions come into the chat just now. So Nick asks, did the transfer redistribution of patients help support equity of care amongst patients representing communities of color?

00:34:27.150 --> 00:35:55.650
Dr. William Fales: That's a great question. And Michigan was particularly struck by a disparity in care based on racial factors. I don't have a great answer to that other than that it impacted care in communities, particularly the communities in the metropolitan Detroit area that had an extremely high African American population that they were caring for and being able to move those patients to hospitals that had capacity I have to think undoubtedly really provided better care. And I give just one example, an anecdote. We had a 900-bed hospital that transferred, in one day, we sent three patients across the state to another hospital that was a small level-3 trauma center in a rural community. Those patients were all mechanical ventilators and we knew at that time life expectancies on mechanical ventilator, and the likelihood of weaning was very low. All three of those patients weaned successfully and two of those three were patients of color. So not exactly the answer to the question, but I think by offloading the badly impacted areas, it couldn't help but to impact areas like the city of Detroit.

00:36:00.540 --> 00:36:11.490
Maria Ramos: We also had another question come in. Can you explain further the differences in the roles of the state MOCC and the regional MOCC? What were the triggers that resulted in engagement at the state MOCC?

00:36:15.360 --> 00:37:12.930
Dr. William Fales: Yeah. Originally, because we live in this emergency management world, ee always want our hospitals to kind of work with their healthcare coalition leadership in their regional medical coordination center. So what we envisioned originally was that hospitals would go to the region and if the region couldn't help them out with a transfer within the region, than the region would contact the state and then the state [would coordinate] patient matchmaking. I think about halfway through the first day we realized that was just putting a middleman in there. So it's pretty apparent that when the region, and we're really talking about our Metro Detroit regions in southeast Michigan, once they got to that point, they would still certainly stay in very intimate contact with the hospitals. But the hospitals would then go directly to the state because they knew they had to find a home outside of southeast Michigan. Hope that helps them.

00:37:14.520 --> 00:37:26.820
Maria Ramos: Thank you. Another question. Did you utilize an indicator that reflected the dynamic fluctuation of resources capacity versus the availability within the regional coalition?

00:37:31.260 --> 00:39:14.790
Dr. William Fales: Great question. I'm not sure if that question is directed on the sending or on the receiving side. The sending hospitals were doing everything imaginable to take care of some of the sickest patients we've ever experienced. So it was clear that they were at a point where they needed to have patient redistribution occur and load rebalancing. On the receiving side, we've always have asked them for as far as back as I can remember, we've asked our hospitals to always be able to surge up to 20% at a moment's notice, consistent with national HPP guidelines. As things started to escalate in Southeast Michigan, we asked hospitals to do what we called “super surge” to 50% above their normal average day census. We had some hospitals in the unimpacted areas and in the impacted areas that doubled their numbers of beds. So, and they also deferred elective procedures and everything. So we felt that we had a very large capacity in these areas and we really were trying to ask hospitals in the less impacted areas to offer up 10% of the available beds so hospitals have super surged up. And then at the same time we're at record low census. So

they really did have pretty good capacity for the sending hospitals. Really it was almost whoever was screaming the loudest seemed to get the most attention, probably from our S-MOCC.

00:39:16.230 --> 00:39:51.930
Maria Ramos: Thank you so much for those answers, Dr. Fales. In the interest of time, I think we're going to need to move on to our next speaker, but certainly if anyone has questions, feel free to submit them into the chat and we may be able to address them at the end of the event. I will pass it over to Dr. Thota. I think you might be on mute.

00:39:57.270 --> 00:49:15.360
Dr. Archana Thota: Hello everybody, I'm Dr. Thota. I'm the corporate Medical Director for the Medical Resorts and I truly appreciate this opportunity to speak to all of you and share our experiences as we move along in this pandemic, which is very unforeseen and unexpected, as we all know. It's a very interesting experience as we are moving along and trying to learn what we have done together as a nation and a country.

Houston, and Texas especially, has been on the map for being impacted with COVID-19 in a very severe manner. For quite some time, Harris County has been hit really hard and around April of 2019, sorry, 2020 is when we partnered with SETRAC to see if we could create alternative care sites that would help us with our patient population in terms of placing them at appropriate locations and to care for them as we were running out of ICU beds. During that time is when we partnered with SETRAC and [converted] some of our skilled nursing facilities into alternative care sites. Now the medical resorts are not a typical skilled nursing facility that has long term care patients. They are more transitional facilities so patients would come get better and go home. That was the intent of those facilities. They are also capable of doing some long-term [Unintelligible] here. We thought, you know, with the surging cases and ICUs being full, this would be the most appropriate place for us to transfer some of the stable patients and care for them. As I was listening to Dr. Fales, I hope I'm saying this correctly, I apologize if I didn't spell this right, but we kind of sort of did like a loose MOCC, where the MOCC cell unit we partnered with was SETRAC and we would direct all the patients into appropriate locations. We never interfered with the day-to-day operations of the hospitals or anything, but we have helped them. We held their hand if they had problems with discharge disposition. Houston actually was hurt really badly in Texas so this alternative care site helped us a lot.

And as I had mentioned the alternate care site was a blessing for us to kind of be able to care for these patients in different locations. The other biggest problem we had was staffing. So by having these facilities that are already operational that could provide care for the patients helped a lot. Houston actually even tried other alternative care sites like taking their football stadium and converting it into a hospital. But the problem for that to be able to be operational was staffing and finding staffing during this time and with all the [Unintelligible] of employees and especially in the healthcare system was not easy for us to tackle, but this provided a better opportunity for us to be able to care for these patients. These are some of the pictures of the medical results and I just wanted to show this slide to see how they looked.

The partnership that we did with the state to care for COVID-19 only patients would allow [unintelligible] during the processes all those other facilities which are long term care facilities, assisted living facilities, independent living facilities, and patients who got COVID-19 would come and stay with this facility. I was the medical director and I was facilitating the placement and transfers in terms of talking to the doctors and improving the transfers and reviewing their medical records, making sure that these patients were appropriate for this level of care and move them quickly so we could kind of keep those hospital beds available for the sicker population. So we were working with SETRAC and with the hospital care coordinators. We would provide them with

our bed situation, just telling them how many beds are available and what we can take for that day and we work hand in hand to take care of our population in the Houston area.

The major hurdle we had was the patient complexity and sometimes the level of care that they needed. For example, for the ventilator patients, I've been in touch with a pulmonologist in the Houston area and we talked about the discharge disposition for some of those ventilator patients as we were in search for ventilator beds. These patients were very, very critical. So that was where my role came into play to evaluate these patients and make sure that we could appropriately care for them in these other locations as we move them from the hospital.

One struggle, that we see in our lessons learned, was electronic medical records. There was not a continuity of electronic medical record systems between the hospitals and the skilled facilities that we were using. So that kind of made the process a little bit more complicated and that was one of the recommendations we made to some of the hospital systems within the Houston area to see if there could be a long term care component to the electronic medical records so that we could easily kind of transfer the data and do the approvals faster. We had some blanket waivers from some of the insurance companies as well as Medicare, which has waived a three night stay which kind of helped us take these patients, even from the emergency room sometimes, where the patient did not require to go to the hospital and spend the three nights before they could come to a skilled nursing facility. All the blanket waivers and things of that have happened during the pandemic, which some of them are still continuing, have helped us a lot.

The Medical Resort of Pearland had about 140 beds and during our peak time of summer in July, August, we had reached a census of about 90 to 95% occupancy. A similar thing happened with Woodlands. Woodlands was a smaller facility that honored a different part of Houston in the Northeast area. It had about 90 total beds and there our census went up to again 94% or 95%. Currently we are at the capacity of occupancy recorded patients like we did during June of this year.

So again, we have put a lot of infection control protocols in place down, which allowed for better care of these patients and preventing the transmission of COVID as much as we could. We had a lot of training for the employees at these COVID designated facilities and that prevented this rounding long term care facilities, assisted living, and independent living facilities to provide them with an opportunity where they did not have to create another COVID unit within their own building. That really kind of helped the situation where we care for these patients in these designated COVID units.

Again, I think this was a blessing in disguise, where it helped the community and not just the hospitals, but the local community itself from the standpoint of assisted livings, independent livings and personal care homes, [because] they were able to place their patients directly into these COVID units to be cared for. We're continuing this partnership at the present time and this is taking away the burden from the local community as well as our hospital partners and our long-term care providers. Any other questions?

00:49:17.340 --> 00:49:27.870
Maria Ramos: Looks like we just had one come in from Neil on how turning these long-term care facilities into alternate care sites impacted core long term care business.

00:49:28.530 --> 00:50:33.900
Dr. Archana Thota: Like I pointed out, like I said early on, this is a very good question. Typically people think about nursing homes as long term care facilities, but these skilled nursing facilities are transitional facilities to begin with. So they did not have a lot a lot of long term patients and the only long term care patients that they ever had were patients that were treating patients that require long

term frequent vent care and those were transferred out to some of their sister facilities and therefore, we believe, able to just stick the specialties only for COVID patients. Long story short, it didn't even impact the long-term care business of these facilities, because they were only allowed to have about nine beds, I think, for Woodlands and 10 long term care beds for more special patients.

00:50:37.650 --> 00:51:17.400
Maria Ramos: Just waiting for a couple more questions to come in here and if anyone has any other questions, you can feel free to put them into the chat or if you want to look at the at the participants icon at the bottom. You can also raise your hand to ask a question, verbally. Okay I'm not seeing any questions come in, so Jack, I might be able to turn it over to you.

00:51:18.660 --> 00:54:36.300
Jack Herrmann: Thanks so much, Maria, I want to thank our presenters for these informative presentations today. And these topic areas are very much critical as we move forward in responding to the increased COVID surge across the country. As many folks know, we are monitoring the data daily as it's coming in from facilities and systems across the country to better understand the impact that the COVID-19 virus is having on the health care sector. We have also been working closely with the Healthcare Resilience Working Group to ensure that you all and your colleagues have the resources necessary to address some of these challenges. And if you have not had the opportunity to access ASPR TRACIE or our other ASPR website resources, including the MOCC toolkit, our workforce toolkit, and our alternate care strategies toolkit, this would be the time to go and review those resource materials. We know that many jurisdictions are experiencing challenges across the country as they look at how to decompress their hospitals to address the surge and the alternate care strategies being just one resource of many that states and local jurisdictions are looking into. But unfortunately, when opening an alternate care site, you inherently are having to address a staffing issue. We hope that you are finding these resources useful in the field and where you're not or where there are questions or you need additional resources, please make sure you pass that information on to us. And then lastly, just want to remind you again that the NHPP Director position is now on USAjobs.gov and Maria provided the link to the job description at the beginning of the webinar. I also want to remind you that we have a couple survey questions out there related to crisis standards of care and suggestions for ways we can be addressing and mitigating burnout and fatigue among frontline healthcare workers. Any suggestions you have a please go to those links and provide those. Just want to thank you all again for your time today and for all the great work that you're doing in the field. And if there's anything that we can assist you and support you with please do not hesitate to reach out to us. And again, thank you for all your support as I've been in this position for the last 16 or 17 months. I wish you all the best and I'm sure will connect with you in in my other roles so. Take care everyone and have a good afternoon.