

## January 2021 Hospital Association COVID-19 Preparedness and Response Activities Cooperative Agreement Monthly Discussion

January 21, 2021

Event Transcript

00:00:08.790 - 00:01:17.280

**Joseph Lamana:** Good afternoon, everyone, and thank you for joining us today. I am Joe Lamana, I'm the Director of Readiness, a division in ASPR where HPP currently sits. It is my pleasure to be with you today as we connect on a variety of related topics about COVID and the COVID response. I look forward to listening and hearing your experiences as you have tried to manage in your own areas. As mentioned in December, Jack Herrmann, who was serving as the Acting Director of NHPP, has moved back to his original position in the Office of External Affairs. In the interim, I will be helping Jennifer Hannah, who is the Deputy Director for NHPP. I just hope that I can stay out of her way and let her do her job. I'll just be here to support as she needs it. So with that, I will turn it back to the facilitator and let Jennifer continue.

00:01:41.820 - 00:04:41.430

**Jennifer Hannah:** Thank you Joe, and good afternoon everyone and Happy New Year to all of you. So first I would like to provide you with a quick update on the Cooperative Agreement Accountability and Management platform or CAAMP. We are still working closely with our HHS Office of the Chief Information Officer to obtain necessary approvals to go live. This is a necessary step, and although it has moved much slower than we had hoped we are confident that we will get there very soon. Once we've been given the green light, we will start with training sessions and office hours to familiarize you with the functionality. A key to the platform, of course, is the ability to report on the on the performance measures and once the platform is open. Please be assured that you will have ample time to complete required reporting, including midyear reports. Please email us at [hpp@hhs.gov](mailto:hpp@hhs.gov) if you have any questions or concerns about the platform.

As you recall from previous meetings, ASPR polled a variety of programs stakeholders, including yourselves, health care workers, and public health professionals to gather information on how the COVID patient surge is impacting them and how the federal government could assist. I wanted to share today a brief overview of the responses that we've received. ASPR received nearly 400 responses to the poll, and we reviewed and grouped each response into one of 17 categories. We then organized the 17 categories into five overarching themes: workforce, patient care, situational awareness and regional coordination, funding, and equipment and infrastructure. The recommendations submitted across each of these themes and categories included workforce support and training, staff augmentation, and additional funding were used to identify potential federal intervention to address the workforce challenges during the COVID-19 surge. You can see from across those five different themes, what the response breakdown was. The majority of the responses of course were related to work force, financial assistance and resource support, staffing, workforce training, mental health, and the second was patient care. We will share the slides following the call so that you can read through each of these much closer. With that, I will now pass it over to Matt Watson from the Healthcare Resilience Working Group. Thank you.

00:04:54.870 - 00:06:12.180

**Matthew Watson:** Thanks for that, Jennifer, and good afternoon everybody. I just wanted to share a little bit with you today about a recently released document. The Healthcare Resilience Working Group, or HRWG, has recently released a document called the Monoclonal Antibody Infusion Model, which provides operational and logistical guidance on how to establish and operate those infusions centers. The document provides a scalable-size model that includes information on patient intake, infusion, post-infusion observation, and discharge stations.

Matthew Watson: The model can be applied in varying community needs facility sizes staffing levels, etc. And it's designed to augment therapeutic confusion delivery capacity at the state, local, tribal and territorial levels. To access this document and other resources related to monoclonal

antibody infusions for COVID, please visit the ASPR TRACIE website. We will also make sure to put the link to this document in the chat. I'm now please to hand it off to Commander Diana Solana.

00:06:17.040 - 00:21:21.120

**Diana Solana-Sodeinde:** Thank you very much sir, and good afternoon, everyone. My name is Commander Diana Solana-Sodeinde, and on behalf of the Healthcare Resilience Working Group, HRWG, want to thank you very much for the opportunity to share the newly developed Surge Roadmap resource with you today.

You'll see our disclaimer with boilerplate language that you can refer to before to after the presentation. The Healthcare Resilience Working Group created strategies for managing of surge in COVID-19 cases, which we refer to as the Surge Roadmap, to provide guidance to various jurisdictions on how to enhance health care capabilities in response to a surge in COVID-19 cases. This resource is hosted on ASPR TRACIE and consolidates multiple resources related to staffing, PPE preservation, and establishing a Medical Operation Coordination Cell, or what we refer to as MOCC, and alternate care sites, or ACS. You'll learn more about each of these topic areas later in the presentation.

These are the three primary steps covered in the Surge Roadmap, which are related to health care workforce staffing, PPE preservation and establishment of MOCC or ACS. The Rural Surge Readiness Team as part of the Healthcare Resilience Working Group is to develop a collection of essential rural health care resources, tools, and workforce training for health care workers to prepare for and respond to COVID-19. These resources, which are searchable by health care sector and topic area, are available on the Rural Healthcare Surge Readiness Web Portal shown here on this slide.

As communities experience a surge in COVID-19 cases, health care facilities and emergency medical services may quickly become overwhelmed with patients and experience staffing shortages due to worker illness, fatigue, and other factors. HRWG created the Healthcare Workforce Staffing Playbook as shown on the slide. This document is targeted at health care facilities and jurisdictions and consolidates resources aimed at addressing staffing challenges, focusing on actions to maximize available resources. This document also helps to ensure that health care facilities and jurisdictions consider and exercise various options and tools available to them before seeking federal assistance. Requests for federal assistance entail discussions between emergency management agencies, FEMA, and HHS regional emergency coordinators to clarify staffing requirements and to determine whether the various options outlined in this playbook have been considered and implemented. Please keep in mind that federal assistance to provide medical personnel to address health care workers shortages are only temporary. Personnel availability typically ranges from 14 to 30 days depending upon the sourcing of this asset. For instance, the National Disaster Medical System or the Department of Defense. The first page of the staffing playbook as shown illustrate how health care facilities and EMS agencies who are beginning to encounter staffing shortages should act. We recommend, for instance, implementing the CDC Surge Capacity Strategy, as well as forecasting using their new Online Workforce Calculator to projects staffing needs in order to effectively retain an appropriate number of qualified staff. After implementing several actions, health care facilities may submit a formal request for assistance to their jurisdiction. These agencies may consider using options such as reassigning staff to augment health care facilities according to the Public Health Service Act of 2019, or leveraging alternate staffing sources, such as using the National Guard, the Emergency Management Assistance Compact, and the Medical Reserve Corps. In addition, we refer to contract options such as the VA Federal Supply Scheduled Service, for which HRWG provided a webinar to regions and jurisdictions in September 2020. After considering implementing several recommendations, jurisdictions may then consider taking federal assistance from FEMA and HHS.

This slide shows the staffing shortage playbook, which provides links for health care facilities and jurisdictions to implement the recommended actions illustrated all the previous slide. In Step Three, we summarize the FEMA Advisory on Medical Staffing Requests, which entails a set of questions

posed by HHS and FEMA Regions to jurisdictions seeking federal assistance to address health care worker shortages. These questions align with the recommended actions for health care facilities and jurisdictions to consider and implement. For instance, telemedicine can be used to provide expert consultation to augment onsite staff, especially in rural areas and may also serve as a force multiplier for onsite critical care staff. Telemedicine can also provide extra support for health care providers who are providing care outside of their usual scope of care, such as ventilator management expertise for providers with little ventilator experience. We hope that this playbook implemented at the health care facility and jurisdiction level will clarify the process to request federal assistance and enhance awareness of available options to be explored before seeking federal assistance.

PPE Preservation encompasses valuable strategies that can be implemented immediately to help alleviate PPE demand. As PPE is being used and PPE resupply may be unknown, preservation strategies are critical to prolong PPE supply currently on hand. They are to be implemented sequentially. Always implement conventional strategies prior to contingency or crisis. We have also developed several resources, including the PPE Best Practices Fact Sheet and the PPE Preservation Planning Toolkit, as shown on the slide, to work through PPE shortages. Always remember to reduce, reuse, and repurpose.

HRWG has developed this PPE Preservation and Resource Request Process Guide to navigate shortages of PPE. Please follow this document sequentially until PPE supply issues are resolved. The first step is to determine current PPE supply and to understand how to implement PPE preservation strategy. Next, contingency capacity preservation strategies should be implemented, while also addressing local PPE shortages through identification of new external suppliers. The third step is to request supplies from health departments and emergency management agencies. Next, resource request must be submitted to the federal government only after completing steps one through four, should this capacity strategy to be employed. This step should be implemented as a last resort only if previous mechanisms are unable to alleviate PPE shortages.

HRWG created a reference table here to help direct health care facilities and first responder organizations to the most appropriate PPE for specific activities. Here, you can see that some PPE is not recommended, even in crisis. For example, if the only PPE available is a surgical mask, then aerosol-generating procedures should be postponed. However, using the table, health care facilities and first responder organizations can prioritize PPE based on need and function.

The MOCC and ACS Concept of Operations were developed and formalized early in the pandemic, and have been deployed by state, tribal, local, and territorial partners during their response. These interventions intended to address systems and space vulnerabilities. However, we recognize that these are not complete solutions and that it is critical to also consider staffing and supplies. ACS addresses clinical space concerns by providing a flexible, scalable, model intended to increase local capacity. MOCC enhances local- and state-level visibility on the health care system and enables load balancing and situational awareness. While valuable on their own, using them in combination likely does provide an additional benefit to stressed health care systems as information, patients, staff, and supply can easily flow to the most appropriate destination.

In addition to the ACS and MOCC toolkits, HRWG has focused on developing a suite of supporting documents and tools to aid implementation. One example is the ACS Resource Package, which combines two resources in a more digestible format. These resources, as you can see on this slide, include those developed by the federal government on how to stand up, fund, and operate an ACS, and some publications describing lessons and best practices from ACSs published earlier in the year. The Critical Care Load-Balancing Operational Template provides a framework for indicators and triggers that may assist states that are implementing medical operations coordination cells. Finally, we have heard that some patients may be hesitant to be transported to an ACS from the hospital. And so, HRWG is adopting a tool developed by state partners to help guide and build those clinical interaction, and we hope that this will lead to increased ACS utilization.

The last topic today is crisis standards of care. Over the last 10 years, a lot of work has been done by the National Academy of Sciences, Engineering, and Medicine to advance this concept. Recently, an external working group has been established to help translate some of that foundational work into more actionable recommendations, and to raise awareness of crisis standards of care among clinicians and the public. In addition, crisis standards of care aren't just relevant to the inpatient setting. There are implications for prehospital, ambulatory, and long-term care settings that are also important to consider. For example, renal replacement therapy and dialysis have been critical to the COVID-19 response, not only for outpatient and at-home dialysis patients with current end-stage renal disease, but also for approximately 20 to 30% of ICU patients that experience acute kidney injury and require acute continuous renal replacement therapy and hemodialysis. To help, HHS and the American Society of Nephrology came together to provide a series of Scarce Resource Roundtable Sessions with clinical experts, and developed a report of best practices, lessons learned, and clinical tools that could be rapidly used by clinicians in rural to urban hospital settings.

These next slides actually provide a summary of the many resources we have covered today. Please feel free to disseminate widely with your partners as you find appropriate. And lastly, before we go into questions, I wanted to definitely appreciate your time and this opportunity to share about the Surge Roadmap and all the resources we've been developing. We highly value your feedback and would like to hear about additional resources that will be helpful to you as well as feedback on your experience with any of our existing services. You may contact HRWG using the email address noted on this slide, and also the Surge Roadmap Webinar recording, which was already done, by just simply clicking on this link below.

Before we open for questions, we do have panelists who will be joining us. We want to welcome Commander Michael Nguyen, Captain Michael King, Mr. Matt Watson, and Captain Cynthia Rubio, who will certainly be on the panel to address your questions. Thank you.

00:21:26.280 - 00:21:40.710

**Zoe Kovatchis:** Thank you, Commander Solana. It does appear that we have some questions in the chat. First question is from Gil, and he asks: Is there an initiative to look at RN turnover in the U.S.?

00:21:55.830 - 00:22:05.460

**Diana Solana-Sodeinde:** That would be a question for Commander Nguyen, or Captain King, or Mr. Jose Gonzalez. The question is about addressing staffing as it relates to nurses.

00:22:07.440 - 00:23:02.160

**Michael Nguyen:** As our staffing playbook states, the nursing turnover is a huge problem in the U.S. This is especially true since you can take locum jobs or other positions that have higher incentives than maintaining your current position. Having said that, the staffing playbook encourages the use of local resources to try to recruit furloughed workers or retired workers and try to use local and regional resources to even out that distribution and provide stability, but there's no current initiative that I'm aware of that's looking specifically at the turnover of nurses.

00:23:12.570 - 00:23:19.530

**Zoe Kovatchis:** The next question is: Will these PPE preservation plans make it to the ESF-8 plans?

00:23:49.920 - 00:24:49.710

**Cynthia Rubio:** Right now, what's happened with supply preservation as we move forward and return functions to agencies that are going to keep them indefinitely is ASPR has stood up a supply chain logistics operation cell good of a supply chain logistics operation cell that houses PPE preservation or supply preservation, which I am taking care of at the moment. The cell's purpose is to coordinate activities and we are ESF-8 so there should be a connection and my group is well aware of these activities. I am always here for questions at [cynthia.rubio@hhs.gov](mailto:cynthia.rubio@hhs.gov) and I belong to ASPR. Thank you.

00:25:06.330 - 00:25:10.590

**Zoe Kovatchis:** The next question is: What standards of regional resources trigger MOCC operations?

00:25:15.750 - 00:25:46.140

**Matthew Watson:** Really good question. It's going to vary region by region, and we have put out an operational template with some suggested triggers and thresholds, with respect to load-balancing so that may start to answer your question, and if there are any follow ups or particular concerns, please feel free to get in touch with us.

00:25:55.890 - 00:26:13.050

**Zoe Kovatchis:** So, the next question is: Will there be updates on this information?

00:26:13.950 - 00:26:33.570

**Diana Solana-Sodeinde:** If there are going to be any updates, they will be available and accessible. Anyone can access those slides and updates as well.

00:26:37.950 - 00:27:22.530

**Cynthia Rubio:** ASPR TRACIE is part of ASPR and a partner group to my supply chain logistics operations cell. They are part of our work plan and we are planning monthly reviews of everything posted from this activity into TRACIE to ensure relevance. Moving forward post-COVID, these resources remain appropriate and easy to access in case something else starts developing.

00:27:38.970 - 00:27:46.710

**Zoe Kovatchis:** The next question is: Is it appropriate to employ this as an EOP development standard?

00:28:06.150 - 00:29:49.290

**Jack Herrmann:** This is Jack Herrmann. Let me take that one. So local emergency operations plans typically don't address crisis standards of care. Great question. Crisis standards of care are going to look different jurisdiction to jurisdiction. As you can imagine, as COVID has unfolded across the country, communities have been faced with very challenging situations as to how to make decisions at the bedside in the context of a constrained resource environment. ASPR TRACIE has a number of resources, including some webinars that have been conducted on crisis standards of care. Also, the National Academy of Sciences, Engineering, and Medicine has conducted a webinar. These are these are really local and state decisions that need to be made as to what constitutes a crisis standards of care practice that is going to be incorporated at the state, local, jurisdictional level, or facility level for that matter. The federal government has no authority to direct on how states and jurisdictions are going to apply crisis standards of care, other than to suggest that each state needs to be working with its public health and health care partners to identify how those partners will respond in the event of a constrained resource environment.

00:30:04.980 - 00:30:20.580

**Zoe Kovatchis:** We have a question in the chat that says: Are there communication pathway recommendations between FMOCs, and SMOCs and/or RMOCs available to access as resources and maintain situational awareness.

00:30:32.250 - 00:31:18.330

**Matthew Watson:** Thanks for the question. A really good question. I would say that they are not standardized communication pathways. You definitely want to leverage whatever information systems are available in the state or region where the MOCCs are established. The other thing I would say is that the person or small team staffing the MOCC should have good connections within the health care system that they can fall back on to know exactly where the most appropriate points of contact are for any given facility or health care system.

00:31:35.700 - 00:31:51.720

**Zoe Kovatchis:** It doesn't appear that we have any other questions in the chat at this time, but as a reminder, anyone can put a question in the chat or raise their hand using the participant function in the bottom toolbar.

00:31:55.110 - 00:32:07.140

**Diana Solana-Sodeinde:** And if you do have any questions after this presentation and meeting today, please feel free to send them over to Zoe and we'll address them.

00:32:27.480 - 00:32:50.670

**Zoe Kovatchis:** Thank you. And since we do have a bit before the top of the hour, we'd like to open up the line for any other questions either for our presenters here or for ASPR in general. I see we do have a question about the ETA on CAAMP.

00:32:57.540 - 00:33:56.370

**Jennifer Hannah:** I can take that question, and that that's a great question. As we stated earlier in the session, we are still waiting for approval from our Office of the Chief Information Officer and unfortunately there is not a specific timeline. We think we're very close to getting that approval. It really is at their discretion of when they complete the review of that system and can approve it for you. As soon as it is available to be launched, we will share that information with everyone and, as I said, establish or set up the training sessions as well as the office hours. Of course, we will give you ample time in order to report any performance measures for mid-year and end-of-year reporting. Thank you.

00:34:02.340 - 00:34:12.270

**Zoe Kovatchis:** Thank you, Jennifer. And we do have another question about MOCC planning, and the question is: MOCC planning is usually grant funded. What is the outlook going forward?

00:34:16.320 - 00:34:23.940

**Matthew Watson:** Another great question, and that that is one I'm going to have to take back, but we will note that and get you an answer on that.

00:34:27.120 - 00:35:28.770

**Jack Herrmann:** Let me take a look at that as well. Clearly from the planning side of it, and I'll let Jennifer weigh in from the hospital preparedness side, there have been funds through the COVID-19 supplemental that have gone out to Hospital Associations, some of which can be used from the MOCC planning perspective. That is an option there, whether or not there will be additional supplemental funding and new COVID bills coming out is pending whether or not there will be additional FEMA funding that comes out, which also is pending. The MOCC planning per se can be covered under NHPP funds. The only thing that can't be used for is direct clinical service. Jennifer, do you want to expand on that at all?

00:35:33.210 - 00:36:14.730

**Jennifer Hannah:** Jack, I think you covered it up pretty clearly. Anything as part of planning can be incorporated as part of the COVID planning, as well as the traditional annual cooperative agreement, as well. As Jack stated, the restriction on all of this funding, both the COVID supplemental funding as well as our HPP funding, there is a restriction that the funds cannot be used for the provision of clinical care or for staff to provide clinical care. The planning for the MOCC should continue to be funded through the annual funding as well as the COVID supplemental funding.

00:36:38.760 - 00:38:00.600

**Maria Ramos:** Diana has posted some of the links to the various TRACIE resources that she referred to throughout today's session and during our last meeting, we had also let you all know that you have been added to the distribution list for the weekly Health Care Readiness Bulletin that our team sends out to you all, which has resources and reminders for the cooperative agreement and general notifications about upcoming events. I just wanted to let you know that links to these

resources, as well as updated resources, are available in that bulletin, so feel free to be on the lookout for that. While we're waiting for additional questions to come in, I did want to make an announcement during this call that we are always looking to spotlight the work that you are doing with your cooperative agreement funding. If any of you are interested in presenting on a future webinar, we certainly would appreciate your volunteering. Please feel free to leave your contact information or insert the topic that you wish to speak to in the chat for today's webinar, and we'd be happy to follow up with you.

00:38:06.090 - 00:38:16.920

**Zoe Kovatchis:** Thanks, Maria. We do have a couple more questions in the chat. One is for Jennifer: can you confirm COVID testing is or is not an allowable expense?

00:38:23.370 - 00:40:15.240

**Jennifer Hannah:** We did include that question within our frequently asked questions on our PHE.gov website. As stated in those questions, the intent of the COVID supplemental funding wasn't for testing. We think if there is a justification for using the funds for COVID testing or if the jurisdiction does not have funding for that from either CDC or from another source, then you can submit a request for our consideration. I think it's important to highlight that we do know that CDC did recently receive \$22 billion in funding for expanded testing as well as vaccination distribution. That should be the first point of contact or first funding stream for testing as well as for vaccination activities. If a jurisdiction found that they are not able to leverage that CDC funding, or additional funds were needed for that purpose, then you can submit a request to ASPR for our consideration to be able to use ASPR funds for COVID testing. Thank you

00:40:22.260 - 00:40:46.080

**Zoe Kovatchis:** Thank you, Jennifer. We do have one more question in the chat about how coalitions and states complete and conduct HVAs, JRAs, supply chain assessments, THIRA, and other traditionally required reports to identify and justify the use of HPP and other federal dollars and how the combined federal funding sources can best be used to complete these activities.

00:40:55.560 - 00:41:50.640

**Jennifer Hannah:** So, the HPP cooperative agreement recipients are required to complete a jurisdictional risk assessment every five years. That's not limited to the five-year project period, but at least every five years. They are also supposed to consider what the vulnerabilities and the needs are for that jurisdiction, and then the Health Care Coalitions are required to complete an annual hazard vulnerability analysis each year and update that. All of that information from the JRA and HVA are used for the planning purposes for their annual cooperative agreement.

00:42:01.380 - 00:42:21.300

**Zoe Kovatchis:** Thank you, Jennifer. There is a question about vaccination and relying on hospitals to be vaccination centers: Can ASPR SHA funds be used to cover the expenses to staff mass vaccination sites in community hospitals?

00:42:30.780 - 00:42:39.030

**Jennifer Hannah:** I think that is one of the questions that we're going to have to take back and explore that further and then follow up with a response related to that.

00:42:53.490 - 00:43:02.400

**Zoe Kovatchis:** Excellent. Thank you for your questions. We will hand it back over to Joe Lamana for closing remarks.

00:43:07.560 - 00:44:05.010

**Joseph Lamana:** Thanks everybody for getting on the call today. Jack, thank you for taking some time out of your busy day to jump on this call. I know you've got a lot on your plate. I want to thank everybody for your continued support of this and all the hard work you all are putting into this response. We're all in this together. We're all working to trying to help each other and it only gets better as we continue to communicate. We look at these forums to really be able to cross talk and

be able to get that information out. Thank you for your time today and hope to and look forward to talking with all of you the next time we meet, which I believe is somewhere around February 10 at the quarterly Health Care Readiness Cooperative Agreement and All Recipient webinars. Thank you and have a pleasant day.