ASPR Health Care Readiness Cooperative Agreements Quarterly All-Recipient Webinar

November 12, 2020

Event Transcript

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Jack Herrmann: I am the acting director of ASPR's National Healthcare Preparedness Program. We're excited to have representatives from a variety of ASPR Health Care Readiness programs on the line today, including our hospital preparedness program or HPP Cooperative Agreement Recipients, Hospital Associations, our Regional Disaster Health Response system, or RDHRS, pilot sites and the National Emerging Special Pathogens Training and Education Center, or NETEC, institutions.

As you may recall, we hosted our first All-Recipient webinar this past August and had the valuable opportunity to hear from some of our RDHRS and NETEC colleagues on their COVID-19 response activities. The purpose of today's meeting is to further support collaboration among ASPR Health Care Readiness Programs by spotlighting cooperative agreement recipient response efforts, while also facilitating conversations on hot topics related to the COVID-19 response.

First, we are excited to welcome our colleague, Dr. Satish Pillai. Dr. Pillai is from the CDC assigned to Operation Warp Speed as a Senior Liaison Officer, and he'll be discussing COVID-19 vaccine implementation strategies. Thank you to those who submitted questions on this topic before this presentation, and Dr. Pillai will try to address some of those during the Q&A portion of the program today. We also encourage you to share other questions or concerns you might have during today's meeting using the options that Maria went over earlier.

After Dr. Pillai's presentation, we will hear from the team managing the Alternate Care Facility at the Wisconsin State Fair Park about their operation strategy and how it has evolved in recent weeks, given the current surge in COVID-19 cases in the state. Finally, we'll hear from the Colorado Hospital Association about their experience with COVID-19 patient transfers through the Colorado Combined Hospital Transfer Center. Without further ado, I'd like to hand it over to Dr. Pillai to begin his update on the COVID-19 vaccine implementation strategy. Dr. Pillai?

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Satish Pillai: Thank you, Jack, and thank you for the opportunity to speak to the group. I'm going to quickly go through these slides because I think at this point, since we are getting very close to actual implementation and it would probably be best to spend time answering questions as best as possible, and [for] those that I can't answer, I'm happy to take back to my colleagues in Atlanta or at Operation Warp Speed here in DC.

So, some of you may have seen this. I know that there are many new members on this call, but I just wanted to quickly describe the multiple components that are being addressed. As we look at vaccine implementation, there is a need for prioritizing populations, thinking about how we will move these vaccine products that are currently in clinical trials that have varying cold

chain requirements that have varying numbers of doses required, identifying locations where they can be administered and stored or redistributed as needed, and given some of these vaccines require multiple doses, have systems in place to be able to recall patients, be able to monitor individuals for, you know, safety signals. All of this is occurring in parallel. While this graph suggests that it's a sequential set of events that occurs, the planning has been happening in parallel, for all of these activities. Similarly, all of these topics require significant communications and guidance products so that all the partners that are involved from the health department and health care partners as well as our commercial side partners that are involved from manufacture to distribution to administration all understand what we're doing, why we're doing it, and the sequence of events that that will be involved. The bottom line is for us to have a substantial public health impact with our vaccine program. It is going to require a rapid, efficient, high uptake of the complete vaccine series, and for that to occur. All of these activities that are delineated on this slide need to fall into place in as seamless fashion as possible.

This graphic is simply to highlight that initially the vaccines that will be available won't be sufficient to cover the entire U.S. population and there will need to be some level of prioritization of target populations. In addition, during that targeted administration period, we're going to want to ensure that there is maximal uptake and limited waste. So, there'll be significant controls put into place at the OWS federal level to ensure that doses are tracked, administration is ensured, and that there's again minimum wasted and processes in place to recall individuals for their second dose. Initial recommendations for those priority populations have been considered by groups such as the National Academies of Science, as well as ongoing deliberations within the ACIP Advisory Committee on Immunization Practices, and it's anticipated that, following an Emergency Use Authorization, or FDA authorization for use of the vaccine, ACIP will convene and provide additional clarifications and indications for priority population. At present, based on what we've heard to date, health care workers and first responders are in that highest tier of priority populations. As doses increase over time as more products become available, receive EUA authorization, and as those vaccines that have already received authorization continue to be produced, there will be likely sufficient supply to meet demand.

While initially, there might have been constrained administration sites using Mass Vax clinics or very targeted locations for administration, we'll be able to leverage additional locations for potential administration, additional pharmacy locations, doctor's offices, and other clinics settings and we will as the vaccine becomes available, we will be able to continue to move down the priority population list and it while we still need to understand better the dynamics of COVID and SARS-CoV-2, it's possible that we will eventually settle into a steady state where there may need to be consideration for subsequent annual or some cadence of follow-on vaccine over time, similar to what happens in annual influenza that campaigns.

This is simply another way of thinking about the select critical populations topic. While this isn't a comprehensive list, it is not necessarily a finalized list, but identifying individuals based on the type of work and essential work that they may be doing as part of the community writ large, whether their health care workers or essential workers for some other indication. Individuals that may be an increased risk for severe illness, whether they're older individuals or have underlying medical comorbidities as well as individuals that may be higher risk for COVID-19

whether it's because of demographic characteristics because of where they may be residing or because of other characteristics that have been identified as increasing the risk for acquisition of COVID-19 disease. And finally, thinking about individuals that have otherwise limited access to vaccine due to distance from providers in rural jurisdictions, inability to go to a provider, perhaps because of underlying disability or other factors. The right side of this graph is just to show that we want to explore the breadth of vaccination sites and continue to expand those sites over time based on vaccine availability, based on the characteristics of those vaccines, such as their cold chain characteristics.

And again, this is simply to highlight or provide a general description of how the vaccine is anticipated to flow from manufacturer to the administration sites. Some of it is to highlight the need for a very tightly interconnected circuit of information. So as the vaccine comes off of manufacturer lines, a majority of the vaccine will be handled through the CDC's contract that they exercise with the McKesson distributor. Other products may have direct distribution from manufacturer to administration sites. Irrespective from the distributor, the product will go to administration sites. And initially, it may be at more circumscribed locations such as Mass Vax clinics, potentially hospitals and occupational clinics, if health care workers are identified as a priority population for Tier One vaccination, as well as leveraging pharmacy partnerships, which HHS announced several weeks ago that they are partnering with several pharmacy chains for reaching residents of long-term care facilities over time. The administration sites are anticipated to expand as there's more product available and additional priority populations can be covered with available vaccines. The left side of the graph which shows the dotted lines and the green boxes are to highlight the iterative process where administrations will request vaccines against the allocations that have been identified, based on the available product and the allocations that had been assigned from OWS and higher levels based on the available product that the US government receives. Those requests then are approved, go to the distributor or the manufacturer, which then subsequently results in distribution of vaccine to the administration sites.

[We're] getting close to the end of this high-level overview. Clearly some of the most important aspects in addition to having a vaccine in a timely fashion, we want to make sure it's a safe and effective vaccine and we're communicating this information in as transparent a fashion in terms of vaccine safety in addition to using existing systems such as VAERS, which is a reporting system that has been in place for years and allows for reporting of safety-related issues from providers and patients to FDA and CDC. There are additional platforms that are being developed, which allows text-based and other electronic systems to report signs or symptoms that may be related to or is following receipt of a vaccine. The goal is to, on the CDC website and other communications, provide information on the vaccine on our processes for monitoring safety following vaccination and essentially providing real-time information to the U.S. public health care providers.

This all falls under the rubric of Vaccinate with Confidence, which is CDC's general strategy to reinforce confidence in the COVID-19 vaccines, and the underlying concepts are to regularly share information about the vaccine. We want to be able to empower the health care providers with timely information so that they can share it with their patients. Recognizing that most individuals are integrated into a community and that the community may have different ways of

sharing information, we want to understand how best to transmit information that meets the needs of individuals within their community.

What are the concrete activities that need to occur right now? We are working across 64 jurisdictions, 50 states, and six territories and freely-associated states, and eight large US cities to have in place locations, providers, [and] the infrastructure in which data can be shared to request vaccines and to track the administration of vaccines. For the first part, the data use agreements are a critical part. We are seeking to ensure all jurisdictions can share information, which requires a data use agreement between the jurisdiction and CDC. We need to identify and enroll provider sites. And again, this is something that we are working [on] with OWS and CDC, to identify with our jurisdictional partners locations that they feel can accept vaccines and administer vaccines for their priority populations and beyond. This is an iterative process. Clearly, the micro plans, which were initially submitted mid-September, reviewed through the month of September and October, that is not a static event. We want to continue to revise and hone in on the exact details of receipt of the product, understanding the [unintelligible] requirements, how product might be moved, how administration sites are accounting for throughput, number of staff they may require, and how they are planning on either using the product that they receive all in one setting, if they have plans for re-icing the -80 product or storing it for additional dates of Mass Vax clinics and thinking about what their reordering cadence might be.

This is the conclusion, and I'm happy to take questions after it. This is an incredibly complicated landscape with multiple products, multiple vaccine cold chain requirements. We don't have an EUA yet, but we can anticipate based on everything we've heard in the press and information that we're seeing that there is a strong possibility that we could have a vaccine in the coming weeks, before the close of the year in mid-December. So, we need our jurisdictional partners and health care partners to be ready to receive and administer a vaccine. Irrespective of that timeline, we want to assure our partners that the vaccines that are deployed are safe and effective and that will be the key issues that our colleagues at FDA are reviewing as they consider the authorization or approval steps. Similarly, our ACIP partners will be evaluating that data simultaneously to understand what the potential target populations are and what the implications are for these vaccines. As I said earlier, initially, there will be probably prioritization given limited doses, but we anticipate that supply will increase over time, allowing us to expand the target populations for the vaccine and more than anything else, just being able to have these forums where we can share information as we have it. [Being able to] learn from the questions that you're asking to improve our communications and improve our messaging [is] critical. And I again appreciate the opportunity to join this call, and I'll end there and see if we if we have time for questions.

00:18:18.600 --> 00:18:33.750
Maria Ramos: Thank you so much, Dr. Pillai, and we do have a couple questions that came into the chat just now. And so, the first one is: are there education strategies that are going on in communities that are traditionally anti-vax?

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Satish Pillai: So, I think I'll take a step back and first acknowledge the concern about being able to share information and help cut through what is incredibly important. We want to educate individuals as much as possible. Some of the information is not available yet. We will

need the EUAs approved and have the information that is accompanying the EUAs, such as conditions of use, to help explain the specific target populations, the indications, and other very product-specific characteristics of these vaccines. So, we are challenged in terms of our timing because of that issue. That's one. Having said that, if you go to the CDC website right now, there is information regarding the process by which vaccines are evaluated and that is starting to get at more general vaccine, product-agnostic information that hopefully can be used to allay fears, ensure that there is a process in place by which we are moving forward to identify safe and effective vaccines. Finally, the CDC continues to develop and will be clearing more material for health care providers that we hope to be able to post soon on our website that will again, be product agnostic and something that we can provide in the coming weeks, even before a candidate vaccine receives an emergency use authorization

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Maria Ramos: Great, thank you for that validation. Moving on to the next question from Ron, it says: I have seen different cold storage requirements for the Moderna vaccine both -70 degrees Celsius and -4 degrees Celsius, can you share the latest storage requirements?

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Satish Pillai: So that's a great question that Ron asked. I don't want to misstate anything. The COVID-19 playbook was updated October 29, and it has, I believe on pages 55 through 58, the clear description of the various vaccine cold chain requirements for Product A and Product B. Just so we're all clear, I think the Pfizer product is the one that has previously been described as the -70, -80 product.

[Dr. Pillai reads excerpt from COVID-19 playbook.]

I would strongly recommend people look at those pages in the vaccine program interim playbook dated October 29, 2020 from CDC. As these products receive their EUA, you will get the formal documentation for each product as part of the materials that accompany the vaccine.

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Maria Ramos: Great, thank you. It looks like we have someone who has raised their hand. Mike Witte, I'll unmute you and feel free to chat.

00:23:57.270 --> 00:24:57.810
Mike Witte: Thank you, Maria, I appreciate that, and thank you for this presentation. It's very helpful. This is such an ever-changing playing field for all of us. One of the things that we've seen, and I'm out in California, is that we're looking at not just the anti-vax population, which is difficult for sure, but I think more globally, the vaccine hesitancy folks. There was a survey recently down here. Only 60% of physicians and 40% of nurses said they would get the vaccine today, if it were made available. I can understand that would change. The other thing we're hearing is that if we have a vaccine, and I understand Pfizer says 90%, but if they have a vaccine with A and B combined, and it has 80% efficacy, let's say, what we're hearing is that the data say that we would then need 82% of the population to be vaccinated to create adequate herd immunity. Could you comment on that and see how we might be able to get from here to there?

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Satish Pillai: So, thanks for the question. [There's] clearly multiple parts. I think for the vaccine hesitancy— what I would say is that the figures that you've highlighted, we've heard that as well. And we are continuing to within CDC conducting focus groups and trying to understand what the reasons are for concern, and what type of information would be helpful to make the end user more informed and more likely to take the vaccine. I think we still need more information like you'd cited one figure about the 90% efficacy or effectiveness of the Pfizer vaccine. I think we will need more time. To understand the percentage of the population that would need to be covered with the multiple vaccines that may be available is part of the reason that we have this infrastructure for monitoring safety and effectiveness. Having one point of data, as you pointed out, it's helpful, but I think it'll require significantly more information to really understand what the implications are for, as you said, the generation of herd immunity and so more than anything else, it's more to follow, but it's an important topic.

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Mike Witte: Thank you.

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Maria Ramos: Great, thank you. We also had another question come in from John Whittaker: Will states be expected to receive vaccines and distribute from a central location?

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Satish Pillai: Thank you so much for that question. One of the things that I learned and what we've seen in the past several weeks is information has been coming fast and furious.

OWS CDC had spoken about identifying one to five sites for pre-positioning of product post EUA prior to ACIP that was potentially misinterpreted because the terminology "pre-positioning" suggested that that would be the initial sites. The intent was not to suggest that those would be the only locations for vaccines. That was initial day one to ensure all jurisdictions had the ability to receive, handle, ask any questions they had or voice any concerns— all of that was addressed up front. If jurisdictions had additional locations subsequently like day two, day three, we are not looking to limit the number of locations that

a jurisdiction feels would be appropriate to cover their, their population. Within OWS and CDC there's a program, Tiberius, which has information that jurisdictions can use for planning principles and helps them think through what their initial allocations might be for planning purposes and help them determine, you know, how many sites? What's the throughput? How many staff might we need to account for that? So, I think the variables that need to be considered are: what is your priority population? How many individuals are you talking about? Where are they located? Recognizing that one of the products, like vaccine A, comes in a tray of 975 doses. How might you handle that, given its cold chain requirements, where it could be stored in a shipper for X number of days, held at two to eight for an additional five days? How would you utilize a tray of vaccine at a given location for a given population? So short answer: we're not asking you to do this in a central location. Every jurisdiction will have a unique set of considerations and we want to be as flexible as possible. Our goal is to maximize coverage for those priority populations initially when there's limited doses while minimizing wastage of doses, and we're happy to walk through and talk with our partners, as they think through different permutations of that.

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Maria Ramos: We just had a question come in and it is: Due to anti-vaccination beliefs, is it possible that herd immunity won't happen? If that is the case, are there alternative measures being planned as a backup?

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Satish Pillai: Thanks, Maria. It's a difficult question. All I can say to that is one, we want to as rapidly as possible get as much information— factual information— about the vaccine products, about why we believe vaccination is an important component of a multi-faceted approach to control the pandemic. I think it's clear that vaccination is one aspect of a multi-pronged approach, which includes many of the things that we've talked about in different forums over the past 11 months: social distancing, mask wear, hand hygiene, contact tracing, case identification. So, this is one more arrow in our quiver. The hope is that we are able to appropriately develop messaging that can help counter hesitancy and concerns about the vaccine and will continue to learn and figure out ways to hopefully expand population coverage.

00:31:33.900 --> 00:32:11.700
Maria Ramos: Okay, great. Thank you, Dr. Pillai. I think we have to move along to our other presenters, just in the interest of time. I see a couple of additional questions came through and hopefully if we have time at the end of the meeting, we can maybe come back to this topic and answer those questions. In the interest of time, we'll move on to the next presenter.

And I am excited to pass it over to the Wisconsin ACS team who will present at their facility. Over to you, Deb.

00:32:12.240 --> 00:35:02.100
Debra Standridge: Thank you very much. And we appreciate the opportunity to speak with all of you today. We're going to talk about the development of the Wisconsin Alternate Care Facility during Phase One of what Wisconsin experienced with COVID-19 now that we're in another surge.

This is how we developed the Alternate Care Facility, lots of arrows, but the point of this being that there was a very integrated structure to the development of the alternate care facility in Wisconsin. We are placed in a 200,000 square foot arena of which we've developed 530 beds in that arena. The Alternate Care Facility reports up to the state's emergency operations center Division of the Department of Administration, and everyone that you see on this slide was very integral to the development of the alternate care facility. We received approval by FEMA on April 7, 2020, and we opened on April 24. What is important about this slide is the integration and the fact that the patient was always our primary concern and our primary focus. We all work together in the development over those less than 20 days of opening

We opened on April 24th. However, due to the great management by our hospitals of COVID-19 during that period, the Alternate Care Facility in Wisconsin did not receive patients, so we mothballed the alternate care facility at the end of June. We remained closed, if you will, in that mothball state until October 7 when Governor Evers, at the request of hospitals throughout the entire state, asked us to reopen because of the incredible surge of cases flooding our hospitals. That's very apparent right now we're, we're in a crisis state right now in Wisconsin.

We opened on October 14 again ready to serve. We received our first patient on October 20, and we've served 55 patients as of this date today. What was really important in all of this integration was the development of our clinical model and the clinical model really sets the pace of how we treat patients here and the evolution of the critical model even within the past month of listening to our health care partners, paying attention to the public health data. And I'd like to introduce Dr. Corey Wilson, who is our Chief Medical Officer that will explain our ever-evolving clinical model here at the Alternate Care Facility in Wisconsin. Dr. Wilson?

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Cory Wilson: Thanks, and hello everyone. Good afternoon. So as it relates to where we started with our scope of care and where we are currently, basically is what Deb said. We did open in April, we mothballed for several months and then reopened just this last month, late in October, and we've had the opportunity during that period to understand and incorporate advances in the clinical care for COVID patients that have occurred over the past few months. So based on that and the needs of our hospital partners, we've made significant changes. Basically five areas of change to our clinical scope of care. With the oxygen treatment, initially we had set a limit of four liters, and then it of nasal cannula oxygen treatment as our threshold as our maximum amount of oxygen. We could safely deliver to the facility. We've actually increased that to be able to deliver Optiflow, high flow oxygen therapy. This allows us to care for a much sicker patient cohort and offload our partner hospitals of these patients and help them quite a bit.

We also sought and received FDA approval for Remdesivir and that was in early October. We were the first Alternate Care Facility to seek out FDA approval for Remdesivir and we're very happy to receive that approval and have used that in the vast majority of our cases. We've developed a parallel admission criteria for patients who are in the emergency department and allows for direct transfer of those patients to our facility that's been highly utilized, especially in the situation that we have currently in Wisconsin where we have patients boarding in the ED because there are no hospital beds available for these patients. So this offloads these hospitals and really decompresses the EDs effectively.

Another couple things that I just want to mention is, we have transitioned from cushion to cots to traditional hospital beds. That's been huge. It's allowed us to expand our admission criteria and care for a much heavier and older patient population. It's also allowed for a longer length of stay, so that combined with expanded our discharge planning to include a respiratory therapist and that allows us to set up home oxygen therapy, and that actually helps us get patients who are stable and improving out earlier, if they do need home oxygen. We don't need to keep them in facility until they're all the way down to room air.

In summary, our emerging scope of care, I believe has allowed us to take care of thicker more complicated COVID patients and take care of them earlier in the course of their illness which has dramatically helped offload our hospital partners in in the current crisis.

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Debra Standridge: Thank you, Dr. Watson. This is another arrows-everywhere slide, but the importance of this is the collaboration that our ACF leadership does with areas all over the state of Wisconsin. Whether it's with our health systems, whether it's with the community and public health leaders, and I want to point out just how responsive our Department of Health

Services is on this, the state's Emergency Operations Center in Milwaukee has been able to help us be flexible, help us be nimble and very responsive. I have boots on the ground hospital leaders and these are people that I talk to every single day, as I'm triaging requests coming through to the ACF. These are CNOs, these are case managers, these are the people who are at the bedside caring for the patient telling us what is going on and helping us begin to continue to evolve our clinical model, to evolve our processes and procedures.

Our job is to be accountable to the hospitals and all of the medical personnel throughout the state of Wisconsin so that we are good partners that they have confidence in us and send their patients to us. So this kind of collaboration goes on daily. It is not in structured meetings. It is through honest communication that allows us to be very flexible and nimble responding to the needs throughout the state of Wisconsin.

I was asked to also respond to: What are the challenges you face? The first one is the biggest one. None of us have been through a pandemic in Wisconsin, none of us have experienced what a field hospital is. This is a huge incur for our hospitals for those at the bedside and importantly for our patients. How do we describe this to a patient when they are approached to be transferred out of their neighborhood hospitals to here? This has been a huge learning curve. We've developed discussion guides for hospitals, we've developed brochures in various languages for patients. This is probably our biggest challenge that we continue to refine and define for everyone in the state of Wisconsin. Staffing has been both a success and the challenge. A success in that we have reached out to all areas throughout the United States and brought in staff who are very key in terms of being skilled in COVID-19 management. However, not everyone can function in a non-hospital setting. You have to have a skill set in being in an unstructured environment unlike what a true hospital is, so some staff members struggle with that.

There was no playbook for the operations of this. There was no clinical playbook. There was no operational playbook. So that is something that we had to build one piece at a time. I describe it like a hub and various spokes being inserted one at a time as we develop. I know for Dr. Wilson, it's not being able to serve all of our stakeholders, like they want to. We do not accept skilled nursing patients or nursing home patients, and there is a dire need in the state of Wisconsin to serve that population. This is not the environment to serve that population as its structured. We would like to be all things to all people, but we can't. Sometimes those are difficult conversations to have.

Success is data, data, data, data. That's how we have evolved our clinical model. We are in constant conversations with the public health experts, with subject matter experts, with epidemiologist, and scientists and that's how we evolve our processes, procedures, and our clinical model. We are very blessed to have one unified medical group here at the ACS. So with those baton passes from one shift to another, the understanding of our patient population, having one medical group makes a big difference. For me, participating in hospital surge planning with the rest of my team, I know exactly what hospitals need in Phase One, Phase Two, Phase Three. That tells me how we're going to be responsive to a certain region's crisis at the time that they need to transfer patients and understand that we may be flooded with requests and need to step to the plate and act.

I will say this on patient satisfaction, believe it or not, in a field hospital, patients are happy with the treatment they received here, and in fact, we had a couple of patients on Good Morning America talking about their experiences here. That was a surprise to us, but we were happy that in the pandemic we're able to treat patients successfully and be able to meet their expectations. Thank you.

00:44:00.210 --> 00:44:14.670
Maria Ramos: Thank you so much, Deb and Dr. Wilson, I have one quick question for you before we move on to the next speaker. We received this question a couple times in the chat: How did you find the clinical staff to treat patients and your alternative care facility?

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Debra Standridge: So, for our clinical staff, like our nurses, respiratory therapist, pharmacists, etc., we worked with the Department of Administration, the state Emergency Operation Center, and they developed the tester contract with a staffing agency and that staffing agency had arms of other staffing agencies throughout the United States. And that's how our staff was recruited.

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Maria Ramos: Wonderful, thank you so much for your presentation. That was really interesting and very insightful. Thank you. I will then pass it over to Lyle Moore to kick off his presentation.

00:44:56.430 --> 00:55:30.690
Lyle Moore: Good afternoon, everybody. I'm going to try and keep us all under time here. So, I'm sure Dr. Darlene Tad-y wishes her best and more likely than suspected was probably pulled into multiple additional discussions after the governor's response committee, so I'm going to work with Plan B, and I'm going to try and move us through this presentation. During this time, with COVID response, CHA has been holding meetings with a bunch of CMOs [during] which we're going through different issues that are impacting the hospitals from that system level and some of the other facilities we have in the state as well. This is where this CHTC, or the Colorado Combined Hospital Transfer Center, originated from or evolved from as well.

So, as we all know, all major health systems and hospitals not only in the state of Colorado, but across the nation routinely accept transfers from either rural facilities or independent facilities using that single contact method, where transfers can be arranged, requested, and completed. Furthermore, each of those hospitals and systems have that capability of assuring that load balance across those multi-hospital systems with access to those real-time, bed capacity figures within there. Basically, what we're saying is hospitals have the data that's needed for that transfer at their fingertips, and they also do this daily. So, how can we build something where we're getting away from that single point to that multiple point issue, which we're finding ourselves in?

So basically what we're doing with building this out and building the scope is the CHTC would manage transfers of COVID patients across those hospital systems should the number of patients needing care exceed that capacity of the health care system. It's created as an ad-hoc convening of hospital and health system transfer center leads, health care coalition directors, state emergency operation center transfer center lead, as well as RETAC coordinators, which

is the Regional Emergency Trauma Advisory Council, which really have that oversight or that overview of EMS. We figured in developing this plan, there's two pieces to any transfer: one is finding the bed, and then the other is actually getting that person from Hospital A to Hospital B. As this ad-hoc committee, CHTC functions as that supplemental resource to existing transfer infrastructure. Again, what we're looking at is moving away from that one-to-one transfer to where we're having multiple entities on this call to then create multiple transfers at one time instead of having one facility have to contact multiple facilities to find homes for these patients. It's really not a replacement either. It's just providing that opportunity for that collaborative process for that transfer of those patients from one facility to another.

The solution— this is where we get into the CHTC. So, for this reason, the CHTC was created by again, those major health systems and hospitals as that collaborative process. That CMO meeting is where this really evolved through and looking at that regional disaster emergency as well from that region. As you can see here, the CHTC provides that centralized process for determining where those transfer patients should go, but also doesn't replace that that usual transfer process. Again, we're just kind of taking out one on one and creating more opportunities through either regional or system-wide transfers.

Here's the tiered system that we've developed to go along with our CHTC. Tier one is really how day-to-day transfers are happening. Tier two, as you can see, is where we move into that, and you can note that we've got one hospital or system capacity exceeded under that capacity scenario. Within our state, we have two regions on the western slope where four hospitals reside within that region, three of those being critical access facilities. So, if we have that trauma level facility go down, that is an issue for that region. So, hence we use that one hospital/system for that regional outbreak and disaster. The CHTC transfer center column there kind of outlines those people that brought to the table or used for that. As you can see in here, we started off with an EMS MAC model, but it's not coming to fruition yet. We've kind of moved that back into those RETAC coordinators, we're bringing in those people that have that overview or subject matter expertise of the EMS agencies in there. And on the far right, you can see we've even developed those activation thresholds. We went over and over these numbers quite a bit, but we’re kind of stuck on that 15% or even as the bottom one more than 20% variance between hospitals within that region. We felt that that was an important other process too, so we are not inundating just one hospital within the region.

This is our activation process. One of the things we needed was a 24/7 number. And as you can see here, our state health department, the Colorado Department of Public Health and Environment, has that emergency reporting line. So, in that partnership, we developed that protocol within our reporting lines so that if a region or facility needs to activate the system, they contact that number and that person on call within CDPHE then contacts to CHTC on-call team leader. We built a batting lineup, so to speak, of systems that will then take on that team lead role for an activation. This is not a decision-making process, but more because we need somebody to lead that that call or that coming together of groups in order to move forward. That’s what that CHTC team lead is, and then they are the ones that then organize that activation meeting, go about notifying the people that need to come to that, and help that meeting progress as we go. We've also added additional senior leaders of local public health agencies. Having that process to activate the CHTC too, what we're finding here in Colorado too is that there are other entities that have a ripple effect that could affect our hospitals,

whether it's the prisons, long-term care facilities, skilled nursing facilities, that once COVID does reach their doors, that tends to ripple into the hospitals. So we wanted to make sure that that was available too as situation awareness for our facilities.

And then finally, we even created a meeting script for this. If you'll notice, the manuscript kind of follows along an ICS 201 form where that CHTC team lead brings a meeting, together validates the attendees, review the agenda, go over the current situation, any safety issues out there, objectives, priorities, and planned actions. It's really where that exchange or that transfer process occurs, bringing in any resources needed. This is really where we get into EMS agencies that we need. In Colorado, we have multiple rural facilities where our EMS agencies are volunteer agencies, so we needed to make sure that that was somehow in ground into this activation meeting and at least talked through during that process. Communication, like anything, and then any other relevant topics, basically making sure that we're circling back around developing those action steps to move forward. If there are any questions, either myself or Dr. Darlene Tad-y can answer those.

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Maria Ramos: Yes. Awesome. Thank you so much, Lyle. Really appreciate your presentation. And yeah, thank you. I don't see any questions in the chat. To folks on the phone, if you have questions, feel free to drop them in here, and we'd be happy to kind of follow up in a follow up email from this call, and I'll pass it over to Jack to close us out for today.

00:55:54.180 --> 00:57:00.390
Jack Herrmann: Thank you, Maria, and thank you to all of our presenters and those of you on the call. I know there were a couple questions in the chat box still around securing freezers and then also, more specifically around elective procedures and strategies to address the surge in hospitals. What I would do is, again, encourage you either to reach out to our presenters today or through us, we can help make those connections or [help answer] any other questions you may have. Please let us know and contact us through the HPP mailbox at hpp@hhs.gov – that's hpp@hhs.gov – and we'll reply to those questions. Thank you again. I hope that you found the information helpful and wish you well for the rest of the day and look forward to speaking with you on a future call. Take care everyone.