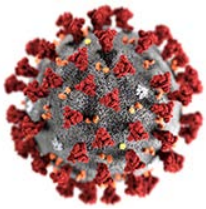
COVID-19 Statewide Hospital Huddle Summary Tuesday, Dec. 1, 2020



KHA President and CEO, Chad Austin, welcomed everyone to the Hospital Huddle. Since our last huddle two weeks ago, we have lots of activities that have been occurring regarding COVID-19. Most recently, you may have seen that statewide PSAs have started to emphasize infection control practices to limit the community spread of COVID-19. Specifically, that campaign focuses on handwashing, use of face coverings as well as maintaining social distancing and not gathering in large groups. KHA is collaborating with the Kansas Medical Society, the Kansas Chamber and the Kansas Farm Bureau. We have been hearing from other stakeholders who are interested in supporting this effort as well. Towards that end, we have created a landing page for this effort: www.StoptheSpreadKansas.org. We will be directing individuals to that website for additional resources. Other items that KHA has been involved with includes the vaccine distribution plans as well as working with KDHE and other partners on COVID-19 testing strategies. Lastly, we want to remind everyone that we've been working closely with not only our partners across the state, but also from HHS related to COVID-19 data reporting activities. We look forward to our guest presenters today to provide information on the Mission Control app that is being unveiled by the State of Kansas. We appreciate your time, and strongly encourage you reach out to us, as we are here to serve you and appreciate everything that you are doing during this challenging time.

Statistics Relative to COVID and Dashboard Update – Sally Othmer
Kansas Hospital Summary – HHS Protect data – See the latest KHA COVID-19 Dashboard online. We continue to report hospital capacity and patient activity based on information submitted by hospitals into TeleTracking. We pull the most current data as of the reporting date, trying not to go back too far. Yesterday's statistics were an exception. Due to the holiday, many hospitals are taking advantage of the option to report the following Monday or Tuesday, so some of these numbers go back as far as 11/25. We understand that reporting staffing shortages is optional, but we encourage hospitals anticipating staff shortages to please continue reporting. It is an important measure that truly speaks to capacity.

Confirmed Hospitalized COVID Patients – HHS has updated their FAQ document by **removing** the guidance "*When counting patients with COVID-19 in any field below, a patient should no longer be counted once they are removed from COVID-19 isolation precaution.*" KDHE has interpreted this to mean that once a patient is confirmed with COVID-19, they are to be counted as a confirmed hospitalized COVID patient until they are discharged. I have reached out to our HHS contacts for verification. And whether this applies to hospital onset.

Bed Availability – We hear from hospitals that the numbers in TeleTracking over-state the actual number of available beds. This is likely due to the definitions in TeleTracking of inpatient beds. It includes all behavioral health, staffed inpatient and outpatient beds in your hospital, including all overflow, observation, and active surge/expansion beds used for inpatients and for outpatients (includes all ICU, ED, and observation). To better capture bed availability, we include Adult Staffed ICU beds. Please review the definitions, be sure you are including only **staffed bed** availability.

Percentage of Positive COVID-19 Tests in Kansas – The source of data for the remaining graphics is KDHE as reported on Monday, Wednesday and Friday combined with US Census data. The percentage of positive COVID-19 tests in Kansas continues to rise steadily, now at over 19 percent. This is calculated as the number of positive tests divided by (negative + positive) tests. It was nice to see a drop in the number of new cases yesterday, but this could be due to the long holiday weekend. The regional graphs now display new cases

weekly. Remember that these regions are determined by patient county of residence, not hospital county (as in the HHS data on page 1).The percent change is based on the number of new cases from last week to this week. All regions show a decrease, coming down from the spike from last week. This may, again, be due to the long weekend but it is nice to see blue arrows down rather than red arrows up.

Maps and Tables – The last page of the dashboard has two maps displaying number of cases by county on the top and the percentage of cases by county population on the bottom. The darker the region, the higher the rate of infection. With nearly 35,000 new cases since our last huddle, the number of confirmed COVID-19 cases in Kansas is now over 157,000. The positivity rate is at 19 percent. Since our last huddle, the virus has taken 294 Kansans, bringing a total of 1,560 deaths reported by KDHE as of yesterday. Check out the KDHE Latest Public Update for additional information.

COVID-19 Reporting Requirements – As a reminder, compliance is now a condition of participation in Medicare and Medicaid. Your facility may have received a letter this week from CMS reviewing submissions from 11/13 to 11/19. If you did and have questions about your current submission status, just let me know. Overall, our Kansas hospitals are doing well with reporting. Most at 100 percent compliance. Hospitals and acute/post-acute medical facilities should report Capacity and Utilization Data daily (all 7 days). Saturday and Sunday data may be reported on Monday. PPE data must be reported on Wednesday. In other words, the 'collected date' must be Wednesday. Submit data to TeleTracking™ https://teletracking.protect.hhs.gov.

A Frequently Asked Questions resource on data (from recent educational webinars) is on the KHA website.

COVID-19 Preparedness and Response Update – Ron Marshall

Staffing Issues – As the number of COVID-19 cases continues to increase across Kansas and more health care workers are COVID-19 positive or a person under investigation for COVID-19, additional pressure is created on already difficult staffing situations. As a result, KHA is receiving more questions about what Kansas allows for providers and staff to continue working to provide care for patients. KDHE confirmed yesterday, while not ideal, the reality of the situation dictates health care workers may continue to work under the following conditions:

- The facility must have exhausted all other staffing options;
- As an essential health care worker, the individual must be asymptomatic;
- They must work in appropriate PPE;
- They must work only with COVID-19 positive patients/residents; and
- The local health officer must approve the individual to work, on a case-by-case basis.

This is in alignment with CDC and CMS guidance for long-term care facilities, and in the future KDHE will update information on their website to reflect this guidance for hospitals as well. KHA will share a link when available.

Capacity and Transfer Issues – During the last couple of KHA hospital huddles we have spoken about the difficulty hospitals are having with capacity and transfer issues. Finding an available bed applies to not only COVID-19 patients but other time-critical diagnoses as well. We have all heard of hospital staff making numerous calls, and sometimes spending hours trying to find a hospital with an open ICU or med surg bed for critically ill patients.

As many of you are aware, either through the Care Collaborative or from KDHE, the staff at Cheyenne Mountain Software have stepped up to the challenge to assist hospitals locating an available bed and arranging inter-facility transport options to allow hospital staff more time to focus on providing patient care. They have expanded the Mission Control App to assist with this process. We are also pleased that the State of

Kansas moved very quickly to contract with Cheyenne Mountain Software to roll this App out to Kansas hospitals.

This morning we are pleased to welcome Dr. Richard Watson, Jesse Thomas and Dr. Martin Sellberg with Cheyenne Mountain Software as our guest presenters. They will provide an introductory presentation on the Mission Control App. Dr. Watson, Dr. Sellberg and Jesse, thank you for the work you are doing and we appreciate you taking time out of your very busy schedules to share information on the Mission Control App.

Mission Control App – Dr. Richard Watson, Jesse Thomas and Dr. Martin Sellberg
[See slides of this presentation in the 12-01-20 COVID-19 Daily Update email.]
This morning, we want to give you high overview of what is involved with the software itself and how it relates to hospitals. I want to encourage you to go to the Cheyenne Mountain software website. There is a contact form there. We are happy to answer any questions, to provide an in person demo, or to touch base as far as anything you would have in the way of concerns, but also to be able to get you into the onboarding and training cycle. Our goal is to be accessible to all the hospitals in the State of Kansas by the end of the year. We will be working and have been working very hard at doing that. Currently, we have accessed probably 30 facilities, mostly Critical Access Hospitals. We also have in the pipeline another 25 at this point that we are actively reaching out to and actively working with. We are well on our way. The software has been in existence for a couple of years. It's managed over 3,000 transports. We've been actively using this backbone as an asset to facilities to help find placement for patients and are there to monitor the state's capacity at any moment to be able to move patients to the appropriate level of care in the quickest manner possible. We'll talk a little bit more about that as we go through. But I want to talk specifically how the software functions and what impact it has on local facilities.

The heart of the software itself is to be able to understand how sick the patient is. Everything we do is based on matching the appropriate destination and the appropriate type of transport with the level of illness presented by the patient. We then combine that with logistical program that allows senders and receivers to talk to each other. It allows dispatch to be in constant communication without having to pick up the phone every five minutes and talk about where the patient is in its transport. We capture data out of that that becomes valuable for analyzing how facilities utilize transport and how they move patients between other facilities and then allows us to do a better job of taking care of the patient. We feed that back into the cycle.

Three parts we discussed, acuity indexing, dispatch and logistics and data analysis. When we deploy to a hospital, the first thing we do is understand their current transport patterns. Our job is not to change what you do, but to understand what you do and offload some of that work to our communication center. We provide the backbone for helping schedule transport but also helping find bed availability for that patient. We base it on acuity indexing which is eight questions that could be answered by anyone who has contact with the patient. The questions are very easy; not onerous. They could be answered in 30-60 seconds. Then we use that with matching algorithms to help recommend air vs. ground, and we have the preferences related to vendors related to air and ground that we fold into the recommendations. Then we depend on final confirmation from the facility as to their wishes in the transport. Eyes at the bedside always win over everything else. This is not software that is designed to take away human judgment. It is to augment human judgment and make the things we do every day easier. We also want to make sure we support local EMS and county services. This is an incredibly critical part of what we do. We have been in contact with EMS at many levels and are very transparent with them on this product. And we have definite dispatch and monitoring capabilities that are EMS-specific that are folded into this. Just want to make sure that everyone understands that's a key part when we do resource management. Taking care of our local EMS resources is just as important as anything else we are doing here.

The logistics dashboard is one that shows the missions. It shows a map of where the transport is going. It also shows the notes section which allows for real time, back and forth, chat function that can exchange non-personal health information inside of that program. It allows us to know if there are condition changes. It allows us to know where they are in finding availability. I think Ron alluded to this that sometimes it is taking 6-8 calls for facilities to find bed availability. We've gone out 25-30 facilities at times to be able to find bed placement. When you're talking about working 30 facilities to find a bed, and you're thinking about offloading that from critical clinical staff, the work savings there are immense and the resources that we have to do that become valuable from the standpoint of allowing the clinicians to stay with the patient and do the work that is necessary. Our goal is transparency and complete visualization. There are no smoke and mirrors here. This is all about letting everybody see what is going on at any given time and allowing everybody to have necessary information they need to make smart decisions. Specifically as related to the COVID-19 pandemic and what we've been tasked by the state to do, is to use that backbone that we have; that hospital network and expand it to become a one request system for bed availability. Our job is very pragmatic, and we certainly appreciate TeleTracking and EMResource and other methods for following bed availability. But we have a very specific purpose, and that is to as quickly as judiciously as possible arrange transport and placement for patients. So our brush strokes are a little bit different on bed availability. We like to keep close contact with the hospitals and understand general bed availability. It still requires hospital-to-hospital contact. It still requires provider-to-provider signoff, but what we're there to do is to make the match and to offload that workload of the 6-8 calls so that we're focused on specifically what hospitals have potential availability based on the acuity index and how we are able to put that together. Again, transparency is key here. We do have the ability to move patients up and down that chain.

I think the goals were pretty basic, centralized structure. A quick ability to train and onboard facilities, minimize the amount of back and forth communication and be able to utilize all the resources in the state. So we have our primary, traditional receiver of patients that we are all familiar with. But we also have a lot of hospitals in the system and have the ability to take care of patients and have open beds. Understanding capabilities and matching capabilities with types of patients is very important with this, so we are able to move patients back down the acuity level, we can repatriate them or move them to a lower level of facilities who may not have been traditional receivers, but have the ability to help the system and offload the pressure. It became front and center about two weeks ago when we had agreed to help start this process and, on a Friday night, we suddenly had no beds in the state. We followed those sorts of trends, and we know there are definitely days of the week now where we certainly have no ICU beds. We certainly have a limited amount of other beds. We are also now seeing more and more requests from out of state. Texas is big at wanting to offload patients to everybody. A lot of people are trying to move, and as a state, we are really coming to grips with the fact that this is not just a Kansas issue. It is a multi-state issue. We are working with Nebraska, Missouri, Colorado, Oklahoma and Texas to be able to try to not only help them out and be good neighbors, but also make sure we are able to take care of our own. I think that is critical here. The data reporting that comes off of this helps certainly the state understand at any one moment where hot spots are. It helps understand what capacity is on a real time basis, not based on individual beds, but how close are we? Are we at capacity? Are we near capacity? Are we at normal capacity? It also looks at trends. Certainly, the number of patients that are moving in the state that are COVID-19 positive or COVID-19 suspected is very important related to PPE and other resources that we have in the system. We are coordinating data presentations so that every facility that is participating is seeing data. Particularly to those sending facilities, they will see the data related to their hospital and have access to the dashboards related to the movements of their patients in and out of their facilities.

I think the big advantages again centralized structure to network hospitals and facilities together across the state. I think the other thing is trying to eliminate the extraneous calls that are distracting to patient care on multiple levels. I think we really came into this with the mantra of "one state one effort" and really being able to pull together in the same direction with so many people who are doing so much good work out there.

Everyone is really, really stretched, not only from manpower standpoint, but mentally everybody is pretty worn from dealing with this every day. Anything we can do to join arms and move as one to get through this season is going to be valuable.

I think the basics of this and certainly the bed finding aspect are to deal with the logistics of COVID-19. Helping facilities with real help, meaning offloading work from them, allowing FTEs to go further. Linking the senders and receivers and breaking down silos that are traditionally there when we are all taking care of patients. Just being able to see the data come off of this pandemic is helpful. We are open to any questions, certainly anything that you are hearing concerning potential problems. This is a state program, and we are doing the work to make sure everyone is included. We don't want anyone left behind here, and we are looking forward to working with each of you and appreciate the interest you have and the willingness to come together. Thanks to Ron and to KHA for being behind us.

Vaccine Planning and Distribution – Karen Braman
[See slides of this presentation in the 12-01-20 COVID-19 Daily Update email.]
Pfizer submitted their request to the FDA for emergency use authorization of their vaccine on Nov. 20; and Moderna submitted their EUA request yesterday. KHA has received quite a few questions related to storage of the vaccine. As a quick refresher – Pfizer's is the only vaccine that requires ultra low temp storage, defined as -70 to -80 degrees Celsius, which equates to -94 degrees F. That said, Pfizer created thermal shippers specifically for their COVID vaccine that will include the vaccine and dry ice. Their vaccine can be stored for up to 15 days in the thermal shipper, as long as the dry ice is replenished.

In our huddle two weeks ago, we noted that the insulated gloves, eye protection were not included in the ancillary kits to be provided to vaccination sites. That has now changed. KDHE notified us last week that starter kits will be provided with the Pfizer vaccine that will include insulated gloves, eye protection, and a scoop for the dry ice. Additionally, CDC will provide the first replenishment of dry ice. KDHE also has the capability to manufacture small amounts of dry ice. Moderna's vaccine may be stored at normal frozen temperatures, or – 20 degrees Celsius, and is stable refrigerated for 28 days.

The CDC's Advisory Committee on Immunization Practices (ACIP) scheduled an emergency virtual meeting for today to discuss:

- Allocation of initial supplies of COVID-19 vaccine in Phase 1a;
- Clinical considerations for populations included in Phase 1a;
- And Post-authorization safety monitoring

Additionally, the FDA's Vaccines and Related Biological Products Advisory Committee is scheduled to meet Dec. 10 to review the Pfizer vaccine and Dec. 17 to review the Moderna vaccine.

A visual from the Operation Warp Speed website was shown that maps out from clinical trials through:

- FDA emergency use authorization,
- manufacturer production – which has been concurrent with the clinical trials,
- review by the CDC ACIP,
- allocation to priority populations – with input from the National Academies of Science and ACIP,
- Distribution, and
- administration

There are a number of state and national resources available to help with vaccine planning. KDHE is now providing weekly COVID vaccine updates on Wednesdays. These updates will be shared via the KS-HAN network, and KHA will include in the KHA daily update for that day. The Kansas COVID-19 vaccination link was provided for reference. KDHE is working on the micro-plan for vaccine distribution and will be sharing a draft

as soon as it is available, and KHA will keep members informed as information is received. The CDC has developed a number of COVID-19 vaccination resources for health care providers. The resources include training videos for health care providers, communication tools for discussing the vaccine with patients, and immunization planning. Additionally, Operation Warp Speed has timelines and a distribution graphic that provide an overview of clinical trials and distribution of the vaccine under an emergency use authorization.

The vaccine allocation phases from the Kansas COVID-19 vaccine plan is in the slides (attached to the 12-01-20 COVID-19 Daily Update email) for reference.

In addition to vaccine, there has been more activity on the monoclonal antibody front with the FDA approval of an emergency use authorization for Regeneron's monoclonal antibody cocktail; which includes two monoclonal antibodies that must be administered together – casirivimab and imdevimab for mild to moderate COVID-19. The EUA indication is for the treatment of mild to moderate COVID-19 in adults and pediatric patients (12 years of age and older weighing at least 40 kg) with positive results of direct SARS-CoV-2 viral testing, and who are at high risk for progressing to severe COVID-19 and/or hospitalization. High risk is defined in detail on the EUA fact sheet, and includes patients with comorbidities or underlying illness that put them at greater risk for severe COVID-19.

Casirivimab and imdevimab must be diluted prior to administration, and then administered together as a single IV infusion over at least 60 minutes. Post infusion monitoring must also be completed for at least an hour. The EUA fact sheet for providers goes into detail regarding the indication, dosage, dilution, administration, reporting requirements, and other instructions for healthcare providers.

As with bamlanivimab, casirivimab and imdevimab are NOT indicated for patients who are hospitalized or require oxygen support. In clinical trials, monoclonal antibodies have not shown benefit in hospitalized patients due to COVID and may be associated with worse clinical outcomes if given to these patients requiring supplemental oxygen or mechanical ventilation.

Several resources for Regeneron's antibody cocktail are included in the slides. As with bamlanivimab, KDHE will use the same allocation and distribution process. HHS created a separate allocation dashboard for casirivimab and imdevimab. Last week's allocation for Kansas was 576 doses. KDHE noted last week that Kansas' allocation of bamlanivimab had gone down from the prior week, however, allocations to almost all states and jurisdictions across the country went down in week 2 and back up a bit in week 3.

Finance and Reimbursement Updates – Tish Hollingsworth
Summary of Funding Sources for Hospitals – KHA has updated the one-page resource document summarizing the various types of funding available for Hospitals during the COVID-19 pandemic. This resource, along with more detailed information, is available on the KHA website.

HHS Updates PRF FAQs – The Department of Health & Human Services updated on Nov. 18 their FAQs for the CARES Act Provider Relief Funds to include some additional information regarding the qualifying expenses for capital equipment purchases and capital facilities projects as well as adjustments to revenues for amounts not related to services provided in 2019 and 2020. On the surface, these updates appear to be a move in the right direction and will help to resolve some of our questions and issues, some of which we recently raised in our letter to the Kansas delegation. We will continue our dialogue with HHS and others to ensure barriers are removed to allow hospitals to appropriately use the PRF dollars received.

New FAQs: Use of Funds – Pages 15-16
Will the Provider Relief Fund limit qualifying expenses for capital equipment purchases to 1.5 years of depreciation, or can providers fully expense capital equipment purchases? (Added 11/18/2020)

Expenses for capital equipment and inventory may be fully expensed only in cases where the purchase was directly related to prevent, prepare for and respond to the coronavirus. Examples of these types of equipment and inventory expenses include:

- Ventilators, computerized tomography scanners, and other intensive care unit-related equipment put into immediate use or held in inventory
- Masks, face shields, gloves, gowns
- Biohazard suits
- General personal protective equipment
- Disinfectant supplies

Can providers include the entire cost of capital facilities projects as eligible expenses, or will eligible expenses be limited to the depreciation expense for the period? (Added 11/18/2020)

Expenses for capital facilities may be fully expensed only in cases where the purchase was directly related to preventing, preparing for and responding to the coronavirus. Examples of these types of facilities projects include:

- Upgrading a heating, ventilation, and air conditioning (HVAC) system to support negative pressure units
- Retrofitting a COVID-19 unit
- Enhancing or reconfiguring ICU capabilities
- Leasing or purchasing a temporary structure to screen and/or treat patients
- Leasing a permanent facility to increase hospital or nursing home capacity

New FAQ: General – Pages 24- 25

Providers may have significant fluctuations in year-over-year net patient revenues due to settlements or payments made to third parties relating to care delivered outside the reporting period (2019-2020). Should Provider Relief Fund recipients exclude from the reporting of net patient revenue payments received for care not provided in 2019 or 2020? (Added 11/18/2020)

Provider Relief Fund recipients shall exclude from the reporting of net patient revenue payments received or payments made to third parties relating to care not provided in 2019 or 2020.

State and Federal Advocacy Update – Audrey Dunkel/Landon Fulmer

Regulatory Information – The Department of Health and Human Services sent out a note on Nov. 25 looking for comments over the next 30 days from health care providers and stakeholders on any regulatory flexibilities that have been implemented to address COVID-19 that we would like to see made permanent. We will be responding to that. If you have any thoughts on that or anything that was particularly useful to your facility, please reach out and let us know so we can include that in our discussion. Other than that, things are winding down on the state and federal level. But I know we have a few more weeks of Congress.

Congress – Over the next few weeks, they are going to get a budget. They will probably have some sort of deal on some elements of COVID relief. The cliff is just too steep in order for there to be nothing, but I'm not sure that there's going to be a very large bill that gets done. Frankly, the situation hasn't changed from when I spoke with you two weeks ago. Although there is a little bit more vigorous negotiation going on right now. We sent out a *Federal Advocate* yesterday that details some of this stuff as well as some of the things that Tish talked about earlier. I think that over the next week and a half things are going to start to break as we get closer to that Dec. 11 deadline at which point they need to pass a budget. That's kind of the make or break point whether or not there's going to be any COVID-19 relief bill. But there are a number of programs, like the moratorium on evictions, different unemployment benefits, different benefits that people can access from certain funds like their retirement accounts that expire at the end of the year if Congress doesn't do anything. So there is impetus to get something done. The question remains the form and how big it's going to be. Not much has changed, but there is pressure building as we get closer to that Dec. 11 deadline.

State of Kansas – We do finally have the last three elections finalized. Looking at the state, we had three outstanding elections that we were waiting for the final counts on. We did get final counts. Two of those seats were in Overland Park, and the winners were Linda Featherston in House District 16 and Jennifer Day in House District 48, both Democrats. In Hutchinson, Jason Probes is an incumbent legislator was waiting to see if he won the election in his district, House District 102. He did come out victorious. So we are left with 39 Democrats and 86 Republicans in the House and 29 Republicans and 11 Democrats in the Senate. The Legislature does continue to do a little bit of work over the next couple of weeks. Today the Legislative Budget Committee is meeting, and they are keeping certainly a close watch on revenue, although so far we are looking good and looking at the COVID-19 funding. The COVID-19 funding that they are really looking at is what the SPARK Committee recommended to the State Finance Council which was approved last week before we all left for Thanksgiving. They did choose to basically recoup some funding from two different sections of the SPARK dollars they had set aside. One for was for eviction prevention, and the other was for childcare. Before you get nervous that it sounds like they are making really bad decisions, neither one of those two buckets of money, they had not spent even half of that money yet, and they only have 24 days left to spend it. So they are keeping back money to help people with rent for eviction prevention and for the childcare programs, which should be plenty of money for the next 24 days. They did choose to redirect that money to a variety of items. One of which is a public health response package that provides $5 million for local health departments to prepare for vaccine storage administration and PPE, money for safety net clinics for remote monitoring. There were some safety net clinics who had not received any additional funding. There was $7.5 million of the $18.5 million for this patient transfer and bed resource platform that we talked about today. Also setting up trailers for testing and vaccine sites. They need to match some funding for the Kansas National Guard. And to fund some non-congregant housing that might be necessary. In addition, they set aside about $2 million for long-term care to go for funding PPE because that continues to be an issue. Interestingly enough, they determined that any money that was not spent out of the SPARK dollars by the end of December would go into the unemployment insurance fund. So there is a plan for those dollars if they have any left over. Be looking for some more of that money to be pushed out in your communities to help with vaccine planning and dealing with the surge.

Member Questions

Q1: *Will Mission Control include Nebraska and Missouri hospitals as well?*

A1: Dr. Watkins shared they be working particularly in the Kansas City metro area with specific hospitals there. We are open to expanding into Missouri. We have a call with the CEO of CHI Health in Nebraska who has been supportive of the Nebraska one-call center. In fact, their hospital system is the one who has organized the one-call center. I have been with the Nebraska one-call center and talked about standardizing the way we talk about patient bed availability so that it creates a seamless look at the states. Not as much interaction directly with Colorado. We are open to that, and certainly Oklahoma the same way. But we are mainly focusing right now on the states that are directly impacting the Kansas situation immediately, but looking to expand as well.

Q2: *Will the VFC program or the state provide dataloggers for the freezers and refrigerators to store the vaccines? Will Aeroscout be acceptable?*

A2: With respect to the digital dataloggers, the answer is yes. I think KDHE's thought is that for providers who are already VFC providers that they should have digital dataloggers. But they have confirmed that any vaccine administration site that does not have a digital datalogger can request that from KDHE. I would recommend reaching out to your immunization coordinator if you know who they are through KDHE. Your local health department may also be able to help with that or email the KDHE COVID vaccine email address. With respect to that particular version of Aeroscout, I am not familiar with that, but because KDHE has said they would provide digital dataloggers, I think Iwould go with that as a first choice, but that is certainly a question that could be posed to the KDHE vaccine team with respect to Aeroscout.

Q3: *What about a patient that was COVID positive and then discharged to rehab at another hospital. Are they still considered positive at the second hospital?*
A3: That is a really good question. Particularly with the latest guidance or lack of guidance that came out from HHS. All they did was remove a bullet that said "consider a COVID patient only until they are removed from precautionary areas." So they are basically back into the regular patient population. I have reached out to HHS to get clarification on this specific question and would recommend that hospitals specifically for rehab facilities continue reporting as they had before. There are two elements within TeleTracking. One is about total hospitalized adult or confirmed positive COVID patients, and I think that is where the question comes in. Whether or not they can now consider those patients still COVID patients. The other one is related to prior days' admissions of COVID patients. That is more specific. It says "who had confirmed COVID-19 at the time of admission." I would say that until we get clear direction for that situation where a COVID patient is transferred to rehab that you continue reporting as we have in the past.

Q4: *My lab is hearing changes in reporting positive cases to the state. Is the reference lab supposed to report the positive cases or the lab that took the swab?*
A4: To the best of my knowledge, there is no changing in the reporting requirements. The laboratory performing the test, in this case the reference lab would be responsible for reporting the results to KDHE and the state lab.

Q5: *We have found that we are needing to make "an appointment" for transportation as EMS and flights are booked everywhere. How does this affect your transportation options?*
A5: Cheyenne Mountain and Mission Control intakes the request. Then we have access to all the vendors in the state to be able to schedule the transfer. So this occurs in concert with finding bed availability as well. We have close working relationships with everybody moving patients. That's part and parcel with what we do is take on the ability to set up that transfer.

Q6: *Children's Mercy would like to reach out, and think we have a couple of the folks who have reached out to us via email. We will be sending that email to you if you want to reach out and follow up.*
A6: We have already scheduled a talk with Children's Mercy in a couple of hours. We were very quickly on the phone to discuss how they fold into this and are very excited about pediatric patient population and the ability to offer care for them.

Q7: *Do we know if facilities will have a choice regarding which manufacturer's vaccine they will receive?*
A7: I think there is certainly the possibility that there is going to be a timing lag. With Pfizer submitting their EUA request ten days in advance of Moderna's, it's highly possible that it could be shipped first. There could be a lag before the Moderna vaccine is shipped out. Something that KDHE has discussed and we have advocated for is equal access to the COVID-19 vaccine to all health care workers at high risk for COVID exposure across the state regardless of their geographical location. I think that is something really to think about in terms of access. There could be a timing lag, not just between the Pfizer and the Moderna, but other vaccines to come down the line. In talking with KDHE yesterday, they shared that they hoped to have a draft micro-plan available this week. We will share that information as it becomes available through KDHE.

Q8: *In regards to the monoclonal antibodies, can hospitals large and small who have been providing this new infusion provide information on how they are managing this traditional need for staffing and proper patient placement?*
A8: We are actually going to have a hospital present on the clinical call on Dec. 8 on how they have managed the planning and the implementation of monoclonal antibody administration in their facility. And for a future clinical call, we have been considering adding several other additional hospital types to present. That certainly is the plan for the clinical call coming up next week. I also do want to mention one of our allied groups, the Kansas Council of Health System Pharmacists. They held a town hall meeting a couple of weeks ago and really

had a nice discussion amongst the hospital and health system pharmacists about how they have implemented monoclonal antibodies in their hospital. I would just mention KCHP as a great resource as well.

Q9: *What is the chance that the FDA would reschedule to be this week since the ACAT scheduled their meeting for today?*
A9: I would say that the chance is probably low, only because the FDA had already scheduled that Dec. 10 meeting to review the Pfizer vaccine. Then the CDC ASIP Committee hurredly called this emergency virtual meeting for today to discuss allocation in advance of the FDA's Dec. 10 meeting. Then the FDA just announced yesterday late afternoon that they had just scheduled the Dec. 17 meeting to review Moderna's vaccine. So I think there is probably a low likelihood, but with that said, things have been moving very, very quickly. I suppose it could be possible, but maybe not likely.

Q10: *Has KDHE provided information on how they plan to distribute the vaccine to hospitals?*
A10: Review the vaccine plan that is on our website if you haven't taken a look at that yet. I do know that KDHE again committed to providing equal access to the vaccine. They have also committed to providing the vaccine to the hospital or to the vaccine administration site and getting the vaccine to the health care workers and not the health care worker to the vaccine. I believe they are planning to utilize immunization coordinators to help with vaccine transport. They have incorporated or at least are discussing incorporating utilizing that 15-day window where we'll have the Pfizer thermal shippers to assist with keeping them at the right temperature as they distribute. In terms of the really micro-details around that, we are hoping to receive a draft from KDHE this week and will sure share that as soon as we've gotten more information from KDHE.

Q11: *Do hospitals call Cheyenne Mountain Mission Control for a hospital bed?*
A11: The access to Cheyenne Mountain to the Mission Control software is through the request interface with the Acuity Index. We can set any hospital up with that interface. It's a web-based application that doesn't require installation of software on any machine. It all occurs through the web-based staff, not through a telephone call. We do have a number that will be pushed out for call-ins, but we are really wanting to go through the process of setting a facility up to be able to make that request. But it is Cheyenne Mountain. LifeSave has been customer of Cheyenne Mountain in the past. Those two entities are separate, and we are using the Cheyenne Mountain resources to address this.

Q12: *Does Mission Control arrange transports for all patients, not just COVID-19?*
A12: Yes, all patients.

Q13: *Regarding KDHE's new determination that health care workers with COVID may work under some conditions mentioned, is there or will there be specific guidance posted on KDHE's website with the requirements and guidance for hospitals to reference?*
A13: Right now that guidance has not been updated, but in an email from Dr. Ahmed of KDHE Epidemiology, she has stated that they are planning on updating the guidance to reflect what we talked about for hospitals as well as for long-term care. And I do know that Dr. Norman has mentioned in multiple conversations really the same thing that health care workers can work under these conditions. So we just need to get the specific guidance in writing on the KDHE website, which I know they are going to be working on. We will let our members know as soon as we get it.

Q14: *Will the sequestration waiver be extended?*
A14: AHA has been pretty active in trying to get Congress to address this. In the original CARES Act, sequestration was waived for the period of May 1 through Dec. 31. So, as of now, unless the law changes, sequestrations goes back into effect on Jan. 1. Obviously, we've communicated with our delegation that this is not a great idea. AHA has communicated with the hill. This kind of extension was part of the original HEROES package that passed the House in late May. It's one of those things that has to be negotiated at this point. This

would be a fairly large ticket item, but it is something that is certainly on the table right now. It is also one of the items that has that sort of hard deadline. It's not like they can just wait until Jan. 25 to do this. It kind of has to happen before then. So it is in the process of being negotiated. It's hard for me to put the odds on whether or not it's going to pass, but it's part of what we're dealing with right now.

Q15: *Have you heard anything about a vaccine mandate for health care workers, or will the vaccine be optional once available? We have several employees inquiring on if they will HAVE to be vaccinated. I wasn't sure if there would be anything coming from the state or federal government regarding this or if it would be a facility by facility decision?*
A15: The CDC is not recommending mandatory COVID-19 vaccination because the vaccine is investigational. FDA approval of an emergency use authorization is not the same as full FDA approval. Safety and effectiveness monitoring will continue through the emergency use authorization.

Next KHA COVID-19 Hospital Huddle

Hospital Huddles will occur on the first and third Tuesdays of each month. Our next Hospital Huddle will be **at 10:00 a.m.** on **Tuesday, Dec. 15.** Email Cindy Samuelson if you have guest speakers you would like to have present on an upcoming Hospital Huddle.