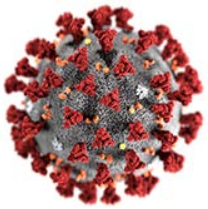
COVID-19 Statewide Hospital Huddle Summary Tuesday, June 9, 2020



Chad Austin welcomed everyone to the Hospital Huddle. He expressed his appreciation for the participants joining to hear the many updates and to share about the work they are doing in their local communities. Chad recommended members contact KHA for any questions they might have.

Statistics Relative to COVID – Sally Othmer
Kansas has 10,650 confirmed COVID-19 cases in Kansas, including 236 deaths. The two Kansas regions with the highest increase in cases are the northeast region, with an 8% increase this week and the south central region with a 13% increase. Though Kansas had been demonstrating a slight decrease statewide in the number of cases in the rolling 14-day average, there has been an uptick in cases this week. See the KDHE Latest Public Update for additional information.

COVID-19 Preparedness and Response Update – Ron Marshall
Data Meeting Update – The data work group is working to streamline COVID-related data collection in EMResource, NHSN and Teletracking. They have met twice so far. KDHE is meeting with Dr. Norman this week to discuss which data elements are needed for future COVID response. Those findings will be shared with the work group, which will meet again for a third meeting. KDHE is exploring the cost of using Palanteer, a data-sharing platform that would share information between EMResource and NHSN so data could be inputted once and shared across various platforms. Additionally, region 7 of CMS has begun discussions about streamlining data entry at the state and fed level.

ASPR Grant and SHIP Grant – Ninety-seven (97) hospitals accepted the first round of funding. Additional funding may be available for the 5-year grant period. KHA is working with the field project officer to determine what the work plan and reporting requirements are for the second round of funding. KHA is working on expense forms and other tracking methods, but want to make sure we are in compliance with ASPR before we send out anything. We are also coordinating the ASPR grant funds with COVID-19 SHIP funding. There is duplication and opportunity to work together to meet expenses and other challenges with COVID.

Provider Relief Fund – A different Teletracking request went out to hospitals, unrelated to remdesivir. Provider Relief Fund is allocation of funds to hospitals that have a high degree of COVID inpatient care. The Teletracking results are due by 1100 ET on June 15, 2020. Request number of COVID-19 positive patients from Jan. 1, 2020 to June 10, 2020.

Laboratory Reporting – An article on pandemic response for laboratory reporting was shared yesterday. This is part of the CARES Act that requires all labs or other facilities performing COVID testing at point of care report test completed within 24 hours of the results on a daily basis to either the appropriate state health or local health department. In talking with KDHE, they are exploring this requirement to see if anything needs to be done differently than we are already doing in the state of Kansas. More information will be shared as it is received.

Long Term Care – Some hospitals are having difficulty discharging patients to LTC, due to testing positive, patients under investigation or even those who tested negative. Some LTC will refuse in some cases to take patients back. KDADS has formed a stakeholder group to work on this issue, and the first meeting will be on

June 18. Ron asked that any hospital that has had issues either positive or negative experiences they have had discharging patients to LTC to send an email to Ron Marshall.

Respirator Use Decontamination – The FDA reissued respirator emergency use authorization for the decontamination and reuse of N-95 respirators. This has a potential impact on the Battelle system. Ron shared with KDEM, who operates the Batelle system. Recommendation that any N-95 made in China should not be decontaminated. Decontamination of N-95 masks should only be used when new masks are not available and there is no other option.

Remdesivir Update – Karen Braman
HHS shared at the end of last week, that after yesterday's remdesivir data request into Teletracking, there will be one final Teletracking data request to aid in the distribution of remdesivir. That will be the final distribution in late June or early July. Beyond the donated supply, Gilead has stated that there will be no further supply available until August or later, due to their manufacturing process. It is not clear if there will be additional donated drug at that point until the emergency declaration expires, if the drug will be available via compassionate use through Gilead or the timeline for remdesivir FDA approval that would allow it to be available on the open market. Karen has reached out to the state and HHS and will post that question as well to keep everyone informed.

KHA has received several questions regarding remdesivir distribution within a hospital system under different scenarios. If an ED has a remdesivir supply, but it is needed by another hospital within the same system for treating an inpatient. If a system has a cohorting hospital and a COVID inpatient was started on remdesivir at one hospital but was transferred to another hospital within the system. KDHE confirmed that it is appropriate to transfer the remdesivir with the patient at a cohorting hospital. The drug should go with a patient. If the ED has the drug available, and one of their affiliated hospital needs it for an inpatient, the most important thing is to get it to that patient. The key is to make sure the information is tracked so they know where the drug is and who it is being used for. KDHE continues to allocate remdesivir based on a 5-day therapy; however, consistent with the emergency use authorization, it can be dosed for up to 10 days. For hospitals who may not have received remdesivir distribution because they didn't meet the threshold of 3 COVID patients needing the treatment, when the hospital requests the drug from KDHE for a specific patient, KDHE is shipping a 10-day supply so they have adequate remdesivir for that patient if they need it. KHA has asked for a FAQs document with the remdesivir distribution guidelines for Kansas, and they have agreed to do that. Staff will send it to our members as soon as we receive it.

3pm UPDATE after the Huddle Call - Attached to the 3-9-20 Daily Update is an updated distribution plan for remdesivir received from KDHE. Included in this document is a revised process for ordering remdesivir. The orders will now be placed through the County Emergency Managers like everything else that is requested. Also included is the required information to be submitted when requesting remdesivir for a patient. There is another shipment of remdesivir coming to Kansas hospitals today from the donated supply distributed through HHS. Those hospitals that are receiving remdesivir from this shipment are being contacted by KDHE staff to let them know a shipment will be arriving today, tomorrow or Thursday.

State and Federal Updates – Chad Austin
Governor Kelly signed the COVID-19 legislative package into law yesterday. Some of the highlights for HB 2016 included provisions related to the governor's emergency declaration, oversight to the coronavirus relief fund, and liability protections for businesses and health care providers. Another provision that was included as part of the package outlined how contact tracing would be managed in Kansas. Lastly, there were several health care provisions included that focused on telemedicine, hospital bed size, and licensure laws. The legislation originally was adopted by the legislature on a vote of 26-12 in the Senate and 107-12 in the House.

In addition, the Governor's SPARK committee has met twice. As part of the COVID-19 legislative package, the Legislative State Finance Council will be required to approve any distributions recommended by the Governor and the SPARK committee. In the first wave, the SPARK committee is recommending that $400M to be provided to Kansas counties to deal with COVID-19 issues. The State Finance Council is expected to consider this request at their next meeting. The second wave of funding is expected to be provided through grants. While details are still being finalized, it is expected that public and private entities will have the opportunity for grant assistance. KHA is planning to provide more details on the SPARK committee next week.

On the federal level, we continue to work with the congressional delegation. It is likely that the next COVID package will not be considered until July.

Finance and Reimbursement Updates – Tish Hollingsworth

CARES Act Funding – HHS has released their work plan to examine the effectiveness of HHS controls over the awarding and disbursement of $50 billion in Provider Relief Fund payments to hospitals and other providers. HHS indicates they will obtain data and interview program officials to gain an understanding of how the payments were calculated and review payments for compliance with the CARES Act requirements. Additional information can be found on the HHS website at https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000472.asp.

HHS Updates FAQs on CARES Act Funding – The Department of Health and Human Services updated their FAQs on the CARES Act Provider Relief Fund to include information on a variety of issues including:

1. Four FAQs on the website regarding the $4.9 Billion HHS began to distribute on May 22 to Nursing Facilities impacted by COVID-19.
2. Information on expenses or lost revenues that are considered eligible for reimbursement for the funding health care providers have received from the various tranches of payment.
3. A comment indicating that HHS will provide directions in the future about how to return unused funds that providers have left over at the end of the pandemic that could not be spent on permissible expenses or losses.

FAQs – Skilled Nursing Facilities Distribution

What is the Skilled Nursing Facility funding amount and how did HHS determine the amount? *(Added 5/26/2020)*

HHS will distribute $4.9 billion in additional funding (over and above General Distributions received) to more than 13,000 skilled nursing facilities. Eligible facilities range in size of between six and 1,389 beds. This represents a range of distributions between $65,000 and $3,255,500 and a national average distribution of ~$315,600 per facility. Each Skilled Nursing Facility received a fixed distribution per facility of $50,000 plus distribution of $2,500 per bed.

Which Skilled Nursing Facility providers received a payment under the SNF Distribution? *(Added 5/26/2020)*

HHS allocated funding for certified Skilled Nursing Facilities with a capacity between six and 1,389 beds.

How will HHS disperse the Skilled Nursing Facility distribution payments? *(Added 5/26/2020)*

Most SNF fund payments will be dispersed electronically based upon banking account information associated with the organization's billing TIN. If the organization's billing TIN does not have a bank routing number associated with it, the organization will most likely receive a paper check.

What constituted a "certified" skilled nursing facility for purposes of the Targeted Distribution? *(Added 6/8/2020)*

A "certified" skilled nursing facility must be certified under Medicare and/or Medicaid to be eligible for this Targeted Distribution. All standalone and/or hospital-based skilled nursing facilities with at least six beds were eligible for this Targeted Distribution.

FAQs – Terms and Conditions

Can providers who have ceased operation due to the COVID-19 pandemic still receive this funding? *(Added 5/29/2020)*

If a provider ceased operation as a result of the COVID-19 pandemic, they are still eligible to receive Provider Relief funds so long as they provided on or after January 31, 2020, diagnoses, testing, or care for individuals with possible or actual cases of COVID-19. HHS broadly views every patient as a possible case of COVID-19, therefore, care does not have to be specific to treating COVID-19. Recipients of funding must still comply with the Terms and Conditions related to permissible uses of Provider Relief Fund payments.

In order to accept a payment, must the provider have already incurred eligible expenses and losses higher than the Provider Relief Fund payment received? *(Added 6/8/2020)*

No. Providers do not need to be able to prove, at the time they accept a Provider Relief Fund payment, that prior and/or future lost revenues and increased expenses attributable to COVID-19 (excluding those covered by other sources of reimbursement) meet or exceed their Provider Relief Fund payment. Instead, HHS expects that providers will only use Provider Relief Fund payments for permissible purposes and if, at the conclusion of the pandemic, providers have leftover Provider Relief Fund money that they cannot expend on permissible expenses or losses, then they will return this money to HHS. HHS will provide directions in the future about how to return unused funds. HHS reserves the right to audit Provider Relief Fund recipients in the future and collect any Relief Fund amounts that were used inappropriately

The Terms and Conditions state that Provider Relief Fund payments will only be used to prevent, prepare for, and respond to coronavirus and shall reimburse the Recipient only for healthcare-related expenses or lost revenues that are attributable to coronavirus. What expenses or lost revenues are considered eligible for reimbursement? *(Added 6/2/2020)*

The term "healthcare related expenses attributable to coronavirus" is a broad term that may cover a range of items and services purchased to prevent, prepare for, and respond to coronavirus, including:

- supplies used to provide healthcare services for possible or actual COVID-19 patients;
- equipment used to provide healthcare services for possible or actual COVID-19 patients;
- workforce training;
- developing and staffing emergency operation centers;
- reporting COVID-19 test results to federal, state, or local governments;
- building or constructing temporary structures to expand capacity for COVID-19 patient care or to provide healthcare services to non-COVID-19 patients in a separate area from where COVID-19 patients are being treated; and
- acquiring additional resources, including facilities, equipment, supplies, healthcare practices, staffing, and technology to expand or preserve care delivery.

Providers may have incurred eligible health care related expenses attributable to coronavirus prior to the date on which they received their payment. Providers can use their Provider Relief Fund payment for such expenses incurred on any date, so long as those expenses were attributable to coronavirus and were used to prevent, prepare for, and respond to coronavirus. HHS expects that it would be highly unusual for providers to have incurred eligible expenses prior to January 1, 2020.

The term "lost revenues that are attributable to coronavirus" means any revenue that you as a healthcare provider lost due to coronavirus. This may include revenue losses associated with fewer outpatient visits, canceled elective procedures or services, or increased uncompensated care. Providers can use Provider Relief

Fund payments to cover any cost that the lost revenue otherwise would have covered, so long as that cost prevents, prepares for, or responds to coronavirus. Thus, these costs do not need to be specific to providing care for possible or actual coronavirus patients, but the lost revenue that the Provider Relief Fund payment covers must have been lost due to coronavirus. HHS encourages the use of funds to cover lost revenue so that providers can respond to the coronavirus public health emergency by maintaining healthcare delivery capacity, such as using Provider Relief Fund payments to cover:

- Employee or contractor payroll
- Employee health insurance
- Rent or mortgage payments
- Equipment lease payments
- Electronic health record licensing fees

All providers receiving Provider Relief Fund payments will be required to comply with the reporting requirements described in the Terms and Conditions and specified in future directions issued by the Secretary. HHS will provide guidance in the future about the type of documentation we expect recipients to submit. Additional guidance will be posted on the Provider Relief Fund: General Information page.

Hospital Huddle Questions from KHA Member

Q1: A follow up on certified skilled beds ... do CAHs with swing beds qualify for that? Long-term care (intermediate care) would not qualify, correct?

A1: ***(NOTICE: UPDATED at 3pm on 6-9-20, after the call)***

According to the May 22, 2020 press release from HHS (see attached notice) nearly $4.9 billion is to be distributed to "Nursing Facilities". The press release references "Skilled Nursing Facility (SNF)" and "nursing homes" throughout the document, which has caused some confusion on the eligibility for the program. KHA is working to receive further clarification from HHS to ensure, but it appears from the news release that SNF and Long-Term Care (LTC) units may have received the funding. Skilled Swing Beds and the Intermediate Swing Beds (ISB) would not qualify as those beds are considered part of the regular hospital bed count. You have to be able to show that you had COVID-related costs in order to keep the funding.

Q2: One member hospital shared that they have a long-term care unit that is not considered skilled but still received the funds.

A2: Each situation is different. Anyone who has received funding but has questions should contact Tish Hollingsworth.

Q3: One member hospital received two sets of funding, May 22 and June 8 for the skilled nursing facility. Was the money received yesterday correct?

A3: HHS began dispersing funds on May 22, and has continued to provide payments to those qualified to receive funding. HHS is developing their work plan to make sure there is effective control over the awarding and the disbursement of the funding. As hospitals have transitioned units that are closing or a change in ownership, HHS may not have caught those situations and may have to request refunds of money.

Q4: Does HB 2016 include testing of nursing home staff and residents on a regular basis for COVID-19?

A4: The discussion about nursing homes was extensive during the special session. That was largely in response to the liability protections and some of the needs of nursing homes that were not being fulfilled by the KDADS. HB 2016 Section 19 on adult care homes indicates KDADS would provide the necessary PPE, sanitizing supplies and testing kits, appropriate to the needs of each facility on an ongoing basis based upon current number of residents, current number of full- and part-time staff, and number of current residents and staff who have tested positive in the last 14 days. In addition, they would have to be able to separate residents with COVID-19 from non-COVID-19 residents. HB 2016 did not include specifics about how often individuals would need to be

tested. CMS guidance made a recommendation that all nursing home staff be tested weekly. Residents should be tested as a baseline and then weekly thereafter if either staff or another resident tested positive. KDADS was to develop a Kansas plan, but it has not been released yet. Ron will follow up and share the plan when we get it.

Q5: Is there any input that can be given to KDADS as they develop the plan for nursing facilities for testing? In the areas that have had very low incidents of COVID, the need to test every resident of nursing facilities and the staff on a weekly basis. They are still having trouble getting testing materials, and the mandate to test all nursing facility staff on a weekly basis will stretch their abilities. Allen thought testing of residents and nursing facility staff that are asymptomatic were not to be sent to the state lab. How are the specimens to be collected every week if they don't use the local laboratory?
A5: KHA will review how far along KDADS may be in drafting the proposal. KHA spoke with the state lab, and all testing would go through the state lab and not through hospital or reference labs. They believe they have the capacity to handle the 48,000 test kits within that system. Ron will discuss the logistics with state lab. Last week during the special session, Chad and Audrey raised the concerns that the testing supplies will have on local hospitals' supplies. The state lab received 60,000 swabs for purpose of doing nursing home testing, but it doesn't have guidance on how those swabs are to be used. While they may have the capacity to do it, there is a 72-hour window in which that testing needs to be completed.

Q6: The hospital in Minneola is going through testing in their LTC unit. It is very time-consuming. They had another associate test positive, so every associate who has not recovered from COVID and every resident who has tested negative for COVID has to be tested every 5-7 days. It has upset the residents. Turnaround times have been good on lab results, and there have been no issues with getting testing supplies.
A6: Are they getting the lab results through state lab? No

Q7: Who is financially responsible for costs of the testing based on CMS or KDADS requirements?
A7: We believe it is State lab, but we don't have the KDADS plan to confirm. Just a reminder, keep a close track on all costs of testing, etc. If the tests are not covered by the State lab, hospitals should be able to use those costs to offset funding received under the CARES Act.

Q8: May we have an updated on the CMS advance payments?
A8: The Medicare program halted the payments for the Medicare Accelerated Payment Program on April 26. The most recent information from WPS, our Medicare Contractor, indicated that HHS has not provided further guidance on when any pending or new applications for whether any additional funding can be released.

Q9: HB 2016 decision to exclude nursing homes from liability exemption that was offered to every other health care facility in the state with the exception of long term care. Of the 20+ states in the country that has offered civil liability exemptions regarding COVID-19, Kansas is the only state to have exempted long term care to this. Several hospitals have long term care facilities attached to them.
A9: KHA is continuing to look into this issue. This topic was a very hotly debated issue and probably received most attention during the debates in both the house and senate. Leadership in House and Senate and Governor's office came to an agreement where they were excluded from the same protections that were afforded to hospitals and other health care provider groups. The governor's chief of staff publicly stated that if the same protections were afforded to nursing homes, she was going to veto. KHA staff have shared the frustrations as they have been working closely with partners at LeadingAge Kansas on behalf of the 25 hospitals that have nursing homes attached to them.

Q10: Is FEMA giving out infrared thermometers through the county emergency managers? Their emergency manager is not aware of the opportunity.

A10: Ron remembers a discussion from an EOC call, but they did not have them in stock. He will ask if they have them in stock.

Q11: Are any hospitals using automated temperature device/screening systems?
A11: On of our member hospitals is trying to get information from a company in Kansas City, but have not purchased it. Seemed to be affordable and easy to use. The hospital in Greensburg has ordered a walk-by monitor with facial recognition and log-in, but it is on a 4-6 week backorder.

Hospital Huddle Question on Hospital Screenings

KHA staff asked several questions regarding how hospitals are screening at their facilities. Specifically, how long are they planning to continue screening? Are they asking screening questions? Do they screen for temperatures at entrances, if so, what method are you using to screen for temperatures?
Are you using a forehead thermometer or under tongue?

1 – The University of Kansas Health System – Their hospital has stopped taking temperatures and symptom check for patients as all staff are wearing face masks and eye protection, whether face masks and goggle or face shields. They are direct-rooming patients in the ambulatory setting and have created significate social distancing. Still doing screening for visitors and vendors. Employees are required to do their daily screening as well. Doing combinations of daily temperature, symptom screen and exposure question. Screening includes the students as well. They are continuing incident command status with daily status updates and follow-up meetings. They are continually evaluating. They have not set a timeline, but ask the questions every day about visitors, students and all the changes that were rapidly put in place due to COVID-19. The hospital has an ongoing list that is constantly being reevaluated.

2 – Mitchel County, Beloit – The hospital is continuing temperature checks for all employees, visitors, vendors and patients coming into the facility and will continue until they have further guidance concerning long-term care units. The hospital is using non-contact temperature devices. If they don't work, temporal ones are used. Can default to oral thermometer if they have issues.

3 – Minneola – They are still using the same approach as Beloit.

4 – Comanche County, Coldwater – They are still screening at the front entrance of the hospital from 7 a.m. to 5 p.m. with questionnaire and temperature checks. They give each person entering the facility a mask to wear while in the building. They place the mask in a receptacle when they leave for washing (as they are cloth masks). After hours the nursing department screens those needing to enter. They have no plans to stop at this time.

5 – Community Memorial, Marysville – They are doing daily temperature checks and questions at a single entry point for patients, visitors and vendors. All are wearing masks. Starting last week, their staff began doing self-checks. They discuss each week for continuation.

Next Hospital Huddle Call

Cindy Samuelson announced that Dr. Lee Norman will be on the Hospital Huddle, Tuesday, June 16 at 10:00 a.m. Please continue to share your COVID-19 questions with us by emailing Cindy Samuelson.