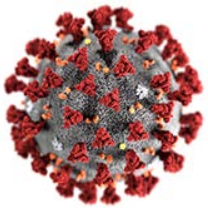
COVID-19 Statewide Hospital Huddle Summary
Tuesday, June 16, 2020



Tom Bell expressed his appreciation for the participants joining the call and for their work on behalf of communities across Kansas.

SPARK Update – Tom Bell

The SPARK Committee has been created by the State of Kansas to allocate the $1.25 billion in federal funding for Kansas allocated through the CARES Act. Those funds are to be used for medical and public health needs related to the COVID emergency and to also provide economic support. These funds are for expenses occurred from March 1 through Dec. 31, 2020. Some examples of expenses for public hospitals or clinics that can be covered include testing or quarantine costs, payroll issues, telemedicine expenses, technological improvements for distance learning, and telework capabilities. Sedgwick and Johnson Counties (because they each had more than 500,000 residents) received money directly from the federal government. Therefore, the $1.25 billion for Kansas that was received by the state will be shared with the remaining 103 counties. SPARK is the state level structure in place to allocate these funds. There is an executive committee (Tom Bell serves on this committee, they have met twice) and a larger steering committee reporting to the executive committee (they have met once). The State Finance Council must approve recommendations made by these committees. There will be three rounds of money allocated. Round one funding will be sent out soon, directly to counties, and it will be based on $194.00 per person in the county. Round one funding is about one-third of the money (about $400 million dollars) is being reviewed today and is expected to be approved today. The counties are being encouraged to share the funds with organizations in the county (anything from a public hospital to a chamber group to a community organization), based on the CARES Act criteria. Hospitals are encouraged to communicate with county leaders regarding how to expend the money. Rounds two and three are going to be based on a RFP process in mid-late summer. The funding has to be spent by the state by the end of 2020. Tom encouraged hospitals to begin thinking about RFPs they could implement in their counties or in their region.

Statistics Relative to COVID – Sally Othmer

Since our huddle last week and per counts reported by KDHE yesterday, confirmed COVID cases have risen from 10,650 to 11,419. This represents an increase of 769 cases or a little over 7%. The state reported 245 deaths as of yesterday, an increase of six since last week. At a regional level, all KHA districts again indicated an increase in cases since last Monday. Most notably, the Southeast Region is at 199 up from 90, a 121% increase. Due primarily to the Crawford County cases, up to 96 from only 8 last Monday. Although counts continue to rise, the trended average of new cases per the region population has decreased or leveled off in the northwest, southwest and northeast. See the KDHE Latest Public Update for additional information.

COVID Data Collection - National Healthcare Safety Network (NHSN) - The Kansas Department of Health and Environment notified KHA this week that they will rely on data reported through NHSN for COVID reporting. KDHE uses the data to determine Remdesivir and PPE distribution; so consistent daily submission is critical. KDHE encourages hospitals to report this data to NHSN through the COVID-19 Patient Impact and Hospital Capacity Pathway module and to report on a consistent daily basis. We also encourage our hospitals to join the KHA Reporting Group in NHSN. Please contact Sally Othmer for the Group ID and Password. EMResource will cease collection of COVID related data and go back to being used for situational awareness for natural disasters, ED incident reporting and diversions; helpful to EMS and for inter-facility transfers. This will reduce hospital's duplicate reporting burden of COVID-19 data to multiple entities. Although HHS may continue to

issue Ad Hoc requests through Tele-tracking, NHSN meets Federal and State requirements and we anticipate this will continue. Particularly, since CMS is requiring LTC facilities to report through NHSN.

COVID-19 Preparedness and Response Update – Ron Marshall
ASPR Grant and SHIP Grant – KHA will have the expense monitoring form out this week for the ASPR grant which will allow hospitals to report how the money was spent. COVID-19 SHIP agreements are due by June 30, 2020.

Long-Term Care – KDADS has convened a stakeholder's group to discuss policies regarding patients being discharged to long-term care, and the first meeting is Thursday, June 18. Ron asked that any hospital with such a situation to connect with Ron so he can take the concerns to the meeting. Dr. Norman thanked the KHA staff and hospital staff for their efforts in reporting data. Nursing home patients are getting stuck in hospitals, and skilled nursing facilities will not take them back. As an advocate for the elderly or disabled persons, if someone has COVID-19, it may take up to 6 weeks for a negative test. He has pushed on nursing facilities to take patients back.

Finance and Reimbursement Updates – Tish Hollingsworth
CARES Act Funding – On June 9, the U.S. Department of Health and Human Services (HHS) announced the distribution of $10 billion in CARES Act Provider Relief Funds to certain Safety Net hospitals that serve a disproportionate number of Medicaid patients or provide large amounts of uncompensated care. According to the HHS announcement, hospitals qualifying for this funding pool will have:

- A Medicare Disproportionate Payment Percentage (DPP) of 20.2% or greater;
- Average uncompensated care of $25,000 or more per bed
- Profitability of 3% or less, as reported to the Centers for Medicare & Medicaid Services in the hospital's most recently filed Medicare Cost Report.

Eligible hospitals will receive a minimum distribution of $5 million and a maximum distribution of $50 million. Kansas has six safety hospitals that will receive the funding under the Targeted Distribution for Safety Net Hospitals. Additional information regarding the CARES Act Provider Relief Fund can be found on the HHS website.

Safety Net Distribution – KHA has received calls from hospitals this week that have received additional payments from the second round ($20 billion) of the General Distribution of the Provider Relief Funds. As we previously have discussed, an initial amount of funding from the second round was automatically paid to some providers on April 24. HHS then instructed providers to submit financial information on the Provider Relief Fund Payment Portal to confirm provider revenue for consideration of a payment. Since April 24, HHS has continued to distribute funding to augment the provider's initial allocation so that the total $50 billion of the General Distribution Funds is allocated proportional to the provider's share of 2018 gross receipts or sales/program service revenue. Payments from the $50 billion tranche of General Distribution Provider Relief Fund payments is generally around 2% of the provider's most recent complete tax year net patient revenue.

Ian Morrison APS KHA Virtual Leadership Forum – Dennis George
From noon-1:30 p.m. on Wednesday, June 24, health futurist Ian Morrison will provide the seven scenarios, the impact of COVID, and how we can move and change health care of the future in a post-COVID environment. Proceeds of the $25 registration fee will go to charity. Register today for the Virtual Leadership Forum with Ian Morrison.

KDHE Secretary of Department of Health and Environment – Dr. Lee Norman
Dr. Norman holds two positions with Kansas as the Secretary of KDHE, which includes health environment and health care financing. He also serves as state health officer. He also does bio-threat analysis and medical

intelligence. He serves on national defense health board. In January, he stood up incident command in Kansas for COVID-19. Lines of effort includes:
1 – Epidemiology and disease tracking – includes contact tracing, isolation and quarantine, brought on 1,000 people. KDHE has pushed out $57 million in PPE and $3 million in meals. Adding 400 contact tracers across the state.
2 – Community testing and lab testing alternatives – has been difficult, due to other states competing for resources. Now the state is more nimble in conducting testing and reporting results.
3 – Media and community engagement – difficult to maintain consistent messaging, doing three press conferences a week. This has been a political issue in terms of school closures, stay at home orders and the effect on the economy.
4 – Isolation and quarantine management and enforcement – for the most part, Kansans have volunteered to obey the guidelines.
5 – Policy and guidelines – includes school closures, higher education guidelines, state fairs, county fairs, music festivals, etc. The Legislature took away some of the governor's executive powers, county health officers are making decisions for their county.
6 – Community relations, schools and local health department liaison – works closely with municipalities and others.
7 – Best practices research – difficult to stay abreast of world literature. Expressed appreciation for Kansas Health Institute's assistance as well as sharing of best practices from others.
8 – Material supplies, stockpile and surge management – includes data information and overflow and alternative care sites. Most hospital administrators would like to handle surge on their own property rather than try to make alternative care sites work. If the second wave surge occurs, Kansas hospitals should be able to accommodate up to four times the number of cases that happened in April or May 2020.

Member Questions for Dr. Lee Norman

Q1: Why don't we routinely do PCR testing for close contacts of confirmed cases through a tracing and testing program? In other countries, they test contacts but we just recommend quarantine and monitor for symptoms. I think we have testing capacity to do this now.
A1: We are doing more and more of that in identified cases. Usually doing it in congregate setting, because the transmission rate is higher. Prisons, meat packing, nursing homes are the three biggest areas. This week, there have been two funerals with 40 cases and one death. The reason KDHE hasn't done blanket testing, as there isn't enough testing capacity at the state ... but there is enough capacity to do if you go to a commercial lab - which hospitals can do at any time. The state requires the person meet the PUI criteria, testing guidelines are on the website. They do not treat every county and setting the same in terms of testing, but they are doing more and more asymptomatic testing. KDHE has purchased a van that will be used as a mobile testing platform.

Q2: On a related question, if we did test close contacts of a confirmed case, do you have a time schedule you'd recommend? I saw Boone County in Missouri recommends testing close contacts at 5 and 14 days post-exposure and they report 61% of cases in the last week of May were found through testing of close contacts.
A2: Negative results only prove that they are negative that day. Still need the quarantining recommendation as if they were positive. When people are exposed, the majority of people become positive between day 4-7. Best practices require retesting on day 5 and then on day 10. The person should voluntarily quarantine until day 10.

Q3: Secretary Norman, there has been a lot of discussion around anti-body testing both locally and nationally. What is your opinion or that of KDHE regarding the broad advertising, marketing, or promotion of anti-body testing by hospitals in Kansas?
A3: Broad antibody marketing has been a problem, and we have turned this over to the Attorney General for

investigation. One problem is company that sells fraudulently to hospitals and clinics that say the antibody test is specifically for COVID-19. Have no authority to say that, and is fraudulent selling. Serology tests are not COVID-19 specific. Hospitals have told those tested that they were positive, and could work in hospitals or nursing homes without PPE because they were immune. Working through IGM validation process on a COVID-19 specific test. Broad advertising and promotion is not good until we have a specific test for COVID-19.

Q4: Is the state planning to implement a testing strategy to test all long-term care residents and staff, given this high-risk population?
A4: KDHE doesn't survey or license long-term care facilities, but it does provide consultation with KDADS in case of large number of cases at a specific location. Not every facility is required to do baseline testing on every staff member and every resident. KDADS is creating a testing strategy, and KDHE helps specifically when an area has a high number of cases in a community.

Q5: Given the fact the WHO "clarified" their statement on the risk of transmission from asymptomatic individuals, what do believe is the transmission risk?
A5: It is very common for asymptomatic individuals to transfer the disease to others. If you take a really good history, many may have had mild symptoms.

A6: With the increased testing capacity at the State Lab, is there a plan to begin allowing testing of individuals exposed, high risk etc. but are asymptomatic?
A6: The state lab is in better position for testing high-risk individuals from high prevalence areas. We have a formal testing strategy in place on our website.

Q7: You spoke briefly last week of doing a large scale randomized COVID-19 antibody trials across Kansas. Is that plan going to be implemented soon? What happens if someone tests positive for the antibody, and should they still wear a mask and practice social distancing?
A7: Yes. Dr. John Rural is coordinating these efforts. The difficulty lies in how to identify individuals randomly. KDHE hopes to do the testing by the end of June. Prudence is recommended for those who test positive.

Q8: The media has published several stories about the accuracy of the different testing methodologies. Is KDHE comfortable with the accuracy, especially the Abbott ID Now rapid test?
A8: Abbott ID Now a rapid test. The White House used it, but KDHE is not comfortable with Abbott ID Now test for screening purposes. If someone is positive with the test, he/she is positive. If the test shows negative, it is always paired with the PCR test.

Q9: What is your best prediction on a second and third wave for COVID-19 in the US and Kansas?
A9: Epidemics typically have a second peak. The United States may not get out of the first wave. States who have had no cases at all are now seeing cases, and we may be reopening too soon. Unfortunately, people are not protecting themselves.

Q10: When will the public learn of the plans to reopen schools?
A10: Kansas Department of Education is making recommendations, which should be rolled out by the end of June. Local school boards make the decision to open or remain closed independently. Each university is also doing their own reopening plan.

Q11: What are the demographics of those individuals tested? Asymptomatic vs symptomatic. The % hospitalized and/or deaths of individuals with comorbidities versus apparently healthy individuals?
A11: Looks like 9% of total tested are asymptomatic; 68% are symptomatic. Half of the test results are done by commercial or hospital labs. 8.7% positive cases are hospitalized. 245 deaths. Average age of those who have died is 79. Deaths have occurred in individuals as young at 29 and as old as 99. There have been 104

pregnant patients. Average age of those with infection is 42. Prisons and packing plants are less likely to have co-morbidities. Range of positive cases are from newborn to 103 years of age. Total number of positives are 8.4% of total tests. Deaths are almost entirely among those with co-morbidities.

A12: As the number of positive cases rise how do we differentiate between a rise due to testing vs a rise because of increased spread?
A12: If the percentage of positives keeps decreasing, that is considered to be a good sign. Also they look to see what the date of onset of symptoms in symptomatic people. Look at reopening matrix on the website. The number of cases will always rise, but the number of cases per 100,000 individuals is going down.

Q13: We are doing pre-op testing for COVID – Our understanding that KDHE is not interesting in these negative tests results? Is that correct?
A13: Dr. Norman was interested ... perhaps KDHE is not asking for those to be reported, he was not sure ... so Dr. Norman will check into this and get back to our members.
3:00 p.m. UPDATE from KDHE
A KS HAN went out last week about the new HHS lab reporting requirements. Yes, all COVID-19 testing results are reportable to KDHE. If a lab is not sending negative results, we would like to know their names so that we can follow-up and make sure they are aware of the reporting requirement. The confusion might be coming because not everyone who is being tested has to be reported to KDHE. Meaning, if a patient is being tested pre-op and not because they are suspected of having the disease, then a facility does not have to report to KDHE within 4 hours to meet the reportable condition regulation. However, all test results still need to come to KDHE, positives and negatives.

Q14: On the last two Thursday KDHE calls we have been told that the state lab has plenty of testing kits for hospitals. However when we reached out to the State lab we were politely told to go through local emergency management. We did that previous to our request but were only provided NMT (Nasal Mid-turbinate swabs) where we wanted/needed NP (Nasopahryngeal swabs). Does the State lab indeed have "plenty of testing supplies to go around?"
A14: Would like hospitals to get their own kits through their own supply chain channel, but still have plenty of supplies. Hospital should send another request to their local emergency manager specifying what supplies are needed. Dr. Norman will follow up with KDEM as well.

Q15: What is the strategy moving forward regarding travel-related quarantines?
A15: Kansas is using recommendations from CDC, and travel-related quarantines are updated each week and are posted online.

Q16: Is NHSN reporting adequate for required federal reporting?
A16: Sally Othmer shared that Teletracking is sending ad hoc requests for data. NHSN is moving forward as the sole platform. If you submit COVID-related data in NHSN using the COVID module for patients and capacity, you have met the requirements. HHS may continue asking for ad hoc requests through Teletracking, and those will have to be entered through there. It is anticipated those requests will decrease and cease. EMResource will continue as a situational response mechanism.

Next Hospital Huddle Call
Please continue to share your COVID-19 questions with us by emailing Cindy Samuelson. Our next call will be Tuesday, June 23 at 10:00 a.m.