

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

March 18, 2021

Event Transcript

00:00:10.139 -- 00:02:27.000

Jennifer Hannah: Thank you for joining us today I am Jennifer Hannah the Deputy Director of ASPR's National Healthcare Preparedness Programs, and it is my pleasure to be with all of you today as we connect on a variety of topics related to the ongoing COVID-19 response. During today's call, Jack Herrmann will first share the latest Public Readiness and Emergency Preparedness Act or PREP Act amendment. Next, Dr. Richard Hunt will share some details on some recent conversations during the Project ECHO COVID-19 Clinical Rounds regarding new COVID-19 clinical patterns. Finally, two members of our CAAMP development team, Kate Gorbach and Emily Koppelman Van den Berg will be available to answer any questions you may have about the platform.

Before we get started with today's speakers, I wanted to poll the audience on whether you are receiving the weekly Health Care Readiness Bulletin. It has come to our attention that some of you are subscribed but may not be receiving the Bulletin in recent weeks. Please complete the poll on your screen. If you are joining by phone and unable to complete the poll, and you have not received the Bulletin since February, please send an email to hpp@hhs.gov and a member of our team will reach out to troubleshoot.

We will now close the poll. Thank you for participating. For those who wish to receive the Bulletin but haven't received the distribution since February, we will be in touch to troubleshoot your subscription. I will now pass it over to Jack Herrmann.

00:02:29.010 -- 00:13:05.820

Jack Herrmann: Thanks so much, Jennifer. It's great to see all of you, albeit in a new position. As Jennifer said, I'm here today to give you a brief overview of the PREP Act. I'll provide a quick highlight of the federal vaccination campaign, some background on the PREP Act, and the declaration, cover the latest amendment and efforts to expand the vaccination workforce, and then finally cover where you can find more information on the recent PREP Act declaration amendment, and also provide some information on where volunteers can go to find info on our website to join the mass vaccine initiative.

As many of you are aware, the federal government under the Biden/Harris administration has been working diligently to accelerate the COVID-19 vaccine rollout. Recently we've had many great successes which have included the issuance late last month of a new FDA Emergency Use Authorization for the new J&J vaccine, a historic manufacturing partnership between Merck and J&J, to increase the production of that new vaccine, and an overall expansion of vaccine access through pharmacies, community centers, federally qualified health centers, and other locations. It's through these efforts and many others that have been focused on the response to the pandemic that we've been able to improve the supply chain, accelerate manufacturing and distribution of PPE and other supplies, and deploy three COVID-19 vaccines. With this increased supply of vaccines and the urgency to get the COVID-19 vaccine to those that want it, we anticipate there will likely be a need for more vaccinators to help get shots into the arms of millions of Americans, particularly those in underserved communities and those more vulnerable to the virus. To aid in this effort, we want to ensure that all qualified professionals play an integral role in the vaccination campaign and provide states and territories a pathway to expand and support their vaccination workforce.

Let me summarize the PREP Act. At baseline, the PREP Act authorizes the HHS Secretary to issue a declaration that provides immunity from liability except in the case of willful misconduct for claims of loss that have a causal relationship with covered countermeasures being used for diseases, threats, and conditions as determined by the Secretary to be a current or future risk of the nation or result in a public health emergency.

As many of you know at the onset of COVID-19 one year ago, the secretary of HHS issued the declaration pursuant to the PREP Act that, among other things, identified qualified persons to administer the COVID-19 vaccines authorized under an FDA Emergency Use Authorization. Equally, numerous actions have also been taken at the state, local, tribal, and territorial levels as well as on behalf of the federal government to respond to this pandemic, including identifying vaccinator workforce and ensuring COVID-19 vaccines are administered to the U.S. population as expediently as possible. What is important to know about the PREP Act? The PREP declaration provides liability coverage to individuals administering approved COVID-19 countermeasures. It covers licensed or certified health professionals or other individuals authorized by a state or territory and it defines those qualified persons as designated by the Secretary. Of particular note: this is the seventh amendment to the declaration. It's been amended several times before, and the third through seventh amendments have added to the list of qualified persons who can administer authorized COVID-19 vaccines. In regard to the impact on state, local, tribal, and territorial jurisdictions, the PREP Act preempts SLTT requirements, including state licensure and scope of practice requirements that would prohibit or effectively prohibit a qualified person from prescribing, administering, or dispensing authorized COVID-19 vaccines. It also allows that states and territories can impose requirements that enhance the ability of or add categories to qualified persons as long as they do not prevent qualified persons from administering vaccines.

Let's focus now on the most recent amendment. As some of you may have read in the news or heard during President Biden's nationwide address last Thursday night or the White House COVID-19 Task Force briefing last Friday morning, HHS has taken action to expand the pool of qualified professionals able to serve as vaccinators. As more and more vaccine doses are manufactured and distributed throughout the country, we recognize that more and more locations and healthcare personnel may be needed to expedite the administration of these additional vaccines. As a result, HHS has used its authority under the PREP Act to include additional categories of qualified persons authorized to prescribe, dispense, or administer COVID-19 vaccines through this new seventh amendment to the PREP Act declaration. As well, states and territories are also encouraged to further expand the categories of persons authorized to administer COVID-19 vaccines in their jurisdictions, in order to respond to the local needs and the availability of potential vaccinators.

This table provides a list of the categories of qualified persons through this latest amendment and includes health professionals, both currently active and those who've been recently retired. It also includes students and those who are authorized by their state or territory. Newly qualified persons are eligible vaccinators under this seventh amendment include dentists, emergency medical technicians holding advanced or intermediate EMT certification, midwives, optometrists, paramedics, physician assistants, podiatrists, respiratory therapists, and veterinarians. This new amendment also authorizes recently retired members of the professions I just mentioned, along with retired physicians, nurses, pharmacists, and pharmacy interns if they held the licensing good standing within the last five years. This amendment authorizes medical students, nursing students, and students of the other eligible health care professions with proper training and professional supervision to serve as vaccinators. As mentioned earlier, states and territories may also authorize additional healthcare professionals and students under their own emergency authorities and those individuals will be covered

under the PREP Act. There are also some training and supervision requirements that have been outlined in this recent amendment, as well as previous amendments, which I'll briefly highlight.

So here are the training and supervisory requirements at a high level. First, there needs to be documentation of the completion of the CDC training module. There has to be documentation of an observation period for these new categories of professions or students by a currently practicing healthcare professional experienced in administering intramuscular injections. They have to have current certification in basic CPR. For the student category, they must also be supervised by a currently practicing healthcare professional experienced in administering intramuscular injections, and then for the pharmacist, pharmacy interns, pharmacy technicians, and pharmacy students, there is additional training or continuing education that's required as well. To help spread the message of the new PREP Act declaration amendment, and more specifically about the expanded vaccinator categories, we've developed a digital toolkit that contains sample messages you can share on your social media channels that are directly tailored to reach your specific target audiences. The toolkit includes posts and graphics with Twitter, Facebook, and Instagram to call health professionals and students to join their community effort to vaccinate. We also have a fact sheet online that gives information on the different categories, as well as the training and education requirements or supervisory requirements.

If you need more information on who's covered under the PREP Act or you have healthcare professionals, retirees or students interested in learning more about this updated list of expanded vaccinators, they can visit our website at www.phe.gov/COVIDvaccinators for information on whether or not they're eligible to administer the COVID-19 vaccine. The site also includes links to volunteer management portals for every state or territory, some of you may be familiar with your ESAR-VHP volunteer registry management system. In closing, I'd like to thank you for support in this important campaign to fight the COVID-19 pandemic and help save lives, and I'm available to answer any questions you have.

00:13:15.060 -- 00:13:25.380

Zoe Kovatchis: As a reminder, if you would like to ask a question verbally, please use the raise hand option in the bottom toolbar or write your question in the chat.

00:13:44.460 -- 00:14:36.000

Jack Herrmann: I don't see any hands raised or questions in the chat box here. If by chance you have a question that comes up after today's presentation, feel free to email us at ASPRstakeholder@hhs.gov and we'll do our best to answer the question. We're also going to be providing a Frequently Asked Questions document, which will be routinely updated to reflect the various questions and issues that have been raised since the release of the PREP Act amendment, and you can find that on our website that's on the screen. Thank you very much, I appreciate your time and wish you all the best.

00:14:39.240 -- 00:14:43.080

Zoe Kovatchis: Thank you, Jack. I will now turn it over to Dr. Hunt.

00:14:46.320 -- 00:29:19.800

Dr. Richard Hunt: Thanks Zoe and thanks Jack. I was asked to share with the group today conversations and experiences shared by clinicians over the past couple of months on COVID-19 emerging clinical patterns.

I think we've shared updates on clinical rounds before during these sessions. They are supported by HHS and by Project ECHO from the University of New Mexico. Those rounds began on March 24 last year and it had a specific purpose: how do we save lives when the science actually hasn't caught up with a disease that rapidly emerged? In terms of clinical rounds, just to refresh everyone's memory, the purpose of those rounds are real-time, peer-to-peer knowledge-sharing on clinical challenges and successes encountered treating COVID-19, which obviously happens in your hospitals and in the pre-hospital care environment as well. At the beginning, it was absolutely highlighting experiences, rather than formal guidance or recommendations, and as most of you probably are aware, formal recommendations on treatment paradigms continue to shift as we learn about this new disease. The participants for rounds include physicians, nurses, EMS, respiratory therapists, we have dentists, veterinarians, epidemiologists, just a wide, wide range of disciplines in healthcare and from a very wide geographic distribution with usually about 40 to 45 states represented on each round and usually about four or five other countries participate on rounds. Through February 25 since the beginning of rounds, we've had 125, we're in the 130s now, with over 45,000 cumulative participants and all those sessions are archived and over 12,000 have actually viewed the archived sessions. The rounds are a collaboration among multiple private sector organizations, mostly professional clinical societies.

There are a lot of limitations to these rounds. They're not science, they're not evidence-based medicine, they're simply clinicians sharing their experiences so we can learn from each other. They're real world, they're real-time. Participants are self-selected, they're not a representative sample. It's not a double-blind controlled trial in any sense, but it's the way clinicians learn together how to take care of patients the best when sometimes the science hasn't quite caught up to the disease. There are many other limitations, but I wanted to make sure the limitations were set up front, so when I share what we've learned on the rounds over the past couple months, you can take it in that context.

So back in January, like any Zoom webinar, there's a green room where the speakers have a chance to talk and make sure their slides work and make sure the audio is right, and so on. One of the clinicians actually from Los Angeles said in that green room: "We've seen a couple of patients with pneumomediastinum or pneumothorax." That was the very first time after 100 COVID-19 clinical rounds that those words had popped up. I was surprised, the other people in the green room were surprised and then another clinician and the green room says: "I have too." Then you begin to wonder: COVID-19, first time hearing this, two people, one was from Texas, the other I mentioned was from Los Angeles, mentioned that this not a new phenomenon that is not new to clinicians but new in our COVID patients.

In the chat function in rounds, as you watch that over the next few weeks, you started to see words like pneumothorax, pneumomediastinum, and also some other new dimensions, new clinical issues that clinicians were facing. So there was this sort of the great mystery of, well, is there anything there or is this people just like having one-off conversations about this? So we actually asked the question with a polling question. And the polling question we did four times on four different rounds. With 334 total respondents to the question: since January 1, 2021 I have seen new patterns of disease in some COVID-19 patients. The range was 30% to 41% of clinicians indicated they had seen new patterns of disease in some COVID patients. Then, realizing that the in-hospital setting is very different than the out of hospital/EMS setting, we asked the same question for EMS clinicians, and indeed we had 26% indicated,

they were seeing some new clinical patterns, even before the patients got to the hospital. So again, you know that this is shared experience conversations, not peer-reviewed literature, not science, not recommendations, but with those kinds of numbers, there was a sense of there's something there.

So we actually convened a rounds specifically on new clinical patterns. We make an effort to be just in time with rounds and we were able to convene a critical care rounds on new clinical patterns and we held that on February 23rd. The video recordings are all archived so you can take a look at it. Certainly, pneumothorax and pneumomediastinum were discussed as we're seeing this more often and with increasing frequency. Also, ventilation management challenges. The clinicians in the chat would say that the ventilation management's a little bit more challenging than it was in the previous wave of patients that we saw. From the United Kingdom, the intensivist who leads high-consequence disease critical care medicine for the United Kingdom who practices, I believe, at the largest hospital in London, said that in their wave of their most recent surge that occurred in January, with almost exclusively the UK variant, they saw an increase in OB patients and particularly gave the number of 600 obese patients and postpartum COVID-19 patients. Then there were some additional comments made about renal, vascular, GI, and endocrine challenges as well, and then also a theme in pockets, certainly not across the country, but in pockets clinicians talk about an increase in severity of disease and increasing mortality. There were some others as well, but I'm trying to hit the highlights. The other thing I want to mention about this slide, and I didn't have it as a bullet item but our UK presenter very generous with his sharing of their experience. He indicated that during their January wave, patients were much sicker and that's actually been borne out with some more recent science in terms of the UK variant. So fascinating that following these discussions over the past couple months, that clinical experience that was shared during rounds landed, much to my surprise in a paper that was published only a couple weeks ago. In terms of pneumothorax and COVID-19 patients. Fascinating that the Inova hospital system clinician, you know Inova hospital is just down the street from us in DC, they took a look at 619 patients and 1.4% of those COVID patients developed spontaneous pneumothorax during their hospitalization and some of those weren't even on ventilators. So was there something there, and quite frankly, 1.4% almost one and a half out of 100 patients developing spontaneous pneumothorax certainly catches my attention. Do I think that that's like the harbinger of disease? Not particularly, but I think there certainly are implications in terms of how we think about the disease far beyond maybe what we thought it might have been way back in the fall or early December.

So, if indeed there are some new clinical patterns that have emerged with COVID-19, why is that? Okay, if they are indeed there, why? Is it because, for example, we just have more experience with a disease, now we have like 13 or 14 months as opposed to one or two months? Is it just more experience and we're starting to see more things? Certainly, a possibility. Is it due to variants or mutations? Certainly, a possibility. Is it other? I don't know. Can you attribute it to variants specifically? I don't think so because I don't think we have the genomic testing as widespread as we would need at this juncture to be able to identify that. So the focus in terms of rounds discussions have been far more on the clinical patterns and what they mean rather than, why are they there.

So if there are some clinical patterns that have emerged, ones that are new to us over the past couple months, do they matter at all? I mean, why does it make any difference at all to talk about them? We see clinical challenges every day and it doesn't make any difference. I think they actually do matter if they are predictive of increased numbers and a new surge like what happened in England in January. Are they predictive of increased severity? Certainly that's important because you need more critical care resources than what we've seen in the past. Is

it predictive? Maybe an increase mortality? Certainly, yeah that makes a difference. From a very clinical very, very clinical-oriented perspective: do you actually need to change your assessment and management to decrease morbidity and mortality and surge, does that make a difference? Yeah, that does make a difference. The bottom line to this is that number one, I certainly do not want this to be alarmist in any way. I think it's an observation that bears attention and I think the theme that emerged absolutely the toward the end of the new clinical patterns rounds is the need to be aware and the need to be vigilant and understand how humbling this disease is, and that would not be surprising that we in do see even further new clinical patterns that we need to pay attention to, for the reasons I've indicated previously. So with that, the one thing is it's easy to like say, well, this is not particularly evidence-based and doesn't really make much of a difference, I'm reminded of what I got taught in my pediatric rotation: always listen to the moms. Always listen to the moms and you're going to get burned, if you don't. What I've learned through the rounds is always listen to the clinicians because what they're seeing is real-time. The science can't catch up to what's actually seen clinically so given where we are with this disease, we need to continue to listen to them. Hopefully, this is helpful to you, and at least thinking through the future in terms of how your institution, your organization, and your region responds as the disease continues on its own course, one that we don't totally control. With that, thanks very much, and I believe I am supposed to turn this over at this juncture to Emily and Kate from the CAAMP team, thank you.

00:29:21.360 -- 00:36:05.790

Kate Gorbach: Hi everyone, I'm going to go ahead and share my screen. We're going to do a quick demo of CAAMP. If you're able to join all the trainings that we have, this might be a little redundant. but the same time, I know where we've had some log-in issues so hopefully people have had a chance to poke in and look around there. Just a couple things I want to bring to your attention. This is a great time to ask questions. If you have any, drop them in the chat and I'll have time for Q and A at the end.

I went ahead and emailed to everybody who was not included or had not logged in yet earlier this week, but that's still the case, feel free to drop your name in the chat and we can connect after this.

I want to show a couple of really great things to do what once you're in the system. So here at the top bar, I'm going to go to Collaboration, and I'm going to click on Community Collaboration. Now this page is a way for everyone to just converse with each other in the Community. When you come to it, you'll see a little button over here. I've already joined the group but it'll say Join Group. Then, I've selected a weekly digest. You can also get an email every time there's a post or your daily digest. That way you'll be able to look at all the conversations that are going on. If there are any questions or anything that would be for the benefit of the group, feel free to post them here and we'd be happy to respond, or just general open questions for any Hospital Association, this is a great place to collaborate.

Another great place to do that is in your Groups. So again, I click Collaboration and then scroll down to Groups. Here, you might see recently viewed. You can see my groups, so you can see I'm just part of the Community Collaboration, but a great thing to do is also to go to your Region Group and join that so you can open it. I'm just going open Region 4. You'll see this Join Group message up here and pages specific to your group. It's just a group of you and your Project Officer all the others possible associations in your region. We had a couple questions about technical assistance, so I'm just going to go over that again. This blue bar is your home base and it can be very helpful if you have a question about the system or experiencing a problem or question about the grant. Any questions whatsoever, feel free to

make a TA request. There's a button here on the right-hand corner, it says new TA request. You click that, this part will pop up to put in your name. Once you start typing you'll come up, and then this is the tricky part that has been tripping a couple people up is your award number, so if you start typing U3R, your award will pop up and you fill in that field. You can put your TA description down here. There's an option to upload a file, so you can take a screenshot of your issue if that's applicable, or any other thing you might want to attach and then you can submit. Go directly to your project officer and from there, they can triage, either answer your question or get started on to the right person to answer it.

One really great thing to do when you get into the system is check that all of your information is correct. So here at our home bar, I'm at Account Info. I can go check out an account. This will just populate with your account name and all of your sub-recipients. You want to make sure that your sub-recipients are correct, you want to make sure that your award information is correct, when you click on the award, you'll will make sure it's all correct. If there's anything that needs to be updated, feel free to make a technical assistance request and I would be happy to help with that.

If there any questions about things that are going on the system, or telemedicine, or anything that might be pertain to Hospital Associations related to this grant, or just generally, a great place to go is the Resources tab. This has program templates, grants management templates, and lots of resources HHS is publishing here for your help. That will kind of lead us into performance measures, so if you're interested in what the performance measures look like, you can find them under the Resources tab here: performance measures. Here's the mid-year data and the end-of-year data by opening up the link, there is a file that I can open and print or download or whatever that has all of the performance measures listed here. So that's where we can find them.

That brings me to my very last point about performance measures. When you're ready to fill them in, you can go to the performance measures tab you click recipient. You can create your performance measures with the blue button in the upper right-hand corner you'll type in your account name and then you'll type in a year. And you'll select either mid-year or end-of-year. Mid-year is due April 12, so please make sure that you submit by then. There are two users for every Hospital Association. If one person creates the form, it will show up for the other person's in that there will only be one form per Hospital Association that both users can edit. Okay, that was a lot of information very quickly, but I want to pause there for any questions whatsoever about the system. I'm also going to drop my email in the chat. If you have any questions, please feel free to email me or hpp@hhs.gov and we'll be happy to help. Great, are there any questions?

00:36:07.770 --00:37:30.840

Zoe Kovatchis: Thanks Kate. If anybody has any questions for any of our speakers today, whether that's for Jack on the PREP Act amendment, for Dr. Hunt on emerging clinical patterns, or for our CAAMP development team, you can write those questions in the chat or raise your hand. If there are no other questions for our presenters today, I'm going to hand it back to Jennifer.

00:37:36.030 -- 00:38:38.040

Jennifer Hannah: Thank you so much and thank you to all of our presenters for their time today and for your active participation in today's meeting. As always, we love to hear from all of you about how you and your sub-recipients are using cooperative agreement funding to make an impact in your community, especially as it relates to the current response. To submit

your story, you may either email the hpp@hhs.gov mailbox or fill out our new Story from the Field submission form, which is available on the Healthcare Readiness in Action Stories from the Field website. Our team will also insert the link directly into the chat for easy reference, and a member of our communications team will reach out to learn more about your story. With that we want to again thank everyone for joining today's call and have a have a great day.