On December 8, 2021, ASPR TRACIE hosted the webinar, *Next Generation Healthcare Coalitions: Learning and Evolving from COVID-19*. During this webinar, speakers highlighted key findings from ASPR TRACIE's Healthcare Coalition (HCC) Engagement in COVID-19 Assessment project and shared lessons learned from two HCCs.

Speakers were not able to respond to all questions during the webinar's question and answer session. These questions were sent to panelists and select ASPR staff following the webinar. Their answers are provided in this document. NOTE: Questions that were similar or covered the same topic area were consolidated and/or reworded to streamline the Q&A.

1. **Panelists mentioned the governor/political leadership played a huge role in the response. How well are HCCs connected with the incident management system?**

Response: Generally, ASPR TRACIE found that HCCs were well-integrated into the incident management system in the communities they serve. At an operational level, HCC staff and members collaborated in the response according to their existing plans. However, in many states, response decisions by state leadership were not aligned with those plans, causing confusion among HCCs. In several states, new response regions were established that did not match the boundaries of existing HCCs. In other states, entirely new response structures were stood up, which, in some cases, duplicated or conflicted with the expected roles and responsibilities of HCCs. These decisions were partially due to the scale of the pandemic and the desire of political leaders to be bold and proactive in their response. They may also reflect a lack of pre-pandemic awareness among political leadership – and to a lesser extent, hospital/health system C-suite executives, state hospital associations, and state departments of public health and emergency management – of the planning, capabilities, and activities of HCCs. Many HCCs described spending significant time and effort early in the pandemic educating decision-makers about the existence of HCCs and how they could contribute to the response. Overall, better awareness of and standardization of HCC functions could alleviate this in the future, but continued communication is needed between the healthcare sector and state executive branches.

2. **Did anyone run into issues with the state health department not being involved with HCC or hospital needs during the response or not providing support to coalitions to accomplish these amazing activities? How did you overcome the lack of information and assistance from the top down? Do you have any advice for others who are going through it?**

Response #1:

- There are always challenges with communication (before, during and after responses), especially with the staffing issues and prolonged COVID response. Usually, setting up standard and more frequent calls is very helpful. If there are additional needs, my advice is to reach out the state health department directly to share the need for additional information and assistance during challenging times.

Response #2

- Our experience with the state health department was a bit of a mixed bag. There were points in time where the state health department requested the HCCs take on tasks that fell outside of our scope and, truly, belonged to other partners (e.g., leading alternate care

site planning in place of local public health) and then there were periods where the operational updates that the HCCs were receiving from partners were not being solicited for/acknowledged by state public health. I will focus on the second scenario, as it more aligns with the specific question.

- Information sharing with the state (info being pushed down) wasn't much of a problem for our HCC. The state did a relatively good job of pushing information down to us for either our situational awareness and/or to share with partners. Because the state is a strong advocate of HCCs being operational, they were cognizant of the types of information that would benefit us and our partners.
- One thing that we did early on was to develop a very tight working relationship/briefing cadence with our state division of emergency management. They have regional field managers, so we capitalized on those relationships to build a structure where those plans coming out of EM were also being pushed down to the HCC. This has been a gap in the past (healthcare tied to state emergency management) and really paid off once state public health and division of emergency management combined to form the Unified Command Center.
- We did run into issues with getting the situational awareness/reports we were receiving from our partners up into the state and to the top decision makers/governor. The state relied very heavily on quantitative metrics and reports from hospital executives for the first part of the response. This was not a huge issue as most of the needs centered around PPE and surge planning (sans the staffing shortages). We still pushed info up, but the disconnect wasn't significant. As the healthcare concerns became much more systemic, we quickly saw a gap between what the state was listening to (hospital executives) vs. what we were hearing from clinical staff and emergency managers at the facility levels. This was problematic for a number of reasons, but the HCC took on the job of pushing for a much more comprehensive and representative view that went beyond the quantitative metrics. We were able to exemplify the types of information we were gathering and how those facility-level reports were integral to decision-making processes at the top. This is when we shifted to more of an advocacy role. We were able to schedule a weekly meeting with the state where each region reports out more of the qualitative info or "chatter" that we hear from our facilities. This is a weekly meeting that still occurs between the state and all the HCCs. Hospitals are aware of this call and report feeling much more "heard" and that their experiences, on the floor, are being considered. It's definitely not perfect but gives our partners a better voice through the HCC.
- We are lucky that we have full support of the state in becoming operational/response entities. While we did have to push for a place, at the state level, during certain points during the COVID response, our state health department was supportive of how we approached regional operationalization within each HCC. Our state has never had operational HCCs, so this was our first opportunity to really put our Response Plans into action, and the state supported and allowed us to work this through with our partners, with their support, as needed.
- Recommend continuing those conversations with your partners and find areas where you can fill a gap at the state level. Exemplify, very clearly, how your work/relationships/operational insight can fill a need that may exist and how that information can impact decision making at that higher level. It may feel like you are on a hamster wheel, but the state needs to see the benefit, to their efforts, in engaging with healthcare partners through a single source – the HCC. We also continued to

communicate our close working relationship with the healthcare continuum and reinforced how we were partnering with local public health to avoid the assumption that our efforts were duplicative with ESF-8.

- We made a point to communicate, to the state, what the cascading impacts may be if hospitals were not supported and/or if our regional briefs were not considered. Oftentimes, we were able to identify (through our partners), early trends or pre-event indicators – this included supply chain issues. This was done through a combination of the quantitative data as well as the qualitative experiences within our facility. That qualitative piece really gave context to the metrics to support higher level decision making/planning. Hopefully, your state is interested in this type of information as it can directly impact their response.

Response #3:

- As initially presented, we did originally have difficulty getting our HCC to the table for state-level conversations. The lack of information of state level response/planning efforts in the beginning was an incredible challenge. We really found that work with our partners through ground truth meetings and communication with our out of region HCC coordinators were and remain some of the most helpful meetings. Essentially, we were able to discuss our regional response and plans within what state level information was received and then adapt as needed to changing guidance.
- The State has since developed dashboards, though it is unclear to what level these are being used at the individual facility level and, due to initial exclusion in activities, our HCC relies heavily on our regional dashboard, developed in collaboration with our partners. Our agency/HCC ended up relying heavily on our own in-house research/GIS folks and hiring our own data analysts who have been crucial.

3. **How are the coalitions funded? We are fully funded through the HPP and PHEP grant and our state health department is the fiduciary for the grants but this has had some challenges. Any recommendations for better collaboration?**

Response #1:

- There are restrictions and responsibilities associated with federal funding (e.g., cooperative agreements) and a plethora of base requirements, benchmarks, and performance measures that are the priority as they are tied to the funding. There are also limitations imposed by the federal guidance for many things written in guidance that are "not allowable" (e.g., HPP cannot pay for patient care). And, of course, these requirements roll downhill from federal to state to sub-recipient.
- The State Authorizing Authority (SAA) is responsible for creating and submitting the application and they are held responsible for the final approved work plan and budget, so they have a delicate balance in identifying and funding priorities. New activities require additional submission and prior approvals all the way through the chain, so they can be submitted for, but the process is not painless and the justification and supporting documentation are important.
- This is why it is very important for HCCs to be as complete as possible in their DRAFT and FINAL HCC work plans and budgets (DRAFTs due to be submitted by January 31 to the recipient so that there is time to review and make any changes before the application submission).

- Strongly recommend anyone interested in highly beneficial activities for HPP to reach out to your SAA and discuss it early to get approvals and then include any new activities in your HCC work plan and budgets, which they can push through to the ASPR HPP Field Project Officer (FPO) for review.

Response #2:

- We are solely funded through the HPP grant. This past year we also received the COVID supplemental funds, but that was a bit of an anomaly. We are incredibly fortunate that we have strong leaders that dedicate their time to support the HCC and our regional activities. In-kind efforts are a key component to our ability to build robust regional plans and then execute them. This is true across our core partner types, as well as those ancillary partners (e.g., long-term care, behavioral health).
- Our state health department is also the HPP and PHEP fiduciary for those grants. We have worked with our state HCC Council to find a balance between those federally required deliverables, state-focused deliverables, and HCC-specific deliverables that all directly tie back into the four HPP capabilities. We usually have to build those HPP/region specific into our work plans and tie them to the capabilities/ objectives/ activities and describe how our plan will address those and benefit the overall mission of the HCC.
- One example is work that we did on an EMS Multi-Agency Coordination Group (MAC). The need for this came out of the 2019 CST. We were able to tie the development of this MAC, and associated plans, to a number of the HPP objectives to justify the expenses out of the HPP budget. This EMS MACC made the most sense living within the HCC, but was not something that the other HCCs or that the state/federal entities required, yet we were still able to work it into our work plans/budget, working with the state. We then had specific deliverables, pertaining to the EMS MACC, in our SOW. As previously noted by the other responder, I would definitely recommend using your FPO, as needed, to support additional activities that your HCC may want to take on.

Response #3:

- We have been funded through a variety of sources, including local philanthropic agencies and CARES funding.

4. Panelists mentioned HCCs took on tasks that they can't sustain after the pandemic. What are the challenges to sustainability?

Response: Sustainment is dependent on requirements, resources, and expectations. Most HCCs have very limited staffing resources and they rely on the contributions of personnel from member entities who provide support as "other duties as assigned" on top of their day-to-day responsibilities. Like other segments of the response workforce, they are also exhausted from working an extended response with no relief.

On top of the limited staffing, many HCCs have taken on greater than expected response roles. Prior to the pandemic, some HCCs considered health care preparedness to be their primary function with only limited supporting roles in response, while other HCCs, in collaboration with the ESF-8 lead agency, integrated their operations into the overall response structure. Many HCCs also played a critical role in supporting less resourced healthcare entities. Whether it was

providing infection prevention training in nursing homes or acquiring personal protective equipment for dental offices, HCCs became the go to source of resources, training, and technical assistance for entities that had no other avenues of support. Some of these entities were already members of the HCC prior to the pandemic while others only became engaged once they had a need.

The COVID-19 response experience has raised numerous questions related to future HCC capability development, including:

- To what extent will HCCs be expected to continue supporting roles beyond communication and coordination within their respective jurisdiction(s) following the pandemic?
- What are the current priorities for HCCs in steady state and response – and how, will, or should they be maintained (e.g., daily HCC calls during a week with pediatric surge)?
- Should HCCs focus primarily on improving acute care surge response or do they need to focus more broadly on increasing operational coordination, integration, and resiliency to support the overall health care delivery system?
- How should HCCs continue to engage and support new members once emergency assistance and support is no longer needed?

HCCs need clarity of expectations about their future roles and responsibilities. Regardless of the new and existing roles performed by HCCs during the COVID-19 response, they may continue to connect the elements of medical response and provide the coordination mechanism among health care organizations, emergency management organizations, and public health agencies.

5. How would the response to the pandemic have been different if HPP had not invested in HCC?

Response: This varies widely from one HCC to another, but a couple of themes stand out. First, survey and focus group participants described how the development of their HCC required years of collaboration with diverse partners and those intensive planning efforts built strong relationships that clarified roles and responsibilities and enabled HCC members to effectively work together during the pandemic. Second, many participants noted that the pandemic provided proof of the HCC concept. They described skepticism about the HCC concept and the role of HCCs in emergency response that existed prior to the pandemic eroding once response partners were able to see the contributions of HCCs during the pandemic.

Additionally, survey respondents were asked to describe successful aspects of their response that would not have been possible without an HCC. More than one-third of respondents mentioned something related to information sharing, with many describing their HCC as a central source of accurate information, providing situational awareness for all HCC members, or having an effective process or system for sharing information. More than a quarter of respondents mentioned something related to resource coordination or command and control. Multiple respondents named patient movement or patient load balancing as a successful activity, describing their use of geographic information systems to inform transport, daily situational updates to track regional bed availability, and load balancing to prevent alternate care site use.