Idaho Hospital Association

COVID-19 Report to Members ~ August 31, 2021

Reports are sent on Tuesdays, unless there's breaking news.

Governor sends help to hospitals

Over the last several days, Governor Little has worked to provide much needed help for Idaho healthcare workers as hospitals face the potential of the first-ever activation of statewide crisis standards of care. This morning, there were only four traditional adult ICU beds available across the state. Nearly all contingency ICU beds set up to meet the surge are also full.

In his comments today, the Governor said, “Idaho hospitals are beyond constrained. Our healthcare system is designed to deal with the everyday realities of life. Our healthcare system is NOT designed to withstand the prolonged strain caused by an unrestrained global pandemic. It is simply not sustainable.”

Today’s announcement of 370 clinical and non-clinical personnel to work in hospitals was welcomed as the surge shows no signs of abating. In addition to activating the Idaho National Guard again, the Governor and his team were also able to secure 200 clinical and non-clinical staff through the US General Services Administration (USGSA), as well as a team of 20 doctors, nurses, and respiratory therapists who will be sent directly to Kootenai Health in Coeur d’Alene.

Deploying both National Guard and the ISGSA personnel will be handled through the Idaho Office of Emergency Management. IOEM officials noted today they understand the application process can be cumbersome for hospitals that are under extreme duress and they are addressing the process to make it less burdensome. Once the request is completed, hospitals will submit it to their local health districts which will then forward it to IOEM for review and action.

In addition to staffing support, Governor Little also offered hospitals $4 million in funding to help address space and staffing needs. Hospitals can complete the **streamlined application** to be eligible for $1,000 per licensed bed. The funding can be used to address the immediate needs hospitals are facing:

- Staffing shortages, including retention bonuses, temporary staff, overtime, new staff at higher pay rates, and other recruitment or retention needs.
- Purchasing temporary physical space.
- Establishing locations to administer monoclonal antibodies. The Governor also announced last week that the state is setting up **monoclonal antibody infusion locations**, with the first being located in Coeur d’Alene following by others in Pocatello and the Treasure Valley.

An additional funding source through the State is also open to allow providers to **receive up to $1,800 per Medicaid participant** served in 2021. This funding, originally approved but not fully utilized in 2020, is available to all Medicaid providers through the Division of Medicaid.

This funding is a general distribution based on providers’ COVID-related service to Medicaid patients from January 1 – June 30, 2021. Applications must be submitted by 5p MTN on October 29. Application reviews will begin Wednesday, September 1.

Governor Little closed his announcements today thanking those who are so tirelessly working to save lives. “I hope it will be enough for us to avoid statewide crisis standards of care, but we are teetering on the brink and there is only one real solution – we need more Idahoans to choose to receive the safe, effective COVID-19 vaccine now."

Reimbursement & Policy

Using provider relief funds for staffing costs

HRSA released an **updated fact sheet** outlining the staffing-related costs that can be covered by Provider Relief Funds, noting “payments can be used for a wide variety of direct and indirect costs of recruiting and retaining personnel during the pandemic”. Examples of expenses for retaining as well as recruiting employees were provided. While not an exhaustive list, HRSA noted that expenses are likely allowable if they are “necessary and reasonable to support patient care efforts” and if the expense is “consistent” with the organization’s policies and procedures.

This Idaho Reports special features healthcare experts from across Idaho discussing the statewide hospital crisis caused by the recent surge.

Resources & Information

Excess mortality associated with COVID-19

IHA has thrice previously reported on excess mortality due to the COVID-19 pandemic, in September 2020 and April and June 2021. Excess mortality is a comparison of the number of actual deaths to the number expected based on multi-year trends. During 2015 through 2019, year-over-year increases in the number of deaths in the United States averaged 1.2%; but in 2020, the percent increase in the number of deaths relative to 2019 was an astounding 17.7%.

Studies included in the previous IHA reports found that for every 100 reported COVID-19 related deaths, there were an additional 20 excess deaths from other causes. These excess deaths from other causes may be due to fear of interacting with the healthcare system because of COVID-19, disruptions in receipt of healthcare, changes in risk factors, and other reasons related to the pandemic but not directly to COVID-19. Rural counties, counties with higher proportions of smokers, higher proportions of residents with poorer health status or who were living with diabetes also had a higher proportion of excess deaths that were not attributed to COVID-19. The West, as a region, had higher proportions of excess deaths not assigned to COVID-19 relative to the rest of the country (with the exception of the Southern United States).

A **new study on excess mortality due to COVID-19** was published in the MMWR on August 20, 2021. This study used data on the weekly number of deaths from all causes and from COVID-19 that occurred during December 29, 2019–January 2, 2021, obtained from the National Vital Statistics System. The investigators compared the observed numbers of deaths from all causes with expected numbers of deaths based on weekly projections from 2015-2019 data.

This study adds to the literature by estimating excess mortality incidence rates, which account for population size and age structure, and describing disparities by age group, race/ethnicity, and time period. During 2020 in the U.S., the greatest excess mortality was among persons aged ≥65 years, compared to <25 and 25-64. Among adults aged ≥65 years, the largest excess mortality incidence rates were seen among Black and Hispanic persons (1,033.5 and 1,007.0 deaths per 100,000 person-years, respectively), followed by American Indian/Alaska Native (650.0), White (500.1), Asian (483.7), and Native Hawaiian/other Pacific Islander persons (426.4).

The total numbers of excess deaths, for all ages, were 85,294 for Hispanics, 5,223 for American Indian/Alaska Natives, 17,009 for Asians, 87,022 for Blacks, 749 for Native Hawaiian/other Pacific Islanders, and 279,491 for Whites. The proportions of total excess deaths that were directly attributable to COVID-19 were higher among persons aged ≥65 years and also varied by race/ethnicity.

The study concluded, “Identifying factors that contribute to racial/ethnic disparities in mortality, either directly or indirectly attributable to COVID-19, can help guide tailored public health prevention strategies and equitable allocation of resources, including COVID-19 vaccination, to achieve greater health equity.”

When datasets on Idaho resident deaths for 2020 and detailed Census 2020 population estimates become available, IHA epidemiologists and the Division of Public Health will be able to better characterize the mortality burden of COVID-19 in Idaho by demographic group and geographic area.

Virtual Meetings & Education

NHSN COVID-19 Basic Training

In this webinar, the CMS final rule calling for mandatory reporting of healthcare personnel’s COVID vaccination data in NHSN (National Healthcare Safety Network) will be reviewed, as well as the process for hospitals to correctly supply the data. The rule goes into effect October 1, 2021. This program is provided at no cost to IHA members by our colleagues at the Colorado Hospital Association.

NSHN Vaccination Reporting Webinar
September 9 ~ 1-2p MTN / 12-1p PAC
Register

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