

COVID-19 Report to Members ~ October 5, 2021

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

Reimbursement & Policy

Funding for hospitals to help with surge

Additional funding to help hospitals and other providers is now available from both the state and federal governments.

On the federal side, [HRSA is making \\$25.5 billion available](#) to hospitals and other providers. [Applications](#) for the funds must be submitted by October 26, 2021.

The application [will apply to both](#) Phase 4 Provider Relief Funds (PRF) as well as funding from ARPA. Both funds can be used to offset changes in operating revenues and increased expenses. The PRF funds are based on the levels of those changes, with smaller facilities receiving a higher percentage. The ARP funds are based on the services provided to rural Medicare, Medicaid and CHIP patients.

At the state level, [applications](#) for the second round of funding for hospitals to help offset expenses related to the latest surge are now being accepted. The funds have been made available by Governor Little with the distribution facilitated by IDHW. Funds can be used to address staffing shortages as well as space challenges and to help facilitate monoclonal antibody treatments.

Vaccines & cancer ~ get the facts

Misinformation has and will continue to increase the number of COVID-19-related deaths and hospitalizations, in addition to likely prolonging the pandemic itself. The claim that COVID-19 vaccines can cause cancer is one example of misinformation that gained traction over the summer and continues to be debated as if it had merit. This article briefly describes why it would be difficult to reliably establish that the COVID-19 vaccines are causing cancer at the population level, and why the biological mechanism cited as the cause of cancer in persons who have taken the COVID-19 vaccine is unfounded.

We don't have the data yet: cancer research and data collection

In the US, [cancer registries](#) are the primary source of population-based cancer data. These programs systematically collect data on cancer cases – the extent of the disease, treatment, patient survival, and other critical pieces of information. They operate independently but work collaboratively with other public health programs at local, state, and national levels. Cancer registries can be hospital-based, geographic in scope (i.e., state or county), or focus on particular populations (e.g., tribal populations). Data are combined across programs and reported at the national level, which provides the public health, research, and policy communities with a population-based view of cancer trends.

These types of cancer-related data are not available in real-time. As with any type of research, the quality and accuracy of the data are paramount. Without quality data, the conclusions are irrelevant. It's the GIGO theory – garbage in, garbage out. Cancer registries and registrars hold themselves to complex and high national and international standards. Ensuring that these standards are met takes time. Generally, the cancer case data for a given year is not finalized for 24 months. Data describing cancer cases in 2021, for example, will not be finalized until the end of 2023. **There are not adequate, verified, quality data to make any type of claim about COVID vaccines in relation to cancer.**

The T cell issue

Some claim the vaccines are reducing T cells which are instrumental in the body's fight against cancer and other conditions. T cells are part of the body's immune response and work in conjunction with antibodies. They are white blood cells that coordinate an immune response (e.g. helper T or CD4+ cells) and attack (e.g. natural killer and CD8+ T cells) the foreign cells. Research shows that the [COVID vaccines increase the body's T cell response](#) in people with and without prior SARS-CoV-2 infection.

Yes, some viruses cause cancer

Decades of prior research demonstrate that many viruses are associated with increased cancer risk, e.g. human papilloma virus (HPV) and cervical cancer, hepatitis C and B viruses and liver cancer, human immunodeficiency virus (HIV) infection and many different cancers. This is why clinical and public health professionals strongly encourage HPV and hepatitis B vaccination. To date, there are no data on the relationship between SARS-CoV-2 and increased risk for cancer, but it is possible that we may see this signal in the future. In addition, we may also learn that vaccination against the SARS-CoV-2 virus – in addition to decreasing risk for hospitalization and death – is also preventive for certain types of cancer.

Prolonging the pandemic will impact cancer treatment and screening

The pandemic continues to wreak havoc on traditional patterns of screening, preventive care, and treatment. Early in the pandemic, data from over 400 healthcare organizations covering 70 million US patients showed about a 90% decline in breast, cervical, and colon cancer screenings. Although the screenings recovered in the early part of 2021, total volumes are down between 13-25% based on the type of screening. The current surge is also impacting cancer treatments and screenings, causing delays in care and diagnosis. Experts have sounded the alarm that these delays could have hazardous results for many. However, the level of that impact won't be known until after the data are available and compared to existing benchmarks.

False and misleading information is derailing the work of healthcare professionals across Idaho, costing lives, and impacting our ability to return to some sense of normal. IHA appreciates the efforts of researchers, journalists, public health experts, and others who are attempting to counter misinformation with science, logic, and honesty.

HIPAA, vaccines, and the workplace

In this recent FAQ, HHS covers common workplace scenarios and how HIPAA does or does not apply

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