July 7, 2020

Captain Paul Reed, MD
Deputy Assistant Secretary for Health, Medicine & Science
Office of the Assistant Secretary for Health
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 715-G
Washington, D.C. 20201

Re: Request for Information – Long-Term Monitoring of Health Care System Resilience; Submitted electronically to OASHcomments@hhs.gov

Dear Captain Reed:

The Joint Commission appreciates the opportunity to provide feedback on the request for information (RFI) titled "RFI – Long-Term Monitoring of Health Care System Resilience." The Joint Commission commends the U.S. Department of Health and Human Services (HHS) for seeking public input on how stakeholders believe the health care system can be more resilient to address a future pandemic.

Founded in 1951, The Joint Commission seeks to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value. An independent, not-for-profit organization, The Joint Commission accredits and/or certifies more than 22,000 health care organizations and programs in the United States. The Joint Commission evaluates health care organizations across the continuum of care, including most of the nation's hospitals. In addition, Joint Commission programs encompass clinical laboratories, ambulatory care and office-based surgery facilities, behavioral health care, home care, hospice, and long-term care organizations. Joint Commission accreditation and certification are recognized nationwide as symbols of quality that reflect an organization's commitment to meeting state-of-the-art performance standards. Although accreditation is voluntary, a variety of federal and state government regulatory bodies, including the Centers for Medicare and Medicaid Services (CMS), recognize and rely upon The Joint Commission's decisions and findings for Medicare or licensure purposes.

The Joint Commission offers responses to these questions posed in the RFI:

www.jointcommission.org

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Key Indicators & Data Sources of Health System Resilience

What is your definition of health system resilience within the context of your organization? Does the definition of resilience need to be defined differently based on geographic region and/or the domain of healthcare being assessed?

The Joint Commission agrees with the definition included in the RFI -"the capacity of health actors, institutions, and populations to prepare for and effectively respond to crises; maintain core functions when a crisis hits; and, informed by lessons learned during the crisis, reorganize if conditions require it." The Joint Commission believes that this definition should also encompass how health care organizations can better prepare to manage a pandemic while also address when and how to be able to continue to provide preventive care services, such as immunizations and cancer screenings.

Barrier and Opportunities for Health System Resilience

What have been the most significant barriers to assessing, monitoring, and strengthening health system resilience in the US?

<u>Federal Government Needs Model to Assess Capacity Demands</u>
The current federal government infrastructure is not designed to adequately respond to a pandemic. The COVID-19 pandemic revealed that the federal government lacked a model to assess health care system capacity demands under a worst-case scenario. As a result, the health care system and the federal government were unable to adequately assess critical supply needs such as ventilators, swabs, and personal protective equipment (PPE), and meet all of those demands during a pandemic in a timely manner. The federal government did not have real-time tools to monitor health care system capacity, including hospitalizations, intensive care unit visits, and surge capacity, as well as the time and requirements necessary to make surge capacity operational throughout the country. Health care system resiliency will require more work from the federal government to be able to capture important data and model system demands while monitoring system capacity.

<u>HHS Should Create a Central Portal for Facilities to Submit Supply Needs</u>
During the COVID-19 pandemic, health care organizations faced significant PPE supply shortages. Health care organizations did not have an official means to communicate supply needs so that the federal government and other stakeholders could accurately assess health care organizations' supply needs during the public

health emergency (PHE). Also, PPE supply needs were assessed differently at the local level, often resulting in a lag in PPE data submission and confusion regarding where supplies were needed.

The Joint Commission monitored various federal, state, and local level supply databases and reached out to their accredited health care organizations to gain a better understanding of their needs. The Joint Commission received a surge of complaints in the beginning of the PHE, frequently related to PPE supply issues, and organizations even reached out to The Joint Commission for PPE supplies. While not a PPE supplier, The Joint Commission had a strong situational understanding of the PPE supply challenges faced by health care organizations across the country and advocated for emergency efforts at the federal level to drastically increase the production and distribution of PPE.

The Joint Commission urges HHS to create a central supply database where health care organizations can submit supply needs. A database that uses a consistent approach to assess health care organizations' needs will provide a better understanding of supply needs and the organizations that are in desperate need of supplies. Health care organizations also need easily and readily accessible information regarding where to request supplies. Lastly, more transparency within the supply chain is needed so facilities know how these supplies are distributed.

HHS Should Ensure Consistent Guidance

Health care organizations faced difficulties providing care for their patients due to inconsistent guidance between federal and state agencies, as well as rapidly changing guidance, during the COVID-19 pandemic. Though The Joint Commission appreciates that the COVID-19 pandemic has created unprecedented challenges for the federal government to frequently update guidance, a more coordinated approach is needed. For example, health care organizations were often confused regarding inconsistent guidance between different federal agencies and were often uncertain which guidance to follow. Health care organizations also had to access guidance on many different federal portals instead of one central place and were often unsure where to look for guidance. Recognizing these needs, The Joint Commission created its own repository of applicable federal guidance, position statements, and other resources on its website.[1] Many health care organizations and policymakers have expressed appreciation to The Joint Commission for gathering this information in one place.

[1] https://www.jointcommission.org/covid-19/

Because accrediting organizations (AOs) provide insight into situational awareness of what is occurring within health care organizations across the country, AOs should be brought to the table with federal agencies early in the decision-making process of a future pandemic. AOs will have frequent and continuous touchpoints with health care organizations and are looked to by their accredited facilities for the latest information. This is even more the case when there is confusion among agency voices. Thus, it is important to involve AOs early with government response teams that include the entire federal response architecture, not just with CMS.

What policies and programs can be improved to mitigate the risk of COVID-19 and avoid negative impacts on patient outcomes?

Ensuring Regulatory Flexibility During a PHE

Regulations governing the delivery of care are numerous and do not allow flexibility for providers to adapt to the rapid changes posed during a pandemic or other emergency. Once the national emergency was declared along with the PHE, CMS made significant regulatory changes through the Section 1135 waiver process. These waivers have been instrumental in such areas as allowing providers to practice to the full scope of their license and permitting providers to practice across state lines if permitted by the state. The Joint Commission commends CMS for their focus on reducing regulatory burden for the health care industry during the COVID-19 pandemic.

Ensuring health care system resiliency will require planning related to the regulatory flexibilities that health care organizations will need for a future pandemic. Many regulatory flexibilities approved during the COVID-19 pandemic have allowed providers to deliver care more effectively and will allow providers to meet new challenges whether or not they rise to a pandemic level. **HHS should work with stakeholders to evaluate which regulatory flexibilities provided during the COVID-19 pandemic should remain in place once the PHE is lifted.** Furthermore, federal agencies such as CMS should develop an expeditious process for issuing those regulatory flexibilities that should be granted specifically upon confronting a catastrophic event.

AOs Should Be Permitted to Perform Virtual Surveys

As part of health care system resiliency, AOs must maintain ongoing communication and contact with their accredited hospitals. However, it may not be safe for accreditation surveyors to always go onsite during a pandemic. In addition, it can be burdensome for health care organizations to undergo an onsite accreditation survey

with a team of surveyors while also responding to a pandemic. In March, The Joint Commission had to suspend onsite surveys because COVID-19 data showed extensive community spread beginning to take place. Therefore, **The Joint Commission urges allowance of virtual surveys for all types of federal government surveys.** CMS permitted virtual surveys only for an initial evaluation of a health care organization. To date, CMS has not approved The Joint Commission's request to perform virtual surveys for routine and follow-up surveys related to deficiencies. Though The Joint Commission resumed some onsite surveys in June, many health care organizations may experience surges of COVID-19 cases for some time into the future; therefore, it is critical for AOs to be able to evaluate health care organizations through virtual surveys when necessary.

Best Practice Playbook for Organizations

The Joint Commission recommends the creation of a standard playbook of best practices during a pandemic or another large-scale emergency that all health care organizations, including hospitals and nursing homes, have reviewed and practiced through simulations or table-top exercises. When there is a resurgence of COVID-19 cases in a community, health care organizations would be able to rapidly implement the playbook, which should address such things as screening facilities, negative pressure rooms, decontaminating N95 masks, invoking crisis standards of care, elective surgeries, and patient transfers. A playbook could similarly be utilized for an influenza pandemic. Many health care organizations have already raised the importance of a playbook and we encourage HHS to take a leading role in its creation.

National Response Plan

The Joint Commission recommends that a national response plan be created to monitor health care capacity and ongoing changes in situations on the ground.

Centralized Site for National Health Care Worker Volunteers

The Joint Commission recommends the creation of a national health care worker volunteer database that would identify professionals with specific skills who are available to work in areas of need during a PHE. During the COVID-19 pandemic, many health care workers, including some who work at The Joint Commission, wanted to volunteer but could not readily find places where they were needed or the right contacts to arrange their services. They also faced difficulties being placed in the parts of the country with capacity challenges. Though many states have a volunteer medical corps and many states activated their volunteer corps, clinicians often faced administrative burdens or were never utilized even though there were health care

work force shortages.[2] A database would more efficiently match those who volunteer their services with areas in need.

Organizational Emergency Preparedness Review Requirements

The Joint Commission urges CMS to amend the Medicare Conditions of Participation (CoP)[3] to require that all health care organizations review their emergency preparedness plans and participate in relevant training annually. Last year, CMS finalized regulations requiring hospitals and other facilities to review their emergency preparedness plans every two years instead of annually. The Joint Commission opposed this policy when it was first proposed because The Joint Commission believes an annual review is critical to respond effectively to a wide range of emergencies such as hurricanes, earthquakes, mass shootings, or those like the COVID-19 pandemic. Because these emergencies are becoming more frequent and widespread, it is paramount that health care organizations are resilient, ready to respond and cooperate with their government and non-government partners in an expeditious manner.

Ensuring the Well-Being of Health Care Workers

The Joint Commission recommends that HHS take action to support the well-being of health care workers during and after the COVID-19 pandemic. A health care organization's ability to respond to the stresses and strains of providing adequate patient care during a crisis – such as the COVID-19 pandemic – is reliant on its workers' psychosocial well-being. The COVID-19 pandemic has created unique challenges for health care workers. For example, many health care workers have had to arrange for different living situations to isolate from family, work longer hours, and play the role of both clinician and family because of visitation restrictions at many health care organizations. Therefore, it is critical that health care organizations have systems in place to support institutional and individual resilience.

HHS must also consider the barriers that may prevent health care workers from seeking mental health services. Many health care workers fear career repercussions if they seek mental health treatment. For example, clinicians have concerns that seeing a mental health professional could adversely affect their career if they are asked about a history of mental health conditions or treatment during the credentialing or licensing process. **The Joint Commission strongly supports health care workers being able to access mental health services without barriers or fears of career**

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[2] Hong, Nicole. (2020, April 8.) Volunteers Rushed to Help New York Hospitals. They Found a Bottleneck. *New York Times*. Retrieved from https://www.nytimes.com/2020/04/08/nyregion/coronavirus-new-york-volunteers.html

[3] 42 CFR §482.15 Condition of Participation: Emergency Preparedness

consequences. The Joint Commission encourages health care organizations to not ask about a clinician's history of mental health conditions or treatment and limit questions to conditions that currently impair a clinician's ability to perform his or her job.

Public-Private Partnerships

Provide ideas of the form and function of a public-private partnership model to continually assess and monitor health system resilience and individual as well as population health outcomes?

The Joint Commission believes the federal government should lead a more effective coordinated response as it addresses a future pandemic. The federal government should operate a command center approach where information is shared, and decisions are made with all appropriate agencies represented. The federal government's decisions and actions should be transparent, and a few designated, trusted federal voices should routinely convey information to the public. These individuals should be from positions known to the public and represent the government's most credible sources. Other individuals such as those from industry can join the communications as needed. These actions will enable the federal government and relevant stakeholders to more effectively speak as a unit to the public.

What private and public sectors should HHS engage as part of such a collaborative effort?

As part of ongoing public health and other catastrophic responses, **The Joint Commission urges that the federal government establish a process by which AOs are brought to the table early in the decision-making process.** AOs should be part of a routine set of established meetings involving an array of federal agencies where actionable information is shared, and appropriate decisions are made. While The Joint Commission has been part of some ongoing meetings during the COVID-19 pandemic with the federal government, they have been siloed and limited in terms of information. The Joint Commission strongly believes that AOs should have regular meetings with a coordinated team of federal agencies including but not limited to CMS, the Department of Homeland Security, the Assistant Secretary for Preparedness and Response, the Food and Drug Administration, and the Centers for Disease Control.

Part of the rationale behind such meetings is that the federal government relies upon AOs to evaluate health care providers for participation in Medicare. This reliance does

not stop during a crisis and without being part of the solution to the federal response, it necessitates that the government takes over this monitoring role for approximately 100,000 health care organizations. AOs can assist and, through regular touchpoints with their accredited facilities, can also provide the government with situational awareness and vehicles to inform health care providers. Because The Joint Commission accredits approximately 80 percent of the nation's hospitals, it has a thorough understanding of the health care system's abilities to respond to the current pandemic as well as future pandemics. This is not new; AOs have a long history of participation in the response to public health and other catastrophic events. However, more formalized input and information sharing is needed with the federal government during a crisis.

Relationships should also be strengthened between local health departments and the health care system. Each brings a set of skills to the table and more understanding by these partners would improve local health care resiliency.

Thank you again for the opportunity to comment on the white paper. Please do not hesitate to contact me if we can be of further assistance, as well as Tim Jones, Associate Director, Federal Government Relations, at tjones2@jointcommission.org or 202-777-1246.

Sincerely,

Margaret VanAmringe, MHS
Executive Vice President for Public Policy and Government Relations