From: Nickelson, Paula
To: Willard, Aaron; Knodell, Robert; Crumbliss, Adam
Subject: Confidential conversation with MHA re: model to assist with healthcare staffing
Date: Friday, July 23, 2021 10:32:17 AM
Importance: High

As requested at yesterday's Region D resource request discussion, we met this morning (John Whitaker and I) with Leslie Porth, Jackie Gatz, Kara Amann-Kale, Jill Williams, Daniel Langdon and Andy Wheeler of MHA. The meeting was called specifically to gain their input on two topics:

- If the state were to put funding into healthcare staffing, what guidance and insight does MHA offer regarding how this should be structured.
- Request MHA's guidance re: the state entering a contract with another healthcare staffing entity, in addition to Vizient.

In the course of gathering this information, MHA had many question about the ACS resource requests, expressed surprise that Region D pursued an acute care ACS and expressed significant concern with this approach. Both Leslie and Jackie pretty strongly indicated they were not supportive of this model based both upon the experience of other states with this ACS model not being effective or well-utilized during this COVID response, as well as the underutilization of the step-down type of ACS which was operated in St. Louis area. MHA indicated they were unaware who/what organization is the driving force behind the second ACS request and emphasized their communications with hospitals state-wide has been consistent throughout the response that beds/physical space is not the problem, staffing is. Thus, MHA's recommendation is to focus state support on enhancing healthcare staffing accessibility and funding for healthcare staffing. The discussion also was that the infusion center, EMS strike teams, RT waivers and any EMACed or federal healthcare staffing would be significant hospital decompression factors, likely decreasing Region D's push for an ACS. There was also a discussion of the ongoing need state-wide to assure LTCFs were accepting discharges from hospitals. As an update, we've communicated through the healthcare coalitions state-wide to provide DHSS the names of any LTCFs denying admissions from hospitals and our SLCR will work directly with each of those LTCFs – to date, no names have been provided by any hospital.

Regarding whether the state should pursue a second healthcare staffing entity in addition to Vizient, they generally agree there just are not many key crisis staffing positions available nation-wide so everyone is competing for the same few nurses, respiratory therapists, etc. That being said, the point was made by Jill Williams, their staffing specialist, that having an additional healthcare staffing firm working on behalf of the state (if the state is putting funding into a contract) might make sense as 'two sets of eyes are better than one'. Their immediate recommendation is APS, which is a firm they work with, there may be some sort of corporate relationship with MHA – that is not fully transparent to me. I do recall that, when we contracted with Vizient, that was a real point of sensitivity for them and what the state's relationship with APS was or would be. Apparently, Vizient and APS are partners in some situations and competitors in others, according to Jill Williams.

Regarding a model for structuring state financial support, if the decision to augment with state funding is made, we discussed several options:

1) State funding staffing for ACS – again, MHA reiterated their counsel on this issue
2) Develop a focused funding delivery model similar to that deployed this winter – MHA counseled they feel the current 'march' of Delta across the state necessitates a different model this time that allows more open access to more hospitals
3) Model that is reflective of HHS/CARES Act provider relief payments, but perhaps less restrictive – MHA counsels generally too complex and not focused enough – the focused need now is healthcare staffing, not generally assuring hospitals can stay afloat during COVID as was the HHS focus with that program
4) RFI to hospitals to identify their needs – for instance, do they need/prefer the state to pay 1/3-1/2 of temporary staffs' salaries OR pay the hourly differential between average hourly rate and contracted rate. RFI would also help quantify how big the issue is currently as MHA has no real-time data to help quantify the need.

MHA thought the RFI model was the most broadly useful for all hospitals and would provide us some real-time information to quantify the need, which could then instruct the state's decision re: level of funding needed. MHA declined to offer an amount of state funding that they thought was needed. If we wish to pursue that avenue, MHA offered Jill Williams to assist with the scope of work for the RFI. Have only had a short time to reflect, but am also thinking this is a viable and reasonable approach given the lack of quantifiable information we have to understand this problem. We have a lot of anecdotal information, primarily from well-intentioned and well-educated providers who are operating so close to this problem and provision of care that 'the fog of war' has to be impacting their assessments and judgements regarding resource needs.

Let me know how you wish to proceed, thanks – Paula

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