

July 2022 HPP-PHEP Joint Business Meeting

July 13, 2022

Call Transcript

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Kate Noelte: Welcome everyone. My name is Kate Noelte. I'm the Deputy Division Director with the Division of State and Local Readiness at CDC. And, on behalf of CDC's DSLR and ASPR's National Health Care Preparedness programs, I'd like to welcome you to the HPP-PHEP Joint Business Meeting. We really appreciate you taking the time out of your busy schedules to join us today. We know that three hours is a lot for any meeting, but we have some really exciting topics lined up to discuss today and really want to thank you for joining. We'll first transition to our HPP update and we'll start off with some discussion on our national health care situation awareness and then an update on national special pathogen system's progress. Next, radiation surge planning and annex and, finally, some HPP administrative updates. We'll then have a five-minute break a little bit after two o'clock and we'll transition into the CDC portion of the agenda today. We'll talk about some budget period 4 updates, field to find the expansion, workforce development promising practices, and then also a few administrative updates from us as well. We'll then have another five-minute break and transition into our third and final session of the day, which will be a joint discussion between HPP and PHEP, focusing on the future of both programs post-COVID-19. Again, if you missed us at the top of the hour, we welcome questions and comments throughout our session today. Feel free to put any questions you have in the chat or raise your hand and the moderator will be able to unmute you and you can ask your question. Without further ado, we'll get into our agenda. I will turn it over to Jennifer Hannah for the National Healthcare Preparedness Programs updates. Jennifer, over to you.

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Jennifer Hannah: Great. Thank you, Kate and good afternoon, everyone. We will actually just go ahead to the next slide because Kate covered the agenda pretty well at the top of the meeting. So, I'll pass it now over to Brittany Seiler who will cover and discuss national health care situation.

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Brittney Seiler: Thanks, Jennifer. For those who don't know me, I serve as a Senior Advisor within the National Health Care Preparedness Programs and also co-lead the COVID-19 data, in addition to being overall involved in situational awareness across ASPR and across HHS. I have the pleasure today to talk to you all about situational awareness and some of the efforts that we're working on. And really trying to work through with it all of you, working on our path forward. Some of you may have heard me give versions of this talk at various different conferences so thank you for your patience. I really just want to make sure that you all have the opportunity to hear some of the efforts that we have ongoing and also just set the stage for starting to work together more earnestly across the sphere with all of you. There is a lot more to come on this. And you'll hear more about that as we go through. Obviously, situational awareness has been a challenge that we've tried to tackle in a number of different ways for those of you who have been with the programs for a long time, you probably remember the HavBed system and various other initiatives that have come along the way to address components of the problem. But we really haven't tackled the challenges from a holistic perspective of really thinking about the policies, the technology, and the various other

components that are really needed from a situational awareness standpoint. We also right now don't have shared essential elements of information that are out there. We know that everyone has them and from an HPP side, we know that it's one of the requirements that all of the states and jurisdictions also have their own EEs not necessarily for COVID, but for an all-hazards perspective or for various different disasters. But none of these have really been unified. Our thought is that if you were to take a look at all of the different EEs nationwide, there's probably some sliver of EEs that are similar across all of the different jurisdictions, across the healthcare systems, and more. Our intent is really to try and get to the heart of what is that core sliver that we can more broadly talk about across the full country so that way we're in a place that there's this foundation already build from a situational awareness standpoint. That'll also help us with the ability to share information and have some level of standardization across the board, since that way questions could actually be compared to each other in terms of the information. We know that saying the word situational awareness and healthcare means many different things. There are a variety of different levels. First, at this very tactical level so hospitals are dealing with having to transfer patients to each other every day. Medical emergency operation centers have to mold coordinating where patients are going, as well as transfer centers and oftentimes coalitions are often at this more tactical level. So, they really need to see what bed is available, right now. Then there's this operational level, which often is served by states and others at a jurisdictional level that are thinking more about load balancing and overarching situational awareness to drive action, whether that's allocate resources or do other work at that level. And lastly, there's the strategic level, which is often where we at the federal government are located and really trying to think about what are the overarching challenges across the entire system. Overall needs, overall impacts, to see from a nationwide level, from a kind of larger lens if there's anything that we can do from a federal level to implement the interventions along the way. So, when it comes to right now, we know that we're at a pivotal moment for really being able to make progress on all of these as we move forward. These have been challenges for a very long time. COVID reporting highlighted these, and we know that all of you, including me, all of us are exhausted from doing the COVID reporting and the challenges that happen along the way. I think all of us are coming out of the COVID reporting with a lot of scars quite frankly. And I think many of us can agree that we never want to go through that kind of a situation again, so the hope really is to make sure that we're capitalizing on that and moving that momentum forward. Next slide. Like I mentioned, there are many different kinds of situational awareness. When it comes to our goal for all of this, we're really focusing more on the area of understanding the concerns that are within an area and understanding the impact so that we can implement interventions. We know that there's this other side of things like we talked about - the more tactical level that's really looking at pleasing individual patients in beds. But the reality is that, from a federal level, we're not typically involved in that level. We're more looking at this overarching strategic level, and some at the operational level. That's really where this effort will be focusing. The hope, though, is that there might be some things that kind of overflow and benefit the other side of this placing patient's piece. Next slide. What we really like to emphasize with folks is that there are a number of key principles that we'll talk about in the coming slides related to this initiative. But we really want to make sure that there's flow across all the different levels of situational awareness and, most importantly, that flow is bidirectional. I can't promise you that from a federal level we'll be able to share every single piece of data that ever existed. As you all know, supply chain data comes with a lot of data restrictions and everything else, but really making sure that bidirectional data flow is at the heart of all of these conversations. And that there is value added across the levels and ideally that they roll up into each other, so there

aren't specific things that are being collected just for this strategic level off in the corner. But that it actually flows up from the information that's already being collected from other things. That also highlights the point that many of you at a state level, jurisdiction level, have your own information collection systems. We do not want to take that away. We do not want to intercept that. We don't want to get in the middle of that. We really want to make sure that that information is coming from you all and moving up the chain, as it makes sense. Next slide. When it comes to the core goals of this, like I mentioned, we ultimately are really looking to move towards a core set of nationwide standards, and I always will air quote it for information sharing. The initiative very much behind this is making sure that they drive action, as well as being based on clinical and emergency response needs so we don't want EEs that are just collecting information to collect information. Very much looking for driving action on all of these. The goal is also to ensure that we have buy-in across all the levels of government and the private sector. And, with our health care partners, starting first with hospitals on all of these EEs so they know what is going to be expected of them from an information sharing perspective, and from an EEs and reporting perspective. And that they are ready to go for them. Obviously, there's never going to be a situation that we can always account for exactly everything that needs to be collected, so making sure that there's still some flexibility built into the systems to allow for things to get added. That's also important because we're really looking at a core set of data elements and knowing that there might be some very specific ones, depending on the type of disaster. Also, like, I mentioned that the information is timely, but it's shared direct bi-directionally and really focuses on making sure that it's easily entered and minimizes duplicative data collections. Obviously, even if you collect all this information, one of the important pieces is that you all can see your own data as well as for those of you who are in border states or regions really thinking about how the data can be shared and used effectively across the different needs. Next slide. Like I mentioned, this initiative is really going to take a number of different partners from a federal standpoint, there is work that's ongoing across ASPR, CMS, CDC, and ONC to really try and start pulling some of these things together. We'll also be pulling in other folks from our federal side, just to make sure that we have all the areas covered down. But, most importantly, this is not just a federal effort. We really don't want to have all the feds just sitting in a room together and coming up with all the EEs. That would really defeat the purpose of all of this because we want them to be things that are helpful to all of you, as well as to the health care system. In terms of coming up with what do we all collectively need to make sure that there's a better common operating picture that's shared. So, from a national level, there are many different partners that we're hoping to include in this initiative and really get their perspectives in all of this. You also are looking at a variety of different initiatives that are connected to this. CDC has a large effort right now on data modernization. There are other efforts that are tied to looking at EMRs and how to standardize some of the data entry within EMRs. We've also flagged for them some searching mechanisms and other things that might be helpful to really try and target this from all of the different levels, all the way from entering the data so that the more technology partners to the hospital partners to more of our local government and state and jurisdictional partners, as well as the coalition's, the RDHRS and various other partners. Next Slide. So, like I mentioned, we really want this to be a collaborative national effort to drive things forward from a situational awareness standpoint. One of the first steps that will be looking at is how do we actually align on the EEs and build out some of the needs. We know that there's been some work, especially in region four to really think about what are EEs especially for low notice event but has largely focused on hurricanes. But we also have seen that there are a number of needs that we haven't really built out EEs yet in terms of

understanding what it actually means for a healthcare facility to be stressed, and the health care system as a whole to be stressed. So, thinking about some of those flow challenges that can happen from getting patients from EMS into the hospital out to post-hospital. Also, defining all the various different components of them, knowing that definitions can vary widely and can be a very big sticking point to trying to find ways to come to agreement on some of those areas and also using some of the efforts that have already been put forward from past initiatives. Also, making sure that we answer some very key questions. First, does this mean what we think it means and does it account for key context? For example, if you ask the number of beds that are available within a hospital, you might not be taking into account the fact that there are ED borders are waiting for those beds. We're only looking at the beds available, maybe giving you a completely different picture than what it actually looks like in the hospital or thinking about things like diversion status. Does it really tell you what you think it's telling you? Other questions that are very important are the, why do you need to see this information, and what are you going to do with it, as well as who's looking at the data, and why should I trust them. Those are really key things from the hospital perspective, and we really need to make sure that this data is value added, not only to us at the federal level, but that it makes sense to partners at the hospital level and they see and contrast what's being done with it. Next slide. So obviously we've run through this very fast and there's a lot of work that really needs to be done with this. More working sessions to really work with all of you, as well as many of our other partners to pull some of these things together. We're hoping to have a variety of different meetings and roundtables and other things, to really get input from a variety of different partners to help us as we go. We've also put out there if people want to send us the EEIs that they already have, we are more than welcome to accept that and really start looking on our end to see if there are similarities across the board to really give us a starting point with where we go and how we build these things out. So, with that, I'm going to pause. We have a couple minutes left to really walk-through questions for from you all, as well as polling questions. But before we go into polling questions, let me just see if there are any questions to start off with or reactions from you all. It looks like we've got one comment from Kelly: *I understand that we already have data on who is presenting to emergency rooms. The nemesis system also provides information on what the EMS system is experiencing. How does all this data help us focus on the health care and public health systems prioritize efforts?* So, Kelly it's a really great point and one of the things that we're hoping to do and that's ongoing right now is trying to identify what data is already out there and is already being collected. Because the goal is to try and plug in efforts that are already happening but are part of the hospitals day-to-day. As much as we can capitalize upon those things, all the better. And so that it's not something that's additional being shared. That's really one of the hoops - to lean on things like NEMESIS and other initiatives to really make sure that we're focusing on some of those key components that are out there and using the data as best as we possibly can, while decreasing the burden wherever possible. And Diane says: *Delaware will be happy to share. Thank you.* If you send it over to your NHPP field project officer, that is probably a great way to do it and I'm sure they would be happy to share it over. So, in terms Karen's question about how states will be able to give input to this collaborative process. We, like I mentioned, are hoping to have a number of roundtables. We also welcome you all to share any info that you would like to with us. We'll probably also be having some individual conversations with a variety of different states and jurisdictions for those who feel like they have a similar effort that's ongoing or other information that would be helpful to really talk about this process. I will be very blunt and very honest with you all. It's going to be a long process. We have a lot of work to do and really pulling it together is going to take a while. I will say right up front, we are not going to get this perfect.

We know that there is a huge amount of work that needs to be done. So really the way that we've been looking at it is even if we can make 10% of an increase in how we're doing this, it was a huge step forward from where we are right now. So, I'm just putting that all out there. We're really excited to be working with you all, as well as our health care partners on this, because this is really going to take the efforts of many partners. But, like other initiatives that will take many partners, it will probably not be a pretty process, so thank you in advance for your patience. So, Edward asked: *With this development of the EEs, does this mean that benchmark eight of the FOA is going to be suspended soon?* I think that piece is still TBD in terms of the path forward and what the benchmark will look like. But I think we all recognize that there are a number of initiatives swirling on these EEs and are trying to make sure that you all aren't putting in a duplicative work wherever we can. So, Julie asked: *Is ASPR going directly to the local hospitals to get the information? Why not go through state, so that both can benefit from the information?* It's a great question, Julie. Our hope really is to make sure that we can go through states as much as possible, which is something that has been set up for the COVID data collection so that all of the states are given the option to collect information on behalf of their state from the hospitals and put it into kind of their own information systems and then send it over. The hope is to maintain that similar option to make sure that there are pathways for that information to come from the state or jurisdiction, but also to have pathways were needed to get that information directly from hospitals. So, we'll see what path is will eventually take, but there is very much an emphasis on state and jurisdiction involvement in this process and not having things be directly federal. And James, thank you. We're looking forward to working with you all too. As well as Tennessee. So, Roslyn asked: *What's the expected time frame for completion and implementation of this initiative, a year, two years?* I have no idea, Roslyn. I wish I could tell you. We're trying to see how much progress we can make over the next couple months to really start getting partners weighing into this. I think we're kind of going into it with the mindset of let's see how much work we can get done in a year and evaluate. I know, just like you all, that event definitions themselves - we could talk about the definition of a bed for the next 40 years and still not have a decision on it. We're trying to figure out what makes sense in terms of chunking this into pieces to have some kind of core set that is not tied to any particular disaster but can at least get us to that starting point to develop things to then align them. I think a year or two years is probably as a starting point, but we'll see what it will actually look like. John asked: *Cadence and feel changes greatly increase the burden. Can those be incorporated into pre-planning?* It's a great question John and I think many of the questions that people are asking now are things related to how do we have things as automated as possible. How do we handle either having things be kind of always in a warm state and then having switches to be able to turn them on or off to be able to make some of those challenges a little bit easier or recognizing there always are some, especially in low-notice or no notice events? And how we can handle that while also balancing the concerns of if you collect information, the whole way through that also comes with kind of additional challenges for everyone. So, it's trying to balance all those things. Edward, we will record you as well as wanting to participate. Thanks guys. In our last two minutes before I switch it over to Dr. Rick Hunt who will present after me, can I ask the Deloitte team to pull up one of the polling questions really quickly. One of the questions that we all wanted to ask you is whether your jurisdiction has a similar initiative that is like this. We've heard from many of you that some of you have one or that you're planning on one in the future, or that you've already created completed work on there. We'll leave that one up for a second. Just for awareness, all of these polls we're going to provide the poll results at a future engagement. We have a joint meeting, so you won't see the poll results right now. I'll give you guys a second. I'm sure I'm

completely hear you in terms of the cost of the data systems and making sure to really think about how that factors in. Alright, so we can close that one. We'll go on to the next question which is: *My jurisdiction sees value in this initiative. We really want to make sure, just a quick gut check, are we insane?* This is obviously a lot of work so really just making sure from you all that this makes sense and it's something that would be value added for you and in your work as well. So really just want to make sure that what we're doing is something that is a good path forward. we've got open for just a second. All right, we'll close it in probably 30 seconds, actually it is closed already. Perfect. So, with that. I thank you all so much. Like I said there's a lot of work to go on with this. The only way that we're going to be successful, is with all of you, and also with all of our health care partners because their voices are really critical in all of this too. You'll see on the screen my email and contact information. Please feel free to reach out. We're looking forward to working with you and keeping you all informed as this develops, so thank you. With that, I'm going to turn things over to our next speaker, Dr. Rick and he's going to be presenting on the NSPS and some of the work that they have underway. Thanks all.

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Dr. Rick Hunt: Thanks, Brittany. Good afternoon. I am Dr. Richard Hunt, the Senior Medical Advisor of ASPR's National Healthcare Preparedness Programs, or NHPP, Branch. It is my pleasure to be with you all today to discuss the National Special Pathogen System, or NSPS, Report to Congress. During my presentation, I will provide an overview of the NSPS Report to Congress and will share information about the progress and accomplishments of the NSPS, including the NSPS's integration with other health care delivery systems of care for emergencies and disasters. Next slide.

In March 2020, ASPR announced the launch of the NSPS, a nationwide systems-based network approach that builds on existing infrastructure and investments in preparing for special pathogen threats. The NSPS includes four components: The National Emerging Special Pathogens Training and Education Center, or NETEC; 10 Regional Ebola and Other Special Pathogen Treatment Centers, or RESPTCs; 62 Hospital Preparedness Program, or HPP, cooperative agreement recipients and their 55 state or jurisdiction Special Pathogen Treatment Centers, or SPTCs; and 53 hospital associations across all 50 states and the District of Columbia, New York City, and Puerto Rico. HHS allocated emergency supplemental funding to support the NSPS as part of the Coronavirus Preparedness and Response Supplemental Appropriations Act and the Coronavirus Aid, Relief, and Economic Security Act, or the CARES Act. Through the four NSPS components, ASPR supports the urgent preparedness and response activities and needs of hospitals, health systems, and health care providers on the front lines of the COVID-19 pandemic. Next slide.

Yes, there's a history here. The NSPS evolved from ASPR's Regional Ebola Treatment Network to broaden the nation's special pathogen preparedness beyond its previous focus on Ebola. With support from annual appropriations and COVID-19 supplemental funding, ASPR transitioned the former Regional Ebola Treatment Network into the NSPS in 2020. Key changes from the transition included: Renaming institutions for an increased and more explicit focus on all special pathogens, such as rebranding NETEC, which was formerly known as the National Ebola Training and Education Center, to the National Emerging Special Pathogens Training and Education Center; Adding hospital associations as a recipient group to distribute funds more rapidly to health care entities without placing additional burden on public health; and Updating the program terms and conditions to reflect an expanded scope of activities, including COVID-

19 preparedness and response activities and a more comprehensive focus on special pathogen readiness. In addition to these changes, ASPR called upon NETEC to develop a strategy for a national system for special pathogen preparedness, building upon and maturing the regional infrastructure of the Regional Ebola Treatment Network. Through this system-wide approach, the NSPS aims to strengthen health care response capabilities at the local, regional, and national level. Next slide.

During the COVID-19 pandemic, the NSPS addressed urgent health care entity infectious disease readiness needs, educated the health care workforce, provided technical assistance, supported research, and enacted surge activities. Accomplishments include NETEC's quick shift to offer virtual educational offerings to address limitations of in-person gathering during the COVID-19 pandemic. NETEC's trainings included participants from all 50 states, the District of Columbia, and four U.S. territories. The most popular offering, viewed by more than half a million people, was a YouTube video demonstrating how to safely use PPE. NETEC developed an integrated national clinical special pathogen research network, or SPRN, to support special pathogens research infrastructure and capacity. SPRN successfully supported a network-wide clinical trial and enrolled patients at all 10 RESPTCs for the investigation of novel medical countermeasures for the treatment of COVID-19 infection in collaboration with the National Institutes of Health. Throughout the pandemic, RESPTCs provided essential isolation capacity, supplies, and subject matter expertise. This included isolating and quarantining Americans returning from Wuhan, China, and the Diamond Princess cruise early in the pandemic. Overall, the NSPS' efforts led to a more coordinated, informed, and comprehensive response to the COVID-19 pandemic. Next slide please.

The NSPS is just one program in the ASPR Health Care Readiness Portfolio managed by NHPP. The portfolio's broader efforts have focused on readying the U.S. health care delivery system and workforce to respond to disasters. As I will review in our next agenda portion, the ASPR Health Care Readiness Portfolio's other key health care readiness programs include the Hospital Preparedness Program, or HPP, the Regional Disaster Health Response System, or RDHRS, and workforce capacity and capability activities. The ASPR Health Care Readiness Portfolio represents a collection of building blocks that form a comprehensive, national system for health care preparedness and response. The NSPS complements and integrates with these other programs by sharing promising practices and coordinating preparedness and response efforts. For example, the 55 SPTCs, as recipients of both HPP cooperative agreement and NSPS funding, coordinate with RESPTCs to transfer patients and provide situational awareness. RESPTCs and RDHRS sites serve complementary roles in regional preparedness, with RDHRS sites specializing in all-hazards preparedness coordination activities and RESPTC sites specializing in special pathogen patient care. All four RDHRS recipients are also RESPTC sites, which drives further coordination and connectivity between these two regional systems. Finally, the NSPS strengthens ASPR's broader health care workforce capacity activities through recipient engagement in training exercises and NETEC's education activities. Next slide.

As a national system embedded within health care delivery, NSPS has never existed within a vacuum – the NSPS, by design, integrates with other health care delivery systems of care for emergencies to enhance special pathogen preparedness in the United States. For the purpose of this report, “health care delivery systems of care” include health care entities and their partners, as well as formal partnerships and networks of care, such as health care coalitions, the national trauma system, and others. We defined health care emergencies as a hazard

impact causing adverse physical, social, psychological, economic, or political effects that challenges the ability to respond rapidly and effectively. Some examples of NSPS integration with other health care delivery systems of care for emergencies include improving access to educational and training opportunities to increase competency of health care delivery systems of care and the broader health care workforce, increasing regional coordination for special pathogen preparedness and response activities by utilizing the regional hub-and-spoke model of the NSPS, and enhancing comprehensive stakeholder engagement with health care organization and their partners, including public-private partnerships, as seen in the engagement of over 100 stakeholders, including the American College of Surgeons – Committee on Trauma, in designing and implementing the NSPS of Care Strategy. Integration is vital to the future success of the NSPS of Care Strategy and full implementation will require coordination with other health care delivery systems of care for emergencies. Next slide.

At the same time that the NSPS responded to the COVID-19 pandemic, the system also initiated the process of building a strategy to prepare the nation against future special pathogen threats. ASPR directed NETEC to lead development of the NSPS of Care Strategy. Ultimately, the strategy seeks to save lives through a sustained, standardized special pathogen system of care that enables health care personnel and administrators to provide agile and high-quality care across the care delivery continuum. The strategy envisions a future NSPS with a national care delivery network, a central coordinating body, and a set of engaged stakeholders with roles and capabilities in readiness, response, and recovery for special pathogen events – with the ultimate goals of providing comprehensive support to the health care workforce and saving lives. Since publishing the NSPS of Care Strategy in summer of 2021, NETEC has been working alongside a multiplicity of partners to implement the strategy. By executing the NSPS of Care Strategy, the NSPS will be better able to ready the nation's health care system for special pathogen response, to coordinate health care's response across localities, states, and regions, and to establish a national infrastructure for special pathogen response more broadly.

To close the gaps between the current state and the envisioned future state NSPS, the NSPS will continue to grow and accelerate progress in the coming years. The components of the NSPS currently act as foundational, building blocks of a tiered, regional system for special pathogen identification, treatment, and research; however, the NSPS is not inclusive of all components of health care delivery, and further effort is needed to reach a true integrated system of care. In the coming years, the NSPS will continue with the implementation of the NSPS of Care Strategy, strengthen regional coordination through efforts such as increasing the number of RESPTCs in FY 2022, and enhance health equity through continued commitments across the ASPR Health Care Readiness Portfolio. Through sustained investment and commitment, the NSPS and ASPR will continue fulfill their mission of saving lives and protecting Americans from health care emergencies.

So, with that I've offered a lot about where we are within NSPS and want to open this up for questions at this point. Ah, I see the funding question out there. I never know what will happen with the funding. Congress knows that far better than we do at this point. Jennifer may want to weigh in on that, from an acting director perspective, but I don't have the answer to that one. Other questions?

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Jennifer Hannah: And Rick, if I may, while other questions are being queued up, I'm happy to respond to the question regarding the funding. You know, as Dr. Hunt, has already stated in his presentation, you know we anticipate for FY 2022, that we will be expanding the number of our RESPTCs. And as a part of that, the field project officers should have sent in an email to all of the existing 10 RESPTCs in the 10 HHS regions to inform you that you have the option of requesting a no cost extension for the current RESPTCs awards, because we will be awarding new awards starting a new five-year project period in September of this year. We anticipate that we will be releasing a notice of funding opportunity which part of that will be for the existing 10 RESPTCs, and the other part of that notice of funding opportunity will be to have a full and open competition for three new RESPTCs so we'll be expanding the number of RESPTCs from 10 to 13. I don't have any additional details regarding that at this point, but we anticipate that notice the funding opportunity or NOFO will be released this month.

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Dr. Rick Hunt: Thank you, Jennifer. I see another question in here.

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Jennifer Hannah: I can take that one as well, Rick. We have a question about whether that funding will go directly to the RESPTCs. You know at this point, we're unable to share any information related to that because the funding opportunity has not been reviewed or approved by ASPR, so more information will be forthcoming.

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Dr. Rick Hunt: Any other questions before I turn this over to our next presenter? Alright, with that, I really appreciate your kind attentiveness and I'm now going to pass this over to Angela Ratzinger to discuss radiation search planning and the radiation surge annex. Thank you.

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Angela Krutsinger: Thank you so much. Thank you everybody for being here today, I am Angela Krutsinger the FPO and acting supervisor for regions 1,3,4,7 and 8 for the National Health Care Preparedness Program and this presentation today is to briefly help share some planning tips and resources to help you all as you work with your healthcare coalitions to develop the radiation emergency search annex that is due in fiscal year 22 which is BP4, with the exercise being due by the end of BP5, along with the other surge annex exercises, which were all continued to be BP5. So, like most of us, I'm not an expert in radiation surge, but there are experts available to us, along with the variety of resources that will help you address radiation surge. So, my goal today is to help point everyone to those resources and help you as you get started on your radiation surge planning. Next slide, please. There are a variety of challenges with radiological events, be they accidental or manmade incidents. Many of them, similar to other types of the surge events and others that are quite unique. As you see the second bullet there where victims may not have physical trauma, but will instead have things like bone marrow toxicity, acute radiation syndrome, ARS, and other health related consequences. So, you know, there are a lot of things with not being able to see or feel radiation and the limitations with radiation equipment, being able to measure the amounts and not being able to quell the fears of the worried well that we really need to take into consideration when we're doing the radiological search planning. The other thing is that, like many of the

search annexes that we've done in the past, such as burn, pediatrics etcetera, there are limited resources available to respond to this type of surge so planning for these events are vitally important. You'll notice there on the slide, federal resources can't be relied upon and mobilized quickly. Assume that you'll be on your own for the first 72 hours and really, we urge everybody with all of the surge planning to keep that in mind be it for radiation or chemical or burn or infectious disease, that really events start locally and needing to develop the plans and response and resources at the local level as much as possible to be able to respond quickly during that first few critical days and hours. I am not going to read this slide to you, but I did want to point out that there is a link here to region seven's RDHRE University of Nebraska Medical Center. They provided a full description of characteristics and response priorities and a watch radiation series there, so I did want to provide that as a resource, as I feel it would be helpful for you. Next slide, please. It's important to realize that each region, state, and even locality has their own unique challenges of resources. You know the first steps of radiation planning are to reach out to your local partners, and you know perform a risk assessment, identify what radiological scenarios or threats are the most common or have the highest concern for you. This will vary a lot by jurisdiction. What might be a threat, you know, there may not be a nuclear power point in your area or stage even and you will feel that this is not a threat to you, however, there are a variety of radiation incidents that occur every day that are not related to you know nuclear power point plants. That's really the big one that everybody thinks about at the top of their mind; however, there's a lot of radiation that is transported over train tracks, over highways and interstates. We see a lot with medical equipment and things of that nature, so it does apply to everybody. There will be something that affects everyone and could affect you even if you do not have a nuclear power plant in your state. When you're looking at performing your gap analysis and identifying your local resources, it's really important to keep in mind your SMEs, the subject matter experts that are available to you locally. For example, in region 7, UMC has developed a team to assist in red nuke response and plus we have some awesome SMEs. Frank Rutar who's a certified health physicist, Director of Radiation at University of Nebraska Medical Center and Angela Leak, who is a certified health physicist bureau chief at Iowa Department of Health. They let me steal some of their great work to share with you all today for this presentation and have been critical SMEs for region 7 in the radiation planning and development there. So, I will go to the next slide, please. To name a few partners who recipients and HCCs can reach out to in radiation plan development, you can read them on the this attached slide for some suggestions. I won't list them out for you. One of the things that will be helpful, is to identify who will be reaching out and how. And I say that because the requirement is for the HCCs to create surge annexes for radiation planning; however, we all know that with radiation planning that it may not be the HCCs that start that. It may be the health department, the recipient, or you who is the point person for this and it's reaching to the HCCs and it out to the other partners. It may be one of your SMEs that has stepped up to help, similar to what we've had in region 7 as I referred to before or maybe someone else. It may be your regional FEMA person, or it may be someone else who has a great interest in real radiation response and search planning. So, first you need to identify who will be the point person, who will be reaching out and how. It's also important to gather these partners to share information and address radiation surge planning is responsibly done together. It is always important to train as you mean to fight. This is something that I've taken away from the military. So yes, that is also stolen, but it is also something that is true. Rather than planning in a silo and hoping that you can come up with something that will fit or connect correctly when an actual radiation event occurs later on, it's much better to get ahead of it and to do the planning together so that you're

not recreating the wheel and you're also making sure that what you have developed is realistic and reliable and that all of the partners understand what their roles and responsibilities are as well and everybody's in agreement with those so that people know who to contact when and how. And I can't stress enough how important that is to do before an actual event happens. Also, just a little quick side tip: FEMA is required to do a radiological exercise every two years, so tying in with your state and regional FEMA points of contacts can be an easy step to help tie in and use what has already been created or developed to springboard your own health care related radiation surge planning and response so next slide please. As we all know, ASPR has provided a template for developing a healthcare coalition radiation surge annex and I put the link in the slide there for you. This radiation emergency-focused operational annex compliments the HCCs response plan, as I mentioned before. It is intended to be a high-level incident-specific response plan, identifying the experts, and specialized resources that exist within the HCC or external to the HCC that are available. Each facility is encouraged to develop more detailed policies and procedures that support their individual operations, but that level of detail is not necessary in this annex. This is a tool that helps focus the questions that need answered in order to respond to a radiological event in your jurisdictions and we do have some folks on the line today who helped develop the tool and will be available to answer any specific questions you might have on the tool itself at the end of this short presentation. Next slide please. Okay, this is just a picture of the template itself. But it's here basically to demonstrate what the template includes, the headings and subheadings, descriptions, and considerations and then, as you see, on the far right there the hyperlinks that have sample resources to provide guidance to help with the various planning that you're doing. Next slide, please. This slide sums it up a little bit easier, it's simpler to see and due to time constraints, I won't review through all of the elements, but it basically falls under categories of introduction, concepts of operations and appendices, and this is just kind of an easy screenshot to see what all the categories look like and fall under for folks. Next slide, please. The Radiation Injury Treatment Network, this provides a comprehensive evaluation of treatment for victims of radiation exposure or other marrow toxic injuries. I bring this slide up and the next few of them are all resources that will be helpful for you and your HCCs as you're doing the planning for the radiation surge and you know, many of the casualties with radiation injury will be salvageable but require outpatient or inpatient care, so the goals of written are to develop treatment guidelines for managing toxicity among victims of radiation exposure to educate healthcare professionals about pertinent aspects of radiation exposure management, to help coordinate the medical response to radiation events and to provide comprehensive evaluation and treatment for victims at participating centers. The website link be on the next slide, and they have a plethora of resources, including training videos and exercises that they have developed that are available that should be very helpful to everyone, as you work to complete your own radiation surge annexes with your HCCs in budget period 4. So, we did want to make sure to mention this resource, as it's a wonderful one, and they have a lot of information on their website, which next slide please, is listed here for you. These two links are basically for treatment and guidelines reference. Next slide please. And then, this slide is basically a variety of free resources that are available to you with the links to them. We will be sending out the PowerPoint presentations with all of these. I know I'm going through the slides a little bit fast, but I only have 10 minutes and I want to get to the questions part. Alright, so, thank you very much, and now let's look at the questions. Okay, it looks like the first question is: *Would our annual Columbia Generating Station (nuclear power plant) exercise qualify for this exercise, if we involve HCCs?* It could, if you involved the HCCs and it's part of your plans that have been built for those HCCs, then yes,

it could. You just need to make sure that the various objectives are met that are required for the BP4 guidance. Any other questions? Seeing none. I will turn it back over to Jennifer Hannah for her presentation.

00:57:35.490 --> 00:59:48.630

Jennifer Hannah: Thank you, Angela. And thank you, Brittney and Dr. Hunt as well, for your presentation. My administrative updates wound up being just one since we already covered the announcement related to the RESPTCs. For the HPP recipients, as you know, the FY 2022 BP notices awards are delayed and should be issued by no later than July 29. One thing I did want to cover is about the benchmarks and when the clock starts for those benchmarks. Regarding the benchmark one and benchmark number five which are 60 and 90-day benchmarks, the clock will start when the notice of awards are issued. So, therefore, it will not begin with July 1st, but once those notices of awards are issued, that's when the clock will start for meeting those 60 and 90-day benchmarks. And that actually concludes the one administrative update that I had but, before the break, we have one quick poll for HPP and PHEP recipients only. And, Megan, if you could bring that that poll up, we would like everyone to take a second to share with us how long you have been serving in your current role. So, this is just for HPP and PHEP recipients only. *How long have you been serving in your current role?* We just want to gauge, to see how many have been in their in their current role, those that may be relatively new and those that may be long timers as many of us within the specific HPP and PHEP programs are. Hopefully, everyone has had a chance to respond to that question. Megan are you able to display the results? Close that and then display the results of that poll question?

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Jennifer Hannah: Okay, it looks like we've got about 59% of our HPP and PHEP recipients that have been in their roles for five years or less and then 19% five to 10 years, 20% 10 to 20 and then we have 3% for 20 plus years. Thanks everyone for taking that poll. We're now going to adjourn for a five-minute break. You can certainly stay on the call. You're welcome to keep your cameras on or to turn your cameras off, but please do mute your phone while you break and we will resume our presentation at approximately 2:05 so it looks like you get about three minutes, but I think we can give you the full five. It looks like that'll be 2:07 and hopefully my PHEP colleagues are okay with that as well. So, at 2:07 promptly, we'll start with our CDC PHEP presentation. Thanks, everyone.

01:01:10.860 --> 01:05:57.780

Chris Kosmos: Hi, everyone. Welcome back. This is Chris Kosmos. We're going to start the CDC portion of our business meeting agenda. I know we always like to do this in-person and feel like this was always kind one of the highlights of our year - to meet with all of you and to have a chance to have dialogue about things that are going on in the programs. We're just going to have to do it a little bit differently this year, and hopefully next year will be different. But I think we've got a pretty good lineup for you today, and thanks to all the CDC staff and Deloitte staff and others, as well as ASPR that have worked very hard on this agenda, and this meeting. Let me do a little bit of an overview of what we're going to hear and then I'll turn it over to Kate and she may want to do a little bit of a deeper dive, but Kate is going to talk about BP4 ORR updates. She's going to give you an update on that and has some information to share with you. And then also we're going to have a conversation about our field assignee expansion. I know all of you have been aware of our expansion of the CFO program over the last year, continuing into

next year and we want to tell you a little bit more about secondary field staff expansion. Our preparedness field staff expansion. For those of you who have had PFAs, you know that they are an amazing asset to your programs, and so we want to tell you a little bit more about that expansion program and give you a little bit more of the details on that. And then I'm going to shift gears and we're going to talk about the crisis Co-Ag, the workforce development piece of that came out of DSLR and share with you some promising practices from Tennessee and Utah because some of you have asked about if we could hear from jurisdictions that have done well with recruiting and hiring and retaining and so Utah and Tennessee will share a little bit of that as well. And then Lisa Walker and OGS are going to talk a little bit about some of the administrative updates that's come up periodically over the course of the year, and so we want to refresh your memories for those of you who've been around a while and for those of you that are relatively new. We want to give you a little bit of information about some of the administrative preparedness issues that I think will be very helpful to you in managing your spending and your spend-down rates. That's our lineup and then of course, Jennifer and I are going to have our portion of the program where we get some feedback from you and we'll talk a little bit more about that. But essentially, just to give you a little bit of a preview and, hopefully, you can kind of begin to think a little bit about it. What we want to do is have a conversation with all of you going to break out in various sessions. But we want to hear from you about your experiences with COVID as well as other responses that you've had recently, and to reflect on that and give us some of your ideas on some of the challenges and the gaps that you've encountered within the public health system and the healthcare system, as we begin to think through a new project period for HPP and PHEP. We want to make sure that we are capturing your experiences in terms of your advice as to what you believe. We should think in terms of future program planning. We want to hear what some of the gaps and challenges have been so that we make sure that we address that. And we want to hear from you about coordination between the ASPR side of the house and the CDC side of the house and see if you have any suggestions for us on that, so more to come on that. But with that I just want to welcome you to our section of the meeting and I'm going to turn it over to Kate Noelte, our deputy division director to talk about BP4 ORR.

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Kate Noelte: Thanks, Chris. Hi, everyone. You can move to the next slide before we get into BP4 updates. I just want to thank all of you for your patience and flexibility with the BP4 ORR process. We know it was challenging in several aspects from modified requirements to code response priorities and, finally, just submitting data using a new IP system. We've all been learning and adjusting along the way, and we will take what we learned to improve the process BP4 and beyond. In order to collect your feedback on BP3, and we know a lot of you have some we've developed a survey about the B3 ORR implementation process, training and guidance. In addition to the system, we encourage all users who have entered data into ports to provide feedback on how to improve the order process moving forward. The survey is currently in clearance and will be available within the next few weeks or months. When it's finalized, we will make sure you're all aware of it and how to access it so more to come on that. Next slide, please. Moving on to our BP4 plans. We first told you last month that we plan to continue to streamline our ORR evaluation. The current budget period will focus on collecting data related to select capability planning element. And, as we said last month, the ORR will focus on recipient level data, meaning that local health departments will not be required to submit data in BP4. Repeat, local health departments will not be required to submit data. We have reduced the

number of evaluation questions in the BP4 OR focus on gathering the central data from across all 15 capabilities to capture a more convinced, but insightful picture of preparedness at the state level. Of the approximately 200 questions in the full ORR, we plan to collect data in BP4 on approximately 50 planning related questions. Again, going to repeat that, out of approximately 200 questions in the full ORR, we plan to collect data in the BP4, we plan to collect data on approximately 50 planning-related questions. You can move to the next slide, please. These questions will align with the operational data elements we focused on and BP3. Primarily, the pandemic COVID-19 incident response or RSP questions. These parallel data elements are designed to maintain our focus on pandemic lessons learned and to capture current plans, policies, and procedures used or revised during the COVID-19 response. We expect to have the BP4 module open later this Fall, likely in early November. We know you all have a lot of questions about BP4 implementation of the ORR, so we plan to spend most of our August recipient call on the ORR and our plans for BP4. To help us prepare for that discussion, we have two questions that we want you to think about in advance of that call and be ready to discuss when we meet on August 1. First, we're interested in hearing from you on the best method for launching PORTS forum. Should we release all the forums, at one time, or should we stage the release of questions in batches? Again, please come prepared to discuss which option you prefer, and why, when we meet again next month. The second question we want some feedback from you all is, *are there preferred delivery methods for orientation and training sessions*. What worked well for the BP3 or ORR imports, training, and orientation. Also, how can we improve that process? Again, both of these questions, in addition to more information about the BP4 content and process will be assessed on our August recipient call. And that's the end of our ORR update for today. Before I turn it over to Scott, my Zoom just crashed, so, Chris, can you take a look and see if there are any ORR-related questions in the chat? I don't see any questions in the chat. Sorry to chime in over you Chris if you were speaking. Thanks, Amanda. and thanks for your patience. Of course, my Zoom has been fine all day until so that's why always good to call in as well. If you have any questions, please put them in the chat hopefully we'll be able to get back on and certainly our DSLR staff can answer them as well as we go on. But if there are no immediate ORR-related questions again, we're looking forward to discussing this with you next month on our recipient call. We will move to Scott Tulloch, who is one of our team leads in our field defining services branch who will update you on our preparedness field assignee or PFA expansion. Scott, over to you.

01:11:12.390 --> 01:16:29.850

Scott Tulloch: Great, thanks Kate. And good afternoon, everyone. Thanks for the opportunity to speak with you today. As Kate mentioned, I'm Scott Tulloch. I'm a team lead with DSLR Preparedness Field Assignee Program. Today, I will provide you with a bit of an overview of our program, share some exciting details regarding our current expansion activities and how some of those activities will benefit you. I will introduce a few of our PHEP partners who will share their experiences serving as host sites for our field assignees. Next slide, please. As for some background, our program began in 2013 and since that time, we have annually been recruiting preparedness field assignees from the graduating class of a CDC public health associate program to fill positions with the defined number of PHEP recipients identified through a competitive process each year. These recruits have historically served in term-limited assignments as embedded field staff with our PHEP recipients where they work to help build and support capacity across all 15 capabilities and since the program's inception, we've been able to successfully recruit and hire more than 65 PFAs who has served 30 states, five large

cities, and 1 U.S. territory. Next slide, please. So, as Chris had mentioned earlier, similar to our CFO program, we are currently in the process of expanding as well to meet the needs of all our PHEP recipients. With that goal in mind, we have initiated a number of key activities to help move us in that direction. First, we are moving away from our prior hiring model for putting staff in term assignments to a new hiring process that will bring staff into permanent career conditional positions. Additionally, existing staff who were originally hired on in-term assignments, will also be converted into career conditional positions later this year. This will bring a new stability for our program, as well as increase sustainability for our field assignments. Along with the shift in hiring practices, there will be a shift in how these positions will be funded. Moving forward, our staff will be funded through division core funding and any staff that previously were being supported by direct assistance have since shifted to core funding as of July 1 of this year. These expansion efforts will continue in a phased approach over the next several years, as we work toward our intended staffing goals. And what this means to our recipients who currently do not have a PFA is there will be future opportunities for you to compete for one in years to come. Next slide, please. So currently, we have 18 field staff that are supporting 14 states and three large cities shown here in the dark blue. We are in the process of completing this year's recruitment cycle, where we will be bringing on 10 additional staff who will be reporting for their new close site locations later this Fall. Those locations are shown on the map here, in the light blue catch. Our next recruitment cycle will begin early next year. In that effort we're really focused on generating interest from vet recipients who currently do not have a PFA. And as we move forward, we will continue to explore opportunities to provide jurisdictions the support from both new PFAs as well as our experienced staff. Next slide, please. Our PFAs have been able to be a valuable resource to our PHEP recipients, and we feel through this expansion, we will only build upon that foundation. As embedded field staff, our PFAs has been able to help enhance planning, training, exercising and response capacity. And as we continue to grow that group of experienced staff, we will further our ability to provide targeted technical assistance to both internal as well as external partners. Also, through this expansion, the PFA program in partnership with our PHEP recipients, will help to create a new pipeline of experienced staff who have developed a strong relationship with our state and local partners, as well as a firm understanding of how preparedness works at that level. We can then bring into CDC to help inform and guide future activities. Next slide, please. Now I'd like to turn it over to a few of our PHEP partners to share some of their experiences serving as host sites for our staff. I'd like to introduce Denise Kern, who is with the Idaho State Department works with the State Department of Health and welfare, as well as Tricia Blocher with the California Department of Health. I'll turn it over to these Denise first. Go ahead.

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Denise Kern: Hello to all of my HPP and PHEP colleagues. I'm Denise Kern. I'm the manager at the Public Health Preparedness and Response section within a division of public health with Idaho Department of Health and Welfare. I'm happy to provide an overview of what our preparedness field assignee, Sarah Starper, has done in our programs, and she has deployed to Idaho in October of 2017. She is an integral member of our team after being with us for close to four years now. One of her first activities was to complete a number of ICS trainings on the Homeland Security exercise evaluation program coursework so she had a better understanding of our work in order to take part in planning, training exercises, and incident response as I just mentioned. In April of 2019, six months into this new role, Sarah asked if she could observe an operation shared response, a full-scale exercise we took part in and was conducted by the

Idaho Office of Emergency Management. During the exercise, IOEM was understaffed so the EOC manager asked Sarah if she can step in as the deputy planning section chief. Sarah was responsible for developing the IAP and CIP routes and she did such a great job during the exercise hotwash, she received high praise from the IOEM staff for her work. Her first major project that we asked her to take on was the Jurisdictional Risk Assessment, also known as the JRA. Sarah researched and explored the methodologies and risk evaluation tools of 17 JRAs from across the country and presented her findings for preparedness and response staff division of public health leadership, seven local public health districts, and five tribes. She and I want to give a quick shout out to LA County because we adopted the health hazards assessment and prioritization tool, better known as HAP, so thank you. Sarah met with 35 state agencies and asked them to provide the data sets over a 10-year period of time to identify hazards, vulnerabilities, and risks in communities across the state. She held community meetings virtually due to COVID with the local public health districts and our partners. The project was completed in June of 2021 after a delay due to COVID response and we had a robust JRA report with a list of the top 25 threats and documentation to support how those threats were identified throughout the process. Upon completion of the JRA, Sarah worked with seven local public health district planners and developed the playbook template to these by state and local public health for the five threats in each jurisdiction. Connecting the JRA, as you know, is a very arduous and lengthy process. She did a fantastic job and is still maintaining the data so we're better prepared for the next era. And then, lastly, related to COVID response, Sarah has worked as a planning section chief again. She's our primary backup to our data management coordinator who oversees the Idaho Research Tracking System, also known as IRTS. She's a part of a team that combines reports from IRTS, which goes out five days a week to over 500 of our partners so they have situational awareness about hospital capacity and stressors in the system. They work with the state of Idaho GIS analysts from the Idaho Technology Support Department to provide GIS mapping of vaccine data collected, facilities enrolled in COVID-19 vaccines and testing locations. She's also a member of the COVID one care strike team as a project coordinator, documenting their activities within a weekly progress checker that goes to state health officials and our director. To close, I encourage all states to consider applying for a preparedness field assignee. They can take part in planning, training exercises, response management, and a lot more. I only went over some of the things that Sarah has worked on for us. We've had an excellent experience with our PFA and we're really grateful to the CDC for supporting this program and I appreciate the opportunity to share the information with everyone. Thank you.

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Tricia Blocher: Hi, good afternoon. I'm Tricia Blocher. I'm the PHEP director for California within the department of public health. Today, we've had our preparedness field assignee for just over three and a half years, and I couldn't be more grateful for her contributions. In our preparedness office, Katie has predominantly supported our emergency pharmaceuticals services unit. In that role, she has been conducting the operational readiness reviews for all of our counties. She's helped them with the state ORR data collection and entry. Kate developed a cold chain management plan for receiving, shipping and storage warehouse and she's developed a cold chain management template for all of our 60 department's teams within their jurisdiction. She provides technical assistance to our local health departments and any emergency needs in the process. During COVID, Kate has also been incredibly instrumental in our response. In the first year, she supported our state warehouse by being the inventory management lead. She helped process requests, track inventory, report inventory for all the

PPE, pharmaceuticals, and a host of other critical supplies. She has been and continues to be a critical member of our vaccine task force. She is the vaccine storage and handling subject matter expert. She's kept up to date with all of the numerous changes to storage and handling distribution, developed job aids for providers and local health departments and conducted numerous training and education sessions for local health departments and healthcare providers on a weekly basis. She's helped spearhead a contract with a third-party distributor so we can send smaller quantities of vaccine for maintenance across California. And on top of the vaccine duties, Kate is also a member of our therapeutic task force. On the logistic side, she handles allocations for all of the agencies. Again, she's the storage and handling SME and she authors our weekly therapeutics updates to all of our partners. This is just a small sampling of the benefits we have received. I highly recommend this program to anyone that's yet to participate and again I echo Denise in thanking CDC for providing this. We are really grateful for Kate and hope she can continue. I'm not sure if we have time for questions but happy to take some. I don't see anything, specifically in the chat at the moment. If not, I think I'll turn it back over to Chris.

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Chris Kosmos: Thanks. All right, let's shift gears a bit. A year ago, it's hard to believe it actually is a year ago, but a year ago, CDC DSLR awarded \$2 billion in workforce funding to 65 jurisdictions as part of the whole COVID funding initiative. Periodically, we ask all of you for progress reports on how what your progress has been to improve the workforce. Much of this, if you recall, had to go to the local level, some of it had to go to support school health initiatives and some of it was to support the public health infrastructure at the state and local level. We know that there's always challenges hiring at the state and local level, especially if the funding is not long-term funding and so some of you have asked us for jurisdictions that have done some innovative approaches to hiring or retaining or training of the workforce. We found a couple of jurisdictions that we think are demonstrating some innovative and creative strategies for hiring and retention and training and we thought we would ask a couple of them to present to all of you today. We have two jurisdictions that are presenting. We have Utah who's presenting Michelle Hale, who is the Preparedness and Response Program Director is going to report from Utah. And then from Tennessee, we have a couple of presenters. We have GW Randolph, who is the Director of the Office of Strategic Initiatives and Paul Peterson who is the Director of the Emergency Preparedness Program and also the interim Director of the Vaccine Preventable Diseases and Immunization program. First, we're going to hear from Michelle. Michelle, take it away.

01:27:26.910 --> 01:28:05.340

Michelle Hale: Thank you so much. As mentioned, my name is Michelle Hale, with the Utah Department of Health and Human Services. I'm the Preparedness and Response Director of our office of EMS and Preparedness. Thank you so much for the opportunity to share what we consider a best practice with our crisis workforce development. And also, I would like to make a quick shoutout to Jenny Starley, our Crisis Management Grant Coordinator, who generously put together this presentation. She wasn't able to join us because she's on a well-deserved vacation, but I do appreciate her putting this together beforehand. During this presentation, I want to talk to you a little bit about a number of programs and projects coordinated by our department. For example, the RISE program which manages our contact tracing staff, the COVID-19 Community Partnership program and the Refugee Services Wraparound

Coordination. So, at the height of the COVID-19 pandemic, our RISE program employed about 300 contact tracers. Of those 300, 7 were promoted to a core leadership team and 28 were promoted as team leads. Throughout the COVID response, we found that the ebb and flow of contact tracing demands created a reduced need for the contact tracers to solely work on those duties. We also experienced a reduction in the number of people applying for other positions to support other critical areas in our response, as well as other administrative positions within our department. It was determined that the best way to retain the contact tracers we had rather than reducing this workforce during those ebbs of demands, was to offer them options to support other areas in the department. This turned out to be a successful strategy because it not only benefited the department, but it benefited these contact tracers by providing them with several opportunities to enhance their own professional skills and work experience. Some examples of the cross training and utilization of this staff included a Utah respond search. This is our ESAR-VHP system. At the height of the vaccine distribution, we did a statewide call for health care volunteers. So with this surge of about 5000 volunteers, our contact tracers were utilized to collect information and credential these volunteers for further referral in use of that vaccine dispensing. They conducted childcare outreach by calling licensed childcare facilities to offer guidance, answer questions and provide resources for these facilities to keep children safe. They provided onsite education and resource outreach including developing a webpage to assist high risk individuals with community resources that were available. They also provided education on current isolation and quarantine guidelines. Currently, the RISE program is developing a care navigation team that will assist people who have recently tested positive for COVID to navigate the healthcare system in order to acquire timely treatment. They will also promote, and direct individuals on where to receive COVID vaccines. RISE is also assisting with the monkeypox outbreak and the avian bird flu response. The objective is to train staff and other diseases, so we can help respond, provide education, resources, and support those individuals who are most at risk. The RISE program has worked hard on ensuring their team members have the opportunity to grow and learn in many different areas, so they'll have the knowledge and skills to take them wherever they go in the future. Some of our contact tracing staff have been recruited by local health departments to become community health workers and seven within our department have become community health workers in the capacity of assisting our refugee population. Five contact tracers are currently working on the grandma team gaining the experience of reviewing and redacting documents and to contact trace. Contact tracers have transferred to Medicaid to assist them with a HRSA project. Now I'd like to tell you about the success with our recruitment of contact tracers to become community health workers through the COVID Community Partnership or CCP project, as well as the refugee community health worker training. By way of background, the COVID Community Partnership Project was established in May of 2020 by the Utah Department of Health and Human Services Office of Health Equity in response to the impact of the pandemic on Utah's communities that experience health disparities. This project was initially funded by crisis response phones and is now funded by the Intermountain Foundation and other funds available through the CDC. The CCP project focused on slowing the spread of COVID-19 among under resourced communities across the state by addressing health disparities. Community health workers were identified as a necessary component in this public health response to mitigate the spread and effects of COVID-19 on communities placed at a higher risk of poor health outcomes. Building community health workers' capacity has been identified as a best practice and as a specific travel strategy of the CCP project. The training has served to help team members to feel supported in their roles as first responders as well as increase their future career successes. Lastly, the refugee

health program in partnership with the CCP project coordinated COVID wraparound services for refugee communities through community-based organization community health workers. Due to the Afghan crisis, the conflict in Ukraine, as well as the pandemic and challenges our population already faced with health disparities, the refugee health promotion and COVID-19 health mentors' contracts had grown substantially in funding, but with very little capacity within the program to manage. In the meantime, the contact tracing efforts of the State had begun to subside, so the refugee health program brought in the refugee contact tracing team members to support these contracts. The contact tracers had provided exceptional support on the refugee wraparound service calls, and we saw the potential for them to be more integrated into the refugee health promotion work. We also understood it would create valuable learning opportunities for the CTs where they could promote into coordinator roles within the department and therefore create a career ladder for them to establish for their professional growth. Utah's Refugee Health Promotion Team provided pandemic response coverage, seven days a week, over a considerable amount of time to help implement and administer this program. And we're able to create a community health worker development program which included mandatory community health worker core skills training, development of a state certification to advance the team members' personal careers and collaboration with local health departments, community-based organizations, and the Navajo nation. This program reached areas throughout the entire state of Utah and wouldn't have been possible without transitioning some of our contact tracers to community health workers within the refugee health program. Because of the overall success and proven need for this program, legislation was recently passed that creates a formal certification pathway with stackable credentials for community health workers. Our contact tracers are hidden gems in an invaluable resource to the department. Many contact tracers were able to internally move to other divisions support other essential projects, and transition to community health workers while gaining valuable work experience. Again, thank you for this opportunity to present. What you see here is the contact information for everybody involved in putting together this presentation, as well as resources regarding each of these projects that I had noted. My presentation has been shared with the host, so I think I believe that can be passed on to the attendees. Thank you so much.

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Chris Kosmos: Thanks so much, Michelle. Appreciate that and love the picture of the cute puppies as well. Nice touch on that one. Alright, so let's turn to our colleagues from Tennessee, JW Randolph and Paul Petersen.

01:37:32.040 --> 01:39:33.810

Paul Petersen: Hey guys. This is Paul Peterson, Director of the Preparedness Program in Tennessee. I just wanted to give a quick thumbnail and then I'm going to hand it over to JW for the meat of our talk. In Tennessee, a lot of coordinated work group effort went into developing our workforce development grant submission and there's quite a few things that we were really, really proud of. A lot of a new and innovative education and training and support for our staff statewide, including paying for a good portion of individuals' doctorates programs, master's programs and others over these last couple years and then going to the future, and paid internship and fellowship programs, and also bringing in new public health talent into the health department for the future. There is a lot of great work with our department of education and then also work with mental health and really trying to invest in our staff to make sure that they have the training they need to diagnose and identify do triage for mental health concerns of

themselves and their staff, but then also working with our health plans to identify EAP benefits that we can both provide to our employees in a really intentional way, both training and then crisis debriefings scenarios, as well as well as engaging in some additional work with mental health strike teams. But one of the things we really wanted to cover today was some initiatives that we're looking at as far as strategic planning and the amazing work that JW's team is doing. I won't brag on this guy a little but he's one of the most humble and intelligent and genuine folks that I've worked with through my years in public health and it's really exciting to see his passion and I think you'll see that once he talks. Over to you, JW.

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JW Randolph: Thanks, Paul. Very kind introduction. I think we all know a lot of folks who poured their heart and soul into pandemic response in the last couple of years, and nobody in Tennessee has done that more than Paul. We're so lucky to have him and the folks that he's working with. Thank you all for a few minutes today to talk about how our team has responded to both pandemic workforce issues, workforce infancy, with a lot of new staff, as well as how we're using our strategic planning process and our local health councils to sort of move back towards a stronger place with other health infrastructure. This is just an overview of the Tennessee Department of Health's strategic plan. The two big buckets we organized around our prevention and access and so you'll see under *prevention*, we have supporting local leadership and county health councils which I'll talk a little bit more about, and then a few other really critical public health issues under *access*. We're talking about internal clinical efficiencies, external primary care access, leveraging a lot of the gains that have been made through telehealth over the course of the pandemic and expanding our partnerships. So, this is the office that I'm lucky enough to be a part of, and so the Office of Strategic Initiatives has two big buckets. We got the Department of Health Strategic Planning Process, and we support our county health councils with the help of the local, regional and central office TGH staff and TGH partners. Tennessee has 95 counties. There are six counties which qualifies metros and then our department manages the 89 we refer to as the rural counties and so in each of those counties across the state, there has been a county health council and we'll talk a little bit more about that. I first want to talk about the impact of the workforce development funds on our team and what that's meant for us. The folks in green here are individuals we have been able to contract with thanks to the CDC workforce development grant funding. They are absolutely incredible public health leaders now, and they are the public health leaders of Tennessee of the future. This has been my favorite team I've ever had a chance to work with. We have a lot of folks who are coming to us from the county level who have worked at county health department, who have experience leading health councils and doing local assessment and implementation work. We have both Chelsei Granderson and Lashan Dixon have been county directors of some large counties and very rural counties. Sarah Bounse is our Community Engagement Coordinator and she's really helping us focus on sales training for county and regional staff. It's an incredible group of people. Through the work of the strategic plan, we're able to really interact with a lot of different folks across the enterprise of the Department of Health and through the county health councils to really interact with a lot of communities across the state, and so this investment for us is helping us to build what we see as a team capable of providing the best local assessment and implementation program in the country. So not everybody is into their ease of change, but I told our team, I was talking to some folks at the CDC today and they couldn't believe their eyes, and so I wanted to share this with you all. We're looking at what's our intended impact. It's that every Tennessee County Health Council plays a leading role in

reducing disparities and then building a strong foundation for Community Health. There are five main actions that we're taking to support them, as they do that. One is establishing a community of practice, which means that folks in West Tennessee and in East Tennessee have opportunities to interact and learn from each other about challenges or opportunities they're facing with their community partners and with our health councils. Two, strengthening structural planning and evaluation. That it involves both regional strategic planning that aligns with the state as well as evaluation support so that people don't come to us at the end of the projects and say *hey we should evaluate this project*, which we know doesn't work. Three is sustaining and deploying funding resources. When we would go to them and say "what else do you need from us? They would say we need money to be able to do anything. And so, for the first time, through a few different federal grant opportunities, provide funds to some health councils to do locally led public health implementation work. We do that through community-driven action plans and providing evidence-based resources so that we're really bringing a lot of public health evidence and know-how and language to folks all across the state. Health councils are a diverse group of local collaborators, and that means it's your folks from your school health, your FQHC, from emergency preparedness, Chamber of Commerce, county mayor, united way, and local nonprofits. It's a place where those groups come together and come up with a shared agenda of work. And so, the health councils are community-led. They're facilitated typically by a health educator in each of our counties but will be chaired by someone who is not affiliated with the health department, and these are external to the health department. They use these partnerships to address health disparities and again, can be convened local staff. Our team, the office of strategic initiatives support health councils through their county health assessment and community health implement improvement plan or CHA CHIP. People use a lot of different acronyms. Hospitals call them community health needs assessments. It's all the same process, and so what we're looking at is a few steps where the first thing we ask health councils to do is look around the table. Who is who is at the table? What voices are being raised? What voices are being heard and responded to? We provide secondary data, but we really encourage them to center Community voice in their process and their assessment process. They'll establish up to three priorities and then develop their action plan and in their CHIP, which we're on a three-year cycle. Our team works really closely with our division of health disparities elimination to make sure that we're engaging low-income, minority, and underserved populations throughout the process, not only in the assessment and planning phases, but in the implementation phase part of applying for those funds is responding to how this project will serve and support these populations that were hardest hit by the COVID-19 pandemic. And so, there's a range of resources that we provide for health councils like day-to-day technical assistance, as I mentioned skills training. We are facilitating a community of practice so that folks have an opportunity to learn from one another and to grow with one another. And then the one that we're the most excited about is funding. For the first time, we have a pot of money from the disparities grant which we're able to provide for counties who are working to address the priorities that come from their CHA. Unsurprisingly, we've seen a lot of mental health substance misuse, obesity, as some of the main priorities and we're really excited to be able to actually provide the County some financial resources to respond to those needs. And I wanted to just really quickly talk about the impact of this funding on the reach of this program. In 2019, prior to the pandemic, we ran a pilot county health assessment process and we had 16 counties from seven of our public health regions who participated in that process. Once the pandemic hit, health councils pretty much stopped in almost every part of our state, and so this was the last time we ran this program. In 2022, we have 43 counties in five of our regions, including two metro

counties, who we're working on their county health assessment process. This means partnerships are being built, data is being used, and evidence-based practices are being implemented. This is a map of places that have participated to some level of the CHA process so far, but the point that I wanted to make to this group is that this is what rebuilding looks like from a public health perspective. With 43 counties doing this process, not only are those partnerships being made and as public health implementation projects being initiated but we're also seeing that our county level staff or public health educators who maybe have an entry level public health education job, our regional staff have an opportunity to engage with community leaders and to really be exposed to those processes that are going to be a huge part of their professional development, and the public health workforce, and so, with so many new staff at that level, TDH is really happy to be able to give them an opportunity to rebuild a lot of the community partnerships that were impacted through the pandemic. And so, with that I'll just thank you all again, and thanks to Paul. Happy to answer any questions if there are any.

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Chris Kosmos: Alright. Thanks so much to you. Thank you, Paul. I think we're going to hold on questions for now. Also, thanks Michelle. We're running a little bit behind so I will get us a little bit caught up so if there are questions, please put them in the chat and we'll try to get to them in a little bit. At this point, I'm going to talk turn it over to Lisa Walker who's our Associate Director of Financial Services to give us an update on some of the administrative preparedness issues. Lisa.

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Lisa Walker: Good afternoon, everyone. With me today are OGS colleagues Tracy Sims and Erica Stewart I'll the turn it over to Erica to talk a little bit about expanding authority in the payment management system accounts. We will, for the sake of time, we will also be covering this in more detail at the July 28 call with business officials that was posted in the Friday eighth update. Additional details about that call will be posted in another update so I'll turn it over to Erica.

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Erica Stewart: Thank you, Lisa. I appreciate everyone's time and attention. I want to go over a couple of things with you regarding expanded authority and PMS. As you know, with expanded authority, the PHEP CoAgs have the approval and authority to use their funds in the next budget period. What that means is, if you have activities that you did not complete in the current budget period, you can carry it over into the next budget period. Now, these are these are for approved activities and it's not to exceed two years so basically you have two years to complete that activity. It's a 12-month budget period with two-year authority. The way that you report the amount is on the annual FFR and there is a section 12 where you would report, the amount that you are exercising expanded authority. A revised notice of award will not be issued. If there's a change in scope, we will have to receive a revised budget and a change in scope is going to be covered shortly. Next slide, please. Now, a change in scope is usually something that's substantial. If it's more than \$250,000 for that particular budget period, that's a significant change so we would definitely have to review that to make sure that it is still aligned with the approved activities. If you're just adding activities to support the goals, then you can continue that work, but we just want to make sure that you are in contact with your project officer to make sure. If you're adding a new contract and again it's still within scope that does not qualify as a

change in scope. Next slide, please. PHEP funds have a two-year budget authority so, for example, your budget period 2 funds that were issued in 2020 expired June 30, 2022. PMS, the way that it's designed, it uses first-in first-out methods so basically you do not have to worry about a lapse in funding. PMS will make sure that it pulls the oldest funds first to ensure that you still are able to function. The key takeaways are you have a one-year budget with a two-year budget authority to obligate without prior approval. Changes in scope do require prior approval. If you have any questions about that, please follow up with your PHEP project officer and your assigned grants management specialist and payment management system draws out old money, first, to reduce the risk of lapses and funding. We will again discuss this in more detail on the July 28 grants management official call. Thank you and I'll turn it back over to Lisa.

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Lisa Walker: Thanks so much, Erica. I will be talking with us a little bit briefly about new GSA ordering agreements and a little bit about the no cost extension options for the workforce crisis NOFO. We can cover more of this in detail at the August all recipient meeting. But in general, CDC and General Services Administration have established a new program to provide emergency preparedness and medical response support services. This program is separate from the existing COVID-19 response package that was developed by GSA and this new program is medical support and emergency response preparedness is available to state, tribal, and territorial jurisdictions during federally declared public health emergencies. We can talk more about that in the August call as well. But essentially, this program includes several agreements which are known as basic ordering agreements. You'll hear the term BOAs. Essentially, these are agreements that are put together in a catalog for jurisdictions to access resources for procuring services and any federal declared public emergency. The available services will vary depending on the emergency and the needs of the jurisdictions. There are eight different components. We can put the list of the components in the chat and jurisdictions will place their own solicitations and subsequent orders in through their general processes. But there will be folks from the GSA that will be trained to assist jurisdictions that kind of make the connections with those vendors. We do have folks from GSA on the line, so if you have questions, you can put questions in the chat and we can compile them and circulate that and get answers for you, following the call. And lastly, if you are a jurisdiction that has used one of the former GSA BOAs for COVID-19, we would love to hear from you, your success stories and/or challenges because GSA has shared that at least one jurisdiction was able to successfully procure services within seven days, and so we really want to learn more about that success story, and the administrative procedures there in that jurisdictions, so we can link their jurisdictions to their peers to potentially help others with their administrative preparedness. GSA is finalizing that buy-in guide, the webpage and some templates to assist jurisdictions and more details will be shared in the Friday update to come. Next slide. Crisis response - we are currently working on a no-cost extension guidance to be uploaded to integrated solutions. If a jurisdiction needs additional time to complete activities, they may request a no-cost extension up to the 12 months. The deadline to submit that no cost extension amendment in Grants Solutions is Thursday, March 2, 2023. And like I said we'll provide more guidance by the end of July via Grant Solutions. Many thanks to our OGS colleagues We just wanted to share that information. Back to you, Chris.

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Chris Kosmos: Thanks so much Lisa. I think now we're going to take a quick break maybe and then go into the breakout rooms. Is that right?

01:58:41.130 --> 01:58:49.380

Kate Noelte: Yes. Let's take a five-minute break.