April 2021 Hospital Association COVID-19 Preparedness and Response Activities Cooperative Agreement Monthly Discussion
April 29, 2021
Event Transcript

00:00:09.630 - 00:02:47.190
Jennifer Hannah: Good afternoon everyone and thank you for joining today. I am Jennifer Hannah, Deputy Director of ASPR's National Health Care Preparedness Programs Branch. It's my pleasure to be with you today to connect on a variety of disaster response topics. Before I go over the agenda for today's call, I'd like to provide some updates regarding the Cooperative Agreement Accountability and Management Platform, or CAAMP. First, I want to thank you for submitting your mid-year reports on time. Our data team is reviewing and analyzing the data submissions. In preparation for opening the end-of-year report on June 1, please ensure that your list of sub-recipients in CAAMP is accurate. You can find it by navigating to the Contacts page and choosing View All from the drop-down menu on the left hand corner the list of sub-recipients. An email contact needs to be up to date for interview reporting. Please update and validate this information by May 31. Please reach out to your assigned project officer or Kate Gorbach at KateGorbach@deloitte.com if you need further assistance. Also, please join the Community Collaboration page on CAAMP. You can get there by going from the navigation bar to Collaboration to Community Collaboration. Move your settings to Weekly Digest or Every Post, so that you get email updates when there are announcements. We also highly recommend joining the group for your region. You can get there by going from navigation bar to Collaboration to Group for region-specific announcements and we will ensure that this information is included in the webinar follow-up email with the recording link and slides from today's webinar.

During today's call Dr. Til Jolly will first share information regarding the National Emergency Telecritical Care Network, or NETCCN. Next, Sonia Bell from Emory University Hospital will demonstrate the National Emerging Special Pathogens Training and Education Center, or NETEC's, new Guide My PPE App. Then, our Senior Advisor Matthew Watson will present on the Guidelines for Regional Healthcare Emergency Preparedness and Response Systems. Finally, we'll have some time at the end for questions from the audience, I will now pass it over to Dr. Til Jolly.

00:02:50.940 - 00:18:10.410
Til Jolly: Good afternoon and thank you for having me in front of this group. We'll certainly have some time for questions. I'm Til Jolly. I'm an emergency physician and I'm supporting ASPR as their Senior Consultant for Emergency Care. I'm working very closely with Jennifer and others on the team on a number of issues related to telemedicine and disaster preparedness before COVID started, but I'm going to talk specifically about a program that we're in partnership with the military and I'll go into how that works in a second. It's called called NETCCN, the National Emergency Telecritical Care Network.

So, as you see here from the logos, NETCCN in a collaboration, a key logo down at the bottom is TATRC, the purple one. The Telemedicine Advanced Technology Research Center of the Department of Defense, which is really the initial incubator of NETCCN. Key to this was Society of Critical Care Medicine, which is the largest society of intensivists, which also has supplied expertise to TATRC in the development, and ASPR is obviously now a major player in this. I'll sort of go into what that means in a second.

So all you have spent, as I have, lots of time at hospitals over the years and, and I'm not going to go into a recounting of all the problems and the resource issues within hospitals around the country both in good times and bad, but what this map shows is what this solution is designed to address. The counties with the dark coloring have hospitals with ICU beds, the areas with the orange coloring have hospitals that don't have ICU beds, and then the other is the gray, which really have

no hospitals. The point of this is that for the sickest patients in critical situations, frequently the strategy is, and as an emergency physician I know this, transfer the patient to a nearby hospital which on a good day is maybe a couple of hundred miles away. With a lack of surge that could somehow be overcome by individual transport either by ground or by air, but in a mass casualty situation COVID or otherwise, demand frequently outstrips supply. As we talk about it from a disaster standpoint, we talked about space and stuff and staff. Spaces, it's an issue that many of you have had to deal with and stuff related to PPE and other things as an issue. Maybe from a staffing standpoint there's live on the ground staffing and then there's telemedicine staffing. Many of you have worked in telemedicine frameworks for many years now in all sorts of areas, particularly the primary care and acute care space, but this is now part of the landscape and the acute care space. This system is designed to bring critical care expertise to the bedside and if you take nothing else from this, you can remember the catchphrase that our friends at TATRC came up with: critical care anywhere.

This is a complicated drawing and I'm not going to go over every element of it, but you kind of think of putting together a tiered staffing model to include expertise from a nursing, physician, and other caregivers' standpoint to support bedside providers, both within hospitals and, with it, other sites of care like gymnasiums, large containment areas, think of the Javits Center or something like that. Rural ICUs, this is not just a rural problem. Bringing expertise to the bedside and in an ideal situation through easy-to-use technologies that involve simple devices, not a lot of build-out, and rapidly be able to turn this on, and that's where NETCCN came from.

So as one thinks through this, and this is really credit goes to our colleagues, TATRC and Society for Critical Care Medicine, for several years ago coming up with this general idea. What they were trying to design and what they ultimately have designed is all these capabilities. Secure mobile communications, capable of synchronous and asynchronous messaging. I'm not going to read every one of these, but you need a documentation platform. Everybody has a different EMR and one needs a way to document care and it's an easy way to register patients into a system, one needs tools for managing handoff and managing communications. It needs to be HIPAA compliant, of course, and it needs to support a staffing model that then provides expertise to the bedside wherever that might happen. All those capabilities together are what has become NETCCN.
So, if you think through the various methods, you can then take the map and then try to provide support levels. For expertise around the map, where critical care capability either doesn't exist or exists and needs surge support either for 24-hour a day staffing for staffing in places that may only have one intensivist. Now, a number of the initial use cases of NETCCN and essentially what has happened with that is that it is now transitioning from phase one to phase two. I'll talk a little bit about what those phases are, but NETCCN has been operational now since late last spring or early in the summer. Phase one essentially started with a with a competitive bid process, they involve 72 teams that bid on the opportunity to join in the NETCCN program funded by TATRC and DoD funding working through a funding mechanism. They had to bring together teams of technology and clinical support into a format that would then do thorough research and development methods and provide operations to hospitals. NETCCN has operated in Guam and Puerto Rico and throughout the upper plains states, the Dakotas, Minnesota, Iowa, to provide care to multiple patients in the sites. There are a number of stories of good outcomes, and in Guam a patient with a critical illness, with a pneumothorax diagnosed by remote by a NETCCN a provider in San Diego to allow for a good outcome, while the only intensivist in that hospital was dealing with cardiac arrest in another part of the hospital, a hospital Minnesota that lost communications, although the hospital was then able to relay communications to a NETCCN provider for the existing cellular network to provide the care they needed. So many of these things happen through phase one.

So how has ASPR gotten involved? This really speaks to how we're now talking with you as part of the HPP Program. Early on in the year, this is an idea that incubated over a number of years, early last year DoD was able to put together initial funding to do phase one, and that ultimately resulted in--after a several down selection process--teams that provided care in the places that I mentioned before. Dr. Bob Kadlec, who is the prior Assistant Secretary of ASPR, felt very strongly that this

kind of model, both for critical care and then is one can imagine, as you're thinking through that, other specialties, whether it be infectious disease or pediatric specialties or others, could work across the similar theoretical platform and our real platform to provide care. So ASPR and TATRC in last September signed an MOA that brought with it funding of $45 million that is now funding phase two, which is being contracted essentially as we speak, and phase two integrates two teams. Instead of having four separate teams, begins to integrate them across the platforms, scale the delivery and begin to do the research and development process to bring wearables and remote-control devices in. Really sort of designing the next phase of telemedicine disaster preparedness. ASPR's been very happy to be part of this led by a large team that I'm only support part of and Joe Lamana, many of you know, has been very integral in working with the TATRC team.

So where do we stand now? As I said, there's a big military component, and so the primary information is available at this URL: TATRC.org/NETCCN. If you Google TATRC and NETCCN, it brings you up to this. This capability is available to you to anywhere in the country. Now there are some barriers to this, and I'll go over those in the in the next couple of slides, but essentially this capability through the existing teams is able to be used now to provide response support. You can go to this site, put in a request, and reach a TATRC support person. These teams are capable, both with technology and with providers to provide service to hospitals anywhere around the country. It works very simply across any device: phone, tablet, or otherwise. It does not require a great deal of infrastructure, but it does require that any hospital that participates to have a need, or not necessarily an overwhelming need, but a need for intensivists, ICU nurses, or respiratory therapists to provide expertise. Obviously the first question is who's going to the procedures? The team and can certainly help with expertise on how to do that. That's obviously a requirement, but that's a requirement in any telemedicine system. This provides a number of things, and you see there under our services, relief coverage, expertise, technology, and communication. We also provide for surge support, which is useful in COVID but, as you think through hurricane season, earthquakes, or other disasters, this kind of service is useful for hospitals to provide. This is currently federally funded so there's really no cost to this, and it's something that the TATRC team, in collaboration with ASPR, is happy to work through.

Now many of you are probably in the middle of your own telemedicine programs, whether they be steady state things with primary care, with stroke care, with behavioral health, with critical care, or otherwise, and there's been an explosion of this driven by a number of things over the past year, including a remarkable number of CMS waivers related to payment. That was the first barrier that went away, and then a number of things, including licensing and otherwise. But some of these are really only partial solutions in the long term, and so we are considering these and figuring out how to manage this in what will be the post-COVID environment at some point. Whether it's state-to-state variations from a regulatory standpoint, reimbursement, interoperability, and coordination, and platforms providers, all these things are important. There are many issues to be managed within ASPR and within the Federal Government and then within the state governments about how service is provided across state lines. You're all familiar with NDMS, that works across in a very specific way. In fact, some could support NDMS teams remotely to provide expertise to them and perhaps reduce the need for some deployments. If what's really needed is expertise on the ground, we may have these policy issues that need to be worked through over time and will be worked through over time. Some of these things are aspirational that need to be managed, but one of the big ones is the licensing and the funding for this and the reimbursement for these services. These are things that people are considering now and, if you think through what various professional societies like the American Telemedicine Association, and then provider societies, and then even the private sector groups that are working through telemedicine issues now. These are things that are being worked through and many of you on this call probably have great expertise in this area and thoughts on this.

So, I do want to make a few points as I close and hopefully leave a few minutes for questions. You know, this is an existing program and now it is capable of providing services to hospitals on the ground and now has done so, as I said, in Guam and Puerto Rico and a number of the upper plains

states. When you go to the NETCCN site through TATRC, you will see the current providers have said phase two contracts are being awarded literally as we speak, and what phase two will do is first, take those operational elements and deploy them to new sites and new hospitals and then a real key for this is to take those teams and build into those teams a network capability and improve capabilities for technology such as remote control and better information exchange to really build what we hope will be the telemedicine systems to support disaster preparedness, ready for the future. Within ASPR and within other organizations we've certainly had discussions about how we can use current technology and future technologies to improve disaster performance. That's another talk for another day, but as you think through NETCCN, it's really more than just NETCCN, it's not just critical care. The same technologies are available for infectious diseases, for burn care, for pediatric specialties, one can envision scenarios where all those things may be needed, and technology certainly can speed up response and improve response and improve the scale of response to really modernize disaster care and use what we're capable of. DoD has been an important partner in this, one can also imagine the support for the warfighter all around the world, and DoD will remain important R and D partner in this, and this is obviously an important function for ASPR and something that that the ASPR team has been working very hard on. So I'm going to stop there. I kind of flew through a lot of NETCCN, but I'm happy to take questions, either now or offline.

00:18:14.520 - 00:18:29.970
Zoe Kovatchis: Thank you, Til. We will now open it up for any questions on the presentation. I do have one question in the chat right now, it reads: is there a vision for NETCCN to support DMAT response or a similar federal response?

00:18:31.410 - 00:19:59.520
Til Jolly: The short answer is yes. The slightly longer answer is part of the one of the use cases, and you have to have a good use case. Part of the one of the important use cases for NETCCN is the support deploy teams. Deployed teams tend to deploy with generalists. They're very good and they're very skilled at managing difficult cases in austere environments, but they tend to deploy with generalists and so, as one might imagine if a DMAT is deployed to an area where, for instance, there's the need for COVID critical care response and they don't have a lot of intensivists, or a need for a pediatric critical care support, or the need for infectious disease support. Having the system available that provides for rapid communications into theater, for lack of a better term, to support a remote team would eliminate the need to try to move those assets to that deployed team when all you need is their expertise. So yes, that's certainly part of the planning and the vision. For follow-up question, is would that include a State Medical Response Team system? Absolutely, yes, this is not restricted to support of a federal team, a state team, you know any team that needs support can certainly access the support regardless of the source of that team.

00:20:03.300 - 00:20:34.920
Zoe Kovatchis: Thank you. As a reminder, if you have any questions on Til's presentation, you can select the raise hand icon from the participants button in the bottom toolbar, or you can write your question in the chat. We do have another question, it says: where there are no ICU beds or critical care clinicians, there's typically little to no broadband and sometimes no reliable cell service. Is there support for connectivity?

00:20:36.540 - 00:21:30.030
Til Jolly: Well, it's an interesting question and a good question. You know, connectivity and broadband are big issues for telemedicine around the country. That is true, there are places where there is little no broadband and sometimes no reliable cell service. This does require a cellular network to deploy, although it could also conceivably operate across a remote or temporary cellular

network which occasionally get deployed to places. The communications companies have the capability of bringing in networks or satellite communications to support this, and that's really all it requires. So, the connectivity support is not directly built into this program, but certainly could coordinate with other connectivity support what was required in a location.

I do want to add parenthetically to that question. We do focus areas. We talked about areas with no ICU beds or critical care clinicians. There are a number of areas with limited ICU beds, or even where an ICU that one hospital might think is ICU, another one would consider that more of a general bed, and so it's not all envisioned to go to even just rural areas. There are other hospitals that aren't too far from urban areas that may have limited capacity and can quickly be overwhelmed.

00:22:35.250 - 00:22:45.900
Zoe Kovatchis: Thank you, Till, and thank you to everyone who asked questions. I'm going to go ahead and pass it over to Sonia Bell for her presentation.

00:22:51.570 - 00:30:18.810
Sonia Bell: Thank you very much, and good afternoon everybody. I'm Sonia Bell and I'm here at Emory and am also one of the program directors for NETEC, and then before we go into the Guide My PPE all, I thought I might actually take this opportunity to give everyone an update on some projects that NETEC is currently working on as well.

So, just reminder that NETEC provides free education and training resources, all of these are available if you just go to our main website NETEC.org. All education and training resources are free, they are tailored for different health care worker groups and public health workers, and many of the free continuing education credits, we provide a lot of credits for lab and other health care workers as well. Coming this summer 2021 and into fall 2021, we are deploying a new curriculum with 70 individual modules, up to 10 hours of content, and all this will be organized into four key user groups so that we can meet learners where they're at. These will be organized into probably infection prevention, frontline care, pathogen awareness, and emergency management.
The content within the learner modules, they will span the breadth of what can be done from infection prevention/control and PPE to special pathogen awareness, waste management, and all of those domains that NETEC typically covers. We also have additional resources and more coming soon resources are all available again at NETEC.org. We will be deploying a podcast here soon, and also some NETEC live sessions. We do still have our webinars. We have a webinar tomorrow at one Eastern time: Overcoming Challenges Supporting Your Workforce. We also have over 1400 online resources in our expertly curated resource library, again online and available for free.

We now also have free expert consultations with technical assistance available still. As many of you are aware, or have participated in before, we have done in-person site visits and with COVID we focused on virtual readiness consultations in order to prepare hospitals and organizations for special pathogen events. We also can provide technical consultations for targeted and focus areas that require assistance. As we went into the summer and fall of 2020, looking at our data and our respondents' questionnaires, 74% of facilities reported other previous interactions with NETEC and the helped their facilities with preparedness and/or the response efforts to COVID-19. Again, please feel free to email us at info@NETEC.com to ask any questions or request assistance. We'll get right back to you, or you can also go to NETEC.org/contactus for more information.
Lastly our big initiative right now as well is the National Special Pathogen System of Care. As written here, the mission for the NSPS is to provide a coordinated and standardized healthcare network to care for patients infected by or suspected infection by special pathogens, such as COVID-19.

To the NSPS vision is to save lives by implementing a standardized special pathogen system of care that enables healthcare personnel and administrators, to provide agile and high-quality care across the care continuum. Right now, we're in a bit of a stakeholder discovery phase. We have more than 70 stakeholders in more than 20 organizations nationwide engaged throughout the development process that we're in. So more to come this summer. That'll be it for the updates. We do have a website that has some material on there at NSPS.org. And also go to NETEC.org and follow us on any of our social media handles on Twitter, LinkedIn, Instagram, and Facebook. We are providing updates there as well, so please continue to feel free to contact us or email us if you have any questions.

And with that, I'll let you go into the Guide My PPE demo. Alright, so this is the landing page for the Guide My PPE app. You can find this at NETEC.org or if you go to PPEGuide.org. And you can see we did develop this with COVID-19 in mind so this is based on COVID-19 PPE principles. We are working on the phase two of this list, which will add some more tweaks to some glove usage. We're also looking at capturing some more of those PPE use cases. When you go to PPEGuide.org you go to launch pad, select My PPE, it will take you to a separate tab and here's where you can either have help choosing your PPE, or you can select your own PPE. We have some disclaimers here, just kind of stating best practices. Also, that this is dependent on your own facilities use of the product, trying to get as much as you can. I would choose I'm using this to care for multiple patients since I'm in a unit. You choose N95, disposable gown. You can choose your own type of eye protection and, of course, gloves. And then, when you hit next you can choose, if you want, donning or doffing. And then, when you actually go into the donning or doffing, you can see that you can still toggle at the top here to go between either one it goes down the process here. It's also very mobile-friendly as it works well on iPads or phones. If you don't want to do this electronically, you can also go to print and when you print, typically we try to keep these to about two pages so they're easy to post and they're very generic. We do have of course NETEC's name on here but no other institutional icons or anything so you can kind of tweak it for your own institution. They can easily toggle to doffing as well, and also print those. If you need help choosing your PPE, it also coaches you going through, whether you are or are not providing care for a COVID patient. This gives you CDC recommended minimum PPE guidance, and then again, you can go through what your scenario is. We are going to be adding other scenarios, since there is less of the PPE shortage situation. Kind of making that one of the options as well, and also kind of treating someone of the glove options here. That is the Guide My PPE app. I will stop sharing unless anyone has any extra questions or anything they'd like me to click through for further information.

00:30:27.930 - 00:31:55.230
Zoe Kovatchis: Thank you, Sonia. If anybody has any questions, feel free to write those in the chat or to raise your hand using the toolbar.
All right, well I see none in the chat at this time, but we may have some time at the end, after all presentations are finished, to answer any questions that you all may have. With that, I will hand it over to Matt Watson.

00:31:57.540 - 00:41:19.470
Matthew Watson: Thank you so much. My name's Matt Watson. I'm a senior advisor for ASPR's National Healthcare Preparedness Program, and I'm here today to give you a quick overview of a project that we've undertaken, looking at the development of regional health care emergency preparedness and response guidelines.

To put the bottom-line up front, building upon its lessons learned from current regional programming, such as RDHRS, and the COVID-19 pandemic, ASPR is writing guidelines for regional health care emergency preparedness and response systems.
Given the outstanding work done by the RDHRS demonstration sites over the years, and the lessons we've learned from other regional programs across ASPR, the government, and industry,

we are well positioned to begin development of guidelines for regional health care emergency preparedness and response systems. These guidelines are required by Congress as a result of PAHPAIA's amendment to the Public Health Service Act in 2019. In that amendment, Section 319C-3 requires ASPR to develop regional health care emergency preparedness and response system guidelines. The purpose of the guidelines is to share practices and protocols for regional systems of hospitals, health care facilities, and other public- and private-sector entities to increase medical surge capacity for public health emergencies. The guidelines are intended to cover all-hazards preparedness and response. They will also include guidance for a public health emergency resulting from chemical, biological, radiological, or nuclear agents, including emerging infectious diseases. The practices and protocols included in the guidelines will provide information as it relates to 5 major buckets of information. First, providing a regional approach to identifying hospitals and health care facilities based on varying capabilities and capacity within a region. Second, the guidelines will include practices and protocols with respect to physical and technological infrastructure, lab capacity, staffing, blood supply, and other supply chain needs. Third, another large component of the guidelines will include protocols to protect the health care workforce. Fourth, the guidelines will include protocols for disease containment, medical triage coordination, and patient transport. Lastly, the guidelines will include considerations for the needs of at-risk individuals and children. As the guidelines are developed, we will be engaging a variety of stakeholders to ensure all perspectives are considered. We will share a summary of those stakeholders on a later slide. Notably as well, ASPR will consider policy and financial implications related to all the content just mentioned. Specifically, as the guidelines are developed, we will consider feedback relating to financial implications for all stakeholders engaged in regional preparedness and response. The guidelines will also include potential incentives for entities to engage in regional preparedness and response efforts. We hope these guidelines will be used to compliment to the Health Care Preparedness and Response capabilities that ASPR has already established.

Through research and robust stakeholder engagement, ASPR has observed several emerging promising practices for regional models. We'd like to touch on these themes because they will be important inputs to the guidelines. One theme we've seen emerge is that regional programs that actively expand partnerships across the public and private sector are better able to tailor their response to the specific needs of a community. Building upon existing relationships and inviting new partners ensures that health care preparedness and response stakeholders can leverage all the resources, innovation, and knowledge at their disposal, while also supporting at-risk populations during an emergency response. Additionally, regional models have successfully increased state-wide and regional medical surge capacity through the development of tiered systems. For example, the success of ASPR's 4-tiered system of care developed for the Regional Treatment Network for Ebola and Other Special Pathogens can be attributed to the inclusion of Regional and State Treatment centers, Assessment Hospitals, and Frontline healthcare facilities. Successful regional models also support patient movement and load balancing through coordinated patient transport from states with limited health care capacity. From ASPR's experience with the Medical Operations Coordination Cells as well as the National Disaster Medical System, we have demonstrated ways that tools can be used to support a regional approach to patient load balancing. Additionally, the use of data and technology has transformed health care preparedness and response, especially during the COVID-19 pandemic. It will be critical to continue prioritizing the collection, use, and synthesis of data to ensure health care stakeholders across the region have access to accurate and timely information. Another trend we've seen emerge is the importance of setting clear delegations of authority. In order to gain a common understanding of the bigger picture, it's critical to identify roles and maintain clear lines of authority and decision-making within individual health care organizations and facilities. We also acknowledge that every community, and every region, is unique. Regional systems should identify and consider a variety of elements, such as climate and demographics, when developing a regional community profile. Community knowledge leads to better, more targeted planning and response. Our research also indicates regional programs should ensure adequate training is available to all hospitals, their staff, and first

responders (including online educational offerings) to better handle emergency situations. And, programs that integrate specialized medical teams into their workforce further a regional system's response capabilities to specialized threats, such as CBRN threats and pediatric casualty management. Lastly, COVID-19 has highlighted the value of innovative care options during disasters. Regional coordination should involve leveraging tools such as telemedicine, mobile care, and in-home care to provide coverage across the region. A regional approach to health care preparedness and response cannot be developed in a vacuum. Given the many regional footprints across ASPR, we want to use feedback from everyone to get it right.

This graphic provides an overview of the stakeholders we plan to consult and engage with as the guidelines are developed, but this list is non-exhaustive. We acknowledge an important consideration to the development of these guidelines is ensuring that the entire spectrum of health care delivery is included in the approach, given that COVID-19 has shown us how important it is for all health care readiness stakeholders to be included in preparedness and planning.
And finally, we welcome your feedback as we move forward in this process. Now, I'll leave some time to answer any questions that you may have, and we look forward to those. Thank you very much.

I do see one question here in terms of the timeline for engagement. It's a great question. We will be starting that process shortly and anticipate continuing into the summer, so, much more to come.

00:41:26.610 - 00:41:37.320
Zoe Kovatchis: We also have another question in the chat that says: what is ASPR's plan for disseminating and using the guidelines once they are completed, and will they be used in a mandatory manner?

00:41:40.200 - 00:41:53.460
Matthew Watson: You know, I think that's a really good and important question. I don't anticipate that they will be in any sense mandatory. I think more to come on how this develops.

00:42:16.710 - 00:42:27.210
Zoe Kovatchis: We do have another question in the chat which reads: with such a limited sample of pilot programs, are you also looking at data from established Coalitions that have many of the points you were looking at?

00:42:28.710 - 00:42:42.900
Matthew Watson: Certainly. The Coalitions are critical to the to the process from beginning to end. We will definitely be reaching out and trying to learn as much as we can from all of our experiences, absolutely.

00:43:09.870 - 00:43:27.210
Zoe Kovatchis: So, it looks like we have a few minutes before the top of the hour, and I'd like to open the line for any questions, either for the presenters or for ASPR in general. Again, feel free to write your question in the chat or raise your hand.

00:43:45.660 - 00:43:47.010
John Wilgis: Jennifer, John Wilgis. I know you mentioned CAAMP being opened up on June 1 for the end-of-year. When will data need to be entered in by? What's the closing date for CAAAMP?

00:44:07.740 - 00:44:21.690

Jennifer Hannah: Yes, good afternoon. You know, I anticipated that question so I'm glad you asked. So, the close date for the for the submission of the data for the end-of-year Report will be July 30.

00:44:25.200 - 00:45:00.480
John Wilgis: Very good, thank you and my follow up question. Is ASPR anticipating an alignment of the fiscal year reporting to kind of get on track with HPP so that quarters align? I know it's a different fiscal year, but are you anticipating that the reporting will kind of align so that mid-year is more in the middle of the fiscal year and the end-of-year is closer to the end of May. I know you were delayed this time around.

00:45:02.850 - 00:45:27.270
Jennifer Hannah: We are anticipating to get the cycle back on schedule, so with the mid-year, typically that would be about three months after the midpoint, which was the October timeframe, and then for the end-of-year as well, for us to be able to get those back on schedule.

00:45:27.990 - 00:45:28.410
John Wilgis: Very good.

00:45:28.860 --> 00:45:37.050
Jennifer Hannah: We experienced some delays this year due to the delayed opening of CAAMP, but good question, thank you.

00:46:14.610 - 00:49:15.090
Matthew Watson: You know, we did have a couple of questions that we'd kind of anticipated with respect to the regional guidelines, maybe just in this next couple of minutes I could walk through a couple of those and in case others on the phone may have had those and didn't want to articulate them.

So, the first is really why is ASPR and particularly NHPP leading the development of regional guidelines? I think you know clearly as the only source of federal funding for healthcare preparedness and response, NHPP manages and administers a variety of healthcare preparedness and response programs that have become increasingly focused on regionalization over the years. HPP has unique perspective and reach across public health and health care and the branch serves as a source of expertise for healthcare readiness in many ways. Additionally, this requirement as part of section 319C-3, as I mentioned earlier, just tied to RDHRS, which is also administered by HPP and ASPR.

Another question could be: is this the same as RDHRS? The answer there is that the regional guidelines will leverage lessons learned from ASPR's regional programs, such as RDHRS, but they are intended to more broadly capture regional health care emergency preparedness from a higher altitude perspective. It's important to mention that the term "regional" with regard to these guidelines is a reflection of more than just state and local jurisdictional boundaries or HHS and federal regions. Instead, we're thinking about regional as a true movement of people and resources across the health care delivery systems and spectrum.

When will the guidelines be shared for input? We are working toward engagement with stakeholders for input from May through July of this year.

How can we give input on the guidelines? You know, we look forward to your feedback when we share an interim version of the guidelines shortly in May of this year. You can also share immediate feedback by emailing hpp@hhs.gov.

When will the guidelines be posted? The answer to that is, we hope to have them publicly posted for you in August of this year.

And finally, will any funded be provided in order to implement these guidelines? Certainly we acknowledge that additional resources will be needed to implement the guidelines, and we will have more information about funding mechanisms that could be used to implement them at a later date.

So, let me just stop there and see if that stimulated any thought or comment.

00:49:37.860 - 00:50:07.680
John Wilgis: Hi Matt, John Wilgis from Florida. I have to ask, as you get down into that outer band of partners that you had on your graph there, who's going to lead those conversations? Are ASPR FPOs going to come to each state and kind of work only with state partners? But then, you know down in different regions, or with the locals, or do you envision a lead agency or a lead convener?

00:50:08.490 - 00:50:43.260
Matthew Watson: So, it's a really good question. You know, maybe, I'll just say I anticipate probably a range of approaches. I think we're going to look for good opportunities, where the community has already convened in order to get some of that feedback. In terms of the regional outreach, I could certainly see a role for the FPOs, but I'm not sure we will be doing it. From a nationwide perspective, we may have to pick and choose a little bit. Jennifer, did you have any other kind of comment or perspective on that?

00:50:45.360 - 00:52:00.030
Jennifer Hannah: I think, Matt, what you've laid out is the is the right approach. Initially, when we will be preparing to receive that feedback, we're going to be looking at it kind of a broadly, leveraging what we would say, meetings of opportunity. Those meetings that are already existing that we may be able to leverage. So, for example, the National Health Care Coalition Preparedness Conference to leveraging those meetings also you know. Meetings that the American Hospital Association, convenes as well as these meetings here, of course. We didn't have a whole lot of time today, we wanted to just kind of introduce what was upcoming related to the regional guidelines. So, we're looking at I think a number of vehicles and a number of media being used in order to kind of gather that input and feedback. Also to ensure, as Matt's last slide showed, with all the various stakeholders to be able to engage folks appropriately at all levels.

00:52:02.010 - 00:52:04.260
John Wilgis: Makes sense, thank you both. I appreciate that.

00:52:08.940 - 00:52:17.940
Zoe Kovatchis: Thanks Matt for going over those additional questions. I will now hand it over to Jennifer for closing remarks.

00:52:20.010 - 00:54:30.840
Jennifer Hannah: Great, thanks Zoe. Of course, thank all of you for the work that you do every single day, and for taking time out of your very busy schedules to join these monthly calls. It's our goal to provide you with content that may not be necessarily specific to the execution or carrying out your corporate agreements but is definitely important information. As you continue to do the important work that you do, as well as those sub-recipients that you provide funding support. We are hopefully providing you and your sub-recipients with tools and resources that you'll find very useful. As we build out the agenda for these calls on a monthly basis, as well as the All-Recipient

calls, please feel free to provide us that feedback regarding agenda items or topics that you may want us to cover during these meetings. You can send those, of course, to our resource mailbox hpp@hhs.gov. With that being said, I wanted to thank our presenters for taking time out of their schedules today and again to all of you for all of your active participation in today's meeting. As always, we would love to hear about how you and your hospitals and other related health care entities are using the cooperative agreement funding to make an impact on their communities, especially as it relates to the current COVID-19 response. To submit your story either email the hpp@hhs.gov mailbox or fill out our new Story from the Field submission form, which is available on the Health Care Readiness in Action Stories from the Field website, and our team will insert the link directly into the chat for easy reference. Following that submission, a member of our Communications Team will reach out to learn more from you. Again, thanks everyone for joining us today and have a great day, thank you.