

ASPR Health Care Readiness Cooperative Agreements All-Recipients Webinar

February 8, 2022

Call Transcript

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Maria Ramos: I will now pass it to Jennifer Hannah, who will open today's call.

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Jennifer Hannah: Thank you, Maria and thank you all for joining us today. I am Jennifer Hannah, Deputy Director for ASPR's National Healthcare Preparedness Programs branch. Before I hand it over to our first presenter, I would like to provide a brief overview of what we will cover today. Next slide.

First, I will provide a few ASPR Health Care Readiness Programs updates. Next Shayne Brannman will highlight some recently published an upcoming ASPR TRACIE resources and presentation. Afterwards, Dr. Richard Hunt will provide an introduction to the ASPR Healthcare Preparedness and Response Capabilities Updates. Finally, we will dedicate time for a general Q&A session. Next slide.

So, I would like to take a few moments to share a few administrative updates with you all. First, I would like to provide a few updates regarding the Medical Response & Surge Exercise, or MRSE, requirement for the HPP cooperative agreement. We have received several inquiries from HPP recipients regarding whether health care coalitions will be granted a flexibility toward completing the MRSE requirement by the end of Budget Period three, or June 30, 2022. We want to respond to concerns related to completing the exercise amidst the ongoing COVID-19 response. Currently, we are leaning toward extending the period of time allotted to complete the MRSE, while also ensuring that those who have already completed the exercise receive credit for the current Budget Period. Health Care Coalitions that complete the exercise in Budget Period three, would not be required to complete the exercise and Budget Period for unless they wanted to conduct the exercise again. Those that have not completed the exercise in Budget Period three will have an extended period of time to complete the requirements by the end of Budget Period four or June 30, 2023. We will provide an official update with specific information regarding the flexibility in the coming days. Next slide, please.

Next, I am excited to announce that ASPR has officially completed the first phase of its transition from PHE.gov to ASPR.HHS.gov. The new website showcases ASPR's mission and priorities, along with innovative approaches to fighting COVID-19 and information on health care readiness, response operations, medical countermeasures, ASPR's budget and funding, and more. For your reference, a member of our team will share the direct link in the chat.

Next slide please. Finally, we would like to take a moment to spotlight ASPR's social media channels and all of the engaging content that is available to you through those platforms. ASPR is active on all major social media platforms— Facebook, Instagram, LinkedIn, and Twitter— and its social media posts contain a wide range of content such as major news headlines, job postings, recipient impact stories, and features of newly published health care readiness resources. If you submit an ASPR Health Care Readiness Story From the Field, you will have the opportunity to be featured on ASPR social media. If you've published content related to the impact of your cooperative agreement funding, you can also tag us at #HealthCareReadiness, and you may see you content reposted to our accounts. We invite you to follow ASPR social

media at the handles on this slide to stay up to date on everything ASPR. I will now pass it over to Shayne Brannman to share recent and upcoming resources for ASPR TRACIE. Shayne.

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Shayne Brannman: Thank you Jennifer and good afternoon everyone. I don't know if you've gotten it yet, but I've sent each and every one of you a virtual hug, teddy bear, and a piece of candy for Valentine's day. You all deserve it for everything that you've endured and overcome in the last couple years. Now going on year number three. So, thank you all very, very much. Next slide.

I'm just going to spend a couple minutes here reorienting you to some of the newly published TRACIE resources we have. I think the best resource, I can put at your fingertips right now is our "Year in Review" report which features links to more than 100 resources we published in calendar year 2021. I wish we didn't have that many resources to inundate you with, but it was all out of needs and requests from people like you. So again, with the help of stakeholders and SMEs, we were able to address a multitude of challenges, through the year, and really focus on patient load balancing, crisis standards of care, civil unrest, workplace violence, and severe winter weather. So again, thank you to all of you that help make TRACIE what it is. We also did a nifty little video highlighting some of our partnerships and contributions since we just recently celebrated our sixth year of TRACIE. So again, it's amazing that TRACIE has been able to advance the way it has, but it wouldn't be here without the support of our NHPP staff and everyone here on the line, so thank you very, very much. Next slide.

Now, I just want to focus on some upcoming resources and make sure that you're aware. By the end of February or around the first week in March, will be distributing an updated climate change resilience and health care some considerations document. This document is important for health care executives and health care emergency managers to just note some of the tangible and practical things that we can all start doing today to begin addressing climate change and the impact it's having. And I don't need to educate anyone on the line today that climate change is obviously one of the driving factors of all the different threats and the pace of those threats that you all are having to respond to on a daily basis. So please check that out. We worked very closely with a lot of very notable SMEs on this, so we look forward to having you review that. And like all TRACIE products, it's always a work in progress. So as you have more tangible stories of what you're doing in the climate change space, please forward those stories to us, so we can include them in the document and continue to share, so we can all learn and be better prepared and the days ahead. We also are doing a couple of special studies that we've been requested to do. One is on crisis days of care and the other will be coming soon on MOCCs and lessons learned. So again, some of you may have already had contact from ASPR TRACIE on the crisis standard of care tracker, so if you have any questions, concerns, or clarifications, please email me directly and I'll make sure that we make this as easy of a lift as possible. Again, probably sometime in the March timeframe, we will be soliciting input from some of you on some of your lessons learned and what you've been able to do with using MOCCs to better respond to surge issues. So again, we look forward to that. I also want to bring something else to your attention, because we got a really an amazing amount of feedback on the Exchange we did on health care workplace violence, and the need for this type of education and what health care facilities are having to endure right now. So, as a continuation of that effort, on March 2nd, will be doing a webinar on that focus area, and we are really excited because in addition to Dr. Hunt and Dr. Hick, and an individual from Hennepin Healthcare, we

have a representative from the Joint Commission, who will be able to explain some of their new standards and thinking in the space. So again, we will be soliciting registration on that next week, through Jennifer's NHPP outreach. And we'll also do a TRACIE Express, but please sign up for that, because I think it's important information that you all need to be aware of. Again, we're continuing to do different health care coalition speaker series and update those, and we have an interesting of speaker series coming up shortly on organ donation and the impact COVID has had on their operations and how they've overcome it. Again, for some of these areas, they may not seem like something you think about all the time, but I think we can learn from different folks like the poison control centers, and what Kentucky did working with the penitentiaries with their health care coalition to overcome challenges on how we can better think ahead and leverage other people's thinking for issues that we're addressing on a daily basis. But again, I'll stop the presentation here and take any questions that you might have. But most importantly, happy Valentine's Day and thank you for what you do on a daily basis and continuing to support TRACIE. Please rattle my cage if we're doing anything to irritate you or we can make your life better. I'm here to serve you, and if we're not doing that we're not doing their job so thanks for the opportunity today.

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Maria Ramos: If you have any questions for Shayne, you can feel free to drop them into the chat box or raise your hand. Okay. So, then, I will pass it over to Dr. Hunt.

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Richard Hunt: First, let me say, I will miss the little box of candy hearts that were distributed my desk every Valentine's Day in the office. That being said, let me transition over to the work for today. Thanks to all of you for taking the time today. We are in the process of revising the ASPR Health Care Preparedness and Response Capabilities document that has been the point of reference for health care facility and health care system preparedness for the past five years. Before we get started with the ASPR Health Care Readiness and Response Capabilities Update, we wanted to administer a quick poll. To do that, I will pass it to Kirsten Albers.

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Kirsten Albers: Thanks Dr. Hunt and good afternoon everyone. the poll question if we can go to the next slide. There we go, so the poll question is "Do you currently use the Health Care Preparedness and Response Capabilities?" And the pop up should appear in a moment and then we'll show the results live. Great we will give everyone, just a few more seconds. Okay, can we go ahead and show those results. Great so we have 88 percent of respondents that currently use the Healthcare Preparedness and Response Capabilities. Okay and thank you for your response, and I will go ahead and pass it back to Dr. Hunt to continue.

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Richard Hunt: I did a lot with the chat like "why wouldn't we?" kind of like, yeah. that's great. So, the goals of our presentation today will be to provide an introduction to the ASPR Health Care Preparedness and Response Capabilities update. We are going to do that by reiterating the purpose of the capabilities, describing plans to update the capabilities to address insights learned during COVID-19 and other responses as well as reflect the ecosystem of health care preparedness and response. And we will also request feedback on the current capabilities

document, sharing how additional feedback may be collected through stakeholder engagement. Next slide.

So, what are the capabilities? I think, actually, most of you may have seen this slide in the past five years. The Health Care Preparedness and Response Capabilities are national strategic and operational guidelines for health care readiness. They are designed to serve as a roadmap for health care preparedness and response functions for entities that support health care readiness. ASPR and others also use the capabilities to support health care readiness, with the capabilities informing the development of funding opportunities, activities, and performance management. The capabilities were originally created in 2012. The most recent version of the capabilities applied to 2017-2022. The new version will provide a vision of preparedness and response capabilities for 2023 and beyond. Next slide please.

The capabilities are high-level objectives that the nation's health care delivery system, including HCCs and individual health care organizations, should undertake to prepare for, respond to, and recover from emergencies.

First is the Foundation for Health Care and Medical Readiness, including guidance on setting up a coalition, developing coalition plans, and conducting drills and exercises. The second, Health Care and Medical Response Coordination emphasizes collaboration across health care organizations, coalitions, their jurisdictions, and the Emergency Support Function 8, or ESF-8, lead agency plan, as well as information sharing. Third, Continuity of Health Care Service Delivery, focusing on providing uninterrupted, optimal medical care to all populations in the face of damaged or disabled health care infrastructure. And then Medical Surge which pertains to delivering timely and efficient way to care for their patients even when the demand for health care services exceeds available supply. These capabilities illustrate the range of preparedness and response activities that, if conducted, represent the ideal state of readiness in the United States. Next slide.

So, the update and the objective of the capabilities update. The update is going to address challenges and developments in health care preparedness and response efforts since 2017, especially during the COVID-19 pandemic. While it's going to be really important to address COVID-19 insights, the capabilities will still provide an all-hazards approach that provides guidance for many types of emergencies. The purpose of health care readiness is to save lives when disaster strikes. To save lives, capabilities need to support patient care and clinical operations. Capabilities also need to support health care organizations and a health care workforce that can continue to function during and after disasters. We will reflect the perspective of frontline health care workers as well as health care leaders and partners so that all entities with health care preparedness and response functions can see themselves in the capabilities. In addition to revising the content of the capabilities, the update may also involve making structural changes to the document to best meet the needs of the field. Next slide.

So, the engagement of stakeholders. Our approach to that is recognition that the stakeholder input is critical to our process of shaping the next capabilities. We are really trying to ensure that a diverse group of stakeholders provides input and helps shape the changes throughout every phase of the process. By stakeholders, we include frontline health care providers, EMS, state and local government agencies with preparedness and response functions, NHPP cooperative agreement recipients, ASPR programs and leadership, federal interagency partners, health care

and disaster professional associations and nongovernmental partners, members of the public, and other audiences with roles in preparedness and response. Next slide.

We're now going to review a few review questions that we have received on this update effort. So what updates are being considered? Based on initial internal discussions and reviews, the following themes have arisen as potential areas that we might be able to update the capabilities on. First, we are considering ways to improve the usability of the document. We are also exploring ways to increase the focus on deliberate planning and engagement to meet the needs of at-risk individuals as well as to ensure preparedness and response functions do not exacerbate existing health inequities and disparities. We are also considering ways to add or expand guidance around Medical Operations Coordination Cells, or MOCC, functions, tactical implementation of ESF-8, load-sharing and load-balancing, critical care transport, telemedicine and tele critical care in surge planning and response, and different types of surge (e.g., prolonged medical surge, pediatric surge, surge plans for crisis conditions, etc.). Finally, we plan to explore content from the MRSE and the Guidelines for Regional Health Care Emergency Preparedness and Response Systems to improve the capabilities in specific areas. Next slide.

So, what is the relationship between the Guidelines for Regional Health Care Emergency Preparedness and Response Systems (the Regional Guidelines) and the capabilities? The Regional Guidelines are being created in response to a statutory requirement to offer approaches to regional health care readiness. The stakeholder feedback and content from the Regional Guidelines may inform the capabilities update, but the documents serve complementary roles. While both documents describe activities that strengthen health care preparedness and response across the health care delivery system, the Guidelines focus explicitly on coordination for regional health care readiness. Next slide.

So, discussion it's not particularly easy to have a discussion in a room of 174 people that I see in terms of numbers of participants, but we're going to give this a shot if we could. So, we have a number of questions for you, and as I kind of like open up this like discussion, our hope is that you really think about this opportunity over the next you know, few minutes here, to really think about and respond to us like, how can we improve the capabilities that currently exist? I mean our experience has been vast in disaster response over the last five years. So really, it's an opportunity for you to respond in the chat. Yes, certainly can raise your hand. We will try to get a couple of your questions. But as sort of a level set in this part of our meeting today, we're really trying to get some initial feedback on, you know, how should we approach the capabilities, with an eye toward really improving what we have today. And we've had just so much experience to be able to inform that. So liberally use the chat, please, and yes certainly raise your hands. We may be able to get to a few questions. So, let's see. I think, Kristin, the next slide has some of our questions.

So, these are the things that we wonder about, okay. And you know again, big picture, you know if you can begin to think about, in the chat, and begin to talk with us in the chat "How do we improve these capabilities," that would be great. We've got specific questions too. My sense is that because we've got all these questions is that everyone will shut down and not want to say anything, but that's okay, because you're going to have multiple opportunities over the coming months to be able to respond to us and be able to provide input. So, this is not the first or the last opportunity to private provide input, as we go along with this. So, um here's question: How do you currently use capabilities? If you have used them, what's good about them? What works? And then what can be improved, in a general sense? And if you don't currently use the

capabilities, why aren't you using them? What's the main reason for that? And we saw there are some of you that don't use them, so especially looking for you to inform us as to what exactly is it that makes it, so you don't use them? Maybe you haven't seen them or before maybe you're new to the program or maybe it's like they were never useful during the past five years. And we would surely like to know why. And then, what are the barriers to actually using the capabilities? Is it too long? Is it too detailed? Is it a format issue like you can't access it on the web easily? You know getting down into some deep dives on that would be really helpful because if we're going to go to the lengths of spending the energy together to do these, we've got to figure out what the barriers are. And then, are there ways that the actual structure of the capabilities, for example, for capabilities with corresponding objectives and activities that could be improved. I mean you have to realize the current iteration of 2017 to 2021, was the first time we ever had the capabilities so we structured it with four capabilities that included objectives and activities... but is there a better way we could approach that in terms of structure.

And yes, I'm sure somebody if somebody doesn't put in the chat, I will. The fact that form follows function, so I get that, but it would be really helpful to get a sense of the structure, from the perspectives. Let's see and then another question, we have, which I think, at least for me it's, the most important: "what healthcare capability has saved the most lives during the pandemic response? And then, what other healthcare capabilities, have you seen that have saved lives over the last five years of response efforts that are critical to include in the capabilities. Many of you been faced with wildfires, on top of pandemics, severe weather emergencies whether those are tornadoes or hurricanes, and on and on. So, of those capabilities, knowing which ones have saved the most lives will be really helpful for us to know, because those are the ones, we are certainly including them in any update. And then in terms of gaps in what we have in the current capabilities, "what's been the most crippling gap- the one that you think "wow we have we missed this one and it ought to be in the updated." So that would be really helpful to know what capability gap has been the most crippling to the pandemic response. And then, not just the pandemic, like the previous question what other healthcare capability challenges gaps you have seen in the last five years of response efforts that are critical to addressing the capabilities.

So those are the questions that we certainly have. And when I say we certainly have; yes, we definitely don't have all the answers. You're the ones that are boots on the ground, you're actually doing this, so your responses to these questions will really help shape how we think about what this update will be in the coming months. So Kristin, did you ever see anything in the chat worth highlighting or that we should address or respond to?

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Kirsten Albers: Yes, I can read a couple of the comments from the chat. We have a comment that says that "they based their entire ask or work program on the capabilities." This individual likes the current capabilities and feels they cover the core preparedness and response work. They like the simplicity of having four capabilities and really like that structure. Colorado noted that they use the capabilities to guide and support HCCs, saying they use them as a point of measurement guiding ongoing development. In terms of improvements both Colorado and Arizona highlighted that we may need different sets of capabilities, based on population. That rural populations may have very different needs and capacities than urban areas. And I think that's something we've already been thinking about as well. We are getting lots of lots of great comments here and we really appreciate them. We did get one question that I'm not exactly

sure how to answer. We got a question from Kenan Jenkins, that says, "Can you provide recommendations for Region K?"

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Richard Hunt: Kirsten, I can't.

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Kirsten Albers: Okay, yes, I wasn't sure how to answer that.

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Richard Hunt: Oh, I don't have that one but when the pandemic is over, I'll be glad to visit that area and try to figure it out. No seriously, I don't have a specific response to that question. There was one comment that you read that I particularly picked up on. It was the whole and urban and rural question and they're not just nuances, they are big differences. And one of the things that I think is worth sharing with our participants, is we've had really robust conversations here NHPP about the equity issues, and how while we always knew the equity issue was out there, it certainly has risen to be at the forefront of many of our conversations based on what's happened during the pandemic. So, um you know how does rural versus urban play into that whole inequity piece? And I think that's a really critical thing that we have thought about for many years, with the program, but I think I'm certainly thinking about it in some new ways is going to be critical moving forward so appreciate that. Any other ones?

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Kirsten Albers: Yeah, I'll keep reading through them. We have one suggested improvement, asking whether it would be possible to streamline the objectives and activities that have almost become wrote at this point? They said they recognize that there is always room for improvement on existing items, but I think they're probably specifically referring to mainly the capability, one on foundation that you know, in many cases, most HCCs at this point already have plans and have done some of those initial steps. In terms of, oh go ahead.

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Richard Hunt: Yeah, let me comment on that one in terms of my experience with that. It is a fascinating as I'm sure many of you may have attended our healthcare response leadership course in Anniston, that we had up until the pandemic basically shut it down, of pandemic. But I think a lot about that foundation piece, in terms of while it may be very much wrote in sort of like, why are we building a foundation and should we have moved way beyond that? The fascinating part is because of turnover in personnel and because of, for example, restructuring of coalitions, essentially the change that occurs over time with coalition's, not to mention everything else, but having that foundation there has interestingly served a purpose even like five years later. That is because of the people coming on board and they're trying to scratch their head and figure out what the heck is this coalition thing? And then suddenly there's a sort of an anchoring document that helps them along and helps them figure it out. And maybe it's an appendix, I don't know just throwing ideas out there to be able to be responsive to that. Before we move on, Jennifer do you have any comments, based on what you've been seen in the chat, before we move forward with to reading some more?

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Jennifer Hannah: I don't have any additional comments right now. I'm thinking just keep moving through the comments. I think the only other thing is that, as folks consider and think about the capabilities- you know when we first developed the capabilities, they were probably focused, well not necessarily targeted to the Hospital Preparedness Program, but they were probably the primary audience that was using that the capabilities. One of the things that we want to ensure, and I mean, as we stated already that this is a strategic national document for the ideal state of preparedness and response for the nation's health care delivery system. But also, you know, we know that the capabilities, as we said, cascaded down to the Hospital Preparedness Program recipients, and many of the capabilities were included incorporated or leverage for our program requirements, for the HPP cooperative agreement, but recognizing that you know, since that time we've had the Regional Disaster Health Response System sites that have been identified as well as the Hospital Association cooperative agreement, and also you know, all of our Ebola act activities over time, which have now become our National Special Pathogen System. So, what we want to do as well, is to think about and look at the capabilities, through the lens of how they can apply a cascade to all of those other programs, as well as how you can consider and think about what improvements can we make to the to the current set of capabilities.

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Kirsten Albers: Thanks Jennifer.

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Richard Hunt: I appreciate your bringing up that our first capability was focused on the coalition building and we built in addition to coalition's other preparedness and response for health care so it's important to incorporate. Kristen, back to you.

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Kirsten Albers: In terms of suggestion on what saved the most lives- we had a comment saying "medical surge has obviously saved the most lives. They mentioned that during a recent New Year's Eve marshal fire that required multiple health care facilities to be evacuated, the fact that they had engaged in multiple trainings and exercises for evacuation had a direct impact on the rapid nature of evacuations, that took place. In terms of the structure of the document we received a comment, noting that most activities are cross cutting across several capabilities. Meaning that the organization of the current document for their grants management agency, creates some redundancy and does not necessarily allow them to highlight how the capabilities work together. So that may be a suggestion when thinking about the structure of the document.

And we've got another comment from Montana, about really focusing on the rural capability needs as well and how they differ from urban which seems to be a continued theme. I see that also from South Dakota as well, noting, that they have many rural and frontier communities with small populations that don't have access to those to those resources. And we have another comment that's looking at that most of their time, effort and funding revolves around capability one, which really helps them so they can better accomplish capability four, which looks at the medical surge; specifically having the structure in place in that foundational capability is more valuable than maybe the other components. We really love seeing all these comments. I'll just keep reading through and Dr. Hunt please jump in if you have thoughts, you want to share on any of those.

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Richard Hunt: Sure, and yeah, I agree. I mean as we mentioned in the green room for this, I really didn't expect much response in Q and A regarding the breadth of what the capabilities are trying to do, plus we have a lot of discussion questions here, but the responses gratifying far beyond what I had imagined for sure. And you know as I'm again just sort of doubling down this is like the first opportunity to really start thinking about it with us, and there will be other opportunities coming. So yeah, Kirsten let's go back to some of these. Go ahead.

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Kirsten Albers: Great. We've gotten a suggestion to consider structuring the annual conference around successful efforts to accomplish the capabilities by states and coalitions. You know, thinking about sustainability and leadership engagement, as well as establishing coalition's as viable regional ESF eight leads and integration with PHEP and others and regional procurement systems, etc. A lot of great suggestions in there. I realized this is separate from the annual conference, but we are thinking about the capabilities and potentially, including some examples of successful efforts, or of promising practices that have been seen. As well as examples to help bring some of the things to life. So that's definitely something we're looking at, even with the document. In Kansas, the capabilities are used to guide and create milestones for the HCCs. They provide the programmatic side of the grant. In terms of the primary barrier, Kansas noted that it really, for them, is the sheer level of reporting and deliverables that are needed that the HCCs spend more of their time creating documents, reviewing documents, and approving documents. And we got another comment agreeing with that comment about the administrative workload there. I see, we got a comment, I believe, from Puerto Rico who based their program on the capabilities. They noted it's important that the activities that are given can be streamlined. Their recommendation would be taking into consideration differences, based on territories, which are different than mainland. I think this is a great suggestion.

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Richard Hunt: Oh Kirsten, while you're scrolling through there, I noted the one comment in the chat about the healthcare workforce piece. I mean this kind of like doubles down back on the health equity piece which we have always known was important, for example, but now, with our healthcare workforce diminished substantially for because of the pandemic. While we certainly included the concept of protecting the healthcare workforce, in the previous capabilities, at least I'm pretty sure we included that in some ways, that's going to be absolutely critical moving forward. Independent of any capabilities. But without a workforce, you have no health care preparedness and response. So, I certainly grasp that, not just grasp it, but I think our entire program grasps is that in a substantive way. And then trying to figure out how to like rebuild it as well, I think is important, independently of the capabilities. That will be important moving forward as well. So, Kirsten, back to you.

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Kirsten Albers: Thanks Dr. Hunt. We have a few questions in here, noting from people that they would love to get share these questions with their team and provide feedback later. We really appreciate that and there will definitely be opportunities. With following up from this session, when the materials are sent out, we can be sure to include these questions and an email address that feedback can be sent to in the meantime. We also will be following up with

you all about potential small group sessions, later on, where there's an opportunity to provide feedback in a smaller group, potentially on specific topics. So, we will definitely be providing these and we'll share and welcome any feedback that comes in, after this. Especially if you want to share this with your team, with your HCCs, and with any others. So, we really appreciate those suggestions in the chat.

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Richard Hunt: I think at this juncture, it makes a lot of sense to turn this back over to Jennifer. I just want to thank everyone for working with us on this. You're already working with us in a really substantive way with all kinds of great chat comments that will help inform us. And yeah, I mean this meeting, unless I'm missing something Jennifer, it's in the public domain. You know, take screenshots of the thing, so we can get the questions out and get us some feedback. So, Kirsten, okay over to Jennifer at this point.

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Kirsten Albers: Yes, Jennifer if you want to do the larger Q and A now that is great. Otherwise, we're happy to go through if you think there's a little more time. Either way.

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Jennifer Hannah: Yeah, we have a few more minutes for this particular session if there's any burning questions that we want to make sure that we get out during this this call. So, we can go through a few more questions, Kirsten, and then I will be happy to take over from there, for a more general Q and A. But I appreciate all of the great response so far.

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Richard Hunt: Good. I've got a little more time. So, I let me ask a specific question and see what we can get the chat. This question is not part of the discussion questions, but something we've talked about a little bit internally, but not extensively, but the length of the capabilities. I mean it's a large document, it really is large, and you know there's some big picture things and there's a lot of granular stuff in there. Based on what it is today, would you like to see it shorter or longer? Would you like to see it with a short overview and then bunch of appendices? I know that's pretty granular, but just trying to get some sort of an end user feedback on that would be really nice to see. Again, this won't be the only opportunity but it's something we've talked about. Kristen, any other chat comments in there that we can go ahead and share?

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Kirsten Albers: Yeah, not sure we can walk through all of them, but a couple ones I really wanted to highlight that are that are things we're really thinking about as well. I see multiple comments about a resilient workforce and especially I think Kurt's comment that says, "we need to have a way to support workforce recovery following major health and medical crises, especially in the shadow of the pandemic." I know even just in my conversations with you, Dr. Hunt, this is always front, and center and I think this is really something that that we are thinking about as we're revising the capabilities, to make sure that we're understanding that and really addressing the workforce piece.

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Richard Hunt: And Kirsten, of one of the things that I've had discussions with many colleagues about is: for the health care workers that have left, and you can see the news reports on this, just like I do. There are a lot of people that left, and I asked, "are they coming back" and people don't think they're coming back. So, you have a workforce that's 100% pre pandemic and then its lower post pandemic, we're we have diminished capability capacity, so how can we collectively in health care readiness, support the coming responses with a diminished health care workforce in terms of its numbers. And then also work to add to get back up to sort of like a level playing field like back to 100% of what it was preparing them and I, you know when. To ignore that, moving forward in health care readiness, again whether or not it's inserted or how it's inserted in the capabilities is a moot point, but it needs to happen. One way or another. So, my editorial comment there.

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Kirsten Albers: Great. The last comment I'll flag here, and feel free to continue putting comments in here about the capabilities, even as we transition on, but I've seen a few comments in here about alignment between the PHEP capabilities and the health care capabilities that we're discussing today. You know, I think that's I think that someone flagged it specifically for ESF eight coordination, and I think that is something that we're definitely looking at as well, so appreciate those suggestions. I think, from here we can turn it back over to you, Jennifer. I will flag, it looked like there was one question that came in at the end, Jennifer, that asks "when do we anticipate that the BP four application will be available, which I think is a question, more for you, rather than our specific capabilities discussion.

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Jennifer Hannah: Yes, I saw that come in, thank you Kirsten and thank you, Dr. Hunt. And thanks to all of you, of course, for the for the great feedback that you have provided so far, regarding this initial conversation and dialogue regarding the update to the ASPR Health Care Preparedness and Response Capabilities. I was not surprised about the response rate on all of the discussion questions. It sounds like people are interested, so I'm pleasantly surprised and thank you for validating my initial thoughts about this particular conversation. But to move on to one of the questions that asking about the status of the FY 22 Budget Period four non-competing continuation application instructions for the Hospital Preparedness Program cooperative agreement, we are working very quickly and diligently on incorporating some of our internal feedback, and then also incorporating the flexibility regarding MRSE into that so that we can move the application instructions forward for grants management and our council to review. Our desire was to hopefully get that out by this this week, but it's more likely going to be early next week so we are committed to getting that out as soon as possible, so that you will have the maximum amount of time to be able to respond. You'll still have the 60 days to respond as all of you, as everyone knows, are currently in continuing resolution and are still awaiting our final budget numbers, so it'll be a two-part application. One is for the initial application, based on your Budget Period three work plan and budget numbers. But then we will keep PERFORMS open until we receive the final budget numbers, and then you'll be able to make changes and make any revisions based upon those final budget members. That information will also be included within the continuation application instruction. I also saw a number of questions that were part of the capabilities discussion about the RLDC, and for those that may not know that is the recipient level direct costs, we will be revisiting the RLDC as a part of our planning for the new five year project period for the for the HPP cooperative agreements. So, your comments are noted there

as well as the challenges that you have encountered, related to the CAT. But that will also be a part of the conversation as well. And I think we will see if there any additional questions. As was said, this is a time when you can ask questions from our presenters, but then also any general questions that you may have. It's not limited of course to the to the HPP recipients. It's for all the recipients that are on the on this particular call. You can either enter your question in the chat or you can raise your hand and you'll be unmuted to be able to ask that question. Ok, I see here that. I have a question that just came in regarding the BP three reporting requirements and flexibilities aren't listed on the HPP website to go with the BP two and BP one. We're currently working on those, I know it's pretty late within BP three, but we will get those flexibilities posted as well. Many of the flexibilities related to the BP three, were included with the continuation application instructions or for BP three. But we'll make sure that those get posted as well. And I have a question here regarding what is the next milestone for the ASPR grant funding report. And Jennifer, if you wouldn't mind letting me know which cooperative agreement you're referring to as we have all recipients on this call. In the interim, if others have questions, please feel free to ask questions. Okay, while we're waiting for that follow up clarification, we've got a question here is that says, "what is the timeline for determining the leaning towards a MRSE extension?" In the coming days I'm actually going to put out the official guidance, basically, what I what I said is probably what is going to be the flexibility that will be in place. I just want to make sure that we have all the i's dotted and the t's crossed, as far as the language for that. And we will put out some official information and will communicate that and socialized that via the Bulletin, which, hopefully, all of you are subscribers to, and then the language will be included in the BP four application instructions for the Hospital Preparedness Program cooperative agreement. Thanks, Jennifer, for clarifying your question regarding what the next milestone is for the ASPR Hospital Association cooperative agreement funding report. The next milestone will be the end of year report. We know that the current Budget Period for the hospital association cooperative agreement ends April 9th of this year and then the end of your report is typically due 90 days after that. So, we anticipate that CAAMP will be back online, and we will provide information in an announcement, for when that end of year module opens for you to submit your end of year end of year data. And we'll give you ample time to be able to respond and to provide the responses and report on those performance measures for the Hospital Association cooperative agreement. Okay, are there any additional questions?

Okay, so there was a question here asking "is not the next milestone, the surge estimator tool?" So, the surge estimator tool applies to the Hospital Preparedness cooperative agreement recipients. We did provide information regarding the surge estimator tool, that we would not be collecting that while we are in the process of reexamining the MRSE to see how those two will work together, and if it will be needed. So, the surge estimator tool which would have been due this this year on March 31st, we have waived that. And that way we'll also make sure that is included within those BP 2 flexibilities that was already requested. A great question.

Okay, seeing that we are about three minutes from the from the top of the top of the hour. Of course, you know feel free to send your questions to the resource mailbox HPP@hhs.gov, but we're going to move to our final slide. Next slide.

Thank you so again, thank you to all of our presenters for their time today and for your very active participation in today's meeting. As a reminder, we invite you to share any stories regarding how you or your sub-recipients are using ASPR funding to make a positive impact on your communities. If you have a story to share, please fill out our Stories From the Field

Submission Form or reach out to your FPO for more information. A member of our team will drop the Story From the Field Submission Form link in the chat for easy reference.

Of course, we look forward to hearing about all the great work that you are doing, we know that's already been stated throughout this call, but we know that this has been a tough of couple of years, but you keep doing what you're doing tirelessly. So, it goes without saying we would be remiss if we didn't thank you all, for the hard work that you are doing. Not only during this response but with all of the other responses you just been great with the overwhelming amount of work that you are being asked to do on a daily basis, but we certainly appreciate your partnership with us and, of course, if there's anything that we can do to assist you, to improve our programs, and to help you, please let us, let us know. And with that, we are going to conclude our call about a minute early. Again, want to thank everyone for your participation. Have a great day. We look forward to meeting with all of our recipients again in this particular venue next quarter. So, thanks everyone and have a great day.