ASPR Health Care Readiness Cooperative Agreements All-Recipient Webinar Transcript

August 10, 2022

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Jennifer Hannah: I am Jennifer Hannah, Deputy Director of ASPR's National Health Care Preparedness Programs, or NHPP Branch. And to begin today's call our provide an overview of our agenda. First, I will provide a few ASPR Health Care Readiness Portfolio announcements. Then I will pass it along to Shayne Brannman from ASPR TRACIE to provide resources an activity update. Dr. Ron Miller from the Office of Resource Management will provide a US Stockpiling Plan Project update. Finally, Commander Eva Mclanahan will provide an update on the Monkeypox Response. We will conclude today's call with general Q&A and closing remarks. First, I would like to start by sharing a few administrative updates. In July, ASPR was elevated from an HHS staff division to an operating division. This puts our organization in the same category as other HHS teams with core operational responsibilities such as the Centers for Disease Control and Prevention, the Food and Drug Administration, the National Institute of Health and the Administration for Children and Families among others. This change allows ASPR to mobilize a coordinated national response more quickly and safely during future disasters and emergencies. This change is an important next step for our organization, which has continued to grow and evolve since its creation in 2006. The pace of which has quickened over the last year. Moving forward, we will be known as the Administration for Strategic Preparedness and Response. The adjustment to our name signals our elevation to an operating division, while maintaining the equity and brand recognition, we have built with key internal and external stakeholders. Although this is an important milestone for our organization, we know that we cannot succeed without collaboration with our partners across HHS as well as all of you. Finally, we look forward to continuing these relationships and improve as an organization now as the Administration for Strategic Preparedness and Response. Next, a new Regional Emerging Special Pathogen Treatment Center Cooperative Agreement Notice of Funding Opportunity is expected to be released in the coming days. If you have been looking for the announcement on grants.gov, please note there are two forecasts listed, one for this fiscal year and one for fiscal year 2023. Agencies are required to forecast upcoming funding announcements on grants.gov. Additional details are forthcoming and will be announced in the Healthcare Readiness Weekly Bulletin that is sent out every Monday, so please be on the lookout for those updates. In addition, the notice of funding opportunity, or NOFO, will be posted on grants.gov. Next, I would like to highlight recently published Stories from the Field, which showcase the hard work and accomplishments of our recipients, as well as our sub recipients. We have two new stories from the field from Illinois and Kentucky. Both stories provide an example of the diversity of support that ASPR funding offers recipients and sub recipients as a bolster to emergency preparedness and response. To read these stories and others go to the Stories from the Field page on ASPR.hhs.gov. For your reference, a member of our team will share the link in the chat. I will now pass it along to Shayne to provide an ASPR announcement.

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Shayne Brannman: Thank you Jennifer so much for inviting ASPR TRACIE to be a part of the conversation today and for what you do daily to make sure that all the strands of preparedness activities get pulled together in a cohesive manner and what you do for TRACIE daily. To all the folks that are on the line today, thank you. Thank you for what you do daily to help advance the thinking, the preparedness, the response, and the recovery activities in your communities, jurisdictions, states, and at the federal level.

Never before have we had so many demands being placed on us and for what you continue to do daily is truly rewarding to be able to observe it and to be a part of. In addition, you continue to support ASPR TRACIE. I can't thank you enough from the bottom of my heart for that continued support. I have two slides for you to just give you a quick update on some of the resources that we currently have and the next one will be about some upcoming resources. Let me first draw your attention to DASH, which I think you all have heard about this. The Disaster Available Supplies and Hospitals, or DASH, tool. We have a webinar coming up on Monday, and it is sold out. So that's a great indicator of the amount of attention this is a drawing across the nation and thank you for that. If by chance you can't get in and you wanted to register for that webinar just send us a note to askasprtracie and we'll make sure you get a copy of the recording and are put on a waitlist in case someone drops as well. We'll get the recording out if not that same afternoon the following morning. A special thanks to Dr. John Hick, Jennifer Morocco, and the ASPR TRACIE team. In addition to our partners at healthcare ready, HAIDA, and certainly those at the regional level and many, many SMEs that are on the line today for helping advanced a very complex module suite of tools. What we try to do at ASPR TRACIE is pick up in some small way, the amount of activity that goes on at the local levels to be able to advance health care system preparedness response recovery. You'll see the National Guard response to COVID-19 that gave examples for what happened in Kentucky and also in Connecticut as well as just a quick synopsis of how important the National Guard was to everyone's response across the nation. For those that are awardees the Chemical Emergency Considerations for Healthcare Facility checklist has been updated and disseminated and again, everything is to help advance your knowledge and abilities to be able to meet forecasted requirements and demands. Certainly, we have a number of updated topic collections and new speaker series. I'm not going to go in detail, but you can see here that we have a lot of information and, especially for those that are involved in climate change, the innovations and hospital design speaker series with our colleagues from Penn medicine and Mayo Clinic really gives some insights on how a configuration of facilities is occurring to be able to better manage surge and infectious diseases and other aspects during the days ahead. This is just some of the upcoming resources that we have. Again, we're going to be refreshing a number of topic collections. Special call out again to Karina Solobrito on the ASPR TRACIE team that will be contacting several of you to update those and get your two cents worth as your time permits to be able to advance and continue to update these topic collections. You'll be seeing those in the days ahead as well as again we'll have the presentations and recording for the DASH webinar out to you as well. Just this afternoon we're going to be doing a speaker series on the radiology practice changes during COVID-19 and start to talk a little bit about some of the shortages within the radiology community, including both staffing and the challenges they've had with supplies. I want to give a special call out to Audrey Mazurek within the ASPR TRACIE team who has done a number of the speaker series flawlessly and through a wide gambit of different topics, so thank you Audrey for everything you do. With that I'll hand it back to the wonderful Jennifer Hannah, so she can pass it on to Dr Miller.

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Jennifer Hannah: Thank you, Shayne. We really appreciate those updates, so I will now pass it on to Dr Ron Miller for a U.S. Stockpiling Plan Project update.

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Dr. Miller: Thank you Jennifer. Good afternoon, everyone. So today, I just want to give you an update about where we are in a big broader picture and I'll take any questions you have on the stockpiling plan. Initially I want to do a reminder about the objectives of the stockpiling plan and they are jurisdictional supported and will help not only the federal and the jurisdictions, but will help the nation increase capacity, if we ever had such an event as another pandemic. As we go through this, I'm not going to read through them, but those five objectives remain constant throughout the plan and the process of the project. So to date, we closed the data information gathering session and right now we're reviewing all of the data sets and synthesizing that data. We received data not only from those that went out to the 62 jurisdictions, but we conducted listening sessions with some of the jurisdictions, which they requested. From my perspective, I learned so much on how different jurisdictions stockpile. From not having a stockpile to having a great capacity of support in their state or jurisdiction. So that was an interesting phase and we're still pouring through that information so far. We've developed preliminary methodology considerations that are in draft form. Those considerations will be for the jurisdictions and will be part of the plan in the Appendix. They will say as a jurisdiction builds a stockpile what should they consider. That's what we're building now. What I'm trying to determine is should that be a scoring metho or a weighted approach. I'm still trying to understand what most jurisdictions use, and that will probably be the approach that will put into the plan. And that is currently in draft right now. The annotated outline for the plan is completed, the Federal Interagency working group is reviewing that now, and they are commenting on it. I hope to have that back, no later than tomorrow close of business to start going in and drafting a plan based off that annotated outline and adjudicate their comments. And where are we headed. This is the interesting phase of the project. This is what we started writing, so they're going to be back and forth with interagency work group partners and federal agencies as we go through this, how they want it drafted, what they want said and stated. We provide periodic updates to the White House and we just had one last week. Once the plan is drafted by the end of September, it will be turned over to interagency work group for their review and comment. Then we will adjudicate those and put into the formal review process where every executive federal agency will be able to review the document and then we'll have that back mid-October to adjudicate all the comments and release a plan in late November. That plan will be formal law, signed by not only the HHS Secretary, but the Secretary of DHS and possibly the Department of Defense, as incorporated with the national strategy, we want to use the same signatures for this plan. Formal discussions and next action briefs will start occurring when the plan is finalized. What that means for the jurisdictions is you'll be able to look at the plan, review it, and you'll be able to come back to us. What that will do is help us when we're into the implementation phase of how we implement that plan, which could be something as testing out the plan and selecting a couple of jurisdictions to test to see if that plan would be viable if they had resources and a stockpile that is outlined in the plan. That’s where we are and that's where we're headed. Once project managers near the completion of the project, you start to breathe a sigh of relief and see the light at the end of the tunnel. I'm ready to pass this plan on, so the jurisdictions can have it for their planning as well. I'll pause for any questions or comments.

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Jennifer Hannah: Before you turn it back over to me, we have one question for you. Once the plan is completed and provided to the to the various jurisdictions, what will be the timeline for the implementation or is there a timeline?

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Dr. Miller: There is currently no timeline, and I say that because the implementation phase has multiple phases within it. It's where we go to Congress, talk about resources, funding, how to increase grants in a recommendation as well as we're going to recommend stockpile calculations to the jurisdictions and how they work to get those and how they accomplish those. I would say, we probably won't start any formal implementation until early spring of 2023, so we can do it right. Because we're going to need jurisdictional feedback once the plan is out and we're going to set a timeline for that, receive that feedback, and incorporate some of that feedback into the implementation phases.

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Jennifer Hannah: Will you be gathering that input from the jurisdictions in between the time the plan is released and the implementation?

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Dr. Miller: We will coordinate that through the ASPR regional MRSE coordinators, so they will reach out to their respective jurisdiction points of contact to share the plan and receive their feedback.

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Jennifer Hannah: Thanks. Another question that has come in is, is there any anticipated plan to expand on the idea of ASPR's newly released, this might have been for Shayne, disaster available supplies in hospital, or DASH tool, as you look to assess state and jurisdictional stockpiles, inventory, and other aspects. It might be a combined question there.

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Dr. Ron Miller: From our perspective, we will not go below the jurisdictional level. We won't go below the state because once we start getting into local governments and private sector facilities, there are various authorities across the nation and there's no way we can touch all of them, but we will coordinate that with the states as part of the recommendations.

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Jennifer Hannah: Thanks, Ron. Eric, we will also send your question over to ASPR TRACIE. Shayne wasn't able to stay on the call, but we'll make sure that she received that question and will address it from the perspective of ASPR TRACIE. It actually looks like it was not for Shayne, but it was an add on to that question, Ron, that was saying a roadmap tool like DASH would help establish common methodologies.

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Odessa Magafas: Jennifer, we also have a question here from David Miller that says, what about directly funded cities. Dr Miller, I think that one is for you as well.

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Dr. Miller: They are considered as a part of one of the 62 jurisdictions before directly funded cities. They are included in the plan as one of the recognized jurisdictions.

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Jennifer Hannah: If you have any questions for Dr. Miller, please enter those into the chat or raise your hand and a member of our team will open your line to ask your question live. We'll pause here for about 30 seconds. I'm not seeing anything else in the chat. Thank you, Dr. Miller, for your update and we look forward to future updates as well. We really appreciate you sharing this very important information. With that we're going to now pass it along to Commander Eva Mclanahan for a Monkeypox Response update.

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Eva Mclanahan: Thank you very much Jennifer. I am a Senior Health Advisor for ASPR and the Liaison to the CDC, so I'm providing this update today on behalf of CDC. You all may have some varying degrees of understanding about monkeypox, so to get us all on the same page, monkeypox virus is a zoonotic pox virus disease that closely resembles smallpox. It t was first described in wild caught laboratory monkeys and confirmed as a human disease in 1970. Patients infected with monkeypox are typically ill for two to four weeks, and there are two known monkeypox virus, the West African and the Central African or Congo Basin. Historically, although the West African monkeypox virus infection generally causes mild disease, it may lead to severe illness and some individuals. And the case fatality rate for the West African is around 1% while it may be as high as 10 or 11% for the Congo Basin for unvaccinated individuals and an immune deficiency appears to be a risk factor for severe disease. In 2003, there were 47 confirmed and probable cases of monkey pox from six states in the United States, this was the first outbreak of monkeypox in the states. And all people infected with monkeypox in this outbreak became ill after having contact with pet prairie dogs. And the pets were infected after being house near imported small mammals from Ghana, this was the first time that human monkeypox virus reported outside of Africa. Since then, in July and November of 2021, cases were identified and individuals who had recent travel history to Nigeria. These were just two cases, one in July and one in November Contact tracing and precautions took place and no additional cases were identified. This slide shows the list of clinical presentations from historical cases compared with the current outbreak. Of note the symptoms, such as fatigue, headache, or a fever are not always occurring in the current outbreak. Also, lesions are being first found in the genital and perianal areas sometimes without dissemination and overall number of lesions is lower. Proctitis associated with severe pain is also commonly noted in the current outbreak. The reasons for the unusual presentations are unknown at this time, and it could be something to do with the route of exposure or the circulating viral strain, a lot of research is ongoing. We all like pictures, so here's a few of the cleaner pictures and examples of lesions from the current outbreak, so these have been published as folks are reporting more cases throughout the world. There are some additional complications that can occur as a result of monkeypox infection and those are shown on this slide. I've heard reports during this outbreak of sepsis, ocular infections, and there have been a few deaths, though none in the United States to date. Next, I'll dive into the current outbreak. Between May 7th and May 16th there were three unlinked confirmations of monkeypox in the United Kingdom. On May 18th, the first United States case of monkeypox in this current outbreak was confirmed. And since then, the CDC stood up their program and center-level responses mid to late May and activated the CDC Emergency Operations Center to provide additional help with communication and staffing of the response at the end of June. As of August 9th there have been 9,492 cases in the United States, including 51 jurisdictions that have been impacted, that's 49 states and the District of Columbia and Puerto Rico. The top five jurisdictions with the most cases are shown in the table to the right, so that's New York California, Florida, Georgia, Texas, and Illinois. As of August 4th the doubling time for the virus was 9.3

days, however, for areas that had more than 25 cases it was reduced to 8.6 days. The median age of individuals infected is 35 years, but it ranges from very young pediatric cases to 89 years old. There have been a handful of pediatric cases in the United States. Male sex at birth was 99% of the cases and those that were infected. 94% of them reported male to male sexual contact and 41% of the cases were HIV positive. These data statistics are updated every Wednesday on CDC website, so you may see some new ones coming out this afternoon. This just shows the map of the United States, so you can see that Wyoming is the only state that has not reported any cases in the United States, and this is also on CDC website, if you want the graphics. They're updated frequently. This is the EPI curve as of August 4th, showing the 14 day moving average and there's not much slowing down right now. Also, as of August 4 this slide shows the race and ethnicity of affected individuals, the Hispanic, white, and black populations are almost equally affected during this outbreak. Globally, there have been 31,425 cases identified in non-endemic countries with the top four countries being the United States, Spain, Germany and the UK. There have been no changes in the top four countries in the last few weeks. In the past seven days 6,377 new cases were identified in 58 different countries, so a total of 82 locations are impacted with Moldova reporting their first case this week. And to date worldwide, there have been five deaths reported in non-endemic locations. Over the last week, Ecuador recorded their first death. Reports indicate that this individual had some pre-existing illness or condition, but we are not sure what it was just yet and it has not been reported. CDC is doing more investigation. Peru retracted a death, it was earlier reported and said that while that individual did test positive and had monkeypox they did not die from monkeypox. They instead died of advanced HIV and sepsis, which was the decision by the Peruvian authorities. Testing for monkeypox in the United States, lesions are the specimens that are used for laboratory diagnosis. They're swabs and we have a capacity to test 80,000 samples per week, using the laboratory Response Network and commercial labs that were brought on board in the last month. There are more details in case you want to know the details of laboratory testing, but most importantly of probable cases defined as being orthopox positive via PCR because we don't have any other orthopox viruses circulating right now that we know of. Confirmed cases of positive for monkeypox is if it has monkeypox-specific PCR testing or sequencing analysis. This slide shows the positivity rate on the right y axis among the select laboratories over the course of the outbreak. You see we're hovering right around at 38% positivity right now. There are currently two treatments for monkeypox in the United States. We have TPOX and it's available for oral and IV administration. It has an FDA EA-IND, or persons with or at risk for severe disease. There's also the Vaccinia Immune Globulin, which can be administered via IV also under an EA-IND. We also have two vaccines available. Jynneos is licensed for adult post-exposure prophylaxis, or PEP, and pre-exposure prophylaxis, or PREP. Currently, the CDC is not encouraging mass vaccination for the general public, or for all sexually active people. While Jynneos' vaccine supplies remain limited, widespread implementation of PREP is not feasible. However, in some jurisdictions consideration of monkeypox vaccine prep for individuals that increased risk of monkeypox from non-occupational exposure might start to be considered. A vaccine is also available from the CDC drugs services for those that are at risk through occupational exposure, so that is for laboratorians. States are provided allocations of these vaccines, which I'll cover, thus there are some differences in state strategies and access to vaccines, as a result. For children, right now, they may be vaccinated under a single patient E-IND Ind there is an EA-IND being developed by FDA at this time. That's all about the Jynneos. The next vaccine is the ACAM 2,000 and this one was used historically in the past for smallpox. It is available from the strategic national stockpile. However, it has not been used in this current outbreak due to the significant adverse event profile. Yesterday, from the joint press briefing at the White House, FDA

announced an emergency use authorization for intradermal administration of the Jynneos vaccine. At the same time, the CDC released the interim clinical considerations for the use of Jynneos during the 2022 US monkeypox outbreak. The EUA announcement yesterday authorizes healthcare providers to use Jynneos via intradermal injection for individuals 18 years of age and older, who are determined to be at high risk for monkeypox infection. This will increase the total number of doses available for use by up to five-fold, and this is a game changer as it was dubbed in the briefing yesterday. Most of you are used to what's considered a subcutaneous dose. The intradermal dose is similar to the tuberculosis skin test. The EUA allows for the use of the vaccine and individuals younger than 18, but those individuals do still receive the subcutaneous injection and two doses are given 28 days apart. You may be asking why this change all of a sudden from subcutaneous to intradermal and a lot of data has been reviewed since the start of this outbreak and the data from the 2015 clinical study of the Jynneous vaccine, which evaluated a two dose series that was given interdermally compared to subcutaneously. The individuals who received the intradermal dose received a lower volume, one fifth of that of the individuals who received the vaccines subcutaneously, and the results of this study demonstrated that the intradermal administration produced a similar immune response to the subcutaneous administration, meaning that individuals in both groups responded to the vaccine in a similar way. In addition, CDC in the next coming few days has a lot of related resources in the pipeline, including a template for standing orders for both the alternative and the standard dosing regimen, storage and handling information, preparation and administration materials, frequently asked questions for the public and for consumers. There will also be graphics, videos, and teaching tools for providers to do intradermal administrations, so those will be posted on CDC's resource website and I have all of those coming up for you, in the end. This is an example of what you'll see on the CDC website and it's listed there to have the interim clinical considerations. On the right side, table two shows the alternate regimen, as I just said, the intradermal administration can be done for people ages 18 and over while the standard regimen is for those less than 18 or have any history of developing keloid scars. HHS including ASPR and the CDC are working together to allocate Jynneous vaccines to meet the needs of at risk individuals and prioritize the hardest hit jurisdictions, which have a high case burden and transmission rates for monkeypox. Currently, HHS is making 1.1 million vials of Jynneous available for free in US jurisdictions. We've recently adjusted the algorithm, so now we're determining allocations based on 25% on case burden and 75% based on the at risk population. They're also reserving a small amount of vaccine for federal entities. Using this algorithm, HHS recently announced the additional allocation of 786,000 vials of Jynneous on July 28th. Jurisdictions were notified of their full allocation on the 29th and ordering began that same day starting on July 29th. The allocations were made available in three waves. We are still in the first wave, so they're taking place over the next four to six weeks based on the review of the status of the outbreak and vaccine administration The first wave started July 29th and jurisdictions can order up to 40% of the amount they were allocated. The next two waves, states will be allowed to order 30% of their full allocation in each wave and the second wave is slated to be on August 15th. And the final third wave or 30% will be available later in August pending an assessment of the outbreak at that time. However, regardless of the date or wave that were in any jurisdiction that can show that 90% of their doses were administered to the intended population can have immediate access to the next part of their allocation. There's a few key issues and questions still remaining in the public health response and some things that CDC is working on and maybe you can take back to your organizations and jurisdictions as well. We're working to characterize the epidemiology of this, including the transmission parameters or asymptomatic possible transmission. There's also a risk of it going from the human population to

animals here in the United States, could it possibly become an endemic here, all the unknowns. They're also working to characterize better the clinical presentation among individuals with HIV and other co-occurring conditions. They are also looking at the illness severity here in the United States. As I said earlier, they are swabbing lesions to test for specimens for diagnostic use. They are trying to see if there are other specimen types that they could use for a diagnosis. We are doing a lot of viral characteristics, looking at genetic sequences and biological properties of the virus. Trying to determine the effectiveness of TPOX treatment and the effectiveness of the vaccines. The vaccines have not been tested in this current outbreak, so we do not know the vaccine effectiveness, that cannot be determined, much like you don't hear until later in the flu season how effective the flu vaccine was. They are also ensuring equitable access and care to vaccines and as I'll talk about it more on the next slide minimizing the stigma for affected populations. The CDC really encourages equitable distribution and access to the vaccines, which includes engaging people from affected communities, planning for vaccine programs, and considering ways to prioritize the populations that are less able to access vaccines, so this is things like holding slots for a particular community-based organization during large vaccine events, doing some more mobile outreach, things like that. CDC is using guidance from our work in HIV and sexually transmitted infections to ensure that we are not further stigmatizing any of the gay and bisexual male community, so keeping the messages fact-based can really help reduce stigma in disproportionately affected populations. The CDC really does emphasize that anyone can get monkeypox and it needs to be promoted as a public health concern for all. One of the biggest lessons learned from HIV is that is critical to have the community most affected involved and ideally leading response efforts, so in this case gay and bisexual men are at the forefront of this response due to the current epidemiology of the outbreak. We've put added emphasis on identifying and using specific channels that will directly reach them across racial, ethnic, socioeconomic, and geographic backgrounds. The CDC is working with community health organizations including multiple partners in the LGBTQIA+ community as well as public health and healthcare partners to raise awareness of the outbreak and share accurate information about what people can do to protect their health and the health of others. Really combating a lot of mis/disinformation, these days, is quite a challenge. We're using listening sessions to promote dialogue, so that we can hear the concerns and needs of these groups, get feedback on products and strategies, and provide updates and information as needed. Here are a few updates that if you're interested in the monkeypox response you may choose to call in. There's the HHS and our intergovernmental and external affairs weekly monkeypox briefing every Thursday at 2 PM EST. You can register to get those invitation. There's a CDC monkeypox partners update every Thursday at 1 PM EST. It's on Zoom, so you can just use that link there's no registration. Then my typo on this one, there's the COCA calls coming up. The clinician outreach doesn't have a set cadence, but they are planning a call for August 11th at 3 PM EST. I encourage you to go to the CDC website to find more information on that call. I just listed a few of the important websites on CDC's page where you can get what CDC is doing the current cases in the United States and globally, what's going on with vaccines, infection control in healthcare settings, frequently asked questions, and then also ASPR's response to the monkeypox outbreak, which includes what's coming out of the Strategic National Stockpile. Then I'll always put a plug in for ASPR TRACIE and the work they do to compile the monkeypox resources. They're a great resource for you as well. With that I'll take any questions you might have and if I'm unable to answer them then we will direct them appropriately. Thank you very much.

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Jennifer Hannah: Again, as a reminder, if you want to ask any questions to Commander Mclanahan please enter that into the chat or raise your hand and a member of the team will lower your hand and allow you to ask that question live. We got our first comment that says thanks to Commander Mclanahan for the very informational presentation.

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Odessa Magafas: Jennifer, I received a message that asked about funding for monkeypox, if COVID-19 funding could be carried over to for monkeypox response.

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Jennifer Hannah: That's a great question. Funding is a question that we are getting asked every day several times a day. The answer right now is no for using COVID-19 funding to monkeypox, but know that the question on funding is being brought up on the Hill quite frequently, so stay tuned. We'll give it another 30 seconds or so, to see if we have any questions or comments entered into the chat or if anyone wants to ask a question. One thing you may have noted in the Healthcare Readiness Bulletin each week is we try to keep the most up to date information regarding any partner updates related to the monkeypox response and, as the Commander stated, it will be on the CDC's website. If you have any questions after this webinar please feel free to send those questions to aspr@hhs.gov and we'll make sure they get to the Commander or sent to CDC. I'm not seeing anything in the chat now, so we'll go ahead and move to opening our line for any general questions that anyone may have. Again, please drop your question in the chat directly or raise your hand and we will lower your hand, so that you can ask your question live. I know shortly after the administrative updates someone asked me to repeat the information regarding the upcoming Notice of Funding Opportunity in the next few days. It will be for the Regional Emerging Special Pathogen Treatment Centers Cooperative Agreement You may have known them previously as the Regional Ebola and Other Special Pathogens and Treatment Centers, but we will be changing the name to Regional Emerging Special Pathogen Treatment Centers. In the coming days, we will be releasing a Notice of Funding Opportunity to expand that network and we will include that announcement in our weekly Healthcare Readiness Bulletin once the Notice of Funding Opportunity itself is posted on grants.gov. Again, we're opening the call now for you to ask any question that you may have for any of our speakers or anything else that has come to mind that you may want to ask.

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Odessa Magafas: Jennifer, we actually received a question in the chat that asks if the CAT will open briefly in early September. Tim noted that it is locked down now and, at least in Wisconsin, they are still executing sub award contracts and the final work plans will not be able to be uploaded within 30 days, so September would be ideal.

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Jennifer Hannah: I actually don't know the answer to that question, right now, but I will certainly get an answer to you. I was thinking that the CAT may be reopening later this month, but don't quote me on that/ We will capture this question and make sure that we send you a response related to that. Apologies for not knowing the answer on the top of my head right now. And I did see another question or information here within the chat that was a question regarding the update on the HPP Notices of Award. The HPP Notices of Awards were released last week and so please check your grant solutions

account for that notice of award. All of the 62 awards were released last week and responses into any conditions of award are due September 16th. And Eric, thank you for providing some information here regarding the CAT, which will reopen from August 22nd through the 31st. And Tim, I see your additional message here, so please reach out to Duane Wagner, who I believe is your field project officer and we'll see what we can do offline related to that. I see a message in the chat from Michelle Hale. Thank you for the updated performance measure guidance, do you know when it will be posted on the ASPR website. Michelle, are you thinking of the training guidance or the implementation guidance?

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Michelle Hale: Whichever one you shared with us a couple of weeks ago.

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Jennifer Hannah: I know the training guidance has already been released regarding the BP3 or FY 2021 end of year performance measures for that performance measure module. Regarding the HPP performance measures implementation guidance, it is currently being made 508 compliant and then it will be posted on the ASPR website. Your comment regarding how it will be helpful to have the BP3 flexibilities posted there as well, we will make sure the BP3 and any of the BP3 flexibilities are posted. In addition to that, we will be posting any of the BP4 requirements and then, as the BP4 progresses, any benefits or flexibilities that we implement we will make sure those are posted on the website as well. And I have another question that asks to please repeat the CAT open dates, August 22nd through the 31st. I don't see any additional questions right now, but we will certainly pause. If you have any questions, please enter them into the chat or raise your hand and we will lower your hand, so you can ask that question. We still have Dr. Miller on the call and Commander Mclanahan as well, if you have any questions or comments for them. Someone just asked about the HPP Notices of Awards. The HPP Notices of Awards were released last week, if you did not receive your notification for it, please email your assigned field project officer or you can email me and we'll get you a copy of the Notices of Awards.

00:50:30.240 --> 00:50:46.320

Odessa Magafas: Jennifer, I received a comment or a question for Commander Mclanahan about community spread and recommendations for mitigating community spread as much as possible, especially as we said before, vaccines can be widely distributed.

00:51:02.730 --> 00:51:41.430

Eva Mclanahan: I don't know the official CDC strategy right now, but I will try to compile things that I have heard, which is to really limit multiple sexual partners, if possible and try to limit contact with unknown individuals in an intimate way or people where you don't know their medical history. That's what seems to be what's going on right now. I can look and see on the CDC website if there's additional guidance, but I don't know the official CDC stance on that right now.

00:52:05.340 --> 00:52:17.610

Jennifer Hannah: Just as a reminder, if you have any questions or comments, please enter them into the chat and or please raise your hand and member of our team will lower your hand and you can ask your question live. We will give you about a minute before we move to the closing remarks.

00:52:45.570 --> 00:52:55.740

Eva Mclanahan: This is Eva. I will just add that, on the CDC website, it says monkey pox prevention steps include avoiding close skin to skin contact with people who have a rash that looks like monkey pox, avoiding contact with objects or materials that a person with monkeypox used, and washing your hands often. They do have a website on prevention, safer sex, and social gatherings. I will put that in the chat.

00:53:21.720 --> 00:55:09.240

Jennifer Hannah: Thank you, Eva. We're getting close to the top of the hour, so I'm going to go ahead and move to our last slide. I want to thank our attendees for your active participation today. Thank you to our speakers for sharing your afternoon with us and providing your expertise. Thanks to Shayne Brannman, Dr. Miller, and Commander Mclanahan as well. In the meantime, we invite you all to stay connected with us on our social media platforms and to receive the most up to date information about how ASPR is contributing to healthcare preparedness and response for communities and the nation. And again, thank you for your attendance and we hope to see you at our next quarterly All-Recipient Webinar. Look out for future invites for the next webinar as well as information that is included within our Healthcare Readiness Weekly Bulletin. With that, we're going to end today's call.