

ASPR Health Care Readiness Cooperative Agreements Quarterly All-Recipient Webinar

May 12, 2021

Event Transcript

00:00:10.710 - 00:07:41.670

Jennifer Hannah: Good afternoon everyone and thank you all for joining us today. I am Jennifer Hannah, the Deputy Director of ASPR's National Healthcare Preparedness Program, or NHPP, Branch. It is my pleasure to be with you all today as we present on a few topics related to the future of health care readiness, especially as it relates to building coordinated response networks to prepare for and respond to emergencies. Before we get started, I would like to provide a brief overview of what we will cover today.

First, I will provide a brief overview of the National Special Pathogen System, or NSPS, and then pass it to Dr. Vikram Mukherjee from the National Emerging Special Pathogens Training and Education Center, or NETEC, to discuss the NSPS Care Strategy. Then, we will hear Nicole Kunko, a Senior Policy and Budget Advisor for ASPR's NHPP Branch, provide an overview of the Biden Administration's health care readiness policies. Finally, Matt Watson, a Senior Advisor for ASPR's NHPP Branch, will provide an overview of the regional guidelines.

To celebrate the first anniversary of the National Special Pathogen System, or NSPS, we wanted to kick off today's agenda by providing a brief overview of this nationwide systems-based network approach to special pathogen response and share some of NSPS' accomplishments over the past year. In March of 2020, ASPR officially announced the launch of the NSPS and administered a total of \$350 million in emergency supplemental funding to support its four components, which include 10 Regional Ebola and Other Special Pathogen Treatment Centers, or RESPTCs, 62 HPP recipients and their 55 Special Pathogen Treatment Center sub-recipients, 53 Hospital Associations, and the National Emerging Special Pathogens Training and Education Center, or NETEC. Through NSPS, ASPR supports the urgent preparedness and response activities and needs of hospitals, health systems, and health care workers on the front lines of the COVID-19 pandemic. In the long term, NSPS aims to create a nationwide systems-based network approach for all special pathogens, similar to other hub-and-spoke models that improve patient outcomes, such as the trauma, cardiac, and stroke systems of care. The NSPS was established in response to the COVID-19 pandemic. With support from annual appropriations and COVID-19 supplemental funding, ASPR evolved the former Regional Ebola Treatment Network into the NSPS. Key changes from the transition include renaming institutions for an increased and more explicit focus on all special pathogens, such as rebranding NETEC, which was formerly known as the National Ebola Training and Education Center, to the National Emerging Special Pathogens Training and Education Center and adding hospital associations as a recipient group to more rapidly distribute funds to health care entities without placing additional burden on public health. The NSPS also expanded the system's focus from Ebola to any special pathogen and matured the regional approach into a formalized national system and strategy for special pathogens, similar to other national systems designed to address specific types of clinical care, such as the national trauma system. As the national strategy continues to evolve, the NSPS aims to strengthen health care response capabilities at the local, regional, and national level.

We would like to celebrate the success of NSPS' first year by highlighting some of the work made possible by COVID-19 supplemental funding. First, early in the pandemic, the West Virginia Department of Health and Human Resources launched a COVID-19 information hotline with the support of HPP Cooperative Agreement and COVID-19 supplemental funding. In support of West Virginia's statewide vaccination program, "Operation Save Our Wisdom," this information line has received calls on topics including vaccine registration, vaccination locations, and adverse reactions related to COVID-19 vaccination, as well as general COVID-19 inquiries. This hotline, in addition to the later-developed COVID-19 Vaccine hotline, improved West Virginia's access to critical information when it was needed most. NETEC began hosting webinars on COVID-19 best

practices, response efforts, and guidance for health care providers including those involved in NSPS, such as how to transform normal/positive rooms into negative pressure rooms to care for COVID-19 patients, including pediatric COVID-19 patients. The Missouri Hospital Association has compiled a report that highlights the clinical and operational lessons learned from the COVID-19 pandemic response among Missouri hospitals. Finally, the Nebraska Medicine and Massachusetts General, both RESPTC and Regional Disaster Health Response System, or RDHRS, demonstration sites, quickly responded to the pandemic through a variety of methods. While Massachusetts created a telehealth platform to coordinate remote expert assistance during emergencies, Nebraska conducted over 110 COVID-19 informational events through its standardized, state-wide information-sharing platform, Knowledge Center.

As always, we want to hear about the impact your organizations and sub-recipients have made in response to the COVID-19 pandemic. We use these stories to not only recognize your accomplishments— by sharing them with your fellow cooperative agreement recipients and publicly via our website—but also highlight the value of investing in health care preparedness and response. Please complete our Story from the Field Submission Form to share your story with us, and a member of our communications team will be in touch for more information. A member of our team will insert the submission form link in the chat for easy reference.

I will now pass it to our partners at NETEC to provide an overview of the National Special Pathogen System of Care Strategy.

00:07:44.250 - 00:17:42.480

Vikramjit Mukherjee: Thank you, and hi everyone, thanks for joining this call. My name is Vikram Mukherjee and I am from the National Emerging Special Pathogens Training and Education Center and an intensive care physician out Bellevue hospital in New York and what we will describe over the next 10 or 15 minutes is the strategy that we've been building over the last six months to implement at NSPS in a more broader sense. NETEC, as many of you know, is a consortium of three institutions at Emory Medicine, UNMC and Bellevue hospital. I present these slides on behalf of my colleagues, Dr. Bruce Ribner and Dr. John Lowe.

What we will talk about is the National Special Pathogens System of Care. So the context is that NETEC was tasked by ASPR to develop a strategy and implementation plan, something that ties across the entire nation's health care system to be able to tackle special pathogens. The background is that there is recognition that the existing system is extremely fragmented, uncoordinated, often counterproductive, and very much inaccessible to sectors of society which might need the help the most. So being tasked by ASPR to do this over the last six months, NETEC has consulted with over 70 stakeholders and, with support from Deloitte, developed a framework for the NSPS. What we've made sure is core to our mission is that it is a multi-disciplinary, multifaceted, patient-centered approach with multiple stakeholders across the entire breadth of health care delivery.

So, as you can see, over the last six months, with the help of Deloitte, we have engaged more than 20 organizations and 70-plus stakeholders which have helped drive and form the NSPS strategy build-out. The strategy is based on eight core tenets, which include public health policy experts, emergency responders, academia, clinical health associations, frontline providers, health system executives, insurance bearers, and government agency leaders. We've intentionally included bearers to make sure that this system is financially sustainable as it becomes possible way to proceed. The future system aspiration once deployed would result in better care and improve patient outcomes. Equity across the health care systems is one of the core pillars of our strategy, along with improved allocation of special pathogen care, more efficient response and very importantly, better support for the health care provider and the front line. We know that many of us have been through hell and beyond over the last year, and health care worker burnout resiliency and so on is something that we are trying to target as a primary outcome of the strategy.

Our mission is very simple. The purpose of the system is to provide a coordinated and standardized health care network to provide high quality, patient-centered care for patients suspected of or infected by a special pathogen in the United States. Our vision, the aspiration of the system, is to save lives through a sustained standardized special pathogen system of care that enables health care personnel and administrators to provide agile and high-quality care across the care continuum. By across the care continuum we mean absolutely from the bench to the bedside across many, many different facets of health care delivery. Some examples of aspirational success measures, and these are extremely aspirational, but this is very we're trying to get: we will know that the system has succeeded when we are able to prevent death after special pathogen infection, we are able to mobilize the network in a coordinated way within four hours of a suspected special pathogen infection, and access to the same high-quality special pathogen care across 100% of the U.S. population, irrespective of where your presence is. These are aspirational, but these are some of the success measures that we are putting in into our NSPS strategy.

We have some guiding principles that are built into the NSPS strategy. The future NSPS strategy will have six guiding principles as follows: most importantly, patient centered. Our primary intent is to improve patient care and outcomes. Noting from the ongoing pandemic, we wish to make the NSPS strategy extremely coordinated and collaborative instead of having a competitive, counterproductive atmosphere of responsive so that we're able to adapt quickly to both internal and external forces, and the evolution of the pathogen. We hope to keep members of this NSPS, the stakeholders, accountable holding the system of care responsible to adopt and deliver. Very importantly, make it equitable. We know very well from the current pandemic that certain sectors of society with poorer access to health care have significantly worse outcomes, so equity and high-quality care across all sectors of society, something that we are trying to achieve. Scalable and sustainable, so we hope to provide the same standard of care, whether it be two or three viral hemorrhagic fever patients like Ebola or a pandemic of this realm where we have millions of patients being affected and hospitalized. We hope to provide a way to scale patient care be it a small cohort of patients or a wide breadth or high volume of patients.

So going into the details, we have a steering committee and that constitutes of Dr. Ribner and Dr. Lowe. We have a core advisory group, that has around 20 people from all different facets of health care delivery, but the bulk of work being done this month are by the three tiger teams. Those three tiger teams are the central body tiger team that is being led by Dr. Laura Evans, some of you may know her, the network tiger team that is being led by Dr. Paul Biddinger out of Mass General, and the financial sustainability tiger team that is being led by Dr. Brandon Carr of Mount Sinai in New York City. These are the three challenges that we are trying to focus on over the next few weeks, so that we have a cohesive coordinated NSPS strategy in the next few weeks.

So here is a somewhat of a schematic, the National Special Pathogen System of Care we hope is going to be all encompassing. Not just COVID, not just Ebola, but just all about all kinds of special pathogens. At the core of this strategy would be a central body, which has a huge responsibility of being able to coordinate, being able to hold people accountable and so on. The Health Care Delivery Network, as you can see in this diagram, would be or four different tiers being frontlines assessments, state treatment centers, and then the regional treatment centers expanding on capacity that's already built into the current system. Factoring into all of these bodies is going to be the financing options, where we're looking at multiple options and how to make this financially salvageable, how to make sure that hospitals don't have a disincentive from a financial perspective, and want to be part of this system from the get go.

There's ongoing legislative education that is currently going on, especially because we feel strongly that there is a need for triangulation of NETEC, of the Regional Ebola and Special Pathogen Treatment Centers, of the RDHRS and any new initiatives that are coming out of this current administration needs to be well synchronized and well-coordinated , so that it falls within the same umbrella of special pathogen care. Later this month, on May the 18th, we have a tabletop exercise testing the core features of the NSPS. The final plan is to deliver a strategy and implementation

plan over the next few weeks. In early June you should have a final version of the strategy and implementation plan coming out.

Sorry if this is text heavy but the strategy would essentially describe the future organization design of the NSPS. Closing the gaps, recognizing the vulnerabilities of the current system and closing those gaps and then, of course, how the NSPS will work alongside existing systems? We do not want this NSPS to work in isolation, in a silo, we want this to be as cross-connected as possible, with the RDHRS, with the infectious disease critical care team, and other already-existing entities and the adoption part, which will include implementations defining how to reach the success measures, socialization campaign, and future steps forward.

Following this will be an implementation plan, and this will also include an executive summary and approach prioritizing the objectives and then an implementation plan for each of the NSPS strategy outcomes, which include care delivery, stakeholder communication, supply chain, financial sustainability, and so on.

And the conclusion would be that we would lay out a plan that how this NSPS would be deployed in the next one to three years, including accomodating for future initiatives, high-level next steps, and so on. So, just a summary, a lot of work has been put in. We've engaged with multiple stakeholders across all sectors of health care delivery and the next four weeks are going to be exciting because we will have a mature product out for public viewing in the next month or so. Thank you for your patience. Happy to answer any questions about these slides.

00:17:53.400 - 00:18:54.180

Maria Ramos: Just a reminder to everyone, you can feel free to submit any written questions through the chat box, or if you prefer to ask the question live, feel free to raise your hand and we can unmute you.

I am seeing no questions come through. If you do find that you have questions as we move further into the presentation, please feel free to send it to us through the chat or let us know, and we can certainly come back to those at the end of the webinar. Without further ado, I will pass it over to Nicole, for her presentation.

00:18:55.980 - 00:22:49.350

Nicole Kunko: Thank you. Good afternoon, everyone. My name is Nicole Kunko, and I am a strategic Policy and Budget Advisor supporting the ASPR National Healthcare Preparedness Programs Branch. Before the election, President Biden identified a set of day-one priorities that he stated he would tackle within hours of taking office. Some of those are changing the course of the COVID-19 pandemic and protecting public health, providing economic relief and support to working families, tackling climate change, creating good union jobs, advancing environmental justice, advancing racial equity and supporting underserved communities and ensuring the government works for the American people. As early as February 4, 2021, each of these priorities were addressed with executive action. Additionally, the first few months of the Biden-Harris administration, President Biden signed the \$1.9 trillion American Rescue Plan into law, which changed the course of the COVID-19 pandemic and aid the country's workers.

The Biden-Harris Administration has been busy at work tackling their key campaign priorities, including policies to combat COVID-19 and strengthen public health and medical emergency response efforts. Over the first 100 days plus, the administration has executed many of their policy initiatives through executive orders, memorandums, notices, and proclamations, several of which will impact the health care readiness space.

With the COVID-19 response as his top priority, President Biden signed several executive orders to tackle the pandemic within his first 24 hours in office. This included mobilizing more Federal resources, expanding testing and treatment, and fortifying the domestic supply chain for critical

supplies like PPE. Additionally, the Administration is seeking to allocate funding towards future pandemic readiness. Most recently, they announced the American Jobs Plan, which includes \$30 billion in new investments in medical countermeasures manufacturing, research and development, and related bio preparedness and biosecurity.

Summarizing these policies, the Biden-Harris Administration has been working to strengthen the domestic supply chain, mobilize federal resources to accelerate the vaccination campaign, which you all have been a part of, increase coordination in the response, improve data-driven decision making, and bring equity and access as well as the climate crisis to the forefront.

Going one level deeper, we can see those themes being executed across various priority areas. While COVID-19 is certainly top of mind, some areas that will likely last beyond this current pandemic include a shift to more domestic sources for medical supplies, a continuation of select coordination structures and partnerships, a highlighted need to improve digital infrastructure and interoperability, reassessment of health care worker needs, and incorporation of health equity and environmental justice considerations. That's a quick overview. I think we're going to have questions at the end, so I will now turn it over to Matt Watson to discuss the Guidelines for Regional Health Care Emergency Preparedness and Response Systems. Thank you.

00:22:52.710 - 00:31:15.540

Matthew Watson: Great thanks so much Nicole. As Nicole mentioned, my name is Matt Watson, and I'm a Senior Advisor for ASPR's National Healthcare Preparedness Programs Branch. I'm here to give a quick overview of a project ASPR is currently working on regarding the development of regional health care emergency preparedness and response guidelines. Some of you may already be familiar with this effort as we have spoken about it on previous webinars, but for others we know this is new.

Given the outstanding work done by the Regional Disaster Health Response System, or 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. 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.

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.

Alright, I think I'll stop there. We certainly welcome your feedback as we move forward in this process. Now I just want to leave a little bit of time to take any questions that you might have.

00:31:18.600 - 00:31:38.370

Maria Ramos: Thanks Matt, it looks like we have one question submitted in the chat from Eric. He asks: by regional, are you planning to work at the ASPR regional level or at the state-defined HCC regional level, or at some mid-point that may be associated with cross-border metro-based regions.

00:31:39.360 - 00:32:14.580

Matthew Watson: That's an excellent question and certainly an important one. So the simple answer to that question is that, by and large, we meet at the ASPR and HHS regional level. However, we also recognize that there are probably elements to regional planning that are applicable at levels lower than that, so I know it's not the cleanest answer in the world, but we're taking our starting point at HHS regions and we'll go from there.

00:32:18.120 - 00:32:30.180

Maria Ramos: It looks like Eric sent a follow up. He said: if the plan is for rollout at the ASPR regional level, what you're proposing is essentially a Health Care Coalition comprised of cross-state representation.

00:32:31.950 - 00:32:45.930

Matthew Watson: That's certainly one way to think about it, and we should also say that the Coalitions are going to be absolutely critical as a building block for this concept, so much more to come, but thank you for the question.

00:32:59.850 - 00:33:43.980

Maria Ramos: It looks like there's no other questions in the chat right now, and certainly we welcome any questions from the audience for this Regional Guidelines presentation, but certainly if you have some from earlier in the presentation on the National Special Pathogen System and certainly would be open to that as well.

We did receive a question earlier in the chat from Dan. He asks: with the Hospital Association final report upcoming, is their continued funding expected to support associations' role? Jennifer, not sure if you want to weigh in on that one.

00:33:45.480 - 00:34:37.260

Jennifer Hannah: Certainly and thank you for that question. You know, at this time, we are unaware of any additional funding for the for the Hospital Associations. Keeping in mind that for that particular award, the project period and the budget period is five years. So, with the Hospital Associations, you still have another four years to continue your work and also expend those funds that were awarded, though the upcoming report isn't a final report, but rather it is the end-of-year report for this current budget period. If the funds are still on that award, then you can certainly continue work and continue to expand those funds for another four years.

00:34:41.370 - 00:34:46.080

Maria Ramos: Great Thank you Jennifer. Vikram, did you have something you wanted to add?

00:34:47.430 - 00:35:41.400

Vikramjit Mukherjee: Thanks. Josh Tobin messaged me a question. I just wanted to clarify that. The question was: could you spell out the difference between a preventable and non-preventable death.

Essentially, the context is that if someone presents to the hospital so advanced in his or her disease phase that irrespective of what you do, the patient might not have a good outcome, we would classify that as a non-preventable death. Preventable death, especially in the world of special pathogens is relevant because we really want to avoid frontline ED providing an altered standard of care because someone has Ebola and no one's going to treat the patient, or what have you. So that's the difference between preventive and non-preventable and very much relevant in

the world of special pathogens, because you want to make sure every patient whether Ebola or malaria, has the same standard of care delivered to him or her. I hope that helps.

00:35:46.650 - 00:36:03.420

Maria Ramos: Great, thanks Vikram. We did have a couple more questions come in the chat and so going back to a follow-up question from Dan, and I assume this is regarding the Regional Guidelines presentation, he asked: can you elaborate on the role of Hospital Associations into the future, please? Matt, would you like to weigh in on that one?

00:36:08.250 - 00:36:22.620

Matthew Watson: You know, I think that may be actually more related to an earlier conversation. Given that the question was about Hospital Associations, I don't know, Jennifer do you want to take that one?

00:36:26.190 - 00:38:11.760

Jennifer Hannah: You know, I think it goes back to what I stated, and I think we had follow up on this comment as well. We agree that there's certainly a role for the Hospital Associations to play, and we will certainly look forward to seeing how we might be able to further formalize that funding and that particular vehicle as a way to provide that direct benefit to those hospitals and other related health care entities. As many know, we don't necessarily have a crystal ball at this at this point, but it is something that continues to be in the front of our minds in our thinking and planning, so we will have to work, of course, with our ASPR leadership. At the same time, it's really important for all of you to work with your Hospital Associations, as well as the American Hospital Association to get that message out regarding this particular activity. I think we have to approach this from different pathways in order to get to the preferred outcome. Unfortunately, there's not a way to necessarily address that at this time without knowing what is on the minds of Congress.

00:38:16.770 - 00:38:30.870

Maria Ramos: Thanks Jennifer. We had a question from Edward come in, it asks: will this rollout be dependent on whether or not the HCCs is are considered response entities within their state?

00:38:32.700 - 00:38:57.570

Matthew Watson: You know, the short answer to that is probably not. I think the intent of Congress in the mandating of these guidelines was to be broader and we are working at that level right above the coalition level. So yes, I think it would be irrespective.

00:39:00.840 - 00:39:31.230

Maria Ramos: Thanks Matt. I see the follow up comment as well that Kansas Health Care Coalitions are considered support and response and the emergency management is the response authority.

I did receive a private chat with a question, and Jennifer this is this is for you: are funds available for carryover or extension on the COVID-19 supplemental funds for regional centers?

00:39:37.350 - 00:40:29.220

Jennifer Hannah: Yes, so for the for the Regional Ebola and other Special Pathogens Treatment Centers, we did receive funding within the FY 21 appropriation, so we will be awarding administrative supplements for those Regional Ebola and other Special Pathogens Treatment Centers. With that being said, you can request a carryover of the COVID-19 funding, and we will

ensure that you are provided with the instructions to be able to request carryover of the COVID funding.

00:40:43.200 - 00:40:50.430

Maria Ramos: Any other questions that folks had? We did just have another question come in, Jennifer, it asks: do you know when those instructions for carryover will be disseminated?

00:40:55.500 - 00:41:40.140

Jennifer Hannah: The carryover instructions are actually posted, I believe, on our website, but we will make sure that we get everyone those instructions out by the beginning of next week. If you don't have the link or have access to that information, typically we do include that within our Health Care Readiness Bulletin, so we'll make sure that we include that again. That will apply not only to our Hospital Preparedness Program recipients, but also to those other recipients that do have upcoming funding for the next year so that you can request that carryover.

00:41:43.860 - 00:41:44.670

Maria Ramos: Thanks, Jennifer. Okay, I'm not seeing any other questions come through the chat and certainly if you think of any, feel free to drop them in. One just came in: regarding carryover, would this apply to Hospital Association awards?

00:42:19.620 - 00:42:37.320

Jennifer Hannah: With the Hospital Associations, as I said, because the project period is five years and the budget periods five years, you do not have to request a carryover because you have five years total to expend those funds. You do not have to request to care for the Hospital Association awards.

00:42:51.390 - 00:42:59.520

Maria Ramos: We just received one more question. It is: is a continuation application necessary for Hospital Associations?

00:43:01.590 - 00:44:03.360

Jennifer Hannah: No, it isn't. The project period and budget period are five years, so you don't have to submit anything in order for those funds to continue for your work to continue. I think I see a follow-on question, Maria, if you don't mind, for Hospital Associations: do you have to submit a revised budget? If you are planning to make any revisions to your work plan or if there is a revision or a redirection for your budget, then you do need to submit an application to redirect those funds, but no continuation application is required and no revised budget is required if you are continuing your work and if you are not making any significant changes to your budget. That is for Hospital Associations.

00:44:08.760 - 00:44:20.310

Maria Ramos: Thank you, Jennifer. There's a follow up question: will the Hospital Preparedness Program move to this type of award.

00:44:24.360 - 00:44:32.730

Jennifer Hannah: I'm assuming that this is asking about a five-year project period and five-year budget period. Unfortunately not, because the Hospital Preparedness Program's appropriation is an annual appropriation. Not necessarily to get too far into the weeds, but with the COVID supplemental funding, it was a five year appropriation, but in order for us to add the funding to

those existing awards, such as the HPP Cooperative Agreement, the Regional Ebola and other Special Pathogens Treatment Centers, that funding had to be awarded as an administrative supplement versus a new award. With that being said, when that funding was added, that funding's period of performance had to align with the current budget period of the existing award.

00:45:24.180 - 00:45:38.490

Maria Ramos: Thanks, Jennifer. The next question is for clarification: was the COVID-19 administrative supplemental discussion strictly about carryover or was there a comment about additional funding and FY 21?

00:45:40.800 - 00:46:56.880

Jennifer Hannah: A little bit of both. If you're talking about the Regional Ebola and other Special Pathogens Treatment Centers, you will receive an administrative supplement for FY 21, which means that you will have another year in order to continue Regional Ebola and other Special Pathogens Treatment Centers activities and also additional funding, but we know that you received COVID-19 supplemental funding. With you getting an additional year of funding, let's say that funding for your performance is being extended through FY 22, or rather, through 2022. Then, in order to use that COVID-19 supplemental funding, you will need to request a carryover in order to still have access to those COVID-19 funds into FY 21 or the new budget period for the Regional Ebola and other Special Pathogens Treatment Centers.

00:47:01.860 - 00:47:29.910

Maria Ramos: Okay, thank you Jennifer. The next question is: could you elaborate a little more on engagement with frontlines, once the NSPS to set up.

00:47:34.770 - 00:48:06.360

Vikramjit Mukherjee: I can try to tackle that one. So yes, the NSPS will have a four-tier strategy. Frontline assessments, state, and the regionals and one of the primary goals is to have the glue that connects these four tiers together in the form of a central body, a coordinating body, that will make sure that there is cohesive communication, data transfer, transparency, and metrics across all four of these tiers.

00:48:28.140 - 00:48:38.490

Maria Ramos: Thank you, Vikram. Okay, I'm seeing no other questions come through the chat or any raised hands, so I think with that, Jennifer, I can pass it over to you to close this out for today.

00:48:46.710 - 00:51:18.450

Jennifer Hannah: Great, thank you, Maria. Thanks to everyone who joined today's call, as well as our speakers, and also Matt. Thank you very much for being on today's call to discuss the NSPS strategy for care, and then Matt for the Regional Guidelines overview. It was greatly appreciated. You know, one of the reasons why we definitely wanted to highlight the NSPS is that all of you that are on today's call, the RSPTCs, the HPP, the Hospital Associations, all of you are an integral part of the NSPS, so we definitely wanted to make sure that we provided this information with you today, and want to thank you all for the very thoughtful questions.

As always, you know, we love to hear from all of you. As mentioned earlier, if you would like to share how you and your recipients are using Cooperative Agreement funding to make an impact on your communities, please fill out our new Story from the Field submission form, or send a quick note to your project officer as applicable or the hpp@hhs.gov mailbox. Our team will insert the link once more in the chat for easy reference. For any of the questions that we may not have gotten to, please feel free to send us an email at hpp@hhs.gov and we'll make sure that we address those

questions. For those questions that might be well brought region or all recipients, we'll make sure that we provide that information in our follow up email and include information in our Health Care Readiness Bulletin that comes out at the beginning of each of each week. So, thank you again to our presenters as well as to all of you. I think it definitely goes without saying, you know we really appreciate all the work that you do, and I'm sure America appreciates all the work that you do, and you continue to deliver time after time, so with that we will end today's call. Thanks again and have a great day.