While ASPR is leading the development of the regional guidelines, it will take an inter-agency and industry-wide approach to get these right and to make them useful for the industry and government partners who treat patients and increase medical surge capacity during, in advance of, and immediately following a public health emergency. Our team is writing these guidelines by building upon lessons learned from current regional programming, such as the Regional Disaster Health Response System, or RDHRS, as well as the Pediatric Disaster Care Centers of Excellence and others. In addition, we’ve looked at past emergencies such as the 2014 to 15 Ebola virus outbreak, which prompted ASPR to turn to a regional approach with the development of the Regional Ebola Treatment Network that ultimately became the National Special Pathogen System, or NSPS. The guidelines are also informed by health care delivery systems across the US that have already embraced interstate regional models, including the American Burn Association, National Trauma System, and the Radiation Injury Treatment Network, each of which demonstrates the value of enhanced coordination across their individual organizational structures and jurisdictional boundaries. And, of course, the guidelines are informed by the ongoing COVID-19 pandemic. Next slide.

Today, we’ll introduce the guidelines effort and what they intend to accomplish. We’ll also provide an overview of how we plan to refine the guidelines, informed by the stakeholder input that we are currently gathering. We’ll then review some frequently asked questions and conclude with our approach for gathering your input and feedback on the guidelines themselves. Next slide.

So, to quickly review the purpose and origin of the guidelines, ASPR is statutorily required to develop these guidelines in concert with health care partners and to publicly release them upon completion. Separately, given the development and expansion of the RDHRS program and lessons we’ve learned from other regional programs, we believe the time is right to develop and, with your help, put forward the guidelines.

The guidelines will cover all-hazards preparedness and response and share leading 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
practices and protocols included in the guidelines will provide information related to several major topic areas. These include identifying hospital and health care entities and their capabilities within the region; considering infrastructure, lab capacity, staffing, blood supply, and other supply chain needs; bolstering surge capacity and undertaking measures to train and protect the health care workforce; planning for disease containment, medical triage coordination, and patient load balancing and transport. The guidelines will also include practices and protocols to address the needs of at-risk individuals, including children, pregnant women, older adults, people with disabilities, and others with access and functional needs.

I want to emphasize that, while we are putting forward a draft of the guidelines, we are still quite early in its development. And to continue to build upon this draft, we are engaging a diverse set of stakeholders, including inter-agency and private sector partners. Next slide.

As I've mentioned, these guidelines provide recommended practices and protocols for regional health care emergency preparedness and response. We gathered the promising practices from past and ongoing regional programs and initiatives, and we're eager to incorporate your expertise into the guidelines and add additional promising practices. After publication, the guidelines will continue to be a living document that will be updated as new recommended practices arise. However, the guidelines are not a legal mandate or a prescriptive framework for regional coordination, and it is not an implementation plan or comprehensive list of all coordination activities.

I'll pause here briefly for any questions on any of the introductory material I just went over. Please go ahead and feel free to type your questions into the chat or come off mute. Lori, that's a great question, and I will get to that in just a moment. All right, I think we can go ahead and head to the next slide.

So, from recent disaster responses including the COVID-19 pandemic, Hurricane Katrina, the H1N1 influenza pandemic, and the 2014 to 15 Ebola virus outbreak, we've seen that a robust response requires regional coordination across multiple healthcare systems. And, as we all know, large scale disasters can overwhelm available resources and require surge support from across state lines, even in the most prepared communities. We recognize that there are challenges involved with a regional approach, such as coordinating patient movement and information sharing among siloed or competing healthcare entities. And we also anticipate that some may be concerned about a regional approach that does not include a clear governing authority to oversee regionalization. However, past experience has demonstrated that the trend towards regionalization can empower separate health care entities to work together more effectively to save lives in a response.

In the guidelines, we've incorporated many lessons into a central document that details how government and industry can collaborate using a regional approach to health care preparedness and response during emergencies. And we are eager to hear your observations on what makes these practices and protocols valuable or not. Next slide please.

Next, I'd like to provide a quick orientation to the guidelines’ four main objectives. First, actively engage public private partnerships. Forming partnerships across the public and private sector is critical. We demonstrate how these partnerships will allow the broad spectrum of health care organizations to better coordinate with one another during emergencies and improve health outcomes for community members throughout the region. Second, align plans, policies, and processes. When reasonable, state and local health care systems should align their plans, policies, and processes to support a more coordinated regional health care response to
incidents and events. We emphasize drawing upon existing documents and methods in order to achieve this alignment. Third, expand statewide and regional medical surge capacity. Medical surge capacity at both the state and regional level is necessary to support a number of critical health care functions during an emergency. And we emphasize load balancing, patient movement, and supply sharing among health care entities to increase the provision of health care across the nation. Fourth, bolster statewide and regional situational awareness and information sharing. Information sharing across health care entities can support the development and completion of incident action plans and provide essential elements of information for operational decisions.

The guidelines also address policy and financial incentives for regional coordination, including professional licensure and liability coverage, readiness metrics, private sector engagement to drive investments in preparedness, and the availability of telemedicine and telehealth modalities. Next slide.

So, before we’re getting into how we are going to be collecting feedback, we wanted to review a few frequently asked questions, which I think a few of us started to allude to already. Next slide.

How do you define regional? Within the guidelines, regions are defined as the 10 HHS and FEMA regions in the US and its territories and freely associate states. While the federal regions guide daily engagement, we’ve seen through patient referral patterns and cross-jurisdiction events that community and market driven healthcare delivery does not always align with federally defined regions. With this consideration in mind, the approach in the guidelines represents, broadly, multi-state and interstate coordination for health care emergency preparedness and response. Next slide.

Will the guidelines be mandatory? No. As of today, these guidelines will not be mandatory. The guidelines are intended to serve as recommended guidelines, not requirements, to share promising protocols and practices to increase medical surge capacity for public health emergencies. Next slide.

Who is the audience for the guidelines? These guidelines are intended for regional systems of hospitals, health care systems, and other public and private sector entities with varying levels of capability to treat patients and increase medical surge capacity during, in advance of, and immediately following a public health emergency. Next slide.

How do the guidelines differ from the healthcare preparedness and response capabilities? While the guidelines were congressionally mandated to be a stand-alone document, they will likely be an input to the next capabilities refresh. While both documents describe activities that strengthen health care preparedness and response across the delivery spectrum, the guidelines focus explicitly on interstate coordination for regional health care readiness. Next slide.

Why is ASPR leading the development of these guidelines? ASPR’s work on the guidelines, is in response to the statutory requirement in Section 319C-3 of the Public Health Service Act, as amended by PAHPAIA. Next slide.

What kind of feedback should we provide? So, I want to stress again that we are coming to you rather early in the development process for these guidelines. And the drafted content in the guidelines that we will share with you, following this meeting, is intended as a starting point that we plan to refine and validate in part through your feedback. Given your roles, expertise, and experience, your feedback is going to be critical. As a reminder, these guidelines are intended
to be high-level, strategic recommendations, not operational guidance. And we greatly appreciate any feedback you're able to share with us. For the purpose of your review, we request that you provide additional promising regional practices, point out areas that need clarification, and even identify language that you would replace or remove. Next slide.

How can we provide input? We're requesting your review and input on the draft version of the guidelines and, as I said, we'll be sending the entire document to you as well as a comment matrix following today's webinar. When you identify an area in the guidelines that you would like to comment on, please use the comment matrix to indicate the relevant line number or objective and provide your recommendation, comment, or revision in the spreadsheet. If you're recommending a new promising regional practice, you can simply provide your recommendation and leave the line number blank. We'll now move to quickly discuss next steps before concluding with an open Q&A session to try and address as many questions as we can on the feedback process. Next slide please.

So, in terms of next steps, as I said, we are engaging with a range of inter-agency stakeholders as well as industry representatives to further refine the guidelines draft. We will synthesize the recommendations we receive and hope to produce a final version in early 2022. We'd like to gather your feedback on the guidelines via comment matrix that we will be sending around shortly. Please review and return the comment matrix with feedback by December 10th via email to my colleagues, Sophia and Sarah. We will also be hosting office hours if you'd like to share your feedback during a live discussion. If you'd like to provide feedback during office hours, please review the guidelines draft beforehand. The links to join these sessions will be included in the follow up note that will be sending after our meeting today. Next slide.

As I've mentioned, we really do welcome your feedback and now want to leave a little bit of time for questions on the guidelines or the feedback process.

00:17:48.300 --> 00:18:10.530
**Sophia Grimm:** Matt, while we wait for questions and people to raise their hands, I'm going to read a couple in our chat to you. If this is a living document, which means the "metrics" or "requirements" may change (which is good to capture the new science, experience, and knowledge) how can facilities track their readiness over time?

00:18:13.710 --> 00:18:25.830
**Matthew Watson:** That's a really good question. I think, you know, in terms of concrete metrics related to the regional guidelines, I think there's more to come there.

00:18:30.780 --> 00:18:40.770
**Sophia Grimm:** Next question. How does ASPR see this regional framework integrating/supporting the National Response Framework and the 5 national frameworks?

00:18:42.750 --> 00:19:10.350
**Matthew Watson:** Yeah, as I said, this document is likely to provide an input certainly to the next capabilities refresh and will likely be represented. And regionalization in general is likely to be a point of emphasis in other ASPR strategy documents. That is our hope at this point, anyway. So, I think that's largely how it will be taken forward, but more to come on that certainly.

00:19:14.880 --> 00:19:32.790
Sophia Grimm: Next, I'm going to combine two questions. Will there be HPP and/or PHEP grant deliverables added as a result of these guidelines? And in addition to that, will there be additional funding for the ever-expanding deliverables in the grants?

Matthew Watson: A really great and critical question. We are aware that additional resources will be needed to achieve probably the most robust version of regionalization. And we do hope that in the future in part through RDHRS expansion, which we've just seen a fourth site be added to that program, that there will be additional opportunities down the road to hopefully more robustly fund regionalization activities. And, as I mentioned, these guidelines are likely to inform the capabilities refresh for the healthcare preparedness and response capabilities.

Sophia Grimm: Next. Your points and intentions are accurate, but the issue is the assistance and participation of government entities (Emergency Management and Public Health Departments) in the Health Care Coalitions. Is there a plan to gain the active support of FEMA and then pushed down to local Emergency Management and to place and unite the hospital preparedness deliverables into Public Health Department deliverables?

Matthew Watson: Yeah, we're aware that there will need to be much more activity and effort to align those authorities, and we do plan to hopefully address that certainly as we move toward releasing these. So, that's very helpful feedback, thank you.

Sophia Grimm: Is the intent of this document to support our regional coalitions that are currently in place?

Matthew Watson: There certainly is, yes, I would say, there is a focus on, sorry, let me think about how to answer that. We are currently focused on the interstate understanding of regionalization, and we know that there may be concern from the coalition members, more broadly, about how this will impact them. And our hope is that this is, indeed, seen as being supportive to coalition activities.

Sophia Grimm: Are these going to be regionally specific guidelines or overall guidelines for all regions?

Matthew Watson: I think the latter. But we do recognize that there will be variability in the degree and interest in any given region around working together and cooperating, so, understood.

Sophia Grimm: Can you provide a hierarchy graphic as to what/how you see this working. Statewide regional HPP MOCCs are in place, and EMAC addresses interstate assistance. Are you suggesting another level of "coordination" over state responses?
Matt Watson: Yeah, I think in the document, I'll refer you to the document once we send that out. I know we do have the more conceptual piece of this mapped out there.

00:23:39.390 --> 00:23:48.150
Sophia Grimm: And, just asking for confirmation, this is not for HHS regions but rather for functional regions that are informally in place?

00:23:49.380 --> 00:24:14.970
Matthew Watson: Yeah, the definition is a little bit of both. We recognize that ASPR and other deployed staff does function via those regions, and so there will be a measure of coordination that has to be taken on there, but broadly interstate coordination is kind of the focus.

00:24:19.410 --> 00:24:24.630
Sophia Grimm: What role will health care coalitions play in the regional framework guidance?

00:24:34.020 --> 00:24:35.700
Matthew Watson: Sorry, could you repeat that one, Sophia?

00:24:37.470 --> 00:24:41.610
Sophia Grimm: What role will the health care coalitions play in the regional guidance?

00:24:43.320 --> 00:25:17.280
Matthew Watson: Sure. Certainly, we are learning, and the work of the coalitions is one, you know, really important input to this document and we're certainly learning from those experiences and hopefully can reflect that out. And you'll see that hopefully work reflected in the guidelines draft, and if there are observations or feedback about how to sharpen that in the context of the draft document that we're going to be circulating, please feel free to add those recommendations.

00:25:27.420 --> 00:25:36.810
Sophia Grimm: We have another funding question. Do you anticipate any changes to the funding formula or any combining of funds or additional funds for regionally focused work?

00:25:39.900 --> 00:25:59.820
Matthew Watson: At this time, I am not aware of any additional funding to support the work of the regional guidelines. We do know that there is work going on at the regional level to some degree, and we do hope that in the future, additional resources will be provided.

00:26:03.330 --> 00:26:35.400
Sophia Grimm: Has there been any discussion to postpone/waive some of the future activities such as radiation and nuclear annexes to allow for more time to work towards these new guidelines? At this point, hospitals continue to have more work added to their plate, while experiencing critical staffing shortages, and the funding stays the same or decreases. Adding more activities does not make us more prepared if we aren't able to give all the work the time it truly needs for us to make sustainable progress.

00:26:36.930 --> 00:26:56.910
Matthew Watson: Yeah, absolutely understand the nature of the stress that everybody is under. I'm not aware of any changes programmatically that will be made as a result of this, but certainly more to come on that. We'll take that back as good feedback, thank you.
Sophia Grimm: Just a comment: this also appears to be a duplication of efforts with other regional planning initiatives that are already in place.

Matthew Watson: Yeah, our hope is that this document really does provide a bit of connective tissue. We know that there are several regionally-focused efforts going on, and our hope here is to kind of align those and elevate the focus on regionalization itself with this document.

Sophia Grimm: Is ASPR sunsetting the Health Care Coalitions concepts?

Matthew Watson: Absolutely not. No, it's very much our hope that this is going to be additive and not take away from the important work going on at the coalition level.

Sophia Grimm: Will memorandums of understanding be required since grant funds can't cross state lines?

Matthew Watson: Yeah, that's an excellent point. I do think it is likely that some level of memorandums of understanding will be needed, but it will likely depend on kind of the particular regional context and how a regional coordinating body is stood up. I know those are mechanics that are incredibly important, and we definitely want to make sure we address that in the context of the guidelines.

Sophia Grimm: Follow up question to that was: Can we provide a memorandums of understanding template if that is the case?

Matthew Watson: That's really good feedback that we'll take back and a good suggestion. And we'll huddle up and think about the best way to do that.

Sophia Grimm: Has ASPR considered large states that have regional systems and counties that are not close to other states? How does ASPR eliminate challenges for cross-state licensing?

Matthew Watson: Yeah, cross-state licensure is clearly an important piece of this. You know, I think it's fair to say that utilizing existing contacts and agreements are great place to start, but to the degree that other authorities are needed, it'll be great to capture that in the feedback process.

Sophia Grimm: Diane said, I may have missed this in the beginning comments, but where is this push coming from? Was this the result of after-action reviews of the COVID response?
Matthew Watson: Really, really good question, Diane. So, certainly, the impetus for the development of this document was a Congressional mandate that was put on ASPR as a result of the passage of PAHPAIA from a couple of years ago. However, it is also certainly true that we've seen the contributions that regional preparedness can offer from the COVID-19 response and have been very intentional about capturing as much of that as possible and integrating it in the context of the guidelines. So, I think that gets to kind of a bit of a dual origin story for the purposes of this document.

Sophia Grimm: Under what authority will this new entity have to coordinate across states?

Matthew Watson: Yeah, we don't provide any new authorities. We do recommend that States work together to bolster their regional capability, but we cannot and do not mandate that. As I mentioned in the presentation, these are very much recommended guidelines, not mandatory ones.

Sophia Grimm: How do you foresee overcoming many States who have legislation that already defines legal authority for emergency coordination at the State and local levels and getting two or more states to overcome competing or differing legislation?

Matthew Watson: Yeah, clearly there are going to be political barriers here to fully realizing a regional preparedness and response lay down. However, we do have, you know, I think examples certainly during COVID where states have recognized the value of working together on a regional response. So, to the degree that places can either emulate that or continue those partnerships going forward, I think that's going to be the best approach here.

Sophia Grimm: What about any changes to the 18 or 15% RLDC restriction? And Kari, I might need you to define RLDC.

Matthew Watson: Yeah unfortunately, I'm not familiar with that but certainly something we can take back. Thank you, Kari.

Sophia Grimm: Have hospital executives and medical societies been consulted on this model?

Matthew Watson: They will be is the short answer. We are going to be doing additional stakeholder outreach. I believe this is the first external to government outreach that we've conducted for the regional guidelines. But absolutely in very short order we'll be getting to professional societies hospital associations, as we recognize those are critical stakeholders.

Sophia Grimm: Will there be a Q&A document provided to reflect the questions in the chat and discussion?
Matthew Watson: We’ll certainly distribute a recording and audio of this presentation in short order here, but I don’t know that there will be a dedicated QA document as such. But if you have questions, certainly you’re more than welcome to get in touch. We’ll put up our contact information here shortly.

00:34:11.250 --> 00:34:17.280
Sophia Grimm: Will there be a point person from HHS in each region to help facilitate this process with the States?

00:34:19.380 --> 00:34:40.920
Matthew Watson: We’ve certainly reached out and are working closely with both the Regional Emergency Coordinators and Field Project Officers for NHPP. And they will be able to answer any questions and if not, certainly, they will have access to our team as we move forward.

00:34:47.430 --> 00:34:57.720
Sophia Grimm: When these elements come out along with the RFP, who is the intended eligible audience to apply for this?

00:35:00.000 --> 00:35:09.100
Matthew Watson: So, this is not a program as such. The document that you’ll be receiving is the draft of the guidelines as we mentioned earlier. And as we move forward with implementation, I think we do need to consider what that looks like, but this, this is not that. This is essentially a strategy document that hopes to put a few guideposts in the ground to guide regionalization, not directly support it. I hope that helps.

00:35:47.820 --> 00:35:57.480
Sophia Grimm: How would we be asked to document or submit proof of interstate coordination? In other words, how will we communicate these activities to APR?

00:35:59.460 --> 00:36:25.260
Matthew Watson: Yeah, that’s an excellent question. You know, I do think it will be largely informal at this stage, although I could certainly imagine call for information, things like that, in the future, as this concept hopefully gets purchase and traction and we do start to see more in the way of regional programming. So more to come on that.

00:36:28.620 --> 00:36:33.960
Sophia Grimm: We have a suggestion to begin with the stakeholders to develop policies.

00:36:38.700 --> 00:36:39.450
Matthew Watson: Absolutely.

00:36:43.740 --> 00:36:52.140
Sophia Grimm: If documentation is submitted, how will the reports and activities be reported out to benefit everyone?

00:36:53.820 --> 00:37:23.280
Matthew Watson: Yeah, as I said, at this time, there is no requirement for reporting specific action items, but like I said I could certainly see, you know, it being useful to share best practices. And I’m sure that we will be doing some version of that in the future, but right now, as it stands, there is no reporting requirement associated with the regional guidelines.
Sophia Grimm: Will there be additional requirements around this in BP4 guidance?

Matthew Watson: There will not.

Sophia Grimm: This "strategy" document will lead to a funded program and we will be told we had input into the guidance and accepted it, without full disclosure. It has been rumored that this is being pushed from larger health care systems across the nation.

Matthew Watson: That's certainly not the case. ASPR undertook this effort and activity because of the Congressional mandate. And again, as well as the need to codify and learn from the experience of the COVID-19 pandemic and seeing the centrality of regionalization in that context.

Sophia Grimm: Without the cooperation of the emergency management agencies and public health departments, some of these deliverables may be unattainable, but we will still be responsible? The Health Care Coalitions have no legal authority to gain the support needed. What do you recommend?

Matthew Watson: Yeah, again, I think the best, you know, the best I can say at this point is certainly reflecting on your current local context, working as best you can to capture the experience of the COVID-19 response, understanding that there is a need and certainly gaps with respect to the authorities needed to operationalize something like this. But again, these are recommended, voluntary guidelines that we hope that will be additive to the preparedness and response landscape. Not necessarily, at this point, any new requirements or activities that are being mandated at this point.

Sophia Grimm: Are these guidelines considered under the umbrella of the hospital preparedness program like RESPTCs or a partnership program in a way like PHEP?

Matthew Watson: Yeah, NHPP is and will continue to be responsible for developing and promulgating these guidelines.

Sophia Grimm: And then I just want to circle back to a question we've got the full spelling of. What about the changes to the 18 and 15% Recipient Direct Level Cost, which is an administrative limitation on funding?

Matthew Watson: Yeah, appreciate that. That's something I'm going to have to take back and find you an answer for.
Matthew Watson: Sure, Jennifer.

Jennifer Hannah: Okay, I can speak to that. So, regarding the recipient level direct costs, currently there will be no impact on the RLDC from the scaling from the 18% to the 15%. As written, that will stand, and the guidelines, as was stated, are not specifically related to any programmatic requirements at this time. And so, therefore, it will not have any impact on the RLDC or any program requirements.

Matthew Watson: Thank you for that Jennifer, really helpful.

Sophia Grimm: I believe that was the last question in the chat. Folks can feel free to raise their hand if they would like to come off mute or feel free to keep typing into the chat. Well, we just got one. Will this just focus on the 10 ASPR regions and their boundaries?

Matthew Watson: By and large, yes, but not in every case. There will be situations where it makes sense for, you know, states to work together bilaterally based on geography, but by and large, we take as a starting point the 10 HHS regions.

Matthew Watson: Alright, I think, if there is nothing further, I think we can go ahead to the next slide and kind of wrap things up. Right, so again, thank you all very much for your time and attention, I know this is, you know, a time when there are many competing priorities and time constraints, so again, I just want to thank all of you for your support as well as any feedback that you're able to provide. As I said, we will post the audio recordings and transcript from today's meeting on PHE.gov and send needed review materials in a follow up note. If you have any questions or comments, please feel free to email me. My email is there, as well as my colleague Sophia, or to attend our upcoming office hours. So, thanks very much, and we look forward to hearing back from you. Take care, everybody. Bye bye.