March 2022 Monthly Hospital Association Recipient Webinar
March 17, 2022
Call Transcript

00:00:04.049 --> 00:02:36.180

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

First, I will provide a few ASPR Health Care Readiness Programs updates. Next, Ericka Thomas from SPPR, will provide a brief update on the Hospital Association Year 2, End of Year Data Collection. Afterwards, Lyle Moore will provide an update on the success of the Colorado Transfer Center. Finally, we will leave some time at the end for questions from the audience. Next slide, please.

So, I'd like to begin today's webinar with a couple of administrative updates. Next slide, please. First, I'd like to announce the HPP recipient fact sheets for 2021 are coming soon. The fact sheets include key programmatic information such as funding levels, spotlights on preparedness and response activities, and COVID-19 response highlights for each of the 62 HPP annual cooperative agreement recipients. A member of our team will drop a link to the website with the 62 fact sheets for your reference. Next slide, please.

Next, we would like to take a moment to spotlight ASPR social media channels and all of the engaging content that is available to you through those platforms. ASPR is active on all major social media platforms— Facebook, Instagram, LinkedIn, and Twitter— and its social media posts contain a wide range of content such as major news headlines, job postings, recipient impact stories, and features of newly published health care readiness resources. We invite you to follow ASPR social media at the handles on this slide to stay up to date on everything ASPR. That wraps up today's updates. I will now pass it over to Kate Gorbach to introduce our next presenter.

00:02:37.230 --> 00:02:59.910

Kate Gorbach: Thank you, Jennifer. Hi Hospital Associations! It is great to connect with you all again, love seeing the familiar names and faces! I'm happy to introduce Ericka Thomas, of our SPPR Evaluation group, who will be running the show from the Evaluation side for End of Year reporting this year. She and I worked on revising the performance measures for Year 2 reporting, so I'll hand it over to Ericka to go over some of those small adjustments

00:03:01.620 --> 00:04:43.980

Ericka Thomas: Hello everyone, it is great to meet you and I'm excited to be here with you today. I'm excited to be here with you today. As we start to look towards the end of year data collection for Year 2 – we anticipate data collection to begin on June 1, 2022 – Jennifer and I will keep everyone updated on data collection methods and will be assisting with open office hours to answer any questions as June 1st gets closer. There will be minor updates to the performance measures this year – all small things that will make data collection smoother.

We're collecting data for funds spent and activities conducted only during Performance Year 2, that's April 10, 2021 through April 9, 2022, we're adding that language to some performance measures to make super clear. We're splitting up the infection control and triage question, so you'll only have to answer "yes" if you've completed the activity – the extra questions won't pop up for activities you haven't completed. We're retiring the measures on telehealth and the questions about which sub-recipients received their funding within 30 days – don't have to answer in Year 2. Overall, very similar to Year 1. We're going to share the old Implementation Guidance for Year 1 performance measures in the chat now. And just know that we're working on publishing a slightly edited version of questions soon. Next slide. I will open it up to any questions from the audience.

00:04:53.550 --> 00:04:59.250

Wassef, Megan: And Ericka, I'll start off with a quick question. Can you remind us when the end of year data collection is going to be?

00:05:00.630 --> 00:05:03.720

Ericka Thomas: So, the data collection kicks off on June 1, 2022.

00:05:03.780 --> 00:05:12.090

Wassef, Megan: Great, thank you. And how much time, should end of year reporting take?

00:05:14.490 --> 00:05:26.830

Ericka Thomas: Thank you for the question. So that the reporting period runs through August. Is that correct, Jennifer?

00:05:26.820 --> 00:06:07.050

Jennifer Hannah: We'll probably have to check that one, I believe, since it's opening June 1st. We will check to see if it's going to be 30 days or if it's going to be 60 days, but we'll certainly follow up with everyone and make sure that you are given ample time to complete the reports. I know, probably potentially one of the other questions that may be in folks' minds, is regarding CAAMP, because that is tied to the types of the data collection. We are working very diligently to get CAAMP set back up very soon, so that you can access that, and will be able to complete those end of year reports, online.

00:06:11.520 --> 00:06:12.990

Ericka Thomas: Thank you. Are there any other questions?

00:06:21.600 --> 00:06:32.790

Howard Dulude: Hi this is Howard Dulude from Rhode island. I'm just, again I don't do this full time and work on this, but I'm assuming there'll be a full set of instructions that kind of come out, this is just giving us the preview?

00:06:35.010 --> 00:07:21.690

Ericka Thomas: Yes absolutely, thank you for that question. A revised implementation guide will be distributed. What we've done and what we have added in the chat is the implementation

guide from year one, so you can have that as a reference. But again, we're working on providing the year two updated implementation guide for your reference.

I do see a question in the chat from Matthew Mary. Thank you so much. It says, "If hospitals used all funds in the first year, will be need to report for those hospitals this year as well in CAAMP?" And for that question, I will have to get back to you on that.

00:07:23.610 --> 00:08:09.450

Jennifer Hannah: Thank you for your question. I can help you out with that one. So, as Ericka's already stressed, you know the reporting period for budget period two is April 10, 2021 through April 9, 2022. So, if a recipient or a hospital or other health care entities' sub recipient has expended all their funds in the first year and did not expend any funds or conduct any specific activities for this current budget period or for the reporting period, then they do not have to report for this term for the current year's data collection.

00:08:24.240 --> 00:08:28.530

Wassef, Megan: Just as a reminder, feel free to ask any questions in the chat or come off mute.

00:08:42.960 --> 00:10:04.600

Jennifer Hannah: I'll just add you know, based upon the information that Ericka has already shared, I just want you all to know that we looked very closely at the data that was submitted for the last reporting period to see how we might be able to streamline some of the questions, and as she stated, you know, to see which questions could be retired. So, we really appreciate everyone, of course, of submitting the data as well as encouraging your sub recipients to submit the data, because we want to make sure that we're able to demonstrate as I'm sure all of you are very interested in doing as well, what has been the impact of this of this funding, specifically for the hospital associations. As we know, I think, when we first issued our release, the notice of funding opportunity, this was the first time that we had structured a funding opportunity that went specifically, of course, to hospital associations. So, you guys are kind of a test case, to see how successful we can be with this type of structure. So that's one reason why we meet with all of your monthly, to stay connected, to hear all the great things that you're doing, but also to be able to demonstrate the impact of the work that you are doing as well.

00:10:21.240 --> 00:11:08.700

Wassef, Megan: Thank you for that Jennifer, any other questions? I'll give a couple moments here. It looks like we have another question in the chat. I'll read it out. "Will all of the subrecipients display as "needing a report completed" or will there be an option to indicate they did not receive any funding during the reporting period so it will be clear to who no longer needs to be submitted in the end of year reporting. In year one- everyone received funding, so all sub-recipients displayed.

00:11:19.260 --> 00:11:21.030

Ericka Thomas: Jennifer, I'll pass that one over to you.

00:11:23.280 --> 00:12:46.710

Jennifer Hannah: Okay, so you know, without CAAMP being online right now, I think, will certainly have to take a look to see how that is going to be displayed. And I think it's almost a two-part response to your question because although your sub recipients may have received funding, did they complete all of their activities within year one, or did they also retain that funding to continue to complete activities because, as you all know, the project period in the budget period are five years, so there may be instances where the sub recipient may have received the funding, but still plans to conduct activities, of course, in year two and in the subsequent years of the of the project period. So I think it's a two part question, I mean two part answer for that. First, did the sub recipient receive the funding and not conduct or not completing the activities within the reporting period, and then the second part of that is, or does the sub recipient received funding and conduct activities within the reporting period. So I think that's going to be a really important distinction, to make and to have, when you are reporting the data for the for the second reporting period.

00:12:50.610 --> 00:12:52.110

Ericka Thomas: Thanks for that clarification.

00:12:55.980 --> 00:13:24.510

Wassef, Megan: Thank you all so much for your great questions and thank you Ericka and Jennifer for providing some insight into the end of your data collection. I think we're going to move on to the next presentation, but if any anyone has any questions, feel free to put them in the chat and we'll make sure they get answered. All right next slide. I'm going to go ahead and hand it over to Lyle Moore from the Colorado Hospital Association, who will be presenting an update on the Colorado Hospital Combined Transfer Center. Lyle.

00:13:25.890 --> 00:36:32.130

Lyle Moore: Awesome. Thank you, Megan. Can everybody hear me okay? Good to go, awesome. Thank you. So yeah, my name is Lyle Moore and I'm with the Colorado Hospital Association, the Director of Hospital Preparedness. I want to thank you for inviting me to talk a little bit about the CHTC. We are actually currently going through an after-action hot wash session, in another room here in CHA, so this is really timely and, hopefully, will give you an update on how policy CHTC work through this last wave. Next slide.

So just as a quick reminder to everybody again where that CHTC fit in. So, the state of Colorado did not have a statewide transfer center or system. Everything was done just within the actual health systems themselves. And so, what we were finding, was a lot of our transfer center calls, increased to where you know, a provider at a hospital trying to find a bed for somebody would end up hours, versus you know minutes from prior to COVID response. So, this is basically where we fit into that peace within that system as well. So, when that sending hospital ends up having those issues, the CHTC comes in and assists with finding those beds and that receiving facility as well next slide.

So, our scope again, you know what it is, transferring patients across hospitals and systems when the number of patients is exceeding the capacity of those hospitals or, more specifically, even some of those transfer centers themselves. And how we do it? You know we don't have a building we don't have a system or a set place. It's basically an ad hoc convening of those

hospitals and health systems transfer center leads, in order to help facilitate that transfer next slide.

Where do we fit with all of this? Well, we saw ourselves kind of fitting, again within that state Emergency Management Operations Center. EMS MAC, as well, was another piece of this and then the health care coalition, was another part where that situational awareness, whether it's out or in, information is impairment or needed for such a system to work as well. You know, on the backside to see CHTC is connected all those hospitals, all of the systems themselves as well. So, you can see how this puzzle kind of continues to increase and continues to connect with each other as well next slide.

So last time I talked to you, these were the original tiers. We had three tiers separated out by the number of ICU beds, you know, or case counts within each of those regions. So, while this work for the most part for the start of the first wave of the CHTC leads got together, and truly reworked the whole system. So, not only did we build the original on the fly we turned around and repaired it on the fly as well, during that second, or moving into that last wave that we had in the latter part of 21 and the start at 22. Next slide.

So, we started off with some objectives. One of the things that we continually found within moving through this process was we needed to make sure that everybody was transferring in that same manner. So, making sure that everybody understood what we're really trying to do is get that appropriate placement for those people. We're not just trying to offload and ED here. We're not working on that waitlisted patients, you know. Really what we're trying to do here is the right patient, the right bed, at the right time. We built some additional triggers to work with some of this, due to the fact that we felt that the original triggers just weren't working and just really lent a little more confusion and just didn't work. Let's just put it that way. So, we wanted to make sure that the CHTC was not the designated entity, even though we weren't an entity, again it was that ad hoc meeting, but wasn't that entity that kind of regulated those actions that need to be managed by each of the hospitals. So, in other words, once when we started rationing back some of those electives or some of those voluntary procedures. That wasn't the see CHTC's job, to make sure that that was happening. The CHTC is truly built on that trust and that working together and those working relationships that are out there. We also turn around and built that escalation process. So, if there was an issue that continue to happen with transferring a patient and we still couldn't find something, we started off with that partnered system moved into that CHTC lead and then finally CHA stepped in. I made a few calls to work out some of those issues that we continually found, and then you know either adjusted what was going on, or a lot of times, it was a lot of education; working through some of those traveling providers, which created issues that when they show up and they don't know the procedure that's already out there, or process. So, we felt that that escalation process needed to be created and included within this tiered system as well. Next slide.

So, we start off with tier zero. This is normal state basically everybody's transferring to their normal transfer procedures. You know, everybody is working, the way it is. In the state of Colorado, we use EMResource as one of those data collection situational awareness tools and. So there has not been a CHTC tab requirement within there yet. You know again everything's steady state. Next slide.

So, this is tier one where we start matching up those rural facilities. So, we built off of that capacity scenario, which is one of those triggers on you know, whether it's that one facility or

20% or more of the patients in that regional assistance through the CHTC that's when we start an act in this so tier one is really about. Making those connections with all of those facilities. So, all of them are allowed to select that system, that health system that they would then match up with, and in those health systems that would give those facilities that that one call instead of those multiple calls trying to find that bed. We agreed as the CHTC group that once when that call would happen, it was on that system to then find that bed, whether it's within their own whether it's in within some of the other partnered facilities as well and that's when we get into the next slide.

This is basically that what that looks like. So, basically taken all those rural partners, matching them up with that CHTC system lead for that. And kind of making them a part of that system, you know, so to speak, excellent. Next slide.

Then we move into tier two this is when we get three to five of those systems that are having issues or need that escalation, to the CHTC in order to find those beds. tier two is actually when we start looking at bidirectional transfers as well. that's what we were calling it. So, in other words a rural facility needed to transfer a patient up for a higher acuity on to a system, the system, then would in turn exchange or bi directionally transfer somebody down to that rule facility. Because we also came to the conclusion that it's really about throughput, for a lot of these bigger hospitals and systems in order to continue moving those patients and having that room for them. So, in tier two is when we start looking at that, but then we also start looking at escalation of those surge measures as well; making sure that that's pushed out there, that you know more of those effects should be reduced. Our meeting cadences increased so when we move into tier one we start having weekly CHTC lead meetings, but then also monthly all stakeholder meetings. So, they all stakeholder meetings are everybody that's within or has that state within that transfer. So that ranges from all the rural facilities, the systems, the health care coalition's, the RETACs, those are regional emergency trauma and advisory councils, that really work with EMS moving forward with that. State health department as well, we started bringing in state health and emergency management. We felt that, within this stage, we're starting to get to that point where some of our systems can't find homes for those people, and we have to start exchanging within the systems. But then due the fact that gaining those resources that are needed or potentially needed to help with that throughput or to help with that finding those beds, we need to make sure that the state is involved, so that they can start working on those because we, we all know that you know it takes time, in order to bring resources to bear, especially when you're looking at the state process or a federal process moving forward. Next slide.

And this is what we're talking about we look at tier two where now we've got the system leads are starting to exchange patients within themselves as well. If one can find it, maybe the other one can and we start moving those patients, you know we're in we're talking onesies, twosies, two z's, you know. Not a lot, but there's again starting to see that increase, that surge, and that expansion that needs to go just pass that one CHTC system lead. Next slide.

Tier three is our highest tier. This is when we've got four more of those systems that are at capacity or exceeded. Again, this is that capacity scenario, where you know what we have to start looking across the state and the whole state comes together as one system as well. Those meeting cases increases. So, during this time are all stakeholder meetings are happening weekly, and then the CHTC leads were meeting daily, and at one point, we had set up three separate meetings every day because, as we all know, even when we're putting in information

into like EMResource or any kind of bed capacity, five minutes later that that number is more than likely changed and off. So, we'd actually set up three separate meetings within each day for those leads to get together and start working on that that exchanging of those patients or finding that facility or that bed for that patient. we also have the CHTC determining some of those transfers as well. So here in Colorado we have a mountain range that goes right through the middle of our state basically. So, transferring a patient from say Durango, to the metro area where all this or a majority of our resources really are here in the metro area, can involve eight hours on a good day. And that's just a drive. We're not including an ambulance. We're not including more than likely the weather like today. I think we're up to about 10 inches of snow today. So, you know add that. On top of it you're taking transportation, not only out of a community where there's a potential in some of our rural communities that you know, maybe they've only got two ambulances. So, you're taking an ambulance out of that community for more than a day at some point. We had to turn around and make some of those determinations on where to transfer. And in tier three also we started working on some of those other pieces like telehealth or doc to doc call in order to hold that patient there at that facility, a little bit longer than usual because we're still trying to find them a bed in an appropriate place. Even on our Western slope finding those beds became an exchange within those CHTC leads themselves just do the fact that that transportation became such an issue this is also where we were able to pull in the state and start working on developing and then an existing contract. That then created additional EMS agencies, so we could start placing some of those ambulances in these other areas to help with those transfers as well, that was an important relationship and tie in that we had with the CHTC just do, a fact that getting those resources there takes so long, but then also just being able to look and have the state here that these are the issues were doing you know, we need to start working on that. There was also some of the issues that we ran into when we started getting to tier three is are those patients, and so we developed a quick informational sheet, the Google sheet, that we then would share during our CHTC lead meetings. And if a system would have a patient that they just couldn't transfer, they would put them on this list, and then, when we would come together for that meeting, we would talk through and walk through where that patient could go across the state and we had different we started off with. Good God I can't remember how many different essential elements of information that we looked at in theory, and then after a few of those transfers, where we started working through that they get narrowed down quite a bit so. I think we're down to things like maybe 12 different pieces of information that we exchange or take from that patient put on that list and then come together and try and find that patient bed, whether it's bi directionally or even you know, an exchange between the systems, but now we're looking across the state as well. This also comes with another piece of education and that's educating the patient themselves and the public. That was one thing we just talked about in our hot wash session, was making sure that we need to increase our communication to the public and our patients to let them understand that, during this situation when we are in this kind of a mode or this kind of lacking and resources available. Resources, you know, you might have to be transferred, you know, an hour out of the city in order to make room for somebody else to come in, or that's the only available bed that we have right now that fits your need, so we need to push you there.

So that was problematic is as well. But I think we work through a pretty well with making sure and the hospital association created a kind of a guide or talking points that could be used within those facilities, when talking to those patients about you know how we're actually at that point where we need to transfer you out aways away, to find a bed for you. Next slide.

And again, here's that depiction of what that tier three looks like. This is when all of our systems are exchanging between each other, between their rural partners, doing that bidirectional flow or even that patient exchange within each of those leads also in order to just find that that. Next slide.

So, this is our quick timeline that we created as well as you can see, on the left-hand side is. November 1 of 2020, and it seems so long ago, but our first activation, we activated the tier one and we deactivated in on February 1, 2021. Within that timeframe, we transferred 3249 COVID transfers. And that's something else that the CHTC had to work through as well. That this was not a typical emergency incident. This emergency incident changed as it moves through these years as well, which had different ripple effects upon not only the health systems, but also the hospitals, out of the rural areas as well, whether was staff or PPE, at this time and during that first wave were just those basic beds and the treatments that go along with that, whether it's ICU or basic treatment, but then, as we moved into that newer wave, we started getting more numbers of patients coming back to the hospital that had stopped going to the hospital for whatever treatment, and now they came back, and it was an exasperated treatment or their treatment took longer, you know. So not only were getting Omicron and all of the patients that was bringing in, but we also started getting more and more patients back too. So that's just and let alone the staffing. You know, staffing has a ripple effect that's truly amazing. An amazing hurdle for health care and it's going to take, you know, years to get back to, but you know, our second activation started on August 30, where we started off with a tier one activation. And honestly we skipped tier two and moved right into tier three by November 1. And at this time, we also changed some of our clientele or those or those patients that were being transferred. In the first wave, you can see, it says COVID transfers, but by the second wave of it was total transfers. We were having to transfer people. for capacity's sake, in order to free up some of those beds for those COVID patients. And so, during that second wave, halfway through it, we actually changed into those total transfers when we activate that tier three. During that time from November 1 to February 27, we transferred 47,608 patients within that system itself. So, as you can see, a tremendous increase with the transfers. And then finally we've deactivated here March 1. Right now, we are going through AAR process, but we're also meeting quarterly now. The CHTC will be meeting quarterly, as we move forward, just to stay on top of all these other different aspects that are going on. So not only just watching all the transfers and COVID and all that but, the relationships that have now been built with the CHTC all of those transfer leads want to keep those going and working together, instead of more in those separate kinds of systema alleys or those systems silos that they were in previously as well. I think that's my last slide. Next slide. Awesome. Any questions?

00:36:40.620 --> 00:36:44.250

Wassef, Megan: As a reminder, feel free to come off mute or put any questions in the chat.

00:36:56.400 --> 00:37:59.880

Jennifer Hannah: Lyle, this is Jennifer here at asked for, and while we're waiting for questions to queue up I'll just get things started, while people get their juices flowing and, hopefully, we can help to stimulate some additional questions. But first thank you again for presenting this. This is really great information and you already answered one of my questions, when I noticed on the timeline that you moved from tier one, tier two, tier three, between September and November, and I guess my initial question was going to be, if this really was a stepwise

approach or could you, you know, skip a tier? So, you already answered that question for that, but just wondering about the overall process here. So, how has Transfer Center infrastructure influenced your response planning in Colorado? We know that this was applicable and work really well within COVID, but in thinking about wildfire challenges, which we know do occur as well.

00:38:01.320 --> 00:41:04.140

Lyle Moore: A great question Jennifer. Yes, the CHTC is starting to discuss moving into an all-hazards kind of approach and building that into the plan, as well, as we move forward. You know, a lot of these different pieces can be applicable for and all hazards event and those relationships that are already there and present actually have helped with some of that already, as well. As you saw with our Marshall Fire, where we had a wildfire that moved into an urban setting with hurricane force winds that then just, you know, decimated a huge area. And in the background, because one hospital needed to evacuate, because they had flames coming up to their doors. Another one partially evacuated. And I just heard the other day they'd actually had people on the roof of the hospital with water, putting out, you know the embers the flame embers, because it was blowing. And these two hospitals are miles apart that's how far the embers were blowing. So basically, in the background due to those relationships built with the CHTC, those leads we're already talking to one another, you know. And that's another good thing I should have included in the in the presentation as well. One of the means of communication, we used was texting. We started off using emails and setting up those meetings and if we needed an impromptu meeting, we would send out an email. But then, due to the fact that, during this incident everybody's email boxes increased exponentially, some of those were starting to get buried, and so we ended up setting up a simple text group and would then start communicating the need to move into a meeting situation. But a lot of that communications was moved through simple phone text as well, which then occurred during the Marshall fire where they were talking back and forth already. So, I think that will see that change or that movement into that all hazards. It's just going to be, you know, a matter of having some breathing room and some time to then, you know start writing that and working that out with the state and how we incorporate this. Because, again, this is not a state plan, this is a plan that was developed by the hospitals with CHA and kept there. So how do we incorporate that into a statewide plan is another piece moving forward too.

00:41:07.650 --> 00:41:17.910

Jennifer Hannah: That when you were activated at the tier three level, you know you mentioned about the you know with the staffing shortages and we know we heard that quite a bit, across the country, but when you are kind of at that tier three level, does a tier three level, then mean, how do you address or manage you know, to maintain the staffing, to be able to support that you know that type of escalation?

00:41:35.940 --> 00:43:24.450

Lyle Moore: Yeah that's a great question. I think that that's you know the hero syndrome, that a lot of medical staff have within themselves. You know the transfer centers have that finger on the pulse of what that bed capacity is within each of those facilities than their system and so you know just working through that and then, making sure that the state knew that this was creating a problem that, then I know that the state's stood up, and I can't remember the date, but they stood up state staffing solution center where they were trying to pull in, you know the traveling

nurse group and all those different aspects and then pushing them out so there was no way that the CHTC was going to solve that but hearing the issues within the CHTC, to then be you know communicated to the state, let alone just having a state representative on those CHTC calls helped to quicken that process and, and you know, get to what could best be done. Because I know that there was no way everybody was going to be completely full in order to handle what they did handle. They're just wasn't enough staff out there, or we just didn't have enough money to pay for the staff that we're now triple or quadruple the cost of what some of those traveling providers were asking for. Those staffing services too.

00:43:28.800 --> 00:44:22.350

Jennifer Hannah: Thank you I'll pause for a minute and see if any of our audience has any additional has any additional questions here. Just a reminder, as Megan has stated, you know you can certainly ask the question in the chat, we can unmute you and you can ask your question, live. So again, while we are waiting, Lyle, I have another question for you. So, I saw on the timeline, and you talked about the activation, so you know after you have transfers the patient and then you get to the point of deactivation, how do you reset to normal?

00:44:23.190 --> 00:44:32.730

Lyle Moore: So yeah that's a great question and we created a couple of different methods. One CHA puts out an electronic newsletter every day. It's called Health Beat, and that goes out to multiple points within all the hospitals across the state; whether it's C suite level emergency management all the different pieces. So, we push out that communication and that step level down on how we move down, but then also what that entails, and that final de-escalation or that deactivation process, we also included and all stakeholders meeting, where we had all the stakeholders again brought back in for one big meeting to provide that information out, but then also provide some of those opportunities for questions that we could help to eliminate their the CHTC group. The system leads also agreed that individual meetings with each of their partnered facilities was a good thing too, and so they actually had meetings with their own partnered rural hospitals, also to walk through those steps and how we're moving back to normal and then that that day, we just moved back to normal. So, it was a lot of communication and I'm sure that there's you know, multiple pieces that didn't work, you know it just as communication always, you can always find improvement that way, but we tried those. You know, three separate movements are those three separate methods of communication like CHA Health Beat, the all stakeholders meeting with everybody, and then each of those CHTC leaves actually having meetings with their partner facilities in order to communicate that.

00:46:32.700 --> 00:46:56.880

Jennifer Hannah: And do you anticipate, when you do get to a point when you do have a have a lull, I think we all would love to have get to the point to have a little bit of a break. But during those students, you know, at some point when you do get kind of a break and get some time period some downtimes as well, are you planning to exercise this at certain times as well?

00:46:58.110 --> 00:48:03.540

Lyle Moore: Yeah definitely. We've already been working with the NDMS project and looking to see the value of bringing the CHTC into that process, you know. And we're going to have to build those triggers off of that, as well as, if we do finally move into that all hazards approach,

you know, what does that look like for the different regions, for the different areas within our state as well. Hopefully, once we get incorporated into the state's emergency operation plan once that gets you know activated, an exercise at moments too. So hopefully yeah and like you said you know once we get that breather.

00:47:47.640 --> 00:48:06.540

Jennifer Hannah: And are the CHTC leads, are those specific individuals that have been identified to serve in those lead roles? Or is that more of a role where multiple individuals, so that you have redundancies in place, can serve in that particular position or as the lead.

00:48:07.140 --> 00:48:43.650

Lyle Moore: Yeah great question. And, yes, each of the systems were allowed to designate. It started off with a CMO group and then quickly kind of transferred over into the transfer centers, and the people that run those and then I made sure that and pushed out that we want that redundancy as well. My background's more emergency management, so I'm always pushing for that three-deep, we didn't get it all the time, but you know we definitely had multiple people within each of those systems to help out.

00:48:46.920 --> 00:49:10.350

Jennifer Hannah: Great, thank you! Well, I'll pause again to see if anyone has any questions, but certainly appreciate you allowing me to kind of pepper you with some questions as well. This is a great interest to us, so thank you. So again, if anyone has any additional questions, please feel free to enter into the chat or we can certainly have you, if you want to, ask a question, live.

00:49:26.430 --> 00:49:28.410

Lyle Moore: I think I put everybody to sleep Jennifer.

00:49:30.570 --> 00:52:19.650

Jennifer Hannah: Absolutely not! But no, I don't see any additional questions. So, I think we're will move into kind of our general question and answer period before individuals can ask any question that you may want to ask of any of our speakers, or any just general questions that you may that you may have and we'll pause here for that as well, to see if there's any additional questions.

Ok, I'm not seeing any questions in the chat or any hands raised so I think we're going to just move into our closing and final remarks. Thank you guys. We will let you get back to your very busy days and very busy schedules, but again want to thank all of our presenters for your time today and then all of you that have joined today's webinar for your active participation in today's meeting. As a reminder, we invite you to share any stories regarding how you or your members hospitals are using ASPR funding to make a positive impact on their communities. If you have a story to share, please fill out our Stories From the Field Submission Form or reach out to your FPO for more information. A member of our team will drop the Story From the Field Submission Form link in the chat for easy reference. We look forward to hearing about the great work that all of you are doing and we know that you are doing. I know everyone is tired, but I just wanted to let you know that we appreciate everything that you are doing, and of course we know that the nation appreciates it, as well. I'm going to be to give you about six minutes back on your calendar, and again want to thank everyone for joining and have a great day, thank you.