

ASPR September Hospital Association Webinar

September 22, 2022

Call Transcript

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Wassef, Megan: I will now pass it over to Jennifer Hannah, who will open today's call.

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Jennifer Hannah: Thank you, Megan, and good afternoon, everyone. I'm Jennifer Hannah, Deputy Director of ASPR's National Health Care Preparedness Program, or NHPP Branch. Uh, before I hand it over to our first presenter, I would like to provide a brief, full review of what we will cover today. Next slide, please.

First, I will provide a few ASPR Health Care Readiness Program updates. Next, Lisa Dillard from the Strategic National Stockpile will give an overview of the Strategic National Stockpile and provide an update on its Monkeypox effort. Afterwards, Kara Amann-Kale, the Missouri's Director of Hospital Preparedness Programs, will present on how the Missouri Hospital Association use COVID-19 lessons learned to inform program development. Finally, we will leave some time at the end of the session for questions from the audience. Next slide, please.

So, I'd like to begin today's webinar with a couple of administrative updates. First off, as you know, the Hospital Association COVID-19 Preparedness and Response Activities Cooperative Agreement data collection period has been extended to tomorrow, Friday, September twenty-third by 11:59 PM Eastern Time. Please access CAAMP. Complete the required performance measures recording for year two of the cooperative agreement by this time. Should you have any questions, please contact Aldo Algarra with your FPO copies in the email. For your reference, a member of our team will drop Aldo's contact information, as well as the Hospital Association CAAMP Support email address in the chat. Next slide, please.

Next, I would like to take a moment and highlight two recently published Stories from the Field. Stories from the Field provides opportunity to highlight the hard work and accomplishments of our recipients and subrecipients. We have recently published two new Stories from the Field highlighting efforts in Colorado and New Mexico. Both stories provide an example of the range of support that ASPR funding offers recipients and subrecipients, to bolster emergency preparedness and response. To read these stories and others, head to the Stories from the Field page on the ASPR.HHS.gov site. For your reference, a member of our team will share the Stories from the Field page link in the chat momentarily. I will now pass it to Lisa Dillard, the Acting Deputy Director for the Strategic National Stockpile for SNS. Lisa.

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Lisa Dillard: Good afternoon, everyone, and thank you, Jennifer, and to the National Health Care Preparedness team for inviting us, uh, to present to your esteemed colleagues, and we're so happy to finally have the opportunity to speak with you all. You know the stockpile of any of you may know, we are new to ASPR. We were primarily under CDC for the most of our inception since 1999, and then 2018 we transitioned over to ASPR. And although we've had a wonderful relationship with the sister program around Public Health Emergency Preparedness, we've never really been able to get into the health care preparedness sector and work with you all, and I think we have seen primarily since Ebola, and now through COVID, and also the

current Monkeypox outbreak, it's extremely necessary for us to collaborate more. So, I am happy to start with this initial collaboration and present an overview to you of the SNS. Next slide.

So, we are the Nation's repository, uh, the emergency medical countermeasures and supplies and equipment. Again, we have, uh, been around since 1999 as the National Pharmaceutical Stockpile, and we currently maintain an inventory of a little over thirteen billion dollars. Our primary mission is around the chemical, biological, radiological, and nuclear threats. But we have also countermeasures for our radiation type of events, emerging infectious diseases and pandemics, and, of course, uh, natural disasters. So, although we don't technically say we're all hazards, we are, but our primary mission and our primary, uh, purpose for the SNS is to support any of those types of, uh, chemical, biological, radiological, and nuclear events that may impact the Nation. We do not own our warehouses, uh, we contract with a third-party logistics provider to provide, uh, basically the logistics management of, uh, the inventory that we hold. We also do not have, uh, trucks that have SNS on the side of them. We are contract with transportation partners as well, uh, some that you all know of, uh, throughout the country. But we do have our warehouses strategically located throughout the United States, and they do have, uh, they are managed by Federal oversight by Federal employees, but we position them across the country to provide the most, uh, time relevant distribution of our countermeasures during the time of that. Next slide, please.

I mentioned why we exist. This gives you a quick snapshot of our formulary, again. Primarily Category A Threat Agents, those that could cause the maximum, uh, health outcomes in the shortest period of time. As you can see, they're listed on the slide here. In addition to chemical nerve agent, those of you in hospital associations, or if you actually do work in in hospitals, you may have some of chem packs within your hospital. Or if you're a first responder, you may have some in your, uh, in your firehouse, uh, throughout your jurisdictions. But those are forward placed from the Strategic National Stockpile, based on the timeliness of chemical nerve agent, uh, response. We have some countermeasures for radiation and influenza. Uh, emerging infectious diseases, not necessarily therapeutics primarily right now, um, PPE, and of course, natural disasters. We have Federal medical stations that can be employed within your jurisdiction to support non-acute care. Next slide

Little deeper dive into some of the items we have. It's our formulary by threat. Um, a lot of them, you'll see in the middle column, are designed for prophylaxis. That means, let's take care of folks before they become ill, or in the case of PPE, protection of primarily the health care frontline health care workers. But then there's also treatment supplies that are designated for hospitals, and uh, I'm not sure if a lot of people understand that a lot of the inventory within the SNS is designated for a point of care in a hospital setting, and you can see some of those types of, uh, medical countermeasures here listed on the slide. And I'll go into a little bit more around smallpox. I do want to just highlight for everyone that the reason we have been so successful with getting JYNNEOS. JYNNEOS vaccine out to support vaccinations for Monkeypox because of the investments we made in smallpox preparedness. So, this is a good news story, uh, JYNNEOS is one of the vaccines that supports our smallpox response effort for those who are, you know, compromised and not able to take the primary drug, which is, ACAM2000, so we did have some within the SNS inventory, and we were able to move that within five days of notification that there was a Monkeypox incident going on, and during that time, when health

care was trying to determine exactly what was happening, we were able to get that moving and to the point of care in less than twenty-four hours. So, uh, more on that though. Next slide.

This is the evolution of our capabilities. I kind of like this slide, because it shows, and we do need to add what's happened, uh since, uh, COVID, we need to expand that for 2022 to talk about, uh, the Monkeypox response. But since we were established in 1999, you kind of see the types of events we have responded to, uh, in support of the Nation's health, and some of the lessons learned or expansion that we've done during that time frame. I will say that I truly was invited into the hospital space during the Ebola response. I think those of you have been around, they remember when we were, uh, tearing hospitals, and we were trying to determine the types of PPE that would be most effective for our frontline health care workers. And then, from the SNS perspective, we had to develop what we call then some Ebola kits that brought the PAPRs into our formulary. Previously we had N95 respirators, but we didn't have PAPRs. And what I learned, I learned from the hospital coalitions, quite frankly, of the types of inventory of PPE that, uh, were within those jurisdictions. That was really the first time SNS had to be reach down into the hospitals and get an understanding of what you had, so we could make the right investments and provide more. Uh, that has evolved during, that relationship evolved especially during COVID-19, when it became important for us to ensure we were protecting health care workers from that. I, we did do that during H1N1 as well, I don't want to gloss over that pandemic. But I think the main point I want to make is; it's we truly need to ensure that we're collaborating more with our hospitals and our associations and coalitions. So, from a supply chain perspective, we can truly understand the needs, and who's going to be responsible for what, uh, during these scenarios that I'm speaking about. At least that SNS is responsible for supporting, and then those that we're not as well. Next slide.

So, some of the key takeaways that I want you to understand, and I want you to hear it from me, we are intended as a bridge and a stop gap. We are not here to supply at the commercial market. We will enforce your distributors, uh, supporting hospitals within your jurisdiction to the extent that we can. We are not a replacement for the commercial market, and as I mentioned to the group before the call, we are actually here in Chicago with the Healthcare Distributor Association, Health Care Industry Distributor Association's Annual Conference, where we're collaborating with a lot of the manufacturers and distributors in the health care setting to talk about supply chain issues, and how we better support our hospitals. We do not define our requirements. You may have people that say, well why doesn't the SNS have this? Or the SNS should have that. There is a formal process through the Public Health Emergency Medical Countermeasures Enterprise. It's a governance body that consists of civilian, Federal, academia, industry, uh, subject matter experts that come together based on the threats that DHS has determined the, uh, nation needs to protect against. And that's how our requirements are established, and that's how we get direction on what to bring into the stockpile. And then the last point on this slide that I think is important, that we have grown since COVID-19, uh, based on investments, but primarily it's through emergency and supplemental funding. I believe that at the state and local level, you all also benefit from emergency and supplemental funding. But we collectively hampered when emergency and supplemental funding stops, and we have to remind our appropriators why it's so important to continue to enforce the emergency and supplemental funding, so we don't end up with an inability to rotate stock. That was important, maybe two years ago, that may not necessarily be as important to others at this particular time. If you understand what I'm talking about cryptically, give me some thumbs up. I'd appreciate it. I know I'm preaching to the choir. Next slide.

I want to talk to you a little bit about our COVID-19 response. Next slide.

So, we actually activated in January of 2020, and it's been, we're still activated quite frankly, and although our deployments around COVID have gone down a little, we are still prepared, uh, as vaccine those, uh, we are still supporting with ancillary kits. Uh, but we did this mission ninety percent virtually, as I'm sure a lot of you did. But it's been, it's been a ride, and I think the next slide will show you some of the activities that the SNS was engaged in. Next slide.

So, this gives you a snapshot of resupply support for the Federal, uh, the Federally deployed responders. Some of you may be familiar with ASPR's National Disaster Medical System, it's the group of physicians that may come and support you, uh, your hospital surge and hospital decompression activities. We are responsible for providing them the necessary PPE, so when they arrive to support you, they weren't a burden, and then take from the stocks that you have. They were also heavily involved in what you see in green a lot of the national support activities around repatriation. There were about seven hundred and fifty folks that had to come out of China and Japan and off of cruise ships at the beginning of COVID, and we had to place them on military bases before they were, uh, sent back to Home Station. Uh, we had a couple of, uh, unaccompanied minor incidents, and Afghan and Del Rio repatriation definitely supporting, ensuring there was enough PPE for folks engaged in those activities. In our pro-rata PPE, we deployed about ninety percent of the PPE that we held in the stockpile to the States for use, and that was further deployed down to our frontline health care providers. In addition to EpiPen distribution, once the vaccine came on board and we saw some reactions, we were able to deploy EpiPen's pro-rata to hospitals as well. You all, uh, within your associations, hospitals may have received, uh, ventilators from the SNS during that time about twenty-eight thousand were deployed during COVID, uh, in addition to support for the Federal Vaccine Campaign. I'll show you a quick slide on that. Uh, ultimate use, uh, high-flow nasal cannulas, uh, instead of ventilators, when that became an option, we were able to deploy those out as well, in addition to some national special security events that you may see, and a couple of national disasters. So, uh, with these, uh, hurricanes that you see here. So, it's been a pretty busy two years for us. I'll close with the N95 mission, if you all recall back in the beginning part of, uh, two thousand and twenty-two, deployed about little over two hundred and fifty million N95s through our pharmacy chains that you are able to get from your local Walmart, SAM's, uh, those pharmacies, so that was us as well. Next slide.

So, although the SNS did not deploy the, uh, COVID vaccine, we were responsible for procuring and working with a provider, and McKesson being the provider, to distribute the ancillary kits that supported the vaccine. So with every shot that went out, there was ancillary kit that provided the necessary needle, syringe, and tools that you needed to administer the vaccine. So, this slide gives you a snapshot of the work we did in that space as well. Next slide.

A little bit about the Monkeypox response that is ongoing now. Next slide.

So, uh, activated in May around, uh, it was around Memorial Day for the Monkeypox response, and we're currently supporting the whole of government response. We are deploying, in this case, vaccine and therapeutics, for this response to the local jurisdictions. And currently, this slide says about a little over eight hundred and thirty million vials of the JYNNEOS vaccine; also, the ACAM, which is another vaccine that can be used, and then the tecovirimat, tecovirimat, or TPOXX, that is going directly to hospitals to support those who may have contracted Monkeypox disease in their treatment. Next slide.

So this slide just gives you a little bit of information around how we have been effectively deploying the vaccine. One of the things that's going on now is we currently have an enhanced distribution strategy. Uh, if you've been involved in the Monkeypox response, originally, the SNS was deploying to about five sites within the jurisdiction, um, when we were deploying the vaccine, we have since contracted with AmerisourceBergen, and we're now able to expand that to up to one hundred and fifty sites within the jurisdiction, so we're very proud of that initial capability, uh, and that's just a good thing. I hope you all are benefiting from that. Next slide.

I spoke about some of the countermeasures that are directly for hospital use. The TPOXX is one of them. It is in IV form, and also an oral pill form. And um, if you are getting TPOXX in your jurisdiction, um, that was primarily going to hospitals for time-sensitive case use, but also being coordinated, uh, through consultations with the Centers for Disease Control and Prevention. So, I do want to highlight, especially for this group, that when we, normally with countermeasures from the SNS are going directly to hospitals, it is for those time-sensitive cases, and normally the providers have reached out to CDC for consult or guidance, and then that comes through the stockpile, and collectively we have discussions of this deployed to the, normally the actual hospital or pharmacy that does need the countermeasures. Next slide.

Some current SNS initiatives that I just wanted to lead with you all. As I mentioned, next slide.

Our primary, um, connection with state and local public has been through the Public Health Emergency Preparedness Cooperative Agreement, as you can see from some of the information I gave you around our formulary, uh, it is important for us to talk about point of care use, and ensuring supply chain issues with that segment of our, uh, stakeholder hospitals primarily, uh, is covered, and we have collaborative plans in place to ensure, not only health care providers are protected, but also patients are treated. So, we are working with Jennifer and hopefully with you all, and your jurisdictions to become better, uh, acquainted in the space, and to come up with some common, uh, working goals that are together to ensure we have an accurate supply chain that is viable and supportable for you all. Some of the things that we've done within the stockpile is started to uh apply for uh presentations within the healthcare coalition conferences. We haven't done that previously. So we were able to be successful in two thousand and twenty-one, uh, in Florida, and look forward to, uh, presenting in Anaheim in November, and then also, excuse me, as I spoke about today being here with HIDA to talk about some of the collaborative, uh, supply chain issues with manufacturers and, uh, distributors, uh, one of the other things that we are also doing is, we're starting some regional meetings, uh, and we'll be going to all ten of the, uh, HHS FEMA regions across the country, and having significant conversations, not only with the public health groups, but also we're hoping you all from the hospitals will join us, and we can talk about some goals for FY23, and some of the gaps that we may have in a collective response supply chain, whichever side of the fence you sit on, we just wanted to ensure we're doing more collaboration. Next slide.

I think that's all. I have a couple of resources for you, um, so I just wanted to, I see some questions up, and I'm not sure, Jennifer, if we want to do them now, or if we're doing them later, I couldn't remember what you said, but uh, I'll turn it back over to Jennifer. Thank you all.

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Jennifer Hannah: Thank you Lisa. And we actually are taking questions now. If you have any questions for Lisa, uh, regarding SNS. A reminder, please enter those into the chat, or you can

raise your hand, and then we'll call on you for you to take yourself off mute, and to ask your question live.

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Wassef, Megan: And Lisa. It looks like there's a question that already came in the chat. I'll go ahead and read out to you. Um, John Wilgis said, "There's a lot of reporting around changing the structure, purpose, material of and within the SNS going forward. Will you speak to the future of SNS? Is there any consideration of partnering with large supply chain partners to create vendor-managed caches? Um, any thought given to diversifying the SNS to more regionally located caches, expediting the delivery of needed supplies and resources?"

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Lisa Dillard: Yes, yes, and yes, I think. I mean we're already engaged in different types of, uh, vendor-managed, uh, inventory acquisition contracts, uh, that's already a part of what the SNS does. Um, there's always talk of what can be included in the SNS. Um. The SNS is already positioned regionally, uh, throughout the United States, to enable, uh, the most timely delivery, and expanding with sites as well, so there, there's a consistent evolution of what we are, what we have, and that those are continuous discussions. I hope I answered your question, but I think one of the things, I'll just follow, I think one of the things that we would, I would like to ensure we do is once those happen, we have a way of informing you all. So, I'm hoping that's what this type of form will help us be able to do more clearly and, quite frankly, you hear it from us. Over.

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Wassef, Megan: Great, thank you so much. Thank you, John, for your question. Um, in the interest of time, I think we'll go ahead and move to the next presentation. But I encourage everyone on the line, if you do have a question, um, please do leave it in the chat and we can visit it, um, the general Q and A portion. Um, thank you so much to Lisa and the SNS team for your presentation today. It was wonderful and greatly appreciated having you on the call, so, thank you very much. Um, I will now pass it over to Kara Amann-Kale, Missouri's Director of Hospital Preparedness Programs who will present on the on Missouri's Hospital Association, and how they use COVID-19 lessons learned to inform program development.

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Kara Amann-Kale: Thank you, Megan, and thank you to ASPR having me here today to be able to share this. I really appreciate it and appreciate everyone here listening. Um, so as, like I said, my name is Kara Amann-Kale, I'm the Director of Hospital Preparedness Programs at the Missouri Hospital Association, and in my role, I manage of two of our preparedness grants. So, the first one, the HPP grant that we get through our Department of Health, um, and we, um, are, um, we lead the Non-Urban Missouri Health Care Coalition, um, and are the administrators for EM resource in our State through that grant. And then also the State Hospital Association ASPR funding that we received. Um, So I lead those two programs and some of our preparedness programming for our hospitals. You can go ahead and go to the next slide.

Um, so today I kind of just want to talk to you about how we're using our COVID lessons learned, um, in our funding. So, when we're looking at the programming for our members as we shift from more of an acute pandemic response to managing, um, COVID within the care

environment, we're really trying to utilize, um, lessons learned during the COVID response, while retaining or kind of returning to an all hazards response, but not wanting to forget what we've learned over the last few years, and then we kind of have three goals of what we're trying to do we're trying to drive long-term improvement of Hospital Preparedness Programs, drive long-term engagement, um, in preparedness programming statewide. And then to drive alignment between emergency preparedness and other areas of the hospital including infection prevention, and clinical and executive leadership. So, we saw many silos break down during the COVID-19 response, and the benefits of this, and how many people knew about, cared about and were involved in emergency preparedness, and how much the different areas of the hospitals interacted with each other. Um, and we want to maintain this, but we have to be intentional about that. If we're going to maintain this going forward, so we're developing opportunities for our hospitals to engage that foster this approach and get people together so we can go to the next slide.

So, to inform that we really, um, as a key to a success of our programming, um, and a key to driving improvement, is engaging our members in development of that programming. So, we ensure that we're getting the educational and technical assistance that they need. Um, so really, again, our members advise our strategy, that's grounded in those COVID-19 lessons learned, also all hazard's approach is always something that we do. So, several different sources that we use to inform our programming. We have an emergency preparedness and safety program assessment that we do annually. It captures a lot of like demographic, a lot of data points, but also the purpose of this assessment is to capture needs of all of our hospitals to inform the programming that we offer. We also have an emergency preparedness and safety advisory committee. Um, so basically our group of subject matter experts from across state, um, that they're very diverse group of people, different sites, facilities, some rural, some urban, um, different levels within the facility, and they vet and inform our strategy going forward, and all this program that I'm going to talk today, they help vet, and they help design. We continue to have member touch points, and then one other point that we have, um, right now is that, uh, unfortunately, as much as we all in COVID gone, I know you all know it's not, um, and so the ongoing responses as we go into the fall and winter. We also have a group of about twelve subject matter experts in this space, again, um, a diverse group of people of different geographic areas of our State, rural and urban, in different, uh, positions within the hospital. They're advising us, um, throughout the COVID-19 response through the fall and winter, coupled with Monkeypox, and flu. Um, just kind of so we can keep our own truth and know what support our members are needing. Um, we again, with all of this, try to keep in mind all of our hospitals, I'm sure in your State, any of your States have hospitals that you know, vary in size and resources, and so we try to make sure we have something that's applicable to all of our members. And then so I'm going to go through five different initiatives that we either have recently completed or are currently working on, that is really based in these goals, and then our members informing the programming, and, as I said so I'm going to just go through the next five slides and kind of talk about what we're doing. If you have questions, please throw them in there, and I'll address them. Um, so first, if we can go to the next slide.

Um, we had about a month ago, on establishing and maintaining collaborative settings of are conference. So, our theme for this was supporting clinical and operational leadership through COVID-19 and beyond. So, when you get the slides, you can see a link to the conference agenda and the details. But really our purpose for this conference was to engage multidisciplinary teams of members from our hospitals to maintain that collaborative approach

that I talked about, and then to share a variety of topics under the umbrella, creating and providing state environments of care. I will tell you, naming this conference was hard because everybody has a different name and what they call the environmental care, if it's TJC, or if it's D and B, you know it's physical environment. So, we had to try to be careful around that not to isolate some people, because people had strong feelings about the verbiage used. Um, and another purpose of this was really to talk about our lessons learned during COVID, how that it impacts future care environments and being prepared for future threats. And we also saw it as a celebration of what our hospitals accomplished in the last three years, because they've done some pretty amazing things. And so, we invited a lot of different people, including emergency preparedness, infection, control, safety and security, facilities management, material management, we saw many, many different disciplines, um, at our conference, which was great. Um, and the topics that we included, um, were infection control practices during COVID, and how that impacted them, what they've done going forward. Um, applying all hazard principles to emerging infectious disease. Um, what our facility likes to call an all-pathogen's response so not an Ebola, not a COVID, not a Monkeypox response, but looking at it all together. Building infrastructure impacts of COVID-19. Incident management for hospitals and a team-of-team approach. Staff well-being and mental health and the impacts of COVID. Violence and health care and patient and family engagement. Um, this is the first time we got these groups together, a lot of times we have separate, um, conferences for different groups of people, but really, we saw the interaction between all of these topics, and how it touched many different areas. And so, some of the quotes from the attendees was: "This event was wonderful to attend. It paid respect to what we have all gone through for the past three years, what we are currently going through, and what can be done to change and approve the future of health care." And then another person's, and "I feel like I'm leaving with a new set of encouragement for my team." So, it was a really good time to get them together. We kind of brought in quality in clinical folks and more of our operational preparedness folks. Where I sit in the Association, I sit in the Quality Safety and Research Department, and so it was a good intersection between our different technical assistant areas. So, consider, I would encourage you to consider that in getting people together from your hospitals in there. So, um, next slide, please.

The next thing that we've really identified is incident command curriculum. We have a need that we've identified for leadership teams and operational staff to have education. And then, through our advisory committee and through our assessment, we really found that, uh, that incident command training for executive, operational and clinical folks is one of the top needs, so based on that we've decided to move forward with that. It's really seen as an opportunity to get some executive engagement, and we want to incorporate incident command training with broader preparedness topics for executives. And then really, we're going to develop post COVID-19 incident command modules really looking at the impact of incident commands throughout COVID-19 challenges to incident command and modifications made. And in this area, we are really looking at, what is the difference in management of a long-term event versus a short-term event? Because I think we saw some ways that incident command was challenged throughout COVID-19. Because um, you know, we didn't predict it an event that would go on for three years and then some future changes. Um, we're really also trying to incorporate best practices from hospitals to help bring those incident command topics to life. Um, so they're not just something on paper, but they can see how they're demonstrated. Uh, next slide, please.

The next area we've identified is supply chain technical assistance. So, unfortunately supply chain issues aren't going away, um, they are continuing. They were very present in COVID, but

we also continue to see those ongoing, so we know it's something we need to address. We know we need to talk and have conversations and convene people to talk about strategies, to address the challenges that have been identified, but also to prevent the expiration of caches and stockpiles of supplies, making sure items are rotated through, so when we need them, and we go out to those trailers that, um, the stuff is usable. So, we are convening material management staff that is specified chain integrity and optimization to include PAR level strategies just in time, training, stockpiling, and all of those lessons learned from over the last three years which there have been many, as the supply chain has been greatly impacted, and then we are going to provide reimbursement through the ASPR State Hospital Association funding for hospitals, supply purchases, as part of a larger hospital defined strategy following participation in that technical assistance and an acknowledgment of a hospital plan, so we can make sure that those caches are going to be maintained, or that increased PAR level has a plan for it. Next slide, please.

The next thing we identified is the emergency preparedness and safety orientation. We know there's been a high turnover of staff in the last three years, um, in our field, um, and there's been a lot of loss of institutional knowledge and competencies, so we know we need some orientation training to help individuals who are orienting to their role and new to their role. Our structure, we review the role within the hospital of preparedness and safety staff, how it relates to all aspects of hospital operations, so you know, infection and prevention, material management, and how to incorporate them also those other disciplines into the emergency preparedness work, and then how to incorporate into the larger community preparedness activities, whether that is more local or regionally of your health care coalition. It provides networking opportunities in contacts throughout the State for others who are new to the feel that they can work with each other, and it's a virtual engagement over several weeks. Um, and then our topics are crediting bodies and standards, uh, EOPs, uh, Hicks, uh, clinical preparedness, battle buddies, tools, exercise and training, and really just kind of incorporating lessons learned from the last few years and different responses that we've had next slide, and I'm almost done.

I'm on my last initiative that we're tackling. And this is one that I might be the most excited about, so we are trying to develop emergency preparedness metrics. So, there are a lot of metrics in health care outside of preparedness that are used to assist with improvement. But emergency preparedness has historically been hard to measure the impact or outcomes, or outputs, sorry outcomes instead of outputs, a lot of preparedness is preventing or lessening the impact which is hard to quantify. So, we're trying to get some metrics together to talk about, what are the impacts of preparedness? What are the returns on investment? So, we have a small group that is tackling this from our advisory committee, we have a subcommittee that's meeting pretty frequently to do this. In first, what we did was we started with defining our purpose and goals. So, our purpose is to inform, analyze and optimize hospital preparedness programs and to understand the overall performance and values of these programs. So, the goal of how these metrics will be used by hospital is to benchmark on their programs, um, and identify areas for improvement. Um, also to compare their programs to other programs in the State. They will all be at an aggregate level; it won't be at individual facility levels. Strengthen programs by communicating best practices through the metrics. Demonstrate return on investment, especially for senior leadership, on what value do these emergency preparedness programs bring their facilities. And then, also at a state level to identify technical assistance and training opportunities that we can provide. If we see some areas where over, across the board, um, we could improve some metrics. We will focus in those areas, and then we have some

guiding principles that we've come up with. We have five categories that these metrics will be in, communications, physical environment, programs, training and exercise, and then some hospital demographics. The hospital demographics is really so we can help, um, compare like size, or like hospitals, and break it down a little bit like that. Um, each area will have three to five metrics within them, and then the goal is to be objective to get objective data, um, define it well and explain why that data is important, and then applicable to all of our hospitals in the State, no matter their size or type of hospital. So, um it seems easy on when we first started, but really getting in and defining this, um, is a little bit difficult, so we're going section by section for the end of the year, and hope to have metrics by the end of the year, and to be rolling out, uh, it out to the next early next year, getting approval of it, and then trying to roll it out to our hospitals in a in a easily collectable form to kind of start that analysis. So next slide, please.

Um, and those are kind of our initiatives. Those are the things we identified, um, through those different sources. So, if you have any questions or want to see anything we're doing, a lot of this is in the work, so I can share where we're at now, and where we're going as we get it developed. But there's my contact information. I know I know a lot of you on the line, but if I don't know you, um, please feel free to shoot me an email or call anytime, and I'm happy to chat about any of this. Thank you.

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Wassef, Megan: And Kara, thank you so much for your presentation, just as a reminder. If you have any questions, feel free to um, come off mute, or put your questions in the chat.

00:41:44.620 --> 00:41:57.559

Jennifer Hannah: And Kara while, this is Jennifer, while folks may be queuing up their questions, and I'll start off with a few questions for you. How many hospitals, how about many member hospitals do you have?

00:41:57.950 --> 00:42:07.020

Kara Amann-Kale: Um, around one hundred and forty. Sorry that number has recently changed because we had one merged together, so one hundred and forty.

00:42:08.430 --> 00:42:27.499

Jennifer Hannah: What are your next steps following the establishing and maintaining collaborative settings of care conference. Yes, and just to follow along with that is and how do you plan to maintain and some momentum in interest following the conference?

00:42:27.510 --> 00:43:17.310

Kara Amann-Kale: Yeah. So, we know we have a short window of time right, especially for some people who are engaged in preparedness to some of the other initiatives that we're doing. We're also having a webinar series, and really trying to be intentional about topics that we're talking about to still engage that wide group. So, for example, one of them that we're having is on about mental health and stigma in in health care, um, and help seeking for that, um, and it's a continuation, actually, of a speaker who is at our conference, and so now she's kind of offering a bigger presentation that we're doing that. So, we're trying to be intentional with our webinar opportunities. Um, and it's also an annual conference, so we're starting to plan the next one,

and then we will keep that going and kind of expand, um, that conference out each year is, um, to bring in a little bit more, um, is our hope.

00:43:20.490 --> 00:43:31.180

Jennifer Hannah: That's great! And thank you for that. And how did you assess and identify the needs for the curriculum or for the different initiative?

00:43:31.190 --> 00:44:37.270

Kara Amann-Kale: Um, so a lot of it, it comes from our, uh, we do a yearly, uh, assessment of emergency preparedness and safety programs across the state, um, this year we're getting ready to launch it. It's about sixty-five questions, but it's ranged from sixty to one hundred questions in the past, and in that we really just ask, um, some of it is objective data that will help us identify needs, and then some of it is also, um, asking members what the needs are in analyzing that for the trends of what is the most needed. And then our advisory committee really also helps to break down that data and to validate that going forward. We also are fortunate that over the last three years we've talked a whole lot with our hospitals, and so they've given us a lot of information about what would be good, so kind of hearing all those different sources of data together to come up with a final conclusion. And I will say, there's probably five other things or more that we could be doing, and so we'll continue to look at that. But these are kind of the first step of it.

00:44:39.300 --> 00:45:04.060

Jennifer Hannah: Thank you for that, and thank you for that additional information, because I was about to ask, you know, I would imagine, with the amount of information that comes in that you also have to, there has to be some prioritization of that now as well to determine. You know which of those things that you'll be able to move forward. And I see a hand raise for John Wilgis. And John, you can take your step off mute and ask your question live, please.

00:45:04.090 --> 00:45:45.139

John Wilgis: Hey, thanks Jennifer. Kara, two quick questions. One is with regards to your incident command. What is your biggest impressions on the changes needed, or the use of incident command with executive leadership? And then my second question is related to supply chain issues and what you're looking at. When do you expect to get any real insight, uh, within your work around supply chain, and to be willing to come back and report out what you learned to me? Uh, that's the biggest issue, uh, it's supplies and resources, and I'd be really interested in learning more about what you guys learned. Thanks.

00:45:45.180 --> 00:49:09.180

Kara Amann-Kale: Um, so first with incident command, one of the big things that we've had is defining what the leadership role is, right. So, are they the incident commander, or are they, you know, more in a different role? Um, it differs by hospital, um, it differs by person you ask an opinion on that, too, but trying to help define that. Um, also the big thing that we see, too, is really in that long, long event management, and how can we, how can we craft incident commands to handle a really long ongoing event? In Missouri, um, it's probably not something you think about with earthquakes, but we sit on one of the largest fault lines in the state. Um, we are very lucky that we don't have a New Madrid seismic zone earthquake, um, often um but we

know it'll be a very big and destructive event, so, we know that we will have a very, very long-term event from that so trying to use a lot of those lessons learned from COVID to inform those discussions, so, when we have any of those in the future going on. I think some people also, though, so trying to balance that with a lot of our events are short-term events, um incident command works very well. Um, and you know you don't want to throw the baby out with bath water, because things didn't go well, so, maintaining that, um, trying to get back to an all-hazards approach with incident command. Um, and then I will get to your supply chain. I see a question about incident management in the chat, so I'm going to do that, and then get into supply chain or the incident management efforts focused on individual hospitals, incident management or other. Yeah. So really trying to develop curriculum to help with facility-based incident management. Also, it is called out in New Joint Commission Guidance, so that will help with the crediting accreditation. We know not all our hospital are for Joint Commission, but the majority of our hospitals in Missouri are. Um, and then for supply chain, yes, I'm super happy to get back on and talk about that. Really, we're trying to get to some understandings of what strategies can be good going forward. We've started with a little bit of a bigger picture. So the health care coalition is how to do a supply chain integrity assessment. And since we run, um, one of Missouri's three health care coalition, we started that we took an approach across Missouri, though with the other two health care coalitions, to have a standardized integrity assessment. Now, that includes more than just hospitals, so first starting to look at that, we are starting to narrow it down to what our hospitals responded to inform our work. Our hospital-specific work. Um, so we're still pretty early in that. Um, but I'm happy to get back on as we develop that, uh, development more because we too, see that it's one of the probably top threats for our hospitals, and is just being able to get it job in, and it and it's constant. You know we; I can probably name all you know five or six different things just recently. Um, that we've had supply chain concerns with, um, and we know pharmaceuticals, there's always different pharmaceuticals that are. So, I'm happy to come back. But it's still very early, and John, I agree with, uh, Hicks. There's also definitely a difference among corporate offices and individual facilities. When we're looking at a system, and we have a lot of big systems, so have to think through that as well.

00:49:20.210 --> 00:49:52.960

Jennifer Hannah: Kara, just one quick, final question, while others might still be queuing up their questions. And that is, you know, has the programming that you have developed and implemented so far, has that supported your hospital response to the Monkeypox, and you know it has that, being able to transfer that program and to be able to take some of those lessons learned, or being able to see how that programming would apply to the Monkeypox response?

00:49:53.270 --> 00:50:50.649

Kara Amann-Kale: Yes, and that's a wonderful question. We really are trying to make sure all of our programming, while it is, so a lot of time a lot of right now, we talk about COVID lessons learned, but really about how it goes to that all-hazards approach. So, a lot of what it, we've been able to, um, to widen, to be applicable to Monkeypox as well. Um, I actually at the conference we had somebody presenting. It was one of our hospitals that was an assessment hospital in the State, and it was really awesome to see, because they gave a presentation about really talking more about emerging infectious diseases, and one plan rather than having individual plans. Um, and they talked about how all the programming from Ebola, and in the

programming from, um, COVID, um, in both the funding, the Federal funding and the State programming that we've been doing around those differences. You just help them, um, in their COVID response, but Ebola helped the COVID, and the COVID health and Monkeypox. So, it was really nice to see that that transition, and how that has helped build.

00:50:54.330 --> 00:53:56.609

Jennifer Hannah: Thank you for it. Thank you for that. And then, of course, just Kara, thank you for such a wonderful presentation. And also, we're responding to all of the various questions. So, we have a few minutes before the top of the hour, and we'd like to open the line for any other questions, for either of our presenters, or for ASPR in general. And just a reminder, as shown here, that you can certainly enter those questions into the chat feature, or you can raise your hand to ask your question verbally. And as I said, you can ask any questions for either of our speakers, as well any general questions for ASPR. I'm not seeing any questions in the chat or any raised hands. So, I think we're going to just move forward with our closing remarks for today. Of course, I want to thank all of you, as well as thank our presenters, Lisa and Kara, for your time today and for our participants, our audience, to thank you as well for joining and for your active participation in today's meeting. I know everyone is extremely busy, and for you to take out, you know, take an hour away from your very busy schedule. We're very appreciative of that, and of course want to thank you for all the work that you are doing on a daily basis. But as a reminder, we invite you to share any stories regarding how you, or your members, are using, asking for funding to make a positive impact on your community. And if you have a story to share, please fill out our Stories from the Field submission form, or reach out to your FPO, your Field Project Officer, for more information, and a member of our team will drop the Stories from the Field submission for link in the chat for easy reference. The we look forward to hearing about the great works that all of you are doing. So again, thanks, everyone for joining today's call, and we hope you have a great day and a great afternoon. Thank you.