September Hospital Preparedness Program Recipient Webinar Transcript
September 14, 2022
Call Transcript

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Megan Wassef: I will go ahead and pass it over to Jennifer Hannah to open today's call.

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Jennifer Hannah: Thank you, Odessa and Megan. Good afternoon and thank you for joining us today. I am Jennifer Hannah, Deputy director of ASPR's National Health Care Preparedness Programs, or NHPP Branch. To begin today's call, I'll provide an overview of our agenda. First, Lisa Dillard, Acting Deputy Director of the Strategic National Stockpile, our SNS, will provide SNS updates. Then, I will pass it to David Csernak and Gbadero Yerokun from the Health Care Medical Response and Search Exercise, our MRSE Team, to provide a demonstration of the MRSE real-world tool. Finally, I will provide a few Hospital Preparedness Program announcements. We will conclude with general Q&A and closing remarks. I will pass it to Lisa Dillard, the Acting Deputy Director for the Strategic National Stockpile, or SNS.

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Lisa Dillard: Thank you, Jennifer. It's wonderful to be here with you again. I think the last time we were able to join you was in June. A lot has happened since June, but some things haven't changed. I'll review for you that we're still the Strategic National Stockpile, the nation's largest repository of emergency medical supplies and equipment and are still working on the 13 billion dollar inventory of medical counter measures for these types of scenarios. We are still primarily responsible for ensuring we have medical countermeasures to support any type of response that we may need within the United States in addition to the chemical, radiation, pandemics, and emerging infectious diseases. An update I have is the monkeypox response, at least from the SNS perspective, has been as quick and successful primarily because of the investments and preparedness planning we have done as a health care community and public health community around the smallpox response. Those of you who may have been with us, may know that through the HPP, we still have those requirements for the "Category A" Threat Agents, which has truly been beneficial for our preparedness and quick response towards monkeypox. For those who may not have been on in June, I provided this slide as an overview of the SNS formulary by threat, not necessarily by type of drug, but by the types of drugs and their purpose. I wanted to share this to remind us that when you look at what we have for the threat, primarily around the prophylaxis side, we are looking at those types of medical countermeasures that may be used by public health in points of dispensing or mass vaccination clinics. When we look on the treatment side, we're looking at those countermeasures primarily designated for the hospital point of care. From an SNS perspective ensuring that the hospital preparedness side and public health care side are linked is truly one of the missions that we have going forward. I have to thank Jennifer for including us on these discussions, so we can bridge that gap together. I want to remind everyone that we are intended as a bridge and a stop gap for the commercial market when it comes to those items such as personal protective equipment. It is not intended to replace or substitute the commercial market, but in some instances, we are, meaning the SNS and the Federal Government, we are the only game in town to support the response. And again, we're seeing that monkeypox is a clear example of this. The SNS does not define our requirements, so if you're looking at our list of what types of drugs or vaccines,

therapeutics we may have in the SNS, it is a governmental, collective body including the government, academia, and everyone at the table around Public Health Emergency. The Public Health Emergency Medical Counter Measures Enterprise is one of the very accurate acronyms that we have that does determine what goes into the stockpile. And lastly, we had the luxury of expanding our inventory, that increased the breadth and depth of the SNS, primarily around the emergency and supplemental funding. But, like you all, for the monkeypox response, we have not received any supplemental funding. I believe the emergency funding has been used for this, but I think as a community we can kind of see the difference when we do not have supplemental funding, and we have to work with the resources we have in order to accomplish the mission. We were activated when I spoke to you last, probably about two weeks in, but we've been activated since May of 2022 for supporting the National Monkeypox Vaccines Strategy. It's a comprehensive whole of government, public health response. We participate in daily calls with, not only the White House, but a lot of the other agencies within the Department of Health and Human Services, CDC, specifically with those who manage vaccines at the State and local level and those grant recipients on the vaccine side. There is a lot of collaborative effort around this. We're deploying medical counter measures, both vaccines and therapeutics, throughout the country. There is about 1, 700 deployments from the SNS warehouses specifically divided between the Jynneos vaccine, according to the vaccine deployments set up by the CDC and HHS, and the oral and IV formulations that are being distributed directly to hospitals. One of the strategies, or, I guess, the primary goal of the National Vaccination Strategy is to ensure that we are equitably allocating and distributing our countermeasures safely and effectively. We have made about one point one million vials of Jynneos available for ordering in the States and delivered as of September 2nd about 800,000. I think today's number was 830,000 vials have been delivered. We're supporting some pilot programs based on certain populations. There were a lot of Pride events going on that support the target population for Monkeypox. We allocated within the amount we had within the Federal Government to those jurisdictions hosting those community events and allowing them to do some on the ground interventions. We are looking at other populations that may emerge, and the one that the ASPR was concerned about was college campuses as school was coming back. We're trying to stay ahead of those types of, gatherings or people coming back together that may require some additional interventions and support. I've been providing some ongoing technical assistance to the jurisdictions, as they plan, but also from our perspective, ensuring they have distribution plans in place to help effectively support getting the vaccine and countermeasures out to the population. BARDA is working to require additional Jynneos vaccines and we're looking to increase our inventory towards the last part of the year. We'll have more information to come as they come into our stockpile. We are looking by the end of the year to truly have a lot more Jynneos within the stockpile. ACAM is not necessarily being used at this point, but it is approved in one of the regulatory mechanisms as an expanded use for monkeypox. It is one of those countermeasures approved for, um smallpox preparedness. I do want to mention that Jynneos was within our formulary along with ACAM for vaccines to deploy for smallpox, but it was primarily approved for smallpox in those populations that may not be able to handle ACAM, the immunocompromised population. We'll also talk about implementing enhanced medical countermeasure distribution strategies. We entered a contract with a distributor and we're going to enhance our current distribution and it is going to be broken down by jurisdiction based on how much vaccines you have been allocated. I hope that works for you all and more information will come out. We are very excited about that because we realized it was a challenge. We realized that equities were involved, and quite frankly, our director, since we don't have supplemental funding, took some

money out of the hive. We'll figure out how to replace that money later because this is important now. I'll close with some current initiatives. I spoke last time about how we are happy to be here because we haven't had a relationship with this stakeholder group as much as we would have liked to. We know the PHEP well and getting to know you is necessary because most of the items that we have in the stockpile are designated for hospitals and point of care use in addition to originally the personal protective equipment in the stockpile designated for the protection of health care workers. There are some equities that we have with the health care community that we're hoping we can continue to talk about and improve upon within this forum. I mentioned we were trying to do things to get into the health care preparedness arena. We are presenting in Anaheim in December 2022. I mentioned we were trying to have some regional engagements. We have our first one on the books for Region 9 within the first week of November and we are ensuring that the health care preparedness, stakeholders within the States are invited. If you're in Region 9 and you have not heard about this yet, I'd encourage you to get with your colleagues or you can get with us directly. Just send me an email at LSW9@CDC.gov and we'll ensure that you are incorporated into that planning because we want you there. We want to hear about the topics that you think we need to talk about as well. I think that is my last slide. Thank you for the opportunity to present.

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Jennifer Hannah: I want to thank you Lisa, for being a partner, and being willing to come on to these calls. I see that we have a hand raised from Aaron.

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Aaron Gettinger: Thank you, Jennifer and Lisa. I appreciate the time you've been putting into these updates. You mentioned that the SNS is supporting a pilot program to provide additional vaccines to some jurisdictions for large community-based events. Could you share how a state would participate in that?

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Lisa Dillard: The pilot was primarily around Pride events that were going on throughout the country within the past month or so. Charlotte, Louisiana, Atlanta reached out to CDC to get some additional support, so they wouldn't necessarily have to use their allocations with that type of a larger population coming in. I would think if you had any type of questions or specific events that were going on within your jurisdiction that were going to strain you, you'd reach out through your vaccination points of contact to the CDC. And that's how they have been getting into us for the National Vaccine Strategy.

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Jennifer Hannah: Just a reminder, for anyone that has questions, please feel free to enter those into the chat or raise your hand, and then we'll call on you, so you can unmute yourself. I'm not seeing any questions in the chat or any raised hands. I think we're going to go ahead and transition to our next agenda item, but please, as a reminder, we will have time to answer questions at the end of today's call if something comes up. And, certainly, you can direct any of those questions to us, to Lisa, and any of the other speakers that are going to be forthcoming. We're going to transition now to the MRSE team with Dave Csernak and Gbadero to give you an overview and a demonstration of the Medical Responses Search Exercise Real-World Tool.

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David Csernak: Thanks, Jennifer. Before we get started, just for everyone's awareness, this tool was created following the feedback that we received from multiple HCCs over the past year. It is a great example of how the MRSE will continue to grow and develop and evolve based on use and feedback provided by health care coalitions across the country. The MRSE is an exercise requirement; however, unlike other program requirements within an HPP, we decided to institute a flexibility in a process for health care coalitions to utilize real world incident responses to satisfy their sustainable requirements. To assist the health care coalitions with determining if an incident response qualifies for the flexibility, we put together a list of criteria and incorporated a pre-screening questionnaire that health care coalitions can review and complete prior to seeking approval from their state as well as from their assigned FPO. Before we go any further into the tool, I'd like to quickly review the criteria. For a response to really be considered, first and foremost, the health care coalition must activate their coalition's response plan. Additionally similar to the exercise itself, the coalition will need to support or respond to a surge that's equal or greater to twenty percent of the required bed types within their jurisdiction. This is similar to the exercise and is the core requirement of the MRSE, so there isn't a lot of flexibility around the twenty percent piece. But this is one of the things that as coalitions become more familiar with what their baseline twenty percent is, it will allow them to more quickly determine whether an actual real-world response would qualify to meet this requirement. We're not anticipating a lot of real-world responses throughout the year. However, you never know what happens. Things may pop up that qualify, but we anticipate there's going to be a lot of responses that health care coalitions support that don't quite cross that threshold. In addition to the total volume of surge itself, at least one of each of the health care coalition members core members have to participate in the response, so each of the core members need some role in the actual real-world response and at least one executive from each of the core members should be participating in the AAR Review. This is one of those criteria that we look at closely with the exercise piece, but when it comes to real-world responses, we tend to see that there's a lot more engagement in AARs, so I don't anticipate there being a lot of issue with this one. Health care coalitions also need to be able to capture all the data points required for the MRSE performance measures, or PMs. So, it's going to be important that health care coalitions are familiar with the performance measures, what those requirements are, and what those data points are prior to any kind of future responses to allow them to ensure that they're trying to collect and address some of that information during the actual response or have the ability to go back and find that information after the fact. Just like an exercise, real-world responses typically will have an AAR with an improvement plan associated with them. The health care coalition doesn't necessarily have to lead the AAR process for the response, but they should be engaged in it, participate in it, and contribute to the AAR. The AAR may be developed by another agency; however, during the review process when we're looking to determine if the incident would qualify, we may request that the coalition provide a copy of the AAR for additional background or understanding of information as to the coalition's role, the type of the scenario, the scope of involvement the coalition had, the impact of the health care system, et cetera. As long as a health care coalition has access to that AAR, that will be key in determining whether or not it qualifies. And then, finally, just like the exercise, the real-world response should be something that has discrete bookends. We're looking for a surge. It takes place within a finite period of time in order to determine whether or not the health care system is truly being surged significantly at any given time or whether it's one of those slow burn over a long period of time in order to try

and get the numbers kind of piece, but we're looking to find responses that do have a specific start and a specific end date. Aside from that, those are the core criteria. There's some additional information that Gbadero will review moving forward. Once we get into the tool, you'll be able to review and assist the coalitions with it moving forward.

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Gbadero Yerokun: Thanks, Dave. What we see on this slide here are the materials that health care coalitions, or HCCs, will use as they prepare to complete the real-world tool. Starting from the left, we have the tool itself, which is located in the CAT only. I'll walk through it shortly to highlight the slight differences from the exercise tool. Next, is the situation manual, which includes instructions for each tab of the real-world tool in Appendix C. The situation manual is found on the CAT and the MRSE website. And then we have the evaluation plan, which provides additional guidance on how to calculate the performance measures. It's also found on the CAT and on the MRSE website. Please note the new ASPR logo for the MRSE supporting materials. So here are some important considerations for sub-recipients to take note of when they're using the tool. As David mentioned, the first tab in the tool is a questionnaire which must first be submitted to the HCCs recipient and FPO for approval to meet the MRSE requirements prior to completing the tool. All tabs preceding the improvement planning tab should be completed in full to ensure all performance measured data are collected. The After-Action Review tab in the tool must be fully populated to support some of the HCCs PMs, or performance measures. And the HCC should have an AAR, or an improvement plan available upon request. Finally, the only optional tabs in the tool are the improvement planning tab, and the participant feedback tab, which I'll show you in the tool. Now I will open the tool and focus on highlighting the key differences from the exercise tool. When the HCCs open the world incident reporting and evaluation tool, the first tab that they'll see is the questionnaire tab, and the intent of this tab is to help the HCC determine whether the real-world incident qualifies for use in rule of conducting the MRSE exercise. I'll start up here in the instructions. We're asking the HCCs to answer all this training questions and to provide additional details about the scenario. As Dave mentioned earlier, they must have core executive member participation in the AAR and should have the AAR and IP available upon request. And we're asking them to submit this completed tab to the recipient and FPO for final review and approval prior to completing the remainder of the tool. If they have any questions about the prerequisites or parameters, we'll be referring them to their recipients and FPO, for additional guidance. Scrolling down on this tab, we ask for the HCC name and the HCC recipient. In this first table here, the real-world incident screening questions are derived from the criteria that Dave went over, so I won't go through all the questions. Ideally, we'd like to have the HCCs respond yes to these questions for the incident to qualify. However, if an HCC responds no to a couple of the questions, and they feel very strongly that their real-world incident does qualify, we're going to refer them to their recipient and FPO to have additional discussion as to whether the incident does qualify. Bringing your attention to question two, which is asking the HCCs to calculate that twenty percent surge threshold to meet that requirement. HCCs will use this table below. This is the exact same table that was created in the exercise tool. HCCs are required to input their total staff bed numbers for these required beds during the time of the incident. Then whichever additional optional beds used for their incident, they can go ahead and input those numbers over here in the second column. The tool calculates that twenty percent for them. If they're able to meet that requirement, then they can move on to providing additional information in this tab. Next over, we're asking for additional details about the incidents. For example, the type and

severity of patient injuries, whether additional agencies were required to help with the incident, and any other information is important for the recipient and FPO to know about the incident. Scrolling down, just like in the exercise tool, we ask the HCCs to choose which incident category best described the real-world incident response. Then, at the very bottom, we've included a section where they can add the start and end dates and start and end time of the overall incident response and the activation and deactivation of the response plan. The good thing about these two last tables here is that the dates and times ought to populate into the AAR tab, so as the HCC is conducting their hot wash, they'll readily have access to that information. At the very bottom, we have a couple of qualitative questions that the HCCs will respond to. Just like the exercise tool, we have qualitative questions that have been positioned throughout the tool. HCCs will respond to those qualitative questions to provide more information about what their incident was about. I'll quickly go through the next couple of tabs because they're the same as the exercise tool. They've just been adapted for the real-world incident. In this tab, which is the incident response details tab, HCCs are required to provide information about the essential or critical resources, and essential critical member organizations that responded to the incident. What we're asking for here are for them to select the pre-identified essential and critical resources, as well as member organizations, based off their response plan and their HVA. In these tables below, the HCC will indicate which resource was essential or critical for the incident and they also have the option of including the non-critical resources that they used for the incident, if they feel it will help add to the story for their real-world incident response. Next over, we have the real-world incident initial actions tab, which is the same as the exercise tool just adapted for the real-world incident. HCCs will respond to qualitative questions that have been listed in their tab to inform incident recognition as well as communications, activation, notification, mobilization, and demobilization. Next over, we have the incident operations tab. Again, this is very similar to the exercise tool and has been adapted for use for a real-world incident. HCCs will provide information about the methods used for information sharing as well as the resources available to them during the incident. Scrolling down, I want to highlight, a key change to this tab. In the previous version of the exercise tool, we had a patient surge summary table that the calculation for PM 19. The table had about ten questions that were used in the calculation. We've paired down the table to about five questions. We have columns A, B and C, which are used to inform the performance measure equation. As noted in our instructions, HCCs must completely fill out this table if they would like an accurate calculation of the performance measure. To give an example, column A asks the number of surge and existing patients requiring admission for inpatient care, with an appropriate number of staffed beds, after patients were discharged. The HCC will look at these three questions at the bottom and go back to their documentation and answer the patient numbers. It's the same thing for column B and C. In row one, we have Adventist Health Hospital, which is the name of the receiving facility, that an HCC would input into this table. We ask if the facility is located within the jurisdiction, so they have the option of choosing yes or no. Then they'll go ahead and enter their patient numbers to respond to each question. If a number is entered that doesn't seem applicable to the equation for the table, the cells will turn red, indicating that there's an error in the table. This gives the HCC the opportunity to go back to their documentation to review their numbers and make sure their numbers were entered correctly. If this tool, say, was uploaded to the CAT and the recipient and the FPO sees the red cells, that will indicate that they need to go back to their HCC, or subrecipient, and ask them to review the numbers in this table. Next over, we have the After-Action Review, or AAR, tab, which is the same as the exercise tool. The one update we've made is transferring over the dates and the times, so they're easily accessible for HCCs when

they're conducting their hot wash. One thing we do require in this tab is for the HCCs to completely fill out this table. To give you more information about the member organizations, we are asking if the organization is a core HCC member, if they participated in the real-world incident response, and if an executive participated in the AAR. The reason we need them to complete the table entirely is because the information from this table helps to calculate PM 20 and 21. Next over, we have the improvement planning tab, which is one of the optional tabs in this tool. This is the same as the exercise tool, so no changes to highlight here. The performance measures have remained the same in terms of the language. We've migrated the language from the exercise tool into this real-world tool. The reason we've kept the language the same, for the performance measures, is that we want to standardize the data across both the exercise tool and the real-world tool. We've highlighted in the instructions that in this context, pre-identified and critical, refer to the resources that the HCC has identified as essential or critical in the real-world incident details tab. Also, exercise in this context refers to the real-world incident. If HCCs, or subrecipients, have any questions about the performance measures, I'll refer them to their recipients and FPO for additional guidance. Finally, the participant feedback form is a new tab added both to this tool and the exercise tool. We'd like to collect feedback from HCCs after they've used the tool and this is an optional tab. We have two parts asking different questions about preparation for completing the MRSE tool, questions about the MRSE tool and supporting materials. I wanted to highlight again the important MRSE updates that I briefly mentioned earlier. In both the real-world tool and the exercise tool, we updated the patient surge summary table. If you see at the top, we had close to ten questions that were used to calculate PM 19, but now it's five questions to ease data entry for the HCCs. I also wanted to highlight that we have the participant feedback form. It's optional, but it's helpful to the support team if HCCs could provide feedback about the MRSE tools. These are the next steps that we provide during our office hours when we present the tools. We ask HCCs to review the materials and provide any questions or comments via the MRSE mailbox. So, the email address for the MRSE mailbox is MRSE@hhs.gov. ASPR holds monthly office hours for HCCs to discuss any questions during review or to provide live feedback for any questions they have about their exercises. We usually announce these office hours in the Bulletin. We've included the resources and websites on this slide, if you have additional questions about the MRSE, or if you need more resources about MRSE.

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David Csernak: I'd like to quickly share with everyone a recent piece of MRSE related news. I know many of you probably have this experience, but as you're working on a project or a program, you're always asking yourself, is this project going to add value to the users, individuals, organizations that it's going to impact? We recently found out that MRSE was utilized by one of our health care coalitions, and in their words, it definitely added value to their efforts. In April this past year, in New Mexico, MRSE bolstered communication and coordination during a real-world response, an evacuation for a wildfire, that occurred one week after they completed their exercise. In the words of Mr. John Hodges, their health care coalition coordinator, he stated that because of the lessons learned from the MRSE we were able to quickly mobilize our assets to provide continuity of care to those that needed it. And we're very thankful for New Mexico for reaching out to us, letting us know of this experience, providing us their insight and their feedback. If you'd like to read the article, we published it this past week in the Bulletin or you can take a look at the link in the chat. It was a fantastic piece of news. We're very happy to share it with everyone and looking forward to receiving hopefully more feedback

similar to this from health care coalitions as they conduct the MRSE and improve their overall preparedness for future response. Without further ado, we'll take a question or two, and then turn it back over to Jennifer.

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Jennifer Hannah: As a reminder, enter your questions into the chat or raise your hand and we'll call on you. You may have noticed the team has been dropping links in the chat that were included in the deck from the MRSE presentation for your reference. Also, the information that Gbadero and Dave shared will be shared because we want to encourage your health care coalition to participate in office hours. It's an opportunity to engage and ask questions live with the MRSE support team. Also, as a reminder, ASPR implemented a flexibility to allow a health care coalition to complete the MRSE at least once in BP 3 or BP 4. However, all health care coalitions need to complete the MRSE in BP 5. We'll pause here for any additional questions. I want to, of course, thank Dave and Gbadero for your update regarding the MRSE real-world tool. I have a few Hospital Preparedness Program announcements that I wanted to share with folks before we move into our General Q&A. A follow up email was sent with the recording, transcript, and slides from the July HPP Joint Business Meeting Webinar. If you didn't receive that, please send an email to the HPP Resource Mailbox, HPP@hhs.gov and we'll make sure that you receive all those materials. As a reminder, responses to the FY 2022 budget period four conditions of award are due Friday, September 16th, so please make sure that you submit those responses. Of the BP 4 requirements, there have been interest about when those will be posted on the ASPR website. We are finalizing them and should be available in a few weeks. Please look for an announcement within the Bulletin for that information. We may send those out to everyone in advance while those are being posted on the website, but you should receive those within a few weeks. The final announcement is related to the HPP end of year performance measure data, which are due on Friday, September 13th. Please access the reformed system and complete the required performance measures for the FY 2022, BP 3, of the HPP cooperative agreement by that time. We would also like to remind HPP recipients that the BP 3, PM 4, organization files are to be reviewed, updated, and returned to the SPPR mailbox, at SPPR@hhs.gov, by Friday, September 23rd. Please note the addresses for non-core member organizations are no longer required. Additionally, ASPR is hosting a second training session to review the performance measures module. The session will be held tomorrow, Thursday, September 15th. Please refer to the Bulletin for further event detail. As we near the end of our discussion today, I will go ahead and transition into general questions. This is an opportunity for you to ask any question that you may have about the information presented during this call, questions that you would like to have answered during today's call, and our speakers are available to respond to any questions that you may have thought of after their discussion. I see a question here. The due date for the conditions of award is Friday, September 16th. I have another question here about the due date of the HPP BP 3 APR listed as November 14th. I will have to look in PERFORMS to see that exact date, but whatever date is posted there is when it is due. I know that it is open, but we'll certainly follow up with that. I'm not seeing any questions, so let's move to our last slide. Again, thank you to our attendees for your active participation today and thank you to our speakers for sharing your afternoon with us and providing your expertise. We look forward to our next webinar and in the meantime, stay connected with us on social media to receive the most up-to-date information about how ASPR is contributing to health care preparedness and response for communities across the nation. We hope to see you at the next webinar.