

Hospital Preparedness Program (HPP) Awardee Technical Assistance Call

Capability 14: Responder Safety & Health

Monday, September 9, 2013
11:00 AM – 12:30 PM EDT

I. Welcome and Introduction

– Scott Dugas, Branch Chief, HPP (Robert.Dugas@hhs.gov)

Scott Dugas welcomed the group to the HPP Awardee technical assistance call on Capability 14: Responder Safety & Health. This call will begin with an overview of the Capability and its associated program measures and indicators. The next section will get into the implementation of this Capability and will feature a number of distinguished speakers from the state and local level to provide real-life examples of the functions underneath this Capability. Following the speaker presentations, the call will be opened-up for questions and answers.

Capability 14 speaks to the ability of how healthcare organizations protect their workers from a variety of hazards. There are two primary functions underneath this Capability that will be the focus of today's call. Scott Dugas introduced Bill Mangieri and Shayne Brannman to provide an overview of Capability 14.

II. Overview of Capability 14: Responder Safety & Health

– Bill Mangieri, Field Project Officer, HHS Region VI, HPP (William.Mangieri@hhs.gov)

– Pamela “Shayne” Brannman, Acting Chief, HPP Healthcare Systems Evaluation Branch (Pamela.Branman@hhs.gov)

Bill Mangieri reiterated that he and Shayne Brannman would be going over the Capability:

- Background and overview
- Program Measures
- Expectations
- Functional breakdown/planning objectives

Over the years, the Hospital Preparedness Program has focused efforts and investment on equipment purchases, investing millions of dollars in equipment and training to better protect responders during an event. The program purchased protective suits, respiratory protection, and decontamination systems that safely and effectively decontaminate a patient while offering the best available level of protection for hospital first receivers. Additionally, federal dollars go towards the funding of point dispensing system so patient care providers can dispense medication and prophylaxis effectively. HPP also financially supported training decontamination teams at local hospitals to meet potential threats to facilities in healthcare systems.

In January 2012, ASPR introduced the National Guidance for Healthcare System Preparedness that recommended specific guidance for functions in resource elements. In addition to funding the items mentioned above, HPP is emphasizing investment in the planning and decision-making processes that occur before, during, and after an incident. This shift supports the preparedness activities of networks of healthcare coalitions.

The importance of Capability 14 is highlighted by recent national and international public health crisis events that have impacted responder safety and health. These impacts have been cross-cutting through all levels of government, the private sector, and partner industries equally.

Mr. Mangieri turned over the call to Shayne Brannman to talk about the HPP-PHEP capability alignment as it relates to Capability 14 (Focus Slide 5).

Ms. Brannman

- Ms. Brannman welcomed the group to the call and highlighted the importance of grant alignment and the strong relationship between the HPP Capability 14 and the PHEP colleagues Capability 8 on medical countermeasures. These two capabilities both work best when there is an alignment and synergy between public health, health care coalition, and the healthcare system emergency planners. Specifically, the alignment between these capabilities helps improve the placement of caches, equipment, supplies and pharmaceuticals and other aspect that would help support responder safety and health, and the maximization of community medical countermeasures.
- Ms. Brannman informed the group of the importance in understanding that the people within HPP have a separate indicator under the program measures of continuity of health care operation, that specifically addresses and attempts to evaluate the healthcare coalitions ability to address its members- i.e., healthcare work for safety needs, and training and resources. Furthermore, Ms. Brannman stressed the importance of insuring the safety and well-being of the healthcare workforce thought documentation, training, and strategy.
- The two program measures for (PB) for HPP specific are medical surge and continuity of operations and under continuity of operations; there is an indicator on responder safety and health. HPP has the ability and the need to be able to track over time the functionality and expanded abilities of the healthcare coalition. To accomplish this, they have established healthcare coalition development assessment factors that helps healthcare coalition and awardees asses the development and stage that their healthcare coalition. Within these factors there are two that specifically address responder safety and health.
- Ms. Brannman encouraged a diverse participation rate within a jurisdictional area of different types of healthcare members, hospitals, public health, EMS, the greater emergency and management community as well as long-term care, and home health. This diverse group would help enhance the level of safety response and health. Healthcare coalition demonstrates resource support among its members under time urgency, uncertainty, and a logistical constraint of an emergency. It is easy to see the intercession point with PHEP on medical countermeasures. This support includes the leveraging and integrating of supplies to ensure the maximum amount of resources during an event or incident. Furthermore, this would include additional measures that would be taken for responder safety and health.
- Ms. Brannman then passed the call over to Mr. Mangieri to discuss the Capability 14 functional components.

Mr. Mangieri

- Mr. Mangieri continued the overview of Capability 14 by reviewing the capabilities functional components and by providing tangible examples for these functions (Reference Slide 8). Mr. Mangieri discussed the 2001 Anthrax attacks; when a highly refined form of inhalational Anthrax was disseminated through our postal delivery system. There were initial recommendations made regarding the treatment of potential victims like the postal workers and other at risk groups. Some of the recommendations were modified and included medications like Cipro. There were two primary postal facilities that were contaminated and one of the two was

given an opportunity to receive the Anthrax vaccine which was at the time an investigational new drug. However, there was a certain level of uncertainty about the recommended antibiotic protocol, the status of the anthrax vaccine, and this became a significant and very complex risk communication environment.

- The H1N1 pandemic is another example to help further reiterate the importance of this capability. For instance, the H1N1 pandemic highlights the enormous complexity of developing, testing, and distributing the noble H1N1 vaccine. During the H1N1 pandemic there was a high demand for the vaccine which caused a shortage throughout the nation and delays in manufacturing the vaccine. However, the availability of the vaccine varied state-by-state. New York had specific challenges with it because New York was trying to make the vaccine mandatory for all healthcare workers. So there was now not only a shortage but they raised the cost of the vaccine when they heard New York wanted to make it mandatory. This caused many nurses to become angry and the state began to fear a shortage of staff due to a potential mandated distribution. In this case, communicating the distribution plan was complex and very important. Furthermore, communicating the distribution plan for the vaccine was another complex task that highlights the importance of protecting the responders and healthcare workers. Mr. Mangieri told the group that he remembered that nurse associations were against mandatory vaccines. This caused people to fear potential staff shortages. This shows that it's not just about buying the resource and training your people on how to use the various resources. Thus, critical decision-making processes that affect the safety and health of the responders have proven to be a key success factor in very complex event.
- Mr. Mangieri then highlighted the **first function** of this capability: **Assist healthcare organizations with additional pharmaceutical protection for healthcare workers.** He then told the group to think about what it would take to assist healthcare organization to provide timely distribution of critical protective medication or immediate treatment for healthcare workers and their families during an exposure incident like a sea burning attack or asthma release. Two important tasks for this function are Pharmaceuticals needs assessments and Pharmaceuticals cache storage, rotation, and replacement and distribution. Pharmaceuticals Needs Assessments is helping the hospitals, in the case of a vaccine shortage, to pin-point the need groups for this vaccine and then to distribute the medications appropriately. The H1N1 pandemic example fits the dynamic of this functional preparedness strategy, and some of the resource elements that are in this function include pharmaceutical needs assessment. During this incident they needed to conduct a needs assessment to accurately pinpoint the at risk groups that need the vaccine first.
- Pharmaceuticals cache storage, rotation, and replacement and distribution is the importance of training employees in the operation of these caches. Some issues that have been hitting the states are the lack of information regarding the caches and the failed rotation of caches, which effects the expiration of the medications. All hospitals should have hazards caches filled with medication to protect their workforce during a medical surge or large access the cache in the case of a disaster. However, there is a lack of knowledge from the nurses that these caches even exist or how access the caches and CHEMPACK.
- Mr. Mangieri then highlighted the **second function** of the capability: **Provide assistance to healthcare organizations with access to additional Personal Protective Equipment (PPE) for healthcare workers during a response.** Mr. Mangieri used the H1N1 example again to further reiterate the importance of this function. During the H1N1 outbreak there was concern of the impending shortage of N95 respirators. There were several moving parts that affected the potential destruction in the supply. For instance, there was a new guidance from the CDC recommending the use of N95 respirators in the healthcare setting where the probability of H1N1

transmission could occur. This action increased the demand for N95 respirators in the healthcare setting. Also, they revoked the certification of N95 product from China, which affected the quantity of the resource available in the market place. During this event, some nurse's would hide N95 respirators incase the pandemic got worse. This caused the supply team to believe there was a shortage when really the N95 respirators were hidden and not in use in anticipation for a nation-wide shortage. This relates to function two because it highlights the important of providing additional protective resources. Mr. Mangieri informed that group that some of resource elements include personal protective needs assessment, personal protective equipment (PPE) i.e., caches, PPE supply and dispensing, and the right PPE for the identified risk in you jurisdiction.

- Mr. Mangieri then explained the Top 5 Planning Objectives for responder safety and health: The who, what, where and how, and why of planning. (Slide 9). *Who*- determine who will need responder health-safety and health assistance? *What*- determine what is needed i.e., information, equipment, and type of medications. *Where*- determine where pharmaceutical and equipment caches will be located, and make sure that people know where they are. *How*- determine how you will assist healthcare organizations in maintaining and distributing cache contents. *Why*- determine why assistance is needed to protect the safety and health of responders.
- Mr. Mangieri then transitioned to the state and local presentations. He informed the group that questions would not be held until the end of the presentation.

III. Healthcare System Preparedness Function Implementation

A. Pharmaceutical Cache Management, Inventory and Tracking:

– Elisabeth Weber, HPP Coordinator, Chicago Department of Public Health
(elisabeth.weber@cityofchicago.org)

- Elisabeth Webber represents 35 hospitals, 28 which are acute care, seven which are specialty and the local healthcare coalition. Ms. Webber manages the coalition in partnership with their hospital association, which is called the Metropolitan Chicago Healthcare Council.
- Chicago made the decision to forward deploy pharmaceuticals to the hospitals, and this was initially done through a process where recommendations were made and funding was applied.
- Now they run their program though a coalition model which has helped them find pharmaceutical cache recommendation. Ms. Webber referred to cache recommendation handout that was sent to the group prior to the meeting. At the top of the handout it defines how one should calculate what kind of medications to use in the cache. Ms. Webber then gave an example of how they calculate what kind of medications to use. She said they first calculate the number of employees in the hospital. They then take the average daily census in a hospital by looking at the number of adult patients, pediatrics patients, and then a 20% search for planning purposes. Then they asked the hospitals, over the last two years, to make the caches ready for about 96 hours. Those medications are then maintained by the pharmacist for their accreditation and about a third of the medications expire every year.
- The expiring of medication had been a problem that Chicago has tried to address. Last year, they asked the pharmacist if they should bring some of these medications into a more centralized or warehousing option. The pharmacist said no, because they want to be able to have all of the medications with them and know where they are at all times.
- The hospitals are “closed pods” and the expectation is that they are going to take care of their patients, employees and their families. However, there has been a challenge with long-term care so they have additional cache of antibiotics for long-term care which is stored at the local VA

facility. In addition, through the PHEP program Chicago has to worry about the rest of the 2.8 million citizens.

- Ms. Webber informed the group their methods for maintaining their pharmaceuticals. They use an Inventory Management System (IMS), and all of the hospitals have access to the system. Currently, they only use the IMS to maintain the grant purchased items. However, they are trying to have the IMS be a direct commission inventory management tool. And if that works, they will then open the system for all emergency preparedness items, not just the grant funded items.
- Chicago also has a designed process as to how people can request additional pharmaceuticals, and that is through a resource request process, which is attached to their healthcare coalition emergency operations plan. They exercise this plan and test it a minimum of once a year with the hospital.
- Their recommendations have most recently been informed by their medical formulary advisory group. When one looks at their pharmaceutical cache recommendations, one can see that they are updated about once a year or when science changes. For instance, the last recommendation was updated in January and their formulary advisory group will look at the recommendations again and see if they need to be changed this January.
- If anyone had additional questions for Ms. Webber they can contact her directly via email.

B. Personal Protective Equipment Management and Inventory Tracking:

– Linda Scott, Manager, Healthcare Preparedness Program, Michigan Dept. of Community Health (scottl12@michigan.gov)

- Ms. Scott gave an overview of Michigan's strategies for PPE management and inventory tracking. She also outlined a couple different projects they have been working on to give the group a sense of where they're at.
- Michigan has eight regional healthcare coalitions, and they have staff dedicated to support the healthcare organization that falls within each region. Any resources that come into the state through ASPR funds are deployed to the regions for distribution to their healthcare organization.
- Since the onset of the hospital preparedness program, any equipment and supplies that have been purchased with the preparedness funds belongs to that region but also that state, the agency, not just the end recipient of that resource. So, when any resources are deployed they can be pulled back and mobilized if needed for an incident in which they are not impacted. Also, the leadership team has worked hard to coordinate purchases to get the best pricing, and also to try to ensure that they have consistent types of equipment so it's interruptible state-wide.
- With mutual aid and one healthcare coalition helping another, Ms. Scott explained how they are trying to standardize as much as they can. For instance, they purchased state-wide decontamination tents and affordable ventilators. Furthermore, any additional equipment that is purchased is also exercised during that year to make sure everything is kept current.
- Ms. Scott then highlighted a few of their specific projects for this capability. First, she discussed the Trailer Inventory Project. Their regional healthcare coalition has established readily deployable mass casualty, alternate care sites or communication trailers that stand ready with equipment and supplies to be mobilized when needed. When this initiative started, each region had various methods to track their content in these trailers, including expiration dates of medications and equipment. On January 2010, each region was asked to refine their trailer inventories for all trailers that housed resources purchased with cursor or ASPR funds.
- The goal was to make sure that all of these inventories had a consistent format that there was a schematic of the insight of the trailer and they are organized. Ms. Scott and her team

suggested a color coding or a numbered legend. However, the ultimate goal was to have anyone assisting with this resource, that was deployed to another healthcare coalition, will have easy access to the Smart Books for loading and unloading any resource. These Smart Books are located on the door of each trailer so as they are deployed, workers will have access to the information. At the state-level they have a copy of these Smart Books at the community health emergency coordination center, in case they may need assistance or in case of an IMAT request.

- Ms. Scott has also recognized that they need to have a better status of overall inventory that was purchased with the ASPR funds. To address this issue, they have developed a share-point platform inventory management system. The state and healthcare coalition leadership established a consistent template and each region submitted an inventory with their midyear report in December of 2011. For this, they were able to get a sense of their inventory and its gaps.
- All of the resources are categorized by communications, decontaminations, evacuation, medical, pharmaceutical, PPE, and respiratory. For each item in the category, there is an item description, estimated time to deploy, model number, serial number, unit of measure, unit price, total acquisition cost, date acquired, funding source, percent of HHS funding, and comment that would be affiliated with that specific item. This current system has been piloted a majority of the regions, and by the end of PP2 all regions will have this inventory system.
- Ms. Scott then discussed some of their challenges, specifically with expiring equipment. She told the group that through their new inventory management program also categorizes expiration dates of the materials. Once an item expires they do not dispose the item, they make sure to keep the items so they can use them in future exercise and trainings.
- Lastly, Ms. Scott gave a quick overview of their pharmaceutical cache inventory project. Their pharmaceuticals are captured in their inventory management system; however, they are also captured in their MEPP which stands for Michigan Emergency Preparedness Pharmaceutical Plan. This plan is at state-level where they categorize all the different types of pharmaceutical caches that have been established throughout the state. They also have specific criteria of information like who is the target audience of the cache, what is the content, and how quickly can it be deployed. The MEPP is updated quarterly and is kept in a very secure location at the state emergency operation center as well as the community health emergency coordination center.

C. Coordination with Joint Personal Protective Equipment and Pharmaceutical Assets:

– Asha Green, Senior Associate, HPP Program, Louisiana Hospital Association
(agreen@lhaonline.org)

- Ms. Green gave a brief overview of their PPE and Pharmaceutical cache in Louisiana. She first explained their institutional level search caches, and then highlighted their participating entities and what's required to maintain and monitor those caches.
- The institutional level caches are only required to have pharmaceutical caches including PPE and decontamination equipment. The decontamination equipment, for the tier one facilities i.e., 24/7 hospitals, they must have a decontamination team and the appropriate equipment for each team member. Each team should try to consist of at least 10 people. They need to also have an A and B team and they should have a call-down roster for those team members and a process to activate their team. The equipment supplied for each team includes poppers, disposable suits, boots, gloves, gown, etc.

- Ms. Green then discussed the pharmaceutical cache. She said that the hospitals must also have some kind of biological cache, and the cache must be able to take care for in-patient, the staff member and their family for a 72-hour period. This cache must be in a separate cache location in their pharmacy department and must be properly labeled i.e., emergency or disaster cache. Lastly, they must make sure to keep a constant inventory of these caches. In these inventories that must be able to tell the amount in the cache and the expiration dates of the items within the cache. Currently, Ms. Green said they use excel to track their cache inventories. However, due to the large size of their caches the excel documents is not useful for rotating items within the cache. A challenge they are facing like so many other states is that many of their medications begin to expire and they are constantly replenishing drugs and wasting money.
- Ms. Green informed the group that they also have a mass prophylaxis plan on how they are going to distribute their medication to their employees, their staff and their staff family members. They also look at the PPE caches and encourage the participating entities to have about 6-8 week caches for CDC. However, many times the PPE caches do not have a plan i.e., workers need to know exactly where the caches is located in the facility, the amount in the cache, and the expiration dates for each item within the cache.
- Currently Louisiana hospitals have about a six-week cache and then the EMA provides a three-week cache. To ensure that they are maintaining these caches Ms. Green said they visit about 20% of the participating entities in the program. If they did not participate in the last grant cycle, they will educate them on how to maintain their caches. If they did participate, they will review their inventories, caches, tracking, and plans. For instance, the pharmaceutical cache must have a plan for distribution of medications. In addition the PPE cache must have a process and protocol for access their cache. On the tracking sheet, there should be a disposition of the cache, the condition, the expiration date, and the year they acquired that information.
- Ms. Green informed the group that when they go on site visits, they first thing that look for is a narrative plan. They want to make sure that the hospitals or other participating entities indicate whether or not they are in compliance with the 11 elements, and to ensure this compliance they ask the entity to walk through each element. Ms. Green then informed the groups of some of their findings from these site visits. Their first finding was limited storage. Due to this, many of the facilities are electing to have smaller caches and then have having a separate location for their remaining cache. In addition, some regions have a regional cache which any participating entity can have access too, but they still require that each institutional level have their own cache.
- They also discovered that many of the facilities do not have a pharmacy department or a pharmacy onsite to control and hold their pharmaceutical cache. Furthermore, many of these facilities have a parent company or they have an agreement with their local pharmacy supply to deliver those drugs once it is needed or once the plan has been activated. A concern that has developed from this is that if the facility do not pay for these drugs upfront, and wait until after the drug is delivered, they may not actually have access to the drugs. So it is important for these facilities to partner with larger facilities to ensure they will have access to those caches.
- Ms. Green informed the group that they have also found low employee engagement in decontamination efforts and teams. To address this challenge, they have been looking for incentives to keep staff members engaged. With staff turn-over they have been forced to do more training on decontamination and they are constantly making sure employees are aware of the decontamination roster and teams and what they specifically need to do.

- Other challenges include the expiration of equipment and the cost drugs. Recently, there has been a cost increase of drugs and man caches are becoming smaller and smaller due to these increases. Also, the life-saving drugs tend to be more in the outlets or in the hospital ED. SO these drugs have been put on the national shortage list and they are hard to come by. Ms. Green informed the group that they now require that these hospitals provide some of these life-saving drugs in the caches.
- Ms. Green then highlighted their regional cache which is also at the coalition level; some of the regions have pharmaceutical chases, PPE caches, and decontamination trailers. But most importantly, they have Buffer Packs. These Buffer Packs are co-located with CHEMPACK containers that are in hospitals and EMS providers. These Buffer Packs give them time to identify the scope and scale of an incident without having to open their CHEMPACK container. The Buffer Pack contains enough supplies to treat about five patients for a 12-hour period.
- Lastly, Ms. Green discussed Louisiana’s training and exercise programs. They go to all of their regional coalitions and provide training. They provide trainers on the grant itself and how important these plans are, not only having a cache but what one should include in the plan. They also have plans listed on their website. They also have exercises. For instance, this past year they conducted a mass prophylaxis exercise.
- If you have any questions for Ms. Green you can contact her directly via email.

D. Preparedness for Decontamination during Chemical, Biological, Radiological, Nuclear, and Explosive Response:

– Jackie Gatz, Director, Emergency Preparedness, Missouri Hospital Association
(JGatz@mail.mhanet.com)

- The Missouri Hospital Association is the sub-contractor of the ASPR Hospital Preparedness Program. They have seven healthcare coalitions in the state of Missouri, and 158 hospitals.
- Ms. Gatz suggested that Missouri sees bioterrorism and decontamination at the forefront of their efforts when looking at hospital preparedness. When Missouri began to develop their preparedness system they focused on decontamination preparedness and the tools and structures needed to assist the hospitals and healthcare coalitions for a more sustainable approach. Ms. Gatz then informed the group that she would talk through a couple of the steps Missouri has recently taken in order to provide others with a framework if they are looking for similar guidance.
- For many years Missouri has been centrally purchasing all equipment for hospitals. This has allowed them to have standardized decontamination equipment from the very beginning, which has seen to be a great incentive and has helped them develop their future plans for preparedness. Specifically, they are talking about the same equipment that helps at the state level also helps at the local level. As Missouri began to develop systems for preparedness present day, they recognized a lack of strength in hospital based decontamination programs. They have many of the elements but they need to connect the elements. To help face this challenge, Missouri uses two specific tools- the coalition structure, and the ASPR guidance. Using both of these tools has helped Missouri move forward to further develop their decontamination programs.
- Ms. Gatz informed the group of Missouri’s decontamination work group. This group consists of members with the strongest hospital programs that are using the tools effectively to build programs that work and provide positive results. The positive result of these various programs are shown though their ability to effectively prepare for and respond to events. They brought all of the members of the decontamination work group together and conducted

a SWOT analysis of decontamination programs across the state. They then took the group and divided it into a policies and procedures group and an equipment and training group.

- The policies and procedures group, in spring 2003, outlined the needs for a foundations level course which ended up being a one-day course that they offered twice. The first day of the course was to the large hospitals, 150 bed plus, and the second day was for the smaller facilities- critical access hospitals and community hospitals with 100 beds or less. This course allowed them to ensure that all member of the group understood the program components, requirements, and regulations. In addition, it allowed them to have a conversation about what is required, what is the projected end-result and the steps needed to get there. Their next steps were to develop plan templates for staff to utilize across the state. At the same time, they were utilizing the Harvard School of Public Health hospital based decontamination program assessment and would accompany their plan templates. This was going to either help the hospital refine their program or help the hospital create a stronger program from those initial templates.
- This coalition has come into view on this policy side because as they conducted their HVAs they were able to identify threats for chemical, biological, radiological, and nuclear explosive threats that the coalition may face. Missouri had a nuclear plant in the center of their state, which highly impacts all coalitions in their state. They have a large agricultural community, and they have several busy highways that cut through the state and connect to the national corridor. So Ms. Gatz informed the group that they are aware of the hazards and that they believe the coalition has helped them have a conversation about the trucks holding chemicals and how this can cause a threat to the state.
- The equipment and education group is where they are doing most of their work today. In the past Missouri was using consultant based educational programs for their training, however, these programs were very expensive, take-up a lot of time, require many resources, and require space. This was not the best use of their grant funds so they established regional training centers in each of their healthcare coalitions. They have been working with one of their strong hospitals in their work group to formalize a quarterly offering by their hospitals where they will open up their program to their coalition members. With this change, coalition members have access to operations level training. This is an economically efficient method for training. Furthermore, the focus of these training programs is correct PPE usage, and important technical processes for decontamination.
- Ms. Gatz highlighted the importance of educating hospital staff and their coalition members on these preparedness efforts. Their next steps for training are to assess and standardize their curriculum state-wide. In order to accomplish this, they plan to provide PowerPoint's for these training practices. This would allow them to train volunteers, front –line staff, nurses, etc. Their goal is to give them the scalable training needed to recognize what's coming towards them. Then in 2014 they will be focusing on specific education. They will focus on how they can get further training out to all healthcare organizations about radiologic threats and decontamination process. Ms. Gatz informed the group that they are trying to use a simple and straight forward approach.
- If you have any questions for Ms. Gatz you can contact her directly via email.

E. Pharmaceutical Cache Management:

- Leah Tolliver, Director of Pharmacy Emergency Preparedness, Kentucky Pharmacists Association (ltolliver@kphanet.org)

- Dr. Tolliver's role is to manage the cache in Kentucky, and this cache consists of medications that treat anthrax, but they also have medications in the past that treat threats that are anti-viral like the H1N1.
- Managing this cache is a difficult job and Dr. Tolliver informed that group that just like many other states, the medications in their cache are becoming outdated this year or the next. Specifically, their cache began to become outdated this summer, and after a lot of research, Dr. Tolliver was able to find a pharmaceutical wholesaler that was willing to purchase short-dated products. This allowed Kentucky to get rid of the medications before they expired so they didn't have to pay for the destruction of the drug.
- Now, Dr. Tolliver is working with other states to provide this resource. For instance, some hospitals have their own cache but their cache doesn't expire until the next year. If they sold their cache they would be able to get a higher price and would be able to replenish their cache with the collected money.
- Another key program to the management of Dr. Tolliver's cache is their rotation program, which is a solution to preventing any of the caches for going out of date. For instance, they are working with pharmaceutical wholesalers that will take their almost expired caches and rotate them with new medications. So within two years of a cache going out of date, they will be distributed into the retail sector and then replenished with the same drug at the same cost.
- This is Dr. Tolliver's goal to develop through their contract with Kentucky, and once they finalize this program they plan to roll it out region four which consists of Kentucky and seven other states.
- If you have any questions for Dr. Tolliver you can contact her directly via email.

IV. Questions and Answers

- **Question 1:** The first question came from Ismael and was directed to Bill Mangieri. Ismael is a CHEMPACK administrator and has been told from his bosses not to tell the nurses the location of the CHEMPACK's due to security implementation. His question was for Mr. Mangieri; how should the hospitals balance having the nurses know about the CHEMPACK's if they don't want the nurses to know where they are, due to security concerns?
 - **Answer:** Mr. Mangieri told Ismael that this question has come-up in the past when he was with the VA. They discovered that although they had all of the hazards cache they needed a certain level of people to know about it, but if nobody knows about it then how would they effectively activate it? Due to this concern, they came up with a protocol where the emergency manager, the director of the nursing, and the executive leadership would know how to activate the CHEMPACK if needed. They also determined that they would at least have to give some level of training to a pre-identified group of people so they can take the cache content with the pharmacist and deploy it where needed. Specifically for Mr. Mangieri, he decided to give that authority to the Emergency Medical Response team. They were in charge of not only decontamination but thing like activating the cache and making sure that the contents got to the right place. They were also in-charge of assisting nursing staff if there is a tornado, and assisting nursing staff on the wards to move patients. Mr. Mangieri told Ismael that the CHEMPACK shouldn't be super-secret but there should be at least a small group of people that know knowledge of it and know how to activate it as well.

- **Question 2:** Nathan Rubio asked Jackie Gatz to give more information on the regional training centers.
 - **Answer:** Ms. Gatz told Nathan Rubio that she would give a little information during the call but in the interest of time, he should follow up with her offline. Ms. Gatz established training centers with hospitals that were already committing resources to training quarterly. They have spent limited funds on their classroom and their training time. They identified funding for future reimbursing equipment that's used for training which supports the rotation of PPE equipment, which is predicted not to be pricy. Ms. Gatz thinks that they should budget \$20,000 to \$25,000 per year for the seven centers to do a slow rotation that that equipment. So the systems that they have put in place are fairly low cost compared to the money they were spending on training in the past. Ms. Gatz told Nathan Rubio that this would be a feasible approach for his training.
- **Question 3:** Chuck Trudo also asked a question for Jackie Gatz. In Northwest Arkansas, they have used DQE. They have training modules for awareness and operation modes of decontamination that only cost \$25 per person. They also have a year that they can do those trainings online and refer back to the total for about five and a half to six hours. He asked Ms. Gatz if she thought those trainings were stratifying the requirement.
 - **Answer:** Ms. Gatz told Chuck Trudo that she was by no means an expert in validating which education program are the best. However, she did look at DQE as an option but determined it wasn't a good approach because they didn't use DQE in the initial operations level training. She has hoped to use it for a refresher but it would have been cost prohibited. She has only heard good things but it specifically didn't work for her program.

This answer was from Mr. Mangieri. He suggested another idea for the operations level training. What he did a few times was bring people from the noble training center in Addison, Alabama. He hosted a three-day training for medical operations. The program is pretty cost-effective and if done right it can be sponsored by the county's EMA. It's a great training and there needs to be a minimum of 20 participants.

V. Closing Remarks

- Scott Dugas, Branch Chief, HPP (Robert.Dugas@hhs.gov)
 - The call was passed back to Mr. Dugas who thanked everyone who contributed to the call.
 - They covered the capability in-depth and he truly appreciated everyone's time and effort for going through each function of the capability.
 - Call minutes from the task calls will be released very soon, and we will potentially have all of the call summaries by the end of the day. Also, if anyone would like the documents from today's call they should email Sue Larkins. Additionally, questions can be directed to each of the featured speakers through their email addresses listed on the agenda.