

ASPR Leadership

Late Breaker Session: H1N1

Tuesday, July 21, 2009

About The Speaker-ASPR Leadership

- RADM Knebel thanked everyone for returning for the late breaker session to talk about/discuss/dialogue/ about the potential for a second wave of H1N1.
- I want to throw out Dr. Lurie's ideas that she mentioned this morning.
- What are the ideas for how we, at the Federal level, can learn from you about what is going on so that we can lead?
- How do you engage at the community level?
- Vaccinations of workers-how and who gets the vaccine?
- Flexibilities that communities need from CMS to do their jobs? What have you learned? What can we do better?

A) Questions Raised/Brainstorming Points: Open to all participants:

1. Go to your call centers and find out what questions you are missing. What questions are your scripts not answering? Strategies for facilitating school closings? What was the data there, this is a great opportunity to learn about closings, what people got, infection rates etc. Closing your schools is huge-do you close them even if children will congregate elsewhere and how do you keep kids educated? How do you do that when every community is different? Do schools need to monitor what is their standard absentee rate?
2. What would be important to measure? Real events tell us a lot and they are important to measure. What we decide to measure in the future should not add any new burdens to people/facilities etc. and that is hard because we are looking to standardize things. Messaging has a life of its own and there needs to be something done to make people more aware of the less formal information channels, such as YouTube, Twitter etc. Was the CDC's use of Twitter and other social media campaigns to disseminate information about the first round outbreak of H1N1 helpful? What about the many people who cannot access social sites at work?
3. Talking to people in Texas ASPR learned that they liked the disaster tents set up to help triage children so that you could treat kids there and divert them from the ER. Even the children's hospitals that were staffed had the issue of people demanding to see a physician only. Can adult care hospitals help decompress the surge by taking on older children into the adult hospital?
4. Coming up with a way of collecting information that is not so burdensome. Idea 1) Could you put HAVBED system on steroids, if you will? Could you add detail to it, since the sampling system is already there, developed and in use. Could you drill it and practice it so that it is more specific to the ideas that you need to discern at the Federal level? Idea 2) What was the epidemiology of H1N1 in hospitals-that remained a mystery? Would it make sense to ask cadre acute care facilities to tell us how they are dealing with influenza numbers in the hospital? If you had sentinel institutions in the right place might that help divert some of the initial problems and give you a heads up? That could add information, yes? What are the pros and cons of using the HAVBED system?
5. There would be a lot of added value from the HAVBED system use because it is a standard that everyone is using. It was very helpful following the Twitter posts from the CDC-we are developing a text messaging system that works off of the same instantaneous comment.
6. Gathering the right data is the important thing because that way you can set expectations at an earlier time. We need to figure out what data to collect and a way to standardize it and then we can deal with it at the local level.

7. If we can identify those things that indicate the stress on hospitals (key indicators of stress on the hospitals) and feed that data through the HAVBED system would that be helpful to figuring out how to make changes and be helpful?
8. There is the barrier that the HAVBED system will not accept altered data at this point (if you change an address, for example) unless you do it manually.
9. Agree on what those data elements are and allow that information to be shared among all three tiers of the government. Figure out what data to measure and dictate that, but not the system that is expected to be used to track such data.
10. Some hospitals refuse to give us information and data if we are going to send it along to the Federal government. What is it that we really want and what are we going to use it for? We have not spent enough time on this topic.
11. In NYC we used a system where hospitals were familiar with entering information in a certain way and they did not want to add more information. It's burdensome for the hospitals and for us, especially because we were not using all the data. Walking away from this H1N1 we need to have more templates in place to report the data we collect to higher levels. Do we share all information all the way up? We need to figure out the best ways to do this.
12. We need to ensure that whatever information the ASPR program requires does not duplicate what the CDC is asking for because we are working real hard at the state level to coordinate that data.
13. How do you go from a county- wide activity to a state -wide activity? Reimbursement issues-when it comes to vaccinations, will that be addressed in the guidance-those were some of the things we learned.
14. Upper NY did a lot of surveys about cases presenting to the hospitals and there are very few admissions to the hospitals because of influenza. People are admitted because of other issues, like pneumonia, and it was very labor intensive for the hospitals so maybe there are better ways to ask that question. You need to be more specific about what you want. Perhaps you could ask for data and information about people admitted with certain symptoms a, b and c.
15. Sentinel programs with papers and looking for best practices is the way to go. What programs might be in place in the various states that are effective?
16. Our long- term facility ran into problems with respirator kits. The CDC guidance is interim guidance so it's just the whole problem of do we need it, where do we find it, how do we pay for it? It's a problem, CMS is not clear.
17. Pediatric surge question-How did you all deal with it? We had a bedside testing scheme and we put an FTE in the front and if anyone presented with influenza symptom they immediately got tested so you knew if it was H1N1, or if you had to look for something else.
18. The Federal reimbursement questions in response are just a huge obstacle at this point. It is critical that our Federal partners set a goal to improve that issue because the questions keep coming up and we have no response.
19. What about the possibility of working with the AMA or other hospitals and institutions because we are hearing that you need different ventilation (critical care ventilators) for people with H1N1? These portable ones we are using now will not cut it. Will these portable ones even be effective for patients? Maybe putting a group together to figure out the best way to ventilate those patients would be helpful.
20. We need that real time communication that looks at those bedside issues in the critical care arena. We need to bring that piece of situational awareness into this topic. In the guidance that came out years ago it was inferred that those portable ventilators would be enough for people exposed to influenza because they were not expected to live long, but they are and they did, so we know that is a concern.
21. If we are pushing the healthcare system to look at systems that will push us to surge, somehow we need to make sure that the reimbursement process is covering these costs; otherwise this system/model is not sustainable. How do we resupply the portable trailers with disposable everything that we use to handle overflow patients in a healthcare crisis? We have to figure out how to work around that and restock those trailers so that we can continue to provide the care that people need in outbreaks and crisis situations.