

Monthly Hospital Association Recipient Webinar

October 15, 2020

Event Transcript

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Jack Herrmann: Good afternoon, everyone. I'm Jack Herrmann the Acting Director of ASPR's National Healthcare Preparedness Program. I want to thank you all for joining us today. During today's meeting will kick off with some updates from the COVID-19 Healthcare Resilience Working Group, as well as ASPR TRACIE. And then we're excited to welcome our colleague Dr. Satish Pillai, who is serving as the Operation Warp Speed Senior Liaison Officer to discuss the COVID-19 vaccine implementation. And then finally, we'll welcome John Fredenberg, who is the information management team lead for the Strategic National Stockpile and John will share an overview of our SNS 2.0 initiative. I want to now pass it over to Matt Watson and he will do the update on the COVID-19 Healthcare Resilience Working Group.

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Matthew Watson: Thanks so much Jack. Again, my name is Matt Watson, I am a Senior Advisor and hospital team lead for the COVID-19 Healthcare Resilience Working Group. I want to just to share a few updates with you today.

First, I'd like to go over our new PPE preservation toolkit. This tool kit is a planning tool to guide organizations and calculating the benefits of various PPE preservation strategies. There are two main features of the toolkit. First, it includes a guide that provides a step by step set of instructions for using the tool. And second, it includes the tool itself to allow users to enter and analyze data relating to their PPE usage and then interpret the output. In particular, certain areas like emergency departments will clearly have different PPE needs. So, this tool can be used as a systems level that can use an average or general set of data for all facilities. We hope you find that useful.

Next I'd like to share an update on efforts to bolster stockpiling of dialysis supplies and equipment. The ASPR Strategic National Stockpile or SNS is actively working to acquire national stop gap continuous renal replacement therapy, in addition to portable chemo dialysis machines and fluids to address acute COVID-19 ICU surge demand and to enable increased manufacturing to support continued demand of those products. Previously, ASPR supported surge in New York City, with its initial 50 dialysis machines and it recently acquired an additional 50 machines to support state requests for local hospital needs.

Finally, I'd like to provide a brief update from our CMS and CDC long term care strike teams. As of October 9, eight waves of strike teams have been deployed to 76 facilities in 21 states, including 24 super hotspots. The Working Group created a qualitative analysis tool for federal nursing home strike teams to track and compare current issues that facilities visited, critical actions for state and local partners, and recommendations for facilities to implement. The tool showed that infection prevention and control or ICP program training and implementation continues to be a leading area of concern for facilities with 48% of all ICP issues related to PPE access and use including concerns such as lack of PPE training and 95 fit testing. The working group is coordinating closely with CDC and CMS to identify areas of opportunity to support nursing homes with PPE training, including recently launched resource and recommendation template to improve the consistency and accuracy of the recommendations strike teams give to facilities. I'm now happy to pass it over to my colleague Shayne Brannman to share updates from ASPR TRACIE. Thanks everyone.

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Shayne Brannman: Thank you so much Matt, and good afternoon Hospital Association shipmates. I hope everyone is continuing to take care of themselves while they're in service to others. And thank you for what you do daily. Next slide. I'm going to spend a couple minutes. One as you heard last time, we were on this call together, ASPR TRACIE recently celebrated its fifth anniversary birthday, and I just wanted to give you a few metrics, as far as what asked for TRACIE's been doing. Just for frame of reference, we've had in the month of September, we had over 550 technical assistance visits that we process. In addition to doing a number of other activities and as you can see on the chart on the left about 25% of total TA that TRACIE has done since its inception has now been devoted to COVID-19 response and we provide this information updates on a monthly basis. And if something on this slide is of keen interest to you, but I do want to gravitate your attention to the big purple bubble all the way on the right hand side because several of you on this call today are included in our subject matter expert cadre. We started out with about 40 people when we first started asked for TRACIE, five years ago, and now have 950 SME cadres that help us with a wide variety of issues, including COVID-19 so I just want

The success story for ASPR TRACIE is attributed large part to partnerships that we have with folks like you and I just wanted to acknowledge and tell you how much we appreciate and need your support on a daily basis. So, thank you very much. Next slide. Again, this one is let you kind of browse through this, you'll be provided this PowerPoint, but these are some of the select new resources, some of it coincides with what Matt was talking about of what we've added to ASPR TRACIE. And then certainly, as you know, because you're on our distribution list, we are very busy with a large array of different webinars, depending upon what piques your interest. But we are currently collaborating with the Pediatric Centers of Excellence here at asked her on a webinar series. And again, we have another webinar coming up tomorrow, and then two more after that. So again, if any of those are of interest to you and Jack highlighted the Optimizing of the Healthcare PPE webinar last time. So, I just want to make sure that you know that we are continually, almost daily, updating different resources on ASPR TRACIE, adding different from a wide variety of individuals and organizations with new resources. So please come back often to ASPR TRACIE, because we're continually updating that and then we do let you know through our outreach through the Expresses about what we're doing as well and drawing your attention to new resources.

But lastly, we're here for you. If you can't find the resources that you need simply email, call, or do an online form. And we'll make sure that we address your needs in an expeditious manner and again, we take care of a wide array of different issues for healthcare system preparedness, response, recovery. So please reach out to us. Now my distinct pleasure to introduce Captain Satish Pillai, who is again going to provide an update on the COVID-19 vaccine implementation and Captain Pillai is a CDC colleagues that is the Senior LNO for Operation Warp Speed. Captain Pillai, over to you, sir.

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Dr. Satish Pillai: Thank you, Shayne and thank you to Jack for the invitation. It's a real pleasure to speak with the State Hospital Association group and give you an update on current vaccine implementation activities. As Shayne pointed out, I'm the CDC's Liaison Officer to Operation Warp Speed. And in that role, I help facilitate communication between our DoD colleagues at OWS with our subject matter experts in Atlanta, and also engage with the coordination with our colleagues across the interagency, including Jack and the HPP program, ASPR writ large and other federal partners. Next slide please.

So, what I'd like to do is just briefly kind of go through where we are currently in the distribution and administration mission for the COVID vaccine planning. As you know, this is a very complex situation right now with multiple different vaccine products currently in various phases of clinical trial. There are

multiple different cold chain requirements for some of these vaccines, varying requirements for administration with one being a single dose vaccine currently in trial. The rest being two dose vaccines. The overarching goal, though, is that we want to have a rapid, efficient, and high uptake of the vaccine series once a vaccine product group receives FDA emergency use authorization and we get guidance from the Advisory Committee on Immunization Practices on the appropriate target populations for which of these vaccines will be utilized. While this graphic depicts something that looks sequential for planning purposes OWS staff, interagency partners are working on every one of these pieces at the same time. And as we think about vaccine implementation, we have to keep in mind like starting at the left of this prioritizing populations, recognizing that allocation of vaccine, especially in the early phases when there may be limited supplies will be challenging.

There will be special consideration needed for groups who may need a very tailored approach such as healthcare workers or those potentially living in long term care facilities and decisions on the prioritization and allocation will have to be made in real time as more information comes available. Irrespective of the fluid nature of a lot of this information, vaccine safety is the most important issue for every phase from the clinical trials, all the way through the administration and subsequent monitoring and data systems are being established or invigorated to ensure that we have real time monitoring of not just the vaccine supply and uptake, but also being able to track safety signals. And overlaying all of this is the importance of communications and stakeholder engagement, such as this, because at the end of the day, we have to engage with lots of different people to help one be part of the planning, as well as the operationalization of this. We can have a robust set of prioritization, allocation, distribution plans, setting up administration sites, but if we don't have sufficient communications and partner engagement, this will not succeed.

On the note of communications, I would point out that just yesterday CDC created and added to the COVID, general COVID preparedness information on our website with dedicated pages to vaccine activities as well as frequently asked questions and as you can anticipate that section will continue to grow as we gain more information about the vaccines as well as once authorization occurs. Next slide please. So successful implementation of the COVID vaccine campaign is going to occur through a multi-phase approach and different strategies are going to be required to ensure appropriate coverage as more and more doses become available.

As I alluded to earlier, what we're hearing from our OWS colleagues is the first round of doses will be available in November to December timeframe and that is where our planning solutions currently are including the plans that we've asked our jurisdictional colleagues at the state, local, and territorial level to plan against. But in those early months we anticipate there'll be a limited amount of vaccine available. And during that phase one, we are anticipating concentrating efforts on critical populations and ensuring that we have the ability to manage the inventory distribution and dose administration very closely to ensure end to end visibility on these limited doses of vaccine. As you can see in in the graphic that to account for that we will probably use closed settings such as mass vaccination sites or places of work to be able to provide vaccine for targeted populations in an account for vaccine. The entirety of the vaccine that's being pushed out.

During Phase two as vaccine doses continue to increase, and multiple products are available we anticipate that supply will be likely to meet demand. And at that point, the focus will shift to ensuring a coverage of all critical populations and ensuring particularly high uptake in highly vulnerable populations such as those that are higher risk for severe outcomes with COVID 19. And with this broader catchment we anticipate jurisdictions would continue to expand their vaccine provider pool to account for the need

to have more and more sites to administer vaccine at. During this expansion we anticipate commercial and private sector partners, including pharmacies, doctor's offices, clinics, as well as the public health side with a federally qualified health centers, rural health clinics, and other temporary sites may be required. And then as we continue on this graphic, you'll see that at a certain point when there will be likely sufficient supply for the entire population and the goals will be to really identify those locations where we've had incredibly hard, you know, or difficult challenges in reaching difficult to reach populations, just to make sure that we are maximally covering the US population with the COVID 19 vaccine. Next slide please.

So again, another cartoon, just to kind of go over the general distribution overview and the key concepts require partnerships with state, local, tribal, territorial health departments and federal partners to allocate and distribute vaccine. And there will be augmenting of this system through direct distribution to commercial partners when we have sufficient vaccine and we have populations that the commercial partners can clearly help us meet the gap with CDC has a centralized distributor, which is what will allow us to ensure that we have a flexible, scalable secure way of tracking orders, allocation, uptake and management and that, but there may be individual vaccine products which have their direct shipment from the manufacturer to the distributor to the administration sites. As you can see in this in this graphic from the manufacturer, there'll be a distributor. There may be additional depots, but the goal is to ensure that we have a breath of administration sites that we can utilize to get the broadest coverage with the COVID 19 vaccine initially recognizing that there may be targeted mass vaccine clinics when they're limited amounts of doses, or very target occupational vaccine clinics. Next slide please.

This slide simply tries to outline a draft concept of operation for select critical populations, as I said in the initial phases when there may be limited doses of vaccine it's important to think through where allocation may need to be directed towards. Both the National Academies of Science, Engineering and Medicine as well as the CDC Federal Advisory Committee on Immunization Practices, ACIP, have worked towards determining these populations of focus and ensuring equity and access to COVID 19 vaccine. We, the key concepts are, you know, we want to be able to use the COVID-19 epidemiology and burden as well as factoring issues such as vaccine safety, efficacy, the quality of data. In thinking through how to prioritize populations. And this chart is notional because we still don't have the final ACIP recommendations and it's not meant to be inclusive, but to highlight how Subject Matter Experts are thinking through the critical populations, when there is very limited doses, it may be important to target healthcare personnel and other essential workers, such as utilizing locations such as occupational health clinics and other settings where we can drive these focus groups towards product.

We also want to think about people that may be at increased risk for severe disease, as we've seen earlier in this pandemic with significant morbidity and mortality in individuals residing in long term care facilities as well as those who may be at increased risk for COVID-19 infection based on their race or ethnicity and based on other unique demographic or socioeconomic risk factors. And then we also want to make sure that we're thinking about equity and ensuring that those with currently that may have challenges with access to vaccine such as those living in rural jurisdictions, or with disabilities we are accounting for and factoring those populations into our, our overall prioritization schema. Next slide please.

Given the limited time I don't want to take, I want to get through all the slides, I will just simply say that the safety focus for COVID-19 vaccine is a stem to stern approach from the development of these vaccines through the entire lifecycle to the administration and post administration follow up. And the goal is to use established mechanisms and partnerships with health systems, academic centers, private

sector partners, CDC plans to leverage existing safety systems such as the vaccine safety datalink and there will be. We will also be looking at developing new platforms such as smartphone text messaging systems to be able to track and have vaccine recipients be able to monitor for unexpected adverse events and allow for timely follow up, if recipients report adverse events. Next slide please.

As I said, on the very first slide the irrespective of the best distribution plan the optimal vaccine candidate and all the safety monitoring systems being in place in the absence of an effective communication strategy this endeavor will have significant challenges and to that end, CDC is leveraging the Vaccinate with Confidence framework which has been successfully used to strengthen public trust in vaccines in other vaccine-preventable disease outbreaks for the COVID-19 scenario that the key concepts are to be able to reinforce trust with. As real time information as we have available about COVID-19 and COVID-19 vaccine, we want to be able to empower the healthcare community recognizing that this is happening at a very fast pace and information is continuing to evolve and we want our healthcare providers to be able to speak to their patients and speak to the populations they serve with trusted information on the disease and the use of vaccine. And finally recognizing that we have to engage with communities and community thought leaders to help strengthen the message and really leverage the fact that people will be more prone to listen to the advice and guidance from their trusted members of their community. So again, reinforcing information on what is available to the public at large. What we're providing to healthcare providers in ensuring we're appropriately engaging with communities. Next slide please.

But in, in summary, you know, I think this is clearly a complicated landscape with multiple products, multiple dosing schemes, multiple cold chain requirements occurring in a very accelerated timeframe, but one that will, you know, only proceed to administration once there's authorization by the FDA and guidance from the Advisory Committee, Committee on Immunization Practices, and that we CDC and FDA and interagency partners will deploy routine procedures and systems to ensure that vaccines are safe and effective. The recommendations on who will get vaccinated will evolve over time as we move from limited doses in the late part of 2020 into an increasing supplies later in 2021 and recognize that vaccine planning is continuing to evolve, new information is continuing to be obtained and with increasing information the hope is that using forums such as these, the updated CDC website and ongoing stakeholder engagement we're able to provide the most up to date information to those that that would benefit from it. I'll stop there, turn it back to Shelley and Jack and thank you very much for the time.

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Shelley Rollet: Thank you, Dr. Pillai. We'll have a few minutes now for the question and answer for Dr. Pillai on the vaccine implementation. So, as a reminder, if you want to submit written questions or comments you can use the chat function, or you can ask the question live by selecting the raise hand feature in the participant tab. Open the line for questions now.

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Jack Herrmann: While we have folks queuing up for questions. Hopefully, there are some. Let me just ask of our State Hospital Association representatives, what are some of the challenges you may be hearing or expecting anticipating in regards to the mass vaccine campaign, if you will, execution strategy on that you have been hearing from some of your own members and in affiliates, it would be helpful to know what's the word out on the street. Where are the concerns in the field, because I think it's important for Satish and his colleagues at CDC, OWS that have some good situational awareness of what's being talked about out there to help drive better communication and or just any communication

and ways that we can attend to some of the concerns and issues that the field is anticipating. And also, whether or not you feel like you've been involved both of the State Hospital Association and your partners and members have been involved in the vaccine planning to date.

As you know, the micro plans are due today. And so it's interesting, it would be interesting for us to hear, to what extent you are involved in informing those plans or not involved in forming those plans and any issues that came up that are particular to your state that you think are important to have on our radar.

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Dr. Satish Pillai: Thanks Jack. Yeah, just to echo Jack's points the 64 jurisdictions their plans are will they will be due back to CDC tomorrow, COB and as many of you have probably seen the goal was to engage with the key stakeholders within their communities that could help enumerate key populations that would be the target of vaccine early phases, later phases, as well as thinking through what would be appropriate vaccination locations to help maximize the coverage and thinking through also unique cold chain capabilities. So, there's probably been outreach and hopefully there has been thinking through minus 20, minus 80 freezer capacity in within the hospitals in your jurisdictions. So hopefully those conversations have been fruitful with your organization in emergency management partners at the health department and would be curious to hear what your perspectives have been. Over.

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Jack Herrmann: Yeah, I'm a bit surprised we haven't received any questions because I have certainly spoken with some folks individually, and we've heard through the grapevine that there's a need for more information or concerns about to what extent state hospital associations have been drawn into the planning effort. So, this is one of those opportunities to kind of share now where you think some of the concerns are, where some questions may still be.

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Dr. Satish Pillai: And if there are - Was that a question? - If not, we, I'm happy to also, Jack, take back to the jurisdictional planning team, like, you know, having an eye towards ensuring that the hospital systems have been engaged and, you know, making sure that that feedback is provided to the jurisdictions. I know that there's been a call for, as I said, the freezer capacity. Some of this is most likely going to be in major hospitals within the jurisdictions. So, I suspect that if there hasn't been outreach there will be. Again, these plans will be reviewed, feedback will be provided back to the jurisdiction. So there will be an opportunity if you haven't engaged with your appropriate immunizations lead within the health department or emergency management lead within a health department to engage with them and ensure that that communication is established, so that any feedback can be incorporated into the into the plans. Over.

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Jack Herrmann: We did have one comment in the chat box, it would be helpful for states to be encouraged to involve hospital associations and planning. Let's be clear. They have been encouraged to include hospital associations in planning. So if you've not, you know, been in contact with the state Health Association, state Health Department or you haven't heard from them, you know, that's exactly what we're trying to hear and ascertain because the state has a responsibility to reach out to the healthcare sector where we know vaccine is going to need to be either distributed to as a population or they're going to be instrumental in helping dispense the vaccine to the population within their state or jurisdiction. So we want to make sure that the healthcare sector is informing this plan that the State is

responsible for executing and if you've not been part of the planning process to date and you aren't up to speed on what your role or responsibility or accountability, Elisa, that's exactly what we want to hear. I see.

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Dr. Satish Pillai: I see Elisa.

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Jack Herrmann: Elisa just responded. Yeah, yeah.

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Dr. Satish Pillai: I think it is like, as with anything there will be some states that are more proactive than others. And I think if I think it's safe to say if you haven't heard it would be a good idea to reach back to the immunizations department. I can also have my colleagues back in Atlanta mentioned this on the all awardee calls that, you know, thinking about the breadth of partners that can help operationalize this large endeavor, but thank you, Elisa. For the comment.

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Jack Herrmann: We'll continue to do our best to bring these opportunities to you as well. But, you know, given the plans as Satish said that are due tomorrow if you've not heard from your state, then it is likely either the plan was submitted without your input or you're in the plan and may not know it. You know, all of these things happen for a variety of reasons. And this is not to be punitive. This is really just to anticipate this is going to be one of the major vaccination efforts of our lifetime and we all want to be on the same page. So, this is all in the spirit of identifying potential gaps and challenges and just making sure that this can come off in as seamless a way as possible.

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Dr. Satish Pillai: And I do have one other comment Jack. It's interesting, like, you know, as I said, there's probably challenges on all sides, given the number of potential partners. And the rapidity with which this is proceeding. So on the on the state planning side, some of the concerns were that provider agreements are going directly to hospital associations and bypassing the health departments and it might lead to numerous, you know, like double counting essentially or the state losing visibility on who is trying to sign up. And so, I think it's just a matter of all of us trying to stay in communication as best as possible. So, you know, the provider agreements, the state should be reaching out to you all to help as well as you know, the medical associations and pharmacy associations within the jurisdiction and vice versa. You know, they should, you know, be keeping you all in the loop on what's going on with the overall vaccine planning and however I can help from my position right now at OWS and linking back to CDC headquarters, as well as engaging with Jack who, you know, is a critical partner in in the healthcare sector, please, just feel free to let me know. Thanks again.

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Shelley Rollet: Thank you, Dr. Pillai. We're going to move to the next portion of our agenda and welcome John Fredenberg to share a little bit about the SNS 2.0. Now if you do have any follow up questions from the last segment, please feel free to continue to enter those in the chat box. Hand it over to you John. Thanks.

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John Fredenberg: Thanks very much Shelley. And thank you for allowing me the opportunity to come and talk to you today a little bit about SNS 2.0 My name is John Fredenberg. I've been with the Strategic

National Stockpile since 2004 in a variety of different roles. I have done pretty much every response that we've been involved in, from very small to now very large across not only the United States but also internationally. I've written a lot of the response plan, so I know how things work in the program. And I offer that because the thing that I'm going to talk to you about now is something that has truly been unprecedented and I heard a couple of the key words that Satish used like rapidity and you know once in our lifetime, like what Jack did and what this project and I'm going to describe to you is about, really has a lot of those kinds of words associated with it.

As a lot of you probably know at the, at the start of this response the inventory in the SNS was largely based on material that we had procured back for the, not for the 2009 pandemic, but in that era and that's kind of the start point that we had for this for this pandemic. And the, the speed with which this took off and the very, very rapid rise in demand. You know it quickly made it, made it apparent that we needed to look at the stockpile a little bit different. And in the past how we have really operated is that we would provide material and then once the event had subsided, we would go through a very deliberate procurement and acquisition process to restock or redesign the approach and the material that we would hold in the stockpile for specific event or scenario.

For the SNS 2.0 project the goal was to, while we were still in the response, to rapidly expand and build a capability for an anticipated next wave or next large demand spike on the system. And so that was the going in position that we had for you know that laid kind of the foundation for what we set out to do really starting in about March, April, while we were still responding. If any of you have ever done that, you know how challenging that is that you're dealing with a particular problem and at the same time, you have to carve out enough space to build while you're responding. And we've been doing that pretty much non-stop since February.

We started with quarantine stations. For those of you who remember that phase of the operation and we are still to this day, sending material out across the country, in response to request for a variety of different products. So 2.0 was a concept that was designed and it was chaired by very, very senior members of the government to lend not only the appropriate emphasis, but the, the ability to draw rapidly on capabilities that the SNS organically doesn't have and would need to do this kind of work. One example of that, that I'll talk about in a second, is contracting. SNS and ASPR, have a capability for contracting, but not to the scale that we needed to do this kind of a rapid build. And so, we relied very heavily on partners from the Defense Logistics Agency, you've had more of that than we did to come together and really form a very cohesive and effective team, quite literally overnight.

There's five work streams that came out of the initial concept design of 2.0 and I'm going to briefly walk through each one of those. The first one was replenish the SNS, as I mentioned, we had to draw on expertise from the Defense Logistics Agency and others like FEMA to bring together the right expertise to rapidly produce contracts that would allow us to procure material on a on a very, very large scale. And I'll give you some numbers at the end to give you an idea of what that what that is. So, to do that it, again, it was not something that could be done by just as ASPR. Or just part of or just one part of an organization. It really involved a lot of different agencies coming together and producing a final solution. The one example of the numbers. And again, I'll give you more in a minute, but we started yeah, we started the pandemic with an inventory of approximately 19,000 ventilators. The way we design our inventory is to be multi event. So, we had them that were able to be used for a pandemic, but for also for some of the other bio events that we have you know plan scenarios against, but we started with about 19,000. We sent probably about roughly 10,000 or 11,000 out in the course of the response. And to give you an idea of the scale of the 2.0 capability we now hold an inventory right at 160,000

ventilators so when you're talking those kind of numbers and that kind of scale there's not only the just the pure numbers of doing the procurements and then buying the machines in a reasonable amount of time SNS also had to grow warehousing and it had to look at other aspects, so that we could be more efficient in our distribution.

But one of the cornerstones of the SNS 2.0 work was that we would have a larger capability of initially PPE but we also added pharmaceuticals too, that we didn't have currently in our inventory so that we would have roughly a 90 days-worth of supply against the demand that was provided to us so that was the initial goal. We're not there yet, but those, that's to give us an idea of the kind of the numbers when you talk about replenishing the SNS.

The second work stream was working on distribution and our network, while it is very capable and national and can push a lot of product out, was really designed for a bioterror event, which was centered around a or multiple cities, but it was a kind of a focused event, and it was not national to the scale that we had to deal with during this particular response. So one of the areas that we knew we had to look at alternatives for was working with distributors who do this kind of national response on a on a day to day basis and tap into some of that capability to augment what we had organically in the stockpile. Through the course of the last couple months we entered into contracts to place product with distributors, so that we're much more nimble and able to respond more quickly to request and other demand indicators like hotspots that we service now with people who do this every day to the places we're trying to go. And so we think that the work that we've done on the distribution side has been, it's been in our background or in our minds for a while, but now this has been an opportunity for us to really implement some of the ideas and put product in places that it may be more efficient for a response like this.

The next one was refining the strategy and structure of the SNS. As you can imagine that we started to grow and gain more capability in warehousing and product. Really, we are we are very much understaffed. And while we have not grown yet there is design to better resource the types of things we're being asked to do now, not only in terms of some of the things that I've talked about but Satish mentioned another one of our kind of portfolio items and that's cold storage, we have gotten a lot of product that now that requires significant cold storage and is one area that while we had a significant capability before. The, the numbers that we are now talking about is much greater than what you know than what we had capacity for and each one of those new capabilities that we desire requires a really thoughtful approach to the most efficient way to do it.

The fourth one is expanding domestic manufacturing. There's been a recognition and a lot more emphasis placed on supply chain analysis, which is really what my background is, and what I did for about five years leading up to the response that there are certain areas that were very vulnerable to the place where material is either manufactured or sourced from and so there has been a significant investment placed in areas that will make us less vulnerable going forward, either in terms of manufacturing capacity based in the United States or sub-tier suppliers that are now in the US or a majority is in the US, where before it was overseas. And part of that vulnerability analysis as an important new feature to what we are really doing holistically, not just the SNS but ASPR, FEMA and others at large that are really looking at the problem a little bit more thoroughly and not just putting you know, putting things in the stockpile but really being thoughtful about how we do it, where it's sourced, and then how, what's the best way to distribute it and the environment right now is such that it allows for a lot of those ideas to really take a lot of forms, you know, have a lot of fruition or bear fruit, where they have out been out there for a while, but we have, you know, we have not had really had some of

the resourcing so we are trying to take advantage of that window of opportunity right now and implement some of those, some of those things that, you know, we've kind of had in the back, we've had in our minds for a while.

And I just looked, and I know I'm at my time right now, but I have one more of the five and I've saved the best for last. And that's the one that I'm kind of a co-lead on at the moment. And that's something called the supply chain control tower. One of the things that we have been very aggressive on and fortunate to be able to work again with some world class people is gaining as much information on the data side as we can to make more informed decisions. So, we collect data now from major distributors, hospital supply through teletracking, long term care through NHSN, and there's a system in place now at ASPR, called HHS Protect, that aggregates a lot of that data. And we're up in the neighborhood of about 120 I believe at last count data individual and unique data streams that come in at various frequencies and provide different sorts of data, but that is a tremendous leap forward from where we were at the start of the response where we, we now have significant data to be able to analyze things like supply and demand where we just did not have that ability before.

And so, I'll close there. This is a topic area that I could talk about for hours. That's why I didn't put up slides because I knew I wouldn't get through them all. But if there's any questions, I'd be happy to answer them right now. Thank you.

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Shelley Rollet: Thank you, John. And again, if anyone has any questions, you can add them to the chat box, or you can raise your hand and we will call on you. Alright, I'm not seeing any questions or comments in the chat box, nor any raised hands so I'll give one last call out to in case someone has been waiting their turn and wants to speak or for other comments, otherwise we'll move ahead and close out the call.

00:50:34.320 --> 00:51:31.800

Jack Herrmann: Okay, Shelley. I don't think we have any questions. Alright, so thank you to all of our presenters today. Hopefully the information that was provided to you was useful and as all the presenters have shared if you have specific questions that you would like to reach out to separate from this call, please do not hesitate to do so, also as a reminder, if you'd like your Hospitals Association to be highlighted in a future call or on ASPR's website or social media accounts, please contact your field project officer or send a message to us here at ASPR Headquarters at hpp@hhs.gov

We thank you again for taking time with us today and look forward to speaking with you during next month's call. Take care everyone.