2011-2016, Public Health Emergency Preparedness Capabilities, Opportunities for Clinician Engagement with State and Local Public Health Departments

Moderator: Loretta Jackson Brown

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Coordinator:

Good afternoon and thank you for standing by. At this time all lines have been placed on a listen only mode until we open for questions and answers. Also today's conference is being recorded, if anyone has any objections you may disconnect at this time. I would now like to turn the call over to Loretta Jackson-Brown, ma'am you may begin.

Loretta Jackson Brown:

Thank you Leslie, good afternoon. I'm Loretta Jackson-Brown, and I'm representing the clinician outreach and communication activity (COCA) with the Emergency Communication System at the Centers for Disease Control and Prevention. I'm delighted to welcome you to today's COCA webinar, 2011-2016, Public Health Emergency Preparedness Capabilities: Opportunities for Clinician Engagement with State and Local Public Health Departments. We are pleased to have with us today Dr. Christa-Marie Singleton, here to provide an overview of the public health preparedness capabilities and to highlight opportunities for clinician engagement.

You may participate in today's presentation by audio only, via webinar or you may download the slides if you are unable to access the webinar. The PowerPoint slide set and the webinar link can be found on our COCA web page at emergency.cdc.gov/coca. Click on COCA Calls, the webinar link and slides that can be found under the call in number and call passcode.

At the conclusion of today's session, the participant will be able to understand CDC's capability based methodology for determining priorities for state, local public health preparedness and response. Describe types of current public health preparedness activities being considered between public health departments and clinical providers, and identify opportunities for clinicians to develop and support a share engagement of public health preparedness capabilities at the state or local level.

In compliance with continuing education requirements all presenters must disclose any financial or any other association with the manufacturers of commercial products, suppliers of commercial services or commercial supports as well as any use of an unlabeled product or products under investigational use. CDC, our planners and the presenter for this presentation do not have financial or other associations with the manufacturers of commercial products, suppliers of commercial services or commercial supporters. This presentation does not involved the unlabeled use of a product or products under investigational use. There was no commercial support for this activity.

Today's presenter, Dr. Singleton is the senior medical advisor in the Division of State and Local Readiness at the Centers for Disease Control and Prevention. As the lead science advisor she provides senior level scientific and programmatic leadership. She is responsible for researching and evaluating key scientific public health policies central to the agency's mission. Dr. Singleton created objective based criteria based upon input from agency wide subject matter experts to support CDC's involvement and a federal interagency review of state, local and territorial pandemic operational plans and missions as directed by the National Strategy for Pandemic Influenza Implementation Plan. She represents the division and the coordinating office in multiple agency wide workgroups to develop products to translate scientific information from federal, state and local public health agencies into practice. Dr. Singleton completed her pediatric residency training at the Thomas Jefferson University and her Master's in Public Health at the Johns Hopkins University School of Hygiene and Public Health.

Following the presentation you will have an opportunity to ask our presenter questions. For audio questions dialing star 1 will put you into the queue for questions, or you may submit questions via the webinar at any time during the program using the question and answer tab at the top of the webinar screen. At this time please welcome Dr. Singleton.

Dr. Christa-Marie Singleton:

Thank you Loretta and good afternoon everyone. I am pleased to be with you today and hope that we can engage in a fruitful dialogue at the conclusion of my remarks. I'd first like to begin with giving everyone an overview of the public health emergency preparedness cooperative agreement so that everyone can be on the same page. This funding stream was first established in 1999 as a $40 million competitive grant and its original focus was on bioterrorism. There were initially 63 awardees across the United States and then as well as now it has been managed by my division, the Division of State and Local Readiness within CDC's Office of Public Health Preparedness and Response.

Today this cooperative agreement supports an all-hazard focus and it is a formula based component which means that there is a formula that creates a funding amount for each of the 62 awardees. There are 50 states that receive these funds, four directly funded cities, eight territories and city associated states. Our current formula announcement began in August of 2011. And we have our awardees actively working on activities around these capabilities. But as we announced our new program or developed our new program announcement in 2011 leading up to that we had a program announcement that started in 2005 and concluded in 2011. And during that process the Division observed several challenges and in front of you are just a few of the ones that came to light most prominently in our review. That we had many different stakeholders in the process, we as an agency, as a component of Center for Disease Control are not the only persons who decide what material goes into particular funding announcement.

We have many different partner agencies that have fed information to us to date and the program has moved from topic to topic over the past almost ten years. There are multiple CDC programs who have had a history of adding material, often at the very last moment to our awardees and to the requirements for the program. And there have been very few formal processes prior to our work over the last couple of years to get to this point. We are funded and exist through an act of Congress and therefore Congress has its own ideas as to what we should or should not be doing.

As I mentioned we have moved quite a bit from topic to topic in the initial phases of the program, we had a very strong and narrow bioterrorism focus. After 9/11 and the anthrax incidents of 2001 and 2002 the focus was very heavily targeted towards anthrax preparedness and response. Then we had smallpox, then we had pandemic preparedness, then we had hurricane preparedness, then we've had you know a minor shift on radiation, we've had multiple competing interests and multiple competing diseases and things that the state and local health departments have had to contend with. And then to cap that off as a science agency, unfortunately to date we had a limited supporting science or evidence base that directed our activities in a particular area.

So we took a step back as a division and decided to look at what are the things that drive the preparedness environment? And as we looked at the programs leading up to now, we noticed that our main awardees, public health departments at the state and local level anchor their work predominantly around the ten essential services of the public health which largely points to an assurance role for the public health, to assure and support the public's health. We also had since - particularly since 2011 been influenced by our colleagues in the emergency management field. Those colleagues tend to anchor their work around the Department of Homeland Security target capabilities list. That document has undergone two revisions, the most recent one in 2007. And it has some very strong terrorism focus and one of the concerns about that document is that public health in particular and the healthcare community has had a very narrow viewpoint. And the activities, the breadth of activities that the healthcare sector can contribute to a response may or may not be fully realized. So you have that universe of activities and then we also recognize that there's the medical services or clinical medical world and typically hospitals and free standing clinics that are credited by the joint commission on accreditation of healthcare organizations. As well as the centers for Medicare and Medicaid services, that group of contributors to the healthcare system has its own perspective that ground its work. And so we see public health emergency preparedness being at the intersection of all of those three elements. So the work that we created was intended to have reflections upon each of those fields and it is our hope and our intention is that this work that is the guidance for health departments at the state and local level will be able to facilitate work that emergency management partners can do to fulfill their requirements for their activities as well as opportunities that clinician groups and facilities can do to facilitate their work.

So again if we move forward for 2011, we revised this cooperative agreement to address and resolve the challenges and issues we identified during the 2005 and 2010 cycle. We wanted to have a more systematic process to engage subject matter experts. We wanted to align with the target capabilities list that I mentioned from our emergency management colleagues. Because we are funded by Congress, we needed to make sure that we answered our congressional constituents. In 2006 the pandemic and all hazards preparedness act was created and that authorized our program.

The next step down from the Pandemic and All Hazards Preparedness act or "PAPA" is a document called the national health security strategy. That document then points to the targeted capabilities list. It also speaks to public health and medical preparedness. Therefore we felt that our work should align with that document. Because we are a component of the Centers for Disease Control we wanted to align with the CDC strategy preparedness plan and then turning inward to the awardees we wanted the awardees to be able to start a program announcement. And then essentially be left alone to be able to continue their work. We wanted them to be able to plan strategically over the lifecycle of the award and look at a more formal self-assessment so that they can define what things they needed to accomplish in terms of preparedness and response. And instead of giving us minutia for response to our recommendations and our requirements to actually have them show up how they are able to demonstrate accomplishment of these capabilities.

Many of these capabilities are being enacted every day in every day public health and medical work and that's the focus we wanted to have a component - as a more active component of the program and harvesting the work that is already being done within those three fields of the preparedness environment. And then parallel to the process we have focused on developing a change management process that's outside the scope of my talk but it's put here to let you know that we are very focused on defining the contributions that the public health community can provide for preparedness, staking our claim in the sand and contributing our piece of the jigsaw puzzle for the preparedness environment. And then if things happen and they do, that when we get a request for input to make a change to the capabilities then we look at it in the whole of how does that request for change impact the program and not just automatically add it on as a new requirement.

So to let you get a sense of where we came from these are just selections of some of the documents that we reviewed to get us to the 15 preparedness capabilities. We look at again because of our need to

satisfy our congressional constituents, we look at and review the pandemic and all hazard preparedness act or PAPA. There are three Homeland Security presidential directives, in particular that we zeroed in on, 5, 8 and 21. We looked at the security strategy, the target capabilities list and then CDC's work. But then we also wanted to take - get outside of just the federal government sphere and look for as an incident form document that came from either the project community or the research community. And so these are examples of some of the documents we looked at, we looked at things from RAN corporation around conceptualizing and defining public health emergency preparedness, documents from Trust for America's Health, Ready or Not, one document in particular from the National Association of County and City Health Officials is a document called Project Public Health Ready which to date is the only real accreditation type or accountability component for local health departments. And then we look to the document from the Association of State and Territorial Health Officials called the Health Preparedness Capability Prioritization Project. Again these are just some of the documents, we looked at probably several hundred documents over the development phase. But to give you a sense, we did not do this in isolation, we wanted to get from all sides of the contributing components.

So over approximately a year or a little over a year, we selected potentially 20 public health preparedness capabilities using an analytic hierarchy process, we then later reduced the 15 through combining of the capabilities. And then because we wanted to have a more again evidence and form process, we put our methodology in front of a peer review. We have a board of scientific counsel that has experts from around multiple disciplines and in September 2009 they reviewed our approach and agreed with it and said go forth. And then we began our work to develop content within these 15 areas. And in March of 2011 we released the National Sandards for State and Local Planning. This is a description of 15 capabilities related functions, tasks, performance measures where they have been developed, and not all of the 15 capabilities currently have performance measures. And then the resources that are necessary for achieving these capabilities. This document suggests activities to help the public health departments organize their work and identify their most pressing need. A key principle of this document is that health departments are to have or have access to these elements and that in particular is where you all as clinicians can be of great assistance, because if a particular content area really resides, it's home in the private healthcare community, and there is a strong relationship between the health department and the clinical or healthcare community, then that's something that we would like to see leveraged to have access so that the jurisdiction has access to that particular resource.

Here in front of you are the 15 capabilities, they start, they're in alphabetical order. Community preparedness, community recovery, emergency operations coordination, emergency public information and warning, locality management, information sharing, mass care, medical countermeasure dispensing, medical material management and distribution, medical surge, non-pharmaceutical interventions, public health laboratory testing, public health, surveillance and epidemiological investigation, responder safety and health and volunteer management. Now in looking at these 15 if you are familiar with the Department of Homeland Security's target capabilities list, you may notice that several of these have identical or near identical components, at least the titles look very similar to what's done by our emergency management colleagues. And that is somewhat by design if you remember there are the three parts of the preparedness environment. One of the concerns that was brought to our attention is that the homeland security list doesn't always have a really strong input place or holder for public health and healthcare. So what we have done with this is built out a complementary fit. Each of the - none of these disciplines exist in isolation and so these documents contain the public health component piece of a jigsaw puzzle called preparedness and response. At the time of our development we were aware that homeland security was in the process of developing a revision to the target capabilities list. We understand now that that has gone to another initiative. But we are aware that our work is still being leveraged as the public health contribution to these larger capabilities. So the work will still be hopefully complementary of other discipline's work.

This is a document that shows you the structure of each of the capabilities so if you have not had the opportunity to look at them, each of the capabilities is - has a definition and then it's supported by three to

five broad what we call functions for capabilities. Except for medical, material and distribution management of distribution it has six. But the rest have three, four or five functions. Those functions are the trip points. If a capability had to be broken apart into key most critical essential components, what would those things be that would allow that capability to exist? And that's what is called a function. Each function is supported by a series of essential tasks and those essential tasks are the things that a jurisdiction would need to demonstrate to say yes I can do this function. They form the basis for training and exercises and their task, they appear in a deliverable to us called a capability or a demonstration plan. This slide is a little bit misleading in that it states that resource elements are connected to the essential task and it has the resources elements are the building blocks that support our function. They are the things that we plan, every capability you need to have a plan to be able to do something. They have - the people need to have skills and training. And then there needs to be types of equipment that occur in a particular function. So the resources tell you what should be in your plan, what types of skills should be brought to the table, what type equipment or technology might need to be brought to a particular capability.

Now I will go into some of the expectations that we had told our state and local health departments regarding - we want them to do regarding engagement with healthcare providers. So what I was going to do now is highlight several of the capabilities that specifically call out our expectations of these health departments. So the first capability is in this capability of information sharing. We have asked them as a requirement that they need to tell us how they're going to work with healthcare providers to exchange information. We are eventually moving as a community towards electronic case reporting and we are aware that the often first sign of illness in the community is at the clinician level. It's at these you know interface of a healthcare provider. Eventually health care providers through the work of the centers for Medicare and Medicaid services will be pushing more for electronic case reporting. But we are well away that over 3000 health departments, that always doesn't happen electronically. But the bottom line is we want health departments to be more actively engaged with healthcare providers, to facilitate an exchange of data and case reports when there are illnesses. We are looking for them to develop or partner with or be engaged in syndromic surveillance systems so that they can better share data around different types of illnesses and different potential indicators for illness. And be engaged with you as clinicians around your ability to support immunization registries.

In terms of medical countermeasure dispensing we uphold then that they need to develop if they haven't already and then during (the time of an incident be able to activate a mechanism or mechanisms for individuals and healthcare providers to notify health departments about adverse events. So for example during H1N1 when clinicians were prescribing antivirals health departments were asked to create avenues so that should there be a potential adverse event they were able to work with either a locally based developed adverse event reporting system or health department or to ask to facilitate reporting into a national adverse event system. But no matter what the incident is, is if there is the expectation that there be a dialogue between public health and clinicians so that you all can more readily do this. It is our intention to try to make this as least burdensome as possible, but the bottom line is that we want that engagement around helping you tell us when there are potentially problems with your patients.

In terms of non-pharmaceutical intervention, this is the capability around what recommendations would happen if there are non-drug related things that could be done to help prevent disease. And so they are – health departments are being asked to come up with agreements with healthcare providers and their jurisdiction that must include at a minimum what will be their locally defined procedures to communicate case definition. And how will you providers report identified cases to the health department. And at the time of an incident assist community partners with coordinating support services such as medical care and mental health to patients in a community. So again this is an area where an active robust dialogue is our expectation, we are aware that this is not been an area - this is an area where there have been some stops and starts. And so it is our expectation that this be more ramped up over the next five years.
In terms of epidemiology which is one of the pretty consistent components of public health across the nation, is that it is our expectation of these health departments for them to support you to help determine the cause and origin of and definitively characterize a public health incident. So when you first see

something in your clinical practices, no matter what your practice is and report that to public health we want to be able to give you feedback more accurately. And so what could this be and not set a system so that you have to wait until everything is in. We want them to facilitate a dialogue with you all so that when something happens that we could hopefully get to the bottom of whatever this public health incident is at the time. And for them to continue to establish processes and protocols to gather and analyze data, but reportable conditions and reportable diseases, every state has a list of reportable conditions and we want them to work with you all to make it easier for you to be able to report into those systems.

In terms of public health laboratory testing we are aware that some healthcare providers package and ship samples to state public health laboratories and so we are asking the health department that has a state run laboratory to better coordinate a system and work with healthcare providers so that you all know what the applicable federal regulations are so that you will be protected both your safety first and foremost. But also to facilitate the movement of those samples so that their integrity is not compromised and then in turn to be able to send laboratory data results back to you as permitted by all the applicable laws, rules and regulations in a particular jurisdiction.

In terms of medical surge, one of the key fundamental components is that when there is an incident that involves public health it is our expectation of healthcare - health departments that they engage in something called a healthcare coalition. So that there is an integration of whatever your office or hospital or whatever clinical practice is doing when there is an incident so that all those plans are coordinated. And then another area, we have four for this particular one is for health departments to work with you to clearly define processes and indicators of when you might have change your standard of care. So currently as we're speaking right now there is a particular standard of care for so and so diseases. But in times of crisis where there may be a scarcity of available countermeasures, there may be a scarcity of equipment, there may need to be choices made, in terms of who gets what drugs, who gets what treatment. The timing, each jurisdiction, each healthcare organization need to come up with those indicators but it is the state and local health departments that should be also part of that dialogue and so we are asking them to more actively engage with you to help get through what will be the triggers in your jurisdiction of when this will all happen. This particular topic is being lead by or influenced by a recent Institute of Medicine panel that was convened in 2009 and later on this spring there will be additional information. But this is one where we are looking for an active dialogue between public health and clinical providers.

Another area we want to see is participation from jurisdictional and regional pediatric providers and leaders. They are Andrew, Katrina and Rita and several of the more recent large healthcare incidents in this country. There has been a lot of attention focused on the fact that pediatric interests have not always been addressed as part of the community's health. And so, one area that has been called out in a couple of the capabilities, most notably community preparedness and medical surge is that we want to see a dialogue between health departments and any pediatric component of the community. And we're not restricting it just to physicians but to any sort of pediatric interest because we want them to be engaged jointly in pediatric planning and response. We also are expecting the health department to assist and coordinate with medical facilities to assure that patients get back to their medical home or something more applicable to their environment. When there is an incident and the healthcare system has to surge, to build up and accommodate more patients, what goes up must come down. Eventually as a healthcare facility changes its practices to accommodate additional patients for that incident, eventually things go back to pre-incident state. Patients will eventually have to go back out of the hospital either to their primary medical provider or if they did not have one they have to go somewhere. And for those uninsured patients they eventually end up in the system somewhere. It is public – our expectation of health departments to work with all the different components of the healthcare community to assure that patients get back to either where they came from medically or an applicable and appropriate medical setting.

I'd like now to give you a brief high level snapshot of some of the preliminary things that we are seeing from our awardees in terms of how they are engaging with providers, healthcare providers. One of those

areas that I mentioned that has a heavy potential component for clinician engagement is the area of community preparedness. And the way we've chosen to define public health contributions in this is in four areas. We first want the health department to be able to determine what are the risks to the health of the jurisdiction, not just focusing on if a building falls down, but can a jurisdiction identify potential hazards, vulnerabilities and risks in the community that are specifically related to public health, medical and mental or behavioral health components. This is an area where we are looking for community health, family health and other kinds of clinicians that potentially serve vulnerable populations. We're calling that out in the document. We mentioned several types of populations as examples and we are looking for the health department and expecting them to be able to show us that they have reached out to and actually produced tangible risk assessment that focus on these three lanes, public health, medical and mental behavioral systems, which means in order to do so they've got to show healthcare community engagement. We don't want strictly a hazard and vulnerability assessment that might determine the probability that a building falls down. We want to know what's it going - what's going to happen or likely to happen to a particular population group in terms of their health? Once they do this risk assessment, we want to see if they have identified community partners and what we mean by community partners we're looking for a faith based community partners, we're looking for childcare sectors, we're looking for mental health, behavioral health, all types of family - you know federally qualified health centers. We want any community partner that has a stake in the public health medical or mental behavioral healthsystem. Those are the community partnerships that we want to see engage. We know that several health departments have been doing this for several years and are quite good at this. We want them to harness it and build these community partnerships and exploit them to focus on those pre-identified risks to the health of the community. We also then want to know, well it's one thing for public health to go out and try to engage partnerships but we want to know is the community - you providers, are you all provided to public health efforts? Do you even know what we are trying to do? We know that that's a barrier in some places where health departments may or may not have plans but providers have said I have no idea what the health department's even doing. And we need the health department to show us that you all know what is going on in their community, to build social networks that can help support the communities.

And then lastly are there - have the health departments pointed you all toward resources that you then can train your constituents, your office staff, your colleagues to make sure that you're connected to the community's preparedness effort. And again this is an area where we have zeroed in on pediatric planning, we want to see that public health is participating in approaches within the community to address how children's medical and mental behavioral health will be addressed in all hazards situations. We want to see how health departments have reached out to pediatric or family practice, anyone who serves children and can work on different approaches to address the topics. And what we have it is listed as a priority, that means it is a requirement of these health departments to do this as part of their funding.

The other big area I'd like to highlight is medical surge and so when there is an incident, the first thing that needs to occur is that there needs to be an assessment quickly, as to what's happening, what's the needs of the incident? What should be the role of partner agencies? So if there is a community hospital for example or a group of physician offices or community health centers, if they are being overloaded with patients, what are their needs right then and there? What are the needs of the incident, what can the public health help coordinate with or alert emergency management that you all have a need? The next piece is then to support the activation of the surge. So if you all have a healthcare coalition what partner should be activated, what should be communicated? You as clinicians, as providers are actively doing what you need to do to take care of the patients. And we see public health contributions to work with you to help coordinate that across the jurisdiction while you focus on taking care of patients. And then in terms of coordinating operations again that's part of our assurance role, we need to work with you all to help coordinate patient tracking, more so at the state level. But again obtaining your needs and then distributing any resources and then again as I mentioned what goes up must come down. And what's the process that you need from us to help release resources and get you back to pre-incident operation.

So again we are focusing in on the areas that are hopefully showing up on your screens in yellow where we want to see that the health department will engage in these coalitions and partnerships, about focusing on crisis standards of care, we particularly are focused on how health departments are engaging or could engage with jurisdictional and regional pediatric providers in multiple settings. We know some states don't have but one or two pediatricians but you may have other models. The bottom line is that we want to see opportunities for how you are going to engage to get children's health issues identified and responded to during an incident. There are a couple states that had done some preliminary focus areas again on two areas, alternate care system planning and pediatric planning. So at the time of our review we had 29 of 57 awardees, we still had some outstanding information from the other awardees. But they say that they're going to partially have alternate care systems planning, partially in place. They had the option to tell us I totally have it done, meaning fully in place or partially in place. And here's a couple of examples. One state had required its health department and given money to its facilities and it's set as a condition on funding, you all need to participate in planning through redistribute patients if there's some sort of emergency. And then has created guidance for if something happens during in this case a pandemic, here are the operating assumptions, here is the law, here's how EMS will operate. And so they use the participation of their clinical providers to create this guidance. Another state has created a medical surge framework that again with the hospitals and clinical providers informed process. That so when there is a need to change the standards of care in that state, the state health commissioner is the person that pulls the proverbial trigger. But the input of the facilities and the clinicians was the one that drove the content for that particular document. A third state created an executive law that says that local emergency managers have to work with healthcare partners to develop written standards to indicate different types of care. They created an allocation of ventilators, guideline documents and they've developed - they're in the process of developing tool kits, again it came from the input of their clinicians. And then lastly one particular health department before the pandemic actually happened had a work group for providers that solely focused on pandemic planning and then after the pandemic they spread it to what could, should be the scope of practice. What are conditions and things we want to consider about provision of care and at this point those recommendations are being finalized by their state health commissioner.

In terms of pediatric planning, two of our awardees had engaged that they are actively engaged in mass casualty planning around for kids issues in terms of medical surge. Twenty one of our awardees have said that they are partially there in terms of getting pediatric experts and providers involved in their surge planning which is an opportunity for again more providers to come to the table. An opportunity for health departments to really reach out to any sort of provider that is interested in pediatric planning to support those needs. Fifteen of our awardees not only are talking to pediatric experts and providers either within their jurisdiction or neighboring jurisdiction but they've also engaged their emergency medical service for children so the EMS side is part of a conversation. And then some of them that are working - that concept of all these standards of care have also looked at what would be the standards of care if pediatric patients, if resources were scarce to support pediatric illnesses? And here's some examples, one of the states has decided to come up with a regional mutual age contract because they recognize they don't have a lot of pediatric providers but yet the need is greater than what the support is. And so they've come up with the five states in effect here in the southeast so they've got a contract so that they will share resources, staff, equipment, etcetera. And one particular state they only have pediatric care in one regional center so what they've done is create guidelines for managing pediatric patients and disasters and so that they will work with other regions within the state. So if a child or group of children become ill in an area that doesn't have pediatric support then it has a guideline for what to do with those patients so that they can either transfer to a population center where there is pediatric support or can be worked - use the health department to help coordinate those options. Another state again one of those working with EMS has come up with a transport matrix that can be used for community hospitals or physicians who are not connected with pediatrics. But it has a transport information and then pediatric guidance to help those providers that aren't - that don't do pediatrics on a day to day basis. And then another state has designated a pediatric liaison because they only have a very small number of pediatricians in the entire state. So that liaison some folks will be able to fill these and helps them treat pediatric patients rather than transferring them so we have one state where transfer has been decided is the way to go. Another state has decided that the liaison will work, help them do telemedicine and other things to help treat patients in

a particular place, in their home or resident.

So next step, as you hopefully gathered from my talk that we need clinician input in terms of public health communities. At a minimum we really need and have written into the document areas of opportunity for topics of community preparedness, community recover, information sharing, non-pharmaceutical intervention, medical surge and responder states and health. And so if you take my bait and say okay Dr. Singleton I would love to be more involved in my area, who do I talk to and what would I even say? But here are some opportunities that we see to give you - we're looking for your valuable feedback. If the expectation of our health department is to work with you about sending data, health departments need to understand what it's like for you to be able to respond to requirements. If it's going to be overly burdensome and impact your office practice, then you need to let us know that, let the health departments know that so we can - so that they can hopefully work on that. If that becomes an identified barrier then that's a place where between the federal, state and local we need to help support you because you are our frontlines, we need to understand what you're seeing and be able to get that data from you. We need to do better at giving you more standardized format to receive - so that we can receive your data, and so again your feedback is critical at the state and local level. Several states have said during a pandemic in particular that their providers would have liked to have access to clinical protocols; we at CDC developed these across the agency. We're looking for your feedback on how you best want to access these protocols. A key, key, key area in order for the survival of the healthcare sector during a public health incident is that you all have continuity of business. That your clinics, your offices, be able to keep going if there is an incident or if you have to close down that you can reopen. The healthcare business model needs to be coordinated with whatever continuity of government, continuity of business is being planned at the state and local government level. And so we're looking for your feedback there. And then what you all - lastly what you all would see as potential viable outlook for patient care during situations where more patients are accessing the healthcare system. So these are just some suggestions, I'm sure there are others but these are areas that we have highlighted as what you really need and would welcome clinician engagement.

And so with that, let's see, I have a couple more. Potential opportunities, small pediatric provider populations, we have heard the states tell us that they are looking for guidance. This is an area where you all can chime in and help direct that guidance. We collectively need to develop better guidance to support pediatric consultants to non-pediatric healthcare facilities so the patients can either be staying in their homes or transfer to someplace else. And then collectively we feel that both of our communities need to partner to develop evidence informed practices that operationalize areas in pediatrics. There are other areas, other vulnerable populations but we zeroed in on pediatrics because we have – there are several responses have put that out as an area of focus. But again the partnership between the clinician community and public health is where we're trying to direct these activities. Our capability project has a mailbox that we monitor and it's at the bottom of the screen, 2011PHEPCA@cdc.gov and that's where we can get information. You can get information about this project or ask those questions or give us some feedback. And with that I will turn it back over to Loretta and I'm looking forward to having an opportunity to answer your questions.

Loretta Jackson Brown:
Thank you Dr. Singleton. We will now open up the lines for the question and answer session.

Coordinator:
Thank you, at this time if anyone has a question from the phone lines please press star 1 on your touch tone phone. Please unmute your line and record your name when prompted. Again star 1 if anyone has a question. Again star 1 if anyone has a question. One moment please.

Loretta Jackson Brown:

Dr. Singleton while we're waiting for a question...

Coordinator:
I'm sorry, (Michelle Samerican) you may ask your question.

(Michelle Samerican):
Hello, thank you for a good webinar. I'm just wondering if you can bring up the screen shot again of the contact information.

Dr. Christa-Marie Singleton:
There it is.

(Michelle Samerican):
Thank you so much. That's all I needed.

Coordinator:
Thank you, again as a reminder if anyone has a question or a comment you may press star 1.

Loretta Jackson Brown:
Dr. Singleton while we're waiting for questions through the phone line I do have one through the webinar system. The question relates to the role of faith based community health providers in meeting these capabilities.

Dr. Christa-Marie Singleton:
Well thanks for that question, there are several areas that where faith based community providers are welcomed and in fact are called out of these documents. Turning the risk to the health of the jurisdiction is the primary component where we really want their feedback. We did a pilot project about almost a year and a half ago where we looked at the existing methodology for risk assessments. And saw that there was a huge gap in community engagement and so we saw as one of the components of the potential community health was that faith based organizations often have ministries that no matter what the religious denomination they have an active health component. And that health component should be leveraged in community planning and so in the community preparedness capability we recommend that these jurisdictions - I mean the jurisdictions reach out to their faith based health providers to help them do their risk assessment planning and give feedback as to potential resources to help support the community's health.

Coordinator:
We do have a question from the phone line. Dr. Robert Ball your line is open.

Dr. Robert Ball:
Thank you, Dr. Robert Ball, South Carolina Department of Health, thank you for a very nice webinar. On your slides where you have alternate standards of care, many states have developed such standards in various formats. One pushback we get from clinicians concerns the legal authority or the legal protection, many clinicians are worried about liabilities when it comes to withholding or withdrawing ventilator support, etcetera. And then emergencies, it's not always the first patient gets every maximum resource and others go by the wayside, it's more of a try to save as many as possible. Can you comment on the various states around the country's legal authorities for this? In South Carolina our state health commissioner has endorsed state wide pandemic flu and other standards as has our medical board and numerous organizations. So we feel we're there, although we don't have a separate state law. But what are other states doing in general?

Dr. Christa-Marie Singleton:
Well we only have like I said a few places, I'd say about 20 or so, they had some states have used commissions or clinicians that put together if you want us to do this state, here's what we would need to be able, here are the steps - it's not a one size fits all. So they have created a staggered approach, if condition A is met here are things that we will want to consider, if condition B is here, so they've

established a set of triggers to look at.They've also - the key thing that almost all of them have done is determine who has the ultimate legal authority because in some states it really wasn't clear, is it the governor, is it the state health commissioner and what will be the process to implement that? So that's why a lot of them are saying well we think we have started doing this, let's say they have example four questions, four hospitals, each hospital has their own separate one that addresses whatever their liability comfort level is. But if it's happening state wide, the attorneys have to get together and figure out who's got the ultimate legal authority. So we're seeing kind of a patchwork, but a lot of times with the clinicians say whoa, their recommendation is up through reports and then present both the health commissioners have taken them on and advocate them at the state legislature level.

Dr. Robert Ball:
And you have a good medical legal resource there at the CDC, Matthew Penn to help with this too.

Dr. Christa-Marie Singleton:
Yes, actually yes, we're actively looking forward to working with him.

Dr. Robert Ball:
Thank you.

Coordinator:
Thank you, as a reminder again if anyone has a question from the phone lines please press star 1 on your touch tone phone, again star 1 if anyone has a question.

Loretta Jackson Brown:
Okay and again while we're waiting for calls - questions through the audio line Dr. Singleton one came through the webinar system.

It is related to the medical reserve core, and the physicians that may be needed or the specialties of physicians that are needed to meet the capabilities.

Dr. Christa-Marie Singleton:
Well it's difficult, in fact almost impossible to say well we need surgeons or we need pediatricians or we need orthopedics, the key what we're asking and requiring a jurisdictions to do is to focus on that risk assessment. What's the probability depending on whatever hazard or health potential health related threats come in to their community or could come in that community, what sort of health impact will there be for the community? So depending upon the type of health impact, that would somewhat color or influence the type of healthcare provider, physician, nurse, allied health, whatever it would be. In terms of clinical care, one of the other areas that I think is sometimes overlooked is that a lot of times the need that health department need is not so much in day to day patient care, but it may be in what we call (epi) support or interviews of individuals where we need persons who understand clinical components of a particular outbreak. So there's for example an exposure to some sort of chemical, contacting people and understanding their health related contact if there's been an outbreak of a particular infectious disease. The surge that the community needs, not so much on treating the patients but understanding what happened to better characterize it. And that's - almost anyone with a clinical background can help in that component of it.

Loretta Jackson Brown:
Thank you. Leslie do we have any questions from the phone?

Coordinator:
There are no questions from the phone lines.

Loretta Jackson Brown:

Okay Dr. Singleton, I have another question through the webinar system. In terms of community preparedness capabilities, what are some examples of at risk populations with which CDC is hoping that clinicians in public health will collaborate?

Dr. Christa-Marie Singleton:
Okay well there is a heavy focus, not really heavy but there is an actual specific call out for pediatric populations so we want people to think of somewhat we call it the functional needs of persons. So we want them to focus on populations and if there are providers that have patients or poor health status, chronic diseases, patients that have limited access to neighborhood health resources, persons who don't have insurance.Those persons are more likely to be at risk for adverse health outcomes. Those patients that have a reduced ability to hear, speak, understand or remember, patients who have a reduced ability to walk independently or follow directions, if you as a clinician take care of patients like this, that's where we're looking for you all to help inform these emergency response planning efforts.So that you can - so that public health emergency management and all these other partners are aware that those communities exist in your practice and their needs need to be addressed. But several times a lot of these community assessments just focus on people of a certain age bracket or persons with a mobility issue and they don't focus on you know health conditions where you're walking around every day and you're fine. But then should there be a chemical, biological or radiological exposure your chronic health condition now makes you at risk for adverse health outcomes. So we want you to be more broad in those type of people. But it's the at risk for an adverse health outcome and it's the functional needs of those patients.

Loretta Jackson Brown:
Thank you. Leslie do we have any more calls, excuse me questions through the audio line?

Coordinator:
There are no further questions on the phone line.

Loretta Jackson Brown:
Thank you. On behalf of COCA I would like to thank everyone for joining us today with a special thank you to our presenter, Dr. Singleton. If you have additional questions for today's presenter please email us at coca@cdc.gov, put Dr. Singleton in the subject line of your email and we will ensure that your email is forwarded to her for a response. Again the email address is coca@cdc.gov. The recording of this call and a transcript will be posted to the COCA website at emergency.cdc.gov/coca within the next few days.

Free continuing education credits are available for this call. Those who participated in today's COCA conference call and would like to receive free continuing education credits should complete the online evaluation by February 24, 2012 using course code EC1648.For those who will complete the online evaluation between February 25 2012 and January 24 2013 use course code WD1648. All continuing education credits and contact hours for COCA conference calls are issued online through TCE online, the CDC training and continuing education online system at www.2A.cdc.gov/tceonline. To receive information on upcoming calls subscribe to COCA by sending an email to COCA at cdc.gov and write subscribe in the subject line. COCA also is on Facebook. Like our page today, Facebook CDC Health Partners Outreach page. Thank you again for being a part of today's COCA webinar. Have a great day.

Coordinator:
That concludes today's conference, you may disconnect at this time.

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