

18-03

STATEMENT OF POLICY

Medical Countermeasures Programs

Policy

The National Association of County and City Health Officials (NACCHO) recommends adoption of the following recommendations at the federal, state, tribal, and local levels to help make medical countermeasure (MCM) distribution and dispensing more efficient, sustainable, and responsive to community needs.

Distribution and Partnerships

- Federal and state agencies should aggressively pursue national partnerships with retail chains, pharmacies, pharmaceutical distributors, and transportation/logistics companies to assist with the movement and dispensing of emergency medication, supplies, and equipment. Local agencies should be engaged throughout the process to ensure the partnerships complement and are coordinated with local planning efforts.
- Federal agencies should identify solutions for everyday supply chain issues for medical products that are regularly utilized by the public health and healthcare sectors and for surge supply chain issues that will occur during public health emergencies.
- Local health departments (LHDs) should partner with healthcare organizations in mass vaccination or mass dispensing planning to reduce strain of opening public points of dispensing (PODs) to serve the entire jurisdiction.
- To ensure equitable distribution and dispensing, LHDs should partner with school districts, community organizations, faith-based locations, and community-based organizations serving BIPOC populations in their MCM dispensing planning efforts. It is recommended to utilize locations that are Americans with Disabilities Act-compliant, when possible.
- The Office of the Assistant Secretary for Preparedness and Response (ASPR) Inventory Management and Tracking System (IMATS) should be continuously improved and enable continuous tracking and monitoring of assets from point of origin to POD. IMATS is freely available to state, local, and tribal agencies but should remain optional for communities that have their own inventory systems, as long as those systems meet established minimum capabilities.¹
- Federal and state agencies should provide additional guidance, support, and training around their capabilities and timeframes for how local agencies can access federal MCM resources.
- State and local agencies should work with emergency preparedness partners and health and medical partners to educate the public on their role in MCM dispensing and be an integral partner in planning and exercising.
- Federal agencies should ensure information sharing is achieved with the state and local levels during all times of a distribution.



Data Management and Information Sharing

- Federal, state, tribal, and local agencies and key private partners should support the sharing/dissemination of data and information associated with MCM deployment through the use of a cross-discipline common operating platform.
- State and local agencies should work with emergency management and coalition partners to ensure interagency and cross-discipline information coordination and data management.
- Federal and state agencies should provide clear guidance on data collection triggers and requirements for tribal and local agencies during MCM responses.
- Federal agencies should identify and develop state and local best practices, systems, and training opportunities for adverse event reporting and tracking. This system needs to have interagency, bi-directional data-sharing capabilities and reporting functions.
- Federal agencies should identify best practices for affected population tracking (such as state vaccine registries) and long-term surveillance across the public health, healthcare, and pharmacy sectors and across local and state jurisdictional boundaries.
- MCM planning at all levels of government should emphasize creating and maintaining greater safeguards related to the collection, use, and management of personal health information associated with a MCM response.

Expanding the Scope of MCM Plans

- Federal agencies should expand MCM program guidance and assessment criteria to move towards whole community MCM planning, encompassing scenarios such as anthrax, other Category A agents, radiological, chemical, burn/blast, pandemic influenza and other communicable diseases, and natural disaster events.
- Federal and state agencies should evaluate local MCM programs based on the jurisdictional risk assessment for their area. Assessing whether each community is prepared for their high-frequency and/or high-risk scenarios (such as complex coordinated attacks, highly acute infectious diseases, and other risks) allows for better cohesion in public health preparedness and emergency management planning and exercising.

Community Resilience

- Local MCM planning and exercises should emphasize engaging representatives of diverse populations including those with access and functional needs to build relationships and tailor response strategies to the needs and preferences of community members.
- Federal agencies should ensure there is an adequate local public health infrastructure for MCM distribution and dispensing by funding public health preparedness consistently and sufficiently and by recognizing preparedness as an essential public health function. This is essential to maintaining resilient communities and systems capable of responding to MCM events and other disasters.

Justification

Dispensing MCMs is a monumental task for LHDs. LHDs must develop partnerships with federal, national, regional, and local organizations, businesses, and BIPOC community organizations to alleviate some of the burden on them. Ongoing partnerships with national pharmacy chains and leveraging their distribution and logistics networks would allow LHDs to focus on setting-up and running public PODs while maintaining their day-to-day operations. Including healthcare organizations and retail pharmacies in dispensing strategies would also

alleviate the strain on public PODs. With additional healthcare and pharmacy support, LHDs would be able to open fewer or more targeted public PODs and with a focus on vulnerable populations with transportation or other assistance needs.

A reliable, accessible, secure, and cost-effective inventory management system that can track all assets including vaccine from origin to POD is required to maintain situational awareness and effectively coordinate a response in a large-scale MCM response. The ASPR IMATS is a resource that fulfills this need, but many state, local, and tribal agencies have chosen to use their own inventory systems due to either information technology barriers preventing IMATS from operating on jurisdictional computers or existing inventory management systems already in place that are more easily utilized by jurisdictional staff.¹ Due to this variety in inventory management systems, ASPR should provide guidance regarding inventory system requirements to assure that required data is being collected properly and can be easily submitted to ASPR before, during, and after the MCM event. To track and monitor MCM resources effectively, LHDs need improved guidance regarding timelines of the availability of resources and capabilities of federal and state agencies to provide these resources.² Local, state, and tribal agencies cannot develop effective plans for MCM operations unless the whole operating picture is available. In addition, continued expansion and development of IMATS with capabilities to incorporate the latest technologies such as smart phones, tablets, and scanning devices will provide a functional system for health departments to use for efficient and accurate MCM inventory management.

Effectively communicating valid and reliable data as well as critical MCM information is essential for a successful MCM response. Decision-makers and those managing a response need ongoing, real-time information about the event/outbreak and the status of response activities to help identify and resolve problems, evaluate progress toward incident objectives, and redirect resources or response activities. Failure to share data and critical information efficiently and effectively can lead to delays that prevent agencies, individuals, and businesses from receiving critical resources and assistance. LHDs are accountable for maintaining safeguards and practices to protect the privacy of personal health and other sensitive information to ensure public trust and to be in compliance with Health Insurance Portability and Accountability Act regulations (where applicable) and relevant state laws.³

Coordinating information and managing data among a variety of agencies from multiple disciplines requires time, transparency, and collaboration. As a result, the information needs to be shared with response partners on an accessible system to facilitate a common operating picture. The platform should include the ability to handle user surge, ensure secure access, be mobile-friendly, and be accessible just-in-time without pre-registration. The goal is to reduce duplication of efforts, promote more effective information sharing and collaboration, and reduce competition for limited resources.

Since the 2001 anthrax attacks, MCM planning efforts have often been anthrax-centric, but over the last decade it has become apparent that many public health threats are not related to anthrax. In 2009, the H1N1 pandemic occurred and MCM materiel was requested and distributed nationwide.⁴ The 2014 Ebola outbreak, Zika virus epidemic, and the SARS-Cov-2 pandemic are other examples of threats where MCM materiel was requested and distributed nationwide. The

aforementioned examples demonstrate the expanded capability of MCM assets and the need for all-hazard MCM planning efforts.

After a century of effectively preventing illness and premature death and thereby increasing the length and quality of life in communities across America, the public health system still faces many challenges due to ever-present 21st century health security threats, emerging diseases, limited access to healthcare, decreased funding for core public health services, etc. In 2018, 38% of preparedness coordinators at LHDs reported spending 100% of their time on job duties related to preparedness as the frequency and magnitude of disasters continue to increase; natural disasters caused approximately \$246 billion in damages between 2018 and 2020.^{5,6} Vulnerabilities to health consequences, occurring before, during, and after emergencies, are firmly rooted in established structural and systemic barriers. Experiences during past crises provide evidence of the damaging effects of inadequate response capacity and planning. Collaboration and on-going dialogue about community issues, options, and alternatives, especially when coupled with community ownership, increases the effectiveness of health improvement efforts.

The adoption of these recommendations at all jurisdictional levels will help make responses involving MCM distribution and dispensing more effective and sustainable, while being responsive to community needs.

References

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Record of Action

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