

2022 USPHS Scientific and Training Symposium

Scientific Program Agenda

Thursday, May 26, 2022

10:00 AM - 10:30 AM

Track 1

10:00 AM -

10:30 AM

Impact of Changes in Utilization Management Programs (UMPs) on the Use of Medications for Opioid Use Disorder (MOUD) and Outcomes in Opioid Use Disorder (OUD) Patients Served by a State Medicaid Program

Mr. William Mullen, PA, MPH, Director for Real World Evidence, Indivior Medical Affairs

BACKGROUND: Limited data exist on how changes in UMPs may affect use or effectiveness of Medications for Opioid Use Disorder (MOUD) in Opioid Use Disorder (OUD) patients.

METHODS: A retrospective study was performed in two phases, using structured, anonymized data from South Carolina's (SC) Medicaid plan* between January 1, 2017 and December 31, 2019. Phase 1 was a descriptive analysis to assess changes in OUD diagnosis rates among the non-dual eligible Medicaid population, and within OUD-diagnosed patients, assess trends in MOUD utilization and opioid use during 2018 and 2019. In this time period, SC Medicaid introduced a number of UMPs, including changes to formulary status of MOUD, and reimbursement of MOUD provided in opioid treatment programs. Phase 2 was a cohort analysis of newly diagnosed OUD patients receiving MOUD vs those not receiving MOUD to evaluate HCRU in the 6 months prior to and 12 months following initial OUD diagnosis (i.e. index date).

RESULTS: Phase 1 results showed that over the study period underlying OUD diagnosis rates increased by 22% (from 32 per 1,000 to 39 per 1,000 Medicaid enrollees). MOUD utilization also increased (from 11.2% to 21.0% of OUD patients), and opioid prescription claims decreased by 36%. For Phase 2, 555 OUD patients receiving MOUD were compared to 2,100 OUD patients not receiving MOUD. The MOUD cohort was younger (mean 36.6 vs 40.3 years, p<0.0001) at the index date, more likely to be white (69.9% vs 51.0%, p<0.0001), and more likely to have comorbid substance abuse disorders (81.1% vs 60.8%, p<0.0001) in the 6 months prior to the index date. In the post-index period, MOUD patients were less likely to have emergency room visits (65.9% vs 75.8%, p<0.0001) and less likely to have received prescription claims for opioid medications (33.2% vs 60.8%, p<0.0001).

CONCLUSIONS: During the time period studied, UMPs designed to improve access to MOUD for OUD patients appeared to have a positive impact not only on MOUD use, but also on HCRU.

*Not official findings of the South Carolina Department of Health and Human Services

At the end of this session participants will be able to:

1. Explain how changes in stat pharmacy formulary coverage affects utilization of medications
2. Describe the impact state health policy has on treatment access for OUD
3. Describe how MOUD policies can impact HCRU for MOUD patients on a health system

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Keywords: Substance Use Disorder, Opioid Use Disorder, Buprenorphine

Track 2	Receipt of Healthcare Provider Recommendation for COVID-19 Vaccination, by COVID-19 Vaccination Status and Attitudes Among Adults - United States, April-September 2021
10:00 AM -	
10:30 AM	<i>CDR Kimberly Nguyen, DrPH, MS, MPH, CPH, Epidemiologist, CDC</i>

BACKGROUND: Vaccination is critical to controlling the COVID-19 pandemic, and healthcare providers play a key role in achieving high vaccination coverage. Understanding how provider recommendations for COVID-19 vaccination affect vaccination rates and attitudes is important for informing interventions to increase vaccine acceptance and vaccination coverage.

METHODS: The NIS-ACM is a household telephone survey of non-institutionalized adults aged ≥18 years that uses a random-digit-dialed sample of cellular telephone numbers. Data from five data collection cycles were used for these analyses (April 22–May 29, May 30–June 26, June 27–July 31, August 1–August 28, and August 29–September 25, 2021).

The survey assessed receipt of healthcare provider recommendation for COVID-19 vaccination, COVID-19 vaccination status, and attitudes toward vaccination (i.e., concern about COVID-19 infection, beliefs about the importance of COVID-19 vaccination, beliefs about the safety of COVID-19 vaccination, and perceptions about how many family and friends had received COVID-19 vaccination).

Prevalence of provider recommendation was assessed overall, and by month of data collection, sociodemographic characteristics, Department of Health and Human Services (HHS) region, and jurisdiction. Additionally, logistic regression was used to generate unadjusted and adjusted prevalence ratios (PRs and aPRs) of the association between provider recommendation for COVID-19 vaccination and COVID-19 vaccination status and the four attitudinal measures. Adjusted analyses controlled for age group, sex, transgender identity, sexual orientation, race/ethnicity, education, income, insurance status, metropolitan statistical area (MSA), Census region, comorbidity status, disability status, essential worker status, and work or school requirement. The interaction between provider recommendation and each sociodemographic characteristic in predicting COVID-19 vaccination status was also assessed. To examine the ecological association of state-level provider recommendation prevalence and state-level vaccination coverage was also assessed using a Pearson correlation coefficient.

Data were analyzed using SAS (version 9.4) and SUDAAN (version 11.0.3; Research Triangle Institute). Results were weighted to represent the noninstitutionalized U.S. adult population and calibrated to COVID-19 vaccine administration data. For all analyses, statistical significance was defined as p<0.05.

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RESULTS: Prevalence of receipt of a provider recommendation for COVID-19 vaccination among adults increased from 34.6% in April 22 to 40.5% in September 25, 2021. Adults who reported a provider recommendation for COVID-19 vaccination were more likely to have received at least one dose of a COVID-19 vaccine (77.6%) than those who did not receive a recommendation (61.9%) (adjusted prevalence ratio [aPR] = 1.12). Receipt of a provider recommendation was more likely among adults concerned about COVID-19 (aPR = 1.31), who believed that COVID-19 vaccines are important to protect oneself (aPR = 1.15), who believed COVID-19 vaccination was very or completely safe (aPR = 1.17), and to perceive that many or all of their family and friends had received COVID-19 vaccination (aPR = 1.19).

CONCLUSIONS: Empowering healthcare providers to recommend vaccination to their patients could help reinforce confidence in, and increase uptake of, COVID-19 vaccination. Healthcare providers who give strong recommendations for COVID-19 vaccination can help to ensure equity in COVID-19 vaccination rates and outcomes. This is particularly important among groups with lower prevalence of receipt of recommendations, such as racial and ethnic minorities, rural communities, and lower income persons. Healthcare providers are uniquely positioned to provide COVID-19 vaccination recommendations, and should continue to promote COVID-19 vaccination in accordance with ACIP recommendations.

At the end of this session participants will be able to:

1. Describe the association between provider recommendation for COVID-19 and COVID-19 vaccination status and attitudes toward COVID-19 vaccination.
2. Identify disparities in provider recommendations by sociodemographic characteristics.
3. Describe the ecological association between provider recommendation and COVID-19 vaccination by state.

Keywords: COVID-19, Provider Recommendation, Vaccination, Vaccine Hesitancy

Track 3 **Building Mass Vaccine Plans Using Points of Distribution in Small and**

10:00 AM - **Large Communities.**

10:30 AM *LCDR Jason Truax, ASCP, OEC, Safety Officer, Indian Health Service*

LT John Naegeli, Pharm D., Pharmacist, Indian Health Service

BACKGROUND: Response time is critical when a community is exposed to a viral or biologic agent. Maximizing resources to efficiently and effectively dispense medical counter measures (MCM) is imperative to address public health and mitigate impacts of adverse health effects. A goal of vaccinating 100% of a community within the 96-hour medical countermeasure distribution goal can be a monumental.

METHODS: A rapid response can be challenging for small communities for many reasons: identifying accessible venues large enough for mass dispensing; work flows with consideration given to medication storage, climate, patient wait times and limiting impact to other services.

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Marketing strategies in rural communities must be all-inclusive to reach and provide a timely message for those who do not have access to television, computer, or social media. Well-planned, coordinated events increase the community's confidence in the mission and the goals of the event. A small critical access/outpatient hospital addressed these challenges by conducting indoor and outdoor delivery methods and extracting best practices.

RESULTS: The team developed an efficient model which is recognized as the “best and fastest vaccine administration process” according to the Northwest Minnesota Regional Healthcare Preparedness Coordinator and the Northwest Minnesota Department of Health Emergency Response consultant. They administers vaccines 38% more efficient than other mass vaccine events, limited the impact to other health care services, prevented staffing burnout and surpassed national goals before they were established. The model is scalable and has been reproducible in a rural and metropolitan settings across the country. The model requires a very small footprint and at a fraction of the cost, compared to larger venues.

CONCLUSIONS: Mass dispensing events provide for efficient use of provider time and minimizes the overall health impacts in the community due to reallocation of vital health resources. Indoor mass vaccine events, based on points of dispensing principles, are more efficient and cost-effective to vaccinate a community and can be deployed by any size community, versus a drive through delivery method.

At the end of this session participants will be able to:

1. Apply LEAN concepts to address work flow and ergonomics to maximize staff productivity.
2. Explain the benefits of an indoor event compared to a drive through event.
3. Design an efficient, cost effective, and reproducible implementation of an indoor medical counter measure event.

Keywords: Emergency Response, Point of Distribution, Mass Vaccine Events, Public Health

Track 4

10:00 AM -

10:30 AM

Nexus of Law Enforcement, Public Health, and Vulnerable Populations:

Developing Public Health Curricula for Law Enforcement Students

CAPT Elizabeth Osborne, BSN, Public Health Law Enforcement

Advisor/Instructor, Immigration and Customs Enforcement

BACKGROUND: In response to Presidential Executive Order, Enhancing Public Safety in the Interior of the United States, Immigration and Customs Enforcement (ICE) developed additional curricula specific to experienced law enforcement officers transferring from other federal agencies to ICE. The law enforcement leadership at the Enforcement and Removal Academy requested assistance in developing a public health curriculum to address public health issues and special circumstances for inclusion in a training pilot program.

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METHODS: In order to fulfill the requirements for accreditation with the Federal Law Enforcement Training Accreditation (FLETA) body, the public health instructor was trained and certified in Instructional Systems Design (ISD) particularly for the aspects of analysis, design, development, implementation and evaluation of the pilot public health curriculum. The analysis included the mandate in the executive order, case studies of Law Enforcement (LE) Officers departing from policy in instances with a nexus to public health, data provided from feedback to previous training. The design was limited to modalities currently available through the Federal Law Enforcement Training Centers (FLETC) and based on the journeymen level skillset of the students. The development included identification of diseases of public health significance in the detained population, basic infection control and disease prevention, access to care, medico-legal responsibilities to individuals in custody, suicide risk identification and prevention, and special circumstances.

RESULTS: The lesson plan was developed in coordination with senior Law Enforcement (LE) and LE instructors as well as experts in ISD. The coordination was invaluable in establishing measurable objectives with real world performance goals which support the students in training as well as on the job and will be validated by the accreditation process.

The curriculum was designed to emphasize the intersection of public health and law enforcement and utilized pertinent aspects of public health law and immigration law to appeal to the applicability to the students' roles as law enforcers.

The public health instructor was able to include enough flexibility in the curriculum to adjust to emerging public health threats and incorporate case studies and news headlines to support policy interpretation and explore the obligation to avoid deliberate indifference with respect to access to care and exposure to pathogens.

Creativity was encouraged to find LE situations that were analogous to public health situations. For example, individuals in custody may be placed in jumpsuits with colors that delineate their respective level of violence such that aggravated felons can be readily identified by the bright color of their clothing while in detention. This circumstance, familiar to all LE trainees, is used to emphasize the need for standard health precautions with everyone in custody just as standard officer safety measures are still taken with non-violent offenders.

Because suicide prevention is an annual mandatory training topic for LE, it was determined that the suicide prevention portion would be conducted as a seminar to elicit an established knowledge base, address misconceptions, elicit actual case examples from experience, and emphasize the nuances of suicide risk in the detained population to avoid redundancy of previous training.

CONCLUSIONS: When establishing a public health training program, work closely with representatives of the target audience to determine background knowledge and any impediments to accepting public health tenets.

Rather than creating certain content independently utilize established sources for example, for public health considerations when travelling with work to other countries, provide resources

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from agencies such as the Centers for Disease Control and Prevention, and the State Department.

Develop lesson plans that allow for trainees to share their experiences and create an environment where they are comfortable asking sensitive questions in the presence of their peers.

Determine what impediments to learning might be based on existing LE culture and myths and encourage discussion of evidence-based practices.

At the end of this session participants will be able to:

1. Describe the role of law enforcement in public health beyond emergency and crisis response
 2. Explain the benefits of employing the tenets of Instructional Systems Design in developing a public health curriculum for law enforcement trainees
 3. List innovative methodologies to build rapport and motivate law enforcement trainees to adopt public health best practices

Keywords: Safety, Trauma Informed Care, Population Health, Medico-Legal, Access to Care, Vulnerable Populations

Track 5 Advancing National Notifiable Diseases Surveillance System Data

10:00 AM - Visualizations

10:30 AM *LT Xia Michelle Lin, PhD, MSPH, Epidemiologist, CDC*

BACKGROUND: The public health Data Modernization Initiative has reinforced the importance of data analytics and visualizations for monitoring disease trends and guiding public health action. Currently, National Notifiable Diseases Surveillance System (NNDSS) data tables are available to the public on the Centers for Disease Control and Prevention (CDC) websites, CDC WONDER and data.cdc.gov, and through disease-specific atlases and reports. National cumulative year-to-date counts are updated weekly and are displayed on interactive national maps. However, case distribution by case definition or demographic characteristics are not available. More robust NNDSS data visualizations, including case trends by case characteristics and the ability to compare NNDSS data with other data sources and allow customization for end users, would help characterize the population affected by each disease and better inform public health decision-making. In 2020, the Data Analytics and Visualizations (DAV) work stream was established to improve NNDSS data analytics and visualizations at CDC.

METHODS: To understand what visualization tools would better support states and territories, referred to as jurisdictions hereafter, we led a roundtable discussion at the Council of State and Territorial Epidemiologists Annual Conference in June 2021. We demonstrated Microsoft Power BI (Power BI) visualizations that showed disease trends over time and by geographic areas, and examples of disease trend visualizations that incorporated both the NNDSS data and emergency department data. Jurisdictions expressed strong interest in using these tools and provided

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constructive feedback. Since then, we have developed an NNDSS dashboard using Power BI to visualize case trends for about 120 national notifiable non-COVID-19 diseases at the county, jurisdiction, regional, and national level. Time-series analyses are stratified by demographic characteristics, case classification status, and data formats. Power BI Data Analysis Expressions functions were used to make calculated variables required by the visualizations. Row-level security was configured to limit users to the conditions they were authorized to access. Additionally, the dashboard was configured to automatically refresh daily.

RESULTS: The NNDSS Power BI dashboard accesses data directly from CDC's Message Validation, Processing, and Provisioning System (MVPS) and refreshes automatically. This dashboard can provide CDC programs and jurisdictions with richer and more flexible views of the data than the weekly NNDSS tables published in CDC WONDER. Additionally, with daily refresh and row-level security, it shows data in a secure and more timely manner than the current WONDER weekly tables.

CONCLUSIONS: We will continue to add analytical features and improve dashboard functions to support CDC programs and jurisdictions in monitoring diseases and identifying aberrations in the data. We will also implement validation procedures to ensure that the dashboard correctly reflects the data in the MVPS and will develop a user guide. In addition, we are developing R programs for integrated visualization of NNDSS data with data from other sources, such as emergency departments, commercial laboratories, and mortality data.

We have developed a robust dashboard to visualize NNDSS case trends by characteristics and geographic areas. This fills a critical gap and advances CDC's Data Modernization Initiative by making more data available for integrated analytics. These modernized, comprehensive, secure, and timely data visualizations will promote NNDSS data use and better inform public health decision-making both locally and nationally, which will help prepare the nation for the next pandemic.

At the end of this session participants will be able to:

1. Explain why it is important to advance analytics and data visualizations for the NNDSS program
2. Describe CDC's effort to assess the NNDSS analytics needs from jurisdictions
3. Identify two questions the NNDSS Power BI dashboards could help CDC disease-specific programs or jurisdictions answer

Keywords: Epidemiology, Surveillance, Data Visualization

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Track 6

10:00 AM -

10:30 AM

The Truth is Out There: How to Effectively Communicate and Promote Resilience to Misinformation

CDR Anna Khan, MA, REHS/RS, Associate Director for Communication, CDC

BACKGROUND: We live in an information-rich environment, and social media has become an engaging source for information, especially if the event is a crisis, is unique, and has its followers' interest. Social media allows people to express their thoughts, opinions, and share information with their friends, family, and others. These social media messages come with content and guidance from different sources. Because misinformation can spread quickly via social media, it's especially important to speak first, communicate first, and engage first with your audience.

METHODS: Promoting public health requires effectively communicating guidance and recommendations to a variety of audiences. However, the public receives an overwhelming amount of information from many channels. In order to encourage healthy behaviors in communities, it has become imperative to help the audience navigate the overload of information and promote resilience to the glut of misinformation abundant in various forms in society.

RESULTS: Participants in this session will learn how to use resources, tools, and methods to help overcome misinformation and effectively communicate with their communities.

CONCLUSIONS: Apply the six principles of CERC. Provide resources and tools for effectively communicating (e.g. Surgeon General's Community Toolkit for Addressing Health Misinformation, CDC tools, and WHO resources)

At the end of this session participants will be able to:

1. Explain the significance of Crisis and Emergency Risk Communication (CERC)
2. List the six principles of CERC and explain how to apply the six principles of CERC
3. Identify rumors and misinformation plaguing your communities and give examples and tips on how to overcome misinformation

Keywords: Effective Communication, Emergency Response

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10:45 AM - 11:15 AM

Track 1

10:45 AM -

11:15 AM

Demonstrating Comparability of Treatment Outcomes Between Generic

and Brand Nar-row Therapeutic Index (NTI) Drug Products

LCDR Daniil Marchuk, PharmD, BCPS, PMP, Senior Regulatory Project Manager, FDA

CDR Trang Tran , PharmD, MBA, BCPS, Senior Regulatory Health Project Manager, FDA

BACKGROUND: Two recently-completed studies comprised of more than 51,000 patients demonstrate the comparability of treatment outcomes for generic vs. brand nar-row therapeutic index (NTI) drug products, one in patients with hypothyroidism treated with generic and brand-name levothyroxine products and another in a senior popula-tion (≥ 65 years of age) treated with generic and brand warfarin. The first study (see Brito et al., 2020) evaluated 17,598 patients and compared patient outcomes within 3 months after treatment with generic or brand name levothyroxine products, characterizing the proportions of patients with normal thyroid stimulating hormones (TSH) levels (4.5–19.9 mIU/L) or markedly abnormal TSH levels (<0.1 mIU/L or >10 mIU/L), in order to determine if there was a difference in the treatment effect or lack thereof, respectively.

METHODS: Two recent research studies

RESULTS: After 1:1 matching between the generic and brand-name drug initiators, the results showed that the proportion of patients with normal or markedly abnormal TSH level within 3 months of filling L-thyroxine prescrip-tions was similar for patients who received generic vs. brand L-thyroxine, 75.4% vs. 76.9%, $p=0.23$ or 4.1% vs. 3.9%, $p=0.65$, respectively.

The second observational cohort study of 33,645 patients, with warfarin (see Desai et al., 2020) showed comparable effectiveness, safety, and risk of all-cause mortality between initiators of brand and generic warfarin products in the Medicare population, 0.97 (0.65-1.46), 0.94 (0.65-1.35), and 0.84 (0.62-1.13), respectively.

CONCLUSIONS: These studies provide real-world evidence to support public confidence in the generic NTI drugs and the FDA generic drug program.

At the end of this session participants will be able to:

1. Evaluate the substitutability of NTI generic drug products for patients
2. Examine clinical studies of substitution in patients, and analyze medical informatics data to evaluate generic utilization and substitution
3. Discuss patient and provider perceptions impacting generic substitution

Keywords: Science/Research,

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Track 2

10:45 AM -

11:15 AM

The Food and Drug Administration's Import Response to the COVID-19 Public Health Emergency

LCDR Krista Ferry, REHS-RS, Supervisory Consumer Safety Officer, FDA

CDR Susan Shaffer, REHS-RS, Consumer Safety Officer, FDA

BACKGROUND: All products regulated by the FDA must meet the same requirements, whether produced domestically or imported from abroad. Since the onset of the COVID-19 Public Health Emergency, medical supplies such as personal protective equipment (PPE), respirators, and clinical thermometers began to reach significant shortages. Due to the shrinking supply, there was significant increased demand to import these products for both public and commercial use. FDA played a critical role in protecting the nation from the threat of the pandemic by addressing urgent public health concerns to expand availability and meet supply challenges for COVID-19 related medical devices. In response to the COVID-19 public health emergency, the FDA's Center for Devices and Radiological Health (CDRH) published 339 emergency use authorizations and 24 enforcement policies for various medical devices. These documents modified the regulatory landscape to help expand the availability of critical medical devices, many of which were imported. With the expansion of the COVID-19 pandemic, over 91 million lines of FDA regulated products were imported into the United States. A line is a distinct product within a shipment and a single shipment may have multiple FDA regulated products, varying in quantity and value. Of these imported lines, approximately 48% were medical devices, many of them subject to EUA.

METHODS: The Office of Enforcement and Import Operations (OEIO) had to quickly spring into action to create specific instructions to review and process entries of these medical devices to cover the Emergency Use Authorizations published by CDRH. The documents were comprehensive and provided instruction for determining admissibility of products offered for importation into the U.S. Additionally, the shift in regulatory requirements covered by the newly established policies and EUAs, created a significant increase in inquiries related to imports. To help facilitate rapid responses, a COVID-19 Import Inquiries team was created for responding to external stakeholders, both nationally and internationally, interested in importing medical products due to the COVID-19 public health emergency as well as FDA Center and field staff.

RESULTS: Six National Instruction Notices were created to cover the import process for clinical thermometers, facial personal protective equipment, gowns, gloves and other apparel, ventilators and accessories and other respiratory devices, sterilizers, disinfectant devices and air purifiers, and infusion pumps. Eight national level virtual training webinars were provided on these National Instruction Notices. Over 1,600 total OEIO staff were training during the national virtual trainings on the National Instruction Notices. These trainings assisted in the review and admissibility decision of over 1.2 million lines of COVID-19 products subject to EUA. In addition, the COVID-19 Import Inquiries team consists of dedicated FDA employees from

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OEIO who have monitored the email inbox 24 hours a day, seven days a week for over 16 months. More than 20 email templates were created to ensure comprehensive, timely responses to provide clear instructions and clarification for importing medical products related to the COVID-19 pandemic. Over 18,900 email inquiries have been responded to as of November 2021, most of which were responded to within 24 hours.

CONCLUSIONS: The exceptional collaboration within OEIO has led to superior oversight of imported medical device products during the COVID-19 public health emergency. Significant contributions to public health and the protection of United States citizens were facilitated by ensuring critical supplies of medical products entering the U.S. adhere to the EUAs and meet the established enforcement policies while also targeting violative products to ensure unsafe products were prohibited from entering the U.S. supply chain.

At the end of this session participants will be able to:

1. Describe the Food and Drug Administration's (FDA) role in the import process of regulated products subject to Emergency Use Authorization (EUA) in response to the COVID-19 Public Health Emergency
2. Explain steps the FDA took in interpreting and applying EUAs to safely facilitate the review of FDA regulated products to determine admissibility of products subject to EUA offered for importation into the U.S.
3. Summarize the impact that the EUA has had on the importation of over 1.2 million lines of FDA regulated critical medical device and supplies needed during the COVID-19 public health emergency.

Keywords: COVID-19, Policy Implementation and Outbreak Response

Track 3

10:45 AM -

11:15 AM

LGBTQi Initiative for Behavioral Health in Detention Settings.

CDR Robert Van Meir, MSW, LCSW, BCD, CCHP-MH, CCTP, Supervisory BHP, IHSC

LT Regena Hardy, MSW, LISW-S, LCSW, BCD, CCHP, Clinical Social Worker, IHSC

BACKGROUND: Behavioral Health professionals who work in a detention setting understand that the LGBTQi population has a higher rate of suicide and are more likely to be targets of sexual violence. This highly vulnerable population requires a targeted response before any issues arise.

METHODS: Working with CoreCivic our custody partners the team is provided with a list of all detainees who identify as part of the community. These detainees are then sought out by the mental health team member are given a packet with psychoeducational materials. This included a handout on mental health available at the facility, PREA information, and a handout

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that was prepared by the National Alliance on Mental Health focused on this community. Lastly, they are provided with discharge information on services that are available in their community.

RESULTS: The effect of this program has seen that 68% of the 168 detainees identify do not seek out any additional mental health services and we have recorded 0 PREA incidents involving this population. The first LGBTQi group was also held at the facility and moving forward this will be an ongoing group for support.

CONCLUSIONS: That this program be replicant in other detention centers to provide much needed care and support to this underserved population.

At the end of this session participants will be able to:

1. Identify the barriers to adequate behavioral health care for this population.
2. Develop a LGBTQi behavioral health care package that will aid in coping and identifying communityresources.
3. Assess the effectiveness of the LGBTQI program in their facility.

Keywords: Disproportionately Affected Groups, LGBTQi and PREA

Track 4 **A Narrative Review between American Indian/Alaskan Native Social**

10:45 AM - **Determinants of Health and Medication Adherence**

11:15 AM *CAPT Carmen Clelland, PharmD, MPA, MPH, MS, Director, Office of Tribal Affairs, Health Resources and Services Administration*

BACKGROUND: American Indians/Alaska Natives (AI/AN) experience a higher number of health disparities as compared to other races in the United States. Medication adherence and understanding social determinants of health play large roles in overcoming certain health issues. Understanding the connection between those two factors and how they are unique to AI/ANs will help public health and clinical programs tailor communications to improve medication adherence for AI/AN populations. The primary objective of this systematic review is to identify how medication adherence uniquely relates to the AI/AN populations' social determinants of health.

METHODS:

Objectives:

Primary research questions included a) why AI/AN experience lower medication adherence and b) how social determinants of health affect AI/AN ability to adhere to medications.

Methods:

We conducted a scoping review of the literature, identifying articles by searching PubMed and Scopus. Medical Subject Headings (MeSH) terms used to search for relevant articles include: "Alaska Natives" or "Indians, North American" or "Inuits" and "Treatment Adherence and Compliance." The initial search results revealed 259 articles. We analyzed a total of 66 articles

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out of the original 259 articles based on their relevance to AI/AN populations, assessment of medication adherence, barriers to compliance, and/or social determinants of health. 9 articles were included in the final qualitative analysis.

RESULTS: Three major themes were determined from the review. First, the importance of having culturally sensitive awareness education for both staff and education of patients. Second, the connectedness of AI/AN culture and its advantages and disadvantages. Third, that no or low-cost medication does not reduce the other symptoms of poverty.

CONCLUSIONS: While programs continue to assess AI/AN health programs for quality and success, it is important to keep elements like the unique AI/AN community and the effects of poverty in mind to either strengthen or weaknesses to avoid. Additionally, using culturally aware materials and education and staff with cultural sensitivity training will assist with adherence to said program.

At the end of this session participants will be able to:

1. Identify that American Indians/Alaska Native populations experience high rates of health disparities and low rates of medication adherence.
2. Describe the connections between social determinants of health as experienced by AI/AN populations and medication adherence.
3. Discuss how medication adherence is viewed by AI/AN populations and how their environment affects adherence helping target communications to improve health disparities in this population

Keywords: Population Health, Medication Adherence, Pharmacy

Track 5

10:45 AM -

11:15 AM

Opportunities and Collaboration Efforts to End the HIV Epidemic through Community Partnerships

CDR Michelle Sandoval-Rosario, DrPH, PACE Region 9 Director, Office of the Assistant Secretary for Health

LT Alberto Pina, MPH, PACE Region 9 Public Health Analyst, Office of the Assistant Secretary for Health

BACKGROUND: In the United States over 700,000 lives have been lost to HIV since 1981. While new HIV diagnoses have declined significantly over the years, progress on further reducing the number of new cases has stalled with an estimated 40,000 individuals being newly diagnosed each year. The Ending the HIV Epidemic in the U.S. (EHE) initiative aims to reduce new HIV infections by at least 90% in 10 years.

METHODS: A collaborative approach has been implemented across US government agencies to support the EHE Initiative. The Prevention through Active Community Engagement (PACE) program under the Office of the Assistant Secretary for Health was developed in three high

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priority regions with the largest number of new HIV infections to facilitate and spearhead the initiative. The primary focus of the regional PACE programs is to actively engage with the communities and partners across all levels to develop public health interventions.

RESULTS: The PACE program in region 9 covers three states (Arizona, California, Nevada), and ten counties. Since August 2019, the PACE program has worked with a variety of communities, public and private partners by providing EHE communications and educational presentations and sharing resources and best practices. As a result of these engagement efforts the PACE program has coordinated EHE activities across partners; supported the strategic planning of innovative EHE approaches at the regional, state and county levels; enhanced EHE community awareness activities, facilitated enhanced provider competencies to expand HIV services, and connected vulnerable communities to HIV services.

CONCLUSIONS: Community input has always been a critical component of EHE. Active community and stakeholder engagement at all levels is key to overcoming HIV inequalities. Engaging diverse community perspectives from those partners that have not traditionally been at the planning table and involving individuals living with HIV and members from the communities most heavily impacted by HIV is needed to Ending the HIV Epidemic.

At the end of this session participants will be able to:

1. Describe the Ending the HIV Epidemic in the U.S. initiative and the role of the PACE program with community engagement.
2. Describe region 9 community engagement activities, examples, challenges, best practices, and lessons learned.
3. Identify innovative strategies for engaging with marginalized communities to address health disparities and inequalities.

Keywords: *HIV/AIDS, Community Outreach, Health Inequalities, Health Disparities, Partnerships*

Track 6

Drumming to the Beat of Leadership

10:45 AM -

CDR David Hunter, MPH, MSW, Branch Chief, Centers

11:15 AM

BACKGROUND: Leaders face continual challenges managing dynamic organizations and adapting to evolving circumstances, developing priorities, new events, and systemic changes beyond their control. To keep up with these developments, effective leaders must constantly adapt, adjust, and adopt new strategies, approaches, and methods. The best leaders challenge their assumptions, remain open to new thinking, and explore novel ideas to maintain a cutting-edge focus to lead organizations into the future.

At the Centers for Disease Control and Prevention (CDC), the Division of State and Local Readiness (DSLR) works to strengthen national preparedness and to enhance state and local

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public health departments' capacity to protect their communities from public health threats. Beginning in 2019, DSLR's Program Implementation Branch (PIB) initiated a significant organizational restructure, substantially expanded the scope of its portfolio, and later responded to the COVID-19 pandemic through deployments and prioritized branch work to support state and local responses. The past three years have presented the PIB leadership team, as well as the entire branch, with an extensive combination of administrative and programmatic challenges.

METHODS: The presenter will describe the contextual events of this major organization change, the merger of two branches into a cohesive operational unit, reprioritization of activities, and the incorporation of brand-new responsibilities into the organization's programmatic portfolio activities while simultaneously responding to the COVID-19 pandemic. Within this context, the presenter will describe the strategies used by the leadership team in concert with the branch's employees to compose a highly participatory approach that incorporated feedback, engagement, and collective problem-solving to develop structural and procedural solutions to meet this crescendo of challenges.

Specifically, the presenter will provide a series of observations and commentary based on the experience of leading a team through organizational and operational change. The presenter will uniquely explore an analogy of musical theory and practice to leadership skills and development. Additionally, he will extrapolate on his personal experience learning to play percussion to express the value of exercising one's mind in novel ways through practice and performance to cultivate broad leadership skills such as perspective, agility, organization, and creativity and use them to manage a workgroup, team, or organization.

RESULTS: Using an analogy to the methodology and experience of the study, practice, and performance of percussion, the presenter will show how a highly cohesive, efficient, and highly effective organization can be described as akin to the harmonious performance of an orchestra. Through this comparative approach, participants will learn key leadership, management, and organizational concepts to apply in practice. Examples of this comparison include setting and keeping the tempo, developing good technique, repetition and practice, improvisation, multitasking, and team performance, and will be used to reinforce core leadership skills and strategies.

CONCLUSIONS: The session will provide participants with the opportunity to explore the practical value of wide-ranging educational pursuits across diverse subjects, such as learning to play percussion, as a means for expanding one's leadership capabilities. The presenter will conclude by describing a set of recommendations for the application of the presented strategies, concepts, and lessons that other leaders could adopt to enhance their ability to adapt to changing conditions, navigate complex challenges, and successfully direct their teams to deliver their optimal performance.

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At the end of this session participants will be able to:

1. Describe at least three leadership strategies and applied concepts using a percussion musical analogy
2. Explain how to draw upon and apply different management approaches to lead an organization in a variety of scenarios and contexts
3. Explain how to employ leadership strategies to effectively manage organization change

Keywords: Leadership Development, Change Management

11:30 AM - 12:00 PM

Track 1

11:30 AM -

12:00 PM

Harm Reduction Services - Critical Public Health Interventions

Advancing the Health and Safety of Our Nation

*CDR Kristine Scherbring, MSN, RN, Senior Public Health Advisor, Office of the Assistant Secretary for Health/Office of Regional Health Operations
CAPT Mehran Massoudi, PhD, MPH, Regional Health Administrator, Office of the Assistant Secretary for Health/Office of Regional Health Operations*

BACKGROUND: The nation is in a substance use crisis linked to a number of substances, primarily synthetic opioids like fentanyl, stimulants like methamphetamine and cocaine, and other drugs often used in combination. During COVID-19, deaths attributable to drug overdose escalated to over 93,000 in 2020, more than a 30% increase over the prior year. This is the highest number of overdose deaths ever recorded within a 12-month period. This increase in substance use has been accompanied by a surge in the number of people who inject drugs leading to overdose deaths as well as a number of infectious disease complications. Nearly 30 years of research demonstrates that harm reduction services, such as access to opioid overdose reversal treatments and comprehensive syringe service programs (SSPs) are safe and effective in helping prevent overdoses, reduce transmission of viral hepatitis, HIV, and other infectious diseases, and promote long-term recovery by providing access to sterile syringes, injection equipment and other health care services.

METHODS: In March 2019, the HHS Office of the Assistant Secretary for Health (OASH) Office of Regional Health Operations (ORHO) launched an effort in partnership with the Office of HIV/AIDS and Infectious Disease Policy (OIDP) and Centers for Disease Control and Prevention (CDC) designed to inform communities about this critical public health intervention and partnered with state and local stakeholders to support the creation and expansion of harm reduction services like SSPs. The project involved the development and implementation of a national webinar series and coordinated outreach with state government and other key partners. Both were successful and led to the development of regionally focused Opioid Taskforce meetings. Throughout 2020 and mid-2021, the Opioid Taskforce meetings allowed partnerships to expand and created a space for federal, state, and local organizations to share

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successes and discuss barriers. In 2021, ORHO developed a strategic approach for harm reduction support under the leadership of the Assistant Secretary for Health. Additionally, regional efforts were expanded to further develop strategic partnerships across government and community-based stakeholders in each region to encourage greater participation from local organizations and provide frequent updates from both federal and state organizations.

RESULTS: Three national webinar events were held in July, September, and November 2019 with 5,048 individuals participating. In the three webinars, feedback was positive with 83% to 86% of evaluation respondents indicating they agreed or strongly agreed that they have a new or better understanding of what SSPs are and how they prevent infectious disease and address opioid/substance use disorders. Sessions demonstrated successes, progress, and opportunities across multiple stakeholder groups including: HHS agencies (OASH, CDC, HRSA, SAMHSA), state health departments (KY, NC, NM), and local communities (perspectives from law enforcement and harm reduction organizations, and an active on-the-ground SSP program). In support of the coordinated state outreach efforts, 22 state meetings have been held with nearly 80 individuals as of mid-November 2019, representing federal, state, and county governments, universities, associations, law enforcement, harm reduction, and other community organizations. These meetings have covered a number of issues, such as infectious disease outbreaks, state and local legislation regarding SSPs, utilization of mobile SSP services, and educational and financial resource needs.

CONCLUSIONS: The impact of substance use on our country's public health is widespread and harm reduction methods represent a powerful convergence point to address both substance misuse and the infectious diseases complications associated with this epidemic. Initial response to our effort has demonstrated a genuine need and interest in expanding and establishing harm reduction services in vulnerable communities. The OASH Office of Regional Health Operations will continue to support this work exploring further strategic opportunities for collaboration and partnership with tribal, state, and local stakeholders to advance the health and safety of our nation.

At the end of this session participants will be able to:

1. Discuss the intersection of substance misuse and infectious diseases, including viral hepatitis and HIV
2. Define harm reduction services, such as naloxone distribution and comprehensive syringe service programs (SSP), and explain how they help combat the overdose crisis and prevent the spread of infectious disease linked to injection drug use
3. Describe the partnership program the HHS Office of the Assistant Secretary for Health (OASH) Office of Regional Health Operations (ORHO) is leading to support and raise visibility of harm reduction services

Keywords: Substance Use Disorder, Infectious Disease, Harm Reduction

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Track 2

11:30 AM -

12:00 PM

The Effectiveness of a COVID-19 Rehabilitation Program in Treating Post-COVID-19 Deconditioning in Incarcerated Males

LT Joshua Caulder, To be added, To be added, To be added

BACKGROUND: During the COVID-19 pandemic, several inmates at the Federal Medical Center, Lexington were hospitalized with cardiopulmonary impairments secondary to COVID-19 infections. The purpose of this case series was to describe the effectiveness of a COVID-19 rehabilitation program in addressing post-COVID-19 deconditioning in six incarcerated patients.

METHODS: Seven patients received physical therapy evaluations for post COVID-19 deconditioning. Six patients completed the course of physical therapy treatment. The COVID-19 rehabilitation program consisted of a physical therapy evaluation, instruction and training in breathing strategies and techniques, instruction in a moderate intensity walking program, upper and lower extremity strengthening exercises, and instruction in cardiovascular exercise. The 5 Time Sit to Stand Test, the 1 Minute Sit to Stand Test, the Two Minute Step Test and the 6 Minute Walk Test were performed on the date of the physical therapy evaluation and on the date of discharge from the physical therapy program.

RESULTS: Six patients with a mean age of 64.0 years, completed the COVID-19 rehabilitation program at FMC Lexington. The mean improvement for each of the four outcome measures were as follows: 5 Time Sit to Stand Test (-7.4 sec), 1 Minute Sit to Stand Test (+8.7 reps), 2 Minute Step Test (+13.2 reps) and 6 Minute Walk Test (+310.8 feet). The mean of the final scores for each of the outcome measures all exceeded the minimal detectable change (MDC) and the minimal clinically important difference (MCID) for each test.

CONCLUSIONS: A COVID-19 rehabilitation program that includes a moderate intensity walking program, an upper extremity and lower extremity strengthening program, instruction in cardiovascular exercise and education/training in breathing strategies/techniques may be beneficial in improving functional lower extremity strength, aerobic endurance and exercise capacity in federal inmates with post-COVID-19 related deconditioning.

At the end of this session participants will be able to:

1. List the four functional outcome measures that were utilized in the COVID-19 Rehabilitation Program at FMC Lexington.
2. Describe the four different types of physical therapy interventions included in the COVID-19 Rehabilitation Program at FMC Lexington.
3. List two strengthening exercises that were included in Phase 3 of the COVID-19 Rehabilitation program at FMC Lexington.

Keywords: COVID-19

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Track 3

11:30 AM -

12:00 PM

Public Health Emergency Response Strike Team (PHERST)

LT Christine Nappa, To be added, To be added, To be added

LT Tessa Fletcher, To be added, To be added, To be added

BACKGROUND: The Public Health Emergency Response Strike Team (PHERST) is comprised of a small, highly skilled, select cadre of full-time active duty United States Public Health Service (USPHS) Commissioned Corps officers, including Licensed Clinical Social Workers (LCSWs). PHERST officers are trained, prepared, and ready to immediately respond and assess critical requirements in emergent situations such as outbreaks, domestic events, and natural disasters. PHERST ensures the Corps has resources to meet its mission for regional, national, and global public health emergency responses and ensures the Corps can rapidly respond to urgent and emergent public health operations with highly trained professional staff.

METHODS: PHERST provides reduced response time, minimizes stress on the system, and allows officers to get ahead of the disaster. If needed, PHERST officers deploy for extended durations; thereby ensuring continuity of care and minimizing information loss that occurs during the rotation of personnel during a deployment. When not deployed, PHERST officers train, maintain their skills, and may fill short-term staffing gaps in priority agencies in the areas of greatest need providing public health and direct clinical care to underserved and vulnerable populations, including Indian Health Service (IHS), Bureau of Prisons (BOP), or Immigrations and Customs Enforcement (ICE).

RESULTS: In recent years, emergency management response demands have expanded considerably. In total, between 2013 and 2020, greater than 47% of Corps officers deployed to support 154 different missions. The Corps has deployed over two-thirds of its officers in support of COVID-19, the highest historic deployment of officers to date.

CONCLUSIONS: As the U.S. continues to experience natural disasters and other emergencies, and risks associated with the COVID-19 pandemic or intentional threat, the Corps must engage in new strategies to better protect the Nation. PHERST is trained and ready to meet the immediate need.

At the end of this session participants will be able to:

1. Discuss the origination and purpose of the Public Health Emergency Response Strike Team (PHERST).
2. Describe the increased need for Corps officers in response to regional, national, and global public health emergencies.
3. Differentiate between previous deployment team types and the Public Health Emergency Response Strike Team (PHERST).

Keywords: Emergency Response,

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Track 4

11:30 AM -

12:00 PM

Deployment Safety During the COVID-19 Response - California

Department of Public Health

CDR Jason Wilken, PhD, Career Epidemiology Field Officer assigned to the California Department of Public Health, CDC

BACKGROUND: As the COVID-19 pandemic began, the California Department of Public Health (CDPH) identified key gaps in its safety infrastructure for deployed staff during emergencies including:

- Staff safety during field deployments was decentralized and individual program Illness and Injury Prevention Programs and oversight varied greatly.
- The Medical and Health Coordination Center (MHCC), which coordinates CDPH incident management, had a limited Safety Officer scope that did not provide oversight of safety for field-deployed staff.
- There was no department-wide respiratory protection program (RPP) or standardized guidance for risk-based use of personal protective equipment (PPE).

Consequently, there was no standardized approach to actively ensure and monitor staff safety while they conduct fieldwork, both during emergency response or programmatic activities.

METHODS: CDPH implemented components of the Emergency Responder Health Monitoring and Surveillance™ (ERHMS™) framework developed by the U.S. National Response Team and National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention. The ERHMS framework was created to help protect emergency responders during all phases of an emergency response and is scalable, all-hazards, and National Incident Management System-compatible. In implementing the ERHMS framework, CDPH:

- Mobilized subject matter experts in disaster epidemiology, health education, industrial hygiene, infectious disease, and information technology to develop and deploy procedures, processes, training materials, and technical infrastructure. CDPH also secured support from executive leadership, emergency operations, and human resources;
- Enhanced the scope of the Safety Officer role at the MHCC to include responsibility for all deployed staff safety, and created a subordinate four-position Safety Unit to support ERHMS framework implementation; and
- Improved deployment safety preparedness and oversight: staff rostering, pre-deployment safety briefings, health self-screenings for field deployment readiness, symptom/wellness checks, and a forum for responders to report possible exposures and resolve health and safety concerns.

RESULTS: Within 6 weeks from initial concept, CDPH implemented an ERHMS™ program including an information technology platform for rostering, monitoring, and tracking deployers. Since implementation, CDPH:

- Trained 23 staff who serve on a rotating basis as Safety Officer and/or Safety Unit staff for the COVID-19 response and future responses;

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- Created a standardized pre-deployment health and safety briefing including a general safety module, a COVID-19 specific module, seasonal modules (e.g., heat and wildfire smoke exposures, winter driving), and setting- and duty-based PPE guidance for fieldwork; and
- Rostered 541 staff involved in COVID-19 response, delivered deployment safety briefings to 425 staff, tracked 612 staff deployments, and addressed 31 reported safety concerns.

The new deployment safety process catalyzed the development of CDPH's first department-wide RPP, which has provided respirator readiness to 689 staff. The newly expanded Safety Officer role, the Safety Unit structure, and triggers for implementing different components of the ERHMS™ framework have been formally implemented into the MHCC's protocols for future activations. CDPH invested in new health and safety staff within Human Resources to bolster future programmatic safety oversight and collaboration with the MHCC Safety Officer.

CONCLUSIONS: Public health crisis response requires implementation of health protective measures for response staff. Public health agencies can adapt the ERHMS™ framework to address safety gaps for deployed staff. Engagement across disciplines, with internal partners and the support of executive management, is required for organizational adoption of effective safety and health practices.

At the end of this session participants will be able to:

1. Summarize and explain the importance of the activities conducted during the pre-deployment, deployment, and post-deployment phase of the ERHMS™ framework.
2. Identify opportunities to improve responder safety and health practices at all stages of an emergency response.
3. List the recommended subject matter experts to engage when developing and implementing an ERHMS™ framework

Keywords: Safety, COVID-19

Track 5

11:30 AM -

12:00 PM

Improving Care for Musculoskeletal Pain Through Understanding Pain-Related Comorbidities Impact on Pain Intensity and Psychological Distress

CDR Steven Spoonemore, Jr. PT, DPT, DScPT, Clinical Specialist Physical Therapist, US Public Health Service

Dr. Ryan McConnell, DPT, DScPT, Associate Professor, Belmont University

BACKGROUND: Musculoskeletal pain affects approximately 47% of the U.S. general population and 7.4% of the population report high-impact chronic pain that frequently limits life or work activities. Similarly, a smaller proportion of individuals with chronic pain account for a disproportionate amount of healthcare costs. Drivers of this increased cost include multimorbidity and high per-person healthcare utilization. Modifiable factors include comorbidities that influence the individual pain experience, referred to as pain-related comorbidities. Along with pain-related comorbidities, the presence of pain-related

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psychological distress has predicted persistence and ongoing disability with musculoskeletal pain.

METHODS: Individuals starting a new care episode of physical therapy for musculoskeletal pain were included. The presence of pain-related comorbidities (anxiety, cardiometabolic syndrome, chronic pain, depression, nicotine dependence, post-traumatic stress disorder, sleep apnea, sleep insomnia) was identified from electronic medical records. Pain intensity and pain-related psychological distress via the Optimal Screening for Prediction of Referral and Outcome - Yellow Flags tool (0 to 11 flags) were captured at the first physical therapy visit. Generalized linear models were used to assess the interactions of these comorbidities with pain intensity and pain-related psychological distress. Models were adjusted for sex, marital status, body region, surgical history.

RESULTS: Complete cases (n=532) were available for individuals ages 18 to 90 (mean 56.7 years, SD 16.1). Comorbid depression increased the odds of baseline pain intensity (1.92, 95CI 1.15 to 3.19, p=0.01). Increased odds of baseline pain intensity was also found when adjusted for spine pain compared to the lower extremity (1.84, 95CI 1.17 to 3.03, p=0.02) and previous surgery (2.25, 95CI 1.27 to 3.97, p=.01). Females had statistically significant fewer yellow flags, representing less pain-related psychological distress, but none of the pain-related comorbidities influenced the number of yellow flags.

CONCLUSIONS: These findings are some of the first to address the relationships between pain-related comorbidities, pain intensity, and pain-related psychological distress for individuals with MSP. These pain-related comorbidities are associated with higher health care utilization and may influence health-seeking behavior. Assessing pain-related comorbidities may better assist clinicians by highlighting the comorbidities that may be most influential on pain intensity and pain-related psychological distress.

At the end of this session participants will be able to:

4. Define pain-related comorbidities for musculoskeletal disorders.
5. Discuss the impact of pain-related comorbidities on healthcare utilization, pain, psychological distress, and functional outcomes for patients.
6. Propose research initiatives to improve care for musculoskeletal pain.

Keywords: Quality Improvement, Pain, Healthcare Utilization, Psychological Distress

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Track 6

11:30 AM -

12:00 PM

"Its Hard to Believe That You Belong" Interviews of 8 Black Medical Students at USU

*CDR Witzard Seide, MD, Clinical Associate Professor of Pediatrics,
Uniformed Services University*

2d Lt Monnique Johnson, MD Candidate, Medical Student, Uniformed Services University

BACKGROUND: The Uniformed Services University (USU) School of Medicine is also known as “America’s Medical School” but is not reflective of the diversity of the nation. Finding that enrollment of Underrepresented in Medicine students at the Uniformed Services University of the Health Sciences was considerably below the national average, researchers initially sought to understand the experiences of minority students. The goal was to develop an academic and social support structure that sustains and attracts students of diverse backgrounds and races.

METHODS: Individual interviews of eight matriculated Black medical students and a focus group were conducted with Institutional Review Board approval to obtain feasible methodologies and implement change. Student's perspectives and experiences regarding their institution were investigated using qualitative thematic analysis.

RESULTS: The analysis revealed six themes from the individual interviews: Experience as a minority; Admission process; Difference in backgrounds; Curriculum culture; Diversity at the school; Military medicine. The overarching message from the students was “If you don’t see yourself represented somewhere, it’s hard to believe that you belong.” The focus group made four recommendations: Add a minority viewpoint to curriculum; Add textbooks that portray black skin; Collaborate with Historically Black Colleges and Universities; Increase recruitment of Black students and faculty. Several ideas and initiatives have since been implemented like those mentioned in the report as a step towards creating inclusion and equity.

CONCLUSIONS: The military has long been viewed as a vehicle of change for the nation, and USU – as the leadership academy for the Military Health System – can lead the way in developing and implementing programs to diversify the health care workforce. It is hard for minority students to believe they belong in environments without the representation and infrastructure needed to support their unique needs. The initiatives implemented can help diversify the healthcare workforce. These programs are also opportunities to both improve clinical care and reduce health disparities, better preparing students to work in multicultural settings. These efforts are particularly important given the diversity of the military population.

At the end of this session participants will be able to:

1. Describe two diversity-related education programs at Uniformed Services University
2. Identify three negative effects of racism on how medicine is practiced today
3. Describe two positive impacts of the Racism in Medicine Course

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Keywords: Racism and Health,

1:30 PM - 2:00 PM

Track 1

1:30 PM -

2:00 PM

The Gender Reveal

LT Lee Ryder, PT, DPT, Physical Therapist, Indian Health Service

BACKGROUND: Discrimination in healthcare is a common experience in the LGBTQ+ community. There is a widespread lack of knowledge and awareness about gender-related issues both within and outside of the medical field. This disparity negatively impacts the safety, inclusion, and quality of life for sexual and gender diverse individuals. Additionally, this lack of knowledge hinders optimal healthcare delivery to sexual and gender diverse populations. Based on evidence from the National Center for Transgender Equality 2015 U.S. Transgender Survey, along with a multitude of other data and literature, sexual and gender diverse individuals experience significantly higher rates of mistreatment and violence, economic hardship and instability, and physical and mental health illnesses. The current norm for clinical and nonclinical practices is operating in an environment with limited understanding of how to provide care to this population.

METHODS: This interactive educational presentation will improve officers' knowledge on how to encourage gender-affirming interactions with all people including patients, colleagues, family and friends. The presentation debunks common myths and stereotypes related to the LGBTQ+ population and provides opportunities for developing directly-applicable, effective communication strategies to use within and outside of the medical environment. Through the use of real-life scenarios to deliver evidence-based information, the presentation decreases hesitancy and apprehension for engaging in difficult conversations related to LGBTQ+ health equity issues.

RESULTS: Based on peer feedback and engagement in previous presentations, this training improves knowledge on language used in relation to the LGBTQ+ community, gender-affirming healthcare practices, usage of personal pronouns, recognition of one's personal gender identity, allyship to the LGBTQ+ population, and the history of modern day understanding of sex and gender. The training results in obtaining strategies to directly implement in daily life during healthcare and interpersonal interactions to create a more inclusive environment for all people. The pedagogical implications of this training allow us to better prepare for future generations and public health needs of the growing LGBTQ+ population.

CONCLUSIONS: Issues related to equity and inclusion for the LGBTQ+ community are pertinent, evolving and will continue to become even more relevant in the years to come. As public health leaders, officers in the USPHS should be equipped to support vulnerable communities, including

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those in the LGBTQ+ population. It would benefit all Commissioned Officers to undergo training to improve knowledge on gender-related terminology, how to create a safe, inclusive and affirming environment for sexual and gender diverse individuals, and how to perform gender-affirming healthcare practices. Next steps after this proposed presentation include development of a Commissioned Corps-specific training program for LGBTQ+ health equity to advance public health practices for this population.

At the end of this session participants will be able to:

1. Explain the difference between gender identity and sex.
2. List at least three examples of personal pronouns commonly used in present day.
3. List at least two effective communication strategies that reduce barriers to medical care for gender diverse individuals.

Keywords: Health Inequalities, LGBTQ+ Health, Health Disparities, Gender-Affirming Healthcare, Inclusive Healthcare

Track 2	USPHS in support of the Biden Administration's International Vaccine Transfer Initiative
1:30 PM -	<i>CDR Avi Stein, MPH, EMT-P, CHEP, Deputy Branch Chief, Assistant Secretary for Preparedness and Response</i>
2:00 PM	<i>LT Schuyler Price, BSME, EIT, Program Management Officer, Assistant Secretary for Preparedness and Response</i>

BACKGROUND: The Biden Administration announced in June 2021 the intent to donate at least 500 million doses of COVID-19 vaccine to low & lower-middle income countries. The US aimed to donate 75% through the World Health Organization's COVAX program intended to distribute vaccines equitably and 25% directly to countries in need, those experiencing surges, immediate neighbors, and other countries that requested immediate US assistance ("bilateral" transfers). ASPR was charged with the on-site transfer of vaccine to foreign dignitaries and coordination of secure transport.

METHODS: ASPR USPHS Officers were identified to develop requirements and support the Biden Initiative of International COVID-19 Vaccine donations. In order to meet the demands of this mission, a multi-pronged approach was implemented. The first priority was to develop protocols and training for both COVAX and bilateral agreements required to support the on-site transfers. This included quickly developing strong relationships with all partners to include the White House, National Security Council, World Health Organization (WHO), Countermeasures Acceleration Group (CAG), US Marshals Service, foreign ambassadors and dignitaries, and commercial distributors. Additionally, this required protocols for all steps that could be replicated across distributors and airports as the mission parameters shifted with every transfer. To support these activities, the International Vaccine Transfer or IVT "Cell" was created to coordinate all logistics requirements for the on-site activities and link supporting

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partners. Additionally, the IVT “Security Team” developed a long-term risked based approach, applying subject matter expertise and analysis of historical data, to provide security and assurance of all IVT shipments by coordinating with law enforcement. USPHS Officers deployed to multiple sites to facilitate the transfer of vaccines to foreign dignitaries, maintain vaccine quality control and cold chain, and assure logistical requirements for movement to international locations.

RESULTS: The actions of this program have successfully transferred 96,000,000 doses of COVID19 vaccine to 41 countries (as of 29NOV), promoting global public health and demonstrating a novel mechanism by which the US can provide humanitarian assistance in the form of medical countermeasures to foreign countries. The importance of quickly developing strong relationships with the right parties and establishing communication best practices was highlighted during this work. Additionally, due to the rapid pace of donations required, it was critical to continuously review actions taken during each transfer and apply lessons learned to the next, sometimes requiring a turnaround of less than a day. This allowed best practices to be identified early on and solidified early, which also helped when bringing on new team members as the mission expanded and shifted.

CONCLUSIONS: These actions required establishing a completely new set of logistics protocols and relationships with partners that had never been developed. With the rapid pace and aggressive goals set by executive leadership combined with international impact, best practices were developed quickly to achieve transfer of vaccine saving millions of lives across the globe.

At the end of this session participants will be able to:

1. Identify the key USG and international partners involved in humanitarian vaccine donations.
 2. Summarize the responsibilities of the major partners involved in coordinating transfers.
 3. Explain two lessons learned that can be applied in future humanitarian donations.

Keywords: COVID-19,

Track 3 1:30 PM - 2:00 PM	Making Human Services an Integral Part of Emergency Management Response <i>CAPT Anita Johnson LT Johanna Paillet-Growl, MA, LCSW, Repatriation Specialist, Administration for Children and Families</i>
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BACKGROUND: Historically, the human services sector has been excluded from preparedness and emergency response efforts. A White House Directive instructed the Department of Health and Human Services (HHS) to coordinate with other departments of the Executive Branch, State governments and non-governmental organizations to develop a robust, comprehensive and integrated system to deliver human services during disaster. In 2006, the Administration for Children and Families (ACF), Office of Human Services Emergency Preparedness and Response

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(OHSEPR) was created by the HHS Deputy Secretary to provide policy development, coordination, guidance and support to the ACF Assistance Secretary and all programs. OHSEPR provides human services expertise and promotes resilience of vulnerable individuals, children, families, and communities impacted by disasters and public health emergencies. This presentation will highlight the importance of human services in the aftermath of a disaster and OHSEPR efforts to develop capability and capacity for human services during steady-state and disaster response operations.

METHODS: Provide an overview of OHSEPR, programs, and OHSEPR's role in disasters.

Provide a primer on disaster/repatriation case management to PHS officers:

- Understand and Apply Case Management Fundamentals
- Explore Case Studies highlighting the complexities of needs for families in disaster/repatriation settings
- Train-the-trainer: develop strategies to empower state and local case management providers.

RESULTS:

Lessons Learned:

Utilize After Action Reports from past disaster missions to impact training and understanding

CONCLUSIONS:

Next Steps:

Develop and implement training plan to fill gaps in disaster human services

OHSEPR collaborate with CCHQ to train and prepare a cadre of officers to augment OHSEPR missions

At the end of this session participants will be able to:

1. Outline the importance of human services in disasters and public health emergencies.
2. List and describe human services programs administered at OHSEPR.
3. Explain the role of PHS officers during human services support missions.

Keywords: Emergency Response, Human Services

Track 4

1:30 PM -

2:00 PM

The Latest Advances in FDA-Approved Heart Failure Drug and Device

Care

CAPT Brian Lewis, MD, Medical Officer, USFDA

BACKGROUND: An estimated 1 million plus heart failure hospitalizations occur each year in the U.S., causing approximately 20 percent of all admissions in those over 65 years of age.

Following on the foundation of major advances in drug and device care for heart failure

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prevention and stabilization, new therapies have been introduced to address gaps, for instance for patients who have not responded to current options.

METHODS: The presentation will review publicly available information on FDA-approved drug and device approaches to heart failure care focusing on describing risk/benefit considerations and magnitude of benefit, number needed to treat and other practical approaches that allow clinicians to determine which of the options best fits the needs of their patients.

Publicly available information in next generation drug and device therapies will be touched on briefly.

RESULTS: Despite continuing innovations, challenges remain, especially heart failure with preserved ejection fraction. Lessons learned from recent drug and device trials, including therapies not shown to benefit heart failure patients will be reviewed. HF.heartfailure2022

CONCLUSIONS: Drug and device therapies for preventing and stabilizing heart failure continue to be developed but challenges remain, including patients with preserved heart function and heart failure symptoms. Understanding current paths of investigation and recent FDA approval help clinicians choose therapies best suited to their patients and give hope of future therapies in development.

At the end of this session participants will be able to:

1. Describe the variety of typical heart failure presentations and types.
2. Describe the general approaches to drug and device therapy for heart failure.
3. Describe areas where drugs and devices have not fully addressed the needs of heart failure patients.

Keywords: *Clinical, Heart Failure*

Track 5 1:30 PM - 2:00 PM	Prevention through Active Community Engagement (PACE) Public Health Train the Trainer Portal <i>LCDR Jennifer Weekes, PhD, LICSW, MPH, BCD, Sr. Public Health Analyst, USPHS</i> <i>LT Lorna Benoit, MHA, BSN, RN, RRT, CRT, Recruitment Specialist, USPHS</i>
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BACKGROUND: PACE was established in 2013 under the Office of the Surgeon General (OSG) and was tasked with providing SMEs to develop public health material and present them to the public using evidence-based educational lesson plans at community engagement events. These educational lesson plans teach officers how to confidently deliver presentations using a workflow process that explains how to: 1) facilitate training sessions; 2) evaluate officer's presentation skills; and 3) engage community participants. PACE developed a customized database to: 1) track officer's training progress; 2) assess training qualifications; 3) calculate the

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number of community events they (which also includes the number of community participants); and 4) gather feedback and lessons learned from the officers. The OSG serves as the final authority to approve these public health presentations that serve as a means to help educate, protect, promote and advance the health and safety of our Nation.

METHODS: During a global pandemic, there was a growing demand for timely and precise communication of public health messages about the spread of COVID19 and Vaccine Hesitancy. In response to cries of fear, lack of trust and anxiety from the communities we serve, the United States Public Health Service Commissioned Corps (USPHS-CC) developed a web training portal for USPHS-CC officers to obtain certification to deliver important public health messages.

RESULTS: In order to become certified to deliver these important public health messages, officers had to: 1) engage in a rigorous training process where they watched informational webinars; 2) completed self-study course materials from agencies such as CDC, NIH, and FDA; 3) passed several skills assessments with a score of 80% or higher; and 4) present the course materials to a panel of subject matter experts (SMEs) in COVID19 and Vaccine Hesitancy. Upon completion of all the required training processes, officers were certified and provided with a certificate of completion. This method became the blueprint/best practice for PACE to train all USPHS-CC officers to conduct future public health messages where the message would be clear and concise no matter the officer's category, discipline or practice. PACE was established in 2013 under the Office of the Surgeon General (OSG) and was tasked with providing SMEs to develop public health material and present them to the general public using evidence-based educational lesson plans at community engagement events. These educational lesson plans teach officers how to confidently deliver presentations using a work-flow process that explains how to: 1) facilitate training sessions; 2) evaluate officer's presentation skills; and 3) engage community participants. PACE developed a customized database to: 1) track officer's training progress; 2) assess training qualifications; 3) calculate the number of community events they (which also includes the number of community participants); and 4) gather feedback and lessons learned from the officers.

CONCLUSIONS: There are 115 officers that are certified in COVID-19 and there were 96 training sessions for COVID-19 (Total of 480 officers have participated). 19 Community COVID-19 Events that reached out 1,545 people. The OSG serves as the final authority to approve these public health presentations that serve as a means to help educate, protect, promote and advance the health and safety of our Nation.

At the end of this session participants will be able to:

1. Describe how the USPHS-CC has trained officers nationwide to deliver in real time, the Surgeon General's prevention messages to increase public awareness/trust. Trainings provide uniformed service officers the ability to meet the needs of all communities.

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2. Summarize the data tracking workflows that provide quality assurance and assessment (QA) that officers are trained and qualified to present on the scientific rigors for a given OSG approved lesson (e.g., COVID 19, Vaccine Hesitancy, Opioids and Vaping)
3. Illustrate how can officers demonstrate their knowledge and expertise of going through the training program and increased coverage by utilizing virtual platforms.

Keywords: COVID-19, Education, U. S. Surgeon General, Prevention through Active Community Engagement

Track 6 1:30 PM - 2:00 PM	Perceived Racism and Associations with Mental Health, Demographic, and Behavioral Characteristics - Adolescent Behaviors and Experiences Survey, United States, 2021 <i>LCDR Jonetta Mpfu, PhD, MPH, BA, Team Lead/ Epidemiologist, Centers for Disease Control and Prevention</i> <i>CDR Jemekia Thornton, M.Ed., MPA, BS, Team Lead, Centers for Disease Control and Prevention</i>
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BACKGROUND: Perceived racism in school, i.e., ever been treated badly or unfairly because of one's race or ethnicity, is an important yet understudied determinant of adolescent health and well-being. Knowing how perceived racism influences adolescent health can help reduce health inequities among racial and ethnic minority youth.

METHODS: CDC's 2021 Adolescent Behaviors and Experiences Survey (ABES) was conducted between January and June 2021 to assess student behaviors during the COVID-19 pandemic. CDC analyzed data from ABES to measure perceived racism and the extent to which perceptions of racism influence behaviors and mental health outcomes. Mental health and behavioral characteristics analyzed included mental health status; virtual connection with others outside of school; serious difficulty concentrating, remembering, or making decisions; and feeling close to people at school. Prevalence of perceived racism is reported overall and by sex, race and ethnicity, grade, mental health, and behavioral characteristics. Associations between perceived racism and demographic and behavioral characteristics are presented stratified by race and ethnicity.

RESULTS: Roughly one-third (35.6%) of all U.S. high school students reported perceived racism. Perceived racism was highest among Asian (63.9%), Black (55.2%), and Multiracial students (54.5%). Students who reported perceived racism had higher levels of poor mental health (38.1%); difficulty concentrating, remembering, or making decisions (44.1%); and did not feel close to people at their school (40.7%). Across different racial and ethnic populations, perceived racism was significantly higher among those students who reported poor mental health compared with those who did not report poor mental health during the pandemic, among Asian (67.9% versus 40.5%), Black (62.1% versus 38.5%), Hispanic (45.7% and 22.9%), and White students (24.5% versus 12.7%).

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CONCLUSIONS: Because of the negative mental health and behavioral characteristics associated with racism among adolescents, it is imperative that future actions resulting from this analysis include mitigating racism in schools and surrounding communities to promote safe school environments for all students.

At the end of this session participants will be able to:

1. Identify racial and ethnic disparities in perceived racism among adolescents.
2. Describe how perceived racism influences adolescent behavior and mental health outcomes.
3. Explain the importance and implications for mitigating racism to promote safe school environments for students.

Keywords: Racism and Health, Teen Health, Health Disparities, Science and Research

2:15 PM - 2:45 PM

Track 1	Psychological First Aid: A Behavioral Workforce Protection Tool for Deployments
2:15 PM -	<i>LCDR Nicole Pascua, MPH, LICSW, BCD, Government Project Officer, Community Support Programs Branch, SAMHSA</i>
2:45 PM	<i>LCDR Candice T. Karber, LICSW, BCD, Chief, Behavioral Health and Wellness Chief, NOAA</i>

BACKGROUND: Disasters and emergency situations can significantly impact the ability of local and regional governments to meet the basic needs of their citizenry. The capacity to triage and treat injuries, maintain utilities, or the ability to transport life-saving equipment or food into an area can be affected by a disaster. On a more micro level, the psychological impact of a disaster and an emergency situation can challenge a person's internal belief system and overwhelm their capacity to cope with stress.

For example, during Hurricane Katrina more than 1,600 people died and more than one hundred billion in damages occurred. According to Galea et al. (2007) the prevalence of Post Traumatic Stress Disorder (PTSD) was at least 30% for survivors living in New Orleans and at least 12% for individuals living in neighboring states. This indicates that the trauma experienced by survivors does not abate over time.

Another study posited that survivors of Hurricane Katrina would have improved mental health overtime however, researchers found that the prevalence of PTSD had increased from 14.9% to 20.9%, suicide ideation increased from 2.8 to 6.4% , and serious mental illness increased from 10.9 to 14% (Kessler et al., 2008). Moreover, a longitudinal study conducted three years after

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the 9/11 terrorist attack in New York City found the prevalence rates of PTSD were 12% among rescue workers and firefighters and 21% for volunteers (Perrin et al., 2007). The study also posited that workers were at greater risk for PTSD if they spent more time at Ground Zero, performed tasks outside their normal work role, or started work shortly after the attack.

METHODS: Psychological First Aid (PFA) is a short-term evidence-informed intervention that is implemented during the immediate aftermath of a disaster to help reduce the onset of serious psychological harm, and promote resilience and stability of survivors. The presenters will highlight the Johns Hopkins PFA Reflective listening, Assessment of needs, Prioritization, Intervention, and Disposition (RAPID) model, and apply it to case scenarios to demonstrate how it can be used to aid survivors in various scenarios. The PFA approach can be taught to non-clinical responders when task shifting is required and patient surges occur in healthcare settings or in disaster related environments. Moreover, the principles of PFA can be utilized as a behavioral health workforce protection tool to reduce burnout and compassion fatigue among front-line staff.

RESULTS: The roots of the Psychological First Aid (PFA) model exists in situations to provide assistance to victims of disasters and other emergency situations. The model was developed for responders who are unlicensed providers and it addresses behavioral health work shortages in the field. It is not just for professionals who are trained in therapeutic techniques or interventions and it does not involve diagnosis or treatment. Lastly, it aims to reduce the stigma associated with needing behavioral health intervention. Simply defined, PFA is a supportive and compassionate tool designed to stabilize and mitigate acute distress, as well as facilitate access to continued care.

CONCLUSIONS: Psychological first aid (PFA) is a short term intervention that is used to promote resilience and coping skills. It is used to stabilize individuals who have urgent and intense psychological and behavioral responses, and does not require a mental health license to implement its strategies. Interventions are unique to survivors during the aftermath of an emergency. Public health professionals are invited to consider the various PFA trainings available to enhance disaster preparedness skills.

At the end of this session participants will be able to:

1. Describe and list the main components inherent in the PFA model.
2. Discuss how Psychological First Aid can be applied in disasters and emergency situations to reduce psychological distress and foster resilience and positive coping.
3. Identify signs and symptoms of caregiver burnout and compassion fatigue and discuss the negative impact of disasters on responders.

Keywords: Behavioral Health, Deployment, Disasters, Emergency Response, Preparedness, Resilience

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Track 2

2:15 PM -

2:45 PM

Lions & Tigers & COVID-19 Vaccines, Oh My!!! - Shifting the Paradigm from Vaccine Hesitancy to Vaccine Confidence

LCDR Carlisha Gentles, PharmD, BCPS, CDCES, Risk Management Analyst, USPHS/Food & Drug Administration

CDR Aimee Young, PharmD, BCPS, CPE, Inpatient Pharmacy Clinical Manager, USPHS/IHS/Alaska Native Medical Center

BACKGROUND: COVID-19 has illuminated the need for vaccine confidence more than ever before. Vaccine hesitancy was identified by the World Health Organization as one of the 10 threats to global health in 2019. Due to racism, gaps in healthcare access, lack of trust and other factors, Black and Latino communities are less likely to be vaccinated against COVID-19. American Indian and Alaska Native communities have also been affected by these challenges as well. The need for vaccine confidence has been highlighted further along with the need for more targeted community efforts.

METHODS: This session will provide an overview of making the shift from vaccine hesitancy to vaccine confidence. It will give an overview of vaccine hesitancy and addressing historical trauma that has contributed to factors affecting vaccine acceptance. The session will also guide the participant through key strategies and real-life experiences on approaches used in the community and Federal agencies to build vaccine confidence.

RESULTS: Using the OARS+ and CASE methods for counseling along with motivational interviewing help to improve vaccine confidence and aide in community members making informed decisions on whether or not to take the COVID-19 vaccines or vaccines in general. This effort is even supported even more by the usage of trusted messengers and messengers who resemble the communities they are targeting.

CONCLUSIONS: Continued efforts should be made to address community members in settings where they are and where they feel safe like community centers, barbershops, hair salons, churches; Efforts should also focus on continued representation of trusted members in the community providing these much needed messages in addition to partnerships with community based organizations and other trusted entities.

At the end of this session participants will be able to:

1. Discuss whether rates of vaccination are equivalent in various geographic/economic populations
2. Discuss the importance of a vaccination's indirect effects

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3. Compare and contrast various approaches to addressing patients, family members and the community with vaccine hesitancy to build vaccine confidence

Keywords: COVID-19, Community Outreach, Community Health, Health Disparities, Health Inequities,

Track 3

2:15 PM -

2:45 PM

The USPHS Ready Reserve: A Program Overview

CAPT Christye Brown, PhD, MBA, MPH, Regional Commander, USPHS

Ready Reserve, Commissioned Corps Headquarters

LCDR Trisha Chandler, PharmD, Deputy Regional Commander, USPHS

Ready Reserve, Commissioned Corps Headquarters

BACKGROUND: The USPHS Ready Reserve onboarded its first officers in July 2021 and have 26 reservists as of December 2021. Projected end-strength of the USPHS Ready Reserve is 2500 officers by end of FY24. HHS Regions 2, 3, 4, 6 are staffed with USPHS Ready Reserve Regional Commanders and Deputy Commanders and the remaining regions are divided among this team for oversight to ensure a leadership framework for all 54 states and territories. This team is tasked with 1) recruiting qualified officers to serve in the USPHS Ready Reserve, 2) establishing partnerships and liaising with various state, local, and federal entities to secure training and exercises for their teams; 3) planning and executing the monthly drill weekends, Inactive Duty Training (IDT); and 4) coordinating the 2-week annual training requirements for Ready Reserve officers.

METHODS: Funded by the Coronavirus Aid, Relief, and Economic Security (CARES) Act and signed into law in March 2020, the mission of the Ready Reserve Corps is to “Provide trained, ready and equipped public health professionals, capable of mobilizing and deploying to augment the Regular Commissioned Corps, under the authorities of the Secretary for Health in response to national emergencies and public health crises.” All applicants must meet and maintain the same appointment standards as the Regular Corps and once commissioned. Reservists train one weekend a month and 15 days a year. They deploy alongside active duty Commissioned Corps officers in support of the various public health and humanitarian missions the USPHS is called upon to support. The command and reporting structure is aligned with the 10 FEMA/HHS Regions.

RESULTS: The discussion will include objective data regarding the total number of reservists, including basic readiness and deployments (as of April 2022). It will also include updates to the Mission Essential Task List currently in development which will guide training efforts for monthly drills and annual training. Descriptions will detail the types of training planned and/or provided during IDT and annual training. The Regional Command Team will provide a brief overview of its newly developed Ready Reserve standard operating procedures and its contribution to both new and updated Commissioned Corps policies. Lastly, the presentation will highlight the regional and national partnerships developed with academic, local, state, and other federal partners.

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CONCLUSIONS: - Continue to foster interagency and external collaborations including the DoD, VA, National Guard Units, colleges/universities, FEMA, non-profit agencies, and volunteer agencies throughout the regions.

- Implement long-term training plans and force generation model
- Assess the need to buildout additional Regional Commands and Regional Ready Reserve Teams
- Monitor effectiveness of deployed assets, both individuals and Teams

At the end of this session participants will be able to:

1. Describe the role of the regional commander
2. Describe the training requirements for the Ready Reserve
3. Describe the contributions of Ready Reserve officers on deployment

Keywords: Deployment, Preparedness, Emergency Response, Partnership

Track 4

2:15 PM -

2:45 PM

FIMR Process: Addressing Health Inequities and Disparities to Improve Infant Health

*CDR Mary Emanuele, RN, BSN, CNOR-E, CLC, Senior Public Health Analyst, HRSA
CAPT Martha Fermin, LCSW, TBD, SAMSHA*

BACKGROUND: In the United States, Infant mortality rates decreased in 2000 with 6.9 per 1000 live births compared to 5.8 in 2017. However, Black infants continue to be twice as at risk than White infants. The Fetal and Infant Mortality Review (FIMR) process is a community-based, multidisciplinary review of fetal and infant death cases focused on reducing fetal and infant deaths by identifying inequities and disparities within local health care systems.

METHODS: The FIMR process is a local, action-oriented review of fetal and infant deaths with a multidisciplinary Case Review Team (CRT) that make recommendations to address inequities and disparities via systems-level preventative measures to avoid future deaths. The second step is where Community Action Teams (CAT) may take action on recommendations from the CRT to develop effective interventions or policies at the local or higher levels. The FIMR process then can evaluate measures for interventions for reduction of fetal and infant deaths. The FIMR process has been utilized as a tool for review of maternal and child health (MCH) sentinel events such as congenital syphilis and pre-term or low birth weight births.

RESULTS: Results of findings include identification of gaps in services and local health care systems and implementation of strategies to reduce modifiable risk factors, supported through data to address the social and system-based determinants of health.

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Lessons learned include challenges related to lack of funding for program creation/continuation in communities for FIMR Case Review Teams (CRT) and Community Action Teams (CAT), the family interview and CRS is an important component of reducing fetal and infant death.

CONCLUSIONS: Recommendations include funding for program creation or program continuation in communities for FIMR Case Review Teams (CRT) and Community Action Teams (CAT), increasing family interview component completion rates, increasing supports for additional case review and consistent data reporting.

At the end of this session participants will be able to:

1. Describe the FIMR process and how it can identify inequities and disparities related to improving infant and maternal health
2. Describe how the FIMR process inclusion of the family interview and Case Reporting System may contribute to reducing infant deaths
3. Identify advantages and barriers of the FIMR process and CRS to improve infant and maternal health

Keywords: Maternal and Child Health, Fetal Mortality, Infant Mortality, Community Health Care Systems

Track 5 **Protecting the Prescription Drug Supply Chain through the Drug Supply Chain Security Act (DSCSA)**
2:15 PM - *LCDR Lysette Deshields, PharmD, JD, Regulatory Counsel, FDA*
2:45 PM *CDR Jennifer Clements, MPH, CPH, MCHES-Æ, PMP-Æ, Project Manager, FDA*

BACKGROUND: The Drug Quality and Security Act (DQSA), was enacted by Congress on November 27, 2013 and Title II of DQSA, the Drug Supply Chain Security Act (DSCSA), outlines steps to build an electronic, interoperable system to identify and trace certain prescription drugs as they are distributed in the United States. These critical steps will enhance the Food and Drug Administration's (FDA) ability to protect consumers from exposure to drugs that may be counterfeit, stolen, contaminated, or otherwise harmful through improved detection and removal of such drugs from the supply chain.

METHODS: The DSCSA outlines supply chain security requirements for trading partners (manufacturers, repackagers, wholesale distributors, and dispensers (primarily pharmacies)). The following key requirements for product tracing, product identification, verification and authorized trading partners have been progressively phased in since enactment and will continue until 2023.

- Product tracing: Trading partners in the drug supply chain are required to provide information about a drug and who handled it each time it is sold in the U.S. market.

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- Product identification: Manufacturers and repackagers are required to put a unique product identifier on certain prescription drug packages, for example, using a bar code that can be easily read electronically.
- Product verification: Trading partners are required to establish systems and processes to be able to verify the product identifier on certain prescription drug packages, quarantine and investigate product, and notify FDA and other stakeholders when illegitimate product is found.
- Authorized trading partner: Trading partners are required to be registered with FDA or have valid Federal or State licensure as applicable.

RESULTS: Many of the requirements of the DSCSA are already in effect and have been implemented including product tracing at the lot-level, authorized trading partner requirements, verification of suspect and illegitimate product, and product identification (involving serialization). The DSCSA establishes enhanced drug distribution security requirements for the interoperable, electronic tracing of products at the package level that will go into effect in November 2023.

CONCLUSIONS: FDA is currently implementing supply chain security requirements of the DSCSA. The DSCSA outlines requirements to build an electronic, interoperable system by 2023 that can trace prescription drugs from manufacture to distribution and establishes licensure requirements for wholesale drug distributors and third-party logistics providers. The new systems will enhance FDA's ability to protect consumers from exposure to counterfeit, diverted, stolen, intentionally adulterated, or harmful drugs.

At the end of this session participants will be able to:

1. Describe the vulnerabilities of and threats to the U.S. drug supply chain.
2. Provide an overview of the Drug Supply Chain Security Act (DSCSA) and phased-in implementation of the Act.
3. Describe how enhanced drug distribution security will help to protect patients from exposure to drugs that may be counterfeit, stolen, contaminated, or otherwise harmful.

Keywords: Policy Implementation, FDA, Drug Supply Chain Security, Prescription Drugs

Track 6

Military Psychiatry: Practice and Pitfalls for USPHS Providers

2:15 PM -

CAPT Joseph Holshoe, PMHNP-BC, Co-Direct, Psychiatric NP Residency Program, Grand Junction VA Medical Center

BACKGROUND: In 2020, the Defense Health Agency (DHA) assumed control of all military medicine (Navy, Air Force, Army, Coast Guard, and Marines) with the goal of streamlining the military health care process and decrease health care costs. DHA will move more care into the civilian world and it is anticipated that DoD will begin to rely more on USPHS providers to

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manage service member care. Thus, it is imperative the USPHS officers become familiar with military structure and the nature of military medicine.

METHODS: This presentation will be an interactive lecture that will review the structure and hierarchy as well as the unique dual-nature of military medicine (obligations to patient and command) that are often unfamiliar to USPHS providers. It will review enlistment and deployment limiting diagnoses and medications and alert potential USPHS providers to the long-term consequences of specific behavioral health diagnoses and medications in military populations (ability to deploy, career progression, and ability to remain on active duty). It will also explore how many common psychiatric disorders may present differently in military populations. This presentation is designed for both behavioral health and non-behavioral health providers.

RESULTS: Officers will learn about the culture and structure of military medicine; learn the enlistment/deployment-limiting diagnoses/medications; expand their understanding of the variable presentation of psychiatric diagnoses and role of non-DoD providers in military medicine.

CONCLUSIONS: USPSH Officers will be able to verbalize the lessons learned [noted above] and will be better able to respond and adapt to the requirements of working within military medicine. Future recommendation would be to include training on military medicine to all UPHS officers.

At the end of this session participants will be able to:

1. Layout the structure and hierarchy of military medicine and the dual role of psychiatric providers within the military medicine.
2. Identify diagnoses and medicines that can limit enlistment and deployment.
3. Discuss possible variances in psychiatric presentations in military populations.

Keywords: Behavioral Health, Psychiatry, Military

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3:00 PM - 3:30 PM

Track 1

3:45 PM -

4:15 PM

Expanding the role of the clinical pharmacist within Home Visit Team

utilizing telemedicine within the Nuka System of Care

LT Aminda Skan, PharmD, PGY1 Pharmacy Resident, Southcentral Foundation

CDR Adrienne Tveit, PharmD, BCPS, Integrated Clinical Pharmacist, Southcentral Foundation

BACKGROUND: Home Visit Team (HVT) within the Nuka System of Care at Southcentral Foundation (SCF) utilizes an interdisciplinary approach to providing healthcare to Alaska Native/American Indian (AN/AI) beneficiaries who are homebound with complex medical needs. Telehealth has become critical in providing healthcare in the current climate thus allowing the opportunity to expand services provided by clinical pharmacists. HVT is an all-encompassing model that allows for seamless integration of a clinical pharmacist.

METHODS: The purpose of this initiative is to expand the role of the integrated, clinical pharmacist within HVT to address gaps in care and further develop the relationship between the customer-owner (patient), the family, and the health care team. A Plan-Do-Study-Act (PDSA) was implemented on September 20, 2021 with a tentative end date of December 20, 2021. A standard approach was created to incorporate an integrated pharmacist (IP) into HVT utilizing a telehealth platform. Specific medication consults and interventions made by the IP during the home visit were identified and documented. Satisfaction of other disciplines within HVT with the IP involvement was assessed using survey methods.

RESULTS: A total of 34 visits were completed with integrated pharmacist involvement. Drug therapy recommendations (41%) and recommendations for adherence strategies (28%) were the most seen intervention; ~9 interventions per visit were noted. Prior to PDSA implementation, satisfaction survey results were largely positive regarding integrated pharmacist support of HVT. Opportunities for improvement were identified in knowing when to, and how to, refer a customer-owner to HVT with an integrated pharmacist co-visit. Post PDSA implementation, survey results remain largely positive and demonstrated improvement with connecting with the integrated pharmacist. Further opportunities for improvement included allowing adequate time for integrated pharmacist preparation when scheduling the co-visit, establishing a process for communication if technical difficulties arise, further education on workflow and referral process, and scheduling follow-up as needed with HVT and/or integrated pharmacist.

CONCLUSIONS: In conclusion, criteria was established to identify customer-owners that may benefit from pharmacist involvement during their home visit, an efficient workflow was created to seamlessly incorporate the integrated pharmacist in HVT, interventions were appropriately communicated and documented, and interdisciplinary satisfaction was addressed throughout

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implementation. Future steps include expansion of integrated pharmacist involvement with HVT to all clinics within Southcentral Foundation, utilize this model to expand HVT services to other disciplines (behavioral health consultants, dietitians), and ensure sustainability of the integration with continuous process improvement.

At the end of this session participants will be able to:

1. Identify patient-specific criteria that would benefit from pharmacist involvement.
2. Discuss types of pharmacist interventions made during a Home Visit Team co-visit.
3. Employ a workflow to seamlessly integrate a clinical pharmacist within the Home Visit Team.

Keywords: Healthcare Access, Telehealth

Track 2

3:00 PM -

3:30 PM

Implementation of a Pharmacy Based Monoclonal Antibody Infusion

Clinic for COVID-19

LCDR Tabitha Dillinger, PharmD, MS, BCPS, BC-ADM, Director of Critical

Care Pharmacy Services (Acting), Whiteriver Service Unit

LT Marcus Harding

BACKGROUND: The COVID-19 pandemic has affected healthcare practices across the country since March of 2020. Over the past 2 years guidance and therapies for the management of COVID-19 have continued to evolve. The pharmacy department at Whiteriver Service Unit (WRSU) has been involved in the procurement and administration of monoclonal antibodies since they first received Emergency Use Authorization (EUA) in November, 2020 with the first doses of Bamlanivimab and REGEN-COV both given in December, 2020. Upon the initiation of mAb use at WRSU patients presented to the emergency department (ED) to receive their infusion. The ED quickly became saturated with mAb infusions due to the increasing number of high risk patients with Covid-19 within the service unit. The pharmacy department together with nursing, planning, and operations developed a plan to expand capacity through setting up an outpatient infusion room within the inpatient ward. The facility also developed an internal algorithm to help identify patients for MAB consideration.

During the initial 2 months of mAb use at WRSU, 983 patients tested positive for COVID-19 with 481 of them meeting criteria for a mAb infusion. Out of the 481 patients meeting criteria, 201 received a mAb infusion resulting in a lower proportion of acute medical visits 29.4% vs 48.6%, hospitalizations 17.4% vs 42.9%, transfers to outside facilities 2% vs 9.3%, intensive care unit admissions 0% vs 4.3%, and deaths 0% vs 2.9%. Of the 8 deaths during the observation period, these patients all met the EUA high-risk criteria but did not receive mAb treatment. Based on positive results seen from mAb therapy, WRSU identified increasing access to mAb infusions as a facility wide priority.

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METHODS: Due to increasing COVID-19 cases at WRSU, and staffing shortages, the pharmacy department designed a process to increase access to mAb infusions while decreasing provider burden. The inpatient pharmacy department developed a step by step guide to provide training on: identifying eligible patients, providing informed consent, ordering, verifying, and preparing monoclonal antibodies, priming IV lines, running the IV pump, and providing clearance for patients after completing the observation period. Pharmacists then were trained starting in November, 2021 to assume the role of running the mAb infusion clinic as the primary provider, increasing access to therapy, and alleviating the need for a medical doctor to manage the mAb infusion clinic.

RESULTS: WRSU has continued to use mAb infusions for high risk patients for prevention and treatment of COVID-19. From 12/1/2020 , $\ddot{\text{A}}$ 12/8/2021. WRSU has administered mAb infusions to 1,289 patients. Pharmacists have acted as the primary provider for mAb infusions for 172 patients from 11/11/2021 to 12/8/2021. With the addition of pharmacists running the mAb infusion clinic WRSU was able to increase the number of appointment slots for mAb infusion from 12 to 24 daily. To date 15 pharmacists have been trained on running the mAb infusion clinic creating a sustainable model for providing crucial medications for patients with COVID-19.

CONCLUSIONS: Monoclonal antibody therapies have improved outcomes for patients diagnosed with COVID-19. Pharmacists are a valuable resource for expanding access to care and ensuring monoclonal antibody delivery for qualifying patients. The pharmacy based monoclonal antibody infusion clinic model can be adapted for use at different healthcare facilities across the country to expand capacity for COVID-19 therapies.

At the end of this session participants will be able to:

1. Identify current monoclonal antibody therapies under Emergency Use Authorization for the treatment of COVID-19 as well as the use criteria for these therapies.
2. Describe barriers to providing mAb infusion therapy to patients with COVID-19.
3. Recognize strategies to increase access to monoclonal antibody therapies for patients with COVID-19.

Keywords: COVID-19, Pharmacy, Monoclonal Antibodies

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Track 3

3:00 PM -

3:30 PM

Creation of a New Process for Tracking Officer Deployments: May 2021

- October 2021

CDR Sara Vagi, PhD, Associate Director of Science, Centers for Disease Control and Prevention

LCDR Victoria Jeisy Scott, PhD, Health Scientist, Centers for Disease Control and Prevention

BACKGROUND: Effective management of deployments and surrounding information is critical to ensure safety and accountability of deployed officers. In May 2021, new operational processes were developed to track the movement and activity of PHS officers responding as part of USPHS Operation Artemis (UOA). A high influx of unaccompanied children crossing the US border in Spring of 2021, led to a request for USPHS to staff a very large response, to multiple locations, in only a few days. The size and scale of this new deployment mission created a need to track officer deployment information more efficiently and effectively than the current process at that time. To address this need, a new command and control team was assembled under the leadership of RADM Childs. The goals of the command team were to (1) Ensure officers who were deployed to the field for USPHS Operation Artemis had the resources and information to successfully meet the mission (including billeting and voucher reimbursement), (2) Provide current and historical mission summary data in a highly visual format, (3) Roster officers based on monthly preference as identified by survey.

METHODS: On May 3, a new command structure (UOA Command & Control Team) was stood up specifically for the Unaccompanied Children response and new processes for receiving and responding to deployment requests were developed. Organizational structure of the UOA Command & Control Team was consistent with the National Incident Management System (NIMS) and integrated a specific section for Data and Information Management (consistent with the 3rd Edition of NIMS, 2017). The Data and Information Management Section created a new relational database in Microsoft (MS) SharePoint to provide a common platform for data entry, management, and reporting across the UOA Command & Control Team. Every Section provided information to the database whether from processing new deployment requests (Administration and Finance Section), contacting officers in the field daily, updating the database with their location (Operations Section), or verifying actual deployment and demobilization dates (Data and Information Section).

The Data and Information Section also imported deployment data supplied by the Commissioned Corps Headquarters (CCHQ) Rostering and Deployment Branch (RDB). RDB data and Artemis data were combined in MS Power BI, creating dynamic dashboards to visualize data for regular reports to leadership. Separate dashboards were created for operational purposes (e.g., tracking how long officers were in the field, when reloads were due, number of officers deploying and demobilizing each day, number of open deployment requests) and for reporting purposes (e.g., number of deployed officers, number of deployment sites, number of available officers, etc.). Reports were provided to HHS leadership such as the Surgeon General,

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the Assistant Secretary of Health, and the Secretary as well as to PHS partners such as the Assistant Secretary for Preparedness and Response (ASPR), Administration for Children and Families (ACF), Customs and Border Patrol (CBP), and others.

RESULTS: The UOA Command & Control Team operated from May 3 – October 11, 2021. During this time 760 officers completed 825 deployments. That is 668 deployments at 18 field sites, 92 deployments as part of the UOA Command & Control Team, and 65 deployments to other central Agency sites such as ACF or ASPR.

Length of deployments during this time averaged 33 days to the field, 39 to the UOA Command & Control Team, and 37 to central Agency sites. When possible, some UOA Command & Control Team and other central site deployments were conducted virtually to maintain social distancing in administrative buildings and mitigate spread of the virus that causes COVID-19.

The Data and Information Management section updated dashboards for UOA Command & Control Team leadership and snapshots of the reports were provided to CCHQ leadership daily. Reports on deployments and availability were initially provided to the Surgeon General daily, reducing to twice a week as needs became more predictable.

Presentation of work described in this abstract will include several examples of the data visualizations and dynamic dashboards.

CONCLUSIONS: After months of successful accurate, timely, and novel reporting, the UOA Command & Control Team was tasked with integrating their process and reporting developments into all PHS deployment missions. This expanded the amount of reporting significantly and, by October 2021, the UOA Command & Control Team and its exemplary model were merged with the Commissioned Corps Headquarters Command Cell (CCCC). The CCCC continues to provide dynamic data visualization reports, updated twice daily, via Power Bi dashboards. The successful integration of data tracking and monitoring, and daily contact with officers in the field created an efficient and highly officer-centric process that has been sustained in the CCCC. The new process for tracking, managing, and reporting deployment data was based on the model started in UOA but continues to be improved by the CCCC and Commissioned Corps Headquarters. These improvements help CCHQ provide better support for deployed officers and help PHS better respond and report to our partners. Overall, this new process helps meet the greater demand for PHS officers who continue to accomplish the critical mission to protect, promote, and advance the health and safety of the nation.

At the end of this session participants will be able to:

1. Demonstrate increased readiness for deployment by describing changes to processes and reporting during deployment.
2. Summarize deployment data management, visualization and reporting.

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3. Explain how improving data management and reporting improves PHS ability to accomplish its mission.

Keywords: Deployment

Track 4 **Biosimilar Transition Project: Clinical Experiences, Current, and Future of**

Reumatology Pharmacotherapy

3:00 PM - *LCDR Jeannie Hong, PharmD, MPH, BCPS, Rheumatology Specialty Pharmacist,
Phoenix Indian Medical Center*

BACKGROUND: Biologics are often the recommended disease modifying antirheumatic drugs (DMARDs) for rheumatologic conditions. Often, affordability and access pose significant barriers for patients to using these life-changing medications.

METHODS: The Phoenix Indian Medical Center Rheumatology team successfully implemented a biosimilar transition project in January 2019 for infliximab becoming the first IHS facility for such an undertaking.

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RESULTS: Outcomes were measured in terms of patients' clinical improvements, laboratory markers, cost savings, and patient satisfaction. Transitioning patients from the more expensive infliximab to the more affordable, infliximab-abda, resulted in cost savings of >\$272,000 in CY 2019 alone. Patient satisfaction, clinical and functional outcomes measures were also improved.

CONCLUSIONS: Biosimilars can be an appropriate therapy for IHS facilities with infusion centers which serve vulnerable, under-resourced patients with rheumatologic conditions. This program shows that biosimilars, as the future DMARDs, can be safely and appropriately used for our underserved patients.

At the end of this session participants will be able to:

1. Describe the roles of biologics and biosimilars in rheumatology therapy
2. Identify opportunities for pharmacists to be involved in rheumatology patient care as the medication experts
3. Apply the knowledge about the biologic and biosimilar therapies in rheumatology and assist patients in getting the recommended therapies by finding alternative resources

Keywords: Clinical, Biosimilars, Rheumatology

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Track 5

3:00 PM -

3:30 PM

**When The Cellmate Complains of Snoring: Addressing Sleep Apnea
Behind the Fence**

LCDR Dara Lee, MD, MPH, Medical Officer, FDA

LT Charles Deljohn Carr, PharmD, MPH, Health Scientist, Division of Individual Health Science, Center for Tobacco Products, Office of Science, FDA

BACKGROUND: One of the clinical dilemmas we frequently encounter is a concern regarding management of possible obstructive sleep apnea (OSA) inside prisons. Prior to working in a correctional setting, when a patient reported symptoms of daytime fatigue and loud snoring, a sleep study and treatment with continuous positive airway pressure (CPAP) was routine and standard. However, there may be secondary gains with this diagnosis in the correctional setting, which may result in malingering.

METHODS: In our experience working in correctional settings, we noticed a disproportionate number of patients reporting the proper symptoms of sleep apnea. Using the home version of OSA testing, we noted that several in-home sleep reports were nearly identical. This made it obvious that the same patient had taken these tests. As we looked into the issue further, we found signs that in this setting, there may have been malingering to obtain an OSA diagnosis. This provided the secondary gain of having both a permanent bottom bunk pass as well as access to a live electric outlet in the cell. However, since OSA is associated with adverse outcomes, the important question to answer is how to make more accurate diagnosis in this setting, and what benefits are gained by which treatments.

RESULTS: On physical exam, clinicians should note the status of respiratory, testing cardiovascular and neurologic systems. After office screening, there are two main forms of testing. The first is full polysomnography in a sleep center, the second, an in-home test which can be ordered through multiple contractors and performed inside the prison. Based on this authors experience, if this latter process is implemented, we recommend being certain that the patient does not transfer the device to another inmate to take the test for them. More importantly, the most critical decision for the correctional provider to make is to determine which OSA related symptoms constitute a serious medical need for which CPAP has shown efficacy. For this author, the primary treatment is always focused on weight loss and lifestyle modifications since these treatments have demonstrated improvement in important clinical outcomes, including overall mortality and decrease in cardiovascular events.

CONCLUSIONS: It is important for the correctional provider to determine which OSA related symptoms constitute a serious medical need for CPAP and to remember that the primary treatment is lifestyle modifications since these treatments have demonstrated improvement in overall mortality and decrease in cardiovascular events.

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At the end of this session participants will be able to:

1. Describe possible malingering related to the diagnosis of OSA in a correctional setting.
2. Describe properly the epidemiology of, risk factors for, clinical features of, and testing options for OSA in a correctional setting.
3. Identify which OSA related symptoms constitute a serious medical need for CPAP, as well as the mainstay of OSA treatment.

Keywords: Under-Resourced Communities, Sleep Apnea, Correctional Setting, Malingering

Track 6	The Holocaust Program: How to Use Experiential Learning to Build Emotional Intelligence Medical Leaders
3:00 PM -	
3:30 PM	<i>LCDR Toya Kelley, MD, Senior Clinical Education Consultant, ICE Health Service Corps</i>

BACKGROUND: On average, close to 60,000 refugees relocate to the United States annually. They come from diverse regions of the world and bring with them health risks that require medical attention in order to prevent the spread of disease. As political conversations regarding healthcare reform in America linger, much attention has focused on how immigrants have drained healthcare resources. Different views regarding immigration policy have caused thousands of individuals including correctional medicine personnel to explore their cultural beliefs, biases and potential prejudices that could potentially lead to the delivery of low-quality care to specific ethnic groups. Given this, the Immigration and Customs Enforcement (ICE) Health Service Corps (IHSC) Assistant Director requested that a program be developed that would assist IHSC personnel in developing emotional intelligence.

To achieve the mission of developing an emotionally intelligent correctional medicine workforce who is prepared to advance the health and safety of the nation, Medical Education and Development Unit (MEDU) personnel partnered with the Levine Institute for Holocaust Education and the U.S. Holocaust Memorial Museum and devised an experiential learning program entitled, "The Lessons of the Holocaust: A Medical Perspective".

METHODS: The Lessons of the Holocaust is an experiential learning program that is designed to utilize adult learning principles to enhance knowledge attainment and sustainment. The course starts with a video on the Nazi rise to power and then participants are led on an interactive 2-hour tour through the museum by Holocaust survivors, followed by a 1.5-hour story-telling lecture from a senior historian with world-renowned accolades in knowledge of the medical providers role during the Holocaust. The lesson concludes with an hour lecture on self-awareness and self-management skills that are essential for developing emotional intelligence. This program provides a platform for the development of vital skills that are needed for correctional medicine personnel and other leaders to operate effectively in high-tempo and emotionally charged environments such as the Department of Homeland Security and other correctional settings.

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Through this experiential learning program over 30 correctional medicine personnel were challenged to explore emotionally charged thoughts and feelings about ethnicity and the value that is placed on human lives when hate is deep rooted. Many had not thought about the emotional drain that occurs while serving in the public health arena. Self-awareness and self-management discussions helped them process emotions that they had learned to ignore and minimize as public health servants of this great nation.

RESULTS: Launching of The Lessons of the Holocaust Program was successful in developing emotionally intelligent leaders. However, there was one major lesson learned during implementation. The first three program sessions left many officers feeling extremely sad and overwhelmed and unfortunately, no one-to-one follow up was provided. Offering one-to-one support is extremely important whenever officers are placed in emotionally aroused situations because group debriefings do not always capture the unique issues or needs of individual officers.

CONCLUSIONS: The Lessons of the Holocaust: A Medical Perspective is an innovative, educational experience, utilizing lessons learned from the Holocaust (1933-1945) as a training and development opportunity for IHSC employees. The program teaches and illustrates the dangers associated with abusing power, permitting prejudice and intolerance, and the critical importance of maintaining integrity in all situations. It emphasizes the importance of individual responsibility and accountability. This program is ongoing. 96% of participants state that they will make a change to their leadership style after completion of the program.

At the end of this session participants will be able to:

1. Describe how lessons from the Holocaust can be applied as a framework for Emotional Intelligence in challenging work environments.
2. Explain the real time benefits to understanding Emotional Intelligence to employee morale, self-awareness and workplace productivity.
3. Assess the benefits of introducing the concept of experiential learning in faculty development.

Keywords: Leadership Development, Racism and Health, Partnerships, Culture and Health, Resilience

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3:45 PM - 4:15 PM

Track 2

3:45 PM -

4:15 PM

Implementation of the Unified Hospital Data Surveillance System for COVID-19 Data

CDR Sayeedha Uddin, M.D., M.P.H., Chief Health Informatics Officer, HHS/OS/ASPR

BACKGROUND: Prior to the 2019 Novel Coronavirus (COVID-19) pandemic there were no facility-level national data available to inform the federal response.

METHODS: To address this information gap, the Vice President sent a letter in March 2020 to hospital administrators across the country requesting daily data on SARS-CoV-2 testing, hospital capacity and utilization, and patient flows to facilitate the federal response to the pandemic. This effort led to the development of the Unified Hospital Data Surveillance System (UHDSS).

RESULTS: This data collection was expanded and adjusted to meet the information needs of the evolving response and currently includes information on supplies, therapeutics and influenza hospitalizations. Stakeholder engagement and cooperation emerged as critical factors in the development of this system.

CONCLUSIONS: This presentation describes the implementation and evolution of the UHDSS and its role in the federal pandemic response. Lessons learned from the implementation of the UHDSS can guide the development of an all-hazards emergency preparedness system.

At the end of this session participants will be able to:

1. State the reason for the development of the Unified Hospital Data Surveillance System (UHDSS)
2. Describe the implementation of the UHDSS
3. Describe the data collected from hospitals to inform the COVID-19 response

Keywords: COVID-19, Hospital Data, Preparedness,

Track 3

3:45 PM -

4:15 PM

ASPR Recovery: Health and Social Services Support for the Long-Term

CDR Jennifer Bornemann, LCSW-C, BCD, Team Lead, Recovery

Coordination, Regions IV & V, HHS/OS/ASPR

CDR Julie Sinclair, MA, DVM, MPH, Dipl. ACVPM, Team Lead, Recovery Coordination, Regions II & III, HHS/OS/ASPR

BACKGROUND: The challenges of disaster recovery are often more subtle and pervasive than the problems common to emergency response. Following the lead from states, tribes, territories, and local communities to set priorities, ASPR's Division of Community Mitigation and Recovery (DCMR) helps communities address these challenges before they grow too significant.

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METHODS: ASPR's Division of Community Mitigation and Recovery (DCMR) advances the nation's ability to recover from the health and social services impacts of emergencies and disasters, leveraging existing federal health and social services programs and resources to help state and local communities recover from disasters. DCMR also promotes pre-disaster health and social services recovery planning and systematic improvements in public health emergency and disaster recovery planning and operations.

RESULTS: The health effects of a disaster last far longer than the initial impact. As the hurricane weakens, the pandemic is overcome, the aftershocks of the earthquake wane, and the wildfires are extinguished, the road to recovery starts.

CONCLUSIONS: ASPR's DCMR, within its role leading the Health & Social Services Recovery Support Function (HSS RSF), provides technical assistance that guides local and state agencies in the identification of specific barriers to recovery, including the addressing of Behavioral Health needs of the impacted population.

The focus on problem-solving helps restore and build health and social service network capacities impacted by disasters. When issues and barriers are determined, the recovery team works with partners to identify funding opportunities, offer technical expertise to fill critical gaps in recovery capabilities, and provide data to support community decision-making and future planning. Special focus is paid to At-Risk Individuals to ensure equity in recovery.

At the end of this session participants will be able to:

1. Identify at least five at-risk populations in emergency response and recovery
2. Identify at least three areas of focus for ASPR's DCMR Recovery Missions Branch
3. Identify at least three examples of recent long-term recovery efforts

Keywords: *Disasters, Disproportionately Affected Groups, Emergency Response, Liaison, Partnerships, Resilience, Preparedness, Under-Resourced Communities*

Track 5

3:45 PM -

4:15 PM

You're Good Enough, You're Smart Enough, and Doggone It - You're a National Security Treasure!

CAPT Michael Schmoyer, PhD, MS, BS, National Security Advisor to the Secretary/Director, HHS/Office of National Security

CDR Jennifer Cockrill, Regional Administrator, ASPR Region 10

BACKGROUND: For more than 15 years, HHS has interacted with national security partners, through the HHS/Office of National Security (ONS), to coordinate Department-wide initiatives that strengthen the Nation's ability to prevent, detect, and mitigate public health threats. For that length of time, HHS has continually been limited in its ability to 1) provide subject matter expertise to the IC via a limited number of 'cleared' HHS personnel; 2) demonstrate a

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coordinated approach to develop USPHS-CC officers' formalized health security career paths; and 3) support the USG's increasing number of priorities as they relate to protecting, promoting, and advancing national health security.

METHODS: This presentation will describe a new national security initiative for the USPHS Commissioned Corps that reflects how the Nation, and the Biden Administration, continues to move towards strengthening national health security-related efforts and to "do things better" to protect our nation's health in the future. For example, since this past January, 22 Executive Orders (not counting National Security Memorandums and other less sweeping directives) have been issued by the President that have a direct juxtaposition between 'health' and 'national security.'

The presentation will describe previous examples of unique partnerships, current examples, and new approaches that the Department (and the Corps) will be taking to support the nation's health security efforts.

RESULTS: The Director of National Intelligence has publicly announced her top three priorities to the IC with 'global health security' as one of those priorities. In fact, over the past 10 months, the majority of ODNI's unclassified reports that have been provided to Congress and the broader public align directly with HHS, OASH, the SG, and the Corps' interests, including prioritizing efforts to address:

- COVID-19 pandemic and future diseases;
- Climate change and environmental degradation;
- Emerging technology;
- Cyber threats to infrastructure;
- Foreign illicit drugs and organized crime; and
- Migration.

CONCLUSIONS: HHS Secretary Becerra has introduced five strategic goals. While all of the goals touch on national health security, one goal, Safeguard and Improve National and Global Health Conditions and Outcomes, is almost wholly focused on national health security. Three of the goal's objectives cross over into both the Administration and IC's priorities relating to national health security:

1. Strategic Objective 2.1: Improve capabilities to predict, prevent, prepare for, respond to, and recover from emergencies, disasters, and threats across the nation and globe.
2. Strategic Objective 2.2: Protect individuals, families, and communities from infectious disease and non-communicable disease through development and equitable delivery of effective, innovative, readily available, diagnostics, treatments, therapeutics, medical devices, and vaccines.

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3. Strategic Objective 2.4: Mitigate the impacts of environmental factors, including climate change, on health outcomes.
4. The 2021 USPHS Commissioned Corps (CC) Doctrine, which defines our vision and mission as we continue to evolve to meet the needs of our Nation, mentions the CC's role in supporting national security 20 times.

This presentation will describe the USPHS Commissioned Corps' role in national health security and new movements within the Corps to move in that direction.

At the end of this session participants will be able to:

1. Identify the USPHS Commissioned Corps' role in national security.
2. List three examples where USPHS Commissioned Corps is supporting national security efforts.
3. Describe how the Corps is a 'natural fit' in optimizing other Departments/Agencies' work in national security.

Keywords: Global/International Health, National Security, Innovation, Partnerships, Leadership Development

Track 6

Every Officer Can Be A Mindful Leader

3:45 PM -

RADM Sarah Linde, MD, Executive and Leadership Coach, Sarah R Linde

4:15 PM

Coaching

BACKGROUND: In order to achieve the USPHS mission to advance the health and safety of our nation, officers in diverse but complementary fields such as disease control and prevention, emergency response, health research, environmental health, health education, regulation of food, drugs, and medical devices, mental health and substance abuse, health care delivery, and global health security bring their sharp minds, fit bodies, and serving spirits to their work every day. With integrity and excellence, each officer is expected to demonstrate leadership in environments which are volatile, uncertain, complex, and ambiguous. As one of four core values of the Commissioned Corps, leadership is an essential skill for each officer to intentionally develop, improve, refine, and practice on a daily basis over the course of one's career.

METHODS: Research shows that intentional establishment of leadership development programs in organizations are critical to the organization's overall success and ability to achieve its mission. Given the decentralized, diverse, and dispersed nature of over 6,000 officer assignments within numerous operating and staff divisions of the Department of Health and Human Services, and among non-HHS departments and programs, it is incumbent upon individual officers to pursue leadership development with intention in order to have meaningful

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impact, exert influence, effect change, and achieve results in service to the protection, promotion, and advancement of the health and safety of the nation.

RESULTS: While some officers may be able to access leadership development resources through their category specific professional advisory committees, agencies, professional associations, or other opportunities, every officer stands to benefit from access to a free and simple framework for mindful leadership development.

This framework includes understanding that 1. the world in which we all live is volatile, uncertain, complex, and ambiguous; 2. all organizations, regardless of size, budget, or mission are networks of conversations, relationships and commitments among people; 3. organizational success is determined not only by the functional and technical expertise of its employees but more importantly by the conversational, relational, and emotional competencies of staff and leaders; and 4. leaders who learn how to have effective conversations, build strong relationships, and cultivate emotional intelligence will have meaningful impact, be more fulfilled, and achieve results for the organizations in which they lead.

CONCLUSIONS: A concise yet thorough discussion of the framework along with a presentation of tools that officers can use to deepen their learning and further their development as leaders will be provided.

At the end of this session participants will be able to:

1. Describe Five Core Competencies for Effective Leadership and Organizational Success
2. Identify Five Types of Leadership Conversations and Two Essential Tools for Every Conversation
3. Define Emotional Intelligence, explain its role in leadership development, and demonstrate two practices that build emotional intelligence

Keywords: Leadership Development, Effective Communication, Emotional Intelligence