FCON COVID-19 Deployment
Oral History Interview
LCDR Jennifer Adams, MPH

FCON History Committee
FDA History Office
Collaborative Oral History Project
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Oral History Abstract

Vanessa Burrows from the FDA History Office interviewed Lieutenant Commander Jennifer Adams, a Public Health Service officer who is in the USPHS Commissioned Corps, about her virtual deployment in response to the COVID-19 pandemic. As the HHS Liaison for Illinois, LCDR Adams was the primary point-of-contact on behalf of the HHS response for external partners including FEMA, USACE, VA, White House Coronavirus Taskforce, State of Illinois, IL National Guard, and City of Chicago officials. She coordinated internally with multiple divisions and offices to provide daily updates on the State's response during the first wave of COVID-19 in IL. She tracked, analyzed, and reported daily statewide COVID-19 cases and deaths; hospital, ICU, and ventilator capacity; Alternate Care Site status; requests for resources and information; and response-relevant current events (e.g., nursing home strike, protest events/closures). LCDR Adams also coordinated with IL Department of Public Health regarding allocation, shipment, and receipt confirmation for response supplies and equipment.

Keywords

COVID-19; Department of Health and Human Services (HHS); deployment; emergency response; Illinois; nursing homes; public health; White House Coronavirus Taskforce; ventilators

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Glossary

510(k)	Section of the Federal Food, Drug, and Cosmetic Act establishing a premarket notification requirement for medical devices that can demonstrate substantial equivalence to approved products
ACA	Affordable Care Act
ACF	Administration for Children and Families
ACS	Alternative Care Site
AEG	Agency Executive Group
AMSUS	Association of Military Surgeons of the United States
ASPR	Assistant Secretary for Preparedness and Response
ASPR TRACIE	Assistant Secretary for Preparedness and Response Technical Resources, Assistance Center, and Information Exchange
BARDA	Biomedical Advanced Research and Development Authority
BOP	Bureau of Prisons
BSL Lab	Biological Safety Levels Laboratory
CAP Team	Capital Area Team, U.S. Public Health Service
CAPT	Captain, U.S. Public Health Service (O-6)
CBER	Center for Biologics Evaluation and Research, FDA
CBP	Customs and Border Protection Agency
CBTS	Community-Based Testing Site
CCHQ	Commissioned Corps Headquarters
CDC	Centers for Disease Control and Prevention
CDER	Center for Drug Evaluation and Research, FDA
CDR	Commander, U.S. Public Health Service (O-5)
CDRH	Center for Devices and Radiological Health, FDA
CFSAN	Center for Food Safety and Applied Nutrition, FDA
CMO	Chief Medical Officer
CMS	Centers for Medicare and Medicaid Services
CONOPS	Concept of Operations
CPR	Cardiopulmonary Resuscitation
CRAFT	COVID-19 Response Assistance Field Team
CTP	Center for Tobacco Products, FDA
CVM	Center for Veterinary Medicine, FDA
DART	Disaster Assistance Response Team
DHS	Department of Homeland Security
DMAT	Disaster Medical Assistance Team
DOD	Department of Defense
ECMO	Extracorporeal Membrane Oxygenation cardiovascular life support device
EHO	Environmental Health Officer
EMS	Emergency Medical Services
ER	Emergency Room
ESF	Emergency Support Function, FEMA
EUA	Emergency Use Authorization
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Agency
FMS	Federal Medical Shelter, FEMA
FOIA	Freedom of Information Act

HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIS	Indian Health Services Agency
HRSA	Health Resources and Services Administration
HSIN	Homeland Security Information Network
HSO	Health and Safety Officer
HVAC	Heating, Ventilation and Air Conditioning
ICS	Incident Command System
ICU	Intensive Care Unit
IMG	Incident Management Group
IMT	Incident Management Team
JIC	Joint Information Center
LCDR	Lieutenant Commander, U.S. Public Health Service (O-4)
LT	Lieutenant, U.S. Public Health Service (O-3)
MCAS	Marine Corps Air Station
MD	Medical Doctor
MMU	Monrovia Medical Unit (Liberia Ebola Response)
N95	Particulate filtering facepiece respirator, NIOSH rated "not-resistant to oil" filtering 95% of airborne particles
NCTR	National Center for Toxicological Research, FDA
NDMS	National Disaster Management System
NIH	National Institutes of Health
NIOSH	National Institute for Occupational Safety and Health
NIST	National Institute of Standards and Technology
NP	Nurse Practitioner
NPI	National Provider Number
OASH	Office of the Assistant Secretary for Health
OC	Office of the Commissioner, FDA
OFDA	Office of U.S. Foreign Disaster Assistance
OLS	Office of Laboratory Safety, FDA
OMB	Office of Management and Budget
OPDIV	Operating Division
OPM	Office of Personnel Management
ORA	Office of Regulatory Affairs, FDA
OSHA	Occupational Safety and Health Administration
PA	Physician Assistant
PAPR	Powered Air Purifying Respirator
PCR	Polymerase Chain Reaction (test)
PHS	Public Health Service
PPE	Personal Protective Equipment
PTSD	Post-Traumatic Stress Disorder
RDF	Rapid Deployment Force
RedDOG	Readiness and Deployment Operations Group
RIST	Rapid Incident Support Team, U.S. Public Health Service
RN	Registered Nurse
RT-PCR	Reverse Transcription Polymerase Chain Reaction
SAMSHA	Substance Abuse and Mental Health Services Administration
SAT	Service Access Team/s, U.S. Public Health Service
Sitrep	Situation Reports
SME	Subject Matter Expert

SNS	Strategic National Stockpile
SOC	Security Operations Center
SOFR	Safety Officer
SOP	Standard Operating Procedure
TAT	Technical Assistance Team
TDY	Temporary Duty Assignment
TPN	Total Parenteral Nutrition
USACE	Army Corps of Engineers
VA	Veterans Administration

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Interview Transcript

VB: This interview is a contribution to the FDA Commissioned Officers Network and the FDA History Officers Collaborative Project to document the experiences of Public Health Service officers that were deployed for the COVID-19 emergency response. I am Vanessa Burrows from the FDA History Office.

It is June 21, 2021, and I am conducting an interview via telephone with Lieutenant Commander Jennifer Adams. Commander Adams would you please introduce yourself and state your name, rank, your position at FDA and any other positions you've had with the federal government that are relevant.

JA: My name is Lieutenant Commander Jennifer Adams. I am currently working at the Office of Bioresearch Monitoring Operations, Foreign Work Planner. I work with a team that plans and conducts all foreign inspections for the Office of Bioresearch Monitoring. And at the time that I was deployed in this role, I was a Domestic Investigator with the Food and Drug Administration of Bioresearch Monitoring based in Chicago. I actually converted from the federal government in that domestic investigator role.

In terms of other positions, I was posted at our New Delhi, India office from 2017 to 2019, leading right into the COVID pandemic. That's an interesting kind of role that I've had within the federal government.

VB: Thank you for sharing that. It must be very concerning for you right now with the state of the pandemic in India having spent so much time there.

JA: Yes, we've got a lot of friends who are there, and then a lot of friends who have been evacuated as well, but I think things are starting to turn around.

VB: I hope that your friends and loved ones are safe and I hope you're right and that things are moving in the right direction.

JA: Thank you.

VB: Without going into too much detail at this point, could you give us an overview of your deployment in the COVID-19 response? The approximate dates that you were deployed and what your assignment was?

JA: I was deployed from April to June of 2020 in the role of the Assistant Secretary of Preparedness and Response liaison for the state of Illinois in Region 5. I worked on a day-to-day basis with our colleagues at the Assistant Secretary for Preparedness and Response, our colleagues at CDC, HHS and then folks at the State. The State has an Emergency Management Team and also a Public Health Team, we worked with both of those. We also worked with U.S. Army Corps of Engineers and also with FEMA, of course the Federal Emergency Management group on a day-to-day basis – contributed to information sharing between all of those parties.

VB: Fantastic. As we start to dive deeper into learning about your deployment. I'd like to try and set the scene for what was going on back in April. Could you tell me a little bit about how you were first contacted and informed that you were going to be deployed? What you were told about what your role was going to be, and how much information you had and if you had any insight into how that assignment was determined.

JA: Sure. I am on what I believe used to be called the RIST Team (Rapid Incident Support Team). I was on the team for Region 5 under HHS which was led by Commander Chris van Twuyver, who's also with the Food and Drug Administration, and he's based out of either Wisconsin or Minnesota, I think it's Wisconsin. As I said before, I had just come back from India in April of 2019, and had a baby, so I was on maternity leave and I was still on a breastfeeding waiver, so I was actually not deployable.

Commnder van Twuyver reached out to me and, said "We have this opportunity coming up for deployment and I'm contacting everybody on the RIST Team I was able to, and have that nursing waiver revoked and deploy in place. If the deployment had not been virtual, I would not have been able to do it. Because I was still nursing my seven/eight-month-old daughter. It was an ideal storm that all of these deployments, or many of them were done virtually and that's how I joined the team. I didn't know until a day or two before that the deployment was actually going to come through and happen. Also, I didn't know what my role would be until maybe a day or two prior to the deployment. It all happened very fast. I think Commander van Twuyver reached out to me mid-April and I started my deployment on the 23rd. So, it was a matter of a week or two.

VB: It's interesting your comment about how important it was that it was a virtual deployment, is this the first time that the Corps has experimented or at least so extensively, with doing virtual deployments, or is it more commonplace than I'm giving it credit for?

JA: This is certainly the first time that we've done it on the magnitude that we did for COVID, and I think it was just the nature of the beast because preventing the spread of COVID by doing things virtually was essential. Not just in the emergency response, but literally in everything from, getting your groceries to staying in shape, all of that had to be

done from home. So, while there may have been prior instances where deployments were done virtually, I think this is probably the first time that it was on this scale.

VB: Fair enough, that makes perfect sense. What is it like when you report for a deployment virtually? What was day one like?

JA: It was very hectic, I'm not going to lie, I had no idea what I was going into. The liaison that I was replacing, Commander Patrick Harper, he was actually off that day. We would get one day a week off, and generally it was a day in the middle of the week, and then every – I think most people by that time had Sundays pretty much mostly off. I'm just looking back at my calendar here. I've got notes every single day of the week in April and May, with just one day off per week. So, I think there were minimal operations on Sundays and then you were allowed to have a Wednesday off.

But my first day just happened to be Commander Patrick Harper's Day off so I was trained by his actor who wasn't super familiar with the day-to-day goings on. Because that actor was a floater, so if a person that was off on Mondays, he would cover for them on Mondays for the state of Indiana, and then the liaison for Michigan would be off Tuesdays and he'd cover for that person. So, it was a little challenging to get up to speed, but Patrick [Commander Harper] was able to give me a brief overview. I think he called in for a meeting in the afternoon just to get me up to speed, and then he was off, that was his last day.

I had to figure it out, and to be totally honest, after talking to Commander Harper since then, that's basically what he did as well. You come in and what was relevant the week before may be totally irrelevant this week, and the priorities of what a Liaison Officer is working on is so highly variable that really the continuity is something that, even when you have the same person in the same role, there's not a ton of continuity.

What matters more is the relationships, and that is not easy to pass from one person to another. Patrick sent emails to a couple individuals saying, “Hey, I'm being replaced by this person.” But establishing those relationships and really getting to know those people is something that has to come organically.

So yeah, the first day was a little hectic and I was very unsure of what I was doing, and what I was going to be doing, and how to do it well. It took at least a couple of days until I felt like I had my feet under me.

VB: It sounds like you really have to bring instinct and experience to bear in order to not just fill in the gaps in the training, but also recognize the demands of the week as they're shifting. Had you deployed previously? Were there any experiences you were drawing on to help figure out how to serve your role?

JA: My former deployment with PHS was working for the Sierra Leone Trial. STRIVE is the acronym, it’s the Sierra Leone Trial to Initiate a Vaccine Against Ebola, I believe is what the acronym stands for. It was [TEC's] Ebola vaccine study in Sierra Leone, so a very different environment. I was on site for a two-month period in Sierra Leone. Very resource poor country, very poor coordination and very little infrastructure. To compare it to this deployment, there really is not a lot of parity between the two, other than the fact that communicating with people was essential.

Sierra Leone was a very heated environment because conducting this trial had to be done with very limited planning, very little resources, very little manpower, almost no continuity of leadership, so it was a very different and much more stressful environment. Helping maintain diplomacy and tact and helping maintain civil communications was much more of a struggle there than it was in this role.

And maybe part of that was the fact that everybody, at least on the Assistant Secretary for Preparedness and Response team was virtual, so everybody was sitting in their spare bedrooms, in a comfortable environment and able to get coffee or tea or use the bathroom when they needed it. That may have been a contributing factor but essentially communicating with other people was – I don't know if you want to call that a skill, but it's a tactic or a strategy that I have worked on in my career and continue to work on and that I worked on in this role.

VB: I absolutely would call that a skill and a very crucial skill, particularly, when you look at the breadth of people that you're communicating with and the partnerships that were so critical to being able to effectively mount a response, being a good communicator and understanding relationships seem like absolutely critical skills. I'd like to learn more about that, can you tell us about the sort of ecosystem of who you interacted with? I'm sure it changed from day to day, but you seem like you were a hub of information and communication and that a lot of people needed your communication skills in order to relay important information. Who were your primary or most frequent points of contact? Who were you in touch with during your deployment?

JA: On our team the Assistant Secretary for Preparedness and Response, ASPR, we were talking multiple times every day. There was a morning sit call and an afternoon sit call and that included all the liaisons for all of the states in Region 5, and then also our leadership. That was maybe a team of 10 or so, that we're talking every single day, twice a day. And then my main point of contact for the state was the Deputy Director for the Illinois Department of Public Health, Winfred Rawls. I coordinated with the state's Hospital Preparedness Coordinator, the Office of Healthcare and Regulation and a number of individuals from their

Emergency Management Team, that were more involved in things like receipt of ventilators from the Strategic National Stockpile and that sort of thing.

Although the FEMA leads were the main point of contact with their Emergency Management, and I think our role under ASPR was to be the main point of contact for the Illinois Department of Public Health (IDPH). We also talked on a daily basis with our FEMA liaisons. There were initially two and then one added later on. They were actually located on site in Springfield, Illinois, but Steve Johnson, Darrell Dragoo and Jennifer Frank were FEMA Liaisons and it always felt like they knew everything before I did.

As nice as it was to deploy virtually they had a distinct advantage of being in the room with everybody. And even more that just being able to communicate and getting the scuttlebutt first, I think they were able to get that face time and build relationships a lot more easily with the people they were working with.

They also had greater continuity. Steve and Darrell, the two Liaison Officers that were present when I rolled onto this project, I think they'd already been working for six months on COVID in this area, so they were able to build those relationships. Also being there in person helps to pick up on nonverbal cues and read a political atmosphere.

A lot of the time, they were the ones who were able to fill me in and say, “Oh, so and so at Preparedness and Response is really not on a talking basis with so and so at Emergency Management because they had thing a couple years back.” or “The city of Chicago doesn't like to respond requests from people that are at this rank, you have to go above this person's head and get an email from this other person.” There's a lot of state and city politics, especially in a state as big as Illinois, where a lot of the different localities are fighting over the same resources.

The relationships between the people are far more critical than at the Federal level where everything is dispersed a little bit more because we just have a larger scope. I was

working with FEMA, the Illinois folks, especially as the testing ramped up, we were communicating with CDC as the federal government was releasing more and more testing equipment to the states and the city, we were coordinating with CDC around the state's questions and concerns about the testing supplies.

As I said, the Army Corps of Engineers, were the ones who set up all of the ACSs, Alternative Care sites, basically the mobile medical units that they were setting up at different hospitals and at McCormick Place here in Chicago. The Army Corps of Engineers were actually setting those up, and that was just finishing up when I rolled into this position.

We also had folks at the Strategic National Stockpile that we were talking to mainly about ventilators by the time that I rolled into this position. And then City of Chicago we were also on calls to see what the city was doing specifically, and again, trying our best to stay abreast of what city and state was parsing apart from one another and the different policies that each had to try to make sure we were in the know as much as possible with the trends and with what each program was currently prioritizing and doing.

VB: That's an amazing array of different groups to be responsible for and in communication with. Were you also coordinating with the White House Task Force at this time?

JA: The White House Task Force came – I didn't coordinate directly with them because they just wanted to know what the states were doing. They weren't working through, at least to me it felt like, they weren't really working through ASPR. They wanted to work directly with the States. But yes, we were on calls with them largely about testing. They really wanted the states to increase their testing capacity. And then the White House Task Force ended up working with a lot of private industries that had either very little or even no experience

preparing testing and medical supplies. They had them mass produce testing supplies just to ramp up capacity for the state labs.

Just to give you an example, and I don't know some of this might need to be redacted, or I guess I can be non-specific about the manufacturer. There was a manufacturer of ear swabs, what you would commonly call a Q-tip, but not that name brand manufacturer. There was a manufacturer of those that they actually had ramp up capacity to mass production nasal swabs and distribute those to the public health labs. That was coordinated through the White House Task Force. But because this manufacturer had no background in producing medical devices of that type, there were a lot of kinks that had to be worked out and a lot of questions that the Illinois Department of Public Health Lab had about what these could be used for and how they had to modify what would be really standard procedure in order to make these supplies work.

[00:19:52]

VB: That's a really interesting example. Thank you for sharing that. So, it's symbolic of some of the granularity that you had to get into in terms of allocating resources or provisioning resources in the first place and the conversations that needed to take place to make that happen. Could you give us an overview of the major issues that came across your desk? I know that there were probably a multitude, and you can't give us an exhaustive list, but what were some of the major things that you had to work on during this deployment?

JA: I'm looking back because it has been over a year, I looked back over my notes and I know when I first rolled in the main points – we were working on the alternative care sites, their production and status, how many patients they had. There was what is called a Mass

Decontamination Unit that the state had purchased via FEMA and that was really vastly underutilized.

Basically, healthcare providers could send off their face mask, this was way back in the time where we couldn't get face masks, and so they could send off their face masks and get them back a day or two later cleaned. So basically, they could take something that is designed to be disposable and make it reusable to some extent. And these Mass Decontamination Units – they couldn't figure out why they were vastly underutilized. We tried to work with the state to increase trust and utilization of these.

Sometime in late April, early May, there was a threat of a nursing home strike for several – I think for 27 nursing homes across the state and that would've been really disastrous. And the state was, working to make sure that they did everything they could to try to have a backup plan for what was going to happen to the people that were in these nursing homes if the strike did occur. Is there any way that the state could help and supply some additional nursing home staff. Luckily that nursing home strike did not happen. They met an agreement with the facility owner. It was 27 facilities were all under one kind of major ownership, and it didn't end up happening.

Then as we went on, there were a bunch of federal pushes of various equipment and supplies. Remdesivir was a big one, but also cloth masks. There was a federal push of cloth masks. There was a federal push of a ton of testing supplies, so [media] and swabs. I'm trying to think of any other major products – besides that it was really the day to day, making sure that we had adequate – we had the right data on what was going on, that we had an idea of what the trajectory was.

Are the case numbers increasing or decreasing? When I first came in April, they were still on an increase and the state was not looking good. When I rolled off in June, we were in that lull in between the first and second wave. And the state was actually looking like it was

in a far better position than it was previously. That's the main day to day, and those are the ones that kind of leap out at me and my memory in terms of major events that happened during my tenure as liaison.

VB: Thank you so much for that. From an outside perspective, remembering what it was like last April and May when we were just ramping up the capacity for testing. I mean the Remdesivir EUA had come through. It does make perfect sense that those were key issues at the top of your priority list. And then just in terms of the day-to-day data tracking, those trends have been so critical to how resources have been directed throughout the pandemic.

Could you share a little bit more about that? I would love to learn what the workflow was like for gathering all of that information about case rates and death rates, but also about resources and hospital capacity and so forth. Where were you sourcing that data from? How did that how did that actually all get aggregated and transmitted?

JA: I was mainly in charge of making sure that aggregate data was communicated up to ASPR leadership rather than the other way around. Like the state of Illinois was the main correlator of the data on the state level, and then I was originally getting the data from the FEMA liaison officer who was getting data from what is called HSIN, I think it's Homeland Security Information Network. I was eventually able to get access to that system myself and see the data they were pulling, but they would just do snapshots from HSIN, and HSIN sourced the data from the state on bed capacities for hospitals, firefighters and police officer outbreaks.

Basically anything you could want in terms of epidemiological staff, case numbers, deaths, numbers of ICU beds, numbers of pediatric ICU beds in use, and available number of ventilators and then it was even broken down by region, so you could actually click on a

different county and get county local information. HSIN brings all of that information together, at least for the state of Illinois. I don't know whether other states were able to use the Homeland Security Information Network in that way. But it's a really interesting program with a great interface. It was sad that it took about a month to get in into that database.

In the meantime, I was taking data that FEMA had stolen from HISN who stole it from the state to compile that together, and then coming up with summary accounts. As time went on it wasn't necessarily critical that we know number of new cases or number of deaths, because as I said, those were both going down for a period of several weeks, but it was critical to know, how many Remdesivir shipments has the state gotten, and how many doses were in each of those shipments, and where did they go? And similarly, how many swabs have we shipped? Did the state confirm that they got all the swabs that were shipped? Is there potentially a shipment that's just sitting on a pallet somewhere that somebody forgot about.

So, keeping track of that sort of stuff was something that I had to do. Just basically sourcing from email, because emails and phone calls were the only ways that we were communicating with other people. It wasn't like I could hop down to the Public Health Lab and check on them. If I needed to do that, it would've been something that I would have asked the FEMA liaisons to do, and I didn't like to do that because I knew they were very busy doing their own stuff. So, a lot of different sources and a lot of beg, borrowing and stealing from each other in terms of our data and doing our best to work as a team and not have any sort of proprietary feelings about data. Focusing more on the shared mission of sharing data to justify resources being given to the state and also to cry for more where it was appropriate.

VB: It sounds like data was flowing in all directions, it's great to hear that there was a sense of shared access and camaraderie about it. Was there a hierarchy? Even if it was HSIN

that sounds like a really great resource for information. They must have had network of transmitting data from the local municipal level to the state level. Are you aware of that?

JA: I don't know how the state, I can't recall off the top of my head how the state got that information. I don't even know if I got a rundown on how the state was compiling that information. The state was collecting data on a day-to-day basis because it was updated every day. They were getting data from the actual healthcare facilities themselves, and I would imagine there was some sort of carrot involved. If the hospitals provided this data, then they would be eligible for some sort of resource or something that the state would provide, but I can't be sure.

VB: Okay. Thank you, I'm trying to get a sense of – having the numbers is such an important view into what was actually happening, and the direction things were moving in and it it's illuminating to hear you talk about the pathway of how the data was transmitted. [multiple speakers] The clover leaf highways and pathways of how it was being transmitted.

Also, you had mentioned early on in your response that just knowing how much Remdesivir was available and being able to track the therapeutic supply was a key to understanding how to treat people as cases expanded or hopefully contracted.

JA: And also, a hotly political. A lot of the resource allocation stuff was all about crossing Ts and trying to be sensitive and sharing information about each state's allocation without sharing information about all the other state's allocation.

Because if Illinois found out what Indiana got and ran the math, they might say they got five cases more per capita than we got, And that's not acceptable. There was a lot of sensitivity around resource allocation, especially with Remdesivir especially early on.

JS: Thank you so much for bringing that up because I was trying to segue to figure out how those decisions were made. I don't want to be unfair in saying this, but Chicago would probably be a much larger pull for distribution, but also might have a little more pull in terms of the cases that would demand treatment, but also might have more political clout to request it. I'm not casting any dispersions on Chicago. I just am very curious about how those conversations were delicately navigated when, just like you said, there could be really big problems that could arise if there was a sense of jealousy or impropriety or just unfairness in how resources were allocated.

JA: Illinois is weird in that the city of Chicago is so big, and Chicago Department of Public Health really was doing its own thing as if it were its own state, but because they weren't working directly with the state and you might be picking up on some of this, there are some collaboration issues between the city and the state.

All of the state staff are down in Springfield, which is a rural area, about four-and-a-half-hour drive from Chicago, so these are very different environments that people are coming from. The city of Chicago, in their communications, as you said, they have a lot of pull because there were a lot of cases there, but also it doesn't mean that everything goes to Chicago. The state sometimes feels like Chicago feels entitled, and Chicago feels like their needs are not always as well addressed from the state. As I said, there were two independent public health approaches that were going on that were not always very well coordinated.

The city of Chicago because they are not a state we at ASPR, were not working directly with Chicago on a day-to-day basis nearly as closely as we were working with the state of Illinois, just because of the way disaster management works from a federal to a state level. It was interesting to see that dynamic. As far as I could tell, when it came to those

really sensitive items, like the Remdesivir, the state of Illinois was very well aware of the potential for perceived inequality or inequity, so they tried their best to be very transparent.

I remember for first shipment of Remdesivir the Illinois Department of Public Health published, that day, a breakdown of where every single vial went, every hospital that a vial was sent to was listed out because at the time Remdesivir was essentially seen as the only lifesaving medication that your loved one might be able to get. Even to the general public, there was a lot of sensitivity about exactly where those went, but they did their best to be transparent about where those Remdesivir vials went and why they went to those locations.

VB: I can't imagine the effort that went into tracking every single vial. That is an incredible detail, and the fact that you mentioned that it was perceived as the only lifesaving therapeutic available at the time makes me curious, and I know this is a politically sensitive issue and I don't mean to bring up any worms, but we had an EUA for Hydroxychloroquine at the time too. Was that not as widely prescribed and not as carefully monitored? In terms of whether the metrics for being able take care of rising case rates. Was the Hydroxychloroquine availability something you even tracked? Was it an issue of concern? Were areas vying for access to it?

JA: I don't know because when I came in, what people wanted was Remdesivir. I don't know what was going on with Hydroxychloroquine. I know there was some skepticism about the EUA for Hydroxychloroquine and why it had been given that EUA. I also know that Hydroxychloroquine was widely available before the pandemic, so there had to have been more of it rattling around whereas Remdesivir the hot new drug. So, for people that were already on Hydroxychloroquine or already tried it, and it had failed, Remdesivir was the last line for them. In addition to being the new and improved therapy that came out that was just

all over the news. I think it drummed up a lot more demand for Remdesivir than for Hydroxychloroquine.

VB: That makes a lot of sense, but it also makes me wonder because it was hot off the presses was it something that was coordinated through the National Stockpile?

JA: No. I don't think it was the stockpile, I think it was the White House. I'm going back through my notes and looking at early June. I believe it was a White House push that actually went through the FEMA supply chain. I could be misremembering, but I don't think it went through SNS.

VB: Okay, that would make sense. I think considering the fact they were ramping up production, it doesn't seem like there was much opportunity for it to be routed through the stockpile.

JA: And, oh, you know what, it was delivered through AmerisourceBergen, (interviewee indicated this may be proprietary information) they outsourced the actual last mile of it. The "distribution" – the paper was done by FEMA, but I think they just said "We're not going to give it to FEMA to mess up" because it had to be temperature controlled. They had it done via AmerisourceBergen.

VB: Alongside the necessity for effective therapeutics were a limited array of devices to help patients in critical condition. You mentioned earlier that you also had to track ventilator supplies that was last spring. There were some really harrowing experiences with ventilator

shortages especially in urban areas. Was that stabilizing by the time you deployed, or was it still an issue?

JA: It was on its way down. I think there were only like two or three shipments of SNS ventilators that happened. Honestly, I think they happened the first or second day that I was in a liaison position. Ventilators were not the hot topic of the day during this two-month period. I don't know if that was because SNS had spent their resources, if they'd all been divvied up or if it was because things were not as precarious anymore. I could go back and look because I know I reported on ventilator capacity, but I don't think we were ever down to 95% capacity in use or anything like that in the state.

I think there was always a little bit of a cushion and the hospitals were sharing with each other, even with the SNS supplies. The hospitals were doing their best to be smart amongst themselves. If one hospital seemed to have a lot of ventilators to spare, they could pass them onto others.

The only interaction I had with the ventilators is that at the end of my deployment in June, a lot of the SNS ventilators were due for their preventative maintenance and so I was trying to figure out how to do that, and they were trying to persuade the states to give the ventilators back. But then the question was, were the states going to be – A, how are they going to get them back? And B, how are we going to keep track of who has what? And which ventilators go back? Would they have to re-request all the ventilators? And of course, they didn't want to do that because there was talk of this second wave, which eventually did happen.

Was the state going to tell the hospitals "You're going to have to pick up the cost of it yourself" or was the state going to pay for the ventilator preventative maintenance? But that

was the only interaction I had with the ventilators. And that was just at the tail end of my deployment in June.

VB: Do you remember how it was resolved? Were you still there when it was resolved?

JA: I was not. This is one of those where the state passed the information onto the city, and the city sent back a scathing reply, it was very sarcastic about how they were not going to be returning the ventilators, because if they had to reorder them, then it would be – they wanted to have them in their hands in case the second wave came early and everybody was thinking the second wave would happen in June or July.

I think it actually held off until later. I don't think it happened in July. July was pretty good. But it was a very hotly contested issue that was still ongoing as to SNS wanted them back and the state essentially said, "No, if you want them back, come and get them." And that was where it was when I left.

[00:40:23]

VB: So clearly there's still a great need, but not such a short supply that it was – we had moved on from the most critical period where –

JA: Yes, I think people wanted them more for future planning because everybody thought that there would be this big second wave, especially once kids started school again, there was the fear that when kids were starting school, they would get teachers sick and then the kids would bring it home and get their parents sick. And we would see this huge, potentially even worse, peak of cases in September and October. And so understandably the hospitals were

saying “What do you mean you're going to take away my ventilators? No. We're having a break, but we need our supplies for the next time around”

VB: Yeah, the emergency's not over yet, we're still going to need these. Yeah, I get that.

JA: Exactly. Yes

VB: I wanted to return to one other thing you mentioned that was critically important in this time period, and that was the testing and not just providing swabs and all of the material that needed to be available in order to ramp up testing, but the logistics of where people would be tested and who would be tested and what labs would process results and so forth. Were you involved in any of the logistical discussions or was it more about resources and allocation and data metrics?

JA: It was more the latter. The state had their own lab, and then there were several labs, I think like Covance and other major large laboratories have their bases in Illinois and the state was in charge of allocating what federal resources they were provided in whatever way they saw fit.

ASPR was not going to tell the state you have to give 500 swabs to this location and another thousand swabs to, Danville, et cetera. That was really something that happened at the state level and the granularity of a conversation that I wasn't really involved in. But the distribution of supplies, and as I said before, there were a lot of questions because the supplies were not – some of the supplies were the traditional stuff that the labs are used to getting, but others were things that they had no idea what to do with. And they may not have been labeled correctly or they were packaged in bulk when they were used to seeing

individually wrapped, or they were not sterile when they were used to seeing sterile. There were just a lot of questions about what they were being given and how that could be useful for them and what the best way was to use them.

VB: That's really interesting. The off brand or the ad hoc supplies that must have presented some unique or at least the need for adaptation.

JA: Honestly, some of the supplies that the White House Task Force provided to the state lab, even after providing all the available information, and talking to the CDC and the CDC saying, “We know this isn't what you’re used to, but here's how we can modify your processes and, we recommend you do it this way.” Even after all of that, when I left the state lab was saying, “There's no way in heck we're going to use these. They're just going to sit on a shelf.” My argument to them was always, That's fine, keep them on a shelf, but if the you-know-what hits the fan and you have nothing, then you will have them.” You may not like these supplies, but the CDC has told us that they can work if you'd use them in this very specific way. Yes, it may be more time consuming, and it may require training and you may have a lot of skepticism, but it's better than nothing at all, isn't it?

So that's essentially what we were providing, but then of course, there were issues with capacity. So the state just didn't have the room to store what we were storing, and the FEMA liaisons, who were physically present, they were actually going to the warehouse locations and the state had to open up new warehouse house locations just to store all the stuff they were getting.

I just looked at the epi curve, and Illinois did have a far worse second peak that happened starting in late October on through the Holidays. It's funny how I've purged that

from my memory. So, the supplies that they were poo-pooing in June when the cases were 700 a day may have come in handy when the cases were 14,000 a day in November.

You just never know what's going to be useful. But there was also this consideration of what do they have room to store and what do they have room to track? So, I was doing my best to communicate with the state lab and trying to get confirmation on if they actually received everything. Do you have your eyeballs on what we're saying we're giving you just to confirm that these aren't going to end up lost in a corner somewhere and somebody forgets about them. But their tracking capacity was not able to ramp up to the scale of deliveries that they were getting.

VB: Was there an opportunity to provide support or direction or even request that they do anything to improve tracking? Or was that just not even an option?

JA: I think it was tough to do virtually. This is another instance where – FEMA had liaisons on site, that third FEMA liaison that rolled onto the project or rolled onto the state in late May. FEMA got her because they decided the state needed help, not because the state asked for help.

The State, and this is another issue where it's there's sensitivities, the State, doesn't want to admit that they're potentially losing lifesaving/life critical supplies. They want to keep that not undercover, but they don't want to admit that they're not able to ramp up their capacity as well. But FEMA also doesn't want to see supplies that FEMA has paid for, and there's some sort of cost sharing, I think with the supplies, that was like 75% federal, 25% state, but FEMA has paid for the majority of these supplies, and they want to make sure the state will actually use them. So, there was a lot of that going on.

But it was really hard to provide support and there's only so much you can do when you can't physically go to a warehouse and see what the situation is yourself. All I had was what the FEMA liaisons were telling me, which seemed pretty dire. But not being able to either confirm it, or to help myself, aside from creating a spreadsheet and mining my emails to try to keep track for them what they should have received, but not knowing where they went is a little difficult.

VB: I can't even imagine. Especially when, not to be a broken record on this, but when the decision making is relying on accurate data, I can imagine putting eyes on the situation would've simplified things a great deal.

I have a delicate question to ask so I'm going to blurt it out, but I don't mean it in a provocative or controversial way. You had to deal with so many different officials at different levels with different interests and different constituents, within the Public Health Service there's a specific structure for how decisions are made and the Chain of Command during an emergency response. How did the Incident Command Structure play out in the context of this extremely diverse group of stakeholders. Did it hold? Was it beneficial?

JA: No.

VB: Maybe That's a fair answer. [Laughter]

JA: Yeah. I think it's just tough because there were so many partners that honestly, they didn't care what our Incident Command System was. We just fit in where they needed us rather than us imposing upon an emergency. We were such a small player in such a massive

kind of infrastructure that – and this is the case actually for both of my deployments, but the deployment in Sierra Leone was similarly not structured according to an ICS.

Honestly, I don't know what it would be like to have a deployment with an Incident Command Structure, it'd be interesting to do one day. But I think due to the nature of both deployments, neither one of them really was right for an Incident Command System from the Public Health Service.

There was an Incident Command System, but we were plugged into that Incident Command System rather than having it derived from the Public Health Service. Does that make sense?

VB: Yes, totally. Did you have a sense that the different groups you were interacting with had a clear understanding of your role, or did you feel like you had to do a lot of hand –

JA: No.

VB: Okay. [Laughter]

JA: And honestly, I didn't either. On a day-to-day basis, you just had to figure out who needed you and why and try to get them what they needed and vice versa. What did you need that week and who did you need to get that information from?

VB: Again, it goes back to what you said at the very beginning of this interview that relationships are so key to being able to quickly or as quickly relay your needs and understand other people's needs and help to find solutions, best fit solutions, and that's

complicated when you have people rotating in and out relatively frequently. And your deployment was five or six weeks. Is that true?

JA: Two months.

VB: Two months. Sorry.

JA: That's okay.

JS: That's a long deployment. You must have seen a lot of people rotate in and out during your deployment and had to build relationships anew, is that false?

JA: Actually, it felt like our team, the liaison officer team, were the ones who were rotating in and out. FEMA was static. The FEMA Liaison officers had been there – the state folks were static. These are civil service employees that work for the state. I don't think they let anybody quit during the pandemic. So it felt like if anybody was hampering this response due to lack of continuity, it was us.

But it also felt to some degree, because there wasn't that continuity, the state and FEMA and all of the partners that were consistent, they had worked out a way to get around it and that was why what was needed from me was not standard, it varied day to day because this is the day-to-day workings, the stuff that was present every day that went on with or without me.

VB: That's really interesting to hear. Back to the nature of a virtual deployment, it seems like one of the things that you rely on a lot or that officers need to be able to rely on during a

deployment is a strong team that supports them and that they know who to go to with certain issues and that they know that they can depend on the people on their team. Of course, to a certain extent, that'll hold true, but it's also sometimes very much supported by in person interactions and being able to spend time together during breaks and things like that. Was that missing in a virtual deployment? Is it just different? Did you get to have downtime with the officers you were deployed with?

JA: It certainly was not what it was in Sierra Leone. I will say that the folks that I was closest with were the ASPR teams that met daily in the morning and the afternoon, the more contact I had the closer I was. The calls with the FEMA liaisons, those were nice because those guys were very experienced, and to be totally honest, they held my hand for the first two weeks that I was there trying to help me figure out what it was I was supposed to be doing.

But again, as the response tuckered out when the cases were going down and things looked like they might be good for the summer my meetings with them even dropped off. I feel like I haven't really kept in touch with the FEMA liaisons afterwards, if that's any indicator. Once my deployment ended, we went our separate ways.

It would've been nicer to have had some facetime to be totally honest, and I think it would've made me a lot more effective. But the pandemic being what it was, and as I said at the start of this, I would not have been able to deploy at all had it not been virtual. I don't want to sound as if I'm ungrateful for the virtual nature of the deployment. It's just it's a sacrifice that you make, right? There are benefits and detractors to both.

VB: Absolutely, I think that's perfectly understandable. So this has been really stressful year for everybody, but given the position that you were playing and the fact that, your

normal tour of duty is, on hold and then you're eventually going to have to return to it, it must have been a very stressful situation for you not having the opportunity to download with team members takes away one outlet for dealing with that. Did you have a technique or an opportunity for stress relief or anyone to commiserate with?

JA: They had canceled our daycare, so my kid was also home the whole time during this whole deployment. She ended up going back right after this deployment ended. What was very helpful was that we were able to get family members to come in and kind of substitute for us in terms of childcare. So, my parents came and stayed for two weeks. My husband's parents both came. We had friends, family, we were beg, borrowing and stealing anybody who we could get to come and take care of our daughter because it would not have been possible to do this deployment and care for a child even half the time otherwise.

Spending time with family was a nice break. It felt like we always had helpers in town. It was nice to not feel quite so isolated as well. We have friends who, in different capacities, were able to actually just take care of their kids and they just bunkered down. It was literally the three of the mom, dad, and kid for two or three months straight without a visit, without a single interaction with somebody in person. The continuity of having that in person interaction with others was I think was pretty important to our sanity.

VB: It really sounds like a lifeline and I'm glad that you guys were able to have that support during such a stressful time.

JA: We were very lucky.

VB: And that you got to have, time with your daughter or it's stressful, but also so good to be together sometimes.

JA: Yeah.

VB: So on a different note, the period during which you were deployed was also a another time of, or another source of sort of national stress and trauma erupted after George Floyd's murder, and I imagine that must have had some effect on the work you were doing in the emergency response. You mentioned that you were responsible for tracking and relaying information about current events. Did any of the Black Lives Matter protests have an impact on the work you were doing?

JA: I think there was a lot of skepticism that the protests would themselves lead to a major outbreak, which of course did not happen. But I think early on there was a lot of concern that these would actually harm our response and they might actually cause a second wave in and of themselves.

There also were some issues so that the Black Lives Matter protests in Chicago that went on for many weeks the city actually responded by shutting down bridges over the river. There's a river that goes through Chicago just to prevent movement of people, and as a result I was very concerned about whether the Remdesivir shipment, which is temperature controlled, how it would be able to get to the state lab in Chicago, where I would say, a good 60% of the Remdesivir shipment was destined.

I was concerned that the AmerisourceBergen person that was responsible for delivering wouldn't know how to navigate. If they were just running off GPS, it would tell them that there were all of these ways into the city and all of the bridges are up, but you're not

going to be able to get in the city unless you go – there's a couple of specific ways in and out of the city off these bridges. So, in that way, it was a little harrowing, but when I reached out to the state with my concerns, it seems like that had been accounted for. Either that or they sent it and coordinated a police escort who could move the bridges to make sure that the shipment arrived in time.

But I would say it really did set the scene for the summer. It felt very much like the pandemic was a little bit usurped in public attention for a matter of a couple of weeks or months. And maybe we all just needed to think about something else as well. I think there were a lot of reasons why George Floyd's death led to all of these massive protest movements and a seed for political change, a watershed moment. But I almost wonder whether the pandemic played some role in marking this as that watershed moment. In addition to George Floyd's death, because there were so many George Floyd's before and after George Floyd, it's that this one particular police killing had this massive wave and effect that is still lasting today.

[01:00:18]

VB: I think there's a lot of wisdom in that, and the fact that in the midst of a pandemic when people are losing loved ones almost inexplicably or so suddenly watching garish disrespect for life is all the worst. Meanwhile, we all so desperately needed some human contact that being able to come out together and protest was a therapeutic thing in a way. But it's really shocking to hear about how the direct impact of the response to the protests possibly impairing the shipment of this critical drug. It's a really difficult problem to solve and I'm sure you didn't need one more problem to pop up in provisioning Remdesivir.

One of the things that I admire so deeply about PHS officers is not just being able to pivot and wear multiple hats and just rise to the occasion no matter what is needed, but then being able to shift back into your normal tour of duty and pick up where you left off or take the reins back from whoever was able to step in your place. It seems to me like a very a very difficult task to shift from one role to the other seamlessly. Could share a little bit about what it was like to rotate off your deployment. Did you take any time for yourself in between returning to your work with planning or if maybe you were continuing any of that work during the deployment? What was it like coming back to your normal FDA tour of duty?

JA: So, my situation is a little funny in that in the process of this deployment I actually I got a new job. So, I'd interviewed for the job, and I knew I was going to get it, but I wasn't sure when they were going to start me. My last day of my deployment was June 19th, and so when they cut my orders, they actually timed it so that I started right after that. I did take a little bit of respite leave at least, but then I pretty much came back and rather than coming back to my old job, I started something new, which was a nice break.

It was a team that I was accustomed with, I detailed with them before, but I'd never done the job full time and doing this current job of international work planning, you can imagine how that might have been affected by the pandemic, which prevented people from traveling internationally. There was an equal amount of difficulty in terms of trying to figure out what we could and couldn't do and doing what little we were able to do to assist the review divisions in their reviews, given we were not going to be able to physically travel to a lot of the locations where we normally would have.

I just hit the ground running, and I got to integrate back with what is now my team, and then we took the punches and rolled with them as best we could. But they had just been rolling with the punches. I actually went back through and detailed again in March, right after

they canceled all of the trips. We have hundreds of trips scheduled every year to do hundreds of inspections abroad for the Office of Bioresearch Monitoring, and in March all of that got killed. The thought was we'll cancel everything in March, and we'll postpone everything, and we'll do it in June or July.

Then June or July rolled around, and everybody thought, "Oh crap, this is going to last a lot longer. Maybe let's try for October. We'll try the next fiscal year." Of course, that was last October, so we kept kicking the can as best we could, but trying to figure out, "Okay, can we do these remote inspections? Is there something we can do in terms of, looking at the data that we have already received to figure out, if we have pointed questions that we need answered."

So that was a learning process in and of itself, and a continuation of the confusion and not really knowing what my role was and trying to do the very best to be useful in whatever way I can in the middle of the pandemic that this deployment was.

VB: Wow, I can't get over this sense that you had, both from your deployment role and obviously from the work you're doing now with the OBIMO Program you have this must have this insight into the relationships behind the data that FDA needs in order to understand not just, drug supply or device supplies, but also how to prioritize and plan for effective inspections and so forth.

Is there any insight from the past year and particularly from your deployment, that you think could be helpful in FDA's work to gain insight into those pathways of information?

JA: I think this deployment as well as FDA's response in general and OBIMO's response to pandemic, it's all about being flexible, right? It's just been one long exercise in adapting to a changing circumstance and trying to figure out, if we can't do what is best, what can we do?

I can't deploy in person. What can I do? Okay, will you deploy virtually? Okay, so what does that mean? And let's define that as best we can and find a hole and attempt to plug it, right?

Find a need and plug yourself in and do the very best you can because nobody expects anything to be perfect in the middle of a pandemic. The nice part is that because we were making up the rules as we went along, and the situation was constantly changing. As a result, everybody understands that nothing is a perfect solution. Nothing is going to get you the ideal. But as a result, everybody is willing to work together, and that's definitely felt.

It felt very much the case when I was with ASPR on this deployment, but even more so at FDA. As I've rolled into this new position everybody is understanding that I can't get everything, and so let's work together to try to accomplish the mission as best we can.

VB: That's awesome, and it does seem like the best takeaway. How can we move the needle forward, even under imperfect circumstances, far from imperfect circumstances? I'd like to flip that question and ask it a different way. Given your experiences during the deployment, what lessons do we have to learn from the deployment that could benefit officers that are deployed in the future? Are there any tips that you would offer in addition to being flexible or any insights that might benefit the Corps in organizing for future response?

JA: I think the one thing that would've been really nice is to have had a little bit more overlap with my predecessor. And I do think we need to take a hard look at the length of the deployments as unpopular as it may be, to have somebody disappear from their day job for 90 days. I think giving the partners that we're working with, especially in a virtual environment, somebody that they know is going to be there day in and day out for at least the foreseeable future, would really help add the value to that person's deployment.

As I mentioned to you before, a lot of what happened, it wasn't contingent on me because they knew I was leaving, right? They knew from day one when I was initially deployed, I was only there for a month. They'd already seen two people roll through my same liaison position by the time I arrived. And so, to some degree, they don't want to rely on somebody for a two-week period to do something. It's just easier to just do it yourself and count on somebody to clean up the stuff that's a one off as opposed to relying on somebody for the day in, day out.

So, I think longer deployments is unpopular as they may be, are probably a good idea. And that was very much the case when I was in Sierra Leone as well. 60 days, yes. It was hard to have 60 days away from my family. If they'd asked me to extend for another 30 or another 60, I would've done it, because it would've been much more valuable to have somebody not having to relearn the ropes every month. And then also having overlap between employees that are in static roles, like the one that I was in.

I know there's a lot of people that deploy and they're like I was just a staff pharmacist, or whatever, but when you're in a role that is very disaster – specifically a liaison to a state it would've been nice to have had two days or three days with Commander Harper. Instead, I had a one- or two-hour meeting with him, which made it harder because I feel like I had to make it up as I went along and I wasn't able to learn from his experiences as much as I really would've liked to.

VB: That sounds like valuable advice, and I want to thank you for sharing those. I have learned so much talking to you in the last hour and a half, and I'm really just genuinely grateful for this interview. And I want to say thank you for your service. I'm going to go ahead and close the recording.

JA: It was an honor to chat with you, and it was an honor to be a very small part of this massive disaster response, and interesting and very self-reflective, to have a conversation about it a year later with you. Thank you.

VB: Thank you Lieutenant Commander Adams.

[END OF INTERVIEW]

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