

Building Public-Private Partnerships to Enhance Disaster Resilience: A Listening Session

Meeting Summary Report

Compiled by the U.S. Department of Health and Human Services (HHS),
Office of the Assistant Secretary for Preparedness and Response (ASPR),
Division for At-Risk Individuals, Behavioral Health, and Community Resilience (ABC)

Please visit the [ASPR-ABC](#) website for more information.

January 2016

EXECUTIVE SUMMARY

On October 5, 2015, the Office of the Assistant Secretary for Preparedness and Response (ASPR) Division for At-Risk Individuals, Behavioral Health and Community Resilience (ABC) and Grantmakers In Health (GIH) co-hosted a meeting *Building Public-Private Partnerships to Enhance Disaster Resilience: A Listening Session*. The listening session supported the National Health Security Strategy's (NHSS) aim to improve community health resilience—a community's ability to use its assets to strengthen public health and health care systems and to improve the community's physical, behavioral, and social health in order to withstand, adapt to, and recover from adversity. The objective of the meeting was to promote connectivity and enhance relationship building among private foundations and key preparedness, response, recovery, and resilience program representatives. The meeting was attended by 50 individuals representing federal government, national partners, and private philanthropy. Attendees were provided an opportunity to educate each other about programs and resources available in the public and private sectors that help support emotionally strong, healthy, and resilient communities.

Stakeholders within the private sector and philanthropy often help to support or foster community wellbeing and resilience through disaster preparedness, recovery initiatives, and community level health promotion efforts. Federal resources assist states and localities during major disasters and public health emergencies with preparedness, response, and recovery assets and resources. Closer collaboration between philanthropic entities and the federal government can enhance disaster resilience while building overall community health. Public-private partnerships hold the potential to bring new, innovative, and sustainable approaches to better address the community's emotional health and wellbeing, including the access and functional needs of at-risk individuals.

Key Themes Discussed:

Community and Culture: Race, culture, language access, and socio-economic status in communities were identified by the meeting participants as influences on a community's resilience and ability to be responsive to incidents. Various approaches to defining community were discussed as well as ways to engage disparate parts of communities in community resilience efforts. How communities are defined was seen as critical, especially when trying to identify resilience partners.

Messaging: Participants explored how preparedness and recovery messages are created. What is included in messages, and who communicates these messages to the community during disaster preparedness, response and recovery phases were seen by participants as vital elements of effective communication. Participants stressed that the credibility of the messenger is crucial, and use of a trusted source (e.g. faith leaders) in the community is an effective way to get important messages accepted by the community.

Behavioral Health: Participants emphasized the importance of expanding the overall understanding of behavioral health, disaster behavioral health, and trauma-informed care. Participants felt that more effective training is needed for those groups who provide different types of services to a community after an incident so that all services are appropriate and trauma-informed. Participants agreed that funders can benefit from better understanding about how communities are affected by disasters or emergency events, and best practices for connecting with the appropriate partners in sustainable ways. Participants emphasized that there needs to be more of an effort to incorporate preparedness and behavioral health into planning and emergency related grant guidance. Additionally, public health, emergency management, and funders should take advantage of opportunities that occur to introduce and highlight behavioral health issues when discussing other clinical health or emergency topics.

Resilience Promotion Strategies: During small group and large group discussions, meeting participants suggested various strategies for enhancing community resilience. The following are some of the identified strategies that communities, funders, and emergency planners can consider:

- Build relationships prior to disasters and emergency events. Establish and improve connectivity with a wide range of partners at the local, state and federal levels that may make significant contributions to preparedness and planning efforts for emergencies or disasters.
- Consider generational impacts versus short-term impacts when developing community policies, programs, and services.
- Learn from experience. Participants discussed the importance of taking advantage of unexpected or emergent opportunities to develop collaborative activities. From these opportunities lessons learned can be captured and used to inform how preparedness and response strategies translate to other public health issues.
- Use children's based programs to engage populations that may be difficult to reach (e.g. adults & veterans).
- Consider rural and small community models when seeking innovation and creative resource utilization as large scale city models may not be suitable or effective for smaller localities.
- Prioritize hospital coalition pre-event planning and, hospital and public health agency crisis communications planning.

- Seek the assistance of private organizations with internal resources such as emergency action plans, employee assistance programs, disaster coordinators, and fire coordinators, that can engage in planning with community leaders and potentially make assets available to help the larger community in time of disaster or emergency.
- Bring philanthropy groups into the discussion about how funding gets utilized as early as is feasible and appropriate.

Potential Opportunities and Suggestions for Future Collaboration:

Plan or Participate in Additional In-Person Meetings: Attendees stressed the value of stakeholders meeting face to face to build and strengthen relationships. Participants suggested that the listening session be replicated regionally with ASPR's Regional Emergency Coordinators (RECs) and Regional Association of Grant Makers (RAGs).

Promote Cross-Disciplinary Information Sharing: Attendees at the meeting came from different disciplines and with different affiliations and, therefore, attend different conferences and educational opportunities from each other. Participants encouraged one another to share collaboration opportunities and learning venues which allow people to participate with other disciplines in order to become familiar with a broader array of partners and to share ideas.

Conduct A Needs Assessment/Analysis: Participants recommended a needs analysis be conducted to determine what people don't know and what they need to know about disaster resilience at a local level, what current perceptions exist, and what types of connections are needed to facilitate better community resilience.

Utilize Local Funders As Conveners And Connectors: Attendees stressed that engaging with local funders is not solely about fundraising. National stakeholders can approach local funders that know community stakeholders and needs so that federal, state and local public health officials can implement locally based strategies to foster resilience.

Build A Community Of Interest: Participants expressed interest in continuing the conversation through development of a community of interest for ongoing dialogue. One mechanism for this would be to develop a web-based mechanism for ongoing communication and sharing of resources and information, including details about upcoming meetings and opportunities to collaborate.

Meeting Summary

On October 5, 2015, a full day, interactive meeting, *Building Public Private Partnerships to Enhance Disaster Resilience: A Listening Session*, was held in Washington, DC, convened by ASPR-ABC. [GIH](#), the leading nonprofit, educational organization dedicated to helping foundations and corporate giving programs improve the health of all people co-hosted the meeting. A total of 50 people participated over the course of the day including federal staff, national partner representatives, and philanthropic group representatives. The meeting goal was to promote development of public-private partnerships to support broader community resilience.

The listening session is part of a longer-term ASPR strategy to promote public-private partnerships pertaining to disaster resilience. ASPR aligns its activities in support of the NHSS, which provides a framework to build community resilience, strengthen and sustain health emergency response systems, improve capabilities, and prioritize resources. The meeting served to support the NHSS Objective 1: *Build and sustain healthy, resilient communities*. This objective focuses on encouraging social connectedness, enhancing coordination of health and human services through partnerships, and building a culture of resilience. The meeting also served as a step toward addressing the Institute of Medicine's Recovery Report recommendation #8 to engage private sector stakeholders to enhance disaster behavioral health.

Participation of GIH in the meeting was significant to the goals of the meeting as GIH helps to broker professional relationships and connect grantmakers with each other and with other professionals whose work has important implications for health. Stakeholders within the private sector and philanthropy often help to support or foster community wellbeing and resilience. Closer collaboration between philanthropic entities and the federal government hold the potential to bring new, innovative, and sustainable approaches to better address the whole community's emotional health and wellbeing and enhance disaster resilience. Partnerships that optimize pre-existing relationships, resources, and systems can address unmet needs and provide disaster and emergency impacted communities with services, training, and educational resources to recover more quickly and effectively.

This meeting summary provides key highlights from presentations and from group discussions¹, a summary of the meeting evaluation, and suggestions for next steps. Appendices are included and contain the meeting agenda and overview of ASPR and GIH. A list of meeting participants is also included to further promote ongoing relationship building and communication.

¹ Ideas and suggestions that are captured in this summary reflect only the opinions of individuals who attended the meeting and do not imply that these organizations as a whole share the same views.

Resilience and Disaster Preparedness; Framing the Issues:

The meeting opened with remarks and presentations from senior leadership from both ASPR and GIH who emphasized that it is vital to advance engagement between ASPR and philanthropy in order to enhance disaster resilience at the local and community level, and that partnerships should be fostered and built in advance of incidents. No one organization can meet the needs of the community alone. Philanthropy, emergency planners, community members and other partners need to think about how to work more effectively together to build resilient communities.

Dr. Lisa Kaplowitz, Deputy Assistant Secretary for Policy, ASPR, HHS, provided an overview of the Office of Policy and Planning (OPP). Dr. Nicole Lurie, the Assistant Secretary for Preparedness and Response, as the keynote speaker, provided examples of how ASPR supports communities; including how in the immediate aftermath of the recent Oregon community college shooting, ASPR deployed a behavioral health team to support community efforts to address the needs of those impacted. Dr. Faith Mitchell, President and CEO of Grantmakers In Health (GIH), shared that collaborating with government around rural health issues, Affordable Care Act implementation, eliminating health disparities, sharing strategies to enhance behavioral health resilience, and disaster recovery and preparedness is of interest to GIH. She emphasized that public-private partnerships require long-term commitments which can open avenues for partnerships. Private sector philanthropy can drive innovation and be flexible and agile when working with communities. Mr. Edward Gabriel, Principal Deputy, ASPR, HHS, stressed that there are thousands of people in corporations who can be trained to help in a disaster and that people have an innate response to help other people and we need to try and harness that innate response.

Ms. Rachel Kaul, Behavioral Health Team Lead, ASPR, HHS, provided background on ABC which focuses on behavioral health needs of responders, and survivors, and the access and functional needs of at-risk individuals. Ms. Kaul shared that the definition of resilience at the meeting is broad and incorporates strengthening everyday systems; broader community partnerships; building resilient leadership; and volunteerism/ bystander response. “Health Resilience” includes a focus on people and their wellbeing and “Community Health Resilience” includes the concept of building cultures of resilience. Participants were encouraged to think beyond the meeting objectives and synthesize next steps. Lastly, Dr. April Naturale, Senior Technical Specialist, ICF International, served as the meeting facilitator and provided examples of partnerships that supported community healing and resilience. Dr. Naturale emphasized that harnessing lessons learned is crucial and that none of us are immune to the behavioral health effects of disasters or emergencies, even first responders. However, resilience is innate and should be fostered. Social support networks continue to have the greatest impact on individuals’ ability to mitigate behavioral health problems.

Resilience: Areas for Partnerships

Meeting participants rotated through four of five facilitated discussions on specific topical areas: behavioral health; at-risk individuals and social services; health resilience and recovery; community engagement and preparedness; and health systems. These topics were chosen as they are cross cutting issues and are aspects of disaster resilience that could benefit from enhanced collaboration and partnering. Participants identified their organizations/programs and highlighted how their programs interact/fit in with the particular topic area, or how it might intersect in the future. Examples of successful partnerships and community engagement concerning the topic areas were shared including any challenges that participants have experienced in developing those partnerships. Below are selected highlights of ideas, suggestions, and partnership examples that were discussed during these sessions.

Behavioral Health: *Behavioral health is a state of mental/emotional being and/or choices and actions that affect wellness. Substance abuse and misuse are one set of behavioral health problems. Others include (but are not limited to) serious psychological distress, suicide, and mental illness (SAMHSA, 2011). Such problems are far-reaching and exact an enormous toll on individuals, their families and communities, and the broader society. Disaster behavioral health refers to mental health, substance abuse, and stress management needs as well as issues concerning: disaster survivors; disaster responders; people with pre-existing behavioral health conditions; behavioral health care infrastructure; individual and community resilience and recovery; and messaging/risk communication (ASPR).*

- Participants stressed the importance of relationship-building prior to a disaster incident.
- Discussions centered on how we train those that engage people helping in the community. Working with traumatized populations requires a special set of skills and understanding of what trauma is, and what is meant by disaster behavioral health.
- Many private funders already incorporate behavioral health into their funding priorities, even if not specifically defined that way. Private funders can benefit from enhanced support and information about how to be better prepared for incidents and better understand how communities are affected by disasters and public health emergencies. Information about how to connect with the right behavioral health partners and make plans for sustainability can enhance funders' preparedness efforts.

Partnership Example: Disney Corporation and the American Red Cross have partnered to create the [Pillowcase Project](#) which includes a behavioral health preparedness component for elementary schools and helps children educate parents. With a focus on preventing home fires, the Pillowcase Project also helps children learn about fires and identify the things they would put into their pillow case in case of an emergency such as a fire.

- The concept of trauma- informed care was a focus of discussion and participants shared that many people do not fully understand what it is or the depths of trauma. Questions were raised about how communities can enhance expertise of those on the front line so that there is more of a long-term solution rather than just a needs-based approach.
- Concern was raised about the effects of a disaster or emergency situation on volunteers that are used and that agencies that utilize volunteers are not well informed about volunteers’ life experiences or trauma stories before sending them out. Ideas were explored about how to build both the volunteer disaster behavioral health knowledge base going into disasters and build their resilience for after their response or involvement in the incident. Participants discussed the availability of funding from the Office of Victim’s Services. These funds can be applied for and used for behavioral health related services and support, but not everyone understands how to access the funds.
- Brain health and neuroscience research shows that behavioral health issues are brain-related, and educating communities about these findings was identified as important for reducing stigma and help communities better understand behavioral health.
- Recommendations were made for agencies and organizations to utilize pre-existing partnerships that may have a focus in other health related areas and look for opportunities to further collaborate on disaster resilience.
- Participants stressed the importance of inviting people who have lived through disaster experiences to similar discussions to share what their needs are.
- Barriers to appropriate language access which can result in inhibiting recovery for some communities were described. One suggestion for helping to overcome this barrier was to develop a language coordinator at federal agencies, in a similar way that the Federal Emergency Management Agency (FEMA) developed language coordination after Hurricane Katrina. The Chevron localized disaster was an example provided of where 8,000 people were not culturally/linguistically able to easily access care from a particular health care and health insurance provider. There is a reliance on local community-based organizations to provide the language services and they cannot always sustain services.

Partnership Example: Emergency Management for Chester County, PA works closely with the Health Department, human service agencies, and spiritual leaders. They also have Disaster Outreach Coordination Teams. VOAD’s guidelines will be out soon for how to establish spiritual care programs.

At-Risk Individuals and Social Services: *At-risk individuals are people with access and functional needs that may interfere with their ability to access or receive medical care before, during, or after a disaster or emergency. Access-based needs require that resources are accessible to all individuals, such as social services, accommodations, information, transportation, and medications to maintain health. Function-based needs refer to restrictions or limitations an individual may have that require assistance before, during, and/or after a disaster or public health emergency. For the purposes of the meeting's discussion, At-Risk Individuals and Social Services includes and refers to those populations that are at highest risk of experiencing negative mental health responses or developing a mental health and substance misuse disorder in the aftermath of a traumatic event and the services developed to address their needs. These populations include families of victims, injured and other survivors, first responders, children, people with functional and access needs, people with prior mental illness or traumatic histories and elderly persons with debilitating or mobility limiting illnesses.*

- Collaboration can take a long time. Some participants shared that the short length of many grants inhibits effective collaboration and a longer timeline would allow for more effective collaboration building. Relationship and trust building outside of a specific grant or prior to an incident remains crucial.
- Work with disaster populations to retrain them. For example, some of the Vietnamese populations who were fisherman and were impacted by Hurricane Katrina and the BP Oil Spill are now being trained in aquaponics and growing organic vegetables.
- American Red Cross partners with disability rights networks to ensure that emergency shelters can accommodate people in the manner which they are accustomed in their own home. Shelter workers are taught how to help people in the shelter manage their daily routine.
- Programs designed for children can often engage parents. The use of local assets on the ground can build community resilience once other agencies leave. For example, the [Arts and Health in Military](#) project has had experience putting together a network of therapeutic activities following natural disasters and have brought in local child life specialists into the shelters.
- A severe lack of clinical mental health professionals around the United States exists. An effort to build up a professional cadre was identified as an important activity to continue nationwide.

Partnership Example: Use pre-existing relationships and connections to reach populations with disaster preparedness information. For example, [March of Dimes](#) whose mission is to combat birth defects, have developed consumer education brochures for populations to get prepared for hurricanes and disasters. March of Dimes had mobile health labs/ vans during Hurricane Katrina, to lessen the impact of disasters on the birth process and disruption to health care.

- Recovery planning should be done before a disaster strikes. Integrate recovery and health resilience planning into existing planning efforts.
- Communities should assess risk in their communities and understand vulnerability on a continuum. The term “access and functional needs” as opposed to “at-risk” or “vulnerable” was shared by participants as the term of choice.
- There is an economic toll of a disaster, especially among small businesses (i.e., day care centers) and more efforts should be made to help the private sector be better prepared.
- How the private sector can engage with federal programs is sometimes unclear. Private foundations want to know what the funding gaps are and best approaches for philanthropy to partner.
- Those who are on the frontlines and deal with pre-disaster homeless populations need to be better engaged in disaster planning efforts and should be considered as important partners to include in any local disaster resilience effort.

Health Resilience and Recovery: *Community health resilience is the ability of a community to use its assets to strengthen public health and health care systems and to improve the community’s physical, behavioral, and social health to withstand, adapt to, and recover from adversity (National Health Security Strategy, 2015). Resilient communities include healthy individuals and families with access to health care, both physical and psychological, and with the knowledge and resources to care for themselves and others in both routine and emergency situations. Enhanced resilience is considered critical to mitigating vulnerabilities, reducing negative health consequences, and rapidly restoring community functioning after a disaster or public health emergency.*

- Participants recommended that we avoid characterizing resilience as a novel concept in our messaging and outreach; many disciplines have been working in resilience for decades.
- Discussions identified that an approach to managing donations post-incident would be useful, particularly in regards to finding ways to use donations to support longer-term recovery and resilience rather than only relying on shorter-term dissemination through direct response-support or immediate support to survivors.

Public-Private Partnership 101: Pre-existing relationships between the public and private sector—including pre-existing written partnership agreements—is essential in order to efficiently work together in disaster recovery.

- Participants discussed the idea that health promotion is an area that can be leveraged as many health promotion goals have synergy with disaster preparedness goals; greater partnership between health promotion and disaster resilience-promotion stakeholders will be beneficial.
- It will be important to provide information and guidance to private partners/philanthropic organizations before an event detailing specifically what they can do to help with disaster resilience and recovery.
- There are many opportunities to continue to develop understanding and relationships among foundations, the health promotion community, and the public health emergency/disaster stakeholders by attending/presenting at the many conferences each discipline routinely convenes.
- Federally-funded programs and the federal grantees in the emergency management mission space, by-and-large, do not know about foundations and how they might better work together; efforts for federal grantors to educate their grantees in this area would be welcomed.
- Resilience is a useful way to message health promotion and preparedness concepts as most people understand resilience on a personal level; that said resilience in this context must still be clearly defined so that targeted actions can be proposed.
- Disaster Risk Reduction may be a useful model to incorporate into resilience as it offers effective, targeted approaches that can be adopted to forward preparedness and resilience.
- Efforts such as this Listening Session are useful to begin the discussion and start to form relationships and resilience is an effective rallying point for this discourse; extensive efforts will be needed, however, to sustain this discussion and forge professional relationships and public-private partnerships.

Community Engagement and Preparedness: *For discussion purposes, community engagement and preparedness was defined as a process which uses a Whole Community approach to emergency management to leverage all of the resources of a community in preparing for, protecting against, responding to, recovering from and mitigating against all hazards. This larger collective emergency management team includes, not only federal and state disaster response agencies, but also local, tribal, state and territorial partners; non-governmental organizations like faith-based and non-profit groups and private sector industry; to individuals, families and communities, who continue to be the nation's most important assets as first responders during a disaster. Both the composition of the community and the individual needs of community members, regardless of age, economics, or accessibility requirements, must be accounted for when planning and implementing disaster strategies. When the community is engaged in an authentic dialogue, it becomes empowered to identify its needs and the*

existing resources that may be used to address them (adapted from FEMA Whole Community definition paper).

- The importance of prevention, and not just recovery, for enhancing disaster resilience was a theme that was discussed. A high priority for participants was the need to have scientific findings and public health information translated and communicated to communities in a way that they can digest and understand.
- Private groups find that it can be difficult to partner with the government. Potential partners have the opportunity to identify areas where there is an overlap in efforts, methods, and practices.
- Private sector grant makers want to know what the funding opportunities are from the government. Grant makers want to be able to match and leverage funds, but the timing of when information is shared about available government funds makes it difficult for better alignment.
- Community engagement was described as an important issue for immigrant communities, as frequently there is a lack of language access or linguistic barriers exist that impedes engagement.
- Trusted community advisers are the trusted sources whom immigrants and those with limited English language proficiency will go to.
- Local government has been working to partner with community non-profits that assist with disaster preparedness to build disaster continuity plans.
- Foundations have roles beyond giving grant making dollars. They can serve as a neutral convener.
- Many local governments do not know how to collaborate with non-profits or what legally is allowable.
- Participants, based on their own experiences, emphasized that the best way to start a partnership is reaching out as a subject matter expert, rather than asking for money. For example, many Medical Reserve Corps (MRC) units provide services to businesses and organizations about preparedness or even with enrollment in health insurance.

Foundation Highlight: The [Avielle Foundation](#) disseminates information that is based in science and research by working through schools, faith-based groups, and town halls and other community settings. Families are the primary audience. The Foundation has found that the most effective audience for promoting brain health is a peer to peer and a peer-down based program with adolescence and young adults. Educational efforts supported within the community aim to ultimately foster enhanced community connectivity to prevent violence.

- Participants stressed the importance of focusing on outcomes (i.e. better health and wellbeing in a community) rather than whether a particular term (i.e. resilience) is used. There is a stigma around the need to get help. Part of being trauma-informed is recognizing how trauma impacts everyone. Self-care, especially for the care providers, fits into the broader area of wellness promotion which is an area where foundations frequently work. Support for building healthy communities is support for building community resilience.
- Faith and spiritual care providers were identified as important partners for community preparedness and engagement efforts. Faith-based disaster spiritual care providers are in need of their own care. Mental health and spiritual care people frequently go to each other for help. Many public health departments have a group of faith based leaders that advise on public health issues.
- Participants pointed out that after a disaster, there tends to be interruptions of education that occur and human trafficking issues can surface. Communities can take the lead and work along with volunteer organizations and invite subject matter expertise from the Administration for Children and Families (ACF) to address the needs of children.

Health Systems: *Health Systems refers to the whole of a community's public health, medical, mental health and addictions treatment capabilities and participants were asked to think about these systems within the context of disaster resilience. Provider agencies can include emergency medical services (EMS), emergency departments (EDs), hospitals, public health agencies, behavioral health programs and facilities, ambulatory care centers, primary care settings, and long-term care facilities (LTCs). Related communication and transportation services, as well as the development of disaster or continuity of operations plans, are also necessary for these health systems components to fully participate in disaster preparedness, response, and recovery activities.*

- Participants suggested that there are many more partners that need to be imbedded in coalitions – non-governmental organizations (NGOs) and volunteer commissions, including free standing assets (for example, federally qualified health centers (FQHCs)) and foundations.
- Suggestions were made that there should be more work to build up the capacity of FQHCs and free clinics that are already struggling, as they will be called upon for unfunded mandates. The challenges that remain are to ensure that FQHCs are included in every community health coalition, and helping the FQHCs to understand their role in continuity of operations planning.

- Many coalitions and groups that focus on disaster preparedness and resilience may not have clearly identifiable actionable items from their meetings, but instead are intended to be about sharing and learning. Participants felt that groups need to think differently about what is considered a successful outcome from a meeting. Often people get contacts out of these meetings which help lead them to building partnerships and future collaboration.
- Participants discussed various types of venues to bring people together including exercises and trainings which can be funded through partnerships.
- Private philanthropy representatives emphasized that funders can be neutral conveners in a community to get potential partners together, without an identified “stake.” Funders are sensitive to the voices of the community and are part of the community and want to see a long-term impact.
- Some meeting participants felt that sometimes families and others that are served during a disaster are made to feel like they are not resilient, when in truth they are and better efforts should be made to be more sensitive in how labels are used with various populations.
- After the acute phase of a disaster, by about day 3, substance abuse, chronic disease, and mental health become challenges for acute care systems. Participants felt that more emphasis should be placed on health care coalitions to think about behavioral health services and include them as partners in the coalitions.
- We need to identify incentives beyond grant funding to encourage partners to come together. Grants cannot be the only fundamental lever.
- Suggestions were made to look at non-traditional groups for preparedness – ATTCs for example (Addiction Technology Transfer Centers). Federal partnerships are just as important as partnerships at the community level.
- ACF informed the group that there have been lessons learned from the standing up of the [Children and Youth Task Force in Disasters](#). Children and Youth Task force is linked with many other systems that report to recovery and disasters, but is focused on children. These lessons learned need to be better disseminated so others may learn.
- Some participants shared some observations that communities sometimes feel preparedness fatigue, especially when a disaster is never experienced at the local level. However, when the discussion and community planning shift to the enhancing of resilience, many can see a benefit and a return on investment every day.

- Participants described the importance of training local health care centers in how to be trauma-informed. By providing this training to local center, when incidents occur, such as during mass shootings etc., these centers can provide appropriate responses instead of requiring an outside specialized team to be brought in that then frequently gets overwhelmed by the needs in the community and is also only there for a short period of time.
- March of Dimes shared about its Neonatal Intensive Care Unit (NICU) family support program which utilizes social workers and suggested that the social workers can be trained to incorporate disaster preparedness into the information they provide to families about the transition to home.
- Participants discussed that there are many resources and capabilities of private foundations that can support health systems resilience in a number of ways especially related to engagement (networks, facilitation). Foundations can help support and facilitate improved access including health literacy and language access. Additionally foundations can foster and promote sustainability planning, including continuity of operations as well as improved integration including that of mental health and substance use services.

Disaster Resilience Partnership in Practice: Scenario Sessions

The participants rotated through three discussion groups addressing the following scenarios: Infectious Disease Outbreak, Natural Disaster and Mass Violence.

Infectious Disease Outbreak (Dr. Daniel Dodgen, Facilitator)

- Participants described some of the main issues and challenges illustrated by the scenario including that more training should be provided to local hospitals regarding treatment, quarantine, isolation and other protocols necessary for treating patients during an infectious disease outbreak, such as Ebola and that pre-planning efforts are important.
- Hospital administrator communication continues to be an important factor during a response to an infectious disease outbreak and in helping to reduce and address employee and public concerns. Public health messaging is critical to manage fear and it's imperative to have messages that are ready to push out in order to get in front of rumors and so that public information officers (PIOs) and others who may use informal networks have the information they need.
- Public health alone does not have the capacity to support people who are quarantined (food, laundry, mental health, etc.) and needs partners at the local level to help provide the needed services and support people during stressful times.

- The importance of good public education was stressed and that it is crucial to counter and correct social media misinformation. Some suggested that nontraditional media—such as Facebook, Twitter and other social media platforms—can be used to amplify public health messages. The use of existing social networks, such as from within a clinical setting to send and reinforce messages (e.g. nurses, other hospital staff) could be used and not to just rely on the public information officer or a government entity.
- Participants discussed ways their organization could assist with a similar crisis. Many agreed that their organizations and programs could relay messages to the community from trusted sources. For example, American Red Cross chapters have experience disseminating information that has come out from the Centers for Disease Control and Prevention (CDC) regarding infectious disease outbreaks and that they could use community based partners (e.g. home health) to transmit information. The MRC members in communities can support messaging efforts as can faith-based organizations and senior centers.
- Proactive steps that meeting participants could take to develop partnerships before an emergency event occurs were shared during discussions. Ideas included working with and leveraging relationships within the NGO community. Another proactive step involved taking advantage of the accreditation mandate for hospitals to hold two real world full scale exercises each year. These often times only take place in the ER and these are opportunities to engage community partners who might really play a role when a true incident occurs.
- Participants stressed that once an accurate message has been developed it is important to consider ahead of time how to translate and deliver the message for the various constituent audiences. Sending a combination of public health and behavioral health messaging was emphasized as important so that the community's concerns can be addressed up front.
- Additional partnership building strategies and suggestions included beginning to build relationships with federal partners and grantees when you do not need it so that relationships can be developed and formed. Private foundations shared that there have been successful collaboratives around the Affordable Care Act.
- Community-wide training in psychological first aid was seen as important by many meeting participants as it enhances community members' ability to help their neighbors and also to help themselves.

- It was acknowledged that the participants who were present at the meeting were there because of their shared concern and care for communities and many had seen how communications impacts crises. Those who were present shared some ways that they could contribute in their roles to improving communications during an incident including:
 - Use an organization’s volunteer database (volunteer connection) to send proactive health messaging.
 - Communicate health and behavioral health messaging to community health workers, social workers, nurses, direct and to allied health professionals.
- Targeted communications to medical professionals focused on the importance of addressing behavioral health needs and concerns of providers, patients, and the community in relation to an incident.
- Use traditional forms of communication (e.g. speaking or writing), as well as other forms such as photos, or a YouTube video to get messages out (infographics, etc.).
- Reach out to the faith community as they can play an enormous role.
- Better support volunteers who may get mixed messages or are vulnerable to information the media relays that sometimes instill fear in volunteers instead of acknowledging the great work that is being done.
- Establish relationships with media ahead of time with local experts so when something happens the media doesn’t report on the rumor but instead they go back to the subject matter expert (SME).

Natural Disaster (Darrin Donato, Facilitator)

- During discussions of the natural disaster scenario participants remarked that resilience takes a broader perspective than just emergency preparedness. For example, there are homeless and behavioral health system steady state issues that predate any disaster. Applying a resilience lens, allows these issues to be addressed so that these systems are less vulnerable when a disaster occurs.

- Typically needs of the elderly, children, and mental/behavioral health are addressed in different silos. Participants provided some suggestions for ways that these issues could be addressed together including:
 - Better connections with local public health to assess the health needs of the whole community.
 - No single agency has all the expertise. Community experts should be brought together to form a community of experts for recovery.
 - Value the people on the ground and in the community. Engage in conversations up front with people that understand the community so that there are no assumptions about the community's needs by outside organizations who come to help, including by the federal government.
- Participants had the opportunity to discuss some of the challenges that voluntary organizations can face in strategically using and disbursing funds to survivors and the community when large philanthropic donations are received immediately following a large disaster. One suggestion was to utilize the regional associations of grantmakers and identify a philanthropic network that can help administer the funds received for use of by a community. Another suggestion was to set up a donor advised fund in the disaster-affected community, in which donors are allowed to say where the money goes, and the community foundation then can be responsible for the structure working.
- Participants suggested ways that a sense of community can be maintained when services have been devastated:
 - A hospital can serve as a node of connectivity within a community in addition to serving as a provider of services.
 - Groups can be formed by state or local government to pull together stakeholders to rebuild the community.
 - When people leave shelters, places of worship or schools can serve as community nodes.

- More support for the planning phase was emphasized by participants to be an important aspect of enhancing a community's disaster resilience. Planning should include continuity of operations so that if a particular service shuts down a plan is in place for how to utilize staff from the closed location someplace else. Often the relationships that are required to have this plan in place are not cultivated until there is a stressor.
- Additional discussion centered on how disasters can be an opportunity to re-think community development. Thought leaders in the community should already have a view for the community's future so, if impacted by a disaster, there is already something the community is moving towards.
- Some participants suggested that there is a need for a planning group specifically for the immediate operational period and a need for a strategic planning group that specifically thinks of the long-term goals.
- Coordinated discussions are needed at the local, state, and federal levels.
- Emergency planners need to work with community based agencies that serve populations, so when shelters open its known what the community looks like and appropriate needs have been anticipated and planned for. Everything should be done ahead of time, including having a discharge plan from the shelters, much like a hospital.

Mass Violence (Dr. April Naturale, Facilitator)

- Agencies should capitalize on lessons learned. Examples provided by participants for how to share these lessons from past experiences included connecting the university president with other university presidents that had to deal with a similar incident such as a campus shooting.
- After a tragedy like a campus shooting, the university can use the opportunity to springboard to general campus preparedness. Suggestions were made that MRCs can engage their local universities in general preparedness efforts.
- Participants took time to discuss that the community mental health system is stretched thin on a day-to-day basis. The existing mental health providers become inundated with their regular client work after a disaster, so they don't have the capacity to deal with the surge to the system after a crisis. Funders have the opportunity to support activities that help to foster mental health of the communities.

- Additional discussion highlighted the need for funding to better support integration of mental and physical health and whether there are ways for private philanthropy to help foster this integration within programs that they support.
- There is a shortage of counselors that represent and/or have expertise in various ethnic or language groups. This gap for specific communities becomes more significant after a disaster when there is a surge in behavioral health needs. It was suggested that foundations can help fund training of teams to work in under-served communities.
- Significant discussion was had among participants about the need and role of training and what it should focus on as it relates to mass violence. Suggestions for training topics included awareness and understanding of the sources of mass violence; violence prevention; and training on how to identify someone who may be struggling and needs help.
- Different leadership roles for philanthropic organizations were discussed including their ability to serve as facilitators, to identify community leaders for training, or to fund community toolkits that can be disseminated.
- It's important to engage in fiscal administration planning in order to ensure that there are efficient mechanisms to distribute funds, including extensive donations likely to be received, following significant disasters or emergencies.
- Participants emphasized that mental health advocacy needs to come from a trusted leader in the community. Leaders can sometimes be uncomfortable talking about mental health issues. Community leaders, including sports celebrities and others who community members may see as role models, can be engaged to be trusted communicators.
- Many private corporations are well schooled in active shooter events and provide help for people with mental health needs. Community agencies can collaborate with corporations to share resources and expertise.
- The mass violent event at Sandy Hook was discussed. Children will need support for the rest of their lives. The longevity of the support needed and the associated issues for the victims are also issues for the whole community.

- The American Red Cross shared about the program [Ready When the Time Comes](#) that they administer through corporations and improves corporate citizenship, trains employees from partnering corporations, and mobilizes them as a community-based volunteer force when disaster strikes. There was discussion about whether universities could offer a certification for *Ready When the Time Comes*, how mental health professionals can be ready when the time comes, and how to enhance a larger cadre of mental health professionals to be knowledgeable and skilled in disaster behavioral health.

Key Feedback Themes:

Community and Culture: *How community gets defined and how race, class, language, and culture impact resilience were concepts that need further discussion.* Throughout the day, participants discussed the idea of community, who gets to define what a community looks like, and how to reach out to various parts of communities. How one defines community is important, especially when trying to identify partners to support community resilience. The impacts of race, culture, and class in a community were described as important influences on a community's ability to be resilient and ability to be responsive to incidents. Limited language access was identified as a significant barrier to community members fully engaging and receiving important services and information to help support resilience and overall healing and recovery.

Messaging: *How preparedness or recovery messages are created, what is included in the message, and who communicates these messages to the community during disaster preparedness, response and recovery phases is important.*

Participants stressed that the credibility of the messenger is important, and use of a trusted source (e.g. faith leaders, local community leaders and elected health officials) in the community is most effective in getting the message accepted by the community. Existing social networks and NGO networks can be leveraged to send messages. Participants noted that the use of social media and regular media for relaying messages needs to be well managed. Translation of technical knowledge to language that all audiences can understand is also critical for effective message delivery.

Behavioral Health: *Behavioral health, disaster behavioral health, and in particular what it means to be trauma-informed, needs to be better understood.* Participants felt that those who engage individuals to provide services in a traumatized community should consider how training to those service providers is given and what the training consists of so that any services provided to the community are appropriate and trauma-informed. Participants emphasized that there needs to be more of an effort into incorporating preparedness and behavioral health into the tools used in a more integrated manner. Public health, emergency management, and funders can take advantage of naturalistic opportunities that occur and bring up behavioral health issues when gathering to discuss other related health or emergency topics.

Strategies: *Meeting participants suggested numerous strategies and ideas for enhancing community resilience.* The following are some identified strategies that communities, funders, and emergency planners should consider:

- Build relationships prior to incidents. Establish and improve connectivity with a wide range of partners at the local, state and federal levels that can contribute to preparedness and planning efforts for emergencies or disasters.
- Consider generational impacts versus short-term impacts when developing community policies, programs, and services.
- Learn from experience. Participants discussed the importance of taking advantage of unexpected or emergent opportunities to collaborate and capture the lessons learned to be used to inform how preparedness and response strategies translate to other public health issues.
- Take advantage of opportunities to bring up behavioral health issues when discussing other aspects of an incident.
- Use children’s based programs to engage populations that may be difficult to reach (e.g. adults and veterans).
- Consider rural and small community models when seeking innovation and creative resource utilization as large scale city models may not be suitable or effective for smaller localities.
- Prioritize hospital coalition pre-event planning as well as hospital and public health agency crisis communications planning.
- Seek the assistance of private organizations with internal resources such as emergency action plans, employee assistance programs, disaster coordinators, and fire coordinators, that can engage in planning with community leaders and potentially make assets available to help the larger community in time of disaster or emergency.
- Bring philanthropy groups into the discussion about how funding gets utilized. Foundations that provide money to response and recovery organizations are sometimes not being engaged when money is turned back into the community.
- Be aware that the term “resilience” may have different meaning for different people or may not be a well- received term.

- Assess community specific risks and integrate recovery and health resilience planning into existing planning efforts.

Evaluation Results

- Ninety-four percent of respondents agreed that the meeting fulfilled their reason for attending and that the meeting should be repeated with new participants. Respondents primarily indicated future interest in attending in-person meetings on the topic and joining a newly formed listserv for meeting participants and partners to share information and resources. Respondents stated they plan to disseminate the meeting report and outcomes to grantees, stakeholders and partners and to reach out to local groups that they learned about to explore partnership opportunities.
- Eighty-two percent of respondents agreed that the new information they learned at the meeting was about potential partners to engage in order to enhance disaster resilience. About half of the respondents learned about strategies to enhance disaster resilience and new information about disaster behavioral health. Some respondents added on the survey additional areas they felt they had learned new information about, such as: strategies for coordinating disaster recovery efforts; philanthropic connections, roles and partnerships; a more realistic understanding of how non-federal actors view disaster resilience; and the role of foundations in disaster relief.

Potential Opportunities and Suggestions for Future Collaboration

Plan or Participate Additional In-Person Meetings: Attendees stressed the value of meeting in-person to build and strengthen relationships. A *“Meeting in a Box”* could be developed and adapted from the October 5th meeting based upon feedback and modified to be easily implemented regionally or locally. Participants suggested that the meeting be replicated with the ASPR Regional Emergency Coordinators (RECs) and Regional Association of Grant Makers (RAGs). The meeting agenda, breakout session descriptions, and scenarios with facilitator guides could be provided. ASPR along with some of the meeting participants could develop video presentations to be shown at regional or local meetings to ensure consistency..

Promote Cross-Disciplinary Information Sharing: Meeting attendees came from various disciplines and with different affiliations and attend different conferences and educational opportunities. Participants encouraged one another to share collaboration opportunities and learning venues, so that they can become familiar with a broader array of partners and share ideas.

Conduct a Needs Assessment/Analysis: Participants recommended a needs analysis be conducted to determine what people don't know and what they need to know about disaster resilience at a local level, as well as what current perceptions exist and what types of connections are needed to facilitate better community resilience.

Utilize Local Funders as Conveners and Connectors: Attendees stressed that engaging with local funders is not only about fundraising. National stakeholders can approach local funders that know community stakeholders and their needs so that federal, state and local public health officials can implement locally based strategies to foster resilience.

Build a Community of Interest: Participants expressed interest in continuing the conversation through development of a community of interest for ongoing dialogue. A web-based mechanism could be developed for ongoing communication and sharing of resources and information, including details about upcoming meetings and opportunities to collaborate.

APPENDICES:

Appendix 1: 25
Appendix 2: 26
Appendix 3: 34

Appendix 1

The Office of the Assistant Secretary for Preparedness and Response (ASPR):

ASPR was created under the Pandemic and All Hazards Preparedness Act after Hurricane Katrina to lead the nation in preventing, preparing for, and responding to the adverse health effects of public health emergencies and disasters. ASPR focuses on preparedness planning and response; building federal emergency medical operational capabilities; countermeasures research, advance development, and procurement; and grants to strengthen the capabilities of hospitals and health care systems in public health emergencies and medical disasters. ASPR provides federal support, including medical professionals through the National Disaster Medical System, to augment state and local capabilities during an emergency or disaster.

The Division for At-Risk Individuals, Behavioral Health and Community Resilience provides subject matter expertise, education, and coordination to internal and external partners to ensure that the functional needs of at-risk individuals and behavioral health issues are integrated in the public health and medical emergency preparedness, response, and recovery and policy activities of the nation to facilitate and promote community resilience and national health security.

The National Health Security Strategy (NHSS) provides strategic direction to ASPR and other agencies to ensure that efforts to improve health security nationwide are guided by a common vision; based on sound evidence; and carried out in an efficient, collaborative manner. ASPR developed the NHSS in collaboration with a broad range of stakeholders, including representatives from local, state, territorial, tribal, and federal governments; community-based organizations; private-sector firms; and academia. National health security is a state in which the nation and its people are prepared for, protected from, and resilient in the face of incidents with health consequences. The NHSS provides a framework to build community resilience, strengthen and sustain health emergency response systems, improve capabilities, and prioritize resources on current and future budgets.

Grantmakers In Health (GIH):

GIH is a nonprofit, educational organization dedicated to helping foundations and corporate giving programs improve the health of all people. Its mission is to foster communication and collaboration among grantmakers and others, and to help strengthen the grantmaking community's knowledge, skills, and effectiveness. GIH generates and disseminates information about health issues and grantmaking strategies that work in health by offering issue-focused forums, workshops, and large annual meetings; publications; continuing education and training; technical assistance; consultation on programmatic and operational issues; and by conducting studies of health philanthropy. GIH brokers professional relationships and connects health grantmakers with each other and with grantmakers in other fields whose work has important implications for health.

Appendix 2

Attendee List

[Diane Ashton, MD, MPH](#)

Deputy Medical Director

March of Dimes

Email: DAshton@marchofdimes.org

[Harvey Ball, MS CCC-SLP, MPH](#)

CDR, U.S. Public Health Service

Senior Public Health Advisor, Operations Team Lead

Division for At-Risk Individuals, Behavioral Health, and Community Resilience

Office of the Assistant Secretary for Preparedness and Response

U.S. Department of Health and Human Services

Email: harvey.ball@hhs.gov

[Laura Biesiadecki](#)

Director

National Association of City and County Health Officials

Email: lbiesiadecki@naccho.org

[Nikki D. Bellamy, PhD](#)

Public Health Advisor

Center for Mental Health Services, Prevention, Traumatic Stress, and Special Programs

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

Email: nikki.bellamy@samhsa.hhs.gov

[Mary Casey-Lockyer, MHS, BSN, RN, CCRN](#)

Senior Associate for Disaster Health Services

Disaster Health Services Program Development

American Red Cross

Email: Mary.CaseyLockyer@redcross.org

[Christine Cichetti](#)

Senior Behavioral Health Policy Advisor
Department of Health and Human Services
Office of the Assistant Secretary for Health
U.S. Department of Health and Human Services
Email: Christine.Cichetti@samhsa.hhs.gov

[Valerie Cole, PhD](#)

Manager
Disaster Health Services and Disaster Mental Health, Program Development
American Red Cross National Headquarters
Email: valerie.cole@redcross.org

[Steve Curren, MSFS](#)

Acting Director, Resilience and Infrastructure
Office of Emergency Medicine
Office of the Assistant Secretary for Preparedness and Response
U.S. Department of Health and Human Services
Email: Stephen.Curren@hhs.gov

[Daniel Dodgen, PhD](#)

Director
Division for At Risk Individuals, Behavioral Health, and Community Resilience
Office of the Assistant Secretary for Preparedness and Response
U.S. Department of Health and Human Services
Email: Daniel.Dodgen@hhs.gov

[Darrin Donato](#)

Senior Policy Analyst
Division for At-Risk Individuals, Behavioral Health, and Community Resilience
Office of the Assistant Secretary for Preparedness and Response
U.S. Department of Health and Human Services
Email: Darrin.Donato@hhs.gov

[Nicole Dreisbach, MPH](#)

Program Director, Children, Families, Population Health
Grantmakers In Health
Email: ndreisbach@gih.org

[Jessica Fantinato, MS](#)

Deputy Director
Office of Emergency Management
Office of the Assistant Secretary for Preparedness and Response
U.S. Department of Health & Human Services
Email: Jessica.Fantinato@hhs.gov

[Alyson Ferguson, MPH](#)

Director of Grantmaking
Thomas Scattergood Behavioral Health Foundation
Email: aferguson@scattergoodfoundation.org

[Edward J. Gabriel, MPA, EMT-P, CEM, CBCP](#)

Principal Deputy Assistant Secretary
Office of the Assistant Secretary for Preparedness and Response
U.S. Department of Health and Human Services
Email: Edward.Gabriel@hhs.gov

[Roberto C. Garza, MPH, MPA](#)

LT, USPHS Commissioned Corps
Planning & Training Team Lead
Office of Human Services Emergency Preparedness and Response
Administration for Children and Families
U.S. Department of Health and Human Services
Email: Roberto.Garza@acf.hhs.gov

[Cynthia K. Hansen, PhD](#)

Senior Advisor, National Healthcare Preparedness Programs
Office of Emergency Medicine
Office of the Assistant Secretary for Preparedness and Response
U.S. Department of Health and Human Services
Email: Cynthia.Hansen@hhs.gov

[Jack Herrmann, MEd, NCC, LMHC](#)

Senior Program Officer
Board on Health Sciences Policy, Institute of Medicine
The National Academies of Sciences, Engineering, and Medicine
Email: jherrmann@nas.edu

[Tala Hooban, MPH, CHES, CPH](#)

LCDR, USPHS Commissioned Corps
Preparedness & Community Resilience Team Lead
Office of Human Services Emergency Preparedness and Response
Administration for Children and Families
U.S. Department of Health and Human Services
Email: Tala.Hooban@acf.hhs.gov

[Lisa Kaplowitz, MD, MSHA](#)

Deputy Assistant Secretary
Office of the Assistant Secretary for Preparedness and Response
U.S. Department of Health and Human Services
Email: Lisa.Kaplowitz@hhs.gov

[Elleen Kane, MA](#)

Public Affairs, Specialist
Office of the Chief Operating Officer
Office of the Assistant Secretary for Preparedness and Response
U.S. Department of Health and Human Services
Email: Elleen.Kane@hhs.gov

[Rachel E. Kaul, LCSW, CTS](#)

Senior Public Health Analyst
Division for At-risk Individuals, Behavioral Health and Community Resilience
Office of the Assistant Secretary for Preparedness and Response
U.S. Department of Health and Human Services
Email: Rachel.Kaul@hhs.gov

[Kathy Ko Chin, MS](#)

President & CEO
Asian & Pacific Islander American Health Forum
Email: kkochin@apiahf.org

[Kimberly Konkel, MSW](#)

Associate Director for Health
Center for Faith-based and Neighborhood Partnerships
U.S. Department of Health and Human Services
Email: Kimberly.Konkel@hhs.gov

[Nicole Lurie, MD, MSPH](#)

Assistant Secretary for Preparedness and Response
Rear Admiral, U.S. Public Health Service
U.S. Department of Health and Human Services
Email: Nicole.Lurie@hhs.gov

[Gregg S. Margolis, PhD, NRP](#)

Director
Division of Health System Policy
Office of the Assistant Secretary for Preparedness and Response
U.S. Department of Health and Human Services
Email: Gregg.Margolis@hhs.gov

[Patricia N. Mathews](#)

President & CEO
Northern Virginia Health Foundation
Email: pmathews@novahealthfdn.org

[Timothy M. McCue, MPH](#)

Director of Grant Programs
Potomac Health Foundation
Email: timothy@potomachealthfoundation.org

[Moira G. McGuire, RN-BC](#)

CAPT, U.S. Public Health Service
Assistant Chief, Integrative Health & Wellness
Walter Reed National Military Medical Center
Email: moira.g.mcguire.mil@mail.mil

[Faith Mitchell, PhD](#)

President & CEO
Grantmakers In Health
Email: fmitchell@gih.org

[April Naturale, PhD](#)

Senior Technical Specialist, Education, Community and Social Program

ICF International

Email: april.naturale@icfi.com

[Robert Ottenhoff, MA](#)

President & CEO

Center for Disaster Philanthropy

Email: Bob.Ottenhoff@disasterphilanthropy.org

[Mili Patel, JD, MPH](#)

Public Health Analyst

Division for At-risk Individuals, Behavioral Health and Community Resilience

Office of the Assistant Secretary for Preparedness and Response

U.S. Department of Health and Human Services

Email: Mili.Patel@hhs.gov

[Esmeralda Pereira, MS](#)

Director of Recovery Coordination

Office of Emergency Management

Office of the Assistant Secretary for Preparedness and Response

U.S. Department of Health and Human Services

Email: Esmeralda.Pereira@hhs.gov

[Alison Perencevich, MPH](#)

Program Director, Behavioral Health and Integrative Health

Grantmakers In Health

Email: aperencevich@gih.org

[Jeremy Richman, PhD](#)

Founder & CEO

Avielle Foundation

Email: jeremy.richman@aviellefoundation.org

[Mary Riley, MPH, RN, CPH](#)

CAPT, U.S. Public Health Service
Director
Office of Human Services Emergency Preparedness Response
Administration for Children and Families
U.S. Department of Health and Human Services
Email: Mary.Riley@acf.hhs.gov

[Shulamit Schweitzer, MHS](#)

Senior Management Analyst
GAP Solutions, Inc. Contractor Supporting:
Division for At-Risk Individuals, Behavioral Health, and Community Resilience
Office of the Assistant Secretary for Preparedness and Response
U.S. Department of Health and Human Services
Email: Shulamit.Schweitzer@hhs.gov

[Terri Spear, EdM](#)

Emergency Coordinator
Substance Abuse and Mental Health Services Administration
Email: Terri.Spear@samhsa.hhs.gov

[Rob Tosatto, RPh, MPH, MBA](#)

Captain, U.S. Public Health Service
Director, Medical Reserve Corps Program
Partner Readiness and Emergency Programs Division
Office of Emergency Management
Office of the Assistant Secretary for Preparedness and Response
U.S. Department of Health and Human Services
Email: Robert.Tosatto@hhs.gov

[Cole Weeks, LCSW, BCD](#)

CDR, U.S. Public Health Service
Deputy Director
Office of Human Services Emergency Preparedness and Response
Administration for Children and Families (ACF)
U.S. Department of Health and Human Services
Email: Cole.Weeks@acf.hhs.gov

[Darielis Williams, MEHS](#)

LT, U.S. Public Health Service
Recovery and Operations Lead
Office of Human Services Emergency Preparedness and Response
Administration for Children and Families (ACF)
U.S. Department of Health and Human Services
Email: Darielis.Williams@acf.hhs.gov

[Laura Kwinn Wolf, PhD](#)

Acting Branch Chief
Critical Infrastructure Protection
Office of Emergency Management
Office of the Assistant Secretary for Preparedness and Response
U.S. Department of Health and Human Services
Email: Laura.Wolf@hhs.gov

[J. Christie Wrightson, MSW, LICSW](#)

Senior Associate, Disaster Mental Health, Program Development
American Red Cross National Headquarters
Email: christie.wrightson@redcross.org

[Janet Zeis](#)

Volunteer Management Coordinator
Chester County Department of Emergency Services
Email: jzeis@chesco.org

Appendix 3

AGENDA

8:30 a.m. – 9:00 a.m.	<i>Registration</i>	Willow Room
9:00 a.m. – 9:05 a.m.	<i>Welcome</i>	Lisa Kaplowitz, M.D., MSHA <i>Deputy Assistant Secretary for Policy Office</i> of the Assistant Secretary for Preparedness and Response U.S. Department of Health and Human Services
9:05 a.m. – 9:20 a.m.	<i>Opening Remarks</i>	Nicole Lurie, MD, MSPH <i>Assistant Secretary for Preparedness and</i> <i>Response</i> U.S. Department of Health and Human Services; Rear Admiral U.S. Public Health Service
9:20 a.m. – 9:30 a.m.	<i>Public-Private Partnerships: Welcoming Remarks from GIH</i>	Faith Mitchell, PhD <i>President and CEO</i> Grantmakers In Health
9:30 am. – 9:40 a.m.	<i>Public-Private Partnership in Disasters & Public Health Emergencies Preparedness and Response</i>	Edward Gabriel, MPA, EMT-P, CEM, CBCP <i>Principal Deputy Assistant Secretary</i> U.S. Department of Health and Human Services

9:40 a.m. – 10:00 a.m.	<i>Overview of the Agenda</i>	Rachel Kaul, LCSW, CTS <i>Behavioral Health Team Lead</i> Office of the Assistant Secretary for Preparedness and Response U.S. Department of Health and Human Services
	<i>Introductions</i>	April Naturale, Ph.D. <i>Senior Technical Specialist</i> ICF International
10:00 a.m. – 10:45 a.m.	<p data-bbox="493 634 756 709"><i>Resilience: Areas for Partnership</i></p> <ul data-bbox="493 751 889 1281" style="list-style-type: none"> <li data-bbox="493 751 889 919">• <i>Rotated Facilitated Table Groups</i> (Participants will rotate through 2 tables at 20 minutes each) <i>Behavioral Health</i> <li data-bbox="493 978 889 1054">• <i>At-Risk Individuals & Social Services</i> <li data-bbox="493 1071 792 1146">• <i>Health Resilience & Recovery</i> <li data-bbox="493 1163 889 1239">• <i>Community Engagement & Preparedness</i> <li data-bbox="493 1255 740 1281">• <i>Health Systems</i> 	Facilitators: April Naturale and Darrin Donato <i>Senior Policy Analyst</i> Office of the Assistant Secretary for Preparedness and Response U.S. Department of Health and Human Services
10:45 a.m. – 11:00 a.m.	<i>Break</i>	
11:00 a.m. – 12:00 p.m.	<i>Resilience: Areas for Partnership (continued)</i>	Facilitators: April Naturale and Darrin Donato <i>Senior Policy Analyst</i> Office of the Assistant Secretary for Preparedness and Response U.S. Department of Health and Human Services
12:00 p.m. – 1:15 p.m.	<i>Lunch</i>	

1:15 p.m. – 2:15 p.m.	<p><i>Disaster Resilience Partnership in Practice: Scenario Sessions 1 & 2</i></p> <p>Facilitated Scenario Exercises – Table Discussions</p> <ul style="list-style-type: none"> • <i>Infectious Disease Outbreak</i> • <i>Natural Disasters</i> <p><i>Mass Violence</i></p>	
2:15 p.m. – 2:30 p.m.	<i>Break</i>	
2:30 p.m. – 3:00 p.m.	<i>Disaster Resilience Partnership in Practice: Scenario 3</i>	
3:00 p.m. – 4:15 p.m.	<p><i>Making Public-Private Partnerships Work: Synthesis of the Day/Next Steps</i></p> <p><i>Large group facilitated discussion</i></p>	<p>Facilitators: Darrin Donato and April Naturale</p>
4:15 p.m.	<i>Adjourn</i>	