National Healthcare Preparedness Programs Teleconference Transcript
Behavioral Health Preparedness for Healthcare Coalitions Webinar

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Operator: Good day, ladies and gentlemen and welcome to the Behavioral Health Preparedness for Healthcare Coalitions conference call. At this time, all participants are in a listen-only mode. Later, we will conduct a question-and-answer session and instructions will follow at that time. If you require any assistance during the call, please press the star, then the zero key on your touchtone telephone. As a reminder, this conference may be recorded.

I would now like to turn the conference over to our host of today's call, Dr. Cynthia Hansen. You may begin.

Cynthia Hansen: Thank you very much, operator and hello to everyone joining us today for this call hosted by the National Healthcare Preparedness Program. I am Cynthia Hansen and on behalf of Dr. Nicole Lurie, the Assistant Secretary for Preparedness and Response (ASPR), Mr. Don Boyce, the Deputy Assistant Secretary and Director of the Office of Emergency Management and Ms. Jennifer Hannah who is Acting Director for the National Healthcare Preparedness Program while Dr. Marcozzi is deployed, I would like to welcome you to the sixth in the series of technical assistance webinars hosted by NHPP as we fondly call the National Healthcare Preparedness Programs.

Today's topic is integrating behavioral health to strengthen healthcare preparedness capabilities in coalitions, and I am the Senior Advisor to the Division Director of NHPP, as well as a clinical psychologist with decades of experience in public and private sectors, as well as disaster response. So with that in mind, I am really excited to host the speakers on today's call and want to publicly begin by thanking them for their great work and generosity in preparing for this webinar.

They are going to squeeze a lot of information in a short amount of time, so that we'll have time for your questions at the end of the call. So you're also

welcome to type your questions into the chat room of the webinar at any time and we'll respond to them at the end of the call. What's actually most exciting to me about this webinar besides the wealth of information is the real variety of strategies that each jurisdiction is using to integrate behavioral health into all eight healthcare capabilities.

You'll hear from each of them about the added value that representation from the mental health and substance abuse system at the state, local, tribal and territorial levels of government bring to healthcare coalitions. You'll hear about -- oh and Ms. Larkins, could you forward the slide? Great.

You'll also hear about strategies for addressing continuity of operations and surge for behavioral health and substance abuse services, how to incorporate behavioral health into your gap and capacity analyses, particularly looking at behavioral health training programs that addresses both responder safety and health, and public health interventions and identify behavioral health objectives for exercising.

Measurement is so critical. All of the HPP awardees on the call know that one of the budget period 2 program measures is the awardee's recovery plan addresses how it will meet post-disaster, behavioral and mental health care needs of communities. Measuring progress is key to our success. We need to know what we're doing, what we can do better, and when we've achieved a really nice, successful outreach and response and recovery process.

So with that in mind, I know you're all probably sitting there Okay, we get what you're going to say, we want to hear it. We want to go to the practical strategies that you've promised us on the webinar, and in order to do that, I'm going to turn the microphone -- the virtual microphone over to Dr. Dan Dodgen who is the director of the Division for At-Risk Individuals, Behavioral Health, here in the Office of Policy and Planning here at ASPR. Dr. Dodgen?

Daniel Dodgen: Thank you, Cynthia. Thanks to everyone for being on this call. It is really a thrill for us to participate in another call with everyone on the line and I particularly want to thank not only Dr. Hansen but also Dr. Marcozzi for

really just how much you all have really looked to our team, and really even broader than that to make sure that these important issues around behavioral health, at-risk individuals and community resilience are integrated into the work of the program.

And I just want to stress that really, we're on this call today to help you, Cynthia and Dr. Marcozzi in terms of the HPP program and then of course, everyone on the phone which is why you're going to hear a little bit more about us and my team and also how to contact us. We're really here to help you out.

If you go to the next slide, you'll see what we're going to focus on a little bit today which is really about integrating behavioral health into the work of NHPP, particularly around the healthcare coalitions and what are some potential strategies for that, and then also, what are some tools, resources, et cetera that exists at the federal level. And of course, how do we know when we're successful. Now we're just going to begin to touch on that and you'll get the federal perspective from Rachel Kaul and my team, and then of course, the individual speakers are going to talk a lot more about that.

If you go to the next slide, it'll give you a sense of who I am and what this office is that I direct here at ASPR. Really, we are the folks who provide the overarching policy guidance and coordination and subject matter expertise for at-risk individuals, behavioral health and community resilience. And again, all that everyone on the phone needs to know about that is that we are here and that we want to be a help to the degree we can to both HPP staff, and of course, to the grantees as much as we can.

If you go to the next slide, the question here is really a little bit about the rest of my office. Some of you I know on the phone know a little bit about my office and you know some of the work that we do for at-risk individuals and community resilience but really, I just wanted to review this slide to remind you that if we're going to be really successful at making our communities more resilient in the health sector, to have the kind of well-being that enables them to respond to and recover from emergencies more quickly, then we think it’s really critical that not just behavioral health but also, the attention to at

risk individuals be included, and you see a number of examples here in the healthcare special services, recovery planning, neighborhoods, health infrastructure, public education, et cetera.

And that resilient communities clearly are communities that have robust connections within the health sector and then in the broader social services, and even just plain social sector. So those are the kinds of things that we think about in my office.

We're going to be hearing about some state-of-the-art projects here today, but we also welcome for those of you on the call who are doing things in this mission space, who are doing innovative things around behavioral health or at-risk individuals or promotion of health resilience, we would really welcome hearing from you and Rachel is going to give you a means to contact us.

So without further ado, let me turn it over to Rachel Kaul who has been with ASPR for a number of years and before that was at SAMHSA and before that was at the Pentagon helping with crisis response coordination. So she has a wealth of experience in disaster behavioral health. So let me turn it over to Rachel.

Rachel Kaul: Thank you, Dan. Good afternoon, everybody. The one piece of my resume Dan failed to mention was I was a state disaster behavioral health coordinator. I'm going to talk a little bit about those in a moment but it's an important perspective to have. Today however, I do want to talk a little bit about the recent federal efforts that have been underway to promote and facilitate behavioral health inclusion in preparedness activities.

In -- next, yes. In 2008, the disaster mental health subcommittee of the National Bio Defense Science Board noted there was a need for improved coordination of disaster behavioral health activities at the federal level. As a result, ASPR convened an interagency working group comprised of representatives from federal agencies, regional staff and even nonprofit stakeholders, and we created the first national Behavioral Health Concept of Operations (CONOPS).

The first version was released in 2011, and the document intentionally went beyond a traditional CONOPS in that it included conceptual language to frame disaster behavioral health and describe not only federal roles and responsibilities, but also, disaster behavioral health activities carried out at the state and local levels. For example, it does emphasize that the role of the state disaster mental health coordinator in each state is critical and important for public health and emergency management entities to connect with and also, to include for -- to really enhance their disaster preparedness and response efforts.

The CONOPS is recently revised to include lessons learned and practices developed during recent responses such as super-storm Sandy, which is a tongue twister at this point, Sandy Hook and the Boston bombing. What we hope is that it will be a resource for all of you and that the information it contains is going to be valuable to a variety of audiences.

You'll find in it links and information, and one of the links is to a behavioral health capacity assessment tool. There's also multiple resources that you can find there from other partners such as the National Child Traumatic Stress Network, the Red Cross, and of course, SAMHSA. Next slide.

And speaking of SAMHSA, here's some other federal resources that SAMHSA has created recently. I want to particularly point out the disaster behavioral health response mobile app. This is a really interesting application that has the ability to locate mental health and substance abuse providers in a disaster affected area, and it's also going to allow responders to quickly link to and obtain population or event specific resources straight from their phones or tablets.

And another resource I do want to mention that's not on this slide is the disaster distress line which is a toll-free multilingual crisis support hotline available at all times nationwide. The number for that, you may want to take out a pen and write this down is 1-800-985-5990 or you can text "Talk with us" to 66746 or you can look them up online. The site is disasterdistress.SAMHSA.gov. Next slide.

So in spite of the numerous efforts going on at federal, state and local levels, we know that there's more that needs to be done to better include behavioral health in our public health and medical preparedness and response efforts. A recent report was released by the Council of State and Territorial Epidemiologists (CSTE) which highlights how far we have to go. Next slide, please.

The CSTE along with HHS's Centers for Disease Control (CDC) collaborated on a needs assessment project to better understand the relationship between public health and mental health in state health agencies. It had a particular focus on surveillance activities related to mental health during emergency events. Among topics they examined were existing use of state or federal mental health surveillance systems, the extent to which mental health is included in disaster preparedness planning, types of mental health data and assessments needed following a disaster, and barriers to mental health surveillance and the use of mental health surveillance data. Next slide, please.

Their analysis confirms what most of us already know. Effective and comprehensive integration of behavioral health into public health and medical emergency planning is sporadic at best across the nation. The CSTE formulated recommendations as a result of this report, some of which are summarized here, but I encourage you to read the full report.

As we will hear later, deliberate and careful analysis of the capacity of the behavioral healthcare system in your state or locality can provide the kind of information you're going to need to leverage, to promote and highlight the value of putting resources and efforts towards collaborating and including behavioral health into emergency preparedness and planning, and also into your coalitions.

We know this is a key aspect of community health resilience and what we hope is on today's call, you'll get some strategies and insights into how to improve and expand on your current efforts, and to engage with and incorporate behavioral health into your activities. Next slide.

So to conclude, please consider our office a resource for you as well as Dr. Dodgen said. Any member of our behavioral health team would be happy to respond to questions or requests for resources or information, and our contact info is on this slide. So to conclude, just thank you so much for taking the time to consider this topic. I'm going to turn this back over to our moderator and our impressive lineup of speakers.

Cynthia Hansen: Great. Thank you so much, Dr. Dodgen, Rachel. It's great to have this overview and it was an amazing amount of information in a short amount of time. So with that being said, I would like to say that this report that Rachel ended up speaking to, highlights how challenging it can be to connect public health and mental health.

Within the 49 states that responded to the survey, only two states have the same department and division for public health and mental health or substance abuse agencies. So that means you really have to work outside your division, outside your department in order to make these connections real and live and sustainable. So the report is very informative in illustrating how challenging this can be throughout the nation.

With that in mind, I think I'm going to move over to one of the nation -- well, it is the nation's capital, the District of Columbia Department of Health. So they are going to speak about how the -- they're bringing behavioral health to the table of their coalition with value-added for everyone's mission. I'm going to turn the microphone over to Peggy Keller who is the HPP Public Health Emergency Preparedness (PHEP) coordinator for the District Department of Health.

Peggy Keller: Good afternoon and thank you for the opportunity to present today. You can move the slide forward please. A goal of the D.C. Department of Health is to integrate behavioral health planning into all planning and response activities. Move the slide please.

And a great example of that is that during the health and medical planning for the inauguration, the Department of Behavioral Health team was at the table

for all the planning, and Department of Behavioral Health staff even paired with the Secret Service agents on the mall. Move the slide please.

We also incorporate five-star training and disaster mental health components into our preparedness and response -- and resilience training. And to elaborate more on this we're going to -- I'm going to introduce two of our key partners. Move the slide please. Next slide. Craig DeAtley from the Emergency Healthcare Coalition and Kevin O'Brien from the Department of Behavioral Health. Thanks.

Craig DeAtley: Well, good afternoon, everybody. My name is Craig DeAtley and I have the pleasure of serving as the administrator for the D.C. Emergency Healthcare Coalition. As you can see from the slide in front of you, our coalition is a multi-organizational element of our healthcare system that includes all of our 12 hospitals, all of our 49 clinics, all of our 20 skilled nursing facilities, all 12 of our dialysis centers, all 9 of our blood banks, our poison control center and several others not shown on the slide itself. So that's the private sector membership.

But equally important to the coalition function is having our government partners which do include both the Department of Health as well as the Department of Behavioral Health services among others. Our particular coalition has been around since 2006, getting off to a rather robust start with coalition start up money in that year. And early on from our inception, we wanted to see ourselves as both the planning organization, as well as the response organization and we realized that if we were to meet the needs of both planning and responding, that we needed to be as inclusive as possible.

And within that concept was a recognition that we could put it all of the staffing and all of the material items that a community could muster together to respond to the physical aspects of a disaster, but no less important was our commitment to trying to address the behavioral health aspects at the same time.

So with that practice in mind, two years ago, we formed as part of our grant deliverables for that particular year, a behavioral health task force. And that

task force was composed of representatives from our skilled nursing facilities, from our hospitals and from the Department of Health, as well as from Kevin's department, the Behavioral Health Department.

Among the objectives that we undertook wasn't simply to better understand the issues, but in the end, we made a commitment to try and establish a more standardized method of planning across all of our healthcare system. And that was in the end, going to lead to a behavioral health planning template that would be given to all of our facilities regardless of what their mission was.

And through standardization, through concept commonality and through implementation across the spectrum of our facilities, we would achieve not simply standardization, not just better understanding but we would better be able to utilize the behavioral health resources that we had in this community, whether it be private sector-based or public safety-based.

Besides that particular accomplishment, one of the other commitments that we've made is to try and better understand the unique aspects of behavioral health as a component of responding to whatever type of mass casualty or mass effect type of incident the community might encounter. So towards that end, we began looking for what educational programs can we provide, not simply to the public, they were truly important, but no less important was for our individual clinical and nonclinical personnel at our respective healthcare facilities to understand the issues and being better prepared to respond to them as well.

And in responding, we not only wanted to focus on taking care of the patients, but we wanted to be better able to take care of ourselves as well. So last year as part of our deliverables, we sought the services of Chip Schreiber and you'll hear more about the PsySTART program, as well as psychological first aid from a subsequent presenter, but we've embraced that not just last year, but we will be bringing him back to provide further education across a wider spectrum of our healthcare community before this current grant period is over. Next slide please.

In so far as the efforts by the coalition are concerned, we tried to focus in that planning template on a variety of issues that one might encounter that would constitute a mass casualty or a mass effect type of a situation. And we recognize that, depending upon that situation, the circumstances, the behavioral health issues could vary depending upon what that circumstance was but whatever it was going to be in the end, it was going to be a community that was going to seek assistance from the healthcare facilities, as well as from the D.C. government and, in particular, the Department of Health and the Department of Behavioral Health.

In our community like many of yours, it's the Department of Behavioral Health that's the lead agency for coordinating all of our behavioral health support systems. And so one of our concerted efforts, particularly over the past two years, is to link as closely as possible with that particular department and through the leadership that Kevin O'Brien, Dr. Kevin O'Brien has shown on their behalf.

Besides having the template available at each facility to use and have some degree of standardization, we've also tried to, as I've mentioned, provide training and education, and expand that training and education not simply for the clinical personnel but to include some nonclinical personnel that would benefit at the same time. Next slide.

Kevin O'Brien: This is Kevin O'Brien. I appreciate the opportunity to speak as well. I want to just say that I know that there's a lot of good work going on in a lot of the other states and the District of Columbia is pleased of the fact that the partnership that we have with the Department of Health, as well as the Emergency Healthcare Coalition. Disaster behavioral health in the district involves both mental health, as well as substance abuse, misuse and basic stress management.

It's an evolving field and we are working on two fronts. One is incident management, and the other is support of vulnerable population. We have done training with the Department of Health for a variety of organizations and providers, both young people, older adults, community service groups, as well to just orient them to what mental health needs are following a disaster. The

behavioral health factors, as Rachel had said earlier, directly and indirectly influence both individual community risks, health resilience, and actually the success of emergency response strategies.

Many of you know that people don't seek out behavioral health services following a disaster. So during the initial phases of behavioral health response, we use an outreach model and that involves a lot of the preparation that we do to help the community become more aware of it. The context of services is actually a myriad of interactions with a number of different jurisdictions.

We recognize that individuals are going to be displaced, they're going to be separated from the common supports that they have and there's going to be some sort of difficulty in terms of communication with information about what to go on. And we also recognize that responders themselves are at risk.

So we do two things in our trainings. One is we provide an overview of behavioral health needs assessment and triage and Craig had already mentioned that we have adopted the PsySTART model for use in the healthcare facilities but we're also training all of our responders in the PsySTART model, and we also work on targeted interventions for some of the vulnerable populations that have been affected.

We have a certification program for disaster behavioral health responders. As Craig had mentioned earlier, the Department of Behavioral Health is the agency that is responsible for the behavioral health response, so we are aware that in a high surge situation, we're going to have to provide many more responders to hospitals and other facilities so we have a two-day training program, as well as background checks and interviews, and we are working now to pretty much triple the number of responders we have available.

In addition to that, we recognize our work with vulnerable populations both in terms of training but also, we are aware that many of the people who are seriously mentally ill or vulnerable populations, so we have done a lot of work with our provider agencies in terms of training them for their continuity of operations so that if a disaster strikes, that population won't necessarily be

surged to hospitals or other situations but the facilities and the training will continue.

So we have not only developed a template for our continuity of operations (COOP) plans but also have done training. And actually, because of the training, the successful training, some of our residential group homes that house seriously mentally ill people have gotten the grant to put a standby generator in place so that they will not have to be moved. Next slide.

It's pretty obvious that the psychological footprint is larger than the medical foot print. In the 1995 Sarin attacks in Tokyo, there were 978 people hospitalized, 63 injured and 12 people died, but over 4,000 people showed up in emergency rooms directly following the attack. In addition, many of you remember the 2001 anthrax attacks here in the Washington area. There were five people dead and 17 people were actually affected, but there were thousands of people seeking treatment in hospitals and emergency rooms throughout the area.

It's not just the media or vicarious trauma that affects the size or the geographical impact of a disaster but we generally assume that for every mortality, 8 to 10 people are directly affected and they're not all in the same area. The psychological and behavioral treatment goes for days and months and years afterwards. Research has shown, and it's pretty obvious, the link of exposure to trauma and other health-related concerns it increased costs and the need for care.

We also have come to see in our work with the healthcare coalition with the Department of Health that responders too can be affected. The trauma affects both individual and families, but also the community as a whole. This is true for also families and healthcare facilities. Incident management goes on for years afterwards. That's all, and I think we're going to take questions at the end.

Cynthia Hansen: Thanks, Dr. O'Brien. And Peggy, I will turn back to you for additional comments from the D.C. Department of Health. Peggy, are you on mute?

Peggy Keller: Yes, I'm sorry. Okay, that's fine. Thank you.

Cynthia Hansen: So did you have any additional comments to add to Craig and Kevin's presentation? All right. Well, great. Well, we'll just move on then which will be wonderful to move on to the Los Angeles County Department of Health Services, the Emergency Medical Services Agency with our speaker, Sandra Shields. What's really noteworthy as you look at the titles on the agenda is how – how differently housed, as it were, what different organizational structures you can find this work being done.

And I think as Dr. O'Brien mentioned, throughout the country, there's some great work being done in a variety of the different areas and so, this is a chance to highlight a few of them but we're looking forward to hearing from others who are doing great work around the country as well. So with that in mind, I will turn the microphone over to Sandra Shields.

Sandra Shields: Well, thank you so much, Cynthia. I really appreciate on behalf of Los Angeles County, the opportunity to present to you all, some mental health, behavioral health initiatives that we've been able to accomplish because of the HPP grant funds. One of the things that you should know is Los Angeles County is a direct recipient of HPP funding along with Washington D.C., New York and Chicago.

So we really have been able to accomplish many things with our stakeholder group and I'm really hoping that what I present today would be helpful to everybody who's listening. And the other thing I want to make you aware of too is that as I'm going through my PowerPoint, you'll notice that there's a lot of links to various things that I'm going to be talking about.

So there's plenty of opportunity to, even though I'm just hitting the wave tops here this afternoon, there's plenty of opportunities for you to click on those links, to look more at what those materials are. Certainly, you can ask questions at the end of webinar or contact me directly and I'll do whatever I can to help you move your behavioral health, mental health planning forward.

So Los Angeles County has done a lot of things in terms of mental behavioral health since the very, very beginning of our grant program. There's a -- they hired me, which I think is a great thing. I'm the first mental health professional ever to be hired by the EMS agency to work on these things.

And we started our planning effort with working with RAND and some key stakeholders, including our Department of Mental Health and Public Health which are separate departments in Los Angeles County, and we developed a basic training called "Preparing hospitals and clinics for the psychological consequences of a terrorist incident or other public health emergency," and this basic training, which can be accomplished in about two hours is, really talks about how to integrate mental health within your disaster planning in the hospital and clinic setting and that was really -- that's been very, very helpful.

And within that training is something called a Repeat tool which is really our disaster planning template. So if a hospital or clinic is planning for the psychological consequences for a disaster, both for the staff and the surge of patients that Dr. O'Brien was so good to talk about, what are the things do they need to have in their disaster plan? So that's what the Repeat tool is, and you can download those training materials from our website.

Certainly, we worked with some key recommendations when we're -- we were doing this training that sort of started -- it was the starting place for integrating behavioral health. We encouraged everyone to add mental health professionals and their -- certainly, their chaplains into their disaster planning team, which in some cases hadn't been done before. We wanted them to work with HICS, hospital incident command, to pre-identify mental health staff or behavioral health staff to staff those positions at HICS that are responsible for mental health for staff and patients.

And certainly, if they needed to recruit a disaster preparedness team or disaster mental health response team, we wanted them to do that ahead. And most importantly, we wanted them to include the surge of psychological casualties in their disaster exercises. Next slide.

So I wanted to make you aware of how we vet these various initiatives that we are working on. We do have a disaster health advisory committee that's been existing since the beginning. We have about 88 hospitals and about 33 clinics that are represented within our HPP program, and we have representatives that come to our advisory committee. Certainly, we always have representation from the county Department of Mental Health and Public Health. And of course, they have dialysis long-term care, hospice, ambulatory surgery centers that meet with our group.

So we meet quarterly but in addition to that, we have stakeholder groups that we pull together when we need to and we go to our Disaster Resource Center group which, there's 13 lead hospitals in 10 geographical locations in Los Angeles and a lot of other hospitals and other healthcare providers who meet more regularly with those lead hospitals. And we work with our DRC group and when we need to bring up the stakeholder group, we ask for them to recommend social workers, other psychologists, behavioral health, mental health staff and chaplains to come and work with us.

So after we -- next slide. Go ahead and turn the next slide. So after we developed that initial work, we began to work with Dr. Chip Schreiber from UC Irvine and developed a number of things, integrating the PsySTART disaster mental health triage within our hospital and clinic settings. And we did some things there in terms of starting out with sort of a pilot group, a small group of hospitals and clinics and then sort of expanding that out.

We also developed, as a result of working with integrating PsySTART, one of the things our stakeholder groups mentioned to us is they wanted a tool for the care of staff following a disaster. So we developed a staff resiliency system called Anticipate Plan and Deter that I'm going to talk to you about. We've developed a CONOPS. We've developed an exercise plan that helps to build a practice, the various tools that we have been working on and certainly, we are working on our sustainability plan.

And one of the things that I wanted to mention is, as we were in the process of developing these various things from the beginning, and especially initially when I start to teach the psychological consequences training, the reaction I

got was that -- to that surge of -- the idea of that surge of psychological casualties to the hospital setting, it was kind of yeah, yeah, like that will really happen. And then we had H1N1.

And everyone started surging to the hospitals asking for Tamiflu and the hospital got to experience what that surge actually looks like, and we actually had a surge of people coming to the hospitals after the earthquake in Japan, thinking that they had been exposed to radiation. So now, I'm happy to report that because of H1N1 and these other situations that I -- I'm sort of preaching to the converted a little bit more than I was in the beginning. So next slide.

So this slide just shows you a picture of the things that you're going to find on our website, our Concept of Operations, our exercise guidebook where we practice our -- are the tools we've developed. The Anticipate and Plan and Deter which is the healthcare worker resiliency training that we have, plus a little picture of what PsySTART looks like. We -- you can use it through your phone, a laptop, a tablet and to enter the triage data.

And then also, it gives you an overall view of where the psychological casualties are by which hospital, which clinic and what the elements of the surge that we're experiencing, what exposure people have had and that's an excellent planning tool that we can use in the county to make some strategic plans during a disaster and following it for the community in terms of how we're going to respond with mental health. Next slide.

So one of the things I really wanted to mention is this Anticipate, Plan and Deter, the -- which is our training that we use for healthcare workers prior to a disaster, and then you can certainly can do it during a disaster as well. And again, this tool was -- grew out of our stakeholder group, really wanting something to take care of staff better.

I think when we're preparing for disasters, I think we really need to own the fact that our staff is going to be impacted by that disaster, and rather than waiting for them to be impacted following the disaster, we need to do something ahead of time to develop resiliency. So this is a brochure and there's a training that goes with the brochure. It's for -- and we go out to the

hospitals and we also do train the trainers so the hospitals can do this for themselves, but it's a one-hour training.

People could do the training and they can write in their various responses. And really, the role -- the goal is for people to develop a coping plan for a not the normal day in the hospital situation, disaster with mass casualties, and to have that in mind prior to the disaster. There are some -- also some other tools that go along with this in terms of monitoring tools that supervisors can use to monitor what their staff was exposed to. There's multi-day forms where staff can sort of -- can look at what they've been exposed to. And again, it helps with facility planning in terms of what's a good response to support staff following a disaster. Next slide.

There some other resources that I want to make you aware of that we have on our website that might be helpful to you, that you can download and use. We've developed a mass fatality management guide for healthcare entities. There was a wide stakeholder group that developed this guidebook. It's very easy to use and adapt. It's in PDF, plus Word so you can absolutely adapt it. We work very closely with our Coroners Department, as well as Department of Mental Health and Public Health and our hospitals and clinics, and other healthcare partners. So I think that'll be useful for you.

The other thing is we developed a Family Information Center guide for our healthcare community, and this is really a planning guide to help hospitals and clinics to bring up like a family assistance center, family information center within the hospital setting, what they would do so that family members can wait comfortably, what would they do with the care of children, maybe unaccompanied minors.

Also within this plan, we use our Ready Net system which is our messaging system that we use with all of the hospitals and clinics, and healthcare -- various healthcare partners so that if a family comes into one hospital and their family member isn't there, then we can use that messaging system to locate their family member in another hospital so that they don't have that dynamic of going from hospital to hospital looking for family members. We think that's very important.

The other thing that's on this slide is that the California Hospital Association has been very proactive with mental health and behavioral health. It's very important to them. They have a number of mental health resources on their website that may be helpful for you and your coalition. Next slide.

The other thing that we did in California is again, this is a state-led initiative with a lot of stakeholders statewide, to develop a framework for mental health/behavioral health planning. And this is another thing you can download and use, and the way that this guide is organized is it's by disaster planning cycle. So it's mitigation, preparedness, response and recovery, and there's all sorts of ideas in that framework. Each section has recommended actions that you can actually consider with your stakeholder group in terms of how to move mental health/behavioral health planning forward in your jurisdiction. So I hope that's helpful for you too. Next slide.

What I want to talk to you about now is sort of some challenges and recommendations of things that we've learned here in Los Angeles County that I hope are going to be helpful for your stakeholder group in your jurisdiction. The one thing I -- the first thing I want to say is kind of a statement of the obvious, is that disaster mental health planning is still kind of the caboose on the train when it comes to disaster planning.

And so, you will experience what we have experienced which is some of our hospitals and clinics are very gung ho. They really want to participate, and others haven't started yet. So we continue to encourage. We continue to do training, and hoping to -- continuing to get other people to participate, but it's sometimes a little bit of an uneven process. And so, you should be aware of that.

The other thing that you need to know is that what really worked for us is to start with some basic training. So that RAND training that we developed was really helpful in terms of beginning the conversation about how you integrate mental health into a hospital and clinic setting, what do you need to have in your disaster mental health or in your plan, your facility plan to make sure that

mental health is covered for patients and staff, and starting with that basic training I thought -- I think was really successful for us.

The next thing I wanted to tell you is that staff resiliency, if you -- developing that Anticipate, Plan and Deter really got more stakeholders interested in what it is that we were going to -- we've been doing. If you offer something that takes care of staff and helps staff, then often, that's the hook that helps people feel motivated to participate because they realize, there's something that you're going to do for their staff.

Another hook has been that the trainings that we have developed, the various things that we've done with PsySTART really has a -- provided a way for mental health and spiritual care staff to be involved in disaster planning. And PsySTART has allowed them to have a bigger, more visible role in disaster planning and response. And so that's been really helpful also. Next slide.

So another thing too is that you really need to develop sort of a champion for disaster mental health within the facilities that you're working with. Somebody has to be sort of the true believer that will help move that planning forward, who gets the kinds of things that Kevin was talking about in terms of that surge of psychological casualties, that they get it, they want to move mental health forward.

Facilities -- I found that facilities, hospitals and clinics where there's been some type of a surge of psychological casualties, a shooting for example or something else, they're a lot more willing to participate because they can see the value even more clearly.

Now, there's two things that I want to say now that really are more lessons learned but they're things that I'd like us to think about as a nationwide effort. The first thing is that we really need to have a way to estimate psychological casualty surge as a routine part of our disaster exercises.

So just in every disaster exercise scenario where you see expected physical injuries, we need to at the same time expect to see -- expected what -- a forecast of what the surge of psychological casualties might look like so that

people can begin to consider that surge of psychological casualties when they're doing their disaster exercises on a routine basis.

And I think we'll know that we have success and we have reach in terms of mental health and behavioral health when we start to see scenarios that routinely mention that surge of psychological casualties, and we have some model or some agreed-upon method to forecast what those psychological casualties might be.

Finally, I wanted to talk about the fact that we really need to use whole community planning tools that allow us to have a common operating picture of what's happening with mental health following a disaster, and that's why I really have appreciated and am a believer in the efficacy of disaster mental health triage, the PsySTART triage that's been really helpful. Because not only does it help with site management in determining who to see first, who was most exposed to that disaster but there's a tool that allows you to -- gives you an overall picture by facility in terms of what those -- where those psychological casualties are and what they are experiencing and how those factors are changing over time.

And I think that you -- that helps to get us, mental health, into the planning piece, into incident command in a much stronger way using emergency management language and perspective because we have data, we have surveillance data that we're bringing to our partners that they can look at and consider. And it's without that kind of tool that all we're left with is sort of that, well there's a bunch of upset people out there, which doesn't give us the level of precision or elevates those mental health needs in a way that our disaster response partners can see.

So I really am urging us to have some kind of common way of looking at surveillance and being able to look at what the psychological impact is following a disaster. So that concludes what I wanted to talk about and thank you once again and let me turn it back over to Cynthia.

Cynthia Hansen: Sandra, thank you for such an excellent stimulating presentation. And I remember -- I'm just going to tell everyone on the call, I was asking Sandra

how does she measure success when we were preparing for this call and she said -- she's talking about the reach and the kind of penetration of the training that she referenced in her call.

I am -- after this discussion that she's actually stood up and said let's put a mark on the wall in terms of looking at data around surveillance, looking at how do we anticipate psychological surge and how do we move the literature into a real world planning scenario for an exercise with behavioral health objectives. And so these measures are so critical for us to really get our heads and our hearts around these needs. And thank you very much, Sandra for expressing them so eloquently.

I'm going to move forward because we have another extraordinary speaker, Deborah Arnold from Kentucky who will have a short amount of time to talk about sustainability and the kind of strategies that have bootstrapped on incidents and events that have happened in Kentucky to create a model for behavioral health implementation that is also -- it's a different type of model than you've heard so far. So I'm going to turn the microphone over to Deborah.

Deborah Arnold: Thank you. The previous speakers did a wonderful job giving you all some resources and ideas and materials about getting behavioral health responses integrated into hospitals and clinics. I'm going to speak to a unique perspective that Kentucky has and how we have integrated even further down into other entities and fully into the emergency management and community level.

Some catastrophic events that brought about the creation of my office, which is a state-funded office, happened with -- starting with a horrible bus crash where a drunk driver hit a bus with children in it, 24 children were fatalities and 3 adults. In the following few months, we had a -- an incident where a gentleman returned to his place of employment and he killed 8 coworkers, wounding 12, and out of these tragic instances along with several natural disaster instances, the need for behavioral health or a crisis response team was identified.

And so, a lot of mental health folks got behind that and we actually got in law, a creation of the Kentucky Community Crisis Response Board. And basically, we're a state agency that's responsible to recruit, train, credential and direct the state crisis response team to provide free disaster behavioral health services statewide to any community who is involved in a critical incident or a natural disaster.

So as we moved forward with this, we have integrated behavioral health response services into healthcare coalitions, local emergency management, responder agencies, by taking some following actions. One and very first and primary is cultivating a very strong relationship with our Department for Public Health who, with them, we help them meet the CDC's fifteen public health preparedness capabilities through lots of initiatives, training, community education and planning efforts that we do for them and they in turn give us some wonderful HPP grant funding to help provide our sustainability of staff.

So we've -- in deliverables, do things that have been very positive in creating an awareness of behavioral health needs such as providing free community training programs for providing disaster behavioral health response services at the community level. We work to support the MRC program and providing training to the MRC volunteers. We also support public health events such like a -- we had a mass H1N1 flu vaccination clinic held in Louisville, and 27 of my team members went and provided stress management to all those poor souls waiting for 45 minutes to an hour in a carload of screaming children to get their vaccine.

So we do some positive things to integrate into the system itself. Another key partner for us is Dick Bartlett with the Kentucky Hospital Association. He invites us to participate in the HPP regional leadership meetings which connects us with all our regional HPP folks who then go out to the communities and are represented in those communities, all the coalition members and we have such a wonderful program. Dick is a great leader. Our HPP leadership are phenomenal people, the things they get done in their communities is just amazing.

But through those relationships, we exercise with our hospitals, we exercise with those private and public agencies on a routine basis which then again is getting -- integrating behavioral health services, all the way down into the local level. We also work side-by-side with our sister agency and that's the Department for Emergency Management. With this partnership, we've grown with our understanding and they've grown with their understanding of the importance of having the disaster behavioral health services involved in any incident or disaster that occurs in our state.

They so much support it that when we conduct -- we have 120 counties in the state of Kentucky. Every county has an emergency manager. Any time a new manager comes into a county or is appointed, they have to go through a training at the state level, and we provide a module to those emergency managers on disaster behavioral health services. So they became -- they become acquainted with what the services are, why they are important to have involved in their community occurrences or critical instances. And also, they get familiar with our state team.

Additional funding from the EMPG grant funds also allows me to send a staff member to each one of these 120 counties, and we provide technical assistance and facilitate the integration of a disaster behavioral health response piece to the county's emergency response plan. So fully integrating disaster behavioral health services at the local level into response planning, preparing and then obviously, resiliency and mitigation. So it's been a wonderful opportunity to have the support of our state emergency management department and that's really facilitated I think the growth and acceptance of the disaster behavioral health.

Our crisis response team is not just made up of mental health professionals. We strongly embrace the peer professionals such as law enforcement officers, EMTs, paramedics, dispatchers, coroners, firefighters and emergency managers, et cetera. So with having team members that are amongst the -- all the first responding agencies, we have an opportunity to educate those entities about the importance of having disaster or behavioral health services involved

in supporting our first responders, as well as the communities that are impacted.

So we routinely, as a state crisis response team, respond to critical instances that occur across Kentucky. Some recent events that made national news you all may have heard of is the line of duty death of the Officer Ellis who was shot and killed on his return home from work or the fatality fire where 8 children and their mother perished in a house fire in one of our smaller communities. We provided crisis response services to the first responders, as well as the coroners, the families and the community as they were impacted as well.

We've also developed free pre-incident training for our first responders and deliver that to them which helps prepare our first responders for the emotional impact of doing their jobs which speaks to one of the HPP-- I'm sorry, I just lost my train of thought, -- one of the public health CDC fifteen capabilities of health and safety of our first responders, and we take that very seriously. We need to keep them strong and emotionally in a way to continue on and sustain their efforts in any of these major events that they respond to.

So we talked a little bit about exercising. Exercising is a huge way I think of educating everyone involved in a community of responding in an emergency, all entities about the importance of behavioral health. One of the largest activities we did was when we had a national level exercise in 2011 over the earthquake of the New Madrid fault line. We touched every mental health association in the state and sent out an invite to all mental health professionals to come to strategically placed regional centers where our team provided just-in-time training for disaster behavioral health folks who would be responding in a surge situation and that was to do two things.

One, to get more mental health people aware of -- our professionals -- aware of the need for becoming responders and educated in disaster behavioral health services. And also to ensure that we would have some professionals who, in that big event, like an earthquake here, we certainly cannot meet the surge capacity with our current team members. So we would be looking for those just-in-time folks to come in. So focusing another capability is focused

on recovery and community resiliency, KCCRB is designated as the state mental health authority for the state when declared disasters happen, and so we can apply for the FEMA crisis counseling program grant.

So even when funding is short and you need to have those continued crisis counseling services and there is no state that has this extra funding to provide disaster behavioral health services that are so needed following a major event, you can apply for the CCP grant funding which allows you to provide services for the -- immediate service program of 60 days following a disaster, and then you can apply if the need is still sustained for a regular service program grant for an additional up to nine months.

So we did that in response to our 2012 tornadoes would be the most recent grant that we did, and it probably brought in an excess of almost $700,000 to the state to be able to provide the crisis counseling program to the most impacted communities. So that's another unique way of providing funding and continuing with supporting a community through a bad event and building resiliency that's sustainable for those communities following the end of the grant by using community resources.

Some unique ways we're attempting to meet needs of the at-risk population for delivery of disaster behavioral health services is through providing free training to the AmeriCorps volunteers to -- who already have established relationships in providing services to individuals such as the homeless, youth in lower socio-economic situations, and the elderly. We partner with Counsel for Developmental Disabilities, the Commission of the Deaf and Hard of Hearing, et cetera.

And I know I'm out of time, so I've got to stop but we just -- I'm very excited. I think that in closing, Kentucky has many best practices to share regarding the provision of disaster behavioral services. I'll be happy to share any information I have on how we do that with interested parties and I just want to say thank you so much, Dr. Hansen for allowing me an opportunity to share briefly what we do here in Kentucky.

Cynthia Hansen: Thank you so much, Deborah, again for packing a lot of information into a short amount of time and for being available for calls in -- from the listeners who want more information, really being poised administratively to be able to apply for and receive those crisis counseling programs funds is another piece of the pie of preparedness, that administrative preparedness is as important as content preparedness as we all know.

So our final speaker will be Kathleen Wescott from the Maine CHHS, Center for Disease Control and Prevention Program. So Kathleen, I'm going to turn the microphone over to you. Kathleen, you might be on mute.

Kathleen Wescott: Thank you, Dr. Hansen. I appreciate the opportunity to talk to you a little bit about some of the efforts we've been doing in Maine. On the slide, you can see most of the efforts in 2012 were to really work like many of the other states to provide training opportunities and volunteer management to build up a team of responders that were available throughout the entire state.

The way that our state is organized is we have three regional healthcare coalitions in the North, in the South and the central area, and those are maintained through different hospital triage trauma hospitals there in those particular regions. And so, we try to push out our program working very closely with the healthcare coalitions and the things -- works that they're doing with all levels of healthcare providers.

The other thing that we've done a lot of is try to work with the county-level emergency managers. We identify within the 16 counties of Maine who the primary crisis agency would be and we paired them up and facilitated having them work with our county emergency managers in signing memorandums of agreement that they would be that sort of resource person in the event of an impacted critical need for their particular county or local town. So that relationship has sort of been codified so they can go in, they actually could sit in the county emergency operations center, they could actually be available as a resource to those towns.

The other approach that we've taken is to -- again, to provide the psychological first aid, skills for psychological recovery and we have a two-

day training for our disaster behavioral health critical response. Something that we tried last year was we really didn't have a good pulse on how many of our behavioral health treatment programs and substance abuse and healthcare providers were in their disaster plans.

And so, we created a survey which will be available, if you see at the bottom of the slide, it's available at our Maine disaster behavioral health website, and some of the results of the survey -- really our focus was to try to identify where some of the gaps were, what kinds of resources did these community partners need. Our response was pretty positive. We had over 82 responders complete the survey. Many of them identified themselves as mental health or substance abuse agencies, primarily community-based providing outpatient services. They responded from all of the 16 counties.

What we found in the preparedness planning is that only, nearly half of them had some type of disaster response plan but it wasn't comprehensive, it was not necessarily ever exercised, they weren't affiliated with many of their own -- again, these county emergency management agencies who are emergency relief or even had an awareness of the healthcare coalition partnerships that they could benefit from.

So from part of that is -- our strategy is to identify some of those who within the survey said that they did not have a plan -- a written plan for sharing ongoing treatment to their agency, clients and participants. So we really are trying to focus on them, getting them some planning resources. The new TAP SAMHSA TAP 34 disaster planning handbook for behavioral health treatment programs, I ordered you know hundreds of those and I'm trying to get out there and make sure people have those.

It has a really nice matrix in the back of the plan which people can just follow right through. It's very specific to behavioral health and the needs for communication to their -- to the clients, to you know the availability of services, how you're going to communicate to your staff, you know maybe they haven't been impacted at that facility but maybe the staff in their own town have been impacted and they can't come to work.

So how are they going to continue to provide service is really important for us at the state because again, as we talk about medical surge, they're going to go and seek services somewhere. So we want to be prepared and knowing what each county's capability is. So we found that over 26 percent of them had a partial plan or had no plan at all. So that really was the group we wanted to target and identify those people that we felt had a high risk in working with very vulnerable populations.

So getting those resources to them, making sure that they understand that we are an asset, that we can provide help with getting -- looking at their plan, getting some people in there to help them to exercise, encouraging them to get into the coalitions which is a broader base of partnerships that have experience and have depth of knowledge that they can really, truly benefit from. And then being part of that regional response, then taking that back and doing their own facility agency specific response.

So that's kind of the focus that -- with this survey, it's given us a lot of information that allows us to sort of make real, specific kind of interventions and planning decisions on where we need to make our efforts. And I think Sandra really spoke to this very eloquently, talking about surveillance and assessment tools, you know really kind of beefing those up. I'm fortunate to be in the public health offices, public health planning and emergency planning because I work in a group of people that all they're doing is emergency planning so their focus and direction is very specific.

One of my colleagues is working on a vulnerable communications plan which is going again, out to these same behavioral base -- behavioral health treatment programs and providers, refugee you know providers, Catholic Charities, many of the larger national organizations and saying, how do we reach and communicate to these vulnerable populations? How do we get the message across in a clear, concise and non- you know scientific way so people will take it and use it, and protect themselves.

So she's working on an initiative of trying to get those providers to sign on as an MOA. So we have a means to send out messages to them. They then take it and deliver the messages the way that they would. If it's a Meals on Wheels

program, they're going to take flyers out and you know deliver it with the meal. If it needs translation services, that's something we're going to be able to provide. So working within the office of emergency preparedness really allows this program to benefit from a -- you know a much larger base of knowledge and expertise.

So the survey is available online. It has a number of questions. If you wanted to see the actual survey itself, I can share that with you or any questions about it. It did provide us with a lot of good information. It talked a little bit about again, how to take care of their own employees which was an important component of you know, are your staff able to come to work and then what's the impact of making sure that they are ready and resilient and you know, able to work.

So that was a big component, probably only 40 percent said they had some kind of plan which actually looked at their staff and how to help them. And so those kinds of -- that kind of information and the way that this was framed I think really provided us a good snapshot of what we need to do for preparedness and planning.

So thank you again so much for allowing us to participate in this, the efforts we're doing here. We haven't had a large federally declared event but you know, that's something we plan for. There's a lot of exercises in the state of Maine that we can participate in, and they have been much more inclusive about including the behavioral health. So thank you.

Cynthia Hansen: Great! Kathleen, thank you so much for the great -- again, brief overview but the resources available via links, I'd like to let all of the listeners know that the links are available on the website. When there isn't a link, then please feel free to contact me, Cynthia Hansen or Rachel Kaul or the speaker to get more information about the topics they're addressing. All of our speakers have been generous enough to offer that option for everyone to be able to contact them directly and get more information.

So I want to thank everyone for very, very engaging and stimulating presentations that give us a nice perspective of some of the work and some

really great work that is going on across the United States. I really appreciate the emphasis on practical tools and strategies, shareable resources so that everybody can learn from each other, and especially your ideas about measuring progress and success.

As you know, that's something that our division, the National Healthcare Preparedness Programs division is focusing on very strongly. And so, you'll hear more about that over the next year. As I mentioned earlier, this webinar is really an opportunity to hear about a lot of good ideas, to spark conversations in your coalitions, state, territory, tribe or other jurisdictions about how to better integrate behavioral health in the healthcare system preparedness capabilities and coalitions.

I want to note that there are so many more ideas and resources that we could squeeze into our allotted time today. Many other programs across the country are doing great work, and I just want to acknowledge that we painted some broad strokes here to give you an idea of the variety of great programs underway at this time.

I -- so there's going to be some -- oh, we just put the instructions up for the chat. We're getting some questions in by chat which we'll queue up, and then we're going to open up the line for callers. Oh, there was one other thing I wanted to say, one of the capabilities that has not been addressed in the presentation so far is mass fatalities. And so, we do know that behavioral health is a key partner in standing up family assistance centers.

And so, if there are people on the line who want to ask questions about that particular function, then we do have all the speakers are available to answer questions about that, and we open up that topic for additional conversations. So with that in mind, operator, could you please instruct the listeners how to engage in the questions -- question period.

Operator: Certainly. Ladies and gentlemen, if you do have a question at this time, please press the star, then the one key on your touchtone telephone. If your question has been answered and you wish to remove yourself from the queue, please press the pound key. Again ladies and gentlemen, if you do have a

question at this time, please press the star, then the one on your touchtone telephone.

Cynthia Hansen: And while we're waiting for people to queue up on the talking part of the Q&A, we have a chat question that has come in. I'm going to turn the phone over to Darrin Donato, a member of the Division of At-Risk, Behavioral Health and Community Resilience to state the question and answer.

Darrin Donato: Yeah, the question had to do with which of these materials and resources were available you know through social media platforms. And while this doesn't entirely answer the extent of that question, I'd like to turn people's attention to the National Library of Medicine at the National Institutes of Health has a Disaster Information Management Research Center (DIMRC: http://disasterinfo.nlm.nih.gov).

And at the National Library of Medicine website, there is a subsection that lists a whole range of disaster apps that are available for use on mobile devices, and a number of them have to do specifically, you know, with behavioral health and stress management concerns. So we can try to get that exact link out to people. It's a bit long but it's at the National Library of Medicine site for disaster apps and mobile optimized web pages (http://disasterinfo.nlm.nih.gov/dimrc/disasterapps.html). Thank you.

Cynthia Hansen: Great. You know actually, one of the places you can go look for that is in the Appendix D of the Behavioral Health Concept of Operations that is in the link from Rachel Kaul's presentation. So if you want to do a quick gander at that, then that will give you an easy link and we won't have to say it over the phone.

Operator, do we have any additional questions?

Operator: I'm showing no questions at this time.

Cynthia Hansen: Wow. What was that? There's another one on the chat?

Sue Larkins: Yes. A couple of questions that came in through the chat, what process do you suggest when a healthcare provider is severely injured by a patient from a vulnerable population such as those mentally ill that are receiving treatment?

Darrin Donato: What was the question?

Sandra Shields: Can you repeat the question again?

Cynthia Hansen: Yes, that was a little low. So I'll say it because I think Sue is a little far from the microphone. The question is about when a healthcare provider is severely injured by a patient from a vulnerable population such as those mentally ill, but receiving treatment? So that's really a question -- that's a daily delivery of care question, is that something Dr. Dodgen that you'd like to address?

Daniel Dodgen: Well, I can say just a little bit but I would certainly welcome other folks to chime in briefly as well. I mean, I think first off the first question, it really is a workplace issue. If you're injured in the work place, then the first line of recourse is really what is your policy and all of the things that go along with that. That would also be true by the way of federally deployed behavioral health workers like PHS officers or NDMS workers, they would be covered by that insurance that they're covered by.

So if your question is really more of a management question, then I think -- you know I think that there are different strategies but I think in terms of actual workplace injury, it kind of has to be treated like any other workplace injury but I welcome thoughts or additional comments from other people.

Kevin O'Brien: This is Kevin O'Brien. One of the things that occurs to me is it's a -- pretty much another commercial for the reason why you want to integrate behavioral health training into this work because if there is a situation where a number of vulnerable people or seriously mentally ill are converging in an area and the staff had no training or no areas of awareness in how to work with them, that is a risk. And similar to what Dr. Dodgen had said, if in the day-to-day practice, it seems to fall under risk management but in the surge capacities where I'm dealing with the public with large crowds, there needs to be advanced training.

Daniel Dodgen: And I think there's good stuff out there by the way on sort of how do you manage crowds and other things that could reduce the risk of public health strain.

Cynthia Hansen: Yes, good point. We have a couple more questions coming in from the chat room.

Rachel Kaul: I'll just go ahead, this is Rachel. We did get a question asking that we address the behavioral health needs of members of the emergency responders workforce, and I think Sandra and Deborah and some of the other speakers you know, certainly brought this up.

We really consider and I think you've seen in the Disaster Behavioral Health Concept of Operations that we never talk about delivering disaster behavioral health services without mentioning responders because their exposure to extreme levels of stress or large numbers of distressing situations, previous responses make them vulnerable in spite of their training, and in some ways, almost because of the nature of their work.

And that's not to say that they don't function even under those stressful conditions but if you want to protect the longevity and the health and well-being of first responders, integrating behavioral health into their training before they even go into responses, making sure that there's appropriate follow-up and services available to them after responses and that it's considered part of the -- it's integrated into the culture so that there's not a stigma to needing or getting information or support.

I think it was mentioned, peer support programs are a real good way to do that, as long as they're supported by professional mental health guidance and staff, and there's a variety of different ways. So I think any of these speakers could probably provide the resources and training and information on how they've done that.

Cynthia Hansen: Yes. Well, great. Thank you, Rachel. I think what I'm going to do is move onto another question and open it up to the speakers. It's a question that says,

during a recent emergency exercise, we found that our methadone treatment facility in one part of the state was not able to get methadone to 12 of our patients. Do any of the states have a great resolution to opioid treatment options?

I know this is an issue for both Louisiana and Texas during Katrina. Now, we did reference the disaster planning handbook for behavioral health treatment programs which focuses very specifically on those facilities that's published by SAMHSA, but I know the caller is asking the question of the state. So let me turn the microphone over to D.C. or California or Maine or Kentucky, whoever can step forward and say what's your experience?

Craig DeAtley: This is Craig from the D.C. coalition and Kevin, if you will join me in answering that question. Last year in one of our exercises across the system, we had a conflagration that resulted in one of our methadone centers actually being caught and having to be closed. So among the steps that were rehearsed was the transfer of information, patient information from that methadone center to one of the others, along with trying to make arrangements to transfer their pharmaceutical cache.

This was done, if I'm not mistaken as a collaborative effort between Kevin's department and D.C. Fire, and I believe even MPD, Metropolitan Police Department, had a notional hand during the transfer. Kevin, can you elaborate?

Kevin O'Brien: That's exactly what occurred. The other issue is that we have a -- recently instituted a policy. The Department of Behavioral Health is a recent merger between the Department of Mental Health and the Department of Substance Use Services. So the substance use and the methadone clinics are now under our jurisdiction.

We have just recently instituted a policy where all of the methadone providers need to have an accurate and updated COOP plan so that we can address it. But I believe the methadone clinics in our area do advanced dosing, and if that's not feasible, we work out the procedure that Craig detailed earlier.

Cynthia Hansen: Great. Thank you, all very much D.C. I'm going to call you all D.C., isn't that terrible, Kevin and Craig and Peggy? But okay, so we have a couple more questions. So I'm going to keep moving through them and then, the speakers can continue addressing them as time allows.

We have a question for, are there best practices -- that I'm going to ask actually, Sandra to address if she can, are there best practices for providing emotional and spiritual support for associates in the midst of a disaster which is being triaged at a major medical center? Sandra, can you speak to that question?

Sandra Shields: Well, certainly. I think that part of the work with PsySTART is to be able to learn how to use mental health triage, but also we want our facilities to think ahead of time and strategize ahead of time in their concept of operations, how they're going to address each level.

So for people who are most impacted by a disaster, how -- what is their strategy going to be based on the resources they have not only for mental health or behavioral health, but what are their strategies are going to be within that system, and how are they going to address people who are less impacted? Are they going to use things like psychological first aid?

We have worked with Dr. Schreiber also on a psychological first aid model that also has been worked with our Department of Public Health which is "Listen, Protect and Connect." So psychological first aid may be appropriate for people who are less impacted by a disaster, but it's not the entire answer in terms of the strategies that need to be -- that need to occur for those people who are most impacted by a disaster.

So we want our facilities to think those through ahead of time in terms of what they would do, ranging from assessment crisis intervention to some other referrals for longer-term treatment. It's something that we want them to think about and identify ahead of time.

But in order to get there, to that strategy, you really need to be able to think strategically about who needs the most care first, to be able to get the right

care to the people who are most impacted and to think about mental health casualties and response more on a strategic site base but also a community-based or operational area, county-based strategy in order to move forward. So I think triage is kind of the lead-in to how you develop those strategies and best practices.

Cynthia Hansen: All right. Thank you so much, Sandra. And our next question, I'm going to turn over to Dr. Dan Dodgen. How are children made resilient in our communities?

Daniel Dodgen: That's a great question for which I think you could get a lot of answers. So in the interest of time, what I'm going to do is say a few words and then direct you to some websites. I mean obviously, the best way to make children more resilient is to make sure that attention to children is integrated into everything we do for emergency preparedness response and recovery if we're serious about helping our children to be more resilient, then I think that means we've got to be thinking about them as not just victims or not just auxiliary members of a community but as really fully integrated into the whole community.

So things that we do to promote preparedness and recovery should include attention to schools and other places where children congregate, et cetera, and I'm sure everyone on the phone has already thought about a lot of these things. A couple of referrals that I would give you, first off, actually for Dr. Marcozzi and Dr. Hansen, we did a webinar a couple of months ago on pediatric preparedness that includes a number of resources for integrating children into preparedness activities and I would refer you to that.

And you can actually go to the -- to my office's website which is just phe.gov/abc, PHE again is public health emergency dot gov slash ABC. I also would encourage you to go to the National Child Traumatic Stress Network, nctsn.net. And also, the Emergency Medical Services for Children program run out of HRSA, EMSC, very easy to find. So I think there's some good work happening that'll -- that will give you ideas about how to integrate children into your preparedness efforts, that I think will promote the kind of resilience that we're looking for.

Cynthia Hansen: Great. Thank you very much, Dr. Dodgen. So we know we have more questions that have come in by chat and we're going to figure out how to pull together some answers and see if we can get those posted on our website. If you have specific questions for speakers, please feel free to contact them directly. And if you have answers that you think NHPP should know, ABC should know and we should share, then please feel free to e-mail any of the ASPR speakers that are on this call.

We work regularly together. We talk to each other all the time, pick your favorite person and build a relationship because that's basically what we do here. With that being said, this is one of many of a series of webinars hosted by the National Healthcare Preparedness Programs. The next webinar will be on May 15 and will be a follow-up call to our pediatric webinar that occurred last June.

On September 18, the focus will be coalitions in response. On November 20 will be a follow-up call on rural health coalitions. And then on January 15 of 2015, we're going to have a call on linking NDMS with HPP. So in the future, if you want to follow up, I've got the slide up there. You've got your HPP federal project officers who are always your first line of questions.

You can contact me, Cynthia Hansen. We're interested in questions but also suggestions, promising practices, challenges and opportunities, please feel free to reach out. The webinar and PowerPoint will be posted by April 20, if not before at our website, PHE.gov/abc and the phe.gov website for the National Healthcare Preparedness Programs which is a longer URL.

So thanks again to our speakers and to all of you listeners who are on the phone today for being here today to exchange promising practices for integration of behavioral health into healthcare preparedness. I hope everyone has taken away some great ideas, new contacts, new resources, and we here at NHPP and ABC look forward to continuing this conversation. Thank you all very much.

Sandra Shields: Thank you.

Operator: Ladies and gentlemen, this concludes today's conference. Thank you for your participation and have a wonderful day.