The Hospital Preparedness Program (HPP) Healthcare Preparedness Capability Review National Call
Capability 3: Emergency Operations Coordination

Monday, July 1, 2013
11:00 AM – 12:30 PM EDT

I. Welcome and Introduction

– Steve Tise, Field Project Officer Supervisor, Acting, HPP (Stephen.Tise@hhs.gov)

Steve Tise provided opening remarks on behalf of Scott Dugas, who was out of the office. The Capability 3 call is the second of four planned calls that provides information on the Capabilities from HPP and implementation examples from Awardees. The Capability 3 call features examples from Texas, North Carolina, Mississippi, Michigan, North Dakota, and Missouri.

The meeting focused on Capability 3, Emergency Operations Coordination. HPP considers Capability 3 to be one of the most important capabilities. He introduced Paul Link and Shayne Brannman to provide an overview of Capability 3.

II. Overview of Capability 3: Emergency Operations Coordination and Emergency Operations Coordination Performance Measures

– Paul Link, Field Project Officer, HHS Region IV, HPP (Paul.Link@hhs.gov)
– Pamela "Shayne" Brannman, Acting Chief, HPP Healthcare Systems Evaluation Branch (Pamela.Brannman@hhs.gov)

The purpose of the national calls is to discuss the background, framework, and goals of the Capabilities. Paul and Shayne provided an overview of Capability 3 and speakers from across the country provided additional details on each of the functions.

Eight Capabilities were released in January 2012 in the *National Guidance for Healthcare System Preparedness*. HPP's Capability 3, Emergency Operations Coordination, is in alignment with the Public Health Emergency Preparedness (PHEP's) Capability, but there are some differences. HPP's Capability 3 provides a framework for how the community will coordinate in a response. It aligns key roles and responsibilities. The primary concept is coalition development and response and a wide range of stakeholders were engaged in Capability development to ensure multiple perspectives were considered.

The National Healthcare Security Strategy (NHSS) has two primary goals:

- Building community resilience (continuity of healthcare operations)
- Strengthen and sustain health and emergency response system (medical surge)

The NHSS takes a systems approach to health, recognizing that many interrelated systems are needed to support health, protect during an incident, and promote recovery after an incident for individuals and the community.

The program measures and strategy are integrated into the Medical Surge Capacity and Capability (MSCC). There is a tiered system of stakeholders that deploy when a medical surge is activated that includes Federal, interstate regional, State, jurisdiction, and healthcare coalition components. Healthcare coalitions provide the framework for involving the emergency community. Coalition development must

be linked to the communication flow and resource adjudication. Agency collaboration should be flexible. Awardees should be developing coalitions and defining roles and responsibilities for a response. **The coalition does not supersede jurisdictional authority**. The purpose of a coalition is to provide leverage in decision making during a response.

On July 1, 2013, Budget Period Two (BP2) implementation guidance on the program measures was released. Two of the medical surge indicators are focused at the coalition level. Immediate bed availability should never be activated unless there is a clear understanding of the scope of the event. When immediate bed availability is activated, 20 percent of beds need to be available within four hours.

For BP2, there are three continuity-of-response indicators. The expectation is for there to be demonstrations of the following components:

- The healthcare coalition has a process to enhance member situational awareness that supports activation of immediate bed availability through continuous monitoring
- The healthcare coalition has demonstrated the capability of having redundant means of communication for achieving and sustaining situational awareness
- The healthcare coalition has tested its ability to address member healthcare workforce safety needs through training and resources

The healthcare coalition must have a structure that is able to coordinate with incident management, such as a Multi-agency Coordinating Group, to coordinate actions that achieve incident objectives during a response. Information management should be managed upward, down, and out. "Outward" information is the information disseminated to the public. This should be a coordinated effort. The ability for a coalition to disperse information does not supersede that of a hospital or other facility's need or desire to share information, but consideration should be given to the potential counterproductive impact of rogue information.

The ability to check the status of resource "needs" should be incorporated into the communication system. Members of the coalition should know what is happening and be able to check on resource requests. The communication system should support the ability to sustain situational awareness.

Resource management and resource allocation is measured by the ability to allocate resources and process requests. This is the implementation portion of Functions 3 and 4 of Capability 1. Coalition members should be able to identify gaps and know how to get what is necessary while working within the framework of what is available. Resource requests can be made to emergency management and healthcare coalitions should know how to make those requests.

Resource elements are an opportunity for cross collaboration between HPP and PHEP and are particularly important at the hospital level. HPP funds can be used for public health elements like epidemiology. Resources should be monitored comprehensively. It is not necessary to know every item available at every hospital, but a system should be in place to monitor inventory.

An after action process should be developed and maintained. It is a way of completing the preparedness cycle and beginning it again. Coalitions must be able to offer honest input for the next planning cycle. The coalitions should be involved in creating that framework.

An article from HealthyAmerican.org about response can be found at http://healthyamericans.org/health-issues/wp-content/uploads/2013/06/HPP-Backgrounder.pdf. It provides examples of how to use HPP funds.

III. Healthcare System Preparedness Function Implementation

A. Function 1: Healthcare organization multi-agency representation and coordination with emergency operations

1. Operational Response

– Ray Apodaca, Team Lead, HPP, Texas Department of State Health Services (Ray.Apodaca@dshs.state.tx.us)

HPP coalitions have a robust response capability in the State of Texas. Because of the size of the State, Texas has always taken a regional approach. The 22 coalitions were founded using the emergency response structure and that resulted in a natural collaboration between emergency management and the hospital systems.

When the coalitions were first formed, a substantial amount of equipment was purchased. In order to track the equipment efficiently, the Texas healthcare coalitions led an effort to create an emergency medical task force system. There are eight task force teams across Texas. Each task force includes multiple healthcare coalitions, assets, and ambulance and Registered Nurse (RN) strike teams. The strike teams assist across regions when necessary. The medical task forces also created mobile hospitals that can be deployed (depending on the size of the incident), developed trainings, and formed partnerships with the medical incidence response system.

The Texas healthcare coalitions were met with resistance when they were first established. The legal authority of the coalitions was not clear at first. The authority issue was resolved when the State hired a Texas-wide emergency management coordinator who became the champion of the healthcare coalitions and task forces. Healthcare coalitions can now be deployed using the emergency management structure.

The healthcare coalitions support the local and regional authorities and are able to respond to regional incidents using mutual aid. They can also be deployed as a State resource. As the system evolves, requests from the emergency management system and first responders are increasing.

More information is available on the ASPR website and brochures will be made available as well.

– Jeff Peterson, Healthcare Preparedness Response and Recovery Operations Manager, North Carolina Office of Emergency Medical Services (Jeff.Peterson@dhhs.nc.gov)

North Carolina's coalitions were created using the eight trauma system regions as a framework. The coalitions are 100 percent HPP funded and are anchored by a trauma center which is typically the referral hospital in the region. The healthcare coalitions also collaborate with emergency management.

Legal authority to act is a challenge faced by North Carolina's healthcare coalitions. They can respond to local events using Memoranda of Agreement (MOAs). The North Carolina Hospital Association has an agreement in place that is also utilized.

North Carolina's healthcare coalitions are similar to their counterparts in Texas. They coordinate responses and manage assets and have integrated a structure for requesting resources that was originally developed by emergency management. The regions maintain situational awareness with up, down, and sideways communications. Local medical assets include special medical needs sheltering units, ambulance strike teams, mobile hospitals, etc. The coalitions act as information sharing centers.

Reimbursement is provided at a local or regional level. Often the requesting agency is responsible for the cost. When the local authority's resources are depleted, a request is made to the State level. Stakeholders have a good understanding of the process for requesting reimbursement using the distinct processes that are in place. Healthcare coalitions support the response arm with assets and personnel.

2. Multi-Agency Coordination Center (MACC) Level Response

– Jim Craig, Director, Office of Health Protection, Mississippi State Department of Health (jim.Craig@msdh.ms.gov)

Mississippi's approach to healthcare coalitions varies in comparison to Texas and North Carolina. They have similar assets, but those caches were developed as State resources to help local government. Healthcare coalitions existed before they were called coalitions. There are currently 10 healthcare coalitions in the State, one of which has been in existence for 30 years. Many stakeholders are engaged in Mississippi's healthcare coalitions and membership is becoming more formalized. The primary function of the healthcare coalitions is to prioritize resources.

Mississippi is a small State but it is vulnerable to many threats and responses occur often. There are currently 20 Federal declarations in the State. Public health is centralized at the State level. Responses are led by the State Department of Health. Mutual aid agreements between the counties are in place so that resources can be shared. There are nine public health regional coalitions that are in the process of being formalized. Local partners in each of the counties have been identified including healthcare facilities and non-government organizations.

Much planning is done before an incident occurs, including regular training and exercise activities. During a response, rapid aid assessments are conducted. Post response, after-action reports are completed. Communication is a focus throughout the response cycle.

During a Mississippi River flood, there was a threat of the levy failing. Emergency plans were reviewed to ensure that if the levy were to break, the population would be managed appropriately.

Mississippi has a mandatory trauma care system. All hospitals must participate or pay a fee if they opt out of the system. Regional coalitions are supported by the State, but there are no

command and control functions. After Hurricane Katrina, it was mandated that every facility have plans in place that are subject to approval from local emergency management agencies.

B. Function 2: Assess and notify stakeholders of healthcare delivery status
– Linda Scott, Manager, HPP, Michigan Department of Community Health (scottl12@michigan.gov)
– Amy Shehu, Region 2 South HCC Coordinator, Region 2 South Healthcare Coalition (AShehu@2South.org)

Linda Scott provided an overview of Michigan's healthcare coalitions. Michigan has eight regional healthcare coalitions that mirror the emergency management districts. Both have committees with similar infrastructure and diverse membership groups. The healthcare coalitions and emergency management districts work closely together to prepare for responses. A medical coordination center is in place to manage the flow of information and resources.

Like other States, Michigan healthcare coalitions struggle with formal authority. The eight healthcare coalitions have been written into the State-wide emergency plan and are managed using HPP funds. The medical coordinating center has also been validated through the State plan.

Amy Shehu discussed specific examples of how Michigan's Region 2 has managed their program. Region 2 covers 2,000 square miles and accounts for 10 percent of Michigan's population. When the coalitions were first formed in 2002, the initial mission was to enhance local preparedness. Several years into the program, the focus became planning and structuring the healthcare coalitions as response organizations.

A primary component of Region 2's program was to determine how an incident has impacted health care delivery. In order to address this need, a common operating picture was developed. Michigan healthcare coalitions in collaboration with the State Department of Health put together a worksheet that identifies the essential elements of information. The coordination centers utilize the worksheet to communicate healthcare delivery status to key partners. Hospitals often coordinate with coalitions and with each other in situations that are not declared as emergencies.

Region 2 has worked with many external partners including the National Football League (NFL) and Major League Baseball (MLB). They collaborated with the Strategic National Stockpile and worked at a national level on the 2012 fungal meningitis outbreak. Using these experiences, they have been able to share their best practices and also gained insight into how other organizations approach similar responses.

C. Function 3: Support healthcare response efforts through coordination of resources
– Julie Sickler, Division Director, Public Health Emergency Preparedness, North Dakota Department of Health (jsickler@nd.gov)

North Dakota conducted a gap analysis and two important points were identified:

- Most of the events in North Dakota are weather related (floods, ice storms, blizzards, tornados, etc.)
- North Dakota is very rural, therefore, distributing resources in a timely manner is a challenge.

This group is responsible for the health and medical response for North Dakota and is one of a handful of state agencies that has developed a department operations center that operates under the North Dakota State emergency operations center. Several systems have been developed that operate together. A communications system (WebEOC) is housed out of the State Emergency Operations Center and is used for communication coordination at the state level and among hospitals, local public health, and county emergency managers across the State. The communications system ensures that people are working together and that resources are being coordinated appropriately.

There is an additional software application (HC Standard) in place that is used to coordinate among hospitals and long-term care facilities. It provides real-time status on bed availability and patient status which ultimately impacts patient transport. When there is a need to evacuate residents, information on the patients, including what is needed for the patients, can be found in the system.

Contracts for resources have been developed with agencies across the State. These are not MOUs or MOAs, but are contracts that outline responsibilities during an event and what the reimbursements will be. The first reimbursements come from an emergency fund through the state emergency operations center. This is in lieu of Stafford Act or federal reimbursement. Contracts are in place with emergency medical services across the state, hospitals, public health units, long term care facilities, bus companies, and major universities that will operate as medical shelters in case of a major event.

North Dakota maintains a 30,000 square foot warehouse that contains $11 million worth of assets. It is funded by the HPP and PHEP programs and through the hospital association and local public health contributions. The items in the warehouse are considered shared assets (State and local partners). There is an online shopping interface that allows anyone to order items from the cache. The order then goes through an incident command process that determines needs and operates 24/7. The assets can be deployed using semi-trailers. Some of these semi-trailers are in the process of being deployed to the major cities to enable more rapid deployment of resources throughout the state.

D. Function 4: Demobilize and evaluate healthcare operations

– Leslie Porth, Vice President of Health Planning, Missouri Hospital Association (MHA) (lporth@mail.mhanet.com)

Missouri coalitions began in 2007, however, it was in 2011 that Missouri launched its coalitions in its out-state area, just two months prior to the Joplin tornado. Despite the newness of the coalitions, many successes were experienced during the Joplin response.

Statewide hospital mutual aid agreements were utilized efficiently for coordination and allocation of shared resources. At the hospital level, it was used for tetanus, staff, personnel, and fatality supplies. At the regional level, the agreements were used for mobile communication trailer systems and regional medical surge supplies.

Regional assets and supplies have been standardized across the state to enable them to be interchangeable and allow for rapid supplementation from non-affected caches without any

required training. The mobile communication trailer in Joplin was destroyed, so efforts to standardize equipment proved to be very useful when a duplicate trailer from another region was deployed.

The association served as a liaison, which is critical because it is not part of the command and control structure, but it distributed materials in the most effective manner possible. There was also coordination with the state Disaster Medical Assistance Team (DMAT). Immediately following the tornado, a decision was made that the MHA would focus on the hospital that was receiving all of the surge and the DMAT would focus on the hospital that was destroyed, helping them set up temporary services. This was done within 30 minutes of the disaster and it allowed for very efficient coordination.

The critical component of the Joplin response was communication and information sharing. There was great situational awareness outside of the Joplin area across the State, however, all of the electronic systems had been destroyed and there was very minimal internet, cell and satellite service in the first few hours after the tornado. Additional redundant systems and standardizing the sequential process of the use of communication systems was important.

The MHA acted well as a liaison, but, because the coalitions were new at the time of the event, they were not fully operational. The healthcare coalitions would be utilized more today so that, rather than coordinating with 150 hospitals across the State, the MHA would communicate with the seven healthcare coalitions, ultimately increasing efficiency and effectiveness. Approximately 24 hours following the event, the MHA began using the coalitions more effectively and took notes on how they could be better utilized in the future.

A confidential hospital hot wash was hosted by the MHA following the event. It was not part of the State documentation and was by invitation only. It included a formal after action report and a comprehensive document review. The MHA spoke with all of the healthcare coalitions to review how they could have been better utilized. Anecdotal and quantitative information was collected and planning was adjusted.

The following are some of the high level conclusions of the hot wash:

- The mutual aid agreement is useful for response, but a trigger point needs to be identified when response becomes recovery. The mutual aid agreement is not the best tool for recovery. It was used for a month after the event.
- The mutual aid agreement worked well for staffing purposes because liability had been addressed. The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) was utilized as a backup.
- It is important to let people know when to stand down. Seven mobile communications units were stood up, but standing them down was neglected.
- Coordination with the Emergency Management (EMS) must be improved.
- Patient tracking did not work well. A plan must be in place for mass patient movement. Patient tracking tools were in place but not an overarching system.
- The communications plan should identify who needs to know what and when. Operationally, it must be determined what is in place and in what sequence redundancies will be used. In the Joplin event, people were using different redundancies at different times.

VI. Questions and Answers

- **Question: Will you release a document with the highlighted points from each of the speakers?**
  - **Answer:** Yes, a meeting report will be provided along with links to additional pertinent information.

- **Question:** Where do the local medical reserve corps (MRC) volunteers fit into the task forces?
  - **Answer:** In Texas, the MRCs play a role with HPP, but more at the local/regional level. They are not usually deployed in a statewide response.

- **Question:** What is the cost associated with developing a strike team and mobile medical assets? It is understood that this would vary by State, but please provide an idea of the cost of development and maintenance.
  - **Answer:** When Texas receives their HPP award, approximately 70 percent of it is pushed out to the coalition level. Every coalition receives at least $250,000 a year with additional funding available for varying circumstances, such as emergency medical task force funding to developing regional teams. When unspent funds are identified, they are redirected to fund State-wide task force activities.

VII. Concluding Remarks

Paul Link thanked everyone for calling in. Questions can be directed to each of the featured speakers through the email addresses listed on the agenda. A meeting summary and any additional resources will be sent through the HPP Awardee listserv.

Thanks to all who shared the experience of their coalitions on this call. Coalitions are different in many different aspects, but what is common among them is they have developed their system of how they are going to operate, whether that be fully operational, or through a MAC-type arrangement. They have gone through the process of information management and resource management in detail, to assess their resources and how they can get those resources. That is the common thread.

Steve Tise reiterated appreciate for the participation. He also thanked the speakers for their efforts. Two additional Capability calls are planned for August 12, 2013 on Capability 6 and September 9, 2013 on Capability 14.

The call concluded at 12:33 PM EDT.