Hospital Preparedness Program Teleconference Transcript
Capability 3: Emergency Operations Coordination

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Operator: Good day, ladies and gentlemen, and welcome to the HPP Capability 3 – Emergency Operations Coordination 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 anyone should require operator assistance, please press star then the zero key on your touch-tone telephone.

As a reminder, this conference call is being recorded. I would now like to introduce your host for today's conference, Steve Tise.

Sir, you may begin.

Steve Tise: Thank you. Good morning, everyone. Scott Dugas, who normally starts these calls, is out, but sends you his regards.

Today, we're having the second round of our four planned calls of HPP awardees in which we provide an overview of a particular capability, and then get input from a number of states on how they're working to meet this capability.

Today, we'll be discussing Capability 3 – Emergency Operations Coordination. In HPP's mind, this is one of the probably three most important HPP capabilities. And so, it's important as you'll – as you'll see.

We'll be starting off with a joint-presentation given by Captain Paul Link, our Region IV field project officer and Miss Shayne Brannman, head of our Healthcare Assistance Evaluation Branch.

Following the presentation, Captain Link will be our moderator for the remainder of the call and introduce our guest speakers whom I would like to thank you – thank for taking your valuable time in making this call possible. They really play an important role. They’re the ones who are helping us figure out how to turn goals into reality, so I'd like to thank them personally for that.

Because we have a number of speakers, I'd like to turn – I don't want to take any – up any more time. I'll just turn this over to our presenters.

Captain Link?

Paul Link: Thank you, Steve, and good morning, everyone. Welcome to today's discussion on the capabilities – capability number three – Emergency Operations Coordination. And thank you to our speakers for being on the line and all that folks that could make it on the line. We have quite a full slate of folks. Today, we're going to be discussing the presentation about the background of the capabilities, just briefly about Emergency Operations Coordination, the framework, the goals of the capability and then we're going to provide an overview of the functions and the associated expectations of those functions.

Steve had mentioned that we have several speakers on the line to basically do a functional by functional presentation on the four functions of the capabilities, so let's go – let's begin into this presentation.

First, we're going to talk about the capabilities. As you know, they came out – Healthcare System Preparedness Capabilities was released in January 2012. There are eight of those capabilities and number three was Emergency Operations Coordination in alignment with capability three of the PHEP.

There are some differences, however. One difference – one point to take into account for is that – excuse me. I have to drink water. The capabilities, the response coordination was framed out to match as much as possible the National Response Framework. This provides context on how the whole community works together and how response efforts relate to other parts of national preparedness.

The National Response Framework is a guide on how the nation responds to all types of disasters and emergencies. It is built on scalable, flexible, and adaptable concepts identified in the National Incident Management System to align key roles and responsibilities across the nation.

The scalable, flexible, and adaptable coordinated structures are essential in aligning these key roles and responsibilities to deliver their response missions areas' core capabilities. This is a primary concept of coalition development and coalition response.

Moving on, our next – one of our next background documents is the National Health Security Strategy, and Shayne Brannman is our HSEB branch director is going to be going over this.

Shayne?

Shayne Brannman: Good morning, Paul, and good morning to, everyone. Thank you for joining and helping us better understand this capability and how people are achieving it.

As Captain Link indicated, the framework for the National Healthcare Security Strategy is also; in addition to the capability is a part of the process as well as the National Response Framework.

The National Healthcare Security Strategy has two primary goals – building community resilience and strengthening and sustaining health and emergency response systems. Like the other documents, the National Healthcare Security Strategy takes a system approach to health in recognizing that there are many interrelated systems and components that are needed to support individuals and communities, to protect them and support them to their recovery after an incident.

Next slide. In addition, just to give a little bit more granularity, the goals for the framework of HPP is community resilience is enhanced through the continued delivery of central healthcare services to the community post disaster.

Number two, there is a strong emergency response system to provide for an effective management for surges of patients, deaths, and concerned citizens, and it gives you the link to those goals.

Again, we're trying to tie in that the program measures along with the response framework, along with the National Healthcare Security Strategy is all integrated into our process and thinking going forward.

I'll now turn it back to Captain Link and will discuss a document familiar to most of us, the MSCC manual.

Paul Link: Thanks, Shayne. Now, for those of you following along, the notes were sent out on Friday. And you can access this PowerPoint presentation and use the links within it.

And if you're following along with these notes, we're going to kind of be referencing those slide deck.

So we're on slide number seven at the current time. As you see on the slide, you see the tiered system of the Medical Surge Capacity and Capability Handbook for healthcare coalitions. Now, when we developed the coordination and development portion of the healthcare coalition in reference to response, there were multiple sources used to develop this.

The coalition guidance – one of the – now, one of the most important take-home messages from the supporting document is that the healthcare coalitions provide means for healthcare organizations and systems to integrate into the existing preparedness and response framework.

So this is one of the biggest concepts that we've had that we're not trying to supersede the authority but they were integrating into a framework using the coalition as that means to get into that system.

We're going to move on, so if you're following along, we're on slide number eight or page number eight. This is the actual definition of Emergency Operation Coordination. We're not going to read this in the capability document.

But one of the things that we want – want to stress for the definition that we provided is that – is about the definition relates to how the healthcare coalition coordination and response activity should be integrated into the response framework of the jurisdiction.

Just as the coalition development is flexible, so is the level of response. However, the coalition development develops – as the coalition develops there must be that link to how the roles and responsibilities that the healthcare coalition are defined to accomplish successful information flow and resource adjudication, which is what we're emergency management is mainly about.

So moving on. This takes us into our first function that relates to a multi-agency coordination. So if you're following along in the notes we're on page number nine or slide number nine. Once again, I want to stress how multi-agency coordination is achieved, is flexible. There are varying levels of response where healthcare coalitions

have operational components that function during response or where coalitions function in a mac or multi-agency coordinating like setting only.

During the presentations of our guest speakers, they're going to be going over several of these different concepts. They ask for us is for the awardee to develop their system and then define the roles and responsibilities as they relate to the information and resource management processes. This includes how decisions are made during response and the specific role of the coalition in those decisions.

Just remember, the coalition is not meant to supersede jurisdictional authority. They are meant to provide better information into the decision-making process. In some cases if the coalition system has been built out a little further, they may be able to provide direct support to their members.

There are some response objectives in which coalitions will have a greater role and these were aligned in the recent performance measure release. Shayne is going to take over on this and we'll go over these indicators.

Shayne, can you go over the next section?

Shayne Brannman: Thank you, Paul. So as many of you on the line already know, the BP2, starting 1 July to 30 June of 2014, the BP2 implementation guidance on the program measures for HPP has been released. And what Captain Link has indicated, especially as it relates to this presentation, let's talk about two of the med surge response indicators that are both the units of measurement is at the healthcare coalition level, and again that you can demonstrate healthcare coalition response operations, and they directly relate to surge management, but have components – and this is very important as Paul talked about, of information and resource management.

You would never want to activate immediate bed availability unless you had good information that of the scope and the severity of the event or incident that is occurring, as well as the outputs that demonstrates that the response implementation of the med surge plan addresses the components of surge outlined in the capabilities.

And again, as you see, both of these are focused around the immediate bed availability, both to be able to demonstrate either to an exercise or a real incident that you have the ability to do the components and the overarching aspect of immediate bed availability and that is to be able to do 20 percent immediate bed availability of

staffed member beds within the healthcare coalition, not the single healthcare organization level, within four hours of a disaster incident of occurring.

It's really important that I focus on – that you understand the output for the resource is the med surge plan and the documentation of implementation of an after action report or improvement plan, which is that continual process improvement that Dr. Lurie continues to emphasize throughout.

Next slide is on slide 11. The community – the continuity of response indicators, again, from – many of you – you've already know that for BP2, we basically have two buckets of HPP program measures now. One is med surge and the other is continuity of healthcare operations and underneath that, we have three indicators that are specific to the presentation today, all of the units of measurement of healthcare coalition that it continues to have that situational awareness of activation of IBA through continuous monitoring.

One of the aspects we want to make sure that you take home from today's presentation on that continuous monitoring is you have to have the ability to understand and leverage how healthcare delivery is done on a daily basis to be able to maximize your performance during an incident or response.

All see the ability to have redundant communication and just the ability to have good communication during an incident is of paramount importance for situational awareness is all – as well.

And then thirdly, we've also continued to make sure that the members healthcare workforce safety needs throughout – through training and resource is accomplished on a continual basis, and that includes the mental health and behavioral health needs of the – of the healthcare workforce after an incident occurs as well.

We have a new component. I'm on slide 12 now. And this is something that's a little bit new, but you've kind of been there before and this is the health care coalition developmental assessment response factors.

And this is the ability to complement our program measure indicators that we just talked about. Again, we have two program measure indicators now for BP2, med surge, and the continuity of healthcare operation.

And we have indicators underneath those two buckets. And then we have a complement of healthcare coalition developmental assessment factor and the one that we want to draw your attention to today, as it relates to the presentation is that the healthcare coalition has an incident management structure, i.e., of mac or an ICS to coordinate actions to achieve incident objectives during response.

And again, those are aspects that we're going to be going through a major training session for everyone on the call today, for the month of July and August, to better augment and explain our entire BP2 process that has been significantly reduced the amount of awardee burden, but it will also be refined. And I think that you'll see that we continue to hold the integration and the importance of capabilities, the response framework as well as pay allegiance to the MSCC and the National Healthcare Security Strategy as it relates to the disaster cycle of preparedness, response, recovery and mitigation.

So now I'll turn it back to Captain Link. Whoops. I'm sorry. One more I was supposed I think I've already talked about a little bit on slide 13. It's again the components and the full discussion of the healthcare coalition incident management structure.

Again I think one bullet point if I don't make it clear to everyone on the line, Captain Link is going to thump me is that healthcare coalitions are not meant – repeat – not meant to supersede the authority provided to local incident management authorities, in conjunction with and in coordination with but not meant to supersede that authority.

And with that, I'll hand it back to Captain Link.

Paul Link: Thanks, Shayne. We really want to stress that point on this call. It's that the coalitions are built into, developed and built into a framework that exists. And how that is done is defined by the awardee and the coalition members themselves as a group until you tell us how you are going to function to achieve these objectives that Shayne just went over in those indicators. That's very, very important. We really want to make that clear.

Now that first function deals with the rules and responsibilities of the coalition moving in to the framework. The next one – the next two functions deal directly with the components of emergency management we really need to be concerned about.

And we're going to start off – we're in slide number 14 and that's information management.

Information management has three components. This capability has three components, and that's basically the ability to communicate up, down and out. And what that means is when you go up the chain there is a system or a protocol or a process in place. Incident management has the ability to see the status of healthcare systems, healthcare coalitions and healthcare organization members so they could see what the status is of their needs. So this is very, very important.

So when we talk about information down, there needs to be that system in place where the coalition members, healthcare organizations, healthcare systems can have an understanding of what's going on, what's the status of their resource requests, where they are going to get their information and basically just what the general frame – the occurrences that are going on in the incident so they can make decisions on their own based off of that information.

Now, continuity indicator number four. So our continuity of healthcare operations indicator number four deals specifically with this one and that's the ACC has demonstrated the capability of redundant means of communications for achieving and sustaining situational awareness, and that's kind of a combination of both those two first components, information up and information down.

The last one talks about information out and that's information out to the public, and getting that information out to the public in a one voice type of setting. Now we would prefer that that's a coordinated effort across the community, say, look, if there is an ability to get status out to the public so they know what's going on, where to go, what to do, that should be kind of coming from one voice. That doesn't supersede the authority of an individual private facility or a hospital to go ahead and provide their own information updates.

But we want everybody to realize that that information out if we have rogue information flying out all over the place it may actually affect the ability of incident management to be able to provide appropriate response because of information that is not quite in sync. So that's what we're talking about communication out. Work with the PIO. Work with the ESFA PIO system there to ensure that that communication is unified. During the call we're going to have some specific examples of this from Michigan and their healthcare coalition.

So moving on, function number three of this capability talks about the resource management and resource allocation. This is, if not one of the most important functions of the entire capabilities document, it is very, very close to it.

It talks basically about the ability to allocate resources or get into that resource request process. It involves a lot of stuff. This is basically building off of function number four, three and four from capability number one. If you view those as your admin or roadmap types of capability functions, this would be the implementation of that.

And this is doing your resource assessment, your capabilities assessment of your members, looking at gap analysis, working through the planning process, saying here's our objectives. Here's our operational priorities and goals. And we have these courses of action that flow toward that and these are our objectives and these are our gaps. And this is how we're going to fill that gap. That doesn't mean you have to have something. That means you have to have the understanding of how to get it if you don't have it.

And that's what this whole function is about, being able to get that and working within the framework that you have. Once again, some coalitions have built out this process and have the ability to have regional caches, the sharing of assets between hospitals, the ability to tap into mobile medical assets from the state, all these different resource processes. But the big one is if you don't have any of that there is still the emergency management, mission assignment request process that you can request through the local emergency management how to fill it. Reimbursements have a lot to do with this process.

However the process is built out this is the kind of thing that you really need to work on as a coalition and as an awardee to say, OK, this is a big one. Let's build this out and let's make sure that we have the understanding of how we can get resources, what is available and what is needed. And that's this capability.

Now we have a lot of indicators and healthcare coalition assessment factors related to this. And some of them are the continuity indicator number two which is the healthcare coalition has conducted a gap analysis to identify resource shortfalls during an event and implementing plans to close those resource gaps. So this is kind of really, really important because this talks really to the resource development

process. And I encourage you to all take that guidance that was just sent out, the implementation guidance and look at that and see what the expectation is there.

And we have the several assessment factors. One very important assessment factor is the healthcare coalition assessment factor number seven which talks about the coalition conducting assessment or the capability of each other's abilities.

Now this is pointed out directly in CPG 101 version two, the comprehensive preparedness guidance from FEMA that talks about community-based planning and this is part of the planning process. Not only do you do a capability of a resource assessment to see what's out there and how to get it, but you look at each other's capabilities and you say, what can they do and what can we do and this is spelled out in the roles and responsibilities of the plan. So how can we talk quite a bit about that one?

Those deal with a lot. There are five resource elements in this capability and that's how, that's where we're looking at. The first one deals with that assessment. The second one deals with implementation of the resource management process and the third one deals with management and resupplying the caches.

If you follow along on the slides, we're going to pop over to slide number 16. Now there are a couple of other resource elements in this capability that I want to point out. And number three, P3, planning element number three talks about the public health resource support to healthcare organizations.

We're beaten up on time here so I am not going to really go into a local example. But just understand and know that this resource element when you read it, it is an opportunity for that cross-collaboration between HPP and PHEP for public health support space, especially syndromic surveillance and epidemiology type of activity.

So this is very important at the hospital level and the healthcare facility level, so just look at that resource element when you get a chance and say, OK, we can actually use HPP funds to do certain activity as it relates to hospital in that public health arena of epidemiology and syndromic surveillance. So it's kind of an important one. If you have any questions we'll open that up later.

One thing I want to get across quite strongly here that we really are looking at the inventory and management process. The ability to have a system in place, you know,

it doesn't necessarily have to be electronic but as things go that's one of the areas that it kind of needs to be electronic to be able to manage it and have a good common operating picture, a good understanding of where the resources are. It doesn't mean you have to get into the hospital logistics warehouse and say we got to know everything within every single hospital or nursing care.

No. This talks about what has been bought and it could be used and shared. And it also includes things such as regional caches, mobile medical assets, state assets and things like that. But we're not going to say OK, we want to see every little inventory item in every single healthcare facility. We're really looking at a comprehensive picture of the inventory management system, information system so that you can have ability to see and track and monitor where your assets are during a response. So it's kind of an important bullet there.

Moving on, we're in our last function. It talks about resource demobilization and then the after-action process. Resource demobilization is basically you're working within that framework to demobilize your assets.

So if there is a process that you're going from state to local and getting your asset there. It talks about the reimbursement processes and such like that. There are other resource options available – how do you resupply those caches, how do you get things back into shape for the next time of deployment, how do you get things paid for, basically.

The last one is a very, very important slide. And we have a good example. A speaker is going to be coming on the line and talking about this on from Missouri. And it talks about the after-action process. And the after-action process is very important because it completes that cycle and starts it anew. So we're talking about that preparedness cycle.

The ability of healthcare coalitions to have a honest and legitimate after-action input into a report and to get that improvement plan in place moving forward to the next planning cycle, so that you can fix your coalition so that you can fix your plan, so that you can fix your resource management process and your information process. These are the kind of things that we really need to see in that after-action type of process and we're going to encourage the coalitions to really get involved with that within the framework that's set up. Once again it's within the framework.

We're right on time here. I don't want to go too much further. But there is going to be a document coming out. It's an article that talks from healthyamerican.org, the Trust for America's Health just came out about certain responses that occurred up in Boston, came out the response that happened down in Texas with the plant explosion and then the Kentucky tornados and how coalitions and HPP dollars were used in those events. And we'll be sending that out in the notes page. I didn't get it in this notes presentation and I apologize for that but we will make sure you get that information afterwards.

So without any further delay, let's go into the talk about function number one. And this is – our first speaker is Ray Apodaca. He is the team lead for HPP in the Texas Department of State Health Services. And he is going to talk about his coalition and a really operational type of approach to coalition response.

So, Ray, go ahead, please.

Ray Apodaca: Thank you, Paul. This is Ray from Texas. And as Paul indicated we very much have a robust response capability with our HPP healthcare coalitions. Since day one because of the size of our state and the number of hospitals we have, we took a regional approach to our HPP program. And what we did is we tapped into our existing EMS and trauma system for the state of Texas and that led to us establishing 22 healthcare coalitions.

Because they were an existing EMS and trauma structure we had a natural relation with them when it comes to responding to real life events. Early on as most states did with HPP, we started purchasing a lot of equipment developing and building HPP response capacity through the establishment of mobile medical assets, regional equipment caches, so on, so on, so forth.

We very quickly realized that we were buying a lot of stuff and there was a lot of stuff, but we needed a better organized approach. So actually our healthcare coalitions came to us, came to the state and said we need to develop a more organized approach.

So our healthcare coalitions presented an idea to us to create through HPP an emergency medical taskforce system. And that's what we did, to be better organized when it comes to response. We established eight emergency medical taskforce teams across the state of Texas that cover the entire state and each emergency medical

taskforce includes multiple healthcare coalitions and all the resources and mobile medical assets available within those healthcare coalitions.

The emergency medical taskforce involves establishment of ambulance strike teams, establishing ambulance buses that can respond and transport many patients if the need arises and serve many other functions as a mobile am bus.

Each of those emergency medical taskforces also is tasked with establishing RN or nurse strike teams to be able to deploy from one region to another to assist medical facilities when they become overloaded or over-tasked during a real life event. Our emergency medical taskforce also involved the creation of mobile medical units, mobile hospitals that are very modular and can be deployed depending on the nature and the size of the incident.

And as part of the emergency medical taskforce we've also been able to develop other things that we've had a lot of success with. For example, we've conducted a lot of training and developed some response capacity with the creation of medical incident support teams that can be forward deployed and assist a local jurisdiction with knowledge of all our existing resources and all of our mobile medical assets and really can be an asset to the existing emergency management structure that is dealing with a real life response.

Now early on we did have a lot of resistance particularly from emergency management because there were questions about our healthcare coalitions and our emergency medical taskforces did not have legal jurisdiction or authority to respond. And so we struggled with that in the earlier stages.

But one of the things that we were very lucky with is the state hired a new emergency management coordinator for the state several years ago, and this individual actually had knowledge and experience with our healthcare coalitions and he has become one of the champions for our healthcare coalitions and our emergency medical taskforce.

So we now have a system in place to where our emergency medical taskforce and our healthcare coalitions actually receive a state mission assignment and can be deployed as a state resource through the emergency management structure in the state of Texas. And that I think has resolved a lot of the issues and concerns about their legal authority to respond.

Our healthcare coalitions have also developed regional medical operation centers that serve as a support to existing emergency management and local and regional health authorities to help coordinate ESFA resources during real life event response. Our healthcare coalitions because of the resources that have been built and put in place through the coalitions are able to respond to local and regional incidents through normal mutual aid and establish MOUs and MOAs.

But for larger incidents they are deployed as a state resource as they have over the years for like the wildfires that we had, hurricanes, tornados and then the recent major explosion at that fertilizer plant in West Texas. But it's interesting how now the system that we have has matured and the more education that is passed on and knowledge about the existing resources and their ability to respond and support existing responders and emergency management, we are now receiving more and more requests to assist during real life response from emergency management, from law enforcement, from fire departments, and other first responders. I know that's a lot of information. I tried to keep it high level because of the time.

But we also have information that you can access on the ASPR Website about the Texas Emergency Medical Task Force system. Just search Texas EMTF and you can find that information. Plus, I also have brochure and other information about our emergency medical task force from our HPP program and our healthcare coalitions and I'm happy to answer any questions anybody may have.

Paul Link: Thank you, Ray. That was a very good presentation.

And we did – our presenter did give us the OK to put their e-mails on there in case you do have questions for them.

Our next presenter is going to provide another type of healthcare coalition operational response. And we've – we have listed on the agenda, Marybeth Strobe, from North Carolina. But the Health Care Preparedness Response and Recovery Operations Manager, Jeff Peterson, is coming on to talk about their coalitions and their response and they have a very robust system also.

So, Jeff, please go ahead.

Jeff Peterson: Thank you, Paul.

Much like what Ray was talking about in Texas, we based our healthcare coalitions here in North Carolina, also had been existing backbone from our trauma system that we had here in North Carolina already.

So with that, with eight trauma regions within the state, so we built up our regions around those eight trauma systems that built our eight healthcare coalitions off that. When the transition was made over the healthcare coalitions, we already had a foothold on this – on the response side due to the fact that we have eight – what we call – type three medical systems within those eight healthcare coalitions already.

To augment those, we have 30 SMAP three teams which are locally-based teams with EMS and fire departments that provide mass patient decon, as well as mass triage and responder health and safety.

But obviously, the focus on this is at the coalition level, so those eight SMAP 2 that will be the focus of this. Our coalitions – and I apologize that Mary-Beth couldn't be with us today. She had a family emergency and was called out of town. But I'm speaking of her notes that she provided.

So, our coalitions are 100 percent HPP funded through a contract with the trauma region lead hospitals. So within all eight of those healthcare coalitions, six of them are anchored by level one trauma center and two of them are anchored by a level two trauma center. And all eight of those facilities pretty much are the referral hospitals within that area.

So with that, there's type two – the state medical system (inaudible) type twos are located with those lead hospitals and then the healthcare coalitions. Much like what Ray said with Texas, we struggled with the fact that our healthcare coalitions had no legal authority to act on their own.

So with that being said, we also investigated ideas in __ two function at the state level under the North Carolina Emergency Management so to speak compact here within North Carolina which is an assistance that grants legal authority and responsibility to coordinate response during an actual statewide declared event.

Locally, our teams respond to local events within their regions based off of MOAs that are provided. There is a county-to-county emergency management MOA that's

on file with the state that all county and tribal agencies within North Carolina are written into.

And then, on top of that, the North Carolina Hospital Association has a hospital-to-hospital mutual aid agreement that's in place. And with our regions being anchored by those lead hospitals, automatically, that brings them under that hospital-to-hospital mutual aid contract as well.

So, diving just a little bit in based off of what Ray had said, we very much – our program mirrors very much what Texas has. But, just to give you a little bit of idea about what our coalitions do on the emergency operation side on a day-to-day basis as well as during emergency and disaster events. Our healthcare coalitions assist to coordinate and manage response within the regional healthcare coalitions themselves with their actual coalition assets. Now, we here in North Carolina have a set structure for calling upon resources and assets that was set by the North Carolina Emergency Management.

And as I stated earlier, we didn't see any need nor did we desire to go around that process which very much allowed us to integrate into the emergency management field because we weren't bringing anything new to the table other than the assets. We fell right under their jurisdiction and how they actually respond during emergency.

So our regions also did – they maintain situational awareness, not only with the state and the region, but also with the coalition members themselves. So that's kind of like that up, down, and sideways awareness and information dissemination that Captain Link referred to earlier.

They do assist in the coordination of regional ESF resources during an event. And like Ray described, from Texas, we have local medical assets here in North Carolina to include mobile hospital facilities. We do have special medical needs sheltering units out of each of the eight regions, ambulance strike teams, ambulance task forces that include our buses.

So there's a lot of assets at like the regional level that are considered regional assets. And in addition, they serve as the liaison between our regional stakeholders, our local stakeholders, and then North Carolina ESF-8 which in North Carolina is led by the state office of EMS, but is co-anchored by our partners with public health as well.

So, I know we're getting through on time, but just to give you an overview of the response in that – so there your local or individual entities utilize the MOAs or MOUs as I referred to earlier. The healthcare coalitions may assist in the coordination of deployment with their own assets.

When this happens, then, reimbursement is typically on a local to regional request. If there is any at all, often requesting agency covers all costs or no reimbursement is requested at all.

And the healthcare coalition serves as a fusion center basically for that information sharing that goes on. And then, also, they notify ESF-8 at the state level when there is a response.

When you look at a state response, that's a whole another bucket, so to speak, and like Ray described, we receive our mission numbers from the State Emergency Management Agency. They send us the ESF-8 leads and then the ESF-8 lead at the state level or our office actually tasks the regions with deployment.

So when the local jurisdiction is overwhelmed or they've exhausted their resources, North Carolina Emergency Management coordinates further resource requests with the state office of EMS with the ESF-8 lead.

The resource request is made to the North Carolina E.N. from the locality or the agency or even the hospital facility through WEB EOC and then, that resource request review is verified and then is attached to the appropriate ESF lead which would be our office in the ESF-8.

The healthcare coalitions are then tasked to assist in the coordination of that coalition and possibly other regional medical assets to augment the need as identified by the mission.

So basically, we have a flow that goes through that emergency management I already set forth. And then, we move through that to provide the resources that are allocated for the mission.

All SMAT 2 and SMAT 3 teams when they're deployed by the state are reimbursed through the state. And our office, ESF-8 lead as well as the regional healthcare coalitions help with getting, completing that reimbursement paperwork and our

regions have had classes with emergency management on financial reimbursement, not only during the EMAC process, but also during federal responses as well.

So they're versed in how to go about applying for reimbursement. And so far, we've done very well. Our coalitions have responded more out of state, their EMAC missions to Mississippi, to Kentucky in 2009. Most recently, we've done some special medical needs, sheltering missions during Hurricane Irene as well. So, our regions, like Ray said, it is a lot to discuss in a short period of time, but our regions – our healthcare coalitions are very integral and they are – they do make up the response arm for ESF-8 with assets and personnel within the state of North Carolina.

Paul Link: Thank you, Jeff.

Those were two outstanding examples of how healthcare coalitions have developed resources and developed the operational components and they work within the framework of emergency management into the management.

I want to move on in this function to a little different kind of concept about how healthcare coalition can be used purely as a multi-agency coordinating system or center or group.

And with that, I'm going to turn this over to Mr. Jim Craig. He's the Director of the Office of Health Protection in the Mississippi State Department of Health.

Mr. Craig?

Jim Craig: Thank you, Paul, and thanks for everyone on the call today.

Mississippi is probably a little bit different in our approach to healthcare coalitions. So while Jeff and our friends in Texas kind of went over a lot their assets, we have very similar assets in our state, but those caches were developed really for state resources.

You know, Mississippi is a small state, a little less than 3 million people, but we have numerous response systems. In fact, currently, we're – we have 20 federal declarations that are still open in Mississippi that we're doing recovery efforts on.

So we respond a lot and these coalitions have been around before they got the formal names of healthcare coalitions under the HPP program. Mississippi is also

centralized for public health which is probably a little bit different way to look at some of the activities that we do.

The State Department of Health is the coordinating agency and leads the state public health and medical response in Mississippi. And as I said, all the caches that we have were developed as state resources to support and local government.

Make no mistake that we had the same types of discussions about command and control and authorities for coalitions as the HPP guys came out. Local government is in charge of responses in Mississippi and we are – we exist to assist them in fulfilling their response missions.

They do have a couple of ways they do that. Jeff mentioned one that we are very similar. We call it SMAC. It's our mutual aid assist is compact between the different counties. So some of the resources that we have developed that are part of county, governments, can be interchanged or used during that cooperative agreement.

So we have 10 coalitions in Mississippi, one of which is our statewide coalition. We call it the Mississippi ESF-8 healthcare coalitions. It's been around for a little over 30 years. It contains all of the ESF-8 partners. There're 23 state agencies, our non-governmental organizations, representatives from the private sector, as well as health care associations that are part of that coalition.

We're formalizing a lot more of that into some of the things to be accountable to the levels that we're looking for in the HPP program. But that group, working together to plan the health and medical response and to assist in the response has existed for a long, long time.

So pre-incident, the statewide coalition really functions on those planning activities, making sure that we meet all the requirements and the governors confidence of emergency management plan, training together, exercising together, and then, of course, doing after action reports together.

During the response, that statewide coalition really helps us with what we call our RNA, our rapid needs assessment of the impacts of any type of event on the health care system in our state, ensuring those communication lanes and conduits are all open and that information is being exchanged to ultimately create a common operating picture for our state as it relates to the health care sector.

More importantly for today's discussion though was we have nine public health regional coalitions that have really existed for a number of years. We're formalizing those into – as was described – MACs, as well as information centers.

So, the local ESF-8 partners in each of the counties are part of what we used to call our ESF-8 coalitions, but now, they're the public health regional coalitions. They include the nongovernmental organizations, as well as many, many health care facilities. Health care facilities are very, very important part of our visibility that we've learned during our responses so that we can make sure that the needs are addressed timely and help local emergency management in supporting the health care system.

You know, Mississippi is also fortunate to have a mandatory trauma care system. Every hospital in the state of Mississippi has to participate in the system and in fact, if they don't, and they have resources they can assist in the system, then they have to pay or play. They have to pay a fine or a fee into the trauma care system for others to take care of patients in the event that they choose not to play in our system.

But as such, there are – the regions have been set up into 501C corporations and really managed by a lot of the C-suite, the CEOs, CNOs. So, decision-makers are part of that process. And I think that's very unique to the MAC process.

For Mississippi, what we want as pre-incident is for these coalitions to obviously do the planning, set the protocols and processes and procedures, business practices and communications to have a system that will allow them to provide multi-agency coordination with various agencies and disciplines. So they can work together much more effectively.

But their primary function is to prioritize the incident demands, those things that local government require for critical and/or competing resources. So, our MACs are really there to help make good decisions about where resources should go.

And we presented it kind of this way. Do you want us sitting up here at the capital to figure out how many of everything needs to go to each county, say, during an H1N1 response or is this better decided by the health care sector in that area? They chose overwhelmingly to form MACs so that they could prioritize these resources and then allocate those resources accordingly.

So, between the trauma care system and the players in the trauma care system and the normal partners that we have for ESF-8, these regional coalitions have been developed and we support here through our state ESF-8 response. But they have no command and control functions. They're strictly there to support our ESF-8 planning section during a response as well as local government requests for services in the health care sector.

You know, Mississippi also, after Katrina, learned the importance of having health care facility plans. In fact, our state board of health, our governing body has passed regulations requiring that every health care facility in the state have a plan that's not only approved by health care, but also approved by local emergency management. That's been part of our success and I think part of what helps formalize the processes that our coalition goes through.

So I'll just give you a quick example as my time expires. But we had a flood of the Mississippi River. You know, we always have more water in the river or not enough water. We can't always have it just right.

But during the flood, there was an opportunity for the levee to fail in part of Mississippi that had probably close to 1,100 health care folks that were in facilities. And the group got together and looked at their plans and prioritized resources and made sure that duplication of resources that may have existed in some of the plans were de-conflicted so that in the event that levee failed, they would be able to take care of that population, healthcare population in that area. And that’s part of the success I think of our group being able to get together to allocate resources and prioritize resources and to assist local governments and being sucessful in their response.

Paul, with that, I’ll turn it back over to you.

Paul Link: Thank you, sir. That’s another great example of a healthcare coalition. And that doesn’t necessarily conform to the operational component that, that the previous two speakers, Jeff and Ray, talked about.

So, you have three very good examples of those roles and responsibilities and how health coalitions could be developed, and they're all perfectly acceptable. Just the awardee, as you as the awardee just needs to define your system, its flexible approach is allowed and tell us how you're going to do it.

So moving on, into function number two, we're going to talk about that information flow, the information up, down, out and a little bit about how Michigan does their response authority. And we're going to start that off with Linda Scott. She's the manager for the HPP program at the Michigan Department of Community Health. So Linda, do you want to take it?

Linda Scott: I will. Thank you. Like Texas and New York, Michigan established eight regional healthcare coalitions within an established framework, so the geographic boundaries of our eight healthcare coalitions near the state's emergency management districts. So the link with traditional public safety has been strong in Michigan since 2002 when our coalitions were formed.

Then when within each of these coalitions, they have a similar infrastructure for committee and decision-making that utilizes the diverse membership that was part of that original formation but has expanded over the course of this project. And this is really important to understand as we look at emergency operation coordination.

So, consistent with the medical surge capacity, and capability document, each of our regions has a medical coordination center. And I want to stress that this is, as the other speakers had noted, a coordination center which functions as a MAC to support healthcare coordination.

Now, that doesn't mean that we have not had our same authority struggles as all of our speakers have talked about and some I'm sure are still having. But the good news is that over the course of this project, our eight regional healthcare coalitions are actually written into the state of Michigan Emergency Management Plan to support an ESF-8 response, in coordination with the state public health. So, that Medical Coordinating Center is validated through our state emergency management plan, so that is with local and state emergency management and local and public health partners.

Also, how we tackled some of these authority issues is that the Medical Coordination Center is also written into the state of Michigan, EMS Mass Casualty Incident Protocol which again gives authority – not really authority but I guess coordination and the ability to make those kinds of decisions that need to happen on behalf of healthcare through the state Mass Casualty Incident Protocol.

Function two really focuses on information sharing, really related to a couple of issues. The impact of an incident on the healthcare organizations, the ability to develop a common operating picture, and to establish processes for notifying and information-sharing throughout the incident.

With that, our HPC leadership is 100 percent funded by hospital preparedness funds. And so, in order to really give you the flavor of this from the coalition standpoint, I'm going to turn this function over to Amy Shehu who is our Region 2 South healthcare coalition coordinator, and she's going to talk about this function from that more hands-on operational role from the viewpoint of the coalition.

Amy Shehu: Thank you, Linda. And thank you for the opportunity to speak about the role of the healthcare coalitions in relation to the Emergency Operations Coordination, and what we've done in Michigan, and for me specifically for operations in southeastern Michigan.

I'm the coalition coordinator for Region 2 South healthcare coalition which serves the counties of Wayne, Washtenaw, and Monroe County, including the city of Detroit. Geographically, Region 2 South covers just over a 2,000 square miles; and from a population standpoint, we have approximately 2.6 million people in our region. That’s 25 percent of Michigan's 10 million populations.

The high population density with a small geographical area, combined with the fact that we share a state border with Ohio and an international border with Canada, as well as we’re serving the major metropolitan area of Detroit gives us special planning in response considerations unique to other coalitions in the state.

When the coalitions were first formed in Michigan in 2002 with the establishment of the original National Bioterrorism Hospital Preparedness Program, my initial mission was to enhance local preparedness through the development of integrated and coordinated planning with local response agencies.

Several years since the program, our mission involved not only to be about planning, but to structure the coalitions as responding organizations to help maintain the delivery of flexible coordinated, uninterrupted healthcare services; not only in an emergency or disaster but also in daily operations.

Our role with the coalition is to provide support to local partners and emergency operation centers, facilitate standardization and interoperability of healthcare operations, and ensure optimal and efficient use of available resources for the healthcare community.

A primary component of the responsibilities of the coalition is to determine to what extent an incident has impacted healthcare delivery so that resources and the needs can be identified. We do this by creating a common operating picture.

To establish this picture, we need to have processes in place to obtain the information needed and mechanisms for notification of this information to key partners. And Michigan, to assist in this process, the coalitions in the state department worked together to create a standardized essential elements of information worksheet to obtain situational awareness information that is critical to the initial response, ongoing response, and recovery operational periods.

The work stream elements were designed to be adjustable and scaled to suit the nature of the circumstances. Once the essential elements of information is obtained , each coalition in Michigan has Medical Coordination Center that Linda spoke of that is able to use any variety of communication tools such 800 megahertz radios, health alert network notifications, e-mail, satellite phones, customized interoperable communication units, even ham radios to communicate the healthcare delivery status to key partners.

We have electronic applications to collect immediate bed availability and incident management systems to report response activities that is accessible to local hospitals, public health, emergency management, regional coalitions, and state public health, and emergency management.

From a Region 2 South coalition perspective in Southeastern Michigan, due to the nature of our region, we've been involved in planning in response activities for many high profile events, as well as situations that have impacted the healthcare delivery status among local partners in Southeastern Michigan.

Our Region 2 South healthcare coalition has worked with Major League Baseball to plan for the All Star game in 2005. We worked with the National Football League to develop medical operations plans for the Super Bowl XL in 2006. We've done the medical operations planning for four Grand Prix races that have occurred since 2007.

And we've also pre-deployed medical assets to strategic locations during these high profile events should an incident occur.

We have also been involved in response activities to local incidents. The Region 2 South Medical Coordination Center was involved in the ongoing assessment of healthcare delivery status and the identification of needed resources, and the request, coordination and management resources from the strategic national stockpile in response to the 2009 novel influenza H1N1 outbreak.

We were also involved in response to the 2012 fungal meningitis outbreak that resulted from foreign lots of contamination steroids that originated from a compounding center in the East Coast, and that was distributed to states across the country from May to September of 2012.

Four healthcare centers in Michigan received contaminated products from this center. The center that received the most products in Michigan sent their patients to a hospital that was located in Region 2 South. This hospital saw and treated over 600 patients related to this incident and became the leading hospital in response to this incident in the nation.

They were so involved with the response and saw so many patients from this outbreak that the treatment guidelines that they developed became the official guidelines adopted and distributed nationwide by the Centers for Disease Control and Prevention.

Due to the fact that the treatment was very labor and resource intensive, the hospital was very much in communication with the Region 2 South healthcare coalition throughout the duration of response, and about three weeks ____ requested assistance from the coalition.

Throughout the event, Region 2 South utilized our essential elements of information form that was in place at that time to assess and notify status of healthcare delivery across the region. Within two hours of request, Region 2 South was able to provide the hospital a list of hospitals that had the capability and resources to assist in the treatment of these patients who needed a very special level of care, and also facilitated their request of medical volunteers who met very defined criteria. These volunteers enabled the hospital to maintain their existing level of healthcare services and provide a three-deep manpower for almost two months for the hospital.

This was an example of the role of the healthcare coalitions in supporting the healthcare infrastructure and level of services, an event that was not a declared emergency but that did impact the healthcare delivery status and daily operations for an ongoing duration of time. Their most critical response was two to three months long, and they're still responding to this incident even today with the treatment of secondary abscesses that are developing in these patients and keep coming back.

So, I've spoken a little bit about the role of the coalition in assessing healthcare delivery and information sharing in Michigan, and briefly discussed several examples about planning and response operations in Southeastern Michigan. I'll be happy to provide the more in-depth information or plans that we have in place if anyone is interested.

And with that, I'm going to turn this back to the facilitator, and thank you for the opportunity to speak on emergency operations coordination.

Paul Link: Thank you, Linda and Amy. That was a very, very good example of the Michigan response and a local level example of coalition activity as related to developing of the essential elements of information. Very, very strong coalition in Michigan, but we're going to move on to function number three and talk about resource management and the resource management process of North Dakota.

On the line, we have Tim Wiedrich from the North Dakota State that he's – the North Dakota State Preparedness Director from the North Dakota Department of Health. Tim, are you on the line?

Juli Sickler: Hi. This is Juli Sickler I am the North Dakota PHEP Director and work directly with Tim, Tim is running late today, so I'm – if you don't mind, I would like to give an overview for North Dakota.

Paul Link: No problem, Juli. Go ahead.

Juli Sickler: Sure. I can tell you that here in North Dakota, we participated in a statewide gap analysis, and found that really two important points for our response. Number one, that most of the events in North Dakota are weather related and that's due to floods. We deal with ice storms, blizzards, tornadoes, those types of responses.

And then number two, as you all may well know, North Dakota is very rural. So for us, it's a challenge to get our resources out to areas of need in a timely manner. What we've done here is developed a department operation center. We are one of only a handful of state agencies that actually have our own department operation center. We operate under the State Emergency Operation Center, and are responsible for the health and medical response for the state of North Dakota.

We have several systems that we've developed that do operate together. The first is the communication system we refer to as WBOC, which is a software application that we purchased sometime ago. It is headquartered and housed out of the State Emergency Operations Center. But not only do we speak and coordinate through that application not only in our department operation center but also the hospitals have access to that communications application.

The local public health units have access to that communications application, as well – as the county emergency managers throughout the state. So in time of either one event or multiple events, we do come together over that communications application to coordinate our resources for response.

Another software application we operate is HC standard and that is really available to the hospitals, the 52 hospitals and long-term care facilities across the state of North Dakota. And this application gives us real-time status of what's going on in those facilities with regard to bed availability and patient status.

I can tell you that when we do have a need to evacuate residents, we will ask our local partners to go into this system and they will enter the status of bed availability for transfer of residents from one area of the state to another. And also, they are able to provide us with other requested information about those patients, such as what is needed to transfer those patients, whether that would be geriatric wheelchairs, stretchers, etcetera. That is all available in HC standards.

We also have developed contracts for resources with our agencies across the state. These are not MOUs or MOAs, so to speak. These are actual contracts that outline what they are going to be providing during the event, also what the reimbursement will be for the assets and resources that they provide.

The first line of reimbursement will come from an ergency fund that we have established with the State Emergency Operation Center, and that will be a form of

payment in lieu of the Stafford Act or other form of federal reimbursement for that response.

Those contracts we have in place are with the emergency medical services across the state. Our hospitals, our local public health units, our long-term care facilities. We have contracts with the bus companies to assist us with transportation of wheelchair patients, and stretcher patients.

We also have contracts with the universities, the major universities in the state of North Dakota to operate as medical shelters and also to provide wraparound services or assistance with us in operating those medical shelters.

Other resources we have are in a warehouse. We have taken on the operation of a 30,000 square foot facility. In that facility, we have about $11 million worth of assets. This comes to us from the HPP program and the PHEP program, and as well, we have a local participation from the hospital association and local public health throughout the state who really have contributed with this collection of assets.

In North Dakota, we don't necessarily consider this warehouse and the things in the warehouse a state asset, it is really a shared asset between the state and our local partners. We do have a system in place. And we consider it an online shopping experience where anybody actually can go in and order items from the state medical cache here in North Dakota. Once that order is placed, it goes through an incident command process here in our office. That system is available 24/7. And we will make a direct contact with those facilities requesting our resources, determine need in transportation. But as I said this warehouse full of its assets really is considered both a state and local asset.

We have also started deploying those assets out into the state through the use of 53-foot semi-trailers. We have four hospital regions in the state of North Dakota, eight public health regions in the state of North Dakota and we are in the process of deploying a 53-foot semi trailer full of the needed assets according to the events that I mentioned earlier, out to the major cities in North Dakota which really provides us more efficient response time with the assets.

With that I think I will let it come back to our host. If you have questions at the end I will be available. And Tim has also joined us for questions if necessary.

Paul Link: Thank you so much. That was a really good presentation. And I'm sure a lot of people are going to be interested on your online shopping experience. I thought that was a pretty nice way to put it.

So moving to function three talking about resource management we've had six speakers that had really talked about basically through their coalition description told us about how they managed resources and information. We're going to continue that with our next speaker who is Leslie Porth. She is the vice president of health planning for the Missouri hospital section. She continues with this resource management process and then tell us a little bit about after-action reporting.

Leslie, go ahead.

Leslie Porth: All right. Thank you. And thank you for the opportunity to share our experiences in Missouri. I want to focus as indicated initially on function three and then I'll transition directly into function four. And the highlights that I'm going to talk about today are the experiences and the lessons learned and the progress made in our coalitions that have been developed in our rural and small metropolitan statistical areas in the state of Missouri.

Like so many that have already spoken today in other states that have really emerging best practices or established best practices, our coalitions really came into fruition approximately 2007. However, really it was the spring of 2011 that we launched our coalitions in our what we call our out-state area. And we launched those coalitions just two months prior to the Joplin tornado. So our experience in function three in coordinating our response during that Joplin tornado using our coalitions which were a brand new concept and entity was a great opportunity for lessons learned.

And some of the successes and the highlights that we had during that Joplin response as far as the coordination of resources, first of all, we used and continue to use our statewide hospital mutual aid agreement for coordination and allocation of shared resources through our hospital mutual aid agreement for our coalition. Our coalitions have not developed a separate mutual aid agreement. There are using the existing state level health sector mutual aid agreement. These are hospital mutual aid agreements these EMS, our local public health, etcetera. So that makes an efficient and standardized process across the state of Missouri.

So during that tornado we used our hospital mutual aid agreement and we used it for both organizational and regional coordination and allocation of resources. At the hospital level we used it for tetanus, staph, personnel and then fatality supplies.

And then at the regional level we used it predominantly for mobile communication trailer system and also medical search supplies. And those regional resources and assets are standardized across the state of Missouri especially in our rural and small metropolitan areas so that we can immediately interchange and add to and supplement resources without any required training.

That example demonstrated itself in Joplin because the mobile communication trailer was destroyed that was located in Joplin. So we were able to quickly bring in an identical trailer from a different region of the state and provide that same resource without the need for training.

The other thing that we did is that the association MHA served as a liaison and that is a really a critical role in distinction because we are not part of the official command and control structure. But in the incident command structure we serve as a liaison between our hospitals, our regional coalitions, the Department of Health and our state emergency operation center. And so, we serve in that role to help again coordinate and distribute and allocate the resources in the most efficient and effective manner possible.

The other thing that we did is we coordinated with our state disaster medical assistance team. And in the early minutes of the immediately following the tornado, a decision was made that the association, the MHA staff, myself and my counterparts and my colleagues, we would focus on the hospital that was receiving all of the surge and support them and DMAT would focus on the hospital that was destroyed in helping them setup temporary services. And so, we did that probably within 30 minutes of the disaster and it allowed through that night for very efficient coordination, MHA focusing on the surge and our DMAT focusing on the destroyed hospital.

Again with all of this as others have talked about, the critical component of all this is communication and information sharing. We had great situational awareness outside of the Joplin area across the state of Missouri but all of our electronic systems had been destroyed and we were – we had very minimal Internet and cell service and

satellite service in those first few hours after the tornado. So again relying on those electronic systems is great.

But what we demonstrated there is that we needed additional redundant systems and standardizing the sequential process of those communication systems in that area that was destroyed and had minimal technology capability.

So that's really how we coordinated. I will tell you in conclusion for function three what we did look at is the association really served as that liaison with the hospital and the regional coordination. Because our coalitions were brand new we did not use our coalitions as effectively then as we would today. Today if that same tornado were to go through the state what we would do instead of coordinating with 154 hospitals we would coordinate with seven coalitions around the state to achieve the same thing ,and I believe that it would be more efficient and more effective than it was during the Joplin response working individually with the hospitals. Approximately 24 hours into that tornado we began using those brand new established coalitions more effectively and were taking incredible notes. And speaking about how we could better utilize it in the future.

I will then transition then to function four which is demobilizing and evaluating healthcare operations. And I will tell you we went through a very comprehensive process and utilizing the tools of process improvement to evaluate at the organizational, regional, jurisdictional and state levels how the hospitals, the coalitions and the association could have better coordinated our response during that Joplin tornado.

And we did this through first of all first and first and foremost a confidential hospital hot wash that was hosted by the association and not part of the state official documents for the disaster. And we did that with invitation-only, very careful note-taking and captured some really great raw data and lessons learned that we've been able to apply in all of our plans going forward.

We did then a formal after-action and coordination with our state partners. We did a – the association did a very comprehensive document review of the documents at both of the hospitals. And then also did a formal after-action with our coalitions, talking to them, especially that coalition in Joplin but also our surrounding coalition and thinking through how we could better utilize their expertise and their roles in those first hours.

And then, finally, we conducted the individual interviews of key leadership both in the C-suite and emergency preparedness staff in the two Joplin hospitals and the long-term acute care hospital in that area as well as surrounding hospitals. So we went through very comprehensive processes as to collect as much anecdotal and quantitative information as possible to help us evaluate what we could do differently going forward.

And as I indicated our coalitions were brand new. And so many lessons learned there on how we could have better utilized them and the skills and the resources they brought and could have contributed to the response. And again, that process some of the high level lessons learned that we had, first of all, our hospital mutual aid agreement worked incredibly well. We were – to be honest with you, we used it two or three times in small ice storms or winter-related events between one or two hospitals but we had never used it in this capacity and it worked much more effectively than we anticipated.

But a couple of lessons learned there; one is we quickly identified that the mutual aid agreement is really a tool and a resource for response. And we have to identify a trigger point, a point in time where you transition from response to recovery. And once you enter truly a recovery phase versus a response phase, the mutual aid agreement is probably no longer the best tool to use. We used our hospital mutual aid agreement for almost a month for some of the staffing needs and in retrospect we should've transitioned that to temporary staffing agencies or other mechanisms at approximately the two-week mark.

The other thing that we learned is it's very, very important if you asked a resource in a community to stand up for possible deployment to let them know and notify them when they can stand down. That first night we asked about seven of our mobile communication trailers to stand up and unfortunately about 72 hours later received a request from one of them could they stand down. And obviously by that point we should have long before that has given them acknowledgement that they could stand down so something easy and quick to remember.

The other thing that the mutual aid agreement worked well for was staffing. And as several people have talked about their mutual aid agreements, our staffing from hospital to hospital for the mutual aid – through the mutual aid agreement works very

effectively because we have worked out issues of liability, compensation, workman's comp, benefits, travel expenses, the rate of pay based on variations across the state.

And so, it's a very clean system for the states to use – or for the hospitals to use across the state to bring in staff. And they've gone through similar credentialing processes. So there's an assurance there.

It's not – that's not to discount the ESR VIC program because it's a very important program and it works very well in our state. But from hospital to hospital staffing, we tend to use as our first final mutual aid agreement and then use our ESR VIC bed pools for sheltering community health centers, vaccination clinics, pods, et cetera, and then, as a secondary line of staffing for our hospitals. So again, our mutual aid agreement worked effectively there.

The other state lessons learned that we used, there were two others that were really critical. One is our coordination with EMS. And it worked well that evening, but we identified many areas where we could improve our coordination with EMS services and it really speaks to the issue that where we struggled and what we identified in Joplin and what we continue to work on is a plan for mass patient movement.

And that includes with it one of the other key lessons learned and that was our patient tracking system. And I say this very candidly. I've said it many times, what we learned just the week prior to the Joplin tornado in the national level exercise that we were part of is that we had tracking tools – patient tracking tools, but we did not have a patient tracking system and that's a really critical difference.

You can have a lot of technology and a lot of tools and resources, but if you don't have a comprehensive system on how you're going to move large numbers of people and how you're going to manage and triage and track those folks, the tools are of limited value and that was a lesson we learned.

So, that EMS coordination and that patient tracking component and that triage component were very critical. They were integrated then to one major lesson. We continue to work on that.

We continue to refine those plans and those processes. We still don't have that worked out. But, really, going through the process of after action and process improvement evaluation really – and all that document review really enabled us to

really dive very deep into those issues and identify some very specific challenges that we continue to work on.

And then last is communication. And again, it is strategic communication, who needs to know what and at what time. It is operational communication. It is what systems do we have in place and in what sequence should we use our redundant system.

We had people using our amateur radios. We had people using ____ radios. We had people using sat phones, all resources that were provided within communication, but because they were all using different redundant systems were not able to talk effectively.

And then, the last level of communication, of course, is that tactical and thinking about the various channels and the allocation of those radio channels and what information is conveyed in what networks and in what time intervals so that you maintain adequate information without overwhelming those radio systems.

And so, again, using interviews, hot wash document review and formal after action of a variety of groups, we were really able to dive into our response, evaluate it and continue to refine our plans as a result of that.

So I think with that, I will turn it back over to the facilitators.

Hello?

Female: Hi.

Paul Link: I was on mute. I don't want to go through the summary here. I want to get right into the questions.

So, operator, can you open up the lines for questions?

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

Again, ladies and gentlemen, if you'd like to ask a question, please press star, then one. We'll pause one moment to see if there are any questions.

Paul Link: So when you ask your questions, just ask – who do you want to ask it to, one of the guest speakers or to ASPR HPP or – and provide your name and your program, please. Thank you.

Operator, are there any questions on the queue?

Operator: Yes, sir. Our first question comes from Anu Nair. Your line is now open.

Anu Nair: Thank you. Hi, Paul, this is Anu from South Carolina, I'm the HPP program manager here.

I was wondering, could we get a document with the highlighted points from each of the speakers? There was a lot of excellent information. I want to make to make sure we captured everything.

Paul Link: Yes, Anu. We will definitely have a post-presentation notes page sent out with all the little links. And if some of the speakers want to provide some other documents that they've provided in the conversation, we will attach those to it also.

Anu Nair: OK. That's wonderful. Thank you.

Paul Link: Yes, ma'am.

Operator: Thank you.

Our next question comes from Holly Peterson. Your line is now open.

Holly Peterson: Hi. This is Holly Peterson. I'm the ASPR HPP health care liaison in Eastern Idaho public health district in Idaho Falls, Idaho. And my question is I know on some of your – to the taskforces that you had, where does your local MRC volunteers fit into that process?

Paul Link: And who's that directed to?

Holly Peterson: Well, all of them, particularly the ones in Texas where they have the taskforces.

Paul Link: OK.

So, Ray, do you want to take that one?

Ray Apodaca: Yes. Our MRCs do play a role in our hospital preparedness program. But they're predominantly used more at the local, regional level. We rarely have deployed them as a state resource for a statewide response. So they do exist. They are part of our HPP program and they are coordinated and led by our state MRC coordinator, the same person that heads our ESAR system. And if you need more detailed information, I'll be more than happy to put them in contact with our MRC coordinator.

Holly Peterson: Thank you.

Paul Link: Operator, any other questions?

Operator: Yes, sir. Our next question comes from Kris Stokke. Your line is now open.

Kris Stokke: Thank you.

I have a question regarding the cost and budgets of developing strike teams and medical mobile assets. I know that was discussed in Texas. And it seemed to me there were different versions of that in each state and I really appreciated the difference of – from rural to more metro concepts. But I'm trying to get an idea of financially what that takes to develop and sustain those systems.

Paul Link: So, briefly, Ray or Jeff, do you want to take that call – I mean, take that or Mr. Craig with Mississippi?

Ray Apodaca: Sure. This is Ray. What we do is traditionally, every year that we get our HPP awardee, award, we push out to the healthcare coalition level between 70 to 80 percent of our state awarded HPP funds.

And what we've done is we've developed a funding allocation system to where we fund all 22 of our healthcare coalitions. No healthcare coalitions, particularly in our rural areas receive – they all receive a minimum of $250,000 per year and then it goes up depending on all of our funding allocation factors.

We also give additional funding just for the emergency medical taskforce development and it varies from year-to-year. But again, we normally give an additional $250,000 just for EMTF and they can use at the regional level both their HPP base funding or their dedicated emergency medical taskforce funding to help develop those regional teams.

And then, we also – as we identify unspent funds as we're winding down towards the end of our funding cycle each year, we will sometimes redirect funds and fund specific statewide emergency medical taskforce projects to further enhance the development of those teams.

So that's kind of in summary how we do it.

Paul Link: Thank you, Ray.

And we're going to – we're pushing up on 12:30. So I'm going to take a couple more questions. So, operator, can I have another question?

Operator: I'm not showing any further questions at this time.

Paul Link: Outstanding. Thank you so much.

We're going to have to wrap it up then. So, one thing I'm going to just stress before I pass it back over to Mr. Tise is that you can direct your questions to us through the link that was sent out in the mail.

So, not the Listserv, but we will send out a way to address your questions through the Listserv that you can contact us and ask whatever question you may need to do.

We'll have a notes page come out. So – and with that, we'll have the multiple links and resources that we talked about. And we want to, again, thank you for joining us and thank you to the seven folks who went over their coalitions.

One thing I do want to say about these coalitions is that they are different in many different aspects, but what is common among them is they have developed their system of how they're going to operate, whether that be fully operational, they've provided the authority through a MAC type instance of coalition development, and then they've gone through the process of information management and resource management in detail to assess their resources and how they can get those resources. So that's the common thread among each of these seven different folks who spoke on the conference today.

Once again, thank you and I'm going to turn it back over to Steve.

Steve, go ahead.

Steve Tise: Thank you, Captain Link.

Again, I'd like to reiterate Captain Link's thanks to our speakers. We really appreciate all the work that they've put in and their help in delivering these calls.

And I'd like to remind everyone that we have two more planned HPP coordinator capability calls focus, you know? On August 12th, we'll have a call on Capability 6, covering information sharing. And on September 9th, we'll discuss Capability 14, responder safety and health. Look for the information that comes out about those shortly before the call.

So, I want to thank everyone and have a good day.

Operator: Ladies and gentlemen, thank you for participating in today's conference. This does conclude today's program. You may all disconnect. Everyone have a great day.

END