Operator: Good day, ladies and gentlemen. And welcome to the HPP Capability 6 Information Sharing 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, Scott Dugas. Sir, you may begin.

Scott Dugas: Good morning, Preparedness Colleagues. I'm Scott Dugas, Branch Chief with the Hospital Preparedness Program. We're continuing our series of National Awardee Specific Calls. We have a great agenda for you today.

We're continuing the series to walk through the capabilities and provide some expert opinion and examples from the field. We know that Information Sharing is a – is a very important Capability along with the others. And we want to do a deeper dive with this Capability, in line with what we did with Emergency Operations Coordination.

So, we're going to trying to make it real world specific as much as we can. And we have an excellent group of folks from around the country going to talk with us and collaborate today and then we're going to have a question-and-answer session at the end. So I'm happy to have with me from OEM's Division of National Healthcare Preparedness, Miss Shayne Brannman and Mr. Paul Link from the HPP side. Paul and Shayne are going to kick off the call. They're going to walk through some of the nuts and bolts of Capability 6. And Shayne is going to crosswalk for you some of our new program measures and indicators.

We're going to try to get our arms around that as a baseline. And then we're going to move quickly into our Information Sharing implementation component of the call. We'll hear from Mike Murphy, Wynn Brannin, Drew Chandler, Wesley McDermott, Craig DeAtley and Tim Bulson.

So, with – and then we'll turn it over for Q&As and then we'll adjourn. So we have an hour and a half to go and we're looking forward to it on our side.

So with that, Paul Link, Region IV Field Project Officer, I'll turn the call over to you, sir.

Paul Link: Thank you, Scott. My name is Paul Link and I'll be co-presenting with Shayne Brannman, the Director of HSEB the Healthcare Systems Evaluation Branch. And we'll be hitting as Scott said basically the background of the Capability, going to go a little bit over the framework of how it was developed and the current goals including the deliverables asked from HPP. And then we're going to hit a functional breakdown and dive a little bit deeper into those expectations. So moving on.

If you're following along on the slides, I'm on a – on the handout that we provided, I'm just going to be indicating which slide number I'm on, so I'm on slide number three. The Healthcare Preparedness Capability was released in January of 2012. It was a long vetting process and it produced eight Capabilities. Next slide.

Information Sharing is Capability number 6. This Capability deals specifically with two different components. The development of systems, plans, and training around situational awareness and development of systems, plans and training around interoperable communications.

So there are some frameworks that this came from. We used a lot of the core capabilities from 2007 in DHS. So, I'm on slide number 5. But with the new DHS core capabilities that came out in 2012 for PPD-8, we are focusing on the two response mission areas of situational assessment and operational communications. So those components there, very closely match up with our Capability number 6.

So, I'm going to turn it over now to Shayne Brannman, the Director of the HSEB Branch, to go over a little bit about our NHSS goals and the correlation there. Shayne?

Shayne Brannman: Good morning, everyone, and thanks, Captain Link. It's always a pleasure to be with everyone. As Paul said, we have integrated specifically for the BP2 Program Measures for HPP, the National Healthcare Security Strategy and it makes perfect sense as we talk about Information Sharing today and that situational awareness and

2

having effective communications are two of the central themes – objectives within the NHSS.

Again, just for a baseline, situational awareness involves an active, continuous and timely data-oriented loop that informs decision making. In the context of health incidents, operational situational awareness captures information related to health risk and health system and response resources and thus informs and improves prevention, protection, response, and recovery operations and also ultimately health outcomes.

Again, this is one of the cornerstones for healthcare coalitions, is the ability to assimilate and share information, so that's why it's so important to today's discussion. Obviously timely and effective communication, you can have the best information possible, but you have to have the ability to have appropriate and interoperable information technologies and consistent messages are a cornerstone of the ability to do information sharing.

And again, that situational awareness must be communicated, not only to responders as a part of an effective incident, but also to the management and the third customer is to the public as well. Again, there's a horizontal and vertical patterns to all effective communications and sometimes when you're in the midst of an incident, it feels like you're actually at a circle. Next slide.

Again, the framework for the HPP goals is that, again, that you build community resilience. And what do we mean by community resilience? We know that resilience is enhanced through the continuous delivery of essential healthcare services to a community post disaster, that's the continuity of healthcare operations.

And number two is that there's a strong emergency response system to provide for effective management for surges of patients, deaths and concerned citizens and that's the medical surge component.

Again, we're not here to talk about all the program measures, but the BP2 Program Measures are completely consistent with the January 2012 Healthcare Preparedness Capability document that Captain Link mentioned. It's consistent with the NHSS and we've collapsed our two primary program measures of which we have aspects for Information Sharing under medical surge and continuity of operations because it's the heart and soul of the HPP Program.

Captain Link, I'm going to turn it over to you for this next slide on expectations.

Paul Link: Great. Thank you, Shayne. So if you're following along with the slides that were provided on the invitation, we're on slide number 8. And when Shayne was talking about the program indicators and the Healthcare Coalition Developmental Assessment Factors, there are specific deliverables attached to those in that new document.

I'm just going to hit a few of these here, but the expected deliverables for this Capability is an information management plan somewhere within the jurisdiction – a communication plan and information and communications systems, now, the important thing about these three components is that they have to be integrated throughout the HCC.

They don't have to be specifically developed by the HCC, but there has to be the roles and responsibilities and the information components for the HCC into those plans so that when a disaster strikes the response is – there is a method to communicate and there's an understanding of how that is done.

Other expected activities include actual implementations. Within our exercise requirements, we have specific exercise implementation requirements around information sharing, including some of our performance measures around continuity indicator number 4 which talks about the implementation of situational awareness components and the demonstration of it.

So we're not going to go into this very much because we have the performance measure implementation guidance out there– just know that they're not done in silo by the coalition they're developed within the existing framework for planning in that jurisdiction and it's based on however it's been developed, locality, region or state. And the implementation is tested through either exercise or real life incident to evaluate the effectiveness of the plans, training and equipment. So – and once again, the implementation of these follow the HSEEP fundamentals.

So I'm going to transition back over to Shayne now to talk a little bit more about these continuity indicators and the Healthcare Coalition Developmental Assessment Factors. Shayne?

Shayne Brannman: Thanks, Paul. Again, we're going at a pretty high pace here only because we have some excellent people on the line who are going to give you illustrative examples of how they've actually grappled with some of these issues and solved them and overcome some barriers.

So we want to move pretty quickly along and we're going to be providing BP2 Program Measure and Healthcare Developmental Assessment Factor training separate and aside from these important calls that are going on like this one.

But I did want to just take a little bit of time is to put into context that we have two specific indicators that one is for medical surge plan and the other for continuity of operations about expected resources – outputs from those. One is the medical surge plan, the surge assessment information and communication protocol. Again, the information and communication protocols for the surge plan include several components starting from the pre-hospital setting and lasting through the surge event. And let's just talk at – just take two minutes and just think through this. Why is this so important?

Again, especially with aspects like Immediate Bed Availability and other aspects of being able to do surge, you don't want to disrupt your daily healthcare delivery system and make dramatic changes in your normal operations because it affects business, it affects your operating margin, it affects patient satisfaction, so that's why you need good situational awareness in order to do good surge planning because you don't want to do any harm to your normal healthcare delivery system, especially when it's being stressed due to an event.

Secondly, again, information and communication plan, there has to be protocols. You have to be able to tie in, again, healthcare coalitions aren't an island unto themselves, specifically it's just the opposite.

Healthcare coalitions are going to tie in to the broader emergency management community and, again, coordinate with and give them additional information but not do anything to disrupt how the local jurisdiction handles their incident.

But they have to be able to – in order to do that, have communication protocols and understand how to be able to talk about resources that they may need or resources they have or, again, provide specific information about the incident and communicate

5

that in a manner that can be understood by the broader emergency management community.

And now, we'll go to the next slide. And again, in addition, we've done something a little bit different with the BP2 Program Evaluation Process for HPP. So now, again, I'm on the Healthcare Coalition Developmental Assessment Response Factors, is that in addition to having program measures, we within HPP are required to be able to define, initially establish a baseline and be able to track over time the actual coalition development.

And with that, we've developed Healthcare Coalition Developmental Assessment Factors and factor number 12 deals specifically with situational awareness that could be achieved by identifying a potential set of indicators to help the community and healthcare coalition anticipate transitions from the type of decision making that must occur.

And again, just for quick context, you're going to have lots of examples later on in this call- is the ability to understand that something unique and atypical is happening from your conventional healthcare delivery system.

Again, factor number 13 is you have to have the ability to address at risk needs and be able to, again, have a resource management process in place. Again, for situational awareness, you have to know who are those at-risk populations and how are you identifying and meeting their needs.

Certainly, during Sandy, the dialysis community, we had a lot of methadone patients, we had unique special need populations across the spectrum during major incidents and you have to be able to identify those populations and communicate the situational awareness of their status so that resources can be brought to bear like electricity or transportation could be brought to bear to make sure that they continue to deliver – or are able to receive the healthcare delivery services that they need.

And then, again, factor 15, this just addresses this evacuation and patient tracking capability of a region. Again, patient transportation evacuation contains many elements that were – other folks are going to go into today. But again, from our standpoint, one of the key aspects for the Healthcare Developmental Assessment Factors is the development of a functional patient evacuation tracking system, and that can take many forms depending upon the region and locality that you reside in.

So with that, I'm going to transition back to Captain Link, and I appreciate the opportunity to participate with you today.

Paul Link: Okay, thanks, Shayne. The next slide if you're following on the slide deck, slide number 11, specifically talks about what we talked about a month ago in Emergency Operations Coordination. Information Management is a component of Emergency Operations Coordination and we've provided quite a bit of a discussion on that on our last call.

But just a reminder, in that second Function there where it talks about the information sharing up down and out.

And I'm just going to hit that, with our deliverables, we have an expected information and communication protocol but then we also have the expectation of information management systems to be able to do what we want them to do in response and that's to provide information up into the management that related the needs of the healthcare – status of needs for healthcare systems, down back to healthcare systems about the incident so they can make appropriate decisions, across the healthcare coalition between partners, and then back out to the community in one voice to provide that joint information needed to tell the status of the healthcare system to the community so up, down and out, that's from the EOC Function number 2 but it's really stressed here in this Capability.

So, our functional components once again if you're following along, slide 12. Function number 1: Provide healthcare situational awareness that contributes to the incident common operating picture Once again, plans, training and equipment that deal with situational awareness. And Function 2 Develop, refine, and sustain redundant, interoperable communication systems. Once again, plans, training and equipment about interoperable communications and redundant systems.

So moving on to slide number 13 if you're following along. The first component underneath Function number 1 is Information Planning and it specifically deals with identifying protocols for healthcare coalition members to provide multi-agency coordination of information to and from the ESF-8 liaison and incident management.

So we want to make that clear. This is within the framework of the structure of the jurisdiction, providing that information back and forth within that framework. And

then establishing protocols for healthcare coalition members to provide and receive timely, relevant and actionable information for response.

And there's a third component, of course, the messages to the public – let's talk about that timely relevant and actionable information for response. One of the key components of this whole planning protocol is essential elements of information, moving on to slide number 14 if you're following alone and it talks about EEI, Essential Elements of Information. So what is that?

As stated before, it needs to be information that is timely, relevant and actionable. So, if you're asking for stuff that means nothing, you shouldn't be asking for it. You need to have the information that you can actually act on. And that needs to be – come at pertinent time and then it has to be relevant to the situation.

It should be able to be reasonably shared during an incident, that means we shouldn't be asking questions that we're asking you to stop the incident to try to figure out – an answer to a question that means nothing, And then – because it needs to inform decisions, to assist healthcare organizations, healthcare coalition members within it to make an immediate decision about resource needs. So this is to informed – to inform the decision makers about resource needs and status.

And one of the big components that we've asked for is that this is coordinated and agreed upon by healthcare coalition members and local, state and federal response partners. Now, we have a speaker today that's going to talk about EEI during the recent event and about how there has to be some flexibility within this program and within this process to get EEI so that you can actually get that information and you could do on the spot questions. But EEI needs to be actionable, timely and relevant, I can't stress that enough.

The other thing is once you get the EEI, you should have a process in place of – slide number 15, to validate that information. This carries over to information that may or may not be accurate. So, the people who are – passing information back and forth may knee jerk like so many of us do in the response situation and say we need A, B, C, D and E and they really only need A or B. So there has to be some kind of component out there or some kind of mechanism in place to validate what is actually being said.

8

I need a DMAT, or I don't need a DMAT, I just need a team of people to help me do, you know, incident management at my – at my facility or help me provide communications. We have to clarify what the actual request is, or if we don't hear anything, we can't assume everything is okay . So that validation of information is very important to understand what the status of needs actually are and what is actually being said.

So, moving on into the actual systems that we want to develop. So the Information Management Systems include things such as bed tracking systems, patient tracking systems, electronic medical record systems, systems for credentialing, volunteer management systems, all these different types of components. We're going to hit a few of these. However, it's very a critical component of our new performance measures including IBA and sharing – continuity of operations.

So the first one we're talking about is your general information management system. Whatever that may be, it may be a separate system such as a component out there that has boards and such, but they can encompass multiple different systems. They don't all have to be in one mega system but there's multiple ways to get this done.

Specifically about bed tracking systems, we're not going to go too much to this. The Hospital Preparedness Program has been advocating HAvBEDs now for the last – many years and just about everybody is complying with the HAvBED system.

Of course, the HAvBED system still needs to be able to provide info on the bed status of the healthcare system in a regional approach – a regional aggregate approach, identifying the beds that we're asking for, the beds within a certain timeframe. Like I said, everybody is fairly compliant with HAvBED, so we understand what that is. That is just one component of the information management system.

Moving on to slide 18, if you're following along, a little bit more about the patient tracking system. A big, big component about continuity of healthcare operations and medical surge is patient tracking. The ability to understand what the distribution of patients from seeing first responders to first receiver is very important.

The goal for patient tracking is to know what transport resources are available versus those in use. So you have your resource matrix, what's in use, but what's in use at the scene, so be able to track those resources. And of course, that's – that are in use for patient care. Keeping track of that patient flow during surge distribution to see where

your patients are headed so that you can understand if they made it to the right facility and if they're getting the right kind of care, and just basically where they are, so that you can help families and other folks out, to let the people know where they are.

For evacuation, it's very, very important. You need to know where patients are going during the movement, and the final destination so that they can assist you with repatriation and reimbursement, and all those types of things, for incident management so that people just know where the patients are.

And so, those are some of the main goals for patient tracking. One of the important pieces of this is we have put in the capabilities document and we'll reiterate it here is it has to integrate with the federal patient tracking system of record, which is JPATS. And we have some experts on the phone about JPATS and there's a lot of initiatives going on in ASPR HPP about that program and about the ability to provide the system to you.

And then, also, there's a lot of information work going on in the nation about the development of the protocols, the interface protocols for JPATS and TEP, and such things like that, HL7 and all that component to make sure that it's – that it's compatible with each other.

So patient tracking, very, very important for us. One of the things that we are highlighting in healthcare coalition developmental assessment factor number 15 about evacuation, ensuring you have a patient check-in system available.

Electronic medical records. Basically, the nuts and bolts of this is, there needs to be a process to access the information infrastructure and exchange system that provides electronic medical healthcare information during response, if it's available and authorized.

We understand that electronic medical records can cost quite a bit of money to do. However, if there's one available, you should be developing protocols to access that, to work in that framework, to get access and authorize users to do that. And of course, there's a lot of legal and HIPAA questions about that to be able to do that. So that's a long and lengthy process in some cases.

So we're not going to go too much more into the electronic medical records. I just want to finish up here and hit the last slide so we can get to our speakers. About

interoperable communications, once again, a requirement to have systems in place that are redundant and then to have plans in place so that everybody can access this.

So we're looking at the communications plans of the jurisdictions, local, regional, state, however you have it developed, and saying are there communication protocols that healthcare coalition members, healthcare organizations can tap into, and are the systems purchased and in place with appropriate training that can be used to actually pass the information back and forth with incident management, with the local responders and with each other.

So that is in a nutshell the summary of that is we have both information management, situational awareness is one of our key components, and we have interoperable communications is another key component. The deliverables for this are information and communication plans and information and communication systems, and then to test those systems within the framework of our performance measures.

So that being said, I want to stop talking. We're going to hold questions until the end of the presentation, but I want to jump right into our first speaker. And our first speaker is Mike Murphy. He's the Region 6/8 MMRS Director in Oklahoma. And he's briefly going to be discussing essential elements of information during the most recent Oklahoma tornado of 2013.

So without any further ado, Mike, you're on.

Mike Murphy: Okay , thank you. Just to try to cover this in as brief a period as possible. As you know, we had a couple of tornadoes that occurred in Oklahoma, both mass casualties, mass fatality incidents, and the essential elements of information came into quite a play quite often.

Just some background, the state is supported by a regional medical response system, basically, the MRS concept throughout the whole state. So we have regions that coordinate information and then feed it up to the state. They also are mutually supportive. In fact we actually used some of the other regions.

Key element is our Medical Emergency Response Center, our MERC, which is medical EOC, similar to a medical operations center or medical intelligence center that other jurisdictions around the country have. The software that we utilize currently is EMResource. It's been in place for many years. It's used for alert and

messaging, and then gathering some EEIs, such as patient capacity and certain broad injury numbers.

We use WebEOC. It's been marginally successful within the hospital. We've had a lot of difficulties with the hospitals accepting it and utilizing it. We're still working on that. It's used for situational awareness and all the other features and resource coordination.

We also just brand new implemented EMTrack about a month before the incident happened. And that's only in Oklahoma City and Tulsa, the two metropolitan areas there. But we gave it a shot. We had an exercise about three weeks before the tornado where we used it for the first time. The size of the area is about 1.2 million. We've got about 40 some-odd hospitals, 13 EMS agencies, about 3,300 staffed hospital beds in the area.

Our EEI approach that we've worked on is, number one, is define the EEI, let the hospitals, medical facilities, organizations know what we're going to be looking for ahead of time so they can be prepared to gather that data for you or to input that data.

Provide value for the reporters. If you're just asking information for the sake of information, you tend to get a compliance problem. So we want to provide reports, situational assessments and dashboards, things like that.

Centralized collection management, that's where the MERC comes in. The MERC offers that one centralized point where people can provide information. They can also go to for validated information, if they have questions and if it comes out of the MERC then supposedly it's validated.

Try to gather some historical context to the data that you're collecting, the developing trends. A big part of ours is what we call our Capability and Capacity Assessment, it is knowing what the norm of the system is before an incident, so you can look for aberrations or look for outliers.

Scale and relevance is another factor. We only want to ask relevant information based upon the incident situation. If you're asking a hospital 30 miles away from the tornado if they've been impacted by the tornado, then all you're doing is just wasting somebody's time.

And then another key element is up-to-date and current contact information. So when you have to validate or when you have to clarify that you're able to reach back and do that.

Some of the EEI that we collected during the tornado, the first essential element that we look at is advisory and warning, and that came into play quite a bit. We actually had staffed the MERC up before the storms hit based upon what the National Weather Service was sharing with us, which we shared with the medical system.

And then once the tornados started happening, then there was active warning through both electronic means, EMResource, as well as actually picking up the phone and calling the hospital and just saying we're making sure you're 100 percent sure that you know that this is going on.

Following the tornado strikes, immediate hospital and healthcare capacity and the ability to receive patients, that's done through EMResource. The hospital system status, we went through an approved set of questions and EEI that we want to collect on the medical system as far as the impact goes on it, things like are you damaged, do you have power, do you still have water and things like that.

And then the general injury numbers from EMS as well as most – we get our most reliable information on injury numbers though out of the hospital. The system that we have found is that 50 some odd percent or more of patients self-refer during these things. So EMS is only going to give you partial information.

Interesting enough, the mass casualty wasn't the biggest issue. We have a large medical system that was able to absorb the patients for both incidents. Where we really got crippled was the water situation. We had a large water plant drop offline and I had about nine facilities that were actually having to contemplate doing some rather drastic things beyond their normal conservation measures.

So gathering the assessment information, not only on what was going on in the hospital system and the long-term care facility and dialysis, but also what was going on in the water department. And all of a sudden, the water pressure and line systems became an essential element of information.

We also did various assessments within long-term care dialysis, handled resource requests. We also were dealing with clinic patient counts through meetings. We used

all sorts of different means both electronic as well as very personal, face-to-face e-mail, general meetings where you would gather data. And a lot of it was not only gathering the data, but validating the data.

For example, the hospitals set up a couple of clinics there and they were giving us some very, very large numbers of patients that they were seeing at these clinics that were set up on site in these tents. And we were just concerned that there was still that much of a medical need out there. And we found out that 90 percent of those patients were patient contacts that had voluntarily looked for tetanus shots before they went out and played in the rubble pile. The actual patient or injury count was exceptionally low.

Some of the challenges that we had right off the bat our pre-hospital, the EMS radio system failed because the tower got hit by the tornado, and of course, we had cell system overload and failure. One thing we didn't anticipate, we had e-mail overload. We actually had to manage the e-mail volumes. And you would get essential information coming through e-mail that if you didn't catch it or have somebody managing it, you missed it.

Some of our electronic systems were not used 100 percent. There were also – we had some confusing data, for example, EMResource. We asked their capacity on EMResource, but we also asked for patient broad injury numbers based upon four categories. And we had some hospitals putting in information thinking it was capacity as opposed to patient numbers. But when we'd see some hospital report 10, 10, 10 across the line, we figured that they didn't get 10 exact patients in each quarter – in each category.

Some of our electronic systems were not used as designed such as WebEOC. WebEOC used the current events or situational awareness board. They didn't use the mission tasking. So we ended up with a very elaborate blog, but it was also a very great situation because everybody could see that elaborate blog.

And then to complicate things for us is that in Oklahoma City the EOC decided to move down to set up operations in a church down by the impact area, which created all sorts of access problems. We also had to set up an IT help desk.

Everybody and their brother wanted passwords and access into our electronic systems, people we hadn't heard to, heard from in forever. Even though we tried to

have that managed at the facility level, they were calling the MERC asking for – they wanted to be able to see WebEOC and things like that.

Some of our lessons learned. Accurate timely assessments, but the EEI are essential for decision-making. I had a DMAP team, actually two DMAP teams get deployed. They showed up and asked do I need them. And without that assessment and being able to know exactly what's going on with the system, I wouldn't have been able to answer that question. But because we were able to know what was going on within our system, we were actually able to say, no, we don't need a DMAP team at this time.

We had great synergism between local and state. The state let us stay and do things at the local area. They actually provided us with a lot of assistance, especially later on when we started getting into the clinic and tetanus operations.

Automated systems are great. They are good for time and manpower saving, but they still need human vetting and follow-up. The information that you get in electric systems are only as good as the people on both sides of the data entry. And if you've got somebody harried or confused or unsure, then you put in wrong data, and you need to have that vetted and be able to look and see what's normal, what's not normal.

The MERC was actually quite important and successful. We were never 100 percent sure whether that medical operation center model would work, but quite frankly, we're not sure how we would've handled all of the information coming through at one time without it, especially the validation and follow-up and the situational assessments and situational updates that we sent out to the medical system.

Redundant communications are an absolute and you also have to have familiarity with the redundant systems. We deployed sat-phones because we couldn't talk to the impact area, but then we had several sat-phone sites not calling us or answering and it turned out because they weren't familiar how to use the sat-phone.

Let's see. Command personnel, be ready for an e-mail flood. They will actually contact your e-mails because they think you're important and you think – they think they can get your – the answer to them and you will literally get a tidal wave of e-mails coming through. You almost need to have an aide-de-camp to manage e-mail like you do in the ICS with radio traffic.

Social media will play a role whether you like it or not. We discovered that we were getting a lot of good information out of social media, but then there was a lot of trash information as well.

The accurate assessment is critical to decision-making. And transitioning from a local regional data collection to a statewide data collection could be a little tricky, because you got to make sure your datasets are incorporated. It's interesting, ours were, but some of the local people in the MERC didn't think they were, so they actually started double counting patients.

And then new EEI will show up based upon the incident. We had politicians, a governor decided that she wanted information to brief the president, and all of a sudden, that became an EEI. We didn't think about water pressure at various stops next to hospitals would be essential elements of information, but in fact it was.

And then one of the things that we're wrestling with, too, is that the assessment we're doing about systems integration and impact, but the other thing we ran across is system augmentation. Every hospital became a level-one trauma center, every hospital had huge capacity, and yet every hospital expected patient distributions to be based upon the way that the system normally runs. And they were upset when all of a sudden these three or four large hospitals who are incredibly augmented managed to keep all of the patients that were sent to them.

So that's the end of my brief.

Paul Link: Thank you, Mike. That was – that was really, really pertinent information about essential elements information and a lot of the challenges. Thank you so much.

Moving on, we're going to jump in to information management, interoperable communications a little bit more with, first, Wynn Brannin. He's the Interoperable Communications Coordinator for New Mexico.

He's briefly going to speak about an incident that happened in New Mexico where he tapped into the four surrounding states about a NICU pediatric surge, specifically neonatal in nature. And then he's going to talk a little bit about his Ham radio and state radio systems.

So Wynn, you're on.

Wynn Brannin: Good morning. Thank you very much. We start off with doing a weekly radio check and a weekly HAvBED check. So I'm going to combine both of these two pieces together as we move through this.

We do HAvBED on a weekly basis with all the healthcare facilities, to be able to allow them, one, to be able to be familiar with it. So on our program measure number 5, we're meeting a bunch of these pieces by getting everybody up to speed at the same time.

Part of the exercise is to be able to demonstrate the medical surge capacity because we do see that throughout the year through different times and by monitoring that on a weekly basis to get, you know, a good baseline and basically good information to be able to move forward, so we know what the kind of capabilities the facilities have.

The familiarity of the users is essential. And as Mike had just got through, you know, discussing is that, you know you can practice things, but if you don't practice them right – people putting in the wrong information, it all still has to be vetted on the back end.

So with this, we've allowed our facilities to be able to get comfortable with it. They know that it's in a timely manner, they are able to get up and ramp it up very quickly and be able to give us pertinent information. The EEI is just absolutely essential in that initial stage of a surge.

So having said that, we had an incident in New Mexico last year that the hospitals in the metropolitan area of New Mexico and Albuquerque called up and said we're basically running out of NICU beds. And we don't have a whole lot of NICU capabilities for the neonatal stuff in New Mexico. Everybody sends them to Albuquerque or into Southern New Mexico.

So at that point in time I contacted Colorado, my counterpart in Colorado, Arizona and El Paso, and then in the Panhandle, Lubbock area, Lubbock and Amarillo area, and they all agreed that, yes, they would be able to participate on this. So we contacted the vendor and we're like Mike and we use EMResource as the bed tracking, patient tracking piece through EMTrack.

So what happened was we called up and said we'd like to be able to link all these states together so that we have a single place for all the NICU people in the

17

surrounding areas to look at. And at that point in time, within an hour, we had a system up and operational to allow Arizona, New Mexico, and Texas, both parts of Texas, the El Paso and border rock area to be able to see the same catchment of information around the NICU to be able to manage that patient flow better.

So, what happened was the unexpected happening of this was is that we found out about NICU transportation on air services as well as ground services that were available within the region which we did not know that before. So, overall that was a tremendous success by being able to use the HAvBED baseline on medical surge and then being able to pull in the Neonatal Intensive Care Unit which we did have a shortage.

And what ended up happening, it flowed through the entire region so we were able to be able to kick off that portion of it. Other states were beneficial in helping us with that and offload for our patients as well as being able to pick up some of their patients as the system evolved across there. So, we are continuing to do that on a weekly basis per request of the NICU people. They think it's an absolutely wonderful piece of information that they utilize.

On second portion of this is on our radio system, we currently use a statewide UHF radio medical system. All the hospitals have the capability. All the EMS providers both air and ground have the same capability. And with that, when we do our HAvBED in the morning on Wednesdays, we also do a radio check with all of the facilities that are on HAvBED as well as emergency management and clinics.

So, we have a robust system that allows us to be able to communicate across the whole state. We have built up the coalitions to be able to allow them to communicate, cross-communicate across the jurisdictions as well as into their local emergency operations center or up to the state emergency operations center.

And then on the back end of that we have been in the process of developing the hospital Ham radio clubs or Ham radio communications or auxiliary communications people. And we just had a conference this weekend where we have more people that are now wanting to be involved in this and we're going to put them through some HIPAA training.

We're going to give them some basic communication skill training for hospital data versus, you know, what you would do at a clinic or what you would do as normal,

you know, Ham radios for, you know, for a special event like a race or something. So, we're going to give them a little bit more training over this next year. We're going to give them some forms to work with so that they all become familiar with it. And we are baselining all of these people through the ESAR-VHP registry in the state of New Mexico.

With that, I will say I will be available for questions later and I'll turn it back over. Thank you very much, Paul.

Paul Link: Thank you so much, Wynn, great, great examples there of pediatric surge and interoperable communications and management of those events.

Our next speaker we're going to go into – go to is Drew Chandler. He's the IT communications manager for the Kentucky Department of Public Health – for Public Health. He's basically going to breakdown his information management system and his interoperable communications as how they apply in Kentucky in specific events.

Drew, you're on.

Drew Chandler: Thanks, Paul.

Paul Link: You got it.

Drew Chandler: Roll back the clock to 2005, the Kentucky Department for Public Health embarked on a project arm our hospitals, public health, key emergency management officials and other members of what would later become our coalitions with a communication system that would allow both horizontal and vertical communications.

The challenges faced were Kentucky's terrain and lack of funds. The money available would barely scratch the surface on a traditional terrestrial-based land mobile radio system like the ones used by state police and military affairs. So, the system we selected is a satellite-based radio and telephone system on the LightSquared network which is formally SkyTerra and Mobile Satellite Ventures.

The radio operates similar to the old Nextel cellular phone systems for those people that are familiar with that. And it's capable of point-to-point communications using the unique device number or multiple device talk groups like a traditional radio system where anyone on the channel can hear what others are saying.

19

The device is also a telephone which can call any other satellite, cellular or landline telephone and it gives facilities the ability to communicate with each other and up in the organizational chart to the state health operation center or the state emergency operations center. This meets our need for both interoperable and redundant communications.

In total, we've got 358 satellite devices under the purview of Kentucky's Healthcare Preparedness Program and a number of agencies have independently acquired equipment to participate in the system which we test quarterly. We consistently see participation in the 90 percent range and it's been as high as 95 percent which has been a pretty big feather in our cap.

This is one of the few initiatives which has received sustained funding since its inception of the program. One of our largest challenges other than covering the recurring cost of services, maintenance of equipment, there are many dishes attached to the roofs of facilities around the state which I have affectionately come to refer to as sails because we get a lot of wind here in Kentucky and once you blow the dish out of alignment, your satellite equipment doesn't have service anymore.

Both of our drill participations and the repair orders or the job tickets to our radio shop contractor are tracked using WebEOC which is a segue into talking about our other situational awareness. A couple of others have hit on WebEOC already and it's a Web-based critical incident management system that Kentucky has been using since 2007. Initially, we partnered with our state emergency management officials to ensure the most basic information sharing occurred in the same manner in which we conduct business at our state emergency operations center.

Several presidentially declared disasters later, our emergency management division acquired their own instance of WebEOC and that allowed the Department for Public Health to really focus its WebEOC efforts on the ESF-8 community.

Early on, our information sharing with the coalitions was limited to message board-like functionality. But as the system grew, we looked for additional processes which could be added to the system. And a couple of the other callers have already made reference to an event log and that's what we were doing initially.

Simultaneous to our process discovery, the realization of the windfall that occurred with 2009 H1N1 left us also looking for ways to save money by reducing the number

20

of services and contracts. One such identified process was that of hospitals status and the collection of HAvBED data.

Late in the fall of 2009, we contracted with WebEOC's custom development team to build a dashboard to our specifications. The concept of the dashboard is that you have all essential elements of information as indicators about the facility and department status in one place, much like the dashboard in your car has indicators for fuel, speed and that annoying seatbelt light.

Our hospital dashboard has indicators for diversion, decontamination, command center activation, water, facility, generator, communications and security. There are an additional 20 department status indicators that facilities can report on to include imaging, lab and cafeteria.

The benefit of the dashboard is that it paints a picture using red, yellow, green color coding which requires little explanation to those looking at the information. And being there are so many indicators, it is easy to process the information visually. All green is a good day, all red not so much.

The facility is responsible for updating their dashboard and that can be done from multiple physical locations if necessary. But the key is everyone is viewing the same information simultaneously or as real time as the Internet will allow.

The regional dashboard allows coalition partners and neighboring facilities to the status of others in the region in order that they may lean forward to anticipate needs of neighboring facilities. The regional dashboard is driven by the facility dashboard, so there's only one place that the facility updates their information.

Also collected and a critical piece of situational awareness that's been talked about previously on the call is the HAvBED data set. Facilities make updates to bed availability on this dashboard in WebEOC similar to how they make updates to the status indicators of the EEIs. We have a custom software interface to push our data from WebEOC to the HHS HAvBED service which has gone through the testing to meet version 3 requirements.

We conduct in-state HAvBED drills on a quarterly basis and consistently score in the 80 percent range which we feel could be better but we're happy with that. Some of

our coalitions test monthly and some even weekly. And those coalitions consistently score higher than those who do not test in between our quarterly drills.

In our population centers of Louisville and Lexington, we see daily use by the facilities of the dashboard. Since WebEOC is a database we can display the information in a number of ways. For example, the Louisville metro dispatch center has a special screen that their dispatchers use 24/7 with some of the hospital facility and department indicators to route ambulances to hospitals. And they do that in real time seven days a week.

We also worked with our partners at the VA to crosswalk the HAvBED types to the NDMS bed types. And the result is the facility updates bed availability in one location and it also meets the requirements of both programs because we can display the NDMS program information on a special screen based on the needs of the VA folks.

In 2012, we began developing a very similar dashboard process for the Long Term Care community and we've spent much of this year training approximately a third of the state's facilities up to this point. We're also working with the state board of emergency medical services to make a dashboard product for ambulance providers and we're identifying stakeholders for a similar product for local public health departments.

All of this to say that folks in WebEOC have access to both message board type information and specific facility information for coalition partners, those essential elements of information. So, we use WebEOC product quite successfully to meet our Capability 6, Function 1 and it's also considered an interoperable communications tool under Function 2.

And I'll also stick around for questions.

Paul Link: Good. Thank you so much. That was a wealth of information, very, very, very good and pertinent to this conversation.

Moving on and we're going to jump into patient tracking and implementation of basic tracking systems in real life events. Our first – our first speaker on this – there's been an agenda change, from the Listserv message that came out we are now instead of

Peggy Keller, we have Wesley McDermott who is the public health advisor for the CDC working in the District of Columbia Department of Health.

He's briefly going to discuss situational awareness and patient tracking there in the 57th presidential inauguration. Now, during that Listserv message there was a presentation attached to that that Wesley will be referring to during this presentation.

So, Wesley, you're on.

Wesley McDermott: Very good. Thank you very much. Good morning, everyone. I wish to convey regrets from Peggy Keller who couldn't be here because of a family situation but I appreciate you having me on to talk about the District's information sharing program here in the 57th inauguration.

Going on to slide 2 of the presentation if you are following along, you see a picture there of a command bus down on the mall just before the Senate building that was one of the sites that information, common operating picture information was piped to during the inauguration as well as the District's departmental operations center just about three miles away and as well to the District of Columbia's emergency operations center about seven miles away and several federal command and control centers that were located across the river in Virginia and in Maryland.

This information sharing occurs on a daily basis here in the District through various different systems and platforms such as Essence and WebEOC. For this inauguration mission DOH had to ensure two specific resources in order to meet that mission requirement. One was – one of the requirements was a patient registration and tracking system capability and the other was an IT platform that could tie in all these different systems, data systems and information systems into one that could be shared across, you know, other different platforms.

So moving on to the next slide, the health and medical planning went on for several months before the inauguration. As you can imagine, there was a concept of operations document that was developed that included what we call critical information requirements and COAs or courses of action for the entire ESF- 8 enterprise. In addition to various specific response requirements, DOH was also responsible for the health and medical common operating picture data.

23

Next – going on to the next slide under situational awareness, DOH developed a common operating picture for this incident or actually for this pre-planned event. But it was a little bit like drinking from a fire hose in that you have these various systems and it's sometimes a matter of sifting through the information that is available to be able to identify those CIRs or those other critical data elements that really are going to tell you what it is that you need to know.

And we had the good fortune to have access to many different data systems such as WebEOC and the hospital information sharing system and several others, some of which were freestanding proprietary systems and some of which were, you know, Web-based systems that were much easier to work with. But GER's HC Standard system that the District bought into a couple of years ago sort of became the focal point of where all of this was going to come together.

So going on to the next slide, just to give you some background or context for this, the – here's a few examples of some of the data streams that we were – that were available to us. The District of Columbia's emergency healthcare coalition which Craig DeAtley will speak about in greater detail following my talk, has a – they field a SharePoint-based data board that keeps track of the status of the hospitals as well as nursing homes and other critical infrastructure in the ESF- 8 mission space. So we have that. This is very useful and provides us good information for allocating resources.

Going on to the next slide, you can see there the board of the HIS hospital status matrix and each of those lines represents a particular facility, each column representing a particular resource status.

Going on to the next slide, the – another example of useful information that we have available to us is the District of Columbia Unified Communications Computer Aid and Dispatch System. And you see here on this slide if you're following along a screenshot of the CAD showing EMS calls that are actually happening in real time. So, this is helpful in identifying system issues such as, you know, folks being out of service at the hospital all at one location or things of that nature.

Moving on to the next slide, our field assets that were deployed for the inauguration were mapped and, as you can see there, there were over 50 sites deployed from the health and medical standpoint some by NDMS and some staffed by NDMS crew, some staffed by DoD personnel, some by contractors and some by human services.

In each of those locations we had a volunteer standing by there with a handheld data entry device at most of the sites. And we'll talk about that in just a second. The information that was collected through these handheld devices we were able to pull that information in and represent that in various custom formats that gave us an easy time of interpreting some of that data. You can see on this slide here that the number of patients and their geographic location was easily, easily represented.

This gave us a good visibility on high acuity illnesses and injuries that were happening or that were being identified in real-time. Going on to the next slide, you can see this overlay on the actual Google Map that gives us some good information about, you know, any clusters or acute large scale incidents that may be happening.

Moving on to patient tracking and the devices would be on slide 11. And I'm trying to wrap-up here real quickly. The volunteer – how this information came to us was – it started at this – at the actual first-aid tent or the warming station or patient reunification center, where we had volunteers with these handheld devices. And these handheld devices are very ruggedized. And they're able to capture as much or as little info as you're able and have time to input.

Going on to the next slide, you could see that it – you can shoot videos, photos. We deployed them with the volunteers along with a package of bar-coded wristbands. So each individual that was entered into the system basically got a wristband and that barcode was scanned so that that created a new patient record in the system and then each subsequent updates were then linked back to that record which was very helpful. This was all done wirelessly.

And going on to the next slide, you see that there was a wireless network that was deployed along with the handhelds and that Ewrap has about a five mile range, so with just a few of those devices, we were able to link them up and bring that data from the field, from the end-user right into the server where we were then looking at it in real-time.

That whole system is actually part of a larger project, if you go to the next slide that was initiated by the Maryland Institute of Emergency Medical Services Systems some years ago and has that – and has since been adopted across the national capital region, in Northern Virginia, DC and Southern Maryland under an Urban Area Security Initiative Grant.

And that project was fielded in the run up to the inauguration so that, not only were we able to see information about patients that were being tracked in DC in real-time, but we were also able to see patient data, Essence data, and all the others, you know, systems in real-time across the four-state area.

One other unique element of the – of this set-up was an interjurisdicational epidemiology fusion cell was staffed. And I think we're on page 15 now. That fusion cell was made up of folks from federal, District and various different non-profits who were here in the Departmental Operations Center.

And they were looking at a wide variety of data streams and looking for, you know, the zebra in the herd of horses so to speak. And that information was, you know, reported out in regular and frequent status reports.

So in tying all of this together, going on to the next slide, the situational awareness provides information that we must have, that planners and decision-makers must have through those critical information elements and having these different data streams coming in and having analysts here, specifically to look at that and identify outliers or issues that need further assessment or evaluation.

The HC Standard system is useful to us in that regard – in the regard that it allows multiple data feeds from disparate systems to be brought together and aggregated into dashboards that we can then export to, you know, third parties and that's exactly what we did.

If you go on to the next slide, you'll see the HC Standard dashboard view and each one of those blocks in that screen represents basically a unique data feed that was coming in and that we could look at just by simply clicking on it and, you know, open it up full screen, but we could get, sort of, the snapshot view of it, you know, sitting all in one place without having to have 15 computer monitors in front of you.

Going on to the next slide, if you wanted to you know, drill down and know about a specific patient, you know, what was reported about that individual whether it was photo, video, patient information or whatever that we needed to have access to. We were able to do that. That's a mocked up screenshot that gives you some idea of the degree of granularity of the information that we have access to.

Moving on to the next slide, which should be 19. This shows a screenshot of the EMS active matrix call. And I'll move right on to the system reports – the HC Standard system that we use as the common platform to bring all this together, it was able to generate pre-programmed reports as well as custom reports that were defined on the fly.

And the next slide down is the event summary report, gives you a picture of, kind of, the varied slices – ways of slicing this data about the patient contacts and patient transports that occurred during the several days of the inauguration. And, of course, any one of those can be pulled out and expanded and drilled down into.

But very robust system, very helpful to be able to pull, you know, many different disparate systems together. And then as I said, to also be able to package that up and to ship that information to the command bus down on the mall or over to the District EOC or over to the federal consequence management center, that would be very useful.

So last slide, that's all I have, I will be around for any questions. Thank you.

Paul Link: Thank you so much, Wesley. That was a great presentation.

Moving right on into the next speaker, Craig DeAtley. He's the Emergency Manager for the MedStar Washington Hospital Center and administrator. He's a DC emergency for the – he's part of the DC Emergency Healthcare Coalition. He's going to talk a little bit more of – focusing on the DC information management system.

Craig, go ahead please.

Craig DeAtley: Hey, good afternoon, everybody. I'm going to try and in three minutes give you the abridged version, so Tim can have a chance to speak.

Between the period of 2006 and 2011, the District of Columbia's Emergency Healthcare Coalition actually had two systems for patient tracking. One was a real-time system that we subcontracted to another agency to maintain for us but at a very costly price.

And subsequently, we lost the grant funding for that last year. So in the interim period of time, we developed and use primarily now a manual system of data entry

27

that is a template on our healthcare information system which is the mother of all information sharing within the healthcare system of the District of Columbia.

There are a variety of different templates designed for different purposes, included among them is a patient tracking template, but we've done one both for the hospitals to report patients, the skilled nursing facilities have one, and the clinics as well as our dialysis centers. Each of those has their own reporting templates, both for capacity on the one hand and patient reporting on the other, if needed.

The HIS system is actually Microsoft shareware that we own, we operate, and we therefore, maintain the responsibility of changing, and part of the beauty of the system, besides it cost us nothing, is that within the context of an emergency or an exercise for that matter, if a problem is identified that requires a new reporting data field that we have the means of quickly fixing that problem and then passing information along to our members as to what we want them to populate in addition to what they're used to.

Whenever we do a bed check, if you will, it is announced – both over the HIS, but over our radio system as well. And we do regular testing of this system for both the overall use of the HIS system and our patient tracking system as well.

When the patient's information is put onto a template, it's seen not only by that reporting facility, but also by the other members of the healthcare system, which includes the Department of Health and the DC Department of Human Services who actually maintain the lead responsibility for sharing that information with the public.

The beauty of the hospitals, the clinics and skilled nursing facilities also seeing that information is that they too, if they are receiving calls from outside family friends, what have you, have the same information in front of them that Human Services and the DC Department of Health have.

That's kind of it in a nutshell. I'm going to pass it back so that Tim has a chance to speak and there is still some time for questions.

Paul Link: Thank you so much, Craig.

Without any further ado, we're going to go to our last speaker here. His name is Tim Bulson. He is the Regional Coordinator or the Region 6 Healthcare Coalition Coordinator for Region 6 in Michigan.

He works at the Muskegon County Medical Control Authority. And he's going to go over the information management for patient tracking. And during the – from the invitation on the listserv, there was a document called and it was labeled the Michigan Patient Tracking Algorithm document, so patient tracking algorithm and EEI form are two different documents attached here. He's going to be referring to those, so if you want to follow along.

And without any further ado, go ahead, Tim. You're on.

Tim Bulson: Okay . Thank you, all, very much. And what I guess, I would suggest as contact or context is to think of the Michigan system that I will describe very quickly is in a slight contrast to what you just heard out of the DC/Virginia area.

And I'll give you a little background on how we got to that point. And the last detail that I would ask you to remember is that the Michigan experience was derived from its eight individual hospitals or healthcare coalition and all their members.

Our starting point like many of the other speakers referencing patient tracking have mentioned. There are different platforms. There are different mechanisms that essentially comprise patient tracking.

And several years ago, we had three or four different systems being used by different coalitions around the state and as we tested those in drills and compared our after action notes, we learned that while they were working to greater or lesser extent in each region, what we were lacking was that single dashboard or snapshot, that you've heard other speakers reference for both the vertical and horizontal patient tracking information.

Realizing that we needed to get a better common operating picture, our state Department of Community Health contracts brought a workgroup together from all the coalitions and I would stress that that was a huge benefit for us to get people from all the coalitions, the leadership teams who had hands-on experience with different patient tracking tools to really analyze the pluses and minuses and to together agree that we needed in Michigan one common operating platform.

The other thing that – benefit that I think we found that's probably germane to a lot of regions and a lot of a states is with the growth of EMS systems and hospital systems, having coalitions or region views, disparate patient tracking or have that type of tools,

we were asking staff in different geographic regions, if you will toknow how to use different tools and that's very awkward and difficult for the staff.

So as I say, from around the coalition leadership and with our state partners, we determined that the tool that we were going to go with is EM Track, one of the EM resource modules that other folks have referenced.

And as we were deciding that, we also felt that a key to understanding of its use by partners was the algorithm that was provided for you all. And if you've opened that, I think you would agree that the right hand side of the page, the actual algorithm itself is relatively simple to get.

And we acknowledge that local hospitals and EMS systems in the top part of that algorithm have some sort of tracking that they use every day for their patients. So what's more important, I think is the data in the left side of that box that all the EMS and hospital and healthcare and long-term care partners need to understand that depending on the type of situation, an MCI, small, large, regional event, on up through significant planned events like we just heard talked about in DC, there will be a point where those daily systems can't handle the volume and are not shareable amongst different entities.

And that's our threshold for kicking in the EMResource module , EMTrack, and asking the EMS agencies and the hospitals to track their patients. Again, as the bullet points in that left hand box point out, the nature of the scenario isn't as critical as the data all the way down there.

Again, you can start this with a, you know, a small MCI that's going to overwhelm one rural type hospital or smaller EMS agency on up through, you know, predictable type of a plane crash, or that the DC folks talked about, a very significant planned event or evacuation moving patients from a long-term care facility to a number of other long-term care facilities.

Again, just the understanding of that algorithm, there will be a trigger point in which everyone shifts over to the common patient tracking platform, then again, I think below that the use of that kind of decision-making tree really helps those individual coalition partners understand those bullets right in the center that a common system helps everyone understand that every patient is accounted for.

We had 125 patients in the long-term care facility that needed to be evacuated. During and after the process, we tracked 125 of them. It enhances their record keeping, helps them potentially provide documentation for reimbursement and early on from all our partners, that bullet, helping the communications with family members is vital.

Again, I think that most of us would agree that healthcare has shifted to systems of, you know, multiple hospitals, multiple size and shape configurations and in an MCI event it is very likely that a small rural hospital may be an initial stopping point for those MCI patients who would then be transferred on to tertiary referral centers. And, you know, while that transfer may occur in an hour or two we don't want to lose that data. Where are those people?

Again, like others have mentioned, you know, any of the patient tracking systems may or may not dependent on real time Internet access. We totally acknowledge that and our experiences in getting to this point did reinforce that. And I think that we also came to agreement that if you don't have that online Internet Web access, the key thing for your partners to remember is to start it as a pen and paper process, catch it up to your system as soon as possible, that allows the EMS record to be merged down the road to the hospital record. That's okay. It builds a more complete record as time goes by, just don't lose that initial data.

And then the bottom set of bullet points there, so it segues into earlier conversations about EEI and the second form we provided which is not, I will clearly state, is not directly related to patient tracking but rather kind of an outgrowth as we looked at the patient tracking system and realizing that whatever system you use, you need to track a handful of critical data elements just like in a broader response you need to track some key elements of information. So we've developed that second form as a kind of a baseline tool that we are going to test in this BP during real life events and drills.

Again, back to the patient tracking sense, you know, we need to – depending on your system, have it generate, if possible, that unique identifier and certainly as much as you can get in, name, the first, last, gender, date of birth, their health or their triage status depending on an MCI or a transfer situation, approximate age, and where they are going and the time frame. Again, getting those basic elements into the system and allowing the system to then develop a robust footprint if you will or dashboard as other folks have mentioned to the situation, we feel is absolutely key.

31

The last thing I will say before we kick it back and open it up to questions is since we've come to the common platform for us and have encouraged certainly all of our coalitions and their partners to test it. We have seen that – and again as other folks have mentioned, at that local level there are some agencies who are kind of doing self testing and some hospitals who are saying we will test patient tracking on whatever, you know, day or week of the month while at the same time the coalitions are pushing for a monthly tracking system.

And what we have seen since those testing dates are starting to be pushed out and used the hospitals getting really used to or accustomed to having that data available and reinforcing the need for EMS to realize that in that threshold situation they need to tag the patients and, if possible, enter then into that patient tracking system. So we are getting a really nice partnership back and forth between the hospitals and the EMS agencies, understanding the benefits to both of those partners in the use of the system.

And the last thing I would say about that is since we've gotten more robust hospital use of the system we found that in some hospital systems here in Michigan it's actually being pushed down to the individual patient registration staff members who of course, you know, in the influx of first receiver, you know, kind of a situation, the hospital ED, allowing those registration staff to get that information into the system quickly benefits everyone and by allowing – or having those registration staff using the system, very comfortable with it and getting a lot of data into it quickly. They are providing great EEI and dashboard type information to the hospital command centers which then flows up to the region and to the state and onto the federal programs.

So with that, I think we'll move into the question period.

Paul Link: Thank you, Tim, so much. And operator, just briefly can you provide the instructions for entering the question?

Operator: Certainly. Ladies and gentlemen on the phone lines, if you do have a question at this time, please press star then the 1 key on your touchtone telephone. If your question has been answered or you wish to move yourself from the queue, please press the pound key.

Paul Link: Thank you so much and we have a few minutes to go over questions. First let me just go over some basic instructions.

When you ask your question please direct it at either one of the speakers or ASPR/HPP or HSEB and please provide your name and your title so that we can know who asked the question.

Operator, are there any questions in the queue?

Operator: Yes, we do have a question from Doris Weiss. Your line is now open.

Doris Weiss: Hi, my name is Doris Weiss, I'm calling from Bismarck, North Dakota. My question was for Craig DeAtley. I was interrupted during your message there and you spoke of using a system in Microsoft that was free. Could I get that from you please?

Craig DeAtley: Yes, this is Craig. We used the Microsoft shareware and if you reach out to me via e-mail offline, I will be glad to share additional information with you.

Doris Weiss: Thank you.

Paul Link: Thank you, Craig and thank you, Doris. Operator, are there any other questions?

Operator: Yes, we do have a question from Jeff Cappe. Your line is now open.

Jeff Cappe: Hi, are these archived and can we get the slides and replay these the conferences?

Paul Link: Yes, well, the presentation is not recorded but we will provide the slides and a meeting notes shortly after the presentations and we are going to try to capture all the technical assistance that was provided such as the one that was asked from Doris to Craig. We'll try to provide all of that and do a summary page and get it out to everybody so that you can have the information.

Jeff Cappe: Okay, thank you.

Paul Link: Yes, sir. Are there any other questions?

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

Paul Link: Okay, while we wait. We are going to give it a few more minutes just before I pass it back over to Scott.

The e-mail addresses for each of the participants are on here. If you have a question for each and any of this specifically go ahead and e-mail them and we are asking the

presenters to share it with us so that if any technical assistance is done, that we can wrap that all up into a nice package for everybody to show that the technical assistance provided might be valuable to you too.

So that being said I'm going to go ahead and ask to see if there are any more questions. We have a few minutes left. Operator?

Operator: Yes, we do have a question from Fred Peterson. Your line is now open.

Paul Link: Go ahead, sir.

Fred Peterson: Good morning. This is Fred Peterson from the Hospital Association of Pennsylvania. The speakers I know from Kentucky and I think New Mexico mentioned inclusion of long-term care facilities and their systems. We have a little trouble in getting interest from some of those facilities in participating. I wonder if you have any thoughts or suggestions about how you got them to participate.

Paul Link: And so, we have two folks, Drew or Wynn, do either of you want to answer that?

Wynn Brannin: Well, this is Wynn Brannin and I can go ahead and put in a little piece of what we have done. We partnered with our hospital association and we partnered with the long-term care people in the state of New Mexico. So the association is basically our driving avenue that we are reaching out through them to all of the facilities to be able to get all the long-term care and we are doing the specific primary care association also.

So it's encompassing of all different groups that we're using the associations that are established in the state to be able to reach out.

Paul Link: Drew, do you have anything to add?

Drew: I do, Paul. I'd be remiss if I didn't bring up our partnership with the University of Louisville and the University of Kentucky and their geriatric education centers and of course our own state long term care ombudsman's office who is in our cabinet here at DPH.

Paul Link: Thank you so much Drew and Wynn. Are there any further questions, operator?

Operator: Yes, we do have a question from Chris Stoke. Your line is now open.

Chris Stoke: Thank you. My question is for Pamela Brannman and – Brannman, I'm sorry. And my question is when it comes to working with multiple disciplines that are utilizing the homeland security core capabilities, the target capabilities and the PHEP capabilities is there an exercise evaluation guide for a PHEP capability for a crosswalk that has been developed much like the homeland security one, linking the core capabilities to the target capabilities list?

Shayne Brannman: Hi, ma'am, this is Shayne Brannman, I go by my middle name. So it is Pamela Shayne Brannman.

                And I am not aware of an actual document that exists today, however, Scott Dugas, Captain Link and others within HPP are – we are going to be actually meeting with our PHEP colleagues because during the hot wash that occurred after this last cycle of grants is that – the need for those kinds of things and a better integration on exercises and technical systems was noted, so I can see that coming, but, to my knowledge Scott or Paul may know differently, nothing exists today that would actually meet what you are communicating, but the need for it has been communicated and it's on our to do list.

Paul Link: And I can add into that, Shayne.

                So we are under development of a tool for the awardee to use to monitor their program. Part of that tool is the exercise program that we had put in Appendix 7. Recently coming to you will be a checklist that has the objectives of each program specifically spelled out that clarifies a lot of the information that we have been providing to the awardees on previous conference calls.

                One other initiative that HPP and PHEP are working on, and it's in the beginning stages, is to peg those EEGs that were developed in the 2007 core capabilities, marry those with that HPP and PHEP objectives and build out EEGs that might be beneficial so that you can actually meet these objectives. So it is a progress that is very, very early in the stages of working but it is underway, so hopefully we will be able to have something to you in the future. And I know that that's not a very definitive answer but that's the best we have right now. Hopefully that helps you.

Chris Stoke: Thank you.

Paul Link:	Operator, I think that we are out of time. How many questions are in queue if there are any?
Operator:	We have one final question, sir.
Paul Link:	Okay, let's go ahead and take that final question and we'll pass it over to Scott and then close down. Go ahead?
Operator:	Certainly, our final question comes from Daniel Lee. Your line is now open.
Daniel Lee:	Hi, I just wanted to give a little quick feedback on the call. I just thought it was really an excellent call in terms of the content being useful right from the overview at the beginning and then the specific information coming from the states. So I really appreciated that.
Paul Link:	Thank you, sir. And I want to thank everybody for your patience for being on the call and I want to thank our special presenters for presenting today. It was a great presentation full of a lot of good information that will be back out to you and hopefully we will able to keep this up with all our other Capability calls. Now I'm going to send it to our HPP Branch Chief, Scott Dugas. Mr. Dugas, please go ahead.
Scott Dugas:	Sure and I want to thank Captain Link and Ms. Shayne Brannman for their support and their help today. It was a wonderful – as well as all the speakers. I think it was another great call. And to follow up on what Paul said, you know, we are really trying to capture – we know that these calls are solid and they work. And we've heard from enough of you in the national audience that the information that we provide has been helpful as clarification points, and then the real world examples and the implementation strategies that your colleagues are doing has helped. So what we are trying to capture and why we are asking and you can feel to e-mail me and I will send the information over to Ms. Sue Larkins who helps us with these calls from Booz Allen and then Sue when she comes up for air will most likely be sending out a couple of tickler e-mails, you know, reminder e-mails as well. But we want to capture, you know, even on a higher level just in terms of delivery when you get calls, any of the speakers get calls from your fellow colleagues on follow-up information and, you know, can you tell me more about what you said and

can we deeper diver little bit because it's more evidence that this works and we are trying to really document that these types of strategies are really helping to educate all and help with execution of the grant, understanding the capabilities, implementing the program measures and the indicators and the coalition assessment factors, all these things that we're involved with as we move through. And so, that's the ask and we really appreciate it.

And I want to thank again thank everyone and with that we could close out the call unless there is any other final thoughts?

Paul Link: I think we are good.

Scott Dugas: All right. Sue, can we turn it over to the host?

Sue Larkins: Operator.

Scott Dugas: Operator.

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