National Healthcare Preparedness Programs Teleconference Transcript
Rural Coalition Development and Immediate Bed Availability (IBA) Webinar

January 16, 2014
2:00– 3:30 PM ET

Operator: Good day, ladies and gentlemen and welcome to the Rural Coalition Development and Immediate Bed Availability conference call. At this time, all participants are in a listen-only mode. Later, we will have a question-and-answer session and instructions will follow at that time. If anyone should require assistance during the conference, please press star, then zero on your touchtone telephone. And as a reminder, today's conference is being recorded for replay purposes.

I would now like to turn the conference over to your host for today, Mr. Scott Dugas. Sir, you may begin.

Scott Dugas: Welcome, national audience. This is Scott Dugas with the Hospital Preparedness Program and I'm here – we're representing this call for the division here, the division of National Healthcare Preparedness Programs managed by Dr. David Marcozzi and we're going to jump into this call on rural healthcare issues and IBA. We're happy to have this call.

It's one in a series of national calls that we've done over the past year and we encourage a lot of participation. We look forward to a robust discussion. We have an expert panel set up for you today to walk through some of these challenging issues with Rural Coalition Development and thinking through the contents of immediate bed availability and our healthcare capabilities that we promote through our national guidance.

With me also is Ms. Traci Pole, the Region VIII field project officer here with HPP and she's going to assist. Traci is going to walk through our speakers and a little bit about what they are going to talk with you about, and then afterwards, we're going to close with a question-and-answer session. And we're really excited about this spirited call and we know that healthcare coalition development is a challenging topic.

We've been promoting it for a number of years here along with the rest of our – and embedded in – our capabilities and doing that in rural and frontier areas, building coalitions has its own unique set of challenges and problems attached to it.

We know this is going to be the first in a series of national calls that we want to have on this topic and we want to start the discussion and this is a great forum to do that and we're excited again.

So with that, I'll turn the call over to Ms. Traci Pole and let her walk through a little bit of more the agenda in detail. Traci?

Traci Pole: Great. Thanks so much, Scott, and good morning, good afternoon to all of the folks that are able to join us on this call. As Scott mentioned, my name is Traci Pole, I'm the field project officer located out in the Region VIII Denver office and I work closely with the folks back at headquarters. In my role, I have the great honor of working with the great states of Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming. And actually, a great majority of our regional conversations look at how we conduct business given the rural nature of our region.

So on behalf of Dr. Lurie, Don Boyce and, obviously, Dr. Marcozzi, we're delighted to welcome everybody to the first rural preparedness call out of our office and as Scott mentioned, hopefully one of many and equally delighted to showcase some of the excellent stories and resources for others to consider as they look at their planning and response roles in a rural environment.

In addition to our great speakers today, I publicly would like to recognize North Dakota, Virginia, West Virginia, Michigan, New Hampshire and Utah and anyone else who I may have missed who actually offered to speak on rural successes as well. So given our 90 minute platform, we have to call on each of them for another time, hopefully keeping these conversations and their successes in the spotlight as we continue to learn from one another.

Lastly, special thanks to the other project officers who helped all of us coordinate and organize this call. This has been an exciting six months. We think it's incredibly important to announce that we have a diverse group of partners participating on our national call today, including but certainly not limited to our partners from CMS, from HRSA, from CDC, from IHS, from Department of Homeland Security, Department of Transportation, our state offices of rural health, our community health centers, our long-term care partners, our state offices of EMS, of course our ASPR team, both in headquarters and in the regions, of course our state and local health departments, ASHTO and NACCHO partners, hospitals and local emergency management agencies, I guess just to name a few.

As our program continues to support healthcare coalition developments, it's critical that the right people are at the table. So a few things that I'd like to ask all of you listening in or participating via web before we get started, please send questions any time in the web chat if you are logged in online. We'll queue these up at the end and do our best to answer each question during the question-and-answer period. Any questions we don't get to, we will try to include, we will include them in the meeting summary.

Secondly, please check out the – our materials, the slides including the recorded sessions today, all of our resources discussed and the question-and-answers will be included on our health hospital preparedness website following the call.

Lastly, I listened to a webinar recently where connectivity was the key for how rural facilities could respond to an event more successfully so please consider exchanging electronic business cards and connecting with somebody from this call at another time.

At this point, I would like to take this opportunity to introduce a dynamic group of presenters. I hope during this call, you'll hear a different approaches on how to maximize healthcare organizations' participation in a rural setting. How rural planning efforts have supported responses and one approach in developing a strong healthcare coalition in a rural setting. We will kick off with Dr. William Mason who's the principal investigator for the Arkansas Department of Health.

Today, he's going to walk us through a rural response that occurred in the southwest corner of Arkansas and he'll share how this disaster led us to new partnerships and some new policy changes across the state. Our next presenter will be Ms. Jean Randolph, a nurse consultant at CDC, the Center for Disease Control, working with the hospital preparedness activities. Ms. Randolph is going to speak about the community assessment tool, its utility and how this tool can help bring people together in a rural setting.

Ms. Randolph's overview of the tool will lead into our next presentation from Randy Boltz. Mr. Boltz is the safety coordinator at the Howard County Medical Center for critical access hospitals in Saint Paul, Nebraska. He's going to share his strategy for implementing the community assessment tool in his small community and how this tool has helped him to date with planning and partner engagement.

Following Mr. Boltz's presentation, we'll hear from Ms. Lesley Schulte, the public health emergency response planner for Andrew, Atchison, Harrison, Holt and Tri-County health departments, all in Missouri. Ms. Schulte is a co-lead for the Region H healthcare emergency preparedness coalition in Missouri and is going to walk us through the healthcare coalition development process in her rural area of that state.

Lastly but certainly not least, we're going to hear from Mr. Jay Taylor, the acting director with the Pennsylvania Department of Health; Amanda Krebs, the EMS System Coordinator for the Susquehanna Emergency Health Services Council; and Stan Hudson, emergency preparedness coordinator at the Evangelical Community Hospital in Lewisburg, Pennsylvania.

These presenters are going to close our call today by discussing a recent Greyhound bus mass casualty incident that took place in rural Pennsylvania and discuss how this region responded together to address medical surge and bed availability.

So without further ado, I'd like to get started with Dr. Mason. Thanks very much. Dr. Mason?

Dr. William Mason: Thank you. Today, I'm going to discuss something that happened in a very rural area in Arkansas and what policy changes we made coming out of this tragedy.

This is the Albert Pike flood. Albert Pike is a – was a very popular campground for residents coming out of Louisiana, Arkansas and Texas. As you can see on this first slide, children, parents could wade in this very clear stream that's coming out of the Ouachita Mountains and camp in this area overnight.

Now, going down into the Albert Pike campground is like I've really never seen anything like it in Arkansas until this tragedy occurred, and you go down into almost a very narrow canyon, only one road leading in and out. And thearea itself is extremely narrow. And so you can see why families are attracted to this very shallow water, clear water and many – during the peak summer months, hundreds of families come here and stay overnight.

So I'd like to go to the next slide and click on this video where our governor, Gov. Beebe describes what happened in that – in the early morning hours of June 11, 2010.

(Start of Video Presentation)

A different kind of devastation than I've ever seen and frankly, it boggles the mind how swift that water was. There are four inch – four and a half inch slabs of asphalt that have been ripped up and forced under other asphalt, moved out of the way. I saw a tractor trailer truck wrapped around a tree. That's the kind of stuff you expect from an F4 or F5 tornado.

That's how powerful that water was, cars that are turned upside down, campers turned upside down at two o'clock in the morning – 2 a.m., the river is about three or three and a half feet. By 5:30, it was 23 feet high. That's roughly a 20 foot increase in just a matter of a couple of three hours. I mean that's a lot of water in a hurry. I don't know how these people would've known. They're asleep first of all.

Most of them at two or three o'clock in the morning are asleep and even if there'd have been – they'd have had a radio or something that they could have tuned to, odds are they were asleep at two or three o'clock in the morning. It was really, really the worst possible time for people to be able to detect it. So I think the folks who have lived here all their lives have indicated that they've seen floods before but they've never seen anything like this.

So I don't know if anybody could imagine what those people will go through. You don't see many major disasters with that much loss of life. This was – obviously, people like to camp out. They like to camp out in the wilderness areas. They like to camp out by rivers. They like to camp out in areas where they can get away. All of those things I think worked in this instance to create a horrific, horrific, horrible outcome for so many people and so many families.

(End of Video Presentation)

Dr. William Mason: Thank you. So next slide, please. So what this describes, what you initially saw is the campground, the pristine campground as these campers saw it, that – the day of the – about the day of the – before the flood and that at 2:30 in the morning, due to heavy rains, the Little Missouri River rose 20 feet in a matter of minutes. These people were trapped.

Even the children who tried to get to some of the rest areas in some of the restrooms were trapped as the restrooms were totally flooded. And so there were 20 people dead, very few people – there were actually no hospitalizations except for a few scratches. People went to the ER for a few scratches.

And so, people were either alive or dead – so there is no hospital surge that was tested on this capability. Now, this remote area – when I went down into this area on the day of the flood, there was no cell service, obviously. Satellite phones did not work. There was no way to communicate deep in this canyon and these people as we mentioned, there was no early warning system in place to alert these campers of this flood. They were totally trapped. So next slide, please?

So what HPP capabilities were tested, I'm just going to talk about two but I'm going to go in the fatality management in a little bit of detail and tell you what we learned in Arkansas. The two primary things that were tested were fatality management and information sharing. The next slide, please?

The information sharing, we had something called Arkansas Wireless Information Network radios which communicated through all agencies through these handheld radios and we could communicate not deep in the canyon but on – as we came out of it, we could communicate with various other individuals and state agencies. Now, the problem with that is when we were talking about individuals who were being recovered, that is the victims who were being recovered, anyone could listen in to this.

And so, what we did is we went to the state legislature and then we have between – around 12 secured channels for use for help only. So the one thing we learned from this for communication was we need secure communications, secure health communications for our A-1s radios. We had to go through the legislature to get this and we do have some secured communications for any future significant health tragedies or in disasters where we have got to have a secure radio network that others can't listen in on.

We also have redundant communications with our Ham radios, A-1s that I've mentioned, satellite phones and our cell phones. We've got our amateur radios or Ham radios set up in almost all of our hospitals in the state of Arkansas so that if everything goes down, we still have Ham radio capabilities.

Now, so we looked at our communication capabilities – we want redundant communications but one thing we did learn is, in a canyon this deep, in something this deep, there is no really way that you can communicate that we found that we could communicate in, and that's going to be always a problem in some of these rural areas. Now next slide, please?

Now about two weeks before this happened, we had been struggling in Arkansas with how do we manage mass fatalities? Now, do we contract with a refrigerated truck of people who – you know who drive refrigerated trucks, you know companies that have refrigerated trucks to store bodies. We couldn't quite figure it out until we came across through one of our coroners here in Pulaski County who did contract work for a company called Kenyan International.

We talked with Kenyan International. They said, "Look, we can provide services for fatality management." It took us several months to get this contract done. And two weeks before the Albert Pike tragedy, we inked the contract with Kenyan International. So what happened?

Well, what happened was during this incident, a local coroner said he called the Department of Emergency Management on the day of this incident and said, "You know, we're recovering bodies and I need some help. I think I can identify all of them, but I'm not sure." We got word of this because we had been working – we had known about the incident and we called Kenyan International.

The coroner, we went down to the incident. We traveled down there. We went down into Albert Pike. The coroner had talked with a refrigerated ice delivery truck company. The company said, we can – if you need storage facilities for more bodies, we know you're recovering. You've got 6 to 10 bodies you've recovered, if you think you're going to recover more, you can use one of our trucks to store the bodies in.

And the coroner said, "Hmm, that's a good idea." But then the company said, by the way, you're going to have to buy that after you store the bodies because we can't use it again. We went down and talked with the coroner, we called Kenyan and Kenyan had an 18 wheeler, that afternoon, come down, late afternoon and sit near the body recovery zone for – with a refrigerated truck in case more bodies were found.

So two weeks before this incident, we just inked the contract and now, we called Kenyan. Kenyan assisted in identification of the bodies. Kenyan assisted the local coroner and so we learned a lot that yes, this system works. Now, the local funeral home – by the way, when we went there, they had a walk-in cooler.

The bodies were stacked and so the funeral home was added to capacity at 20 bodies. The refrigerated truck was there in case more bodies were found. We didn't find any more bodies but the truck was available and it was a very hot June by the way and the bodies were quickly – were deteriorating and we were very concerned that if they

found more bodies, the capacity of the local funeral home in Nina, Arkansas was already – it was already at capacity. So what we learned from that is that this contract worked.

It was very – it was a very timely sort of thing. So we now have a good mass fatality plan as a part of our health care capabilities in reaching out. Our coroners are now part of our coalition. So next slide, please?

So the mass fatality incident, such as this as an incident that produces more fatalities and can be managed locally. We are also concerned about the conditions of human remains, the accessibility of the incident, possible multiple scenes of fatalities, complexity of the remains recovery and resources and capabilities of responding agencies.

Again with this particular private company, they managed almost all of this. They will manage almost all of this for us with regard to recovery of human remains and also, working with the families of the victims. So next slide, please?

So there were no survivors. There was no hospital surge but there was a surge with regard to human remains. So our coalition then involved our coroners and we realized then that we had a real problem working with coroners in Arkansas. Do they know about mass fatality? Do they know how to work with the Department of Health in recovery of human remains. Our take on that was they did not. So next slide?

So what we did there was we went to the legislature to develop a coroner's law, a statute for training of coroners to establish education programs for coroners, establishing mass fatality and mutual aid agreements, establish a coroner’s education training and importantly, a certification for coroners in their training. So once our coroners attend our training course and again, this is what came out of Albert Pike was a law, an act. They can attend this.

They will get certified. They will get trained in mass fatality management, how to work with the Department of Health and that's what came – this was the best practice that came out of this event. This is what we learned from this event. Now, it's very important to know that in Arkansas like many areas, our coroners are elected so we cannot mandate that they enter into any training at all. We can say, here it is. We'd like you to engage in this training. So next slide, please?

So what we have and we developed through our mass fatality responses, mass fatality response kits, these kits contain cameras, checklists of items needed to identify bodies, and documentation at the scene, but here is the – that's the carrot for the coroners. In order for coroners to use these kits, they have to engage and go through our certification, our certificate program and its two levels and it's – hopefully, we'll be able to get it really down pat.

But they have to go through our mass fatality training in working with the Department of Health in how to use these kits. They can't just use these kits without going through the training.

So in – so that's kind of a best practice for mass fatality. And we also worked as part of our coalition with our medical examiner's office and we found that we had a – we actually had a good partner in our medical examiner's office and they were very impressed with what we did and they were certainly very important in getting – in assisting us in getting this law passed. We also worked with the Arkansas Association of Counties and they were very positive in getting this law passed and how it's – and also the funding of this.

Now lastly, I'd like to say that – next slide, please? This individual, Graig Cowart, is a pastor of a small church that sits at the entrance, near the entrance. It's about a mile from the entrance of Albert Pike, this campground. So this church sits on a little hill. This pastor recognized what was happening and opened the landmark missionary Baptist Church.

It's called Pilgrim Rest Landmark Missionary Baptist Church in a little town called Lodi near this campground, opened the church up and his members of the church gave a lot of respite, rest, brought in counselors and invited counselors from – not just from his church, from other areas to work with the victims' families. He was recognized by several different agencies for his help during this event and was a very important to us.

He rose to the occasion and suddenly, we had a coalition in this very small Baptist Church. So suddenly from Arkansas, we have someone that opened up the church, that gave us his time and of his church's time to help these – the victims' families. So in Arkansas, we kind of know everybody. Everybody pretty much gets along with each other and we consider these – we consider religious organizations as a part of our coalition and Reverend Cowart is certainly someone that we didn't know before

this, but he's certainly a valuable member of the coalition now that certainly would assist us in any way possible, as our other religious organizations.

So that concludes my presentation, what we did, what we recognized. Part of this involved legislation and bringing in coroners into our coalition and other organizations.

And now, I'd like to – this concludes my presentation and I like to turn it over to Jean Randolph to discuss community assessment tools and thank you very much.

Jean Randolph: Thank you, Dr. Mason. Good afternoon. This is Jean Randolph from the Healthcare Preparedness Activity in the Office of Public Health Preparedness and Response at CDC. I'm going to speak to you this afternoon about the Community Assessment Tool. This is a tool that was developed by the Healthcare Preparedness Activity. We began work on this in 2007, used it with a community in 2008. What we used at that point in time was a very rough draft and certainly, a very scaled-down copy of what is currently on our Internet site.

This tool is meant to provide a framework to build a coordinated, integrated response for surge to a healthcare system and it does that by identifying the resource needs, as well as partners that may need assistance in planning and overlapping use of resources, which could lead you to a lack of resources. The partners that are included in this community assessment tool are listed on the slide here.

As you can see, most of them are part of the healthcare sector except for the three on the right-hand side, public health, emergency management and local government. Those sectors are not actually involved in day-to-day care of patients. However, when there is a disaster, they are very important to the healthcare system. And so, we included them in the assessment that we put into this – the tool.

I should tell you that the website at the bottom of this has just been discontinued and the website that's listed on both your agenda and throughout this, and at the end of this presentation, are the correct URLs to go to, to find the tool.

The CAT was piloted as I said early on– as part of a pre-workshop preparation and when they – when the community – there were two communities that used it at the same time. The workshop was a dual community workshop we were doing and the communities that used the tool told us after they used it that they felt it would be very,

very useful to other communities to do an assessment and they helped us to develop it the rest of the way, as well as to be subject matter experts for us for content.

They helped us also to determine priority questions which as you will see, as we show you the pages at the end but the partners that helped us were both local responders, practitioners. They were people from past workshops and meetings as well as federal partners.

Now I mentioned, DOT and NHTSA there, but there were a number of federal partners that assisted us. The audience for this is a community planner, healthcare emergency preparedness planner. If you have a coalition, your coalition lead would be a perfect person for this and you might want have a small steering community work with that leader because this is a pretty big job and when you set out to do this to assess all of the healthcare sectors within your community, that is a large number of partners and you want to have enough people that, should somebody decide to change jobs, you have some else to back them up.

It informs the audience about the capabilities and resources within each one of those sectors. It also informs you of the case of the gaps in those capabilities, in the planning, as well as potential shortages in resources. The design and organization, each section is customized into part one which should be filled out by either that coalition lead or emergency planner or it may be that little steering committee.

They put in the pertinent information and to give you an example, if you were talking about urgent care clinics, all it asks is the name of the urgent care clinic, the main contact and the – either the e-mail address or the website or phone number to reach them and that's the listing that you put in part one. Part two asks a significant question to get at the information about resources and about planning. The questions in the – in each section can be edited, added or deleted and clearly, you should know that you have the ability to do that, you download the CAT into your computer.

If you were to use, you can customize it as you want to and it is also not something where once you put information in answering these questions, no one has access to it except the community. The document is in Word format.

As I just said, it can be downloaded. It's collected for the community's use and not shared with CDC. And questions marked with an asterisk and those are the ones that

you need to answer first if there's a limited amount of time available to complete questions.

Around the time of H1N1, we had already posted this on our website and people who were using it suggested to us that, that was a – that answering these questions quickly helped them out prior to that time.

So those questions are basically questions that address either regulations, state or federal regulations, or requirements such as joint commission requirements. And that's why they're so important. If they're not answered on the first half or they're not answered with good information, whoever is the coordinator needs to go back to that group and tell them they have to get back to those questions and get that information put together.

This is the – this is section J, urgent care centers and this is part one. And as you can see, as I mentioned to you before, the person filling this out is the community coordinator, healthcare coalition leader, emergency planner.

The first question is how many centers are there in the community? And that just means the total number and then just list them out and as you get the information back from them, you check off if they've completed it or not completed part two.

This is part two and as you can see, that person indicates the name, what role they'll play during an influenza pandemic and several other questions, and there's an asterisk question asking if they have looked at how they might be able to increase their staff 30 percent, and how they may be able to implement staffing if they have 30 percent of their staff who are ill and cannot come to work.

That's a question that's important and if you are in the middle of a pandemic, you want to know you got a plan to get extra staff if you need it. This is the web address for where you can find the Community Assessment Tool, as well as a number of our other tools. The CAT specific address is right there, as well as our web address. There was a COCA call back in 2011 that went over this in much more detail and that is archived on the COCA site and they – the URL is there.

We also have a listserv and you can sign up for that and get updates as we put new tools out. We're currently in the process of beginning to update some of our tools. So the ones that have been out there over a period of time, three to four years, we're

updating. The community assessment tool is this year in process of getting updated and made all hazards. Thank you.

And now, I believe I go back to the coordinator or do I – oh, I'm sorry. The next person to speak is Randy Boltz from Howard County. Randy?

Sue Larkins: Randy, you may be on mute?

Randy Boltz: I believe I'm on now. Can you hear me?

Sue Larkins: Yes.

Randy Boltz: OK, sorry. My name is Randy Boltz. I'm from Howard County Medical Center and we're trying to get our first slide up.

Randy Boltz: We're not able to see it, unfortunately.

Sue Larkins: I'll just go ahead and take it back Randy, that's fine.

Randy Boltz: Great. Sorry. So what we're going to try to discuss today is how we actually used the CAT with the work with the CDC last spring and they asked us to do this because they were going to assist us in planning a workshop for – planning for pandemic or public health emergencies.

Female: Next slide.

Randy Boltz: Next slide, and you can do the next slide too. Thank you. The population of Howard County is 67 – just over 6,700 people. Saint Paul is about 2,300 people. Healthcare facilities that we have in Howard County, we have Howard County Medical Center which is a 25-bed critical access hospital. Along with the hospital, we have two rural health clinics, one located here in Saint Paul and the other one in Greeley, Nebraska.

And we also have two retirement homes and nursing homes in the facility or in the town, sorry. We do a little bit of coordination with other facilities but unfortunately, it's not really enough.

Grand Island is a community of about 50,000 and they're about 25 miles from Saint Paul. St. Francis Medical Center is the largest tertiary hospital closest to us and we have not really completed any recent coordination for any types of disasters, however, we do have transfer agreements in place with them.

We also kind of work with good Samaritan Hospital in Kearney, Nebraska which is about 70 miles but again, we haven't done any extensive coordination but pretty much have transfer agreements in place. We also work with emergency management, Loup Bas Public Health Department and the healthcare coalition of Tri-Cities Medical Response System (TRIMRS) which includes 19 hospitals in a 23 county region. We also have MOUs in place with all the hospitals through the TRIMRS organization. Next slide, please?

So why do we use the CAT? We found that it would help us provide a list of partners to engage with our planning efforts and to see where our – to help identify planning and resource gaps within our community. It helped us form the creation of a consolidated list of community resources as well and find where we had resources that we didn't know. It provides information on the capabilities of hospitals and other partners in the community, and partners outside of our community as well. Next slide.

The Howard County planning team had a conference call to brainstorm on who would – or who should fill out the CAT. We all came up with similar people but everyone came up with additional names. So together, we were able to come up with a comprehensive list of people we knew would be able to assist us in filling out the CAT and assist us in our future planning efforts. In rural communities, people have multiple roles and sometimes priorities have to take precedence.

We had to remind several people multiple times to bring – you know to fill out the CAT for our project and we tried to emphasize how important it was to have this completed for the workshop and for our future planning efforts. Because people have multiple roles, our emergency manager assisted several partners in filling out their sections.

She came up with unique ways to be able to get the CAT completed. She called several people and asked if they have a few minutes to go over the questions, and she would actually write down the answers. She went and visited several people and asked questions while they were actually doing their other responsibilities.

She also completed one of the sections over the phone while the person drove to their next job site. Each planning member received a copy of completed CAT to review once they were completed. We discussed the CAT together and this helped us to

identify what part of our plans and resources are working well and what needs improvement. Next slide, please?

Howard County had assistance completing the CAT from agencies outside of Howard County as well. As a rural community, we know we don't have all the resources we will need in a public health emergency. We have to partner with other emergency managers and hospitals in order to receive the resources and support we need.

We need to know the extent of their capabilities, resources and how they would handle staffing issues or need their assistance just to get supplies. We had the 911 call center fill out the section and we found that they only have one person there at all times. We have our clinic manager fill out a section. For emergency management, we have our Howard County emergency manager and the Holt County emergency manager fill it out.

We also asked St. Francis and Good Samaritan Hospitals to fill it out so that we could know kind of what their resources were and what their plans were for additional staff and things. We did asked the two local nursing homes to fill it out and also, mortuary services, pharmacy and public health. Next slide.

We used this in the preparation of our workshop, the planning workshop for addressing healthcare surge in rural settings. This served as a catalyst to share the CAT with members of the TRIMRS members because we believes that this would be a very useful and important tool for all hospitals in our area to employ.

If we could get to a point where hospitals use this with their communities, we could easily more identify regional capabilities and opportunities for enhancing those capabilities to support the region as a whole in individual communities. It is likely that what we found will be very similar in other rural areas of the same size or even areas that are larger. Next slide, please.

Our 911 call center, we found out consists of only one person at a time and they also served as the police dispatcher. So they're very limited in what they're able to do by themselves because if we were to have a public health emergency, they're going to be overwhelmed very quickly.

Our local EMS will be overwhelmed as well because our EMS squads are all volunteer and have low numbers of units. Many EMTs may be unavailable due to

their employment requirements. We may need to use EMS transport from services outside of Howard County. Next slide, please.

The clinic will be overwhelmed with new and existing patients. It's possible that patients will come from surrounding communities if their regular clinic is busy and we kind of really see that coming from Grand Island because of the number of clinics that are there. Just they think they might be able to get in quicker because it's a smaller community. Long-term care facilities may need to take care of any overflow patients that we may have or that are not critical enough to be admitted and mortuary services, the capabilities are limited including for storage. Next slide, please.

For the hospital itself, some of the limitations that we found. We found of course our bed capacity will be limited because we're only a 25 bed facility. We don't have any ventilators and we only have one respiratory therapist. Patients requiring ventilators may or may not be able to be transferred to another facility. Facilities may also be overwhelmed. The level of transfer would have to be an ACLS. If we could get ventilators, we would need to do just-in-time training for all the nursing staff. Next slide.

In a public health emergency, we would really have to consider rapid discharge. We would definitely cancel elective procedures. Staffing supply agreements between the hospitals may not be a sufficient or usable during a large-scale event. We may not be able to utilize staff agreements in place between all the TRIMRS hospitals during a pandemic.

We need to collaborate planning between Howard County Medical Center and St. Francis Medical Center of Grand Island and Good Samaritan Hospital in Kearney to understand how practitioners will deal with crisis standards of care. In Nebraska as with other states, people actively avoid discussing the topic in any meaningful depth.

We have traditionally lacked leadership when it comes to bringing the right people to the table to discuss this. For instance, the state, the hospital association and the medical association have all stated that they have not talked to hospitals or practitioners about this topic.

During our workshop, the Nebraska Department of Health and Human Services attorney discussed what the HHS can and more importantly, cannot do with crisis standards of care because of the boundaries of the regulatory authority. We need to

work with them and the Associations to bring people to the table so that conversations can begin to take place. Next slide, please.

We found that some of the terminology could be confusing to different sectors of personnel. Some of the areas, for example, of the CAT didn't apply to our local health department, Loup Basin. Nebraska's health departments are structured differently to accommodate rural communities. Some questions referred to health departments that were located in the same town as the community.

It is very different for us. We are a small regional health department and located an hour away. It asked about specific things such as labs in the community that public health would use, we only use the Nebraska Public Health Lab in Lincoln, which is two hours away from Saint Paul.

Individuals who complete a section may not know all of their section's information. It did not capture all the resources that we found out at the workshop about additional resources that partners had within our collaboration.

During the workshop, an EMS representative identified a cash of donated materials and supplies that we had in the community that we had no idea. The public health section of the CAT was more – was written more about a one county, high population health department and didn't really apply to our frontier regional minimal staff health department.

It asked about specific things such as labs in the community, but yet, like I said earlier, we would use the public health lab in Lincoln. And of course, they found that it was very difficult sometimes to get people to actually fill out their sections. Next slide, please.

By completing the CAT, we actually found a lot of benefits out of the whole experience. It helped us to identify a lot of assets like we had a good start in our planning efforts and plans. We found out we had extra supplies in the community. For our needs, we did find out we need more planning and we need more planning partners. For some of our strengths, we already have some community collaboration and we're now looking to build on that a lot more.

As far as the weakness that we found, we found out you know we have a very small number of volunteers and unfortunately, that number is getting smaller all the time.

As far as some building blocks, it helped us begin our local emergency planning community meetings with partners sitting around the table.

It provides a good overview of the community resources especially helpful for new people and partners in preparedness roles and when they come into town. It seemed to be really overwhelming at first to do the CAT, but then came to see how valuable the tool really is and when you break it down by sectors, it's very easy to understand. It helped us connect and reach out to partners that we don't normally connect on a regular basis.

And now, we're going to try to keep them involved as well. It helped us realize that we need more partners in our planning and to get through a public health disaster. And also important to include – it's important to include and learn about resources everyone has and what they don't have so that you can try to get everything in place.

And that's the end of my presentation and I'll turn it over to Lesley Schulte.

Lesley Schulte: Thank you. My name is Lesley Schulte and I'm a public health emergency response planner in the Region H and I would like to share with you the Region H Healthcare Emergency Preparedness Coalition Development in Missouri.

For reference, Region H is the northwest corner at the state of Missouri. Within 15 counties, we have just over 239,000 people, population density of about 32 people per square miles. A couple unique landmarks, we have three university and colleges, five correctional facilities, we have one nuclear power plant across the state lines of Atchison County and we border three states of Iowa, Nebraska and Kansas. You can see, we're very rural jurisdiction, a lot of farmland sprinkled in with a lot of industry and our largest area is the city of Saint Joseph.

Prior to 2010, the Region H health resource committee was presented and brainstormed and developed by the hospitals and health department of the region. We looked at each other and said, "We're a rural jurisdiction. If something were to happen, we know we would need each other to be able to respond." And so, the group started meeting over a lunchtime period.

We would share agency facility updates and develop relationships that consisted more of just a name and a phone number on a piece of paper and a plan in our office. We really worked on getting to know each other and how to communicate with each

other, not only during business opportunities and meeting opportunities but how that communication would then roll over into an emergency or disaster.

And then the biggest piece of the Region H health resource committee was about resource sharing, we really felt we needed to find out what we have in our region and how we can get to it if we ever get to a point where we need it. Initial challenges for the group included lack of guidance or national models in which we could develop the group especially into the planning and response phase.

We were able to manage getting together and sharing information but really into that planning phase that we didn't have a lot of guidance going forward. In 2010, the Missouri Hospital Association has sent letters to our health departments and hospitals to the region asking us to attend a meeting to discuss regional coalition development.

It was a statewide effort so we went to the meeting and I remember listening to a presentation and how things were developing into a coalition and looking at our partners in the room and saying, this is what our health resource committee has been doing and we're moving toward and it became very easy transition into a coalition. An easy fix was to change our name and move toward the development.

So MHA was able to push out some of that guidance that was missing from the early stages of our coalition providing now mission, objective, memberships, suggestions and guidance as we move forward.

So the Region H Emergency Healthcare Coalition current membership, we have nine hospitals in our region, seven critical access hospitals, our one trauma center in the city of Saint Joseph and our one state mental health hospital all have membership to the coalition.

We have 13 local public health departments representing 15 counties and in our region, we only have one Federally Qualified Health Center. They are also represented, as well as the five Department of Corrections facilities' employee health nurses. American Red Cross has become a member over the years, especially related to the sheltering issues and functional need pieces that have come along.

In 2013, we engaged EMS and emergency management bringing them on as, one as a member, but two as a liaison back to their own discipline – so our EMS and emergency management coordinator are members and they go back to their own entity meetings to make sure we have communication across all agencies.

In 2014, we hope to engage the new membership and our regional mental health providers, as well as figuring out a connection with long-term care centers.

In addition to that, we have had discussions about a coroner and how we can bring them on so that we're covering as many of the ESF-8 functions as possible.

Current leadership for our coalition, we have three facilities that take the leadership role and form the coordinating Council for the coalition. Currently, myself as a public health planner, one of our critical access hospital planners and one of our trauma center or our trauma center hospital planner serve in that coordinating council role.

The three of us then report back to the Missouri Hospitals Association coordinating council which is made up of all of the leadership of the coalitions across the entire state. In 2013, we increased our leadership through subject matter experts in our coalition. We brought on a communications expert who really has taken that piece on and works with every bit of communications equipment for the coalition.

Our exercise subject matter expert has helped make sure we have good value-driven exercises on timely manner and coalition development expert which includes our documents, attendance, meeting minutes, membership, those types of things. In 2014, the Missouri Hospital Association will push out decontamination training centers through the coalition so that will be a new subject matter expert for us.

And specific to our coalition, if you remember, when I talked about the old days, resource management is very important to us knowing what we have and so at our coalition level, we have discussed having a subject matter expert who comes very detailed in their resources within their region. What we have, where it is and how we need to get to it. For example, if it's a trailer of supplies, what type of truck is needed to move that trailer, what types of ball, that type of thing.

First steps for developing our coalition. In the beginning, as well as every first of the year so January's meeting included these things. We developed our routine meeting schedule for the entire year. We use a combination of face-to-face and conference calls. Early in our development, we felt that it was important to meet every other month so we did conference calls on the off month.

For 2014, we've moved into the development phase fairly well so we pushed back our face-to-face meetings to quarterly with conference calls between. We do use meeting locations all across the region so that you can attend 2 to 3 at least of the face-to-face meetings throughout the year. And of course, our contact information we keep current and adding our redundant communication systems as they become available.

For example, Missouri has pushed out and will continue to push out an interoperable system across the State of Missouri called the Missouri Statewide Wireless Interoperable Network (MOSWIN) as our coalition members receive that equipment, that communications system will be updated for use in our coalition efforts.

The mission statement of our coalition is to improve all hazard medical response for the region through support of our healthcare organizations, providers and regional partners by facilitating all hazard planning, coordinated exercises and real event response during the mitigation, response and recovery phases.

When we talk with each other at meetings and when we started brainstorming, what we want to do as a group, it was really about improving the overall health system response for our entire region and the things that we use to do that include our planning exercises and response to real events.

Looking at objectives, we have two different types of objectives. Under the planning section objective, we wanted to identify the hazards across the entire region, get outside of our individual facilities and look at the entire region and then discuss mitigation strategies for those hazards.

In training and exercise, we want to have timely value-driven exercises and training related to specific things we'll be using such as online systems, as EMResource or WebEOC.

We identified our regional strengths and shortcomings, as well as developed a regional plan. And that plan, like every other plan is continually adapting and changing and we're adding pieces as we can.

On the response objectives, information sharing and situational awareness we recognize is very important during any event response so that our health partners can make the best decisions that they can.

So it's very important during a response, our coalition provides accurate and timely information sharing across the coalition. And of course, resource support again, knowing what we have available and how to get to it. We want to interface well with our local emergency operation center, as well as our multi-area coordination center. And then overall, coordinate our coalition's response activities.

The success that our coalition has is the statewide implementation of EMResource, an online computer-based system in which we can look at – the screenshot you're looking at is the Region H and you can look at by region, you can look at by state, but it gives you an overall picture of how the facilities are functioning.

You can see emergency healthcare preparedness coalition is listed on the top under normal operations, all of our hospitals then are listed below and their current status, followed by our regional assets and this screen rolls down all of our local public health agencies can then list their operations.

Up here by Region H Emergency Preparedness Coalition is a set of keys and if I were to click the set of keys, our other success is our regional state – or regional notification system. This allows me to change the status of our coalition, based on the need that we may need from our members. If we were to name them "On Advisory", an event may be happening but no response is necessarily required, we might put somebody on advisory for a winter storm coming through. "On Alert" means there's a possibility something did happen or may happen that may lead to a full activation. And of course, "Full Activation" means our coalition members need to please respond.

So within a click of a couple of buttons, a few comments, I hit save and all of our coalition members within a few minutes will be notified of an event that is happening. That notification then triggers them to log on to the systems for more information. Also within EMResource is the development of the hospital incident command system. This system allows our coalition to virtually have a response to an event anywhere in our region.

So from our own offices or my own desk, we can login and assign coalition members to specific positions that may come with objectives and things that we need assistance with in their response. The first question I get from a lot of places, well, if you're the agency being impacted, you don't have time to sit down at this computer system and that's exactly correct.

As a coalition, we recognize the agency or facility that is impacted by the event may not be sitting at their computer but behind them, the coalition has stood up on the incident command system structure and is ready to help them with anything that they may need, and this is one way we can share information very quickly as well as resources.

We completed our regional hazard vulnerability analysis. Each facility and agency is required to complete their own HVA. We took a look across the region at the types of events we may have, the probability, risk and how well we are prepared to identify our top hazards for our entire region. We have an exercise schedule, again, we do that at the beginning of the year and set it for the entire year in 2013, and 2014 looks very similar.

At least twice a month, we're testing some type of communication tool, and four times a year, we are testing desktop exercises where we all remain in our offices and our agencies and test our Hospital Incident Command System (HICS) application. We also participate in the state emergency management agency exercise in the fall.

Another success, the formalized guidance that had – comes out from Missouri Hospital Association, I can't say enough about the team at MHA who helps bring guidance in and prepare it to come to the state level coordinating council, of coalition leaders who can then sit and look at documents and say, what works well for local coalitions and what does not work.

What this allows is documents can be tweaked instead of having to be developed at the coalition level, it's provided a lot of consistency across the state and it gives the state coordinating council the ability to have that voice and that input into it.

The Missouri Hospital Association has always taken the approach of an 80/20 look when we're looking at documents. If we can look at a document and know 80 percent of this document can stay similar so it stays similar across the state, but they recognize each coalition throughout the state of Missouri has been set up differently, you do need to change things based on your coalition. We take that approach in all the documents that come from MHA.

We've worked really hard to develop a relationship with our emergency management directors and our multi-area coordination center. We've established our coalition as a health response within our MAC and we participated in state emergency management

agency exercises. We started this process with presenting our coalition development and approach, as well as our HICS application at our regional emergency management coordinator's meeting.

At that point, we knew they were in a development phase of their MAC and we've been testing it a couple of years. They've asked the coalition to be a representative in the MAC development so we can make sure, we're staying on the same page. Incident – emergency management directors, they're in the command chair of every incident. We wanted to make sure as a coalition, we were falling into the structure they were developing.

Coalition exercises over the last couple of years, we've participated in several things from the 2010 national level earthquake exercise, hoof and mouth, several ice storms and/or tornado storms. We continue with our communication test and our notification testing. In the future, we look forward to an asset moving test of some sort.

Coalition response experience recently in May of 2013, a late snowstorm moved through the area dumping heavy wet snow which took down power in three of our counties including two of our critical access hospitals. Coalition members in that counties put the coalition on alert status so they could share information and provide regular updates, as well as have agencies and entities ready if conditions were to deteriorate throughout the day.

In October of 2013, a town of about 10,000 in our region expected a demonstration of about 3,000 people. They knew that 3,000 people could potentially disrupt their health system. Again, putting the coalition on alert. It was a peaceful demonstration. We had no issues, but they felt the need to reach out to provide information and be prepared with resources if needed.

So when I look at our coalition and the things that the coalition offers, you know sometimes I'm asked why join or form a coalition especially when we're talking with other entities or agencies about potentially joining our coalition. Our coalition has really given us the avenue to develop relationships for a whole health system across our region. We've gotten to know each other very well and know what we all bring as far as assets and personal assets to our group.

Information sharing has picked up immensely over the last several years, among our health entities across the entire region whether it just be a training opportunity

information or maybe it's even information about the influenza cases that we're seeing recently. And again, human and material assets are very important to our region.

As we know, we're a very small rural area, we're going to need assistance from each other so they provide that additional support. I guess I would like to end this piece with the idea that the support that the coalitions provide to our entire region, you know when we have an event at the local level, the coalition does not come in and say, we are command and control. We're here and we'll take over.

At the local level, if something were to happen in Holt County, a county I support, our Holt County Health Department would report to our local EOC as a health representative and would take care of health needs at the local EOC as Holt County can. At the point where those needs exceed the ability to respond, standing behind us at Holt County health Department is a network of 30 other healthcare entities and agencies across our region. So if we have a need, we very quickly can move things.

Next step for our coalition, we look to continue our regional plan development, as well as our exercise development and improve our leadership depth, it's very important at our coalition set up, virtual the way we have it, that every coalition member feels the ability to take a role and be ready to respond.

And the last thing I would like to share with you is a resource and the link to the Missouri Hospital Association guidance documents put out in 2013. This document will give you a look at – an overview look at all the coalitions across the state of Missouri as they're all set up just a little bit different based on their needs, as well as an MOU that coalitions are moving forward and signing this spring, as well as two planning documents. One being information sharing and the other, mass fatality planning.

Thank you for your time today and I will turn things over to Jay Taylor and his team who will discuss medical surge in a rural setting, the Greyhound bus rollover.

Jay Taylor: Thank you so much and I really appreciate the opportunity to give a quick presentation here on an incident that occurred up here around our central part of our state with a bus incident with a tractor trailer out on an interstate.

Today, we have Stan Hudson with me from Evangelical Community Hospital and Amanda Krebs from our EMS Regional Council up in that region.

Just to give you kind of a layout here of the state, we have 15 regional EMS councils across the Commonwealth of Pennsylvania, and we also have nine regional task forces.

When it comes to our coalitions in the Commonwealth of Pennsylvania, it should be noted that we are fortunate here that a law actually created the task force many years ago and really molded into the national incident management system and each one of these task forces all have the ESF-8 function within their health and medical committee that really represents our coalitions that bring all of our hospitals and our emergency medical services and all key players in the health and medical arena to the table, each one of these coalitions or task forces. So we were quite fortunate in the way that, that has been built out and it made it real easy for us to build the coalitions here within the Commonwealth of Pennsylvania.

On 9 October at 1:36 AM in White Deer Township, we had a vehicle accident involving a bus and a tractor trailer. It should be noted that you know the 48 passengers on this bus and the driver, when the first units arrived on scene around 1:41 AM, we had the incident noted that there was like 8 to 10 feet of intrusion into the bus. We are talking about a real heavy impact on this bus had the potential to be probably a lot worse than what it actually was.

The other part of this too is where they are located at out there is, being in a remote area out in Pennsylvania, there ain't immediate access to where you would have close to a city for healthcare but we do have a robust system in place out there where we're able to respond rapidly and get the resources that were needed.

And you can see that the scene was secured at 5:44 AM that same day. EMS use, we had 25 of them that were involved in six counties that included three of our EMS councils. So 16 Basic Life Support (BLS), nine advanced life support and three air medical units that responded and 46 patients being transported to four local hospitals and of course, we have one who did decease on scene.

The level I trauma center in that area is Geisinger. We received 18 patients overall. Two were actually transferred for definitive care from one of the other hospitals, from Evangelical Hospital who had received 14 patients, Muncy Valley Hospital received 10 and Williamsport Hospital had received six.

And I was thinking, I'll let our folks here, we can actually give you the kind of distance how much they have traveled, I think it was probably around 20 to 30 miles in any direction as for some of these hospitals that they had to travel to. So the incident was managed very, very well.

The accurate assessment by triage obviously was the key to getting control of the incident and also, was a key part of having the proper persons sent to facilities that were capable of meeting the needs of that patient. They also – they had the process alone saved considerable time and conserved valuable resources by getting those assets that needed to get back to the scene to transport to somebody else back on scene quickly.

Obviously, as I had mentioned that the triage was very, very right and it was very critical to the total operation to have somebody able to do that, and interoperability, you have the 25 EMS companies coming in from six counties, three regional councils, we had fire department, law enforcement all work together with a common cause. And obviously, that is the overall objective of having a coalition is having that working together in that common cause. And the incident command worked well on scene as well as the hospital incident command.

As to what could be improved, there was some issues on scene with patient tracking, being able to know the number of people that you had and where you sent those individuals to.

Leadership, some of the initial people who took the leadership role were very inexperienced. They did step up and they were able to take control of the situation, but they could've done a lot better. Obviously, with experience and obviously you don't have these type of incidents out in these locations happen every single day.

Information sharing, that becomes one of the issues whether it was HIPAA-related in some hospitals and their policies and being able to communicate across with each other became probably some of the more, some of the difficulties that were experienced during this incident.

And with that, Amanda, I'll let you speak to the EMS side of the house and some of the things that you noted there for the incident and how we came together as a group.

Amanda Krebs: Okay. Well like you had said, there were 25 EMS units responding from six different counties within the central Pennsylvania area. All of those EMS units were able to

communicate with each other through the 911 center. And the 911 center upon learning of this incident quickly notified all of the hospitals in the region and told them what was going on and said that they should be expecting a large number of patients.

So fortunately, all the hospitals, except one I believe, was notified and were prepared for the amount of patients they were going to receive. Like Jay said, the triage – they set up triage outside of the bus and inside. They had one paramedic go inside the bus and start triaging patients.

Then as he said, with the lack of experience, I do want to bring up that both of the paramedics that initially responded to the call have been paramedics for less than five years. So this isn't anything that some of us had been in it for 20 years have seen, let alone, people just coming in off the street.

All in all, everything went very, very well. The biggest challenge to the EMS that was on scene was the fact of the language barrier. I believe only two or three of the patients on the bus spoke English. There were six or seven languages represented. Fortunately, two of – or one of the firefighters from the company who had an initial incident command was able to speak Russian and communicate with two of the victims, and I believe, one of the EMS providers was able to speak Spanish and communicate with others.

But some of the patients who – excuse me, were Korean and the deceased was actually Vietnamese which was another challenge in itself. So triage and treatment areas and finding for the incoming EMS to actually find/locate the patients was very difficult because with the limited resources, keeping victims who can't speak English and are scared to begin with in a small location for treatment was very difficult.

Excuse me, I'm suffering from this cold that everybody seems to have. But generally, the treatment and transport went well. I believe Stan is on, he'll be able to help you out with the hospitals side of things.

Stan Hudson: Yes, thank you, Jay and Amanda. I would say that our hospitals did a very good job. We were all able to set up a hospital command center and through that, we – we're all HICS compliant and used – are NIMS compliant and we used our HICS command system to manage the situation.

I don't think that would've been possible a few years ago but, because of the funding we've received and I know here, the Pennsylvania Bureau of Public Health Preparedness has stressed that we use our funding not so much with the purchasing of equipment and toys as they say but to direct it more towards training. All of our coalitions have seemed to do that and it really paid off here.

We were able to manage it the way it should be managed. We were all on the same page. We all used the same terminology. So it worked out very well, and I will also say that the communication that we had between the hospitals worked out very well.

If I could just kind of mention without pre-dating myself, you know a few years ago, hospitals looked at themselves as competitors and that still may be true to a certain extent but through the coalitions, we sat down with one another at different regional sessions and meetings, we get to know one another face-to-face. So we look at it more as coopera-tition.

There's times where we're individuals but other times, we we're – because we sit down and come together, we've learned the importance of cooperating one with another. So that's been a big, big plus in how it was handled. All of the hospitals did basically the same thing and I thought they all did a good job.

Jay Taylor: Thanks, Stan, and I will note is you know the things that went right and part of the HPP program, what they've done for us is you know bring those hospitals on board with the incident command system and get them in compliance with that. And building those command centers and having those instruments in place really contribute to the success of the overall operation and how well it worked. And now, we're going to continue to build on that and to grow our regions and our coalitions to continue to be the best we can possibly be.

And so with that, I will turn this back over to our host, Traci and for questions and answers.

Traci Pole: Great. Thank you guys so much. I think from everybody listening in, we really appreciate the questions, for the presentations and for what everybody has to share.

Looking at – I'm hoping the operator will kind of queue up how we go about questions for the folks on the phone but we did get a question for Dr. Mason specifically around who is in the hospital, operates a Ham radio. You made reference to that in your presentation so folks are interested in that.

(Off-mike)

Dr. William Mason: Yes, the local Ham operators are trained by our communications person to respond to the hospitals. So we also have – I know we also have some ham operators within the hospitals. So we have training for the hospitals but with local ham operators …

(Off-mike)

Dr. William Mason: Yes and monthly tests also.

(Off-mike)

Dr. William Mason: Yes and also we're –Steve mentioned that we're doing some training in some of our local high schools with regard to Ham operators. So we want to reach out to some of the high schools that have an interest in Ham operator clubs and make sure – in their – well, I think they would be part of the coalition also.

Traci Pole: Great. And a follow-up question for you Dr. Mason is I guess some of the folks on the phone are interested and wondering if maybe you will or won't know the answer to this but do you know if there are other states who are using the certification class for the coroners? In addition to the work that you guys are doing there in Arkansas, is this something you've heard or mainly something that you guys are taking lead on?

Dr. William Mason: Yes, we are – we have something called the Arkansas Law Enforcement Training Center in a little town called Camden, Arkansas and what we're working with the law enforcement training center is to develop kind of level I, level II, or a basic course and an advanced course in certification and training for coroners. Okay.

Now, it doesn't certify a coroner but they've got basic and advanced training. We're basing that off of a model and I'm just – I'm probably not correct here exactly but it may be coming out of St. Louis University or – and also New Mexico. They have apparently some very good modules for coroner training, okay and I can certainly – we can get you information on this if you will just send a note to Steve Whisnant and I can send you the information.

Also, when I was a preceptor for an MPH student, she did an excellent research paper on coroners in not only Arkansas but within the United States about the various

coroners, whether they're elected, whether the coroners are medical examiners, whether they're a mesh between medical examiners and just elected coroners, we can send that paper to you also.

That paper also we sent to the CDC. It was kind of the first of a – it really was a very good outline of coroner training in the United States. To my knowledge, there are probably a couple of areas that as I said, one in Missouri and I want to say it's in St. Louis and one in New Mexico, Albuquerque that have the – what I would call the – really the excellence in coroners training. And many of our – and some of our coroners have actually gone up there.

It's not inexpensive and it requires time, and remember, these are elected officials and I'll just give you of interest, the coroner that was at Albert Pike actually was a – he owned a pawn shop. So you can see how much education he would have had in something like a mass fatality event. But we would – we are just wrapping this up right now.

We are – through our legislation. We are just getting it started and we'll have – but we'll be happy to share any information that we have with other states if they're interested, if they could get with you and we'll funnel out whatever we have to any interested parties that are on the call today.

Traci Pole: That sounds perfect. I appreciate that and we will try to get that material up with all of the other materials from this call as I mentioned earlier that will be up on our website.

We – and we got a couple of questions circulating around how the materials will get out, the distribution centers, the way that we distributed the information about this call hopefully through the HPP listserv, as well as your Field Project Officers if your field Project Officers are trying to share, and then the state level leadership team help to share with other state partners and local partners, we ask that once we get the link out that folks continue to share in that same fashion. We certainly don't want to miss anyone. So we have a – go ahead.

Sue Larkins: Can you give instruction for how to ask questions via the conference call please, operator?

Operator: Certainly, ladies and gentlemen, if you have a question on the phone lines, please press star, then one on your touch-tone telephone.

Sue Larkins: Traci, I had sent you a couple of questions via e-mail. Did you want me to read those or do you want to …

Traci Pole: I can proceed. I just wanted to give 10 seconds for the folks online.

Sue Larkins: Okay.

Traci Pole: So we had another question, Jean, I'm hoping maybe you can take this one, wondering about how the CAT is being piloted with the awardees. How did you sample your pilot sites or how are your pilot sites selected for the assessments?

Jean Randolph: We actually have done workshops with a number of communities across the U.S. When we did these pilots, it was back in 2008 and we were working with two specific communities at that point in time. We did not have any sense or I'm sorry, any PHEP capabilities at that time so we didn't actually have awardees. Well, there were awardees but we were not working with them.

So we worked with communities that we were doing workshops with and they actually were communities that represented very large urban areas, midsize cities and rural areas such as Howard County. And we've asked all of those communities to work with the CAT prior to our workshops and give us feedback about them.

Traci Pole: Great. Thank you for that. We have a question for Pennsylvania, specifically how did the ambulance transport drivers know which hospital or facility to go to? Who determined that destination?

Jay Taylor: Obviously the incident command on scene, you would have a transport officer there that would determine where to send each individual that is being removed and through our coalitions and through our planning efforts in those type of regions where we communicated and have everybody at the capability through our ESF-8 component.

We know the capabilities of the hospitals that are in that region, so it's pretty easy to send those who are severely hurt who are our priority. You have a level I trauma center that is fairly close by and that is on automatic, you're sending those patients to that type of facility.

Stan, do you want to add anything to that?

Stan Hudson: Yes, I could. One of the things that make it successful was the triage it took place right at the scene and our triage officer was pretty familiar with the level of acuity and what hospitals could handle what level. So they saved a lot of time by getting those patients to the hospital that was best suited to handle them.

Like Jay just mentioned, all the reds went right away to our level one trauma center. They knew what type of patients we could handle at our hospital, and some of the real minor patients were sent to another hospital. So they were familiar with it. They did a good job of triage and they pretty well knew where to send those victims.

Traci Pole: Great. Thank you. So a few follow up – a few additional questions, one for Missouri. The question is, are all healthcare coalitions in Missouri regional or are there more local-based coalitions as well?

Lesley Schulte: The coalition set up across Missouri has gone by regions with the one exception of Southwest and they have a little bit different set up. They have a larger region outside of just our Highway Patrol regions that we use and then they have sub-coalitions based on the large geographic area they cover. It's broke down smaller then into smaller local coalitions.

Traci Pole: Thanks, Lesley. And then for – this is …

Female: Operator …

Traci Pole: … go ahead.

Sue Larkins: I'm sorry. Were there any calls from – the teleconference …

Operator: Yes.

Sue Larkins: … or questions?

Operator: Yes, we have a question from Nathan Rubio. Your line is open.

Nathan Rubio: Hi. Good afternoon. Thank you. It's not necessarily a question but just a quick little thing that we did at our coalition, our HPP coalition here in Laredo, Texas is we incorporated a gentleman from Texas Department of Public Safety who manages a CERT team and what they do is they have, it’s a community emergency response team and every one of those individuals is Ham certified.

So in the event of a situation or a mass fatality or a mass casualty or just a big exercise, they provide volunteers and what they do is they sit them at hospitals to man Ham radios.

We've also included the local authority on Ham radio in our coalition as well for our communications and they provided a huge amount of expertise and a huge amount of help and guidance in that aspect for redundancy. Not necessarily a question but just something I wanted to throw in there and to show that we were actually doing with our coalition and with the diversity that we have. Thank you.

Traci Pole: Great. Thanks, Nathan. We really appreciate that comment. So you know I think that's one of the things that people have echoed throughout the course of the call today is you know really just trying to identify some of those unique partners and the CERT members having maybe Ham certified is certainly one that's we should consider taking advantage of if folks haven't already.

Operator, do we have anybody else in queue?

Operator: Again, if you have a question, please press star, then one.

Traci Pole: So I have another one that came in through the web, I'll answer, I'll take in the meantime. I think this is probably open for the majority of folks on the call, do any of your coalitions charge for membership and is this something you are moving towards?

Dr. William Mason: In Pennsylvania, we have no charge as a membership but it definitely is a – it is just partnerships that we've developed through relationships with all of our key partners.

Lesley Schulte: Same thing with Missouri, it's a partnership of all the entities and agencies in the region that want to be involved.

Traci Pole: And the same probably for Nebraska as well, wouldn't you say, Randy, you know …

Randy Boltz: Nebraska is the same way, we do not charge any fees to be a part of a coalition.

Jay Taylor: Same with Arkansas.

Traci Pole: Anybody in queue, operator?

Operator: I show no further questions.

Traci Pole: All right. I got an additional one via web, did any of the presenters who shared regarding mass fatality incidents coordinate with County Justices of the Peace? That's probably for you, Dr. Mason, maybe to kick off?

Dr. William Mason: Well, we do coordinate with our County judges, not Justices of the Peace but County judges. They play a very important part in our counties, and our coroners also – we do make them aware of our mass fatality through their coroner training, through Kenyan's contract, they do go out and talk with our various counties including county judges.

Traci Pole: Great. Thanks for that. I do have time for one final. Operator, did you get any?

Operator: I show no questions.

Traci Pole: Okay.

Sue Larkins: Traci, we have one here at HPP.

George Tobin: Yes, this is George Tobin, Hospital Preparedness Program here in Washington, D.C. And we talked a lot about information sharing and all that and I guess this question goes out to Lesley.

You had mentioned about keeping the contact information current, et cetera. Now, what kind of carrots and sticks do you use to make sure that everybody keeps their data updated and contact information, et cetera?

Lesley Schulte: I would say it's just – if the coalition is answering, it'd probably be more like, "Lesley doesn't leave me alone until she gets the information she's wanting." But most of the time, it's put out on a coalition library within our HICS application and I ask coalition members if they notice any changes, they can make the changes themselves, they don't have to necessarily go through any one person.

But basically, you know membership gets those three major components we talked about. Partnership is all about the relationships, the communication and typically, that communication tool as far as knowing what's going on, what training opportunity is available, typically lends pretty quickly to the coalition members saying here's a change and please revise it for me. So it's not been a struggle for the most part.

George Tobin: Thank you.

Sue Larkins: Traci, if you want to go ahead and wrap up, and then Scott has a few closing remarks, I think we're good to go.

Traci Pole: Super. I just – again, I really want to thank our presenters and I – at one point, I looked up and there were 290 folks on via the Live Meeting option. I'm glad we got such a great audience for this. And like I said, we will be getting the materials out. Hopefully, a link out to tell you where to go to be able to grab the information that was shared here on this call and look forward to many more discussions around rural preparedness. Scott?

Scott Dugas: Thank you, Traci and you know, I want to thank Traci Camilli for all her work in setting this up and you know her dedication to the topic. And also, to our speakers, our CDC colleagues and the state and local presenters, thank you so much. I think it's been an excellent call. And again, the first of what we hoped to be many as we continue to explore this topic of rural healthcare coalition development and of course, you know the topic of rural healthcare delivery which transcends with that.

But in closing this call, I mean I got a lot out of it and if you're new to the call and new to this work, you know one thing that this room, we're looking at each other, things we can take away is that you know coalitions are forming in rural areas and that's important.

There's a need for it, rural areas is experience events, small and even a small event can have a big impact especially with limited healthcare resources and EMS transport is certainly an issue and I thank the Pennsylvania folks for highlighting that, and I want to thank Lesley for talking a little bit about how the coalition works to find its way and assist jurisdictional command.

So those are a couple of key takeaways that the room had here. Wonderful and we want to thank all – again, thank all of the speakers. If we had more time, we'd get into some more details but we can always have a follow-up call. And most likely, we will.

This call will be taped and when we get our website finished, we're going to be posting the call conference there so folks can re-listen to it. And with that, we could close out the call and I want to thank everybody for listening.

Sue Larkins: Thanks, operator. Operator, did you want to close the call?

Operator: Ladies and gentlemen, thank you for your participation in today's conference. This does conclude the program and you may all disconnect at this time.