NEW JERSEY HEALTHCARE COALITIONS

National Healthcare Coalition Preparedness Conference (NHCPC) 2024

Compendium of Presentations and Associated Materials Categorized as

Expanding and Sustaining Coalitions

Please contact our team at RHCC@NJHA.com should you have questions or if you encounter any difficulties accessing these presentations.

Table of Contents

Achieving Efficiencies in Exercise Design & Delivery

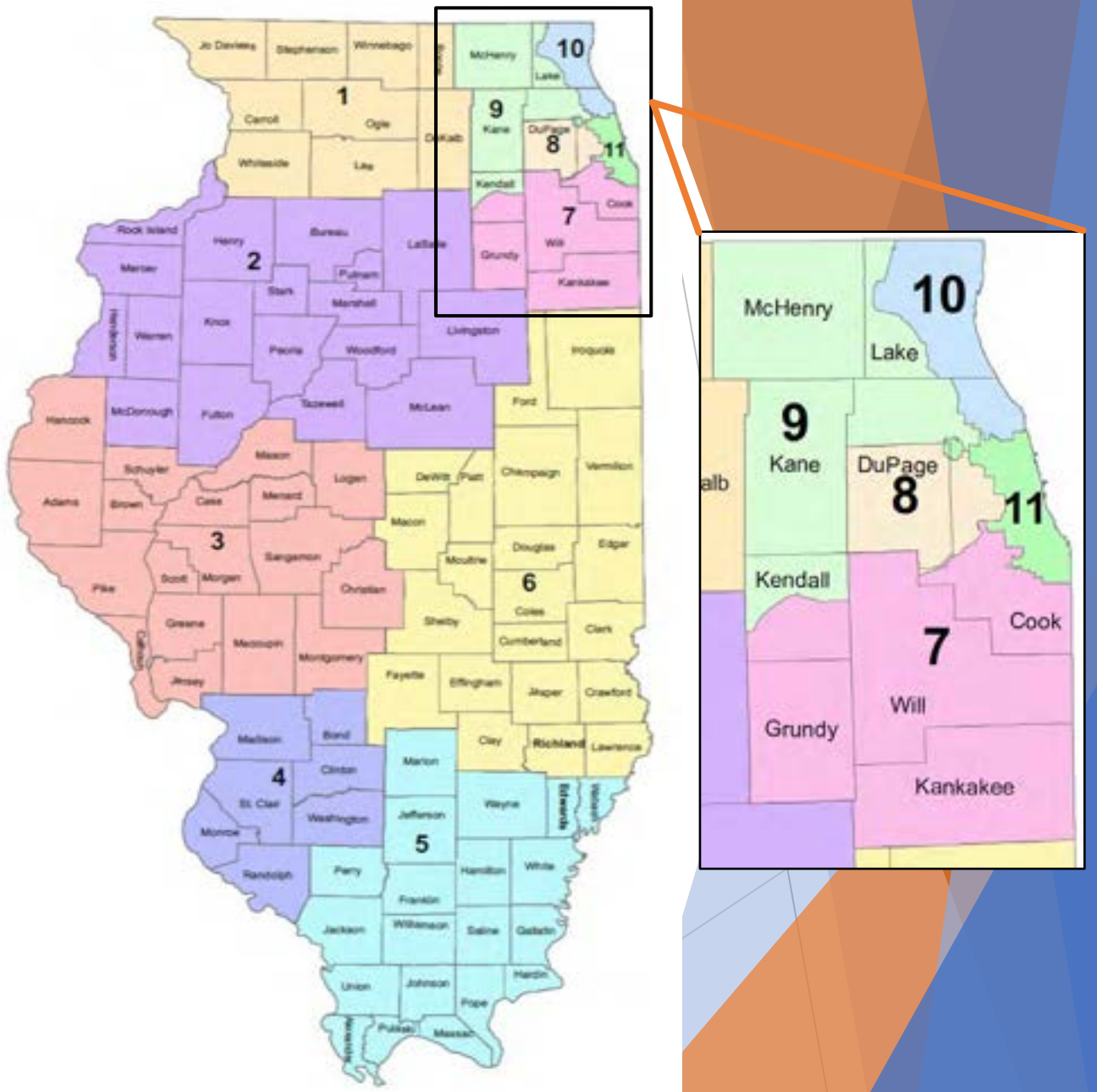
NHCPC – December 12, 2024

HCCs in Illinois

County Population Data:

Suburban Cook County: 2,448,913
DuPage County: 920,762
Lake County: 714,342
Will County: 696,757
Kane County: 516,522
McHenry County: 314,042
Kendall County: 131,869
Kankakee County: 107,502
Grundy County: 52,533

Total Population Regions 7-10: 5,903,242



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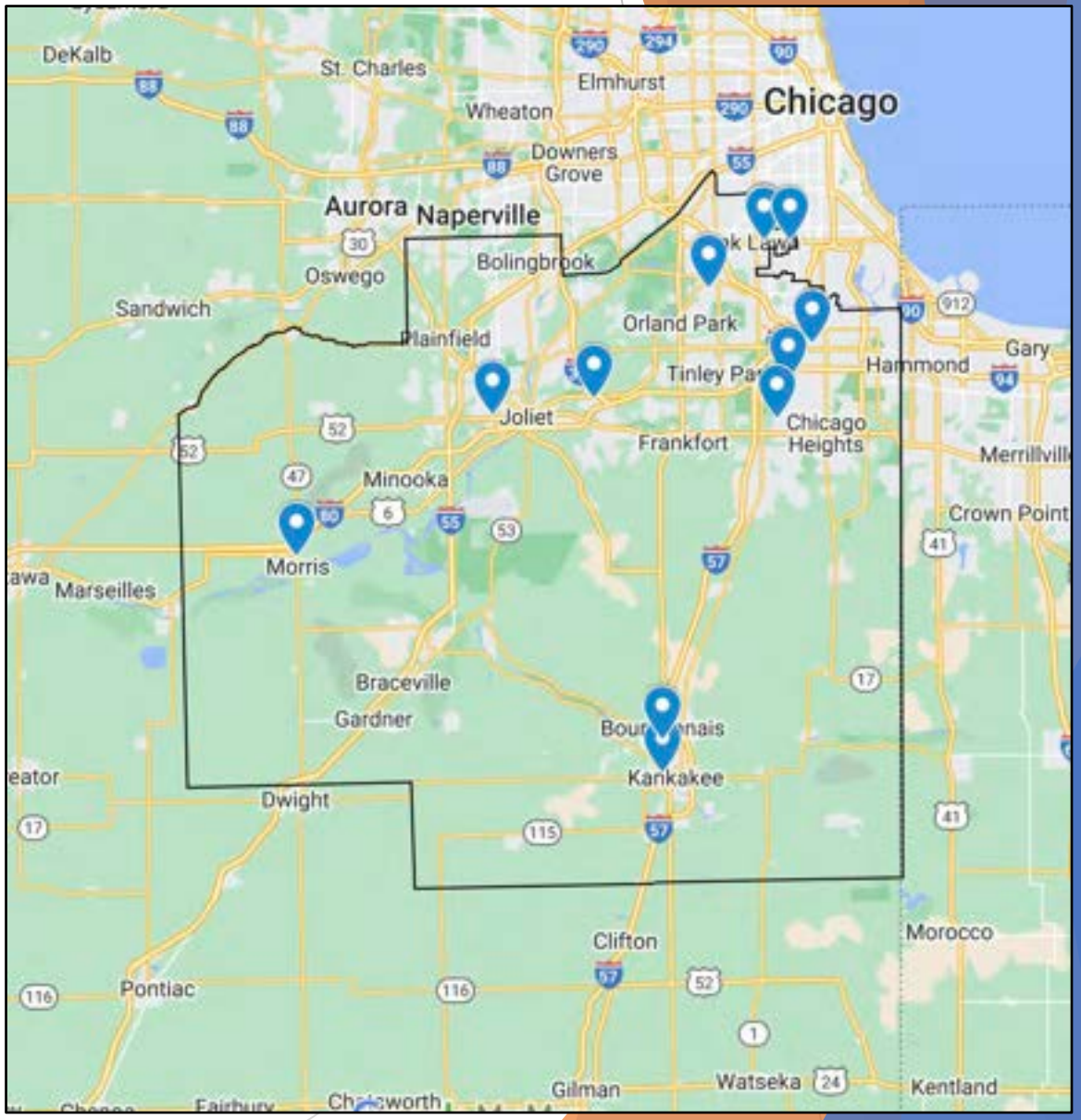
Region 7 HCC Background

- Encompasses the "South Suburbs" of Chicago and west to border with Indiana.
- Approximate population: 1.48 million
- Includes 14 acute care hospitals.
  - 2 Level 1 trauma centers
  - 1 Children's Hospital
- ***Chicagoland (NASCAR) Speedway is located in Joliet, IL.***
- ***The Dresden and Braidwood Nuclear Power Plants are also located in Region 7.***
- ***Actor Nick Offerman was born in Joliet, IL in the northern portion of Region 7.***



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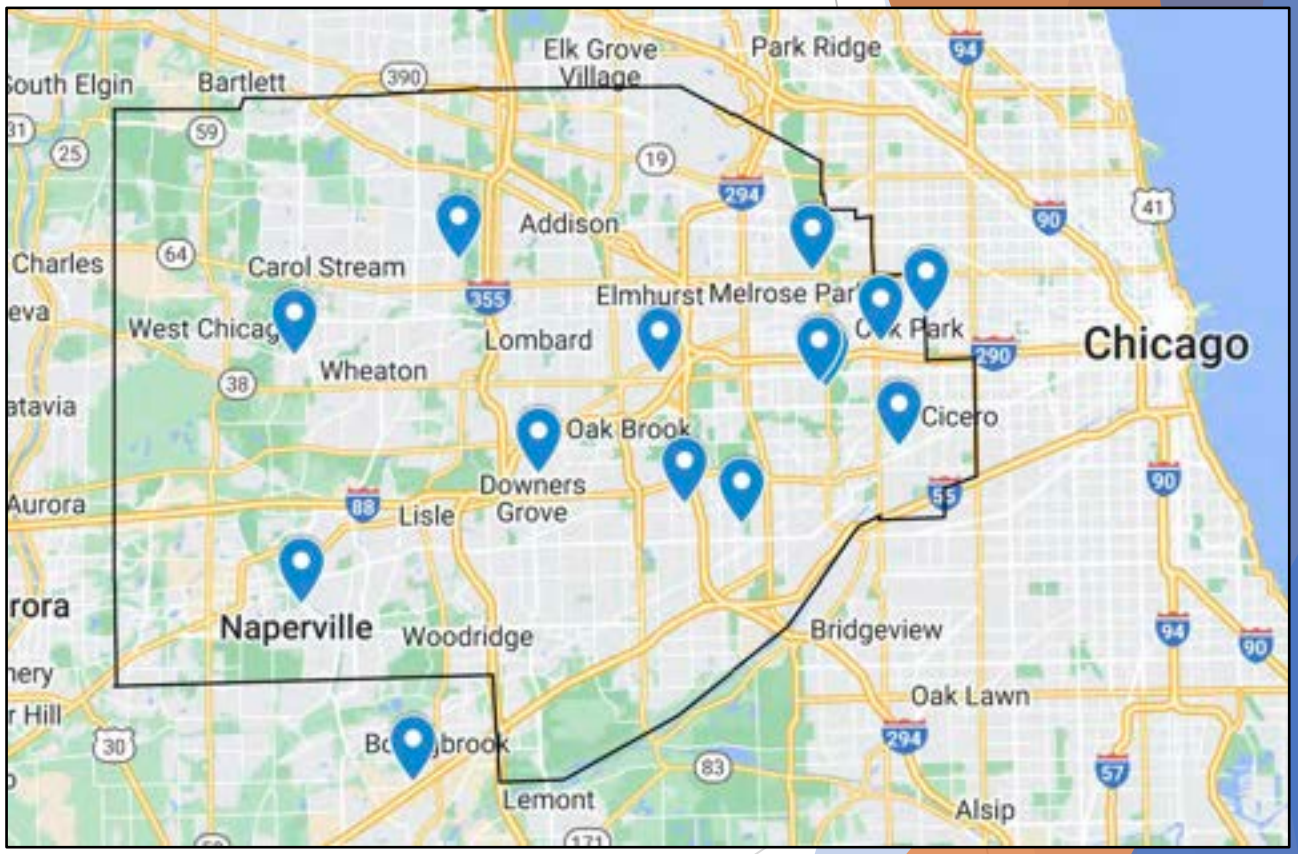
Region 8 HCC Background

- Encompasses the “Western Suburbs” of Chicago.
- Approximate population: 1.5 million
- Includes 14 acute care hospitals
  - 3 Level 1 trauma centers
  - State Burn Coordinating Center
- ***Naperville is the 3rd largest city in Illinois (pop. 149,540).***
- ***Oakbrook Center is a shopping center established in 1962 and located near Interstate 88 and Route 83 in Oak Brook, IL. It is the second-largest shopping center in the Chicago metropolitan area.***
- ***Wheaton, in the western portion of Region 8, is the childhood home of John Belushi.***



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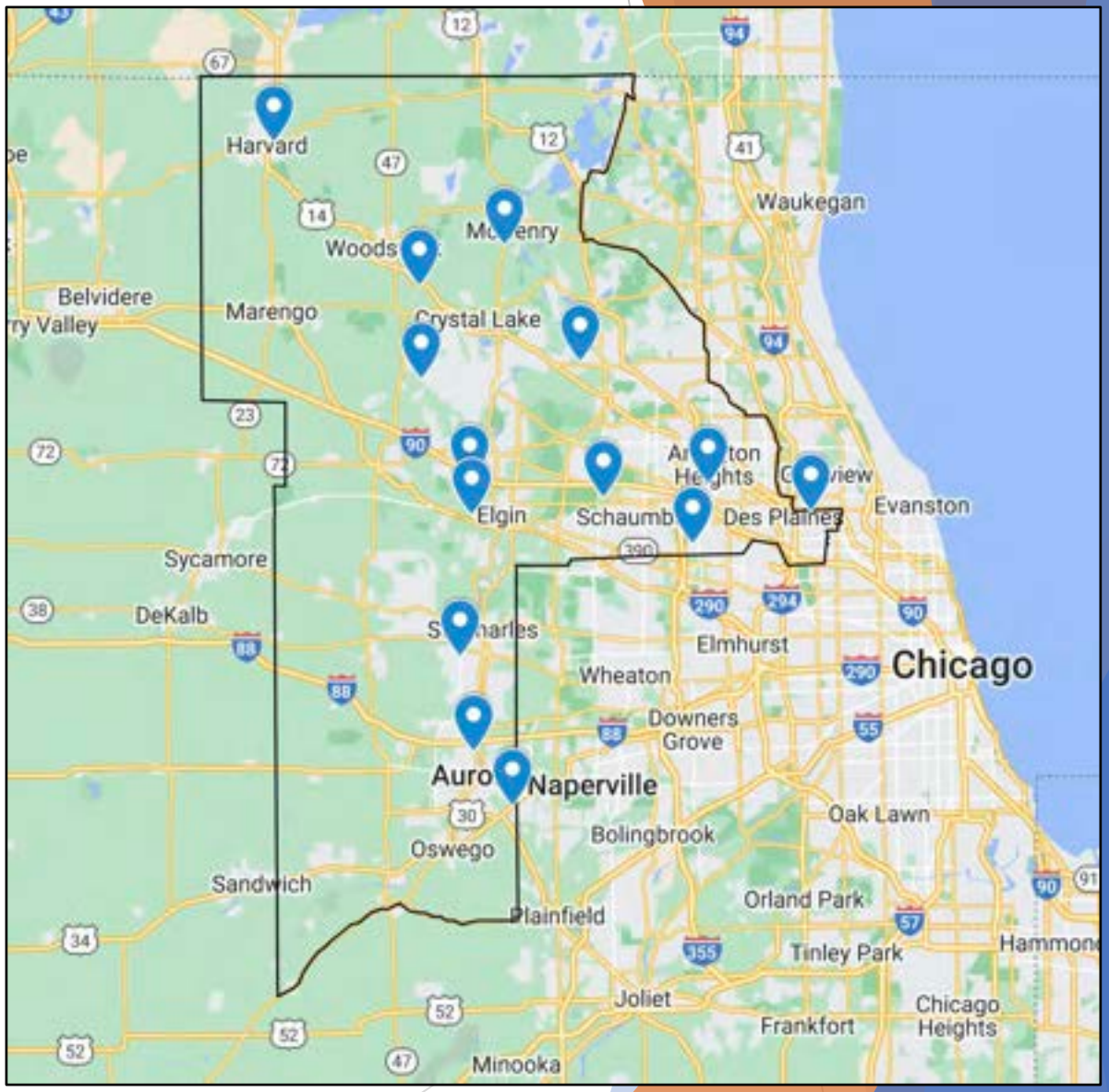
Region 9 HCC Background

- Encompasses the areas immediately West of the Western Suburbs and North to the border with Wisconsin.
- Approximate population: 1.72 million
- Includes 14 acute care hospitals
  - 1 level 1 trauma center
- ***Aurora is the 2nd largest city in Illinois (pop. 180,542).***
- ***Kane County, IL was key point along the Underground Railroad.***
- ***Football player Jimmy Garoppolo was born in Arlington Heights along the eastern edge of Region 9.***



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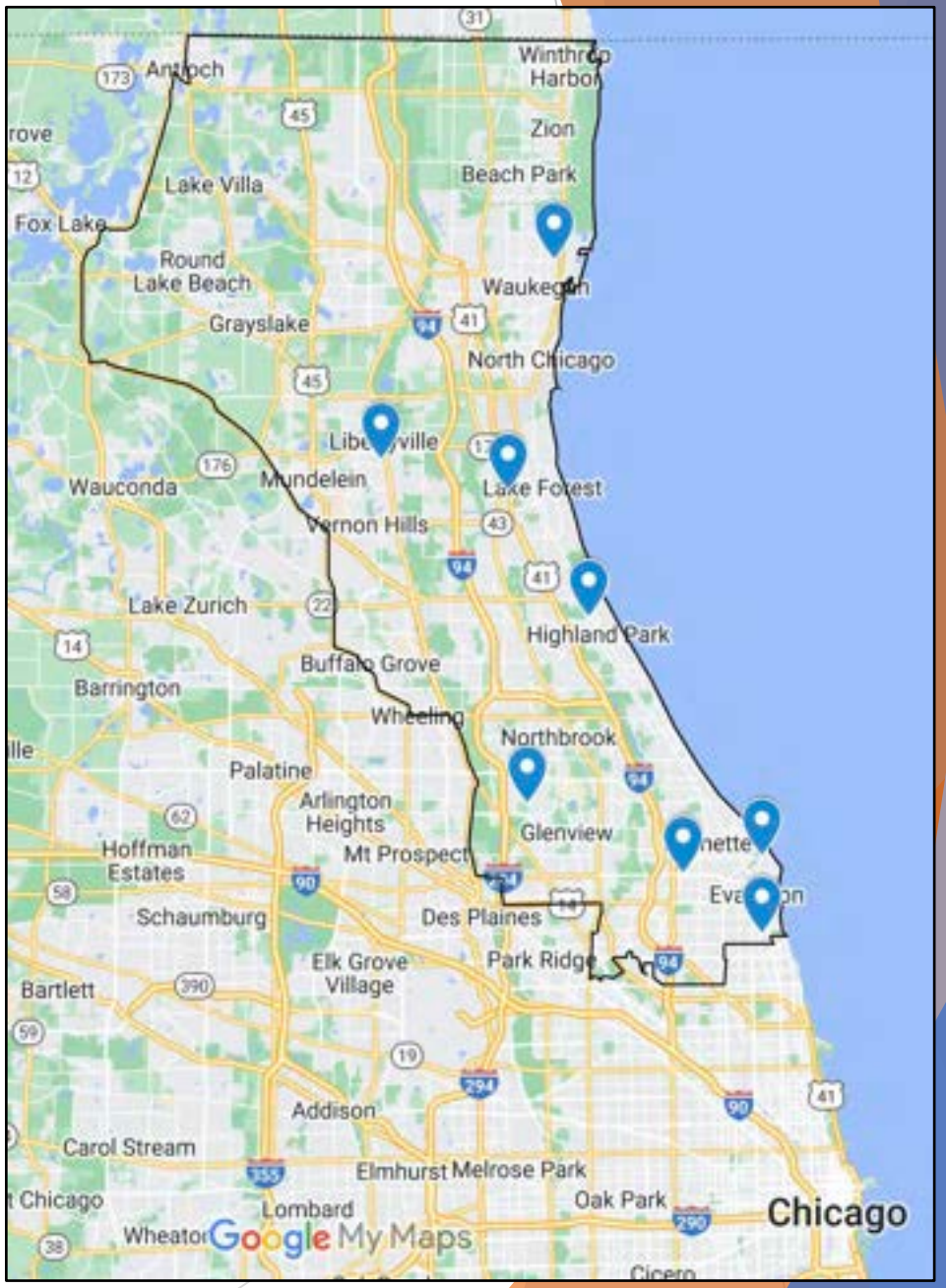
Region 10 HCC Background

- Encompasses the “Northern Suburbs" of Chicago up to the border with Wisconsin.
- Approximate population: 1.09 million
- Includes 8 acute care hospitals
  - 3 Level 1 trauma centers
- ***Some of the wealthiest cities in Illinois are located in this Region including Highland Park.***
- ***U.S. Naval Station Great Lakes and Northwestern University are located in Region 10.***
- ***Author Ray Bradbury was born in Waukegan, IL, and basketball player Michael Jordan was born in Highland Park, IL, both along the eastern edge of Region 10.***



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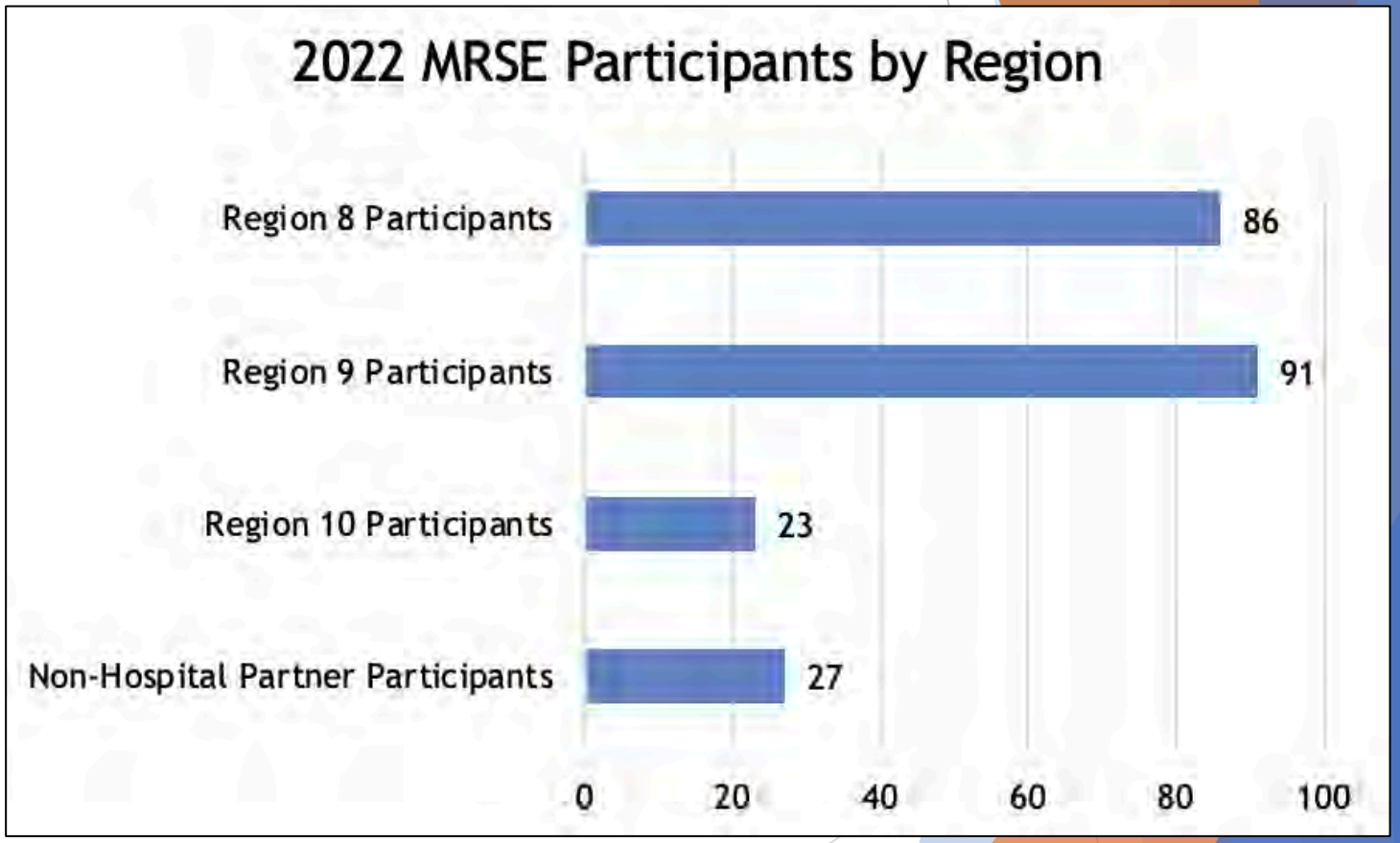
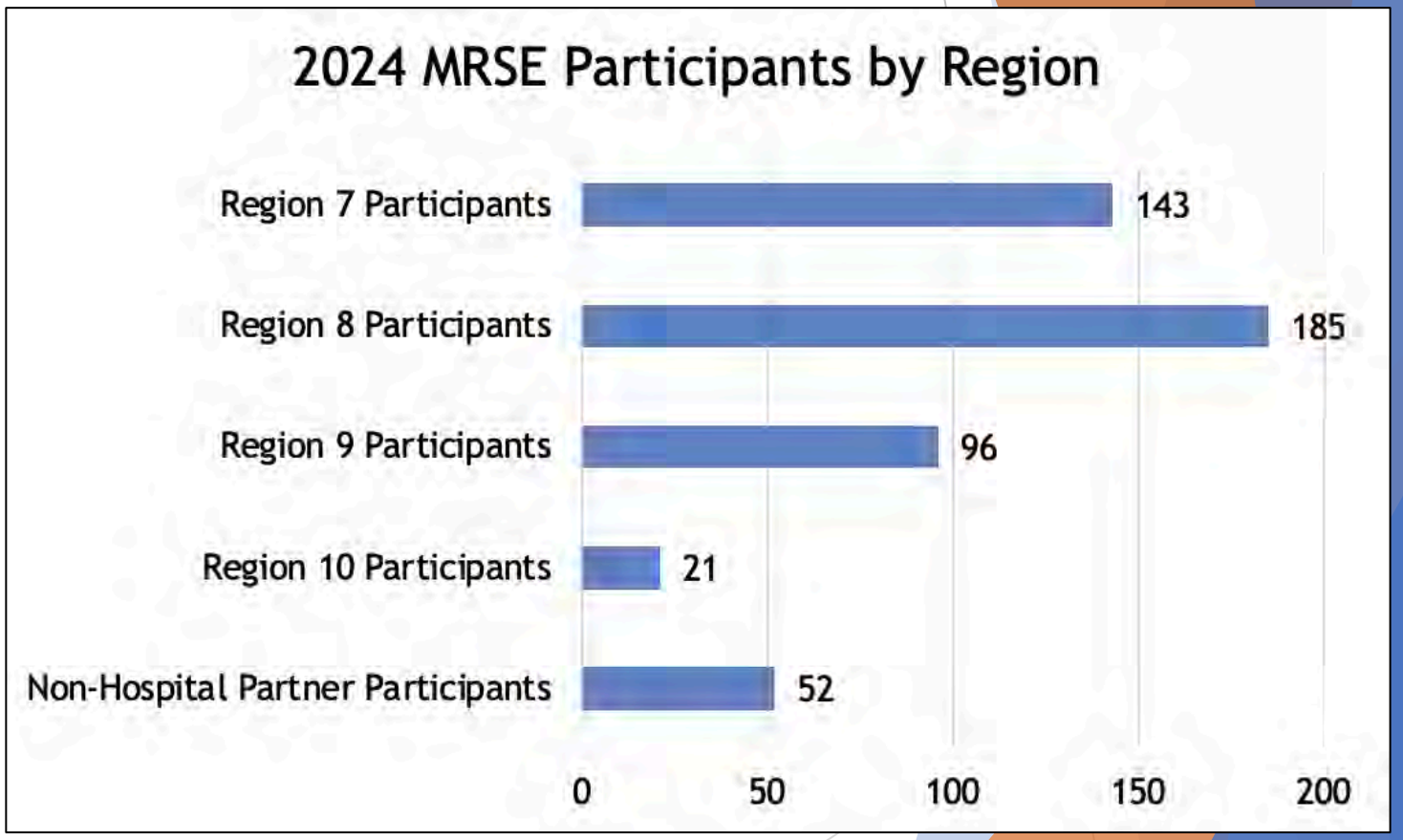
2022 MRSE Participants

- Total Participants: 227
  - Region 8 Participants: 86
  - Region 9 Participants: 91
  - Region 10 Participants: 23
- Non-hospital Participants: 27
  - EMA Participants: 3
  - Health Department Participants: 9
  - Fire/EMS Participants: 9
  - Other Participants: 6



2024 MRSE Participants

- Total Participants: 497
  - Region 7 Participants: 143
  - Region 8 Participants: 185
  - Region 9 Participants: 96
  - Region 10 Participants: 21
- Non-hospital Participants: 52
  - EMA Participants: 7
  - Health Department Participants: 17
  - Fire/EMS Participants: 20
  - Other Participants: 8



The Challenge

- Multiple exercise demands in addition to planning for special events and responding to real-life incidents.
  - MRSE
  - Chemical Annex Tabletop
  - CHEMPACK Training
  - Decontamination Training
  - Democratic National Convention
  - Cyber incidents at hospitals

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Pre-Exercise Briefing

- The briefing was held one week prior to the MRSE exercise.
- During this briefing, all materials and expectations for participants were reviewed.
- The briefing also helped ensure participants had access to the data collection tool.
- The pre-exercise briefing is critical to the success of the exercise!

Scenario

- Summer festivals are in full gear across Chicagoland.
- Summer weekend in July, Saturday night fests with concerts in the following locations:
  - (Region 7) Tinley Park, IL: 7,000 people (MABAS Div. 24)
  - (Region 8) Elmhurst, IL: 7,000 people (MABAS Div. 12)
  - (Region 9) Carpentersville, IL: 5,000 peoples (MABAS Div. 2 & 13)
  - (Region 10) Grayslake, IL: 6,000 peoples (MABAS Div. 4)
- A domestic terror cell has been able to acquire 18 gallons of agent Yellow (a 50/50 blend of blister agents Sulfur Mustard and Lewisite).
- Members of the terror cell conduct a covert operation at neighborhood festivals/concerts in Chicagoland suburbs (Tinley, Lake County, Carpentersville, and Elmhurst) where they utilize an aerial drone with an 18-gallon capacity to circle the concert grounds for 5 minutes from about 120 feet above to disseminate the agent, Yellow.
- The agent Yellow is released over a crowd of ~ 5,000 people at each of the 3 festival sites. The mildly warm temperature along with a light breeze aided an effective release.
- Many participants begin to feel the effects of the exposure within minutes with some experiencing respiratory distress and burning eyes. Venue security and EMS decide to end the event and evacuate. The HAZMAT team has been notified and are enroute. The scene is considered a mass casualty incident and multiple transports to local hospitals should be expected.

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Casualties by HCC Region

Type	Region 7	Region 8	Region 9	Region 10
Green Adult	285	314	297	142
Yellow Adult	174	118	137	78
Red Adult	63	47	72	30
Total Adult	522	479	506	250
Green Pediatric	37	39	45	23
Yellow Pediatric	11	26	12	13
Red Pediatric	9	13	13	5
Total Pediatric	57	78	70	41
Total Patients	579	557	576	291

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Method of Arrival to Hospitals

Method of Arrival	Region 7	Region 8	Region 9	Region 10
EMS Transport (50%)	289	279	288	146
Self-Transport (50%)	290	278	288	145

Exercise Agenda

Agenda Item	Time
Introduction/Scenario/Format/Rules	8:30 AM
EMS/Pre-Hospital Coordination	8:45 AM
Task 1: Initial Actions	9:30 AM
Task 2: Initial Bed Counts	10:00 AM
Task 3: Decompression/Rapid Discharge	10:30 AM
Task 4: Patient Triage/Admission Decisions	11:00 AM
Task 5: Patient Transfers	11:30 AM
Task 6: Staff Needs/Resources	11:45 AM
MRSE ENDEX	12:00 PM

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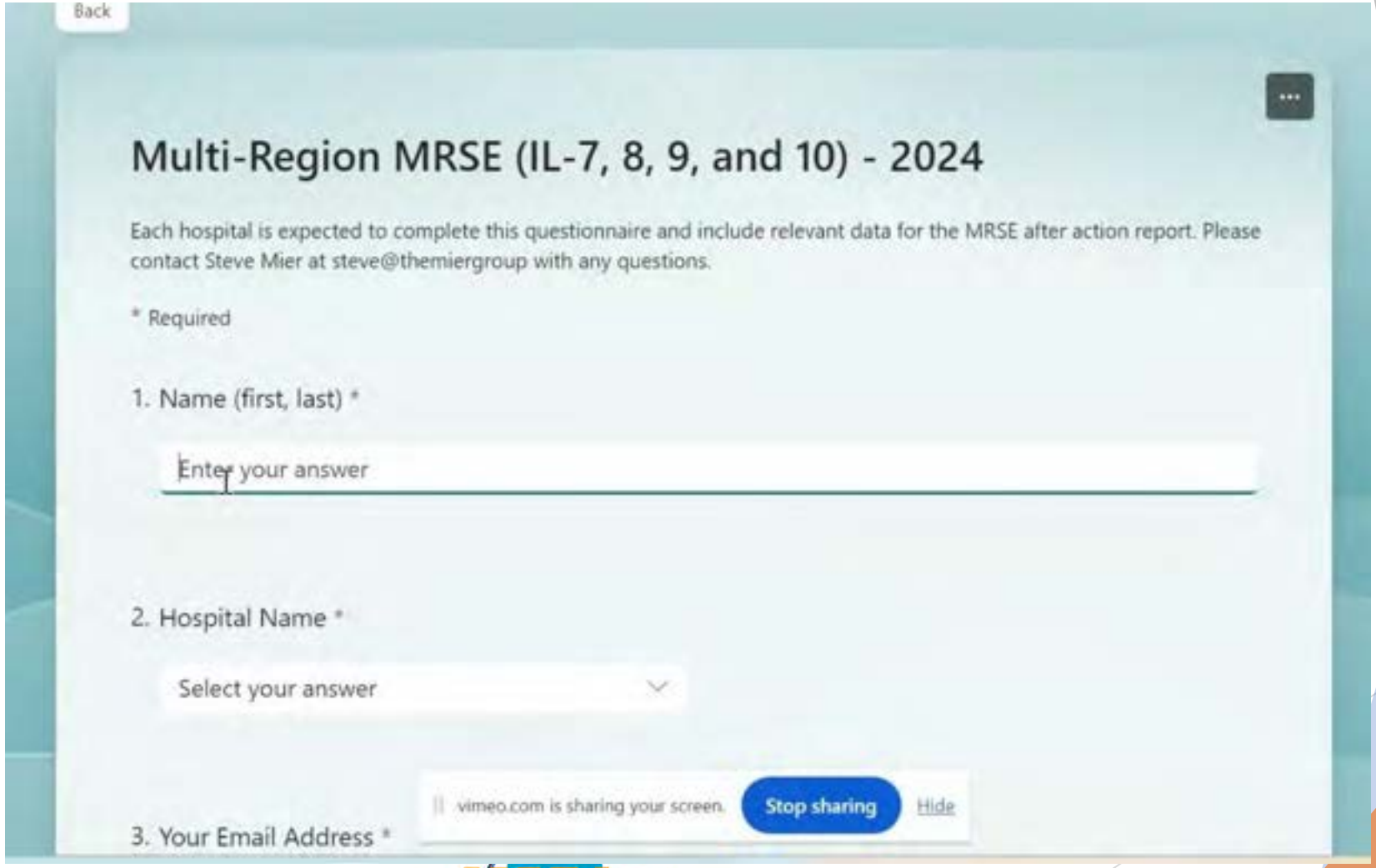
Data Collection



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Notifications

- At the start of the MRSE exercise, each HCC (7, 8, 9, and 10) sent out an Everbridge notification to hospitals within their regions (Region 10 utilized ReGroup). The notification achieved 100% acknowledgement from at least one person at each hospital.
- ***Sample Message: EXERCISE - MEDICAL RESPONSE SURGE EXERCISE***
- ***THIS IS AN EXERCISE - "The multi-region medical response surge exercise (MRSE) has begun. Hospitals – please mobilize your teams for participation for an 8:30 AM start".***

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Escalation of Mutual Aid

- MABAS can mobilize emergency response and EMS resources in coordination with the Illinois Emergency Management Agency (IEMA) and Illinois Department of Public Health (IDPH)/Emergency Medical Services (EMS). Some of the resources that MABAS can provide include EMS vehicles, passenger vans, temporary shelter, and decontamination functions.
- *There are five levels of Box Alarms* that are designed to provide additional support to on-scene EMS. An assessment on-scene will help EMS/MABAS determine which level of alarm is required. A fifth alarm can bring 10 fire engines, five trucks, four squads, and 30 ambulances to a scene. Additionally, MABAS can activate strike teams to be deployed if multiple scenes exist. These strike teams consist of five ambulances and a supervisor.
- If the resources MABAS can provide are insufficient for the scale of the incident and additional assets are required, MABAS can coordinate through IEMA to request inter-state mutual aid.

Patient Profiles

Adult/P	ID	Triage Lev	Age	Gender	Injury Description	Medical HX	Means of Arr	Hospital	Region
Adult	A11	Red	22	F	Patient has crush injuries to right forearm and head from being trampled during melee/evacuation. Patient is displaying symptoms of shock. Blistering of skin/yellow in color, difficulty breathing.	+/- DM, HTN, HLD, Anxiety, Depression	EMS transport	Adventhealth - Bolingbrook	8
Ped	P25	Green	15	F	Patient was walking their dogs outside approximately 3 miles from the concert venue. She does report seeing a large drone overhead. Patient is presenting with difficulty breathing.	3 months pregnant	Self-transport	Adventhealth - Bolingbrook	8
Ped	P26	Green	15	F	Patient was walking their dogs outside approximately 3 miles from the concert venue. She does report seeing a large drone overhead. Patient is presenting with difficulty breathing.	3 months pregnant	Self-transport	Adventhealth - Bolingbrook	8
Adult	A1	Green	18	F	Burning eyes, nausea, and sweating. Bloody nose.	3 months pregnant	Self-transport	Adventhealth - Bolingbrook	8
Adult	A4	Yellow	19	F	Burning eyes, bloody nose, blisters on face. Injured ankle in evacuation.	6 months pregnant	EMS transport	Adventhealth - Bolingbrook	8
Adult	A5	Green	19	F	Patient was a parking lot attendant at the concert. Patient is agitated and is concerned that they have been exposed to a chemical. No injuries.	6 months pregnant	Self-transport	Adventhealth - Bolingbrook	8

Master totals

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Initial Actions – Public Health

- Includes notifying health department leadership and internal communications departments, especially Public Information Officers (PIO) and their teams, as well as Epidemiology and/or Environmental Health/Surveillance teams to begin population monitoring. From there, the communications teams would begin crafting messaging to go out to the public. Regarding resource coordination, health departments would work with their logistics teams to make sure they are aware that requests for personal protective equipment (PPE) may be coming from EMS or hospitals.
- Health departments would also coordinate with their local Emergency Management Agencies (EMAs) in case the resource requests are more than they have on hand or in warehouses. They would also make notification to and begin coordination with their IDPH Emergency Response Coordinator (ERC) that there may be resource requests coming.

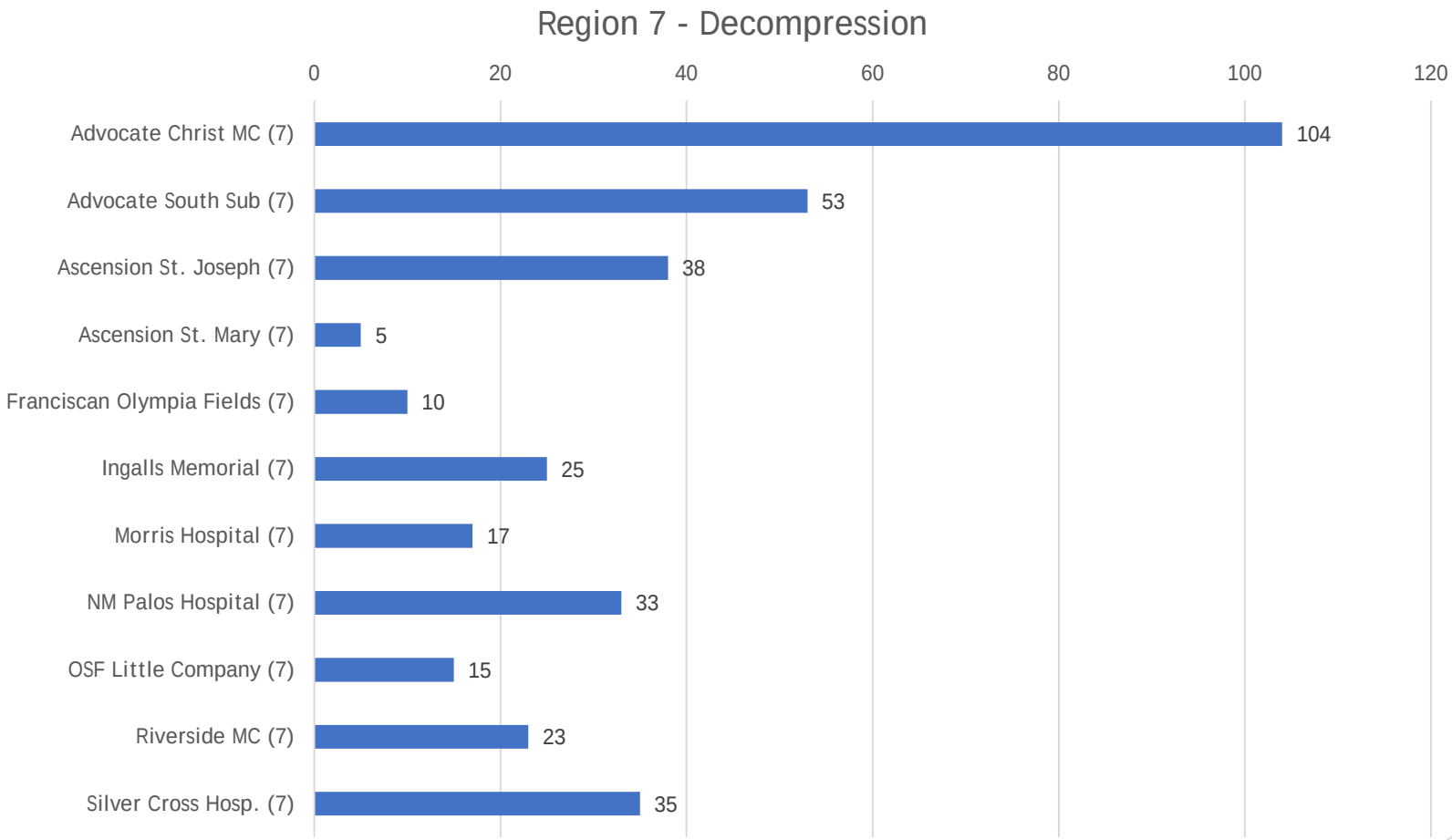
Initial Actions – Emergency Management

- In addition to supporting the larger resource requests from local health departments, one of the primary roles that EMAs would play in this type of response would be supporting other local/municipal response partners in whatever way they may need. EMAs would coordinate with other local public safety organizations such as police and fire to help guide public information messaging and directing phone calls.
- EMAs would also be looking at activating their Emergency Operations Centers (EOC) to help facilitate coordination and force multiplication. This coordination could also potentially include working with the Federal Bureau of Investigation (FBI) and working to establish family assistance and reunification centers. Additionally, EMAs may decide to send liaison officers to the municipalities/towns that have been impacted to provide additional support.

Initial Actions – Hospitals

- In addition to supporting the larger resource requests from local health departments, one of the primary roles that EMAs would play in this type of response would be supporting other local/municipal response partners in whatever way they may need. EMAs would coordinate with other local public safety organizations such as police and fire to help guide public information messaging and directing phone calls.
- EMAs would also be looking at activating their Emergency Operations Centers (EOC) to help facilitate coordination and force multiplication. This coordination could also potentially include working with the Federal Bureau of Investigation (FBI) and working to establish family assistance and reunification centers. Additionally, EMAs may decide to send liaison officers to the municipalities/towns that have been impacted to provide additional support.

Decompression – Region 7



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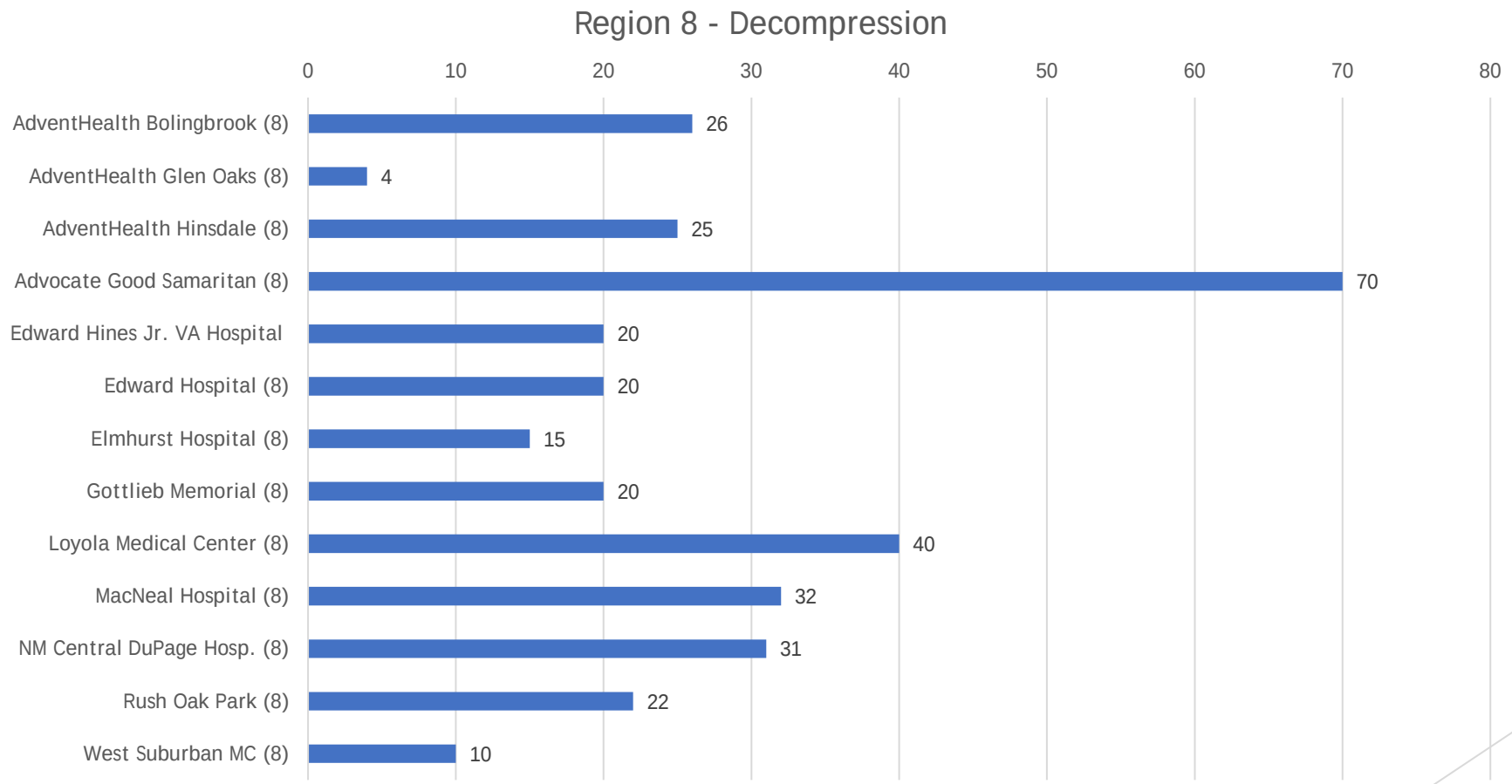
Decompression – Region 8



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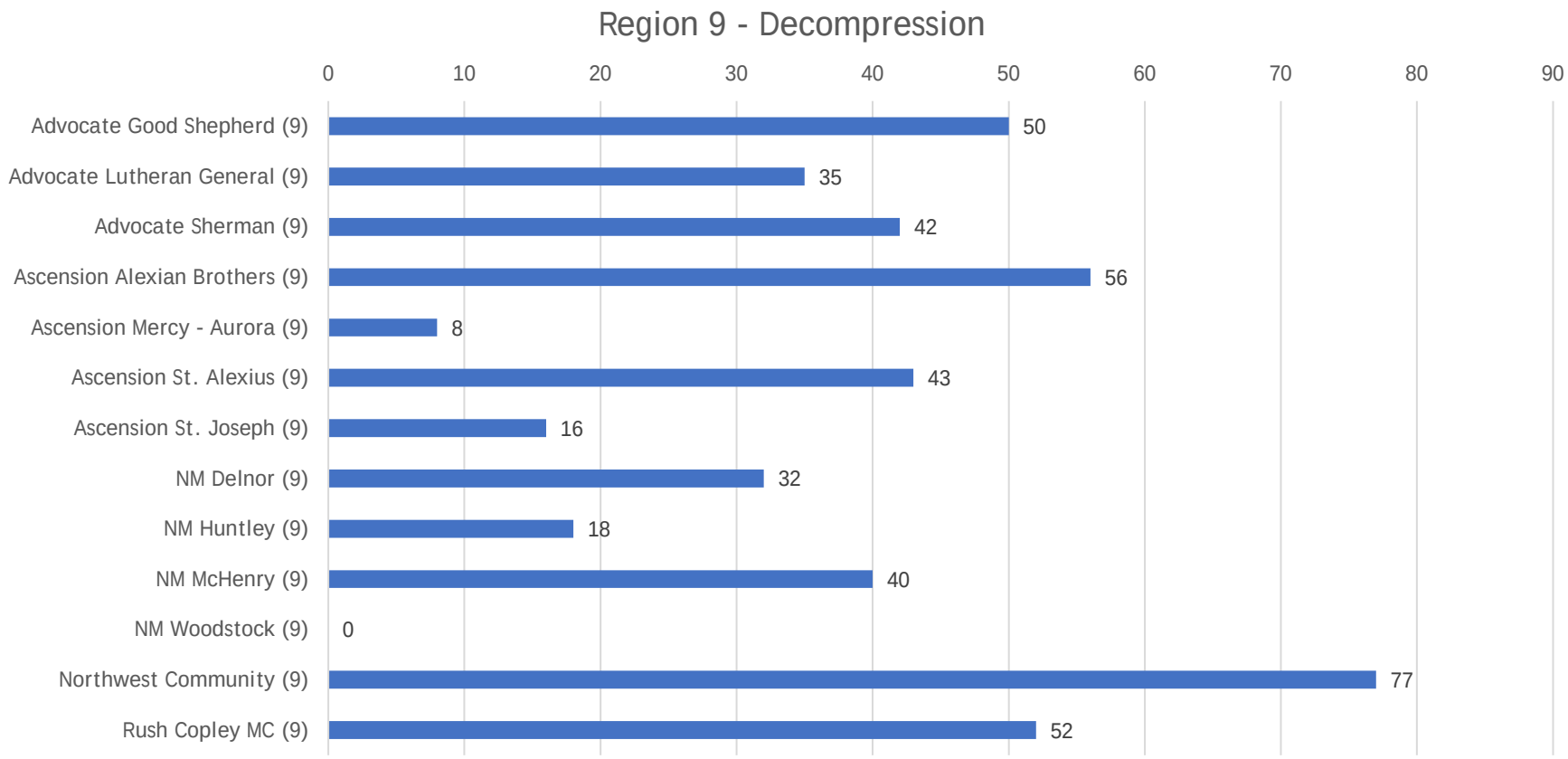
Decompression – Region 9



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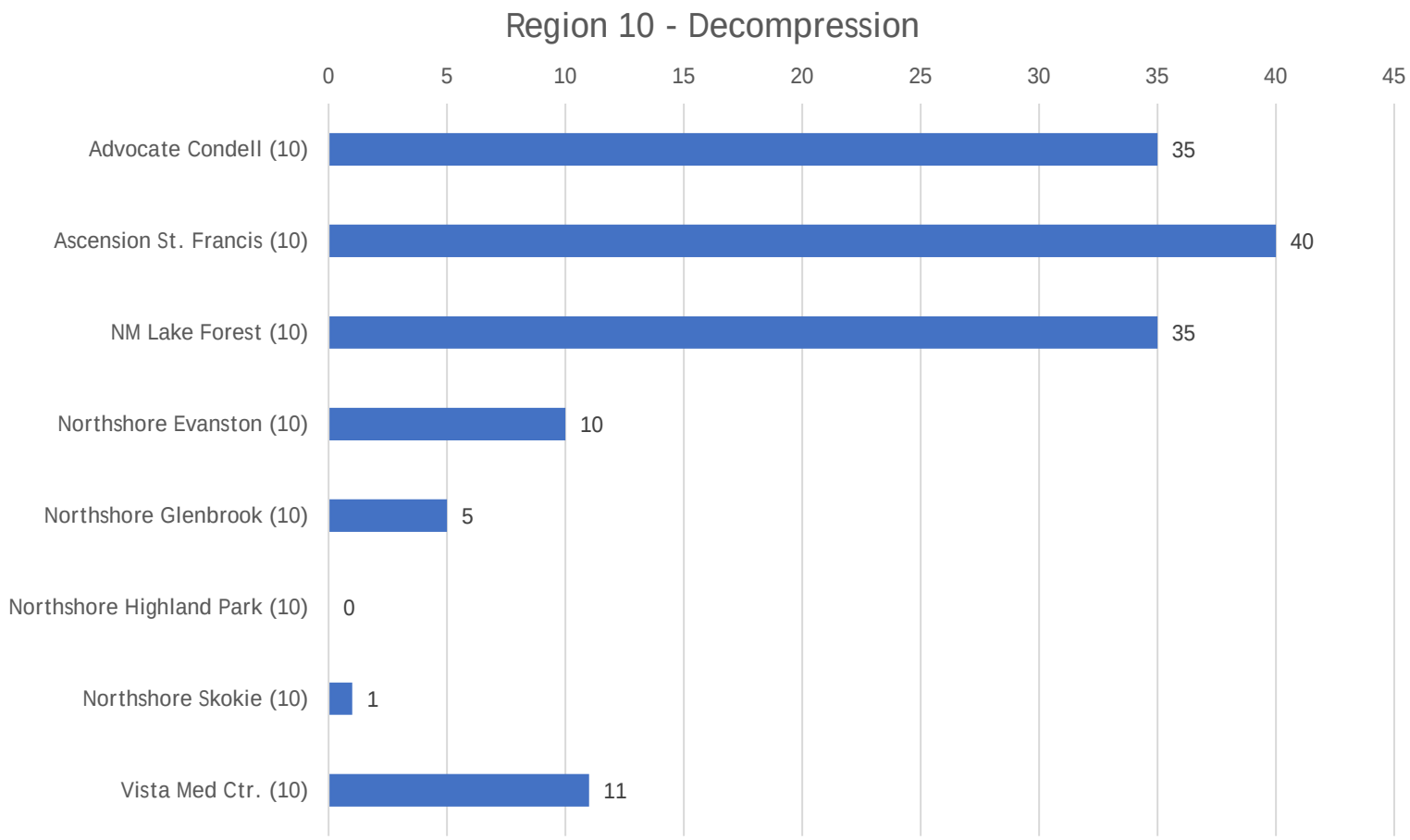
Decompression – Region 10



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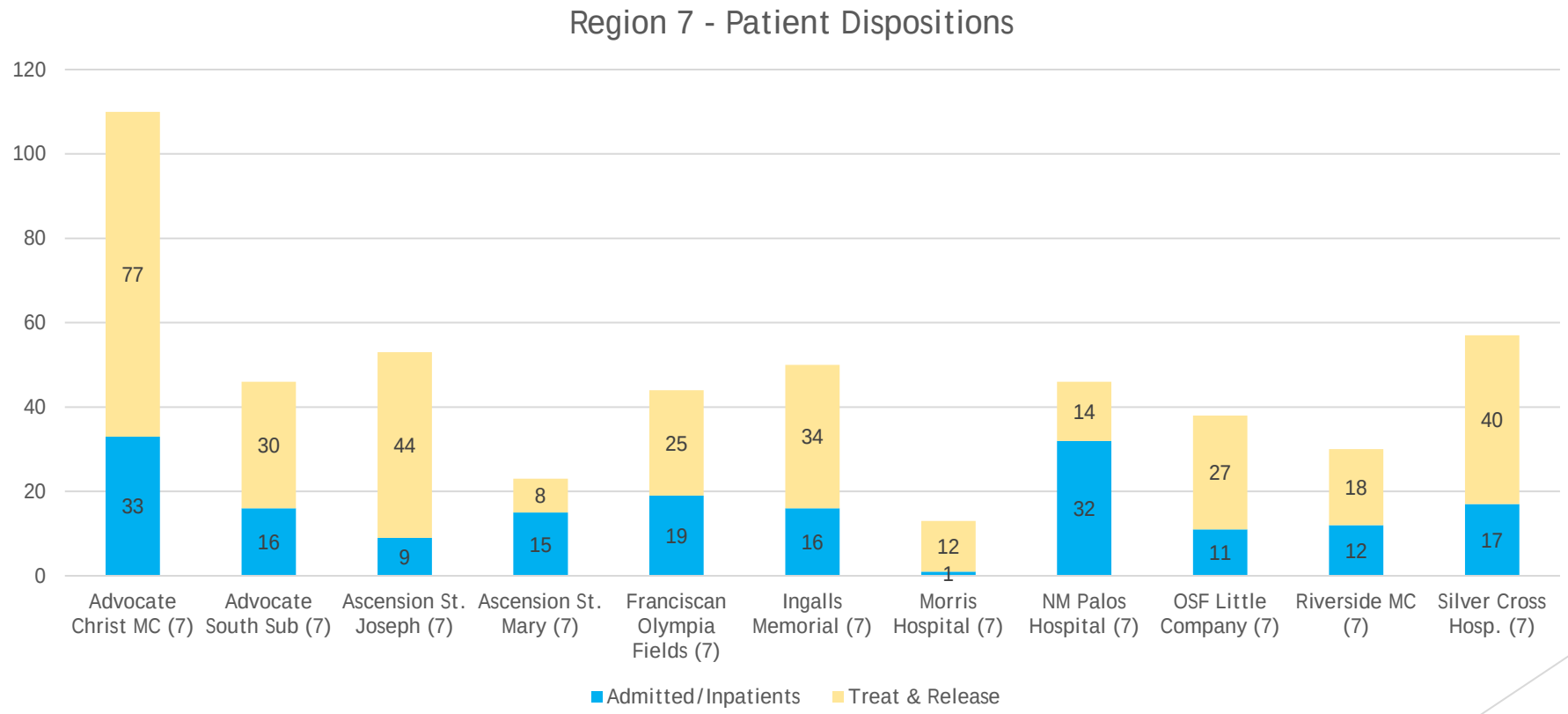
Decompression Summary

- Region 7:
  - A total of 358 patients can be rapidly discharged for an average of 33 patients per hospital.
- Region 8:
  - A total of 335 patients can be rapidly discharged for an average of 26 patients per hospital.
- Region 9:
  - A total of 469 patients can be rapidly discharged for an average of 36 patients per hospital.
- Region 10:
  - A total of 188 patients can be rapidly discharged for an average of 24 patients per hospital.

Patient Triage/Admission Decisions – Region 7



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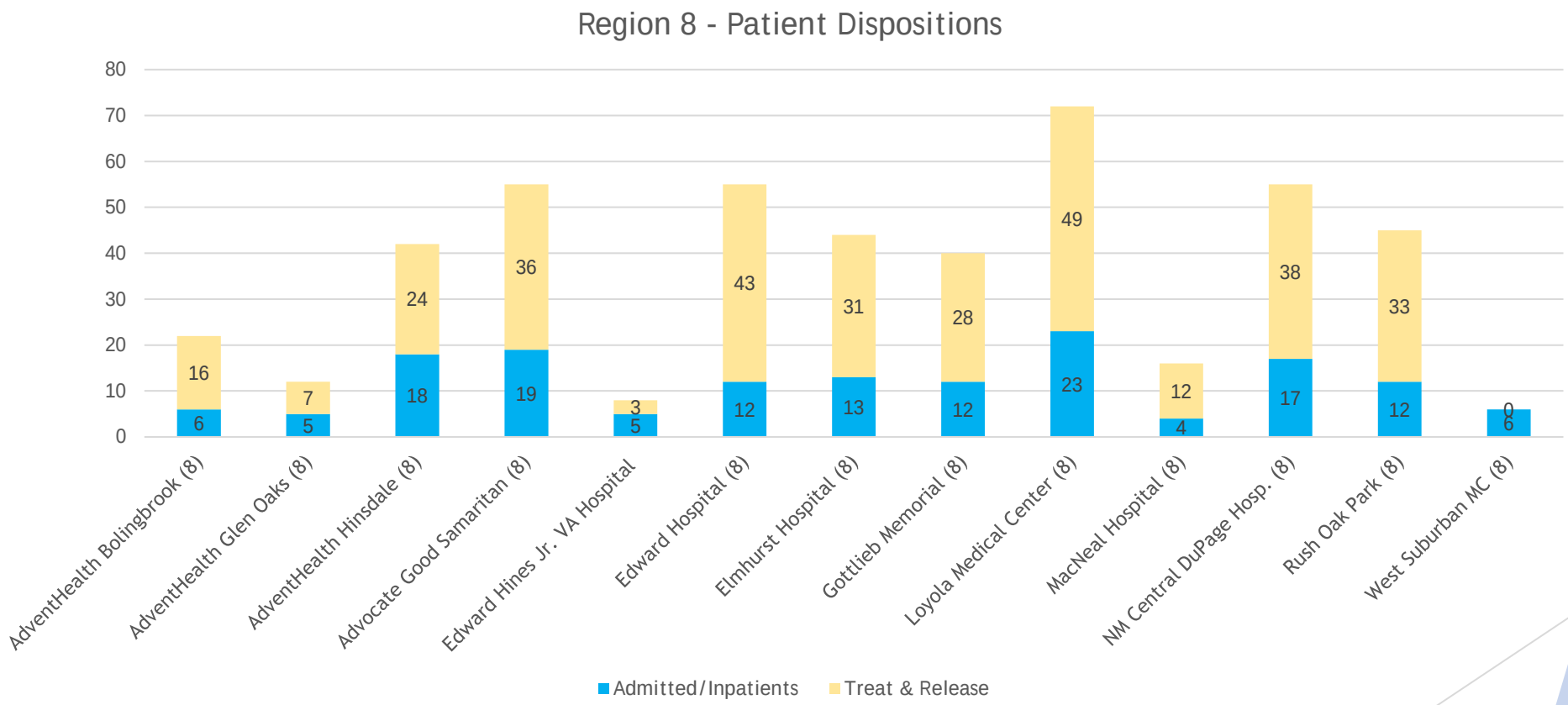
Patient Triage/Admission Decisions – Region 8



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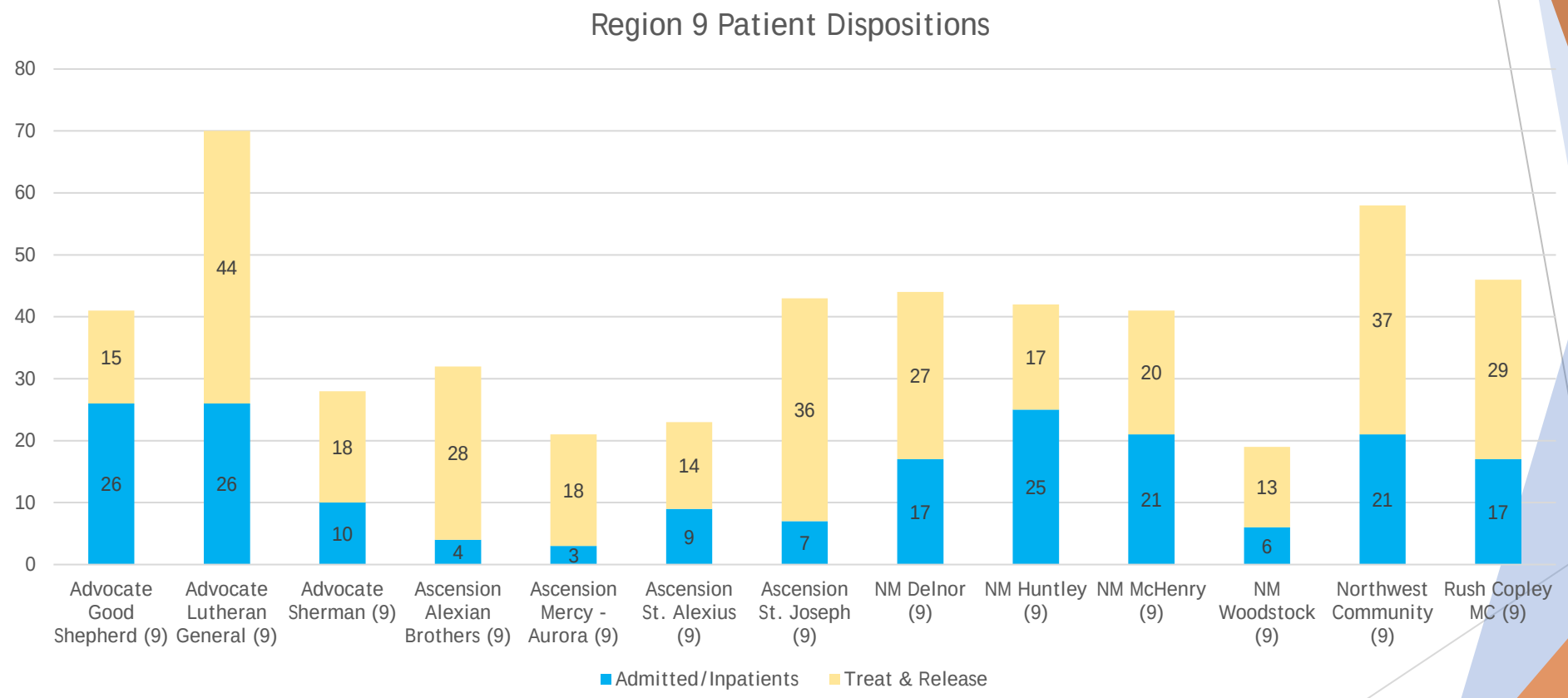
Patient Triage/Admission Decisions – Region 9



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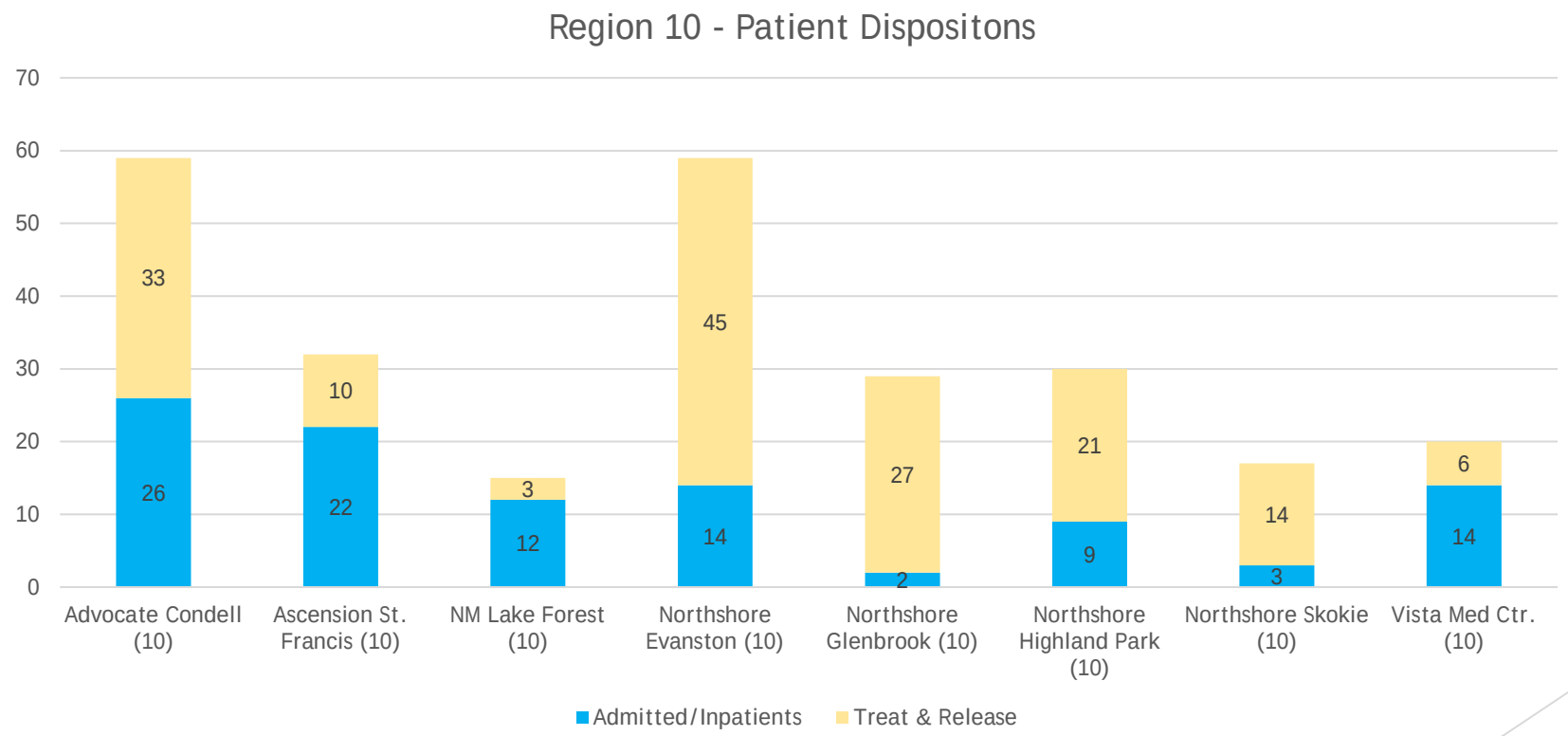
Patient Triage/Admission Decisions – Region 10



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Triage/Admission Summaries

- Region 7: *Total Patients Triaged = 510*
  - 181 admitted (35%) into inpatient unit
  - 329 treated and released from ED (65%)
- Region 8: *Total Patients Triaged = 472*
  - 152 admitted (32%) into inpatient unit
  - 320 treated and released from ED (68%)
- Region 9: *Total Patients Triaged = 508*
  - 192 admitted (38%) into inpatient unit
  - 316 treated and released from ED (60%)
- Region 10: *Total Patients Triaged = 259*
  - 100 admitted (39%) into inpatient unit
  - 159 treated and released from ED (61%)

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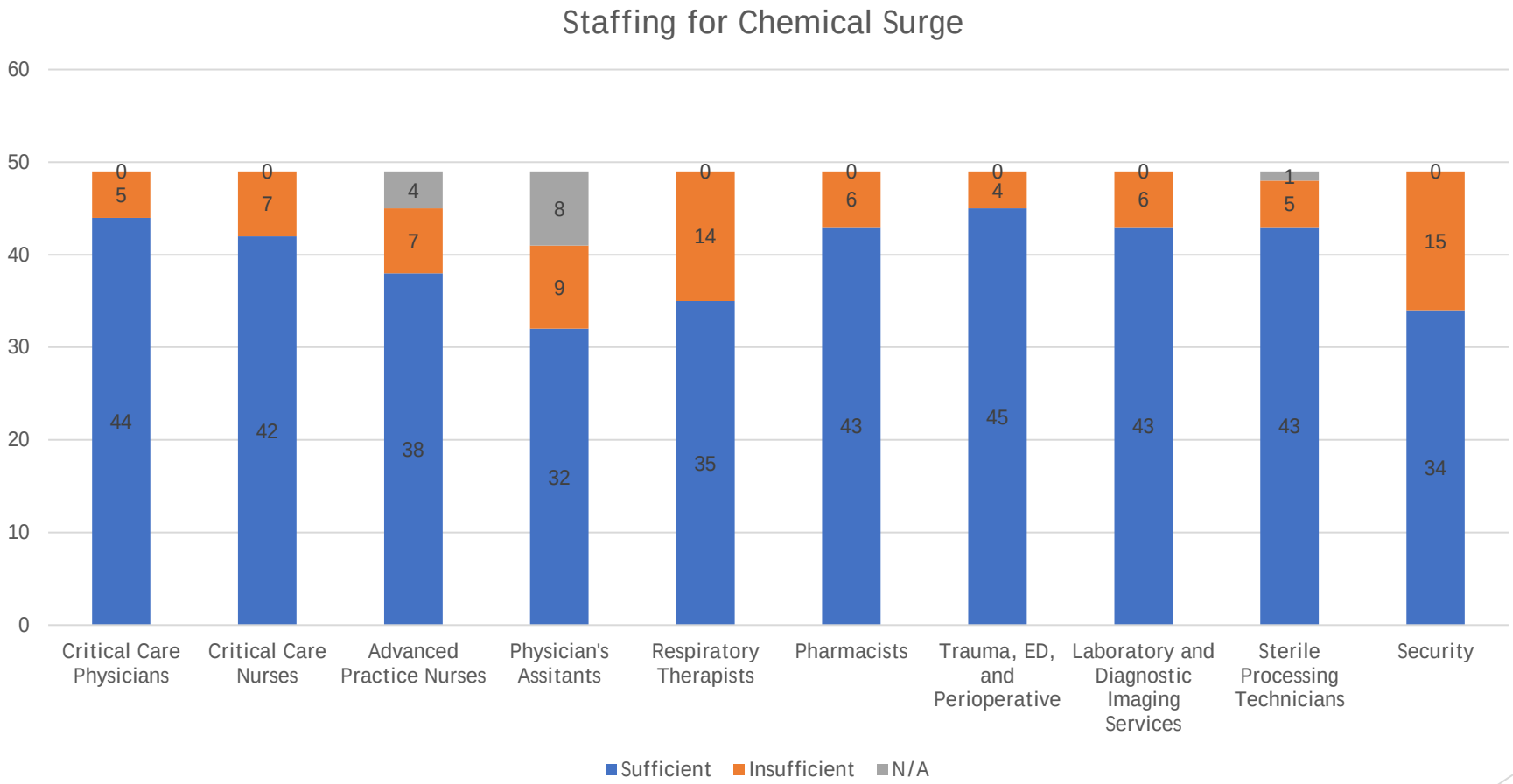
Patient Transfers Summaries

- Region 7: *510 patients* were successfully admitted across all hospitals (this includes ED treats + release).
  - 41 patients requiring admission also need transfer (from 4 hospitals). All (100%) of those patients were designated a transfer facility.
- Region 8: *472 patients* were successfully admitted across all hospitals (this includes ED treats + release).
  - 30 patients requiring admission also need transfer (from 4 hospitals). 26 (87%) of those patients were designated a transfer facility.
- Region 9: *508 patients* were successfully admitted across all hospitals (this includes ED treats + release).
  - 46 patients requiring admission also need transfer (from 6 hospitals). 44 (96%) of those patients were designated a transfer facility.
- Region 10: *259 patients* were successfully admitted across all hospitals (this includes ED treats + release).
  - 33 patients requiring admission also need transfer (from 5 hospitals). 27 (82%) of those patients were designated a transfer facility.

Staffing Needs/Resources



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Resources

- ***Inject: your hospital is experiencing a shortage of CBRN filters for PAPRs due to continuous use and wear. In addition, your pharmacy is going to need to request BAL to administer to the more severe patients. What is your resource request process for this? Please submit the resource request in accordance with your established procedures.***
  - 213 RR process with Health Dept or EMA
  - Request from the RHCC
  - Request assets through mutual aid compacts
  - Request from local fire department/HAZMAT
  - Resources requested from system HQ

Strengths

- *MABAS-IL is a well-established system* that can rapidly identify and deploy EMS assets in large enough volume to meet this patient demand. This includes sufficient amount of Advanced Life Support (ALS)-capable assets and multi-patient transport vehicles.
- Health Departments and EMAs described the types of support they could provide to the HCC in a chemical incident to include notifications, resource coordination, risk communication as well as surveillance information exchange with hospitals.
- While it is manual and paper-based, *EMS agencies in Illinois have a well-established triage tagging system for patient tracking*.
- All Hospitals and relevant response partners (e.g., EMS and Public Health) were notified at the beginning of the exercise to demonstrate effective notification capabilities for all four regions utilizing the Everbridge system and ReGroup system.

Strengths

- Most hospitals provided comprehensive descriptions of their patient decontamination capabilities, along with patient throughput data.
- Hospitals *demonstrated effective initial response actions* including activation of the Incident Command System (ICS), development of an Incident Action Plan (IAP) and decompression/expansion actions to accommodate a large surge of patients.
- All hospitals were able to *rapidly triage patients* and make appropriate decisions as to patient admission or treat/discharge.
- The vast majority of hospitals were either able to accommodate a surge of inpatient admissions or were able to find appropriate destination hospitals.
- General consensus among hospitals was that *there were adequate staffing capabilities* collectively across the regions to accommodate the surge in this scenario.
- Most hospitals were able to articulate *the resource request process* for equipment and supplies (i.e., within the context of this scenario).

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Opportunities

- It is unknown how quickly *ambulances could cycle back* (e.g., after transporting contaminated patients) to the scene and bring additional patients to hospitals.
- While at least one person from each hospital acknowledged the initial alert at the beginning of the exercise, there is a need for all hospitals to review their Everbridge and ReGroup recipients and ensure they are included on the HCC distribution.
- Hospitals and EMAs should conduct planning to formalize a communication/information sharing process during mass casualty incident (MCI) response.
- While hospitals were able to effectively articulate their decontamination capabilities, *there is a wide variance among facilities as it relates to patient throughputs.* Hospitals and associated Regions should ensure validation of decontamination throughput occurs at all facilities (e.g., through operations-based exercises) and this information should be updated in EMResource.
- *Pediatric care capabilities are somewhat limited* in all participating HCCs. Additional planning should occur with respect to pediatric transfers out of the Regions to hospitals with appropriate levels of care.

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Opportunities

- Staffing in general was sufficient in most categories – *with the exception of Security and Respiratory Therapy.* Hospitals and HCCs should explore sources for private security surge as well as identification of Respiratory Therapists (e.g., via MRC or other means).
- *Not all hospitals were able to identify an appropriate facility to accommodate a patient transfer for inpatient admission*. It is recommended that facilities work closely with their Regional Hospital Coordinating Centers (RHCCs) to determine transfer options in future planning.
- There were some hospitals that struggled with the *resource request process*. It is recommended that health departments and EMAs provide additional briefings and materials to instruct hospitals and that resource request processes be included in future exercises.
- Hospitals should consider activation of *incident command for their regional system* in large MCI's. This could help ensure coordination for transfers, redeployment of staff, etc.
- HCCs should continue to advocate for *multi-region EMS/MCI exercises* such as this to most accurately reflect reality.
- There is a need for hospitals to adequately *project the need for decontamination resources* to include trained personnel, PPE, equipment, and supplies for a surge of exposed patients.

Adjustments for 2025

- 10% surge – more realistic and considerably less complicated
- Functional or FSE
  - Command center-based
  - Mock/volunteer patients
- What will we do different?
  - Public information
  - Interfacility transfers
  - Increased security participation
  - Reunification

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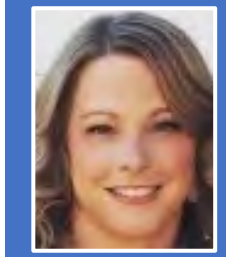
Acknowledgments

Robert Horsley, Reg 8



Sarah Farley, Reg 10

Elizabeth Regan, MD, Reg 7

Steve Baron, Reg 9

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Questions & Thank You!

steve@themiergroup.com

#NHCPC24

NATIONAL HEALTHCARE COALITION PREPAREDNESS CONFERENCE

Visions of Progress: Sustainable Strategies for Emergency Preparedness & Resilience

Presented By:

MESH

Community Coalition Building

Bringing together Fire, Police & Healthcare

White Plains Hospital

NEW YORK STATE Department of Health

Director Ed Tangredi, CEM
Deputy Chief John Nichols
Captain Daniel McMahon
NYS Rep Gyongyi McQueston

Objectives:

- In the beginning….Police and Fire in the same room
  - Where is the hospital?
- Healthcare Coalitions – Who, What and Why
- Real World Event, Exercises and Training
- Situational Awareness
- City of White Plains Emergency Preparedness Task Force
- Building and sustaining your very own local coalition

J

In the beginning...

The Fire Service Perspective

"*You do your job, I'll do mine…"* (to anyone not a Firefighter)

This was the typical mindset the fire service had when I started shortly before the terrorist attacks on 9/11. I'm confident it had been like that for as long as anyone could remember. That was about to change... very slowly, as change in any large organization does, but especially so when you are talking about the notoriously tradition obsessed fire service of the northeast United States... Unlike many other areas of the country, fire departments in this area are steeped in traditions that run so deep, it usually takes the death of our own to make changes. Not all traditions are bad, in fact many are at the core of what creates the strong bond we have with each other. Unfortunately, we live up to a commonly repeated quote poking fun at ourselves by some unnamed comedian Fireman...

"The two things that firemen hate the most are change and the way things are."

In the beginning...

Pre-Coalition Inter-Agency Relationships

- **Silo approach:** Each department (Fire, Police, Hospital, EMS) operated independently with little to no communication across disciplines.
- **Lack of communication:** Fire, Police, and EMS operated in isolation, often unaware of what the other was doing during incidents or whom to speak to if there was a problem.
- **Hospital involvement:** White Plains Hospital was largely an afterthought to the First Responders, only considered when medical intervention was required, with no proactive engagement in planning.

In the beginning...

The Need for Unified Command

- **9/11 exposed gaps:** The 9/11 attacks highlighted the critical failures in communication and coordination between agencies, both locally and nationally.

- **White Plains Public Safety discussions:** Recognizing the need for improvement, White Plains Public Safety began discussions between Police and Fire leadership to improve cooperation.

- **Goal:** The primary goal was to improve coordination during emergencies, enhance communication, and strengthen relationships between departments to operate more effectively as one unit.

In the beginning...

The Formation of USOC
(Unified Special Operations Command)

- **Established to address issues:** USOC was created as a solution to the communication and collaboration problems identified post-9/11.

- **Leaders:** A Deputy Chief from the FD and a Captain from PD were appointed to lead this new unified command unit, focusing on joint planning and operations.

- **Focus:** The initial focus was on joint training, shared response protocols, and developing efficient channels between agencies.

In the beginning…

Changing the Approach: From Silos to Teams

- **Initial mindset:** Initially, departments believed they were independent entities with little overlap in responsibilities, leading to compartmentalized operations.
- **Metaphor:** Think of it as a relay race—each department is a runner in the same race at different points, handing off responsibility (the baton) from one to the next.
- **Realization:** The shift in thinking was that we weren't separate teams in separate lanes. Instead, we were part of the same team working toward the same goals, each with different roles and responsibilities.

In the beginning...

Expanding the Coalition

- Gradual inclusion of other agencies: As the coalition developed, it wasn't just about Police and Fire. White Plains Hospital and NYS OEM were doing similar things and eventually got together to round out the team and improve response.
- New perspectives: Each new member brought valuable perspectives. For example, the hospital brought medical expertise and emergency planning skills that were previously lacking in the other departments.
- Joint exercises: Regular, joint training exercises and planning sessions allowed everyone to learn how to work together effectively, discovering gaps and fixing them.

In the beginning...

Department of Health: Regional Resource Centers (RRCs)

- Identified 8 RRCs across NYS
- Regional Resource Inventory
- Coordination of planning and preparedness
  - Workforce Training
  - Exercises
  - Outreach to planning partners

In the beginning…

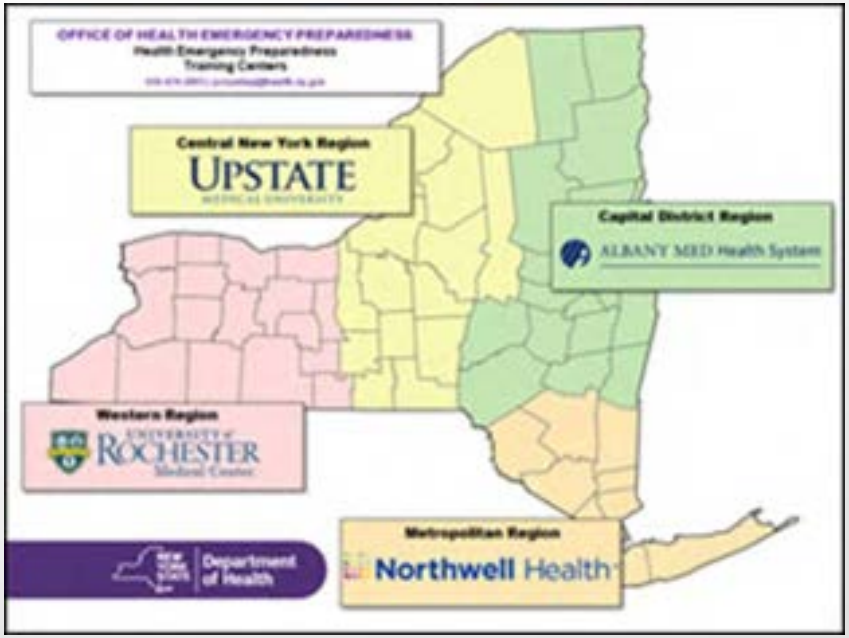
NYS DOH Hospital Preparedness Program

- Healthcare Coalitions
- Revised Structure
  - Reduced RRCs
  - 4 coalition areas
  - Leadership
  - Core Focus – ESF 8
- Regional Training Centers (RTC)

In the beginning…

NYS DOH Health Emergency Preparedness Training Centers (HTCs)

- 2022 new RFP
- Award period 2022-2027
- Health Emergency Preparedness Training Centers (HTCs)



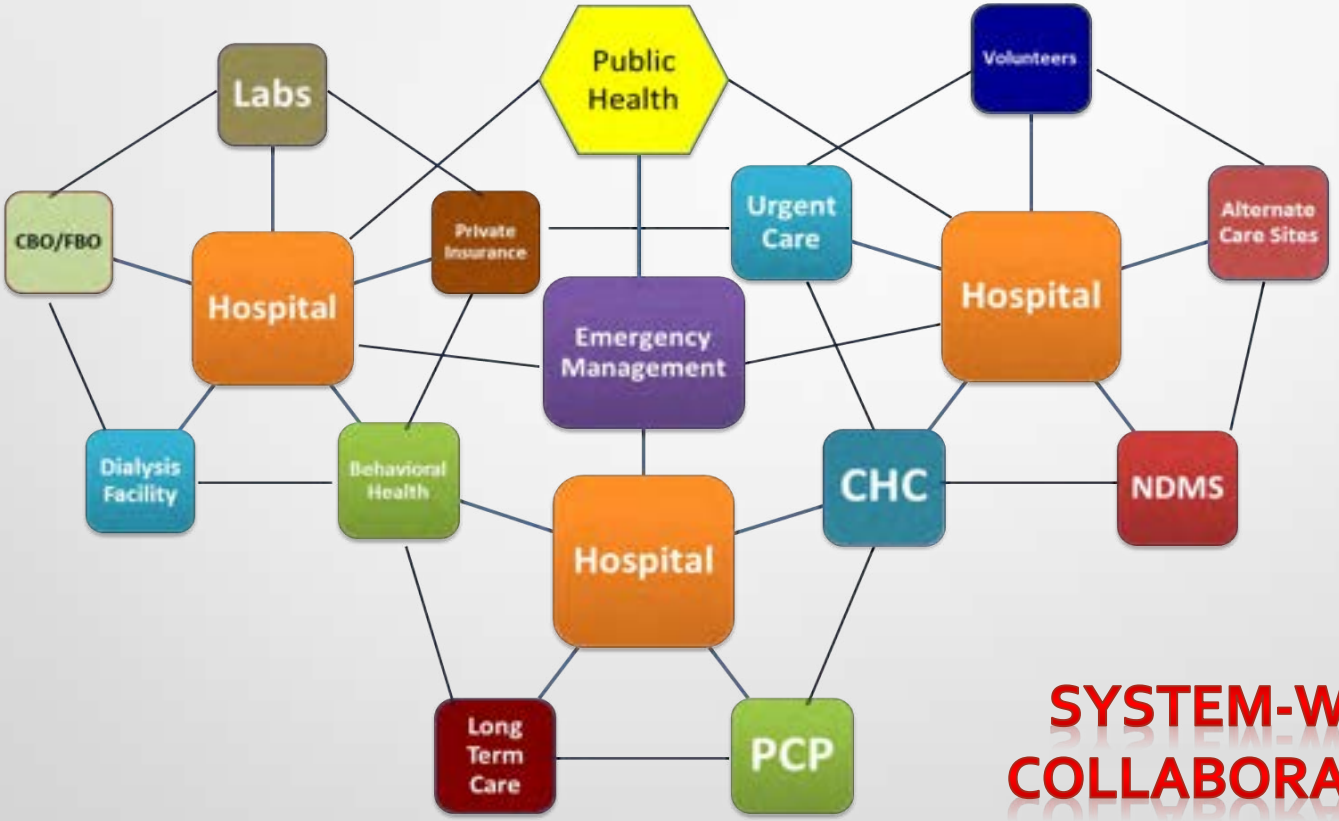
In the beginning...

At the Hospital.....

- 9-11 happened and hospitals realized they need to restructure how they respond to disasters. Everyone should not go to the ED.
- Federal Grants – HRSA – provided direction through deliverables for grant dollars
- Senior Leaders in healthcare needed to get on board or loose a lot of grant money. They will also be out of compliance with standards
- Who is going to do all of this? Hospitals realize they need to hire a full time Emergency Manager
- Revised FEMA training guidance – ICS 100HC, TJC Standards – New EM Chapter, and CMS CoP's – K Tags help drive the Comprehensive Emergency Management Program in healthcare
- The five families in NY begin to drive the path towards an integrated EM program
- The knock on the door from Public Safety – We'd like to invite you to participate in our exercise

Let's Talk Coalitions

Immediate Resource Availability



SYSTEM-WIDE COLLABORATION

NATIONAL HEALTHCARE COALITION PREPAREDNESS CONFERENCE

Let's Talk Coalitions

Healthcare Coalition (HCC)

Health and Human Services Definition of healthcare coalition (HCC):

A collaborative network of healthcare organizations and their respective public and private sector response partners that serve as a multiagency coordinating group to assist with preparedness, response, recovery, and mitigation activities related to healthcare organization disaster operations.

Purpose of a Healthcare Coalition

System-wide approach for preparing for, responding to, and recovering from incidents that have a public or medical impact in the short-and long-term.

Primary Function of the Healthcare Coalition

Sub-state regional emergency preparedness activities involving the healthcare member organizations (HCOs). This includes planning, organizing, equipping, training, exercises and evaluation.

NATIONAL HEALTHCARE COALITION PREPAREDNESS CONFERENCE

Let's Talk Coalitions

IS

- A **Multi-agency coordination** group that includes multiple healthcare organization members (HCOs) within the response community
- A **collective team** that assists Emergency Management and Emergency Support Function (ESF) #8 partners
- A **collaborative effort** to plan, organize, equip, train, exercise, evaluate and outline corrective actions

IS NOT

- One individual agency/organization
- Two individual agencies/organizations
- Hospital-only regional group
- Public health-only regional group
- A deployable response team
- Made up primarily of individuals, but of organizations

NATIONAL HEALTHCARE COALITION PREPAREDNESS CONFERENCE

Let's Talk Coalitions

DOES

- Focus on the cycle of preparedness, response, recovery, and mitigation activities
- Promote situational awareness for HCOs
- Conduct regional healthcare coalition meetings
- Engage partners in Hazard Vulnerability Assessment (HVA) discussions

DOES NOT

- Conduct non-preparedness or non-response related activities or business
- “Command” the actions of Coalition members or any other response entities it might interact with during an emergency
- Use only one county-level Hazard Vulnerability Assessment (HVA) for substitution of the entire regional HVA

NATIONAL HEALTHCARE COALITION PREPAREDNESS CONFERENCE

Let's Talk Coalitions

DOES

- Have the ability to share Essential Elements of Information (EEIs) data electronically across the HCC (e.g., bed status)
- Utilize subject matter experts from across the region for information sharing

DOES NOT

- Have to own the electronic systems being shared or utilized within the region
- Have to have the resources locally, but have access to resources within the region

Let's Talk Coalitions

Local Emergency Management Coalition

Response of the Local Coalition

Coalitions should represent healthcare organizations and Public Safety by providing multi-agency coordination advice on decisions made by incident management regarding information & resource coordination

Advice through:

- A multi-agency coordination group to assist incident management (area command or unified command)

OR

- Through coordinated plans to guide decisions regarding healthcare organization support

Sounds like a MACC…

Let's Talk Coalitions

Local EM Coalition Member Organizations

- **Hospitals (at least 1)**
- **Public health**
- **EMS providers**
- **Emergency Management**
- Mental/behavioral health providers
- Long-term care providers
- Specialty service providers (e.g., dialysis, pediatrics, woman's health, stand alone surgery, urgent care)
- Primary care providers
- Community Health Centers
- Other healthcare providers
- County Coroner
- Public safety
- Private entities associated with healthcare (e.g., Hospital associations)
- Support service providers (e.g., laboratories, pharmacies, blood banks, poison control)
- Federal entities (e.g., NDMS, VA hospitals, IHS facilities, Department of Defense)
- Volunteer Organizations Active in Disaster (VOAD)
- Faith-based Organizations (FBOs)
- Community-based Organizations (CBOs)
- Volunteer medical organizations (e.g., American Red Cross)

Let's Talk Coalitions

How will the coalition enhance local capability and capacity?

- Align regional response capabilities of the healthcare system with national guidelines as outlined in the Incident Command System and the National Response Framework
- Creation of more accurate and detailed situational awareness reports for regional partners
- Creation of a “one stop shop” for regional partners to communicate with for all needs during an event.
- Eliminating duplicate notifications to regional partners
- Eliminating duplicate requests for various mission critical information from the regional partners

And then this happened…

Fire in the City of White Plains

Date: Wednesday, 7 July 2010

Fire began: 14:35 hrs

Last Patient Arrived at Hospital: 22:20 hrs

EOP Terminated: 23:00 hrs

Ed Tangredi, Director of Emergency Management

Donald Keinz, Deputy Fire Chief, City of White Plains

Exercises and Real-World Events

Incident Overview – "Bengal Tiger Fire"

- Multiple commercial buildings were involved in the fire (full city block).
- The FD was already operating at another fire in an electrical power substation, when this fire was first reported.
- Extreme heat due to weather caused significant strain on all responders (High humidity & temps over 100 degrees).
- Fire began at approximately 2pm and primary operations lasted the better part of twelve hours.
- Fire departments from 8 neighboring municipalities assisted, as well as a large EMS and LE response (over 300 responders from multiple agencies and disciplines)

Exercises and Real-World Events

Immediate Response

- Established triage & treatment areas in the hallway outside the ED – AC
- Established Decon utilizing exterior deluge showers and internal shower room
- Dispatched Liaison Officer to the scene
- **Established Unified Command at scene – FD-PD-Hospital-EMS**
- Opened Burn / MASCAL response cart
- Held briefing for Command Staff & IMT

Incoming Patients:

- 37 Firefighters, 2 Civilians
- 1 Admission
- No burn patients
- All went through decon
- All turnout gear left in ED parking lot
- Assigned one staff member to manager personal clothing, etc. to match with turnout gear

Exercises and Real-World Events

Law Enforcement Operations

- Initial response to clear traffic and secure access for arriving FD units.
- Officers quickly checked buildings adjacent to the fire for civilians and reported pertinent info to IC. (Particularly helpful because FD resources were limited during the initial response due to the other structure fire).
- WCPD assigned an airborne asset to the incident. Along with verbal communications, a live feed via a thermal imaging camera was provided to the command post.
- WPPD ESU members, who were paramedic trained, provided additional staffing to assist with medical units.

Exercises and Real-World Events

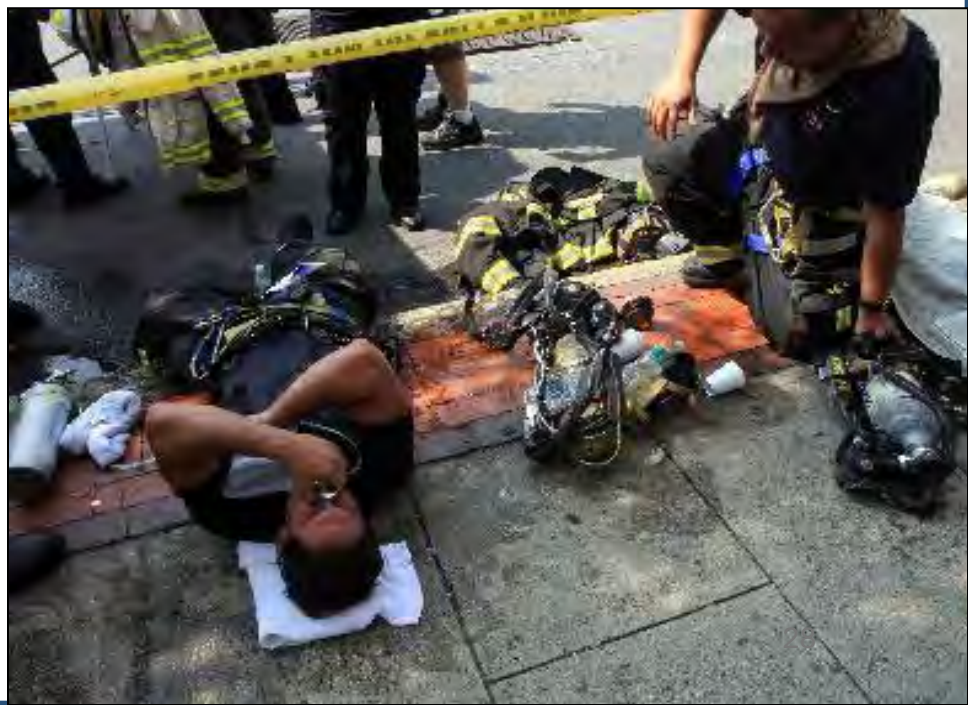
Unified Command & Multi-Agency Coordination

- Liaison officers dispatched to the scene from hospital.
- Hospital personnel assigned to multiple ICT positions including Medical Branch Supervisor.
- They worked directly with the EMS supervisor overseeing medical transport, to handle patient tracking, communications, and logistics.
- Staffed and operated Rehab for on-scene firefighter rehabilitation and medical checks.
- Joint command meetings held between sectors and IC, as well as representatives from various agencies.
- Having a hospital liaison at the scene was crucial for timely patient transport and accountability.
- Integration of hospital representatives into the Incident Command structure improved efficiency.


EMS


Bengal Tiger
FIRE LINE DO NOT CROSS
FIRE LINE DO NOT CROSS
FIRE LINE DO NOT CROSS
FIRE LINE DO NOT CROSS


Lyric Hi-Fi inc.




STAR
CLEANERS

Exercises and Real-World Events

- New Years Eve – City Ball Drop with 10-20k spectators
- Protest and Marches
- VIP's at the Hospital
- Burke Rehab Hospital exercise
- Chlorine exposure at NYP
- Mass Shooter Tabletop Exercise with PD-FD-Hospital-EMS-County
- Crane exercise
- ConEd Transformer fire
- Active shooter exercise at Galleria
- Decon exercises
- Infant abduction drills
- Operation: Ka Boom – East Post Road apartment building
- Training at 1 EPR before demolition – Car accidents and roof cutting

Building was set for demolition

Operation: Ka Boom

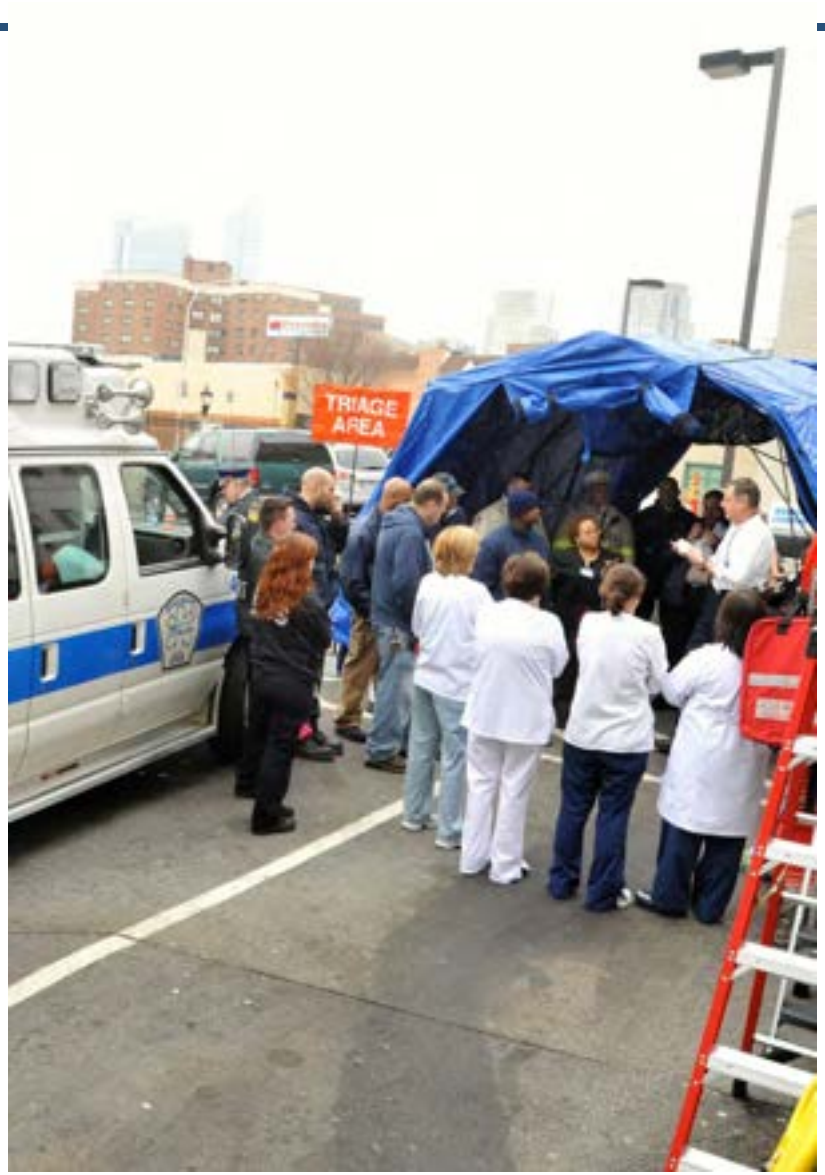
Joint Training Opportunities – Blast Injuries


POLICE


ONE WAY


104

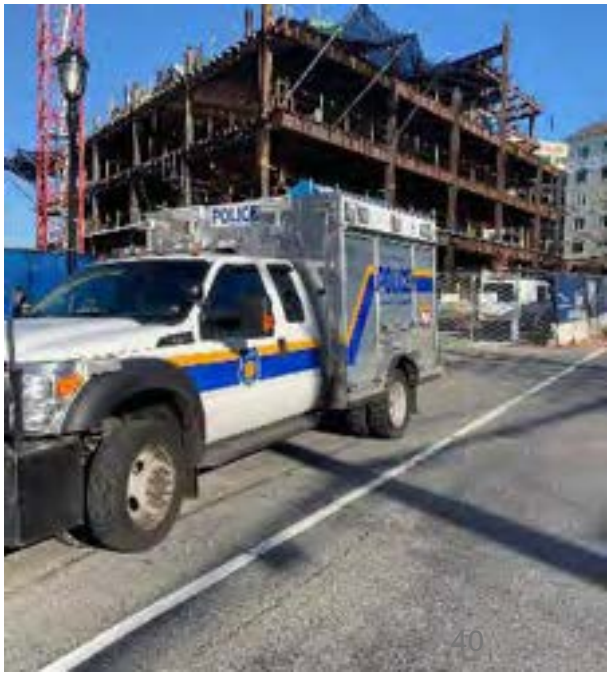

WPFD
DOUGLASS


TRIAGE
AREA

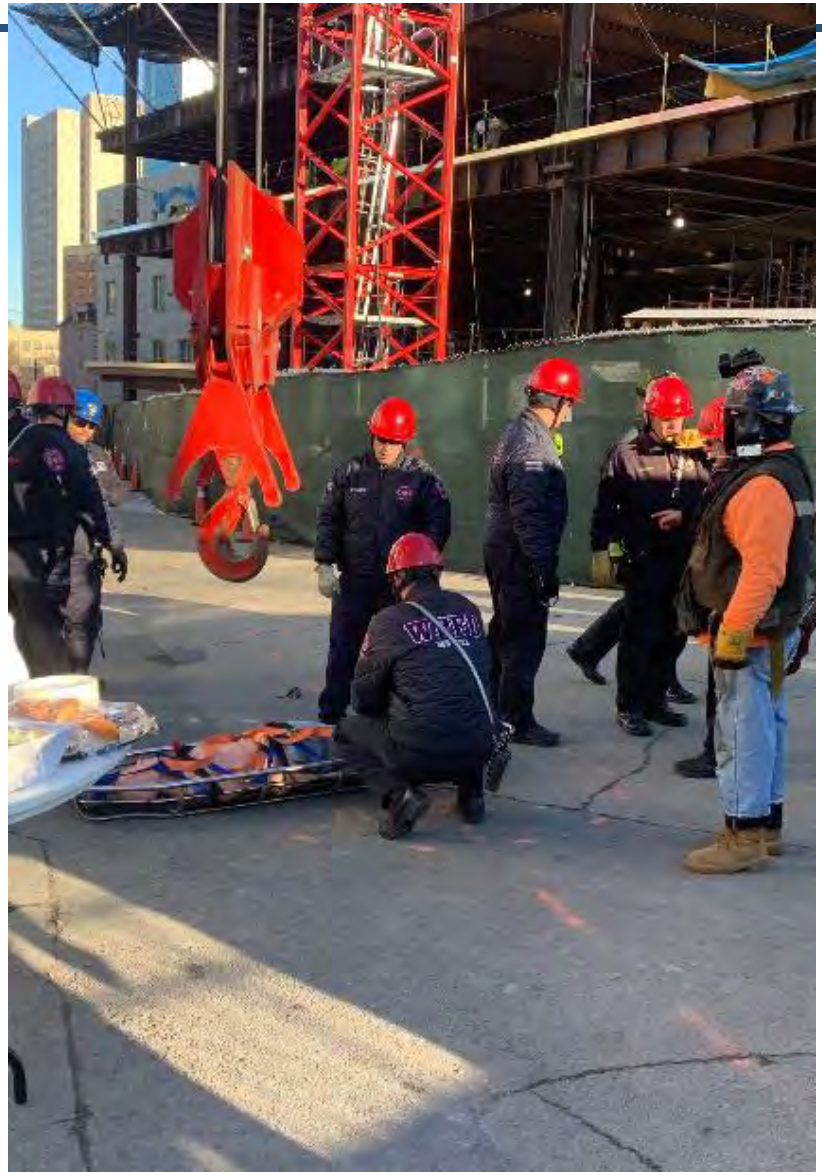

TRIAGE
AREA


It starts with buy in from the top!

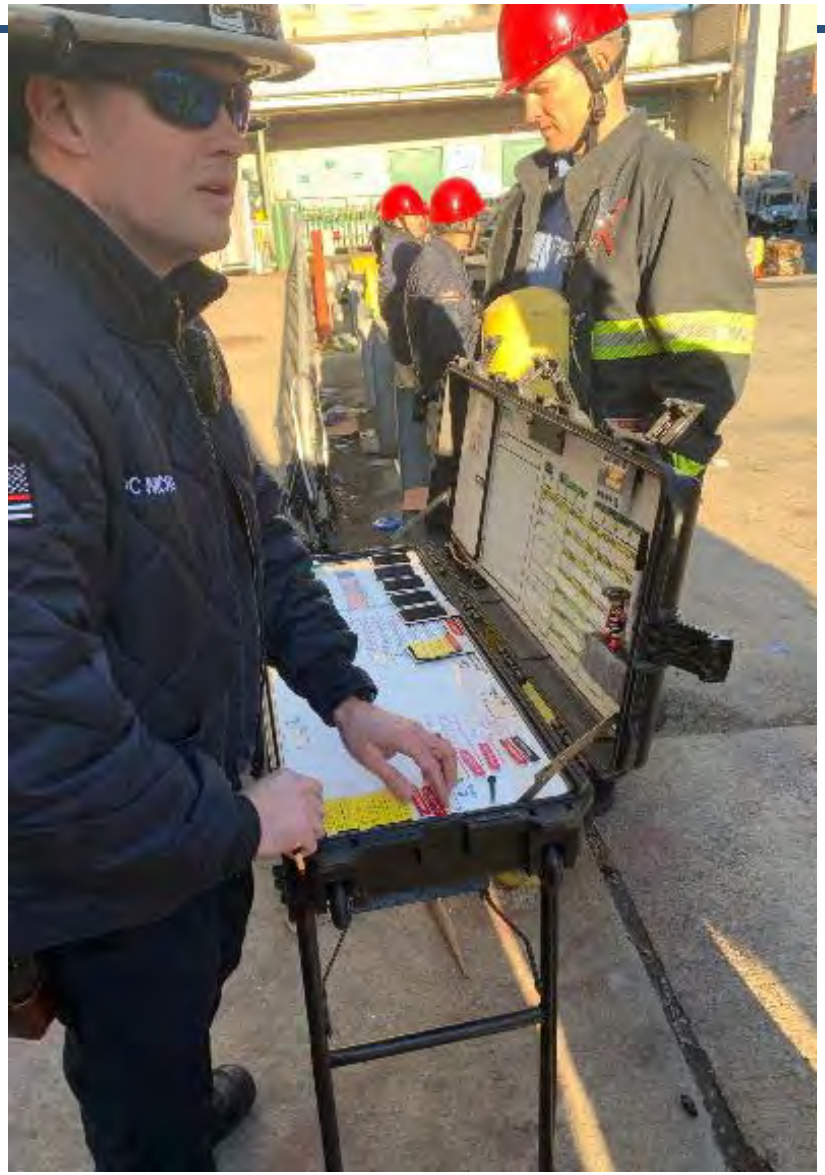

WHITE PLAINS
FIRE RESCUE


POLICE

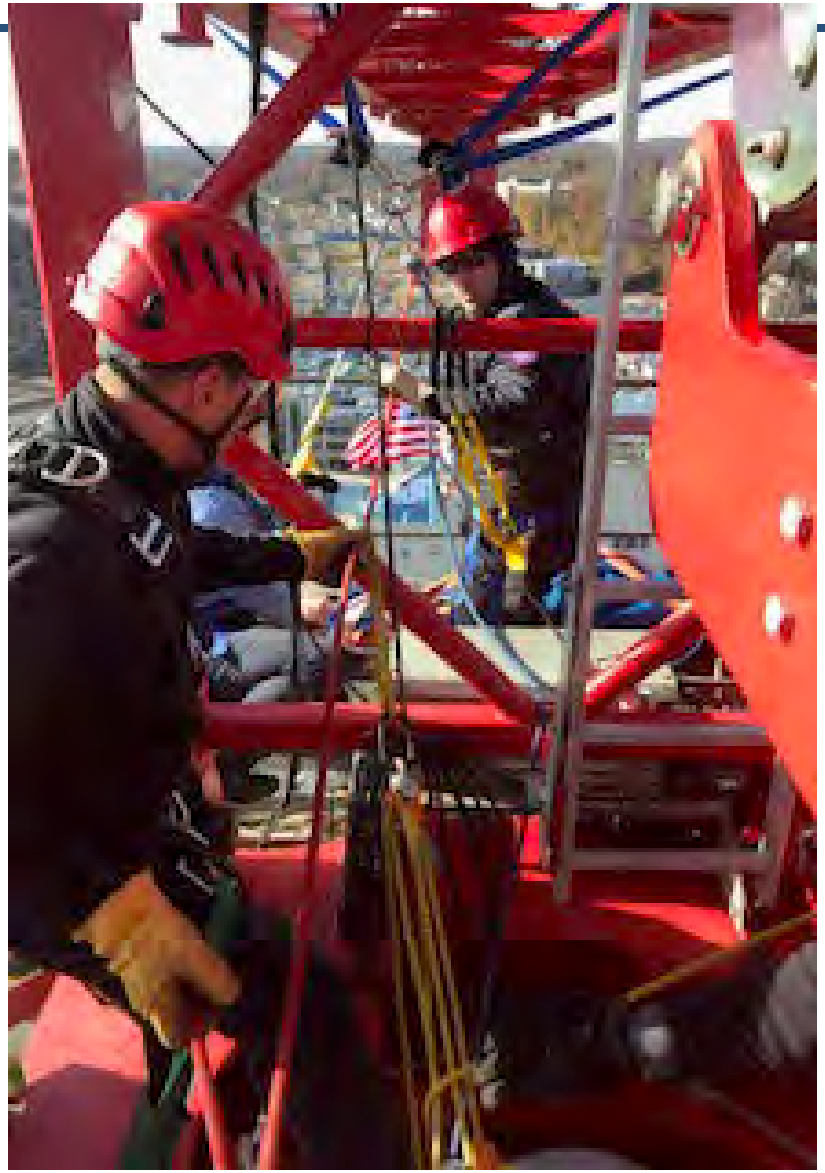
Think outside the box! Use construction sites for joint training

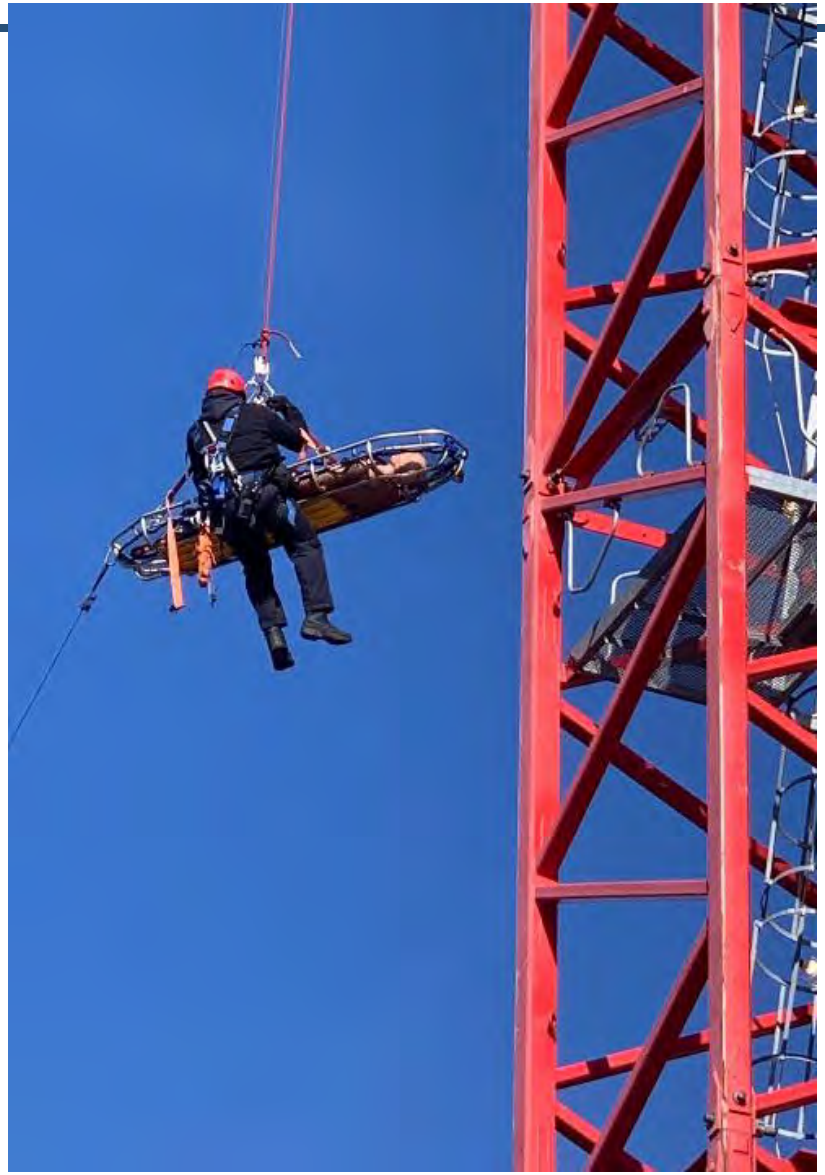


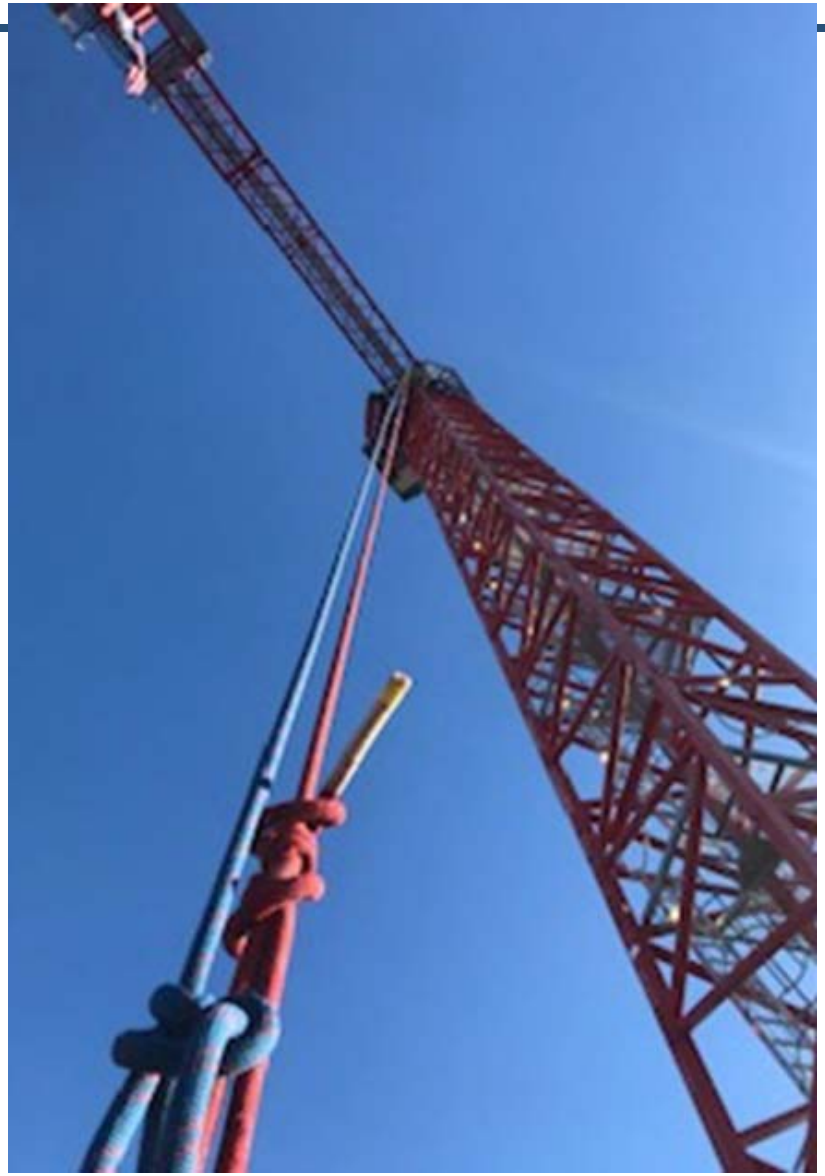
Mmmm, that command board looks old……



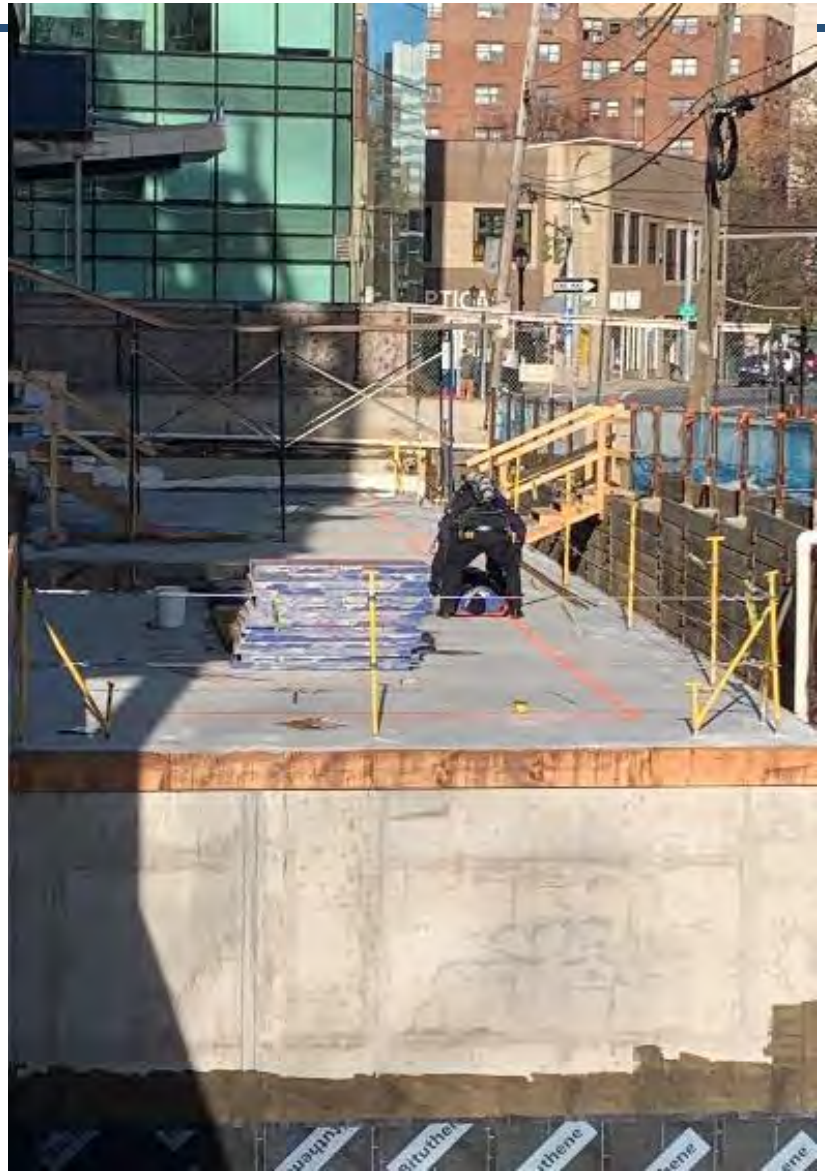
The view from the top!

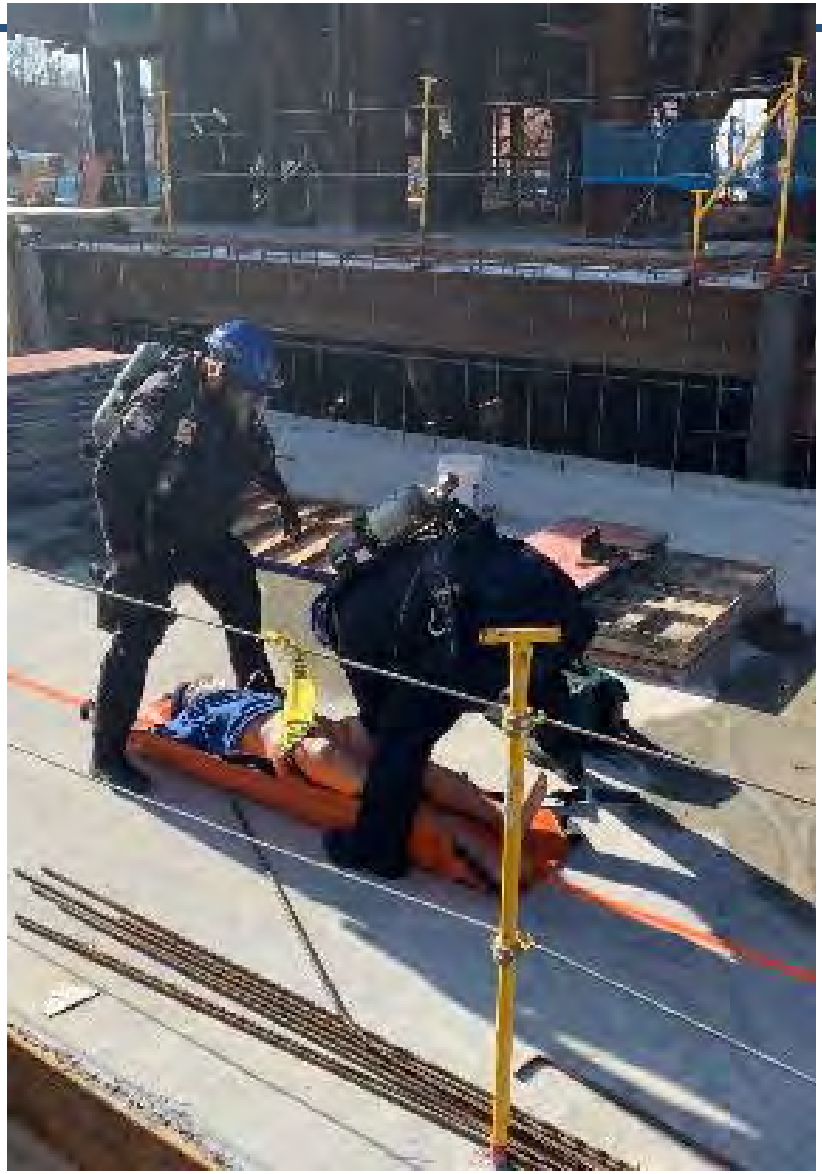







EMPRESS
EMS
SPECIAL OPERATIONS





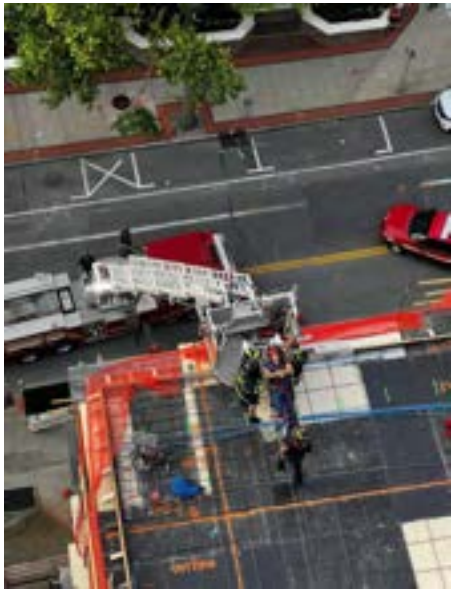

754
(888) 965-5040
EMT

And then…..

Real World Event

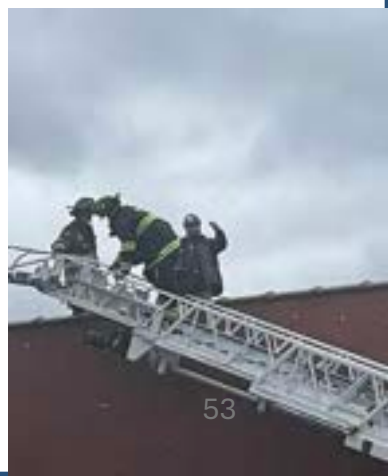
Training proved effective!!!!


WPFD




2630-30694
4 980 LBS

Joint Training & Exercise Opportunities




Empress


HEROES
WALK
THROUGH
THESE
DOORS

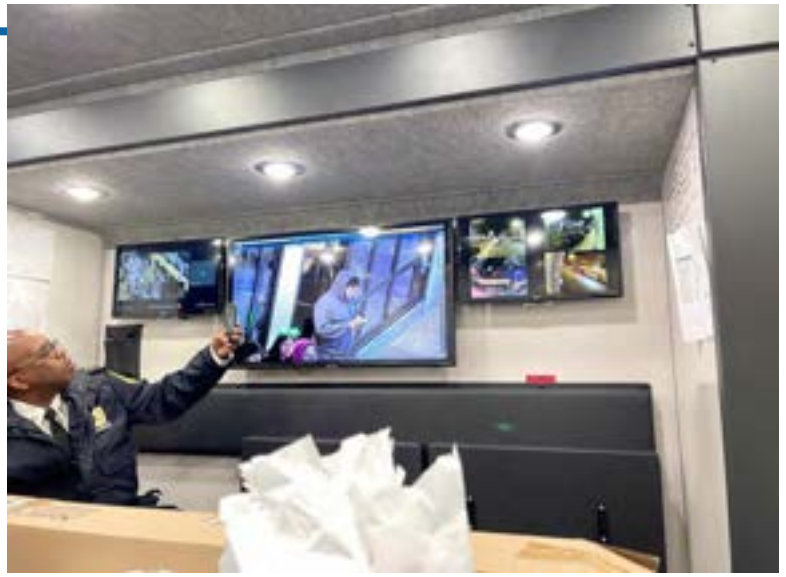

POLICE


WP
White Plains
Hospital
THIS IS ONLY
AN EXERCISE


FIRE

WP Fire Department on site and evaluated both trainings – OR and Hyperbaric

New Years Eve = Unified Command! Hospital – FD – PD – EMS at the City Command Center



Westchester County Airport Exercise


KANSAS CITY
CHIEFS

Exercises and Real-World Events

WP Active Shooter MCI FSE

- June 12th, 2023
- White Plains Galleria Mall
- Joint Learning Objectives
  - Establishment of Unified Command
  - Formulating Rescue Task Force
  - Communication
  - Triage Area & Victim Transport
  - Victim coordination with hospital
- Duration of exercise: 2.5hrs
- Number of participants: 159
  - Police- 96
  - Fire- 11
  - EMS- 9
  - Hospital-43

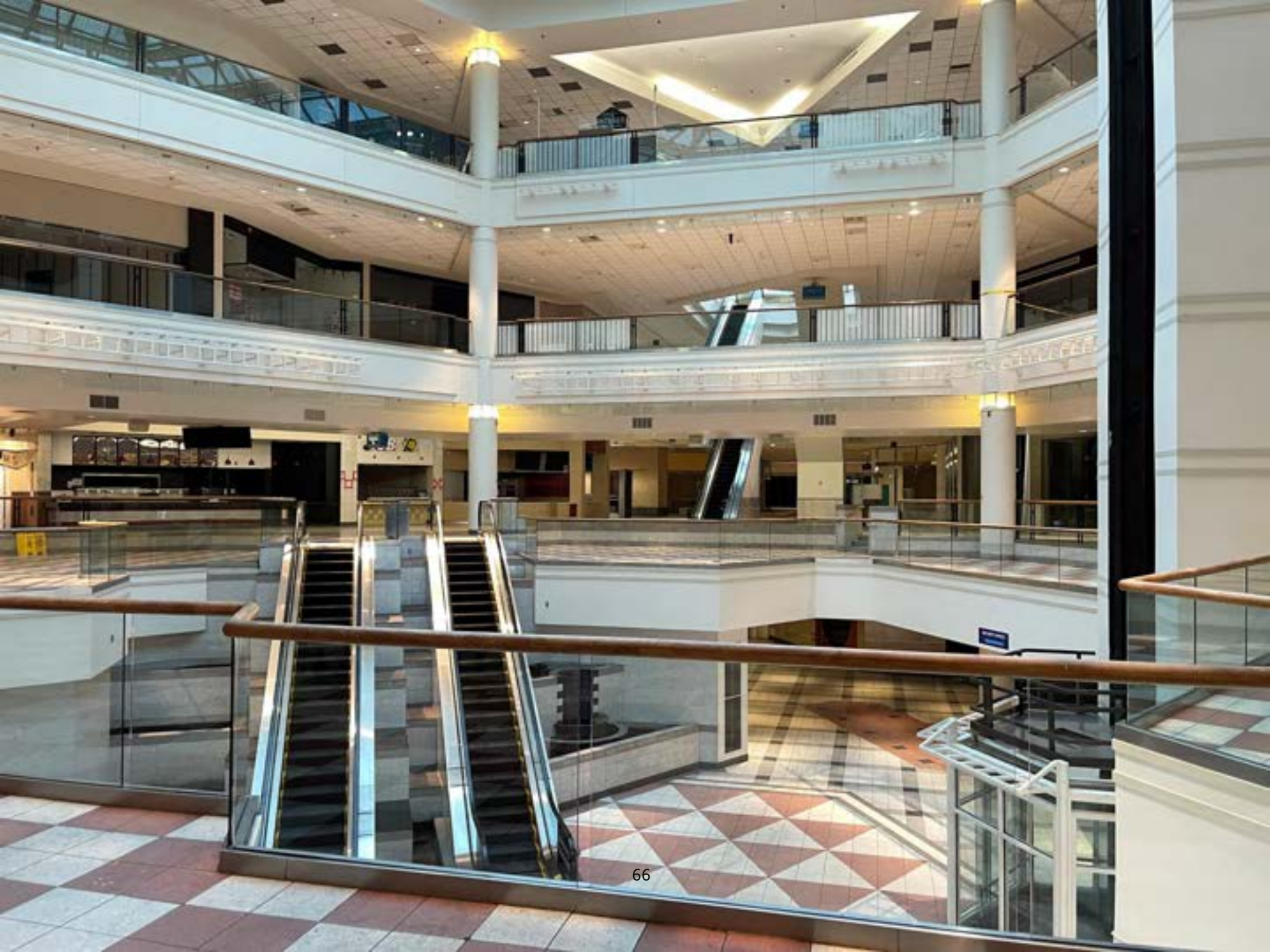
- Real world simulation- No stacking the deck in your favor.
  - Drill staffing and equipment available reflected actual levels on that day.
  - Actual response times- any recalled personnel were held in staging

NATIONAL HEALTHCARE COALITION PREPAREDNESS CONFERENCE

Exercises and Real-World Events

Lessons Learned

- Unified Command established quickly and effectively
- Hospital Liaison at command post assisted with preparing hospital for victim influx. Direct shoulder to shoulder communication with hospital
- Victim accountability. At end of the exercise both command and hospital reported the same number of casualties.




CCC


POLICE
LADDER
67

City of White Plains Emergency Preparedness Task Force

City of White Plains
Emergency Preparedness and Response Task Force
Meeting of Wednesday, July 6, 2022

Topics for Discussion:

- Introductions and Purpose
- Exercise Design – MCI and Decon at WPH
  - Saturday, Sept 17th or 24th / Wednesday, September 14th or 21st
- Agency Updates:
  - WPH:
    - HVA
    - Construction – 3F/ICU/Sprinkler Tie In/OR/Service Drive – Dec.
    - Covid Response
    - Familiarization Tours – CAMS
    - MCI Plan Revisions
    - Capacity Management Plan – Surge Matrix
    - The Joint Commission Survey - TBA
  - WP FD
  - WP PD / ESU
  - NYP
  - Burke Rehab
  - Empress
  - Westchester County OEM / DOH
  - Salvation Army
  - Red Cross
- Meeting Schedule

Challenges

Challenge #1: Preparedness funding realities

Possible Solutions:

- **Capitalize on policy initiatives and resources**
  - Force Multiplier - A capability that, when added to and employed by a combat force, significantly increases the combat potential of that force and thus enhances the probability of successful mission accomplishment.
  - Racing. Drafting or slipstreaming is a technique where two vehicles or other moving objects are caused to align in a close group reducing the overall effect of drag
- **Collaboration Effect**
- **GRANTS – GRANTS - GRANTS**

Challenges

Challenge #2: Coalition integration into disaster response

Possible Solution:

Challenges

Challenge #3: "surge" capacity

"Surge" capacity is shrinking

Possible Solution:

Coalition immediate bed availability

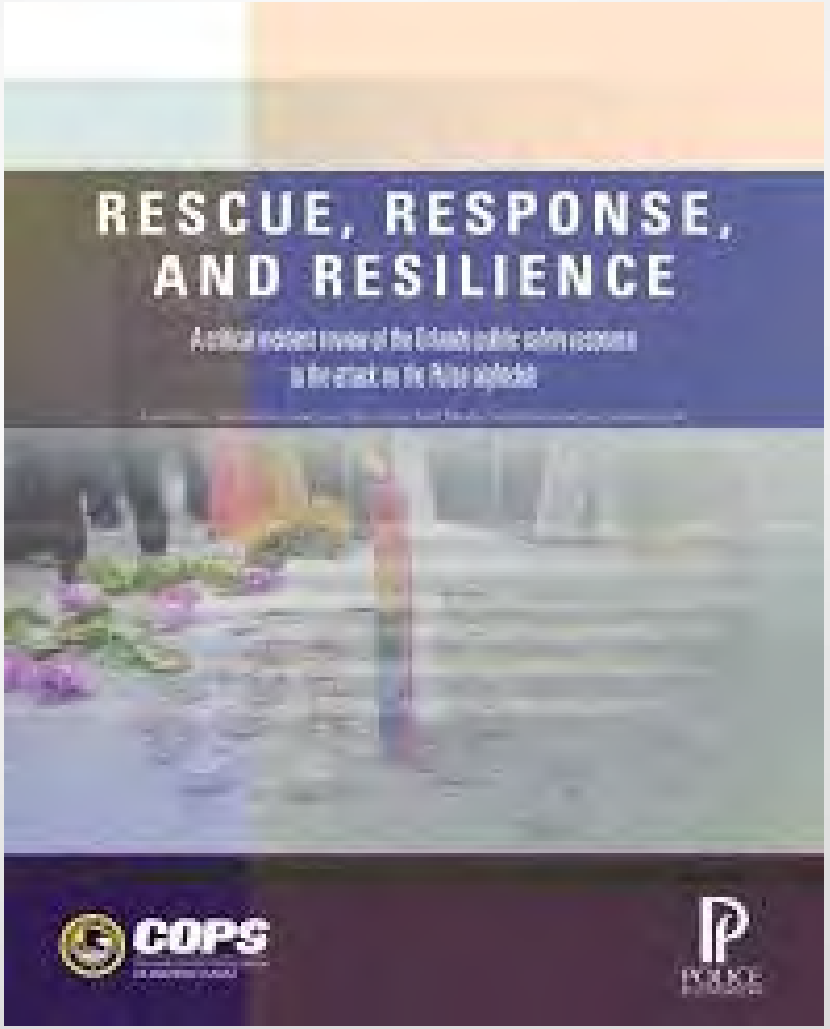
- ❑ Immediate bed availability (IBA) is built into the existing system
- ❑ Uses regional capacity
- ❑ Expanding local capabilities
- ❑ Builds on current regional structures
- ❑ Builds on regional collaboration

IBA principles

Constant acuity monitoring across the coalition
Patient awareness and continuous discharge planning
20% acute care offload (IBA)

Unintended Positive Outcomes

Coalition Inter-Agency Relationships



Unintended Positive Outcomes

- Observation 5.2. The OPD should continue to build relationships, train, and develop protocols with medical personnel from area hospitals, especially the regional level 1 trauma center, to improve the law enforcement response to mass casualty incidents.....

- Lesson learned 5.2.2. Identify medical protocols and practices that can be adapted and administered in life-threatening situations.

- While emergency medical care and tactical medical training can be cost-prohibitive for some agencies, partnering with hospitals and local medical professionals can provide law enforcement with practical training and can foster or enhance partnerships with critical stakeholders. In Orlando, ORMC staff commended officers and deputies for rescuing and saving the lives of so many victims and offered to engage in planning and training exercises to enhance the public safety and hospital response to mass casualty events.

Unintended Positive Outcomes

Improved Communication During Emergencies

- **Example 1:** Widespread flooding from heavy rainstorm
- Enhanced communication: When flooding began on the hospital grounds, a quick cell phone call was all that was needed to prepare for worsening conditions.
- Both FD and PD were called to rescue multiple people in a van trapped fast moving water that was rapidly rising.
- Allowed clearer channels for inter-agency updates during incidents, previous training together, understood each others' operations, comms and resources.

Unintended Positive Outcomes

Operational Flexibility and Equipment Access

- **Example 2:** COVID Response - Joint response enabled better sharing of resources, equipment, and personnel.

- **Example 3:** Some of us may or may not have almost lost jobs due to resource allocation challenges… (Note to self: keep the boss up to speed regardless of operational period).

- **Example 3:** While attending joint training at a FD station near the hospital, access issues were highlighted. This led to sharing of a city-wide access system already in place by the FD.

Unintended Positive Outcomes

Enhanced Skill Sets through Joint Training

- Through joint training, personnel have acquired new skills and increased the capabilities in others.
- **Skills:** Advanced triage techniques, improved mass casualty skills in line with our partners, tactical response strategies to assist PD in various scenarios, ICS enhancements and emergency planning.
- Tower crane training made possible by the hospital gave our technical rescue members real-world experience that would never have happened otherwise.
- These skills were put to good use shortly after, when those same Firefighters were called to rescue an injured worker in what was almost an identical scenario to the one they had trained on.

Unintended Positive Outcomes

Improved Inter-Agency Relationships

- Regular joint training has fostered trust and understanding across all our departments.
- Improved communication during both training and real-world events is very evident.
- Increased collaboration in day-to-day operations has resulted in joint problem-solving for improved community safety.
- Our assistance to each other with resources, ideas, and past experiences cannot be under stated.

Building a Coalition Takes Work!

"Plans are worthless…

Planning is everything."

Dwight Eisenhower

How to build your own coalition…

A lot of hard work

A lot of hard work

A lot of hard work

A lot of hard work

Coalition

Senior Leader Buy in

Commitment

It starts with a phone call….

Tools to Help…

- Meeting Agenda & Schedule
- Coalition Membership List
- Exercise & Training Program
- IMT Sample

Final thoughts...

Emergencies start and end locally, keeping everyone at the same table saves lives

Location coalitions break down competitive walls and foster collaboration and cooperation

Emphasize the importance of regular meetings, planning, training and effective communication.

There is no better plan than putting a name to the face having the number in your cell phone

Local coalitions create a sense of safety and comfort – I got your back!

Enhanced response to minor and major emergencies, better coordination, improved community safety.

THANK YOU FOR YOUR TIME!

Open Discussion / Questions

NATIONAL HEALTHCARE COALITION PREPAREDNESS CONFERENCE

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Gyongi McQueston

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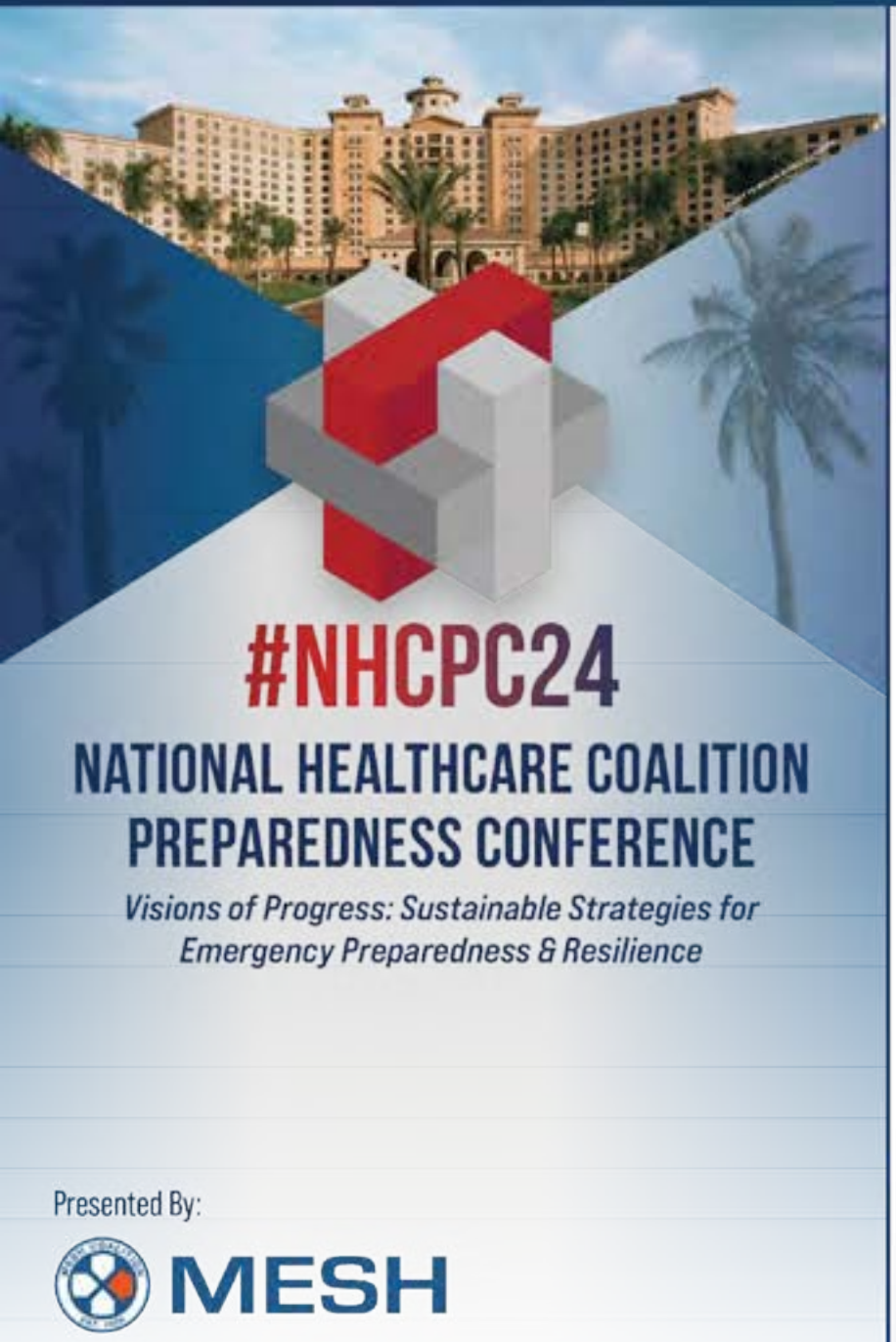
Gyongyi.mcqueston@health.ny.gov

914-654-4995



Creating a National Network to Interconnect Regional Entities with ASPR Assets

Marie M. Lozon, MD
Deanna Dahl-Grove, MD
Region V For Kids Pediatric Disaster Center of Excellence

DISCLOSURE

The Pediatric Disaster Centers of Excellence are supported by awards from the Administration for Strategic Preparedness and Response within the U.S. Department of Health and Human Services (Region V for Kids #U3REP190615-10-10).

THE NEED

Recent health crises exposed and exacerbated disparities: mental health crisis, respiratory surge, COVID-19.

Disproportionate risk, limited resources and infrastructure, and high consequence outcomes!

25%

Percent of U.S. population - children - with unique healthcare needs

47.5%

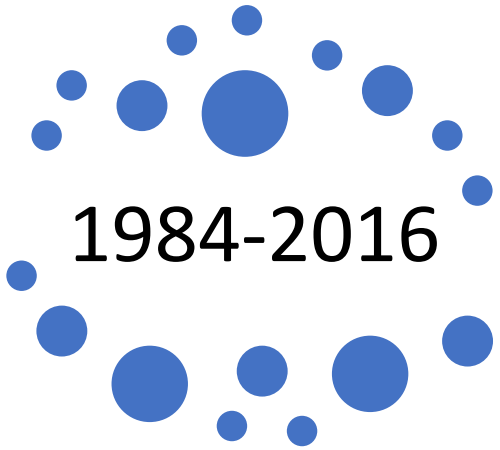
Hospitals with pediatric-specific disaster plan

30 MILLION

Children who seek emergency care each year

69.5/100

Median score of Emergency Departments pediatric readiness in the U.S.



- **1984** – EMSC Program Authorized
- **2012** – Launch of National Pediatric Readiness Project
- **2016** – EMSC Innovation & Improvement Center replaces the National Resource Center

2019

- Launch of **Prehospital Pediatric Readiness Project**
- ASPR Launches **Two Pediatric Disaster Centers of Excellence** (WRAP-EM & Region V for Kids)

Present

- **2021-2022 –** Creation of Pediatric Pandemic Network
- **2022** – ASPR Adds **Third Pediatric Disaster Center or Excellence** (Gulf 7)

Three Pediatric Disaster Centers of Excellence

- Funded by the Administration for Strategic Preparedness and Response (ASPR)
- Bring together children's hospitals, private and public entitites, and national organizations
- Designed to disseminate best practices in pediatric disaster preparedness, response, and recovery on a regional level

Gulf 7–Pediatric Disaster Network

- Awarded in 2022
- Anchored at Texas Children's Hospital (Houston, TX)
- 7 states/terrirories: Alabama, Florida, Georgia, Louisiana, Mississippi, Puerto Rico, Texas

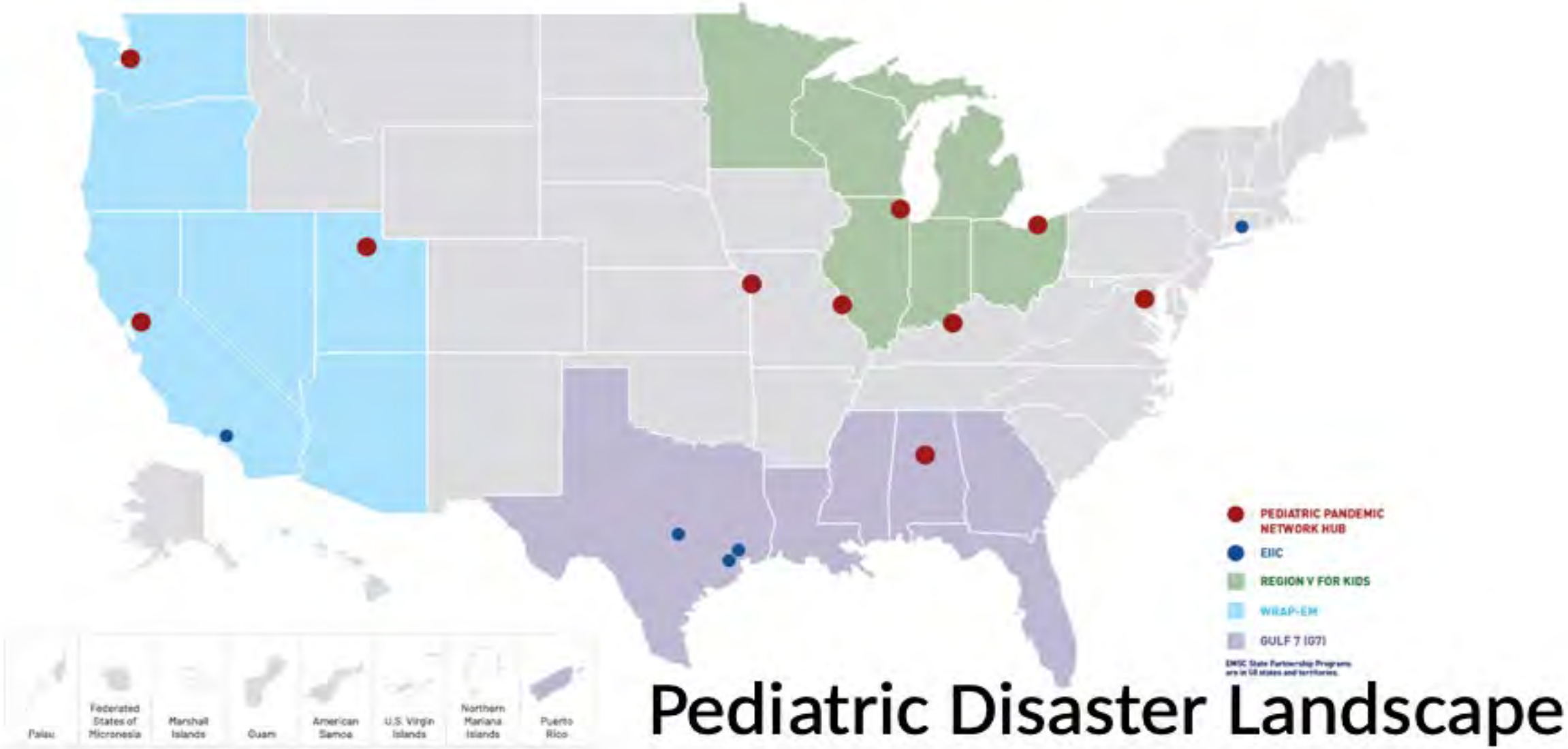
Western Regional Alliance for Pediatric Emergency Management (WRAP-EM)

- Awarded in 2019
- Anchored at UCSF Benioff Children's Hospital (Oakland, CA)
- 6 states: Arizona, California, Nevada, Oregon, Utah, Washington

Region V for Kids (formerly EGLPCDR)

- Awarded in 2019
- Anchored at UH Rainbow Babies & Children's Hospital (Cleveland, OH)
- 6 states: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin

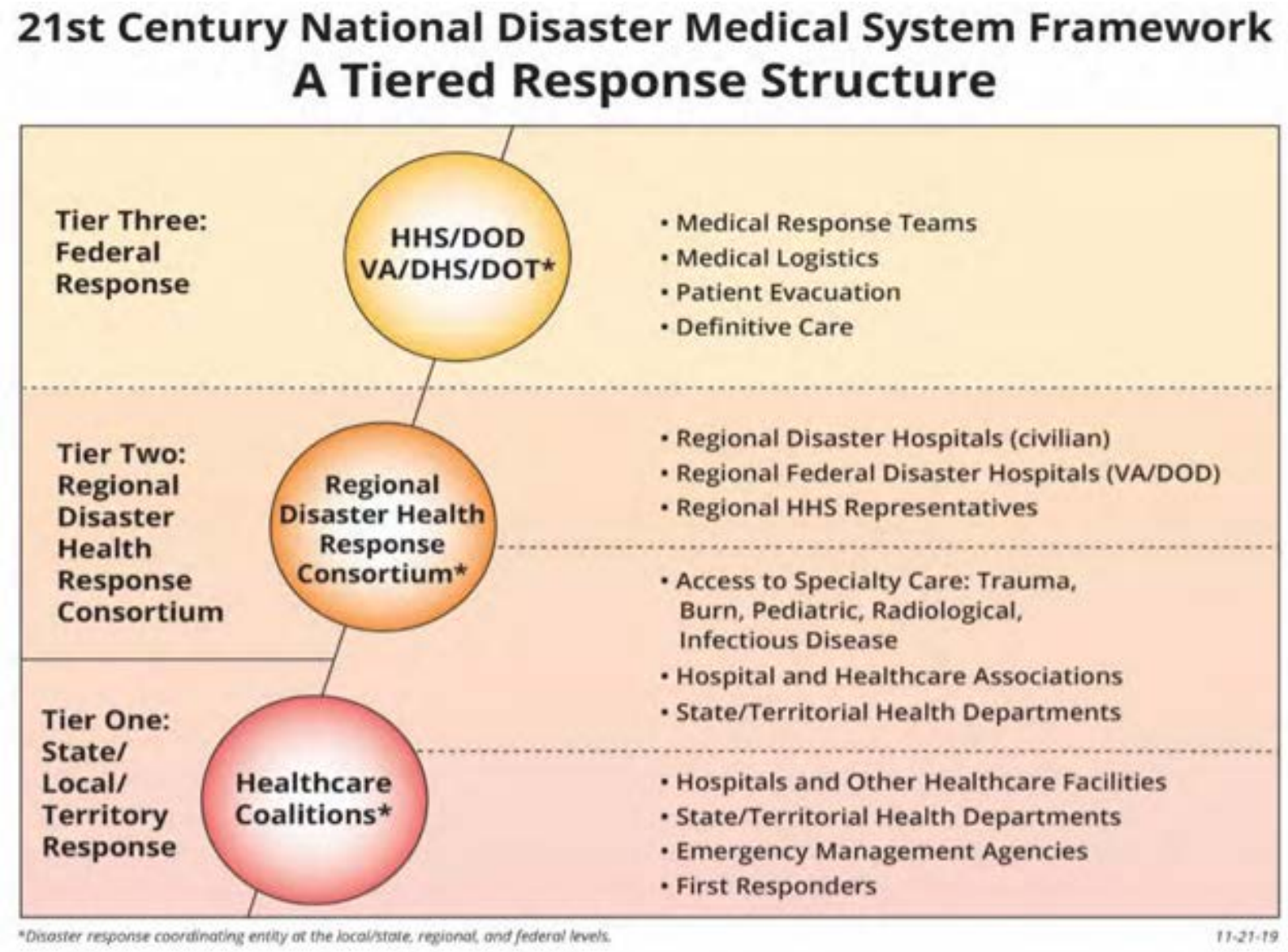
Federally Funded Networks for Children in Disasters



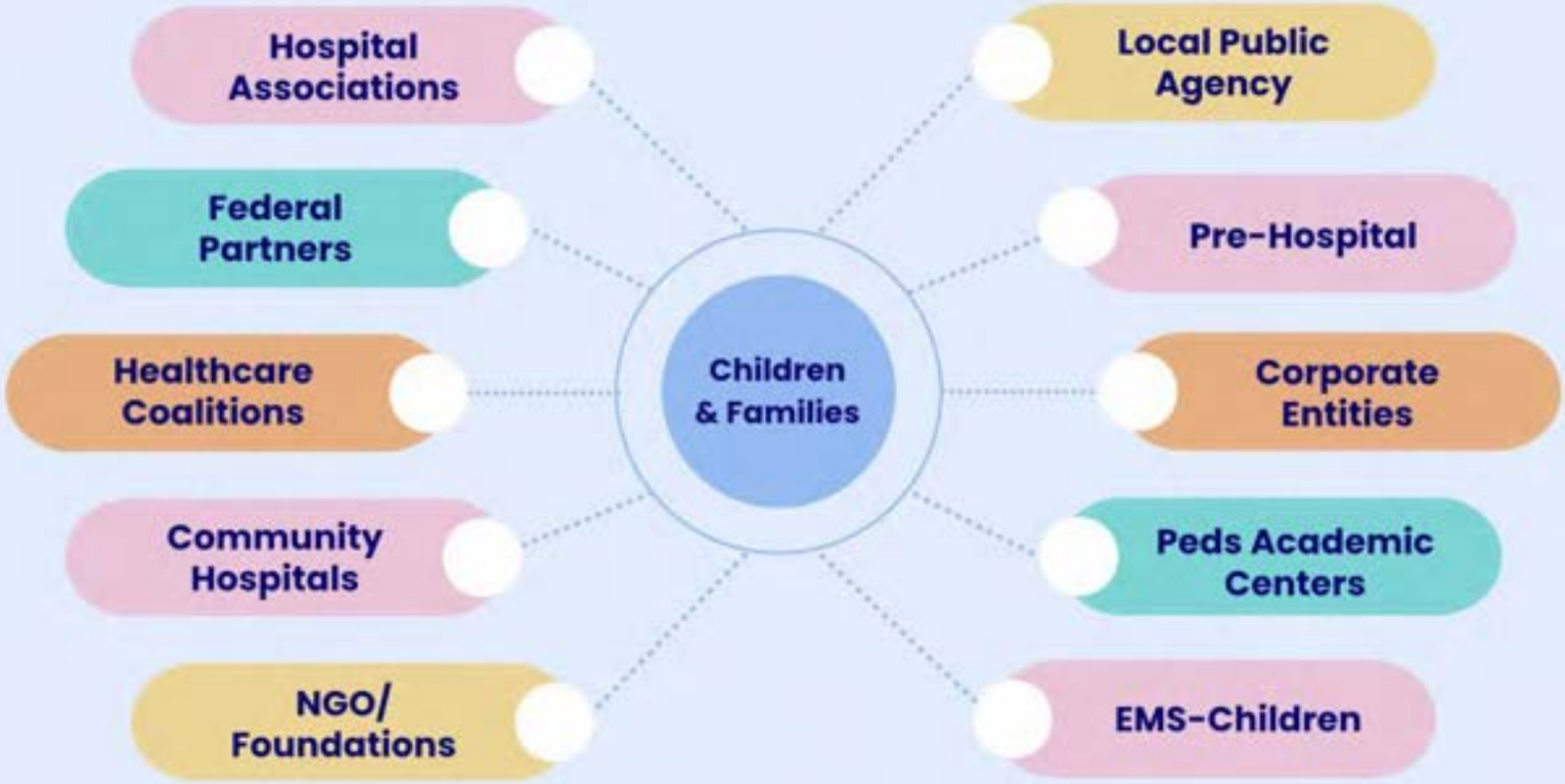
Pediatric Disaster Landscape

Geographic Reach: Regional Disaster Health Response Systems and Pediatric Disaster Centers of Excellence

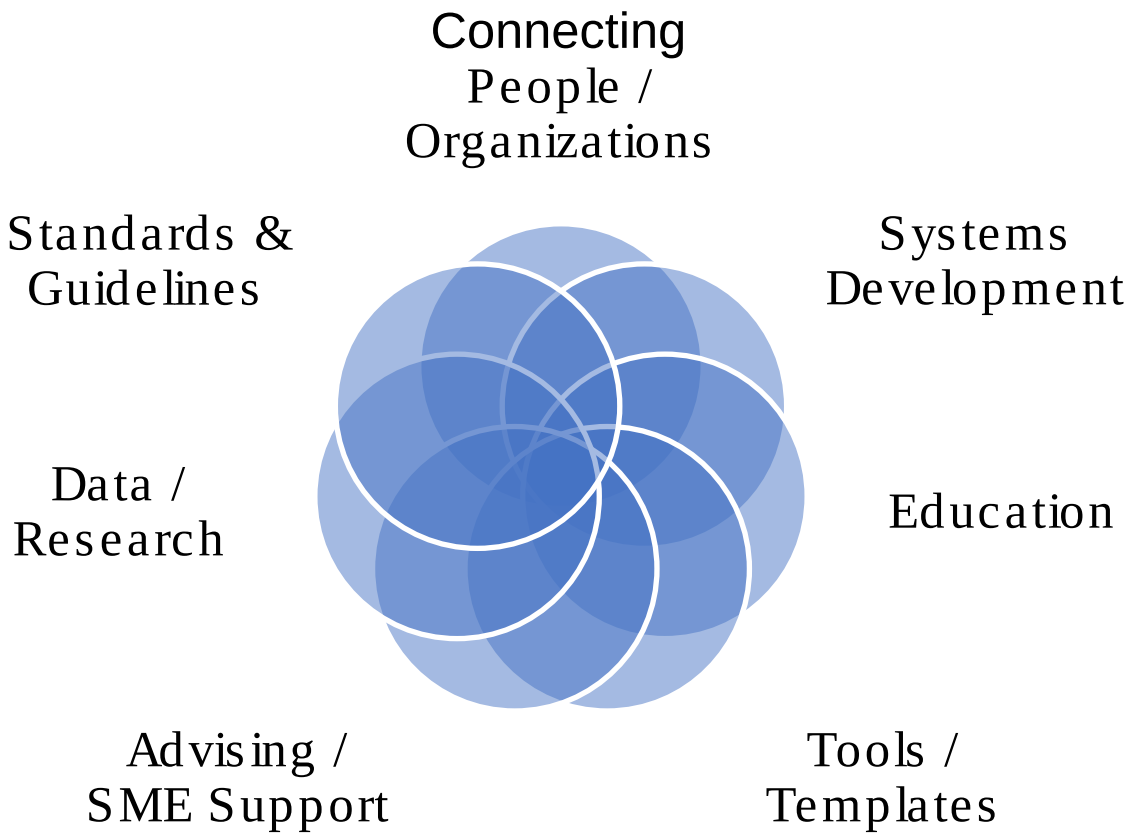
The ASPR Vision of Pediatric Disaster Centers of Excellence



PDCOE Partners



The PDCOEs: WE ARE HERE FOR YOU



PDCOE Pillars

- **Develop** a coordinated pediatric disaster care capability
- **Strengthen** pediatric disaster preparedness plans and coordination
- **Enhance** state and regional medical pediatric surge capacity
- **Increase** healthcare professional educational competency
- **Enhance situational awareness** of pediatric disaster care across the spectrum

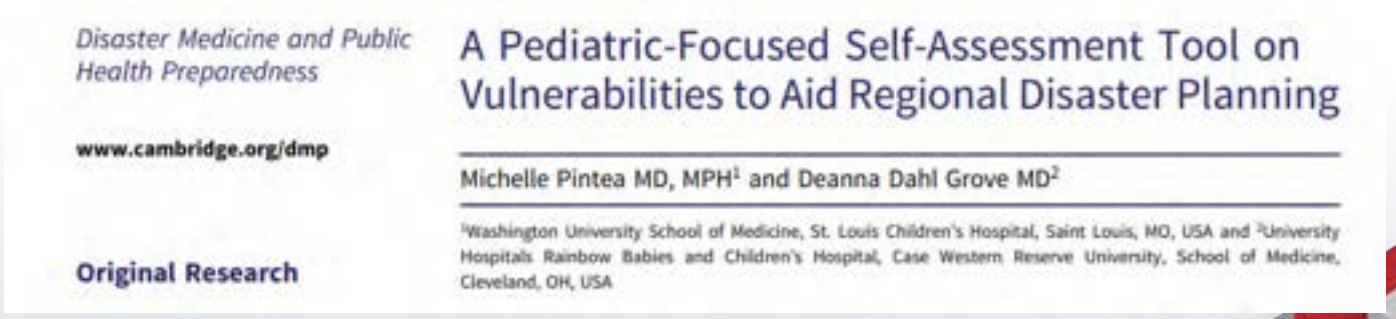
HOW WE CONTRIBUTE TO PEDIATRIC PREPAREDNESS CAPABILITIES

- Approachable subject matter experts
- **Trusted Consultation: preparedness & response efforts**
- Real time **situational awareness** in region
- **Identify gaps in addressing pediatric-specific concerns**
- **Create resources** to educate pediatricians, hospitals, and caregivers of children
- **Discussions** inclusive of health disparities & inequities

PDCOE in Action

- Respiratory Surge
- Responded to our Regional Healthcare Coalitions
- Real-time Situational awareness
- Disseminated tools for Just-in-Time care of children
- Participated in 10 ASPR-hosted regional webinars to listen to HCC, hospitals and others and provide resources

- **COE range of work**: domains, expertise, educational output, preparedness products
- **Deep connections with Children's hospitals**, the American Academy of Pediatrics, Emergency Medical Services for Children and the Pediatric Pandemic Network (although funded by HRSA and not ASPR, much overlap in mission and investigators)
- **Most investigators/leaders in COE work in academic medical centers** at children's hospitals and have had significant preparedness experience (education, experiential with deployments, advocacy, HCC and state partner involvement, etc)
- **Academic** products
  - COE outreach efforts on behalf of children
  - Addressing disparities
  - Surge playbook
  - Regional Planning



- History
- Funding
- Purpose
- Scope
- Geo reach

These Systems stood up with funding from ASPR starting in 2018, predating the Pediatric Centers of Excellence by a couple of years, but the missions of the RDHRSs and the PDCOEs have much alignment around the pediatric population

RDHRS Goals

The four primary goals of the RDHRS are to:

REGION 1
Regional D

RDHRS Disaster Telehealth

MASSACHUSETTS GENERAL HOSPITAL
CENTER FOR DISASTER MEDICINE

Providing Care for Pediatric Patients with Acute Respiratory Illness:

The Region 1 RDHRS has established a weekly educational series comprised of six sessions to provide clinical teams from nursing, provider, and respiratory therapy disciplines with information and resources that can support their work to meet the healthcare needs of pediatric patients.

RDHRS WEBINAR SERIES
PROVIDING CARE FOR PEDIATRIC PATIENTS WITH ACUTE RESPIRATORY ILLNESS

nechanisms that link
unity partners and
l patient care during

Just-in-T

Pediatric Resources

- Region VIII Pediatric Respiratory Surge Resource Page (updated 1/18/2023)
- ASPR TRACIE
  - Pediatric Surge Resources
- Children's Hospital of Colorado
  - Clinical Pathways from A to Z
- EMS for Children (EMSC)
  - Colorado
    - EMSC Colorado | Pediatric Respiratory Resources
  - Montana
  - North Dakota

Region 8
MOUNTAIN PLAINS
Regional Disaster
Health Response System

Management of Burns in a Disaster Setting

July 2024

Annette Newman (Matherly)

Management of Burns in a Disaster Setting

Region VII
Disaster Health
Response Ecosystem

Region V for Kids (PDCOE) and Region VII collaborated to have pediatric burn care experts review the regional burn plan before their recent regional exercise

MIDWEST BURN REGION DISASTER RESPONSE

MINNESOTA

Duluth	Essentia Health St. Mary's Medical Center 877.786.4944
St. Paul	Regions Hospital Burn Center 800.922.2676
Minneapolis	Hennepin Healthcare 612.873.2915

NEBRASKA

Lincoln	CHI Health St. Elizabeth's Regional Burn and Wound Center 800.877.2876

KANSAS

Kansas City	Burnett Burn Center 913.588.6540
Wichita	Ascension Via Christi Regional Medical Center 316.268.5388

MISSOURI

Columbia	George David Peak Memorial Burn Care Center 573.882.2876
Kansas City	Children's Mercy Hospital Burn Unit 816.234.3520
Kansas City	Grossman Burn Center at Research Medical Center 816.276.4325
Springfield	Mercy Burn Center 417.820.2910
St. Louis	Mercy Hospital St. Louis' Burn Center 314.251.6055
St. Louis	Barnes Jewish Hospital 314.362.5345

WISCONSIN

Madison	University of Wisconsin Burn Center 608.263.1490
Milwaukee	Children's Hospital of Wisconsin 414.266.2000
Milwaukee	Ascension Columbia St. Mary's Regional Burn Center 414.585.1163

IOWA

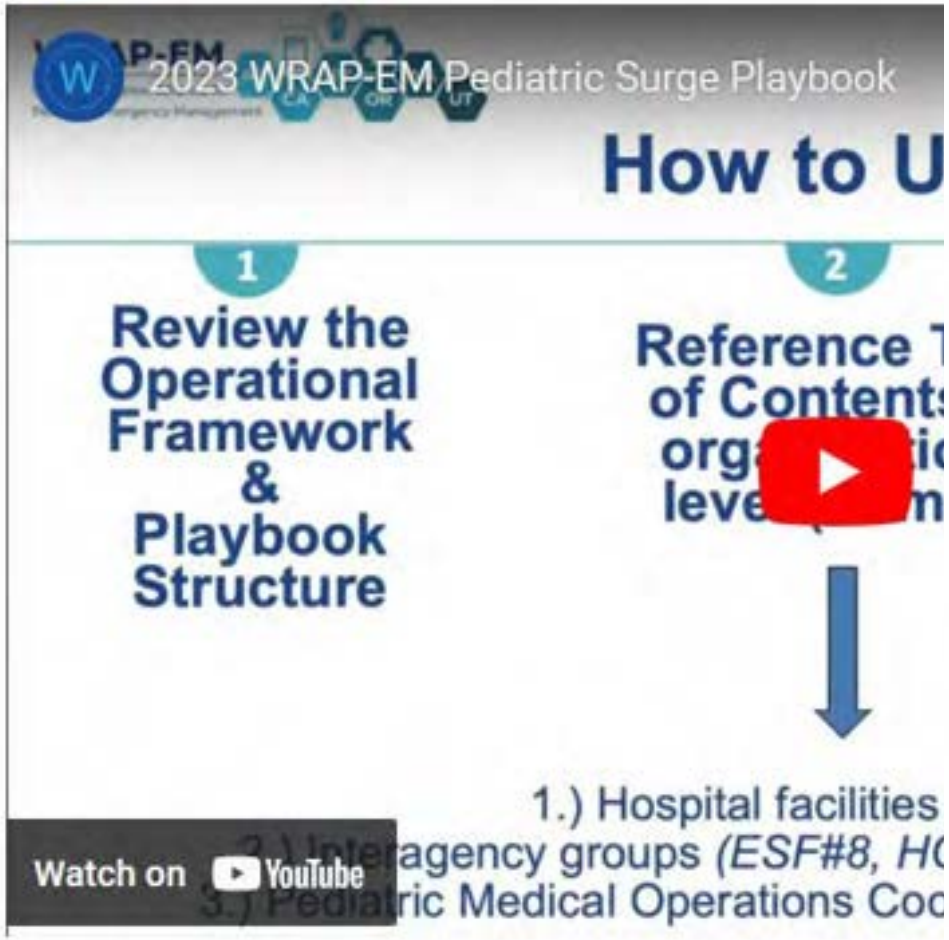
Iowa City	University of Iowa Burn Center 866.890.5969

ILLINOIS

Chicago	University of Chicago Burn Center 800.621.7827
Chicago	Sumner L. Koch Burn Center 312.864.3144
Maywood	Loyola University Medical Center 708.216.3988
Springfield	Regional Burn Center 217.788.3325
Rockford	OFC St. Anthony's Medical Center 815.395.5313

REGION VII
DISASTER HEALTH
RESPONSE ECOSYSTEM

2023 WRAP-EM Pediatric Surge Playbook



TELEMEDICINE SPECIALTY COLLABORATIONS

Tele-EMS

Region V for Kids began to collaborate with RDHRS Telemedicine Project Team(s)

- This cross-sites work began with participation in mass casualty exercise to demonstrate telemedicine use regionally (kudos to Dr. Tehnaz Boyle, Region 1 Telemedicine leader)
- Region 1 RDHRS and Southern Region have some mature telemedicine projects
- Pediatric COEs and RDHRSs meet monthly and our cross-sites team includes ASPR leaders working on a national delivery platform
- We endeavor to explore the use of virtual care technologies in all aspects of the disaster cycle, including prehospital care AND to ensure that the needs of children are considered throughout

NETN: National Emergency Telemedicine Network

ASPR Disaster Telemedicine Program Updates

Region 5 Partner Webinar
October 2, 2024

CDR Dina Passman, USPHS, Director

Dr. Chris Crabtree, Sr. Emergency Management Specialist

CDR Lisa Tung, USPHS, Data Scientist*

Amy Keim, Sr. Medical Officer

Mission and Vision

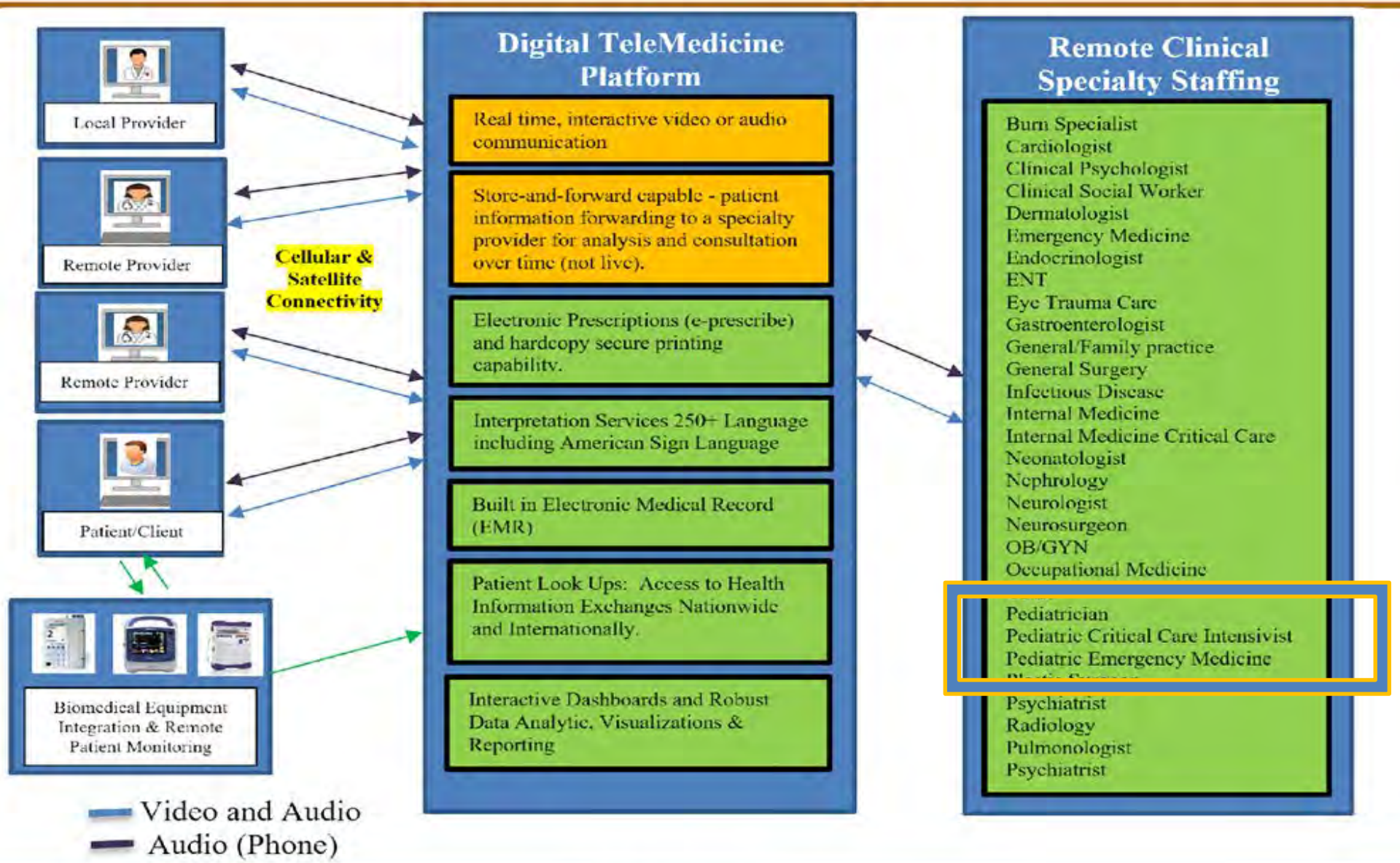
Mission

The ASPR Disaster Telemedicine Program's mission is to provide the best care to disaster-stricken communities using remote clinical specialists when and where they're needed.

Vision

ASPR will provide unrivaled virtual specialty support to federal emergency responders and their partners.

The Disaster Digital Telemedicine Architecture



The <u>Pediatric Disaster Centers of Excellence</u> *engage* with our RDHRS colleagues AND ASPR so that when developing Telemedicine responses to Disasters and Pandemics, the needs of children are considered throughout planning and response

Purpose and Goals of PDCOE and RDHRS Cross Sites Project- Kick Off January 2024

Purpose: Share and develop advanced pediatric disaster innovations across a network of regional disaster health response systems.

Objectives:

Create a venue for sharing pediatric disaster expertise across a network of federally funded regional health response projects.

Leverage existing pediatric disaster preparedness and response expertise.

Identify and develop methods for pediatric gaps in disaster preparedness and response.

Announce open-invitation opportunities for pediatric-centric conferences, workshops, education, and exercises.

Promote advancements in pediatric disaster preparedness and response.

Cross-sites Disaster Preparedness Forum: Pediatrics

Forum Meeting Notes – **16 April 2024**

Mountain Plains

Virtual pediatric exercise involving state EMSC, public health, load leveling and peds transport

Pediatric Critical Care Course for non-pediatric providers

Region VII

Project to establish a PMOCC at Children's Mercy to coordinate transfer and load leveling? concern for the regional bed capacity as a major pediatric challenge

Cross-sites Disaster Preparedness Forum: Pediatrics

Forum Meeting Notes – **16 July 2024**

Presentation on PPN *Implementing a Checklist to Improve Hospital Pediatric Preparedness and Response*

Research project – presented by Dr. Jefferson Barret to improve preparedness for NON-children's hospitals

Cross-sites Disaster Preparedness Forum: Pediatrics

Forum Meeting Notes – **16 July 2024**

Presentation on a *National Pediatric Dashboard* – presented by Dr. Matthew Denenberg from Region V for Kids PDCOE

The project seeks to establish a user-friendly, 50-state dashboard tracking the real-time availability of various
inpatient pediatric beds and services Currently a manual, daily update, but future plans for Application Programming Interface (API) would automate real-time

PPN Disaster Response Collaborative

HRSA funded Pediatric Pandemic Network, which has much overlap in personnel and focus as the PDCOEs, sponsors a collaborative to improve preparedness of children's hospitals

Cross-sites Disaster Preparedness Forum: Pediatrics

Forum Meeting Notes – **16 July 2024**

Midwest Region Burn Exercise

Multi-region exercise to review and validate a Midwest Region Burn Plan – open invitation for observers to attend

Mountain Plains RDHRS

Virtual pediatric exercise completed: need resources to understand if increased pediatric mortality related to vaccine hesitancy: Recommendation and offer to connect with PPN Infectious Disease and sharing of WRAP-EM/PPN Emerging Issue webinar series

R1 RDHRS

Plans reconstitute a pediatric workgroup and web-based pediatric resource tracking application

Cross-sites Disaster Preparedness Forum: Pediatrics

Forum Meeting Notes – **15 October 2024**

New ASPR guidance to HPP includes opportunity for update of Pediatric Annexes

Push to incorporate pediatrics in ASPR TRACIE MOCC toolkit

MCI featured a pediatric deployable team attached to state DMAT

□

Cross-sites Disaster Preparedness Forum: Pediatrics

Forum Meeting Notes – 15 October 2024

Gulf-7 PDCOE

Trauma and Grief Component Therapy (TGCT) program
Pediatric Preparedness Courses- 7 completed

WRAP-EM PDCOE

New package of chemical surge education
“Emerging Issue” workshop series

Region 1 RDHRS kicked off their pediatric workgroup (and their deployable team is recruiting *pediatric* team members)

Opportunities Highlighted

Be Ready for Our Kids: Preparing for Everyday and Disasters

Every child at every hospital should receive appropriate care based on their needs. Data shows more than 50% of hospitals disaster preparedness plan lack the health care needs of children. AHA convenes Region V for Kids representatives to share evidence-based practices emergency departments can implement to meet the needs of children during disasters.

Register Here

Cross Sites October 16 Meeting: Region VII Burn Exercise of BURN PLAN Report

REGION BURN EXERCISE

Quick Facts

- 4-hour virtual exercise held on August 14, 2024
- Over 120 participants from 53 different organizations
  - Local (healthcare coalition coordinators), state (DHHS, public health) and regional (HHS - ASPR) partners
  - Burn centers & trauma centers

Exercise Objectives

- Identify the communication, coordination and transfer process of patients within the Midwest Burn Region during a large-scale event
- Discuss and define the burn plan and/or process for acquiring additional supplies for burn patients at a frontline facility during a prolonged delay to a burn center
- Review existing burn care assets and identify gaps that may occur
- Discuss alignment of HHS Region VII, ABA, R7DHRE during BMCI

Pediatric Disaster Centers of Excellence Joint Initiative

- ASPR & PDCOE PIs presented *Pediatric Issues Informing Current and Future Disaster Planning* (slides, recording)
- Informational briefing packet & *Joint PDCOE Pediatric Surge Report* to be released soon
- Visit the PDCOEs at a sponsored NHCPC table

New Logo

Region V for Kids

RV4K strategy meeting held in September. Key projects:

- Pediatric HVA
- Family Reunification
- Cybersecurity Workshop
- Telehealth Bystander Project
- Pediatric Disaster Medicine Educational Modules

Other Projects for Consideration as a Result of Focus Groups with Critical Access and Rural Hospitals.

Expanding Workforce to Include:

- Business Administration
- Communications
- Public Health
- IT/CISO

October 16 Cross Sites Project, cont.

WRAP-EM
Western Regional Alliance for Pediatric Emergency Management
AZ CA NV OR WA UT

Western Regional Alliance for Pediatric Emergency Management

New training pages:

Chemical Surge Planning: Pediatric Considerations,

EMSC Collaborative Webinar Series, JIT Video Series

15 ‘til 50 MCI Toolkit

Pediatric Disaster Centers of Excellence and the Regional Disaster Health Response Systems will:

- **Continue** to strengthen their **collaboration** to ensure pediatric care resources are shared regionally and nationally
- **Continue** to work with **ASPR** and each other to develop methods to use telemedicine to provide care in disaster or pandemics, ensuring children's needs for pediatric providers are considered
- **Continue** to **advocate** that our team members effectively work and **support their Healthcare Coalitions** by contributing expertise, especially in pediatric care, and exploring best practices to deliver care **where the impacted community lives** using technologies such as **telemedicine**

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Info@pediatricdisaster.org


www.PediatricDisaster.org

#NHCPC24

NATIONAL HEALTHCARE COALITION PREPAREDNESS CONFERENCE

Visions of Progress: Sustainable Strategies for Emergency Preparedness & Resilience

Presented By:

MESH

Environmental Justice and Civil Rights Considerations in Emergency Preparedness

Measuring success and demonstrating compliance in preparedness programs.

Timothy Gablehouse
tgablehouse@gcgllc.com
303.572.0050

WHAT YOU ARE GOING TO HEAR

- A “Civil Right” to adequate emergency planning process exists
- “Meaningful” Community Involvement is the Key
- Lack of Community Awareness is a Fundamental Gap that must be Addressed
- We need a good way to Measure Success of the Planning Process

CIVIL RIGHTS & ENVIRONMENTAL JUSTICE

[T]he fair treatment and meaningful involvement of all people …

[E]veryone enjoys:

- The same degree of protection from … hazards, and

Equal access to decision-making in the planning process …

A constitutional right enforced by the federal civil rights act and the ADA.

As sovereigns the ADA mostly doesn't apply to tribes. The Indian Civil Rights Act might.

MEANINGFUL INVOLVEMENT

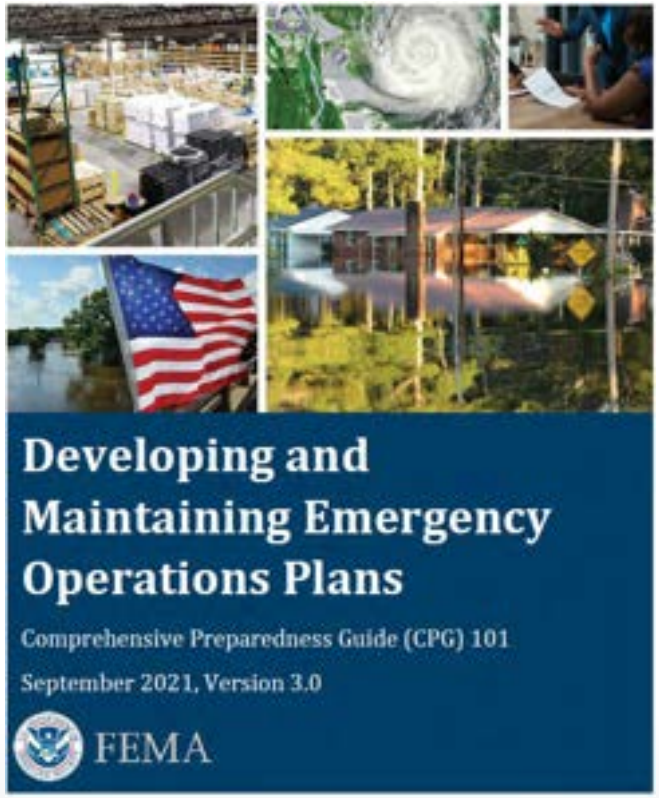
There must be a meaningful opportunity to participate in planning decisions.

BUT IT'S ONLY MEANINGFUL when community concerns are considered in the process

Decision makers must facilitate participation

This obligation is the most common failure.

POTENTIAL FOR LIABILITY IS CLEAR
CPG 101 Ver. 3.0



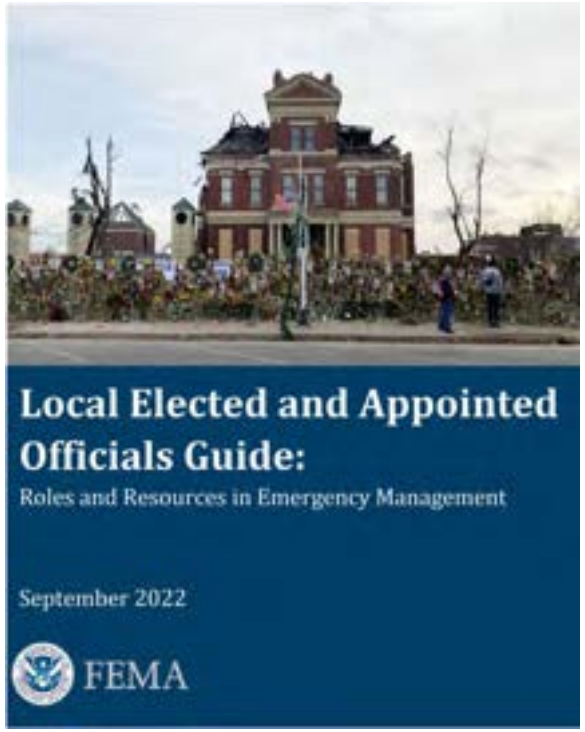
[1]Look at *ada.gov* to understand the mandate.

In addition to the ADA, planners must comply with the Civil Rights Act … and other … anti-discrimination laws.

"In the nation's system of emergency management, the local government acts first to address the public's emergency needs. …

At a minimum, these measures include priorities such as warning, emergency public information, evacuation, shelter, security, emergency medical care and tactical communications."

LOCAL OFFICIALS GUIDE



A "One-Size-Fits-All" approach to emergency management planning, resourcing and information dissemination does not work ….

Establish a core planning team with … representatives from among people with access and functional needs;

Integrating people with access and functional needs through public outreach in local and regional plans, trainings and exercises;

Key Message:

Support equitable and comprehensive disaster preparedness, response and recovery.

#NHCPC24

HAZMAT ROUNDTABLE REPORT and RAIL TRANSPORT THOUGHT LEADERS

- 2021, 2022, 2023 & 2024 meetings
- Key findings/recommendations:
  - Local planning to identify, prioritize and fill capability gaps.
  - Emphasis on community awareness and public involvement.
  - LEPCs and TERCs are a foundational element in promoting community discussion and awareness
  - Measure success in filling capability gaps.

KEY STEPS

- ENGAGE – BE PART OF THE COMMUNITY
- EDUCATE ABOUT RISKS AND CAPABILITIES
- EXPLAIN HOW RESPONSE WORKS
- TELL PEOPLE WHAT YOU CANNOT DO — BE HONEST & CREATE EXPECTATIONS
- IDENTIFY AND EXPLAIN GAPS
- EDUCATE ON THE PUBLIC ROLE

MEASURE SUCCESS

Progress & success are demonstrated by measurable results

Pick projects designed to close gaps

- **Meaningful & relevant.**

Measure, evaluate and repeat

- **Exercises**
- **Include ALL community members**

QUESTIONS

Timothy Gablehouse

tgablehouse@gcgllc.com

303.572.0050

U.S. Department of Health and Human Services

ASPR Administration for Strategic Preparedness & Response

Every Dollar Counts: Collaboration is Key to Overcoming Resource Limitations

Jessie Steinhart
Division Director, Emergency Finance Services

Sara Azimi-Bolourian, PhD, CDR, US Public Health Service
Chief Data Officer ASPR Data Program

National Healthcare Coalition Preparedness Conference (NHCPC)
11 December 2024

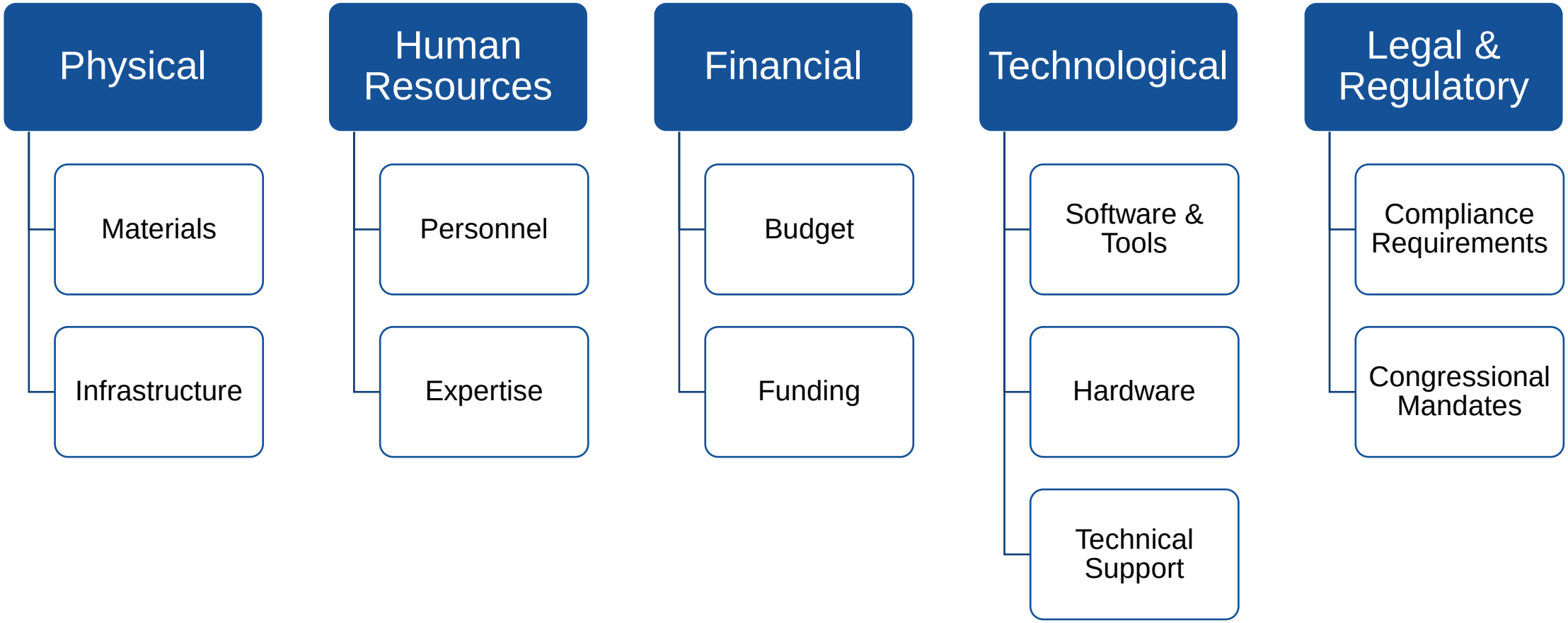
Introductions

Learning Objectives

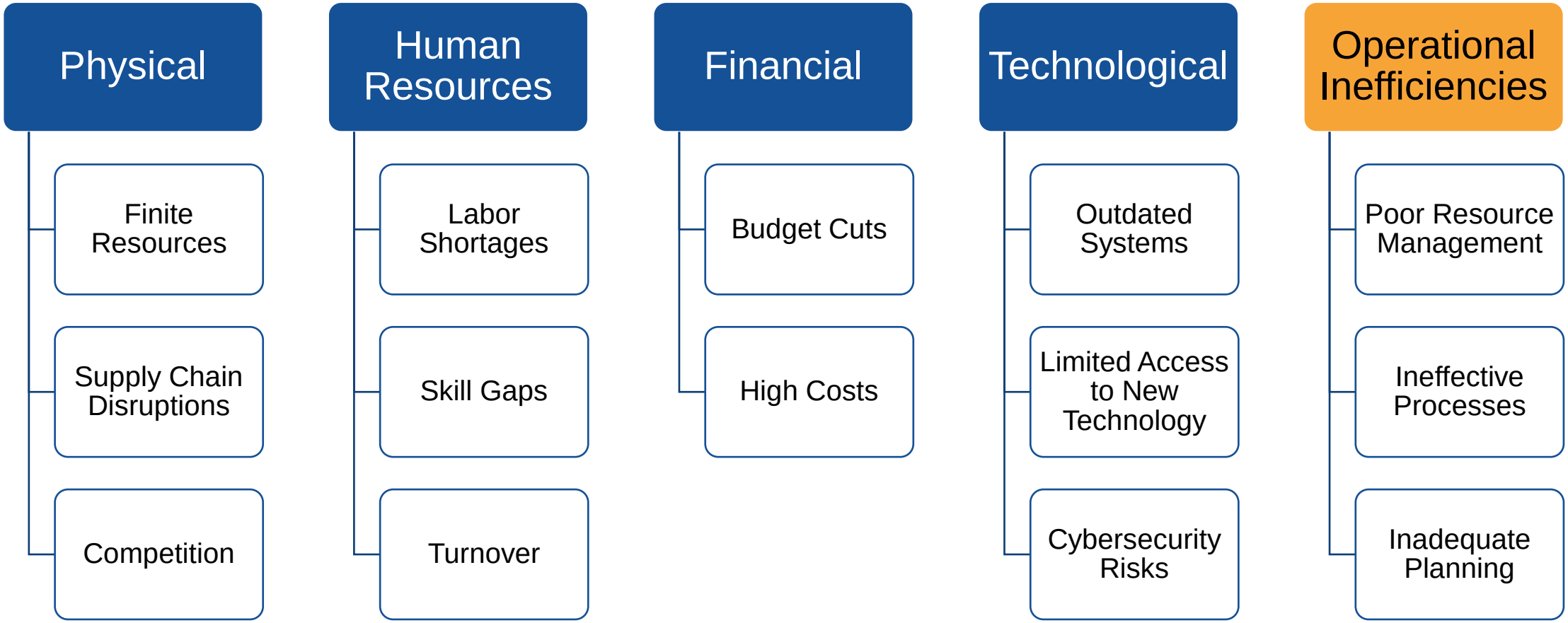
- Understand Resource Limitations: Types, Causes, & Impact
- Examine Solutions & Alternatives: Trade-Offs, Priorities, & Ideal End States
- Measure & Assess Collaborative Success: Key Performance Indicators & Transparent Reporting

Resource Limitations

Resource Limitations: Types



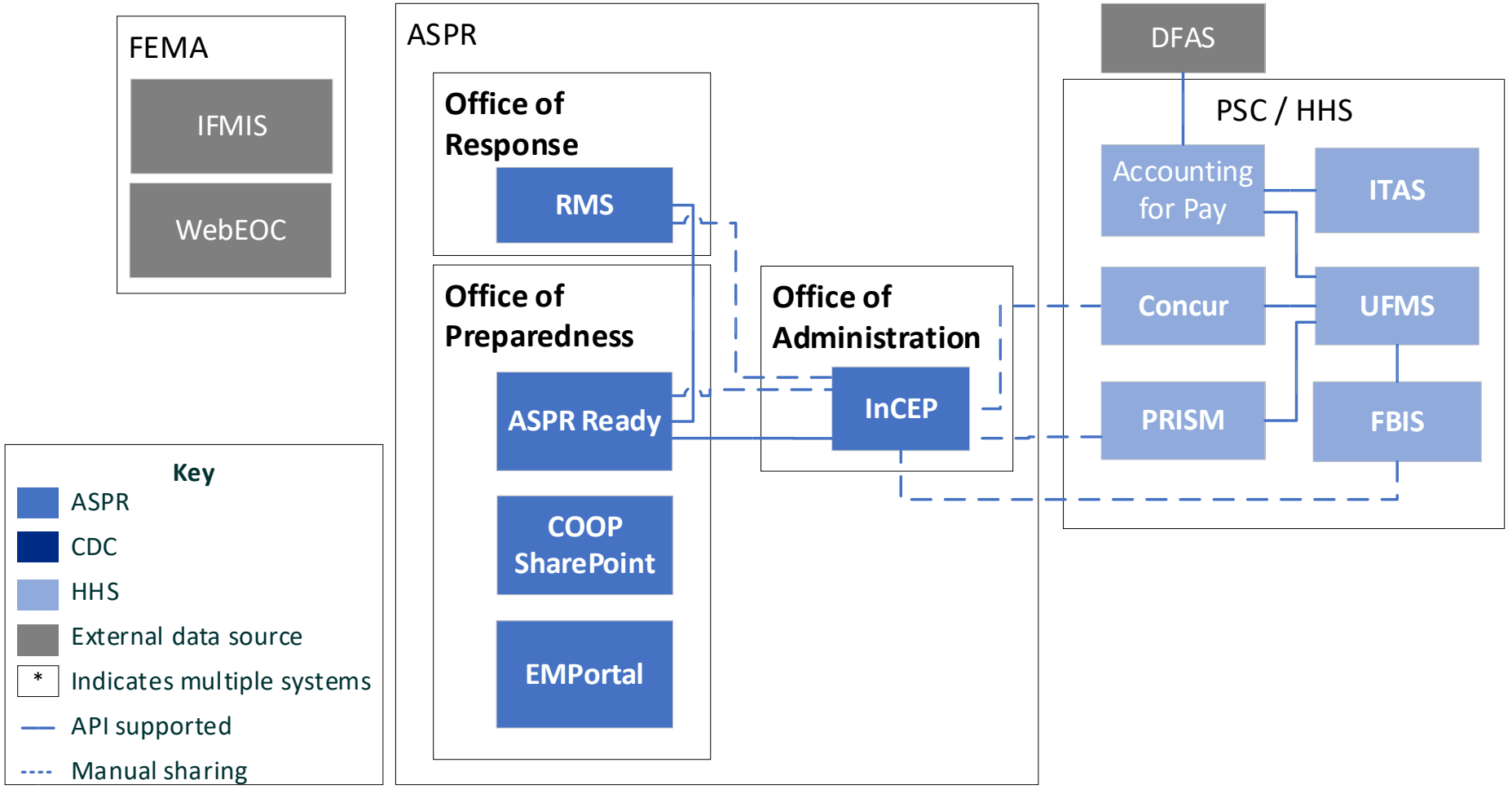
Resource Limitations: Causes



ASPR Resource Limitations: Data Systems

ASPR Data Systems Overview v2.1

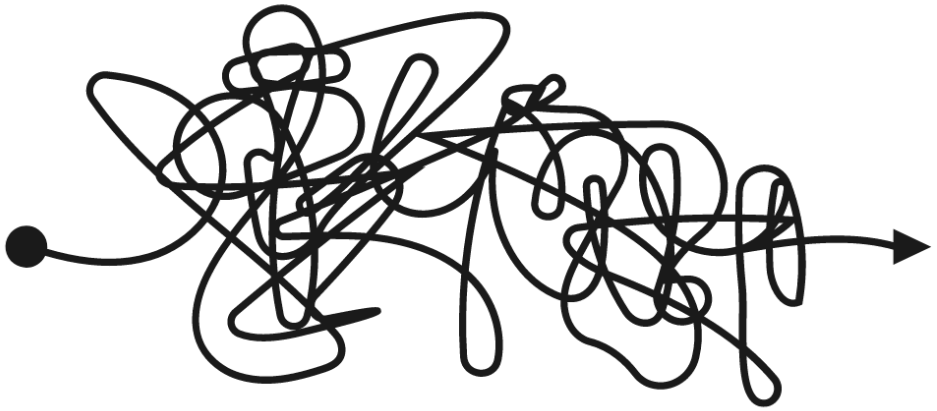
Last Updated: 2024-11-12



Resource Limitations: Impacts

- Reduced Productivity & Efficiency
- Decreased Quality of Products or Services
- Higher Operational Costs
- Lower Employee Morale & Higher Turnover
- Inability to Meet Demand or Scale Operations
- Increased Risk of Compliance & Safety Issues
- Lower Organizational Resilience & Adaptability
- Negative Customer Experience & Satisfaction

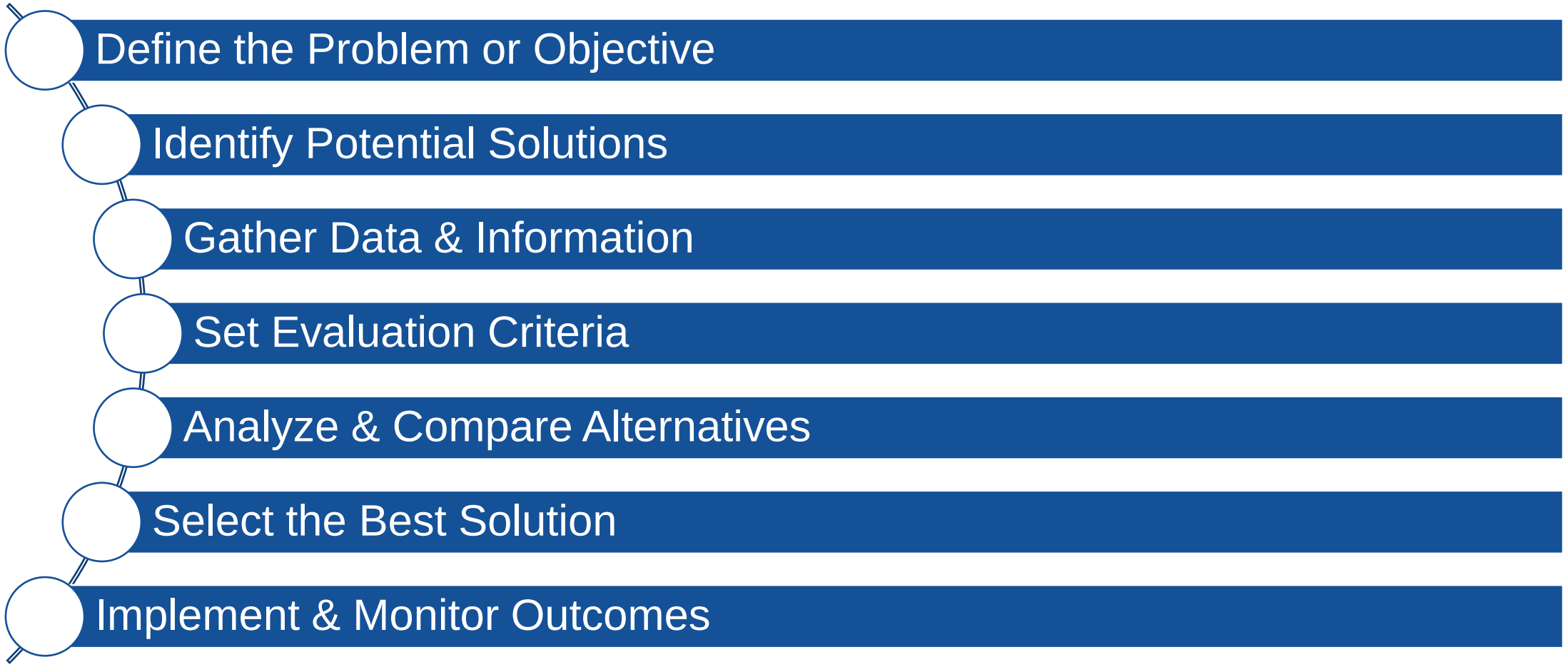
ASPR Resource Limitation Impacts



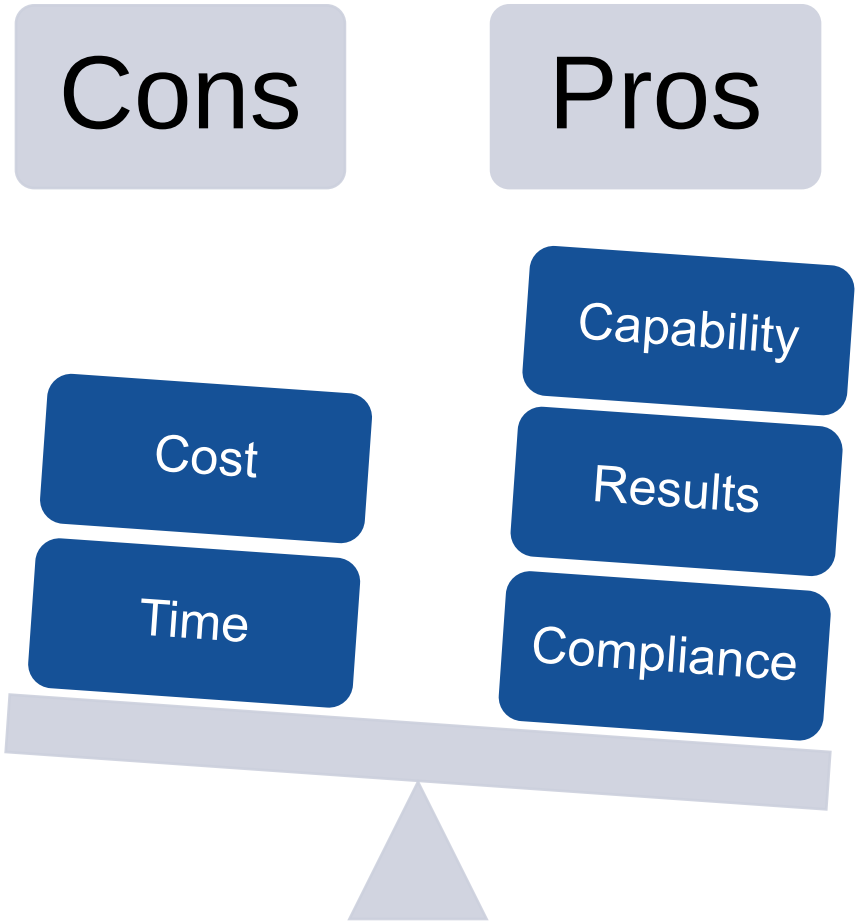
- Late to mission need
- Response varies by Region
- Response varies by emergency
- Burden to personnel
- Financial liability with FEMA Mission Assignments
- Cycles of inefficiency increasing organization risk

Solutions & Alternatives

Solutions & Alternatives



ASPR Data Systems Analysis

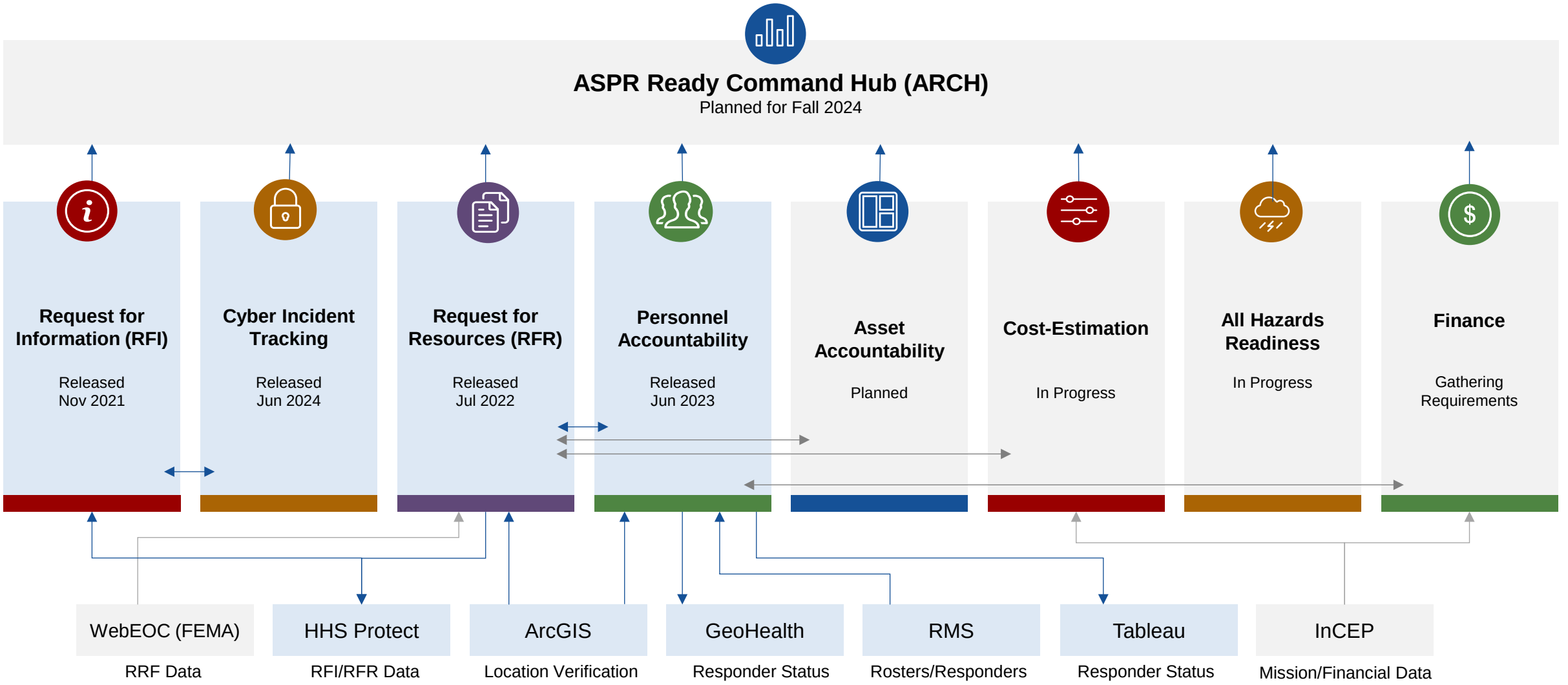


Ideal End State:

- Automation
- Efficiency
- Demonstrated Compliance
- Accuracy
- Quicker Processing Times

ASPR Ready Concept of Operations

Legend
Released
Planned



Benefits of ASPR Ready

Modern Technology

Advanced technology, leveraging innovative technical solutions

Security

Hosted in AWS GovCloud environment to meet Federal security compliance requirements

Reliability

Resilient framework, protecting critical capabilities

Efficiency

Streamlined processes and increased automation

Centralized, Mobile-Friendly Platform

Cost-Effectiveness

Cost-effective solution, reducing time and resources

Scalability

Scalable solution, providing opportunities for growth

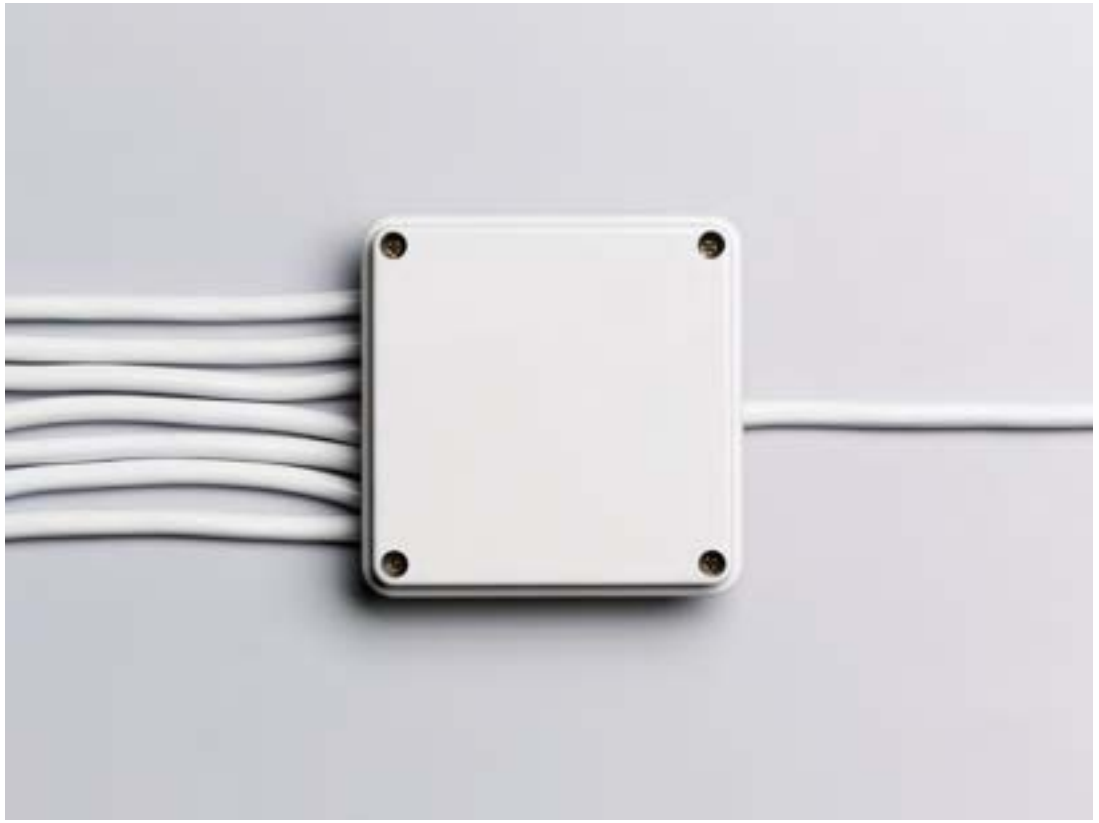
Maintainability

Consolidation of technology makes it easier to maintain

Usability

Intuitive, user-friendly interface that provides mobility and versatility

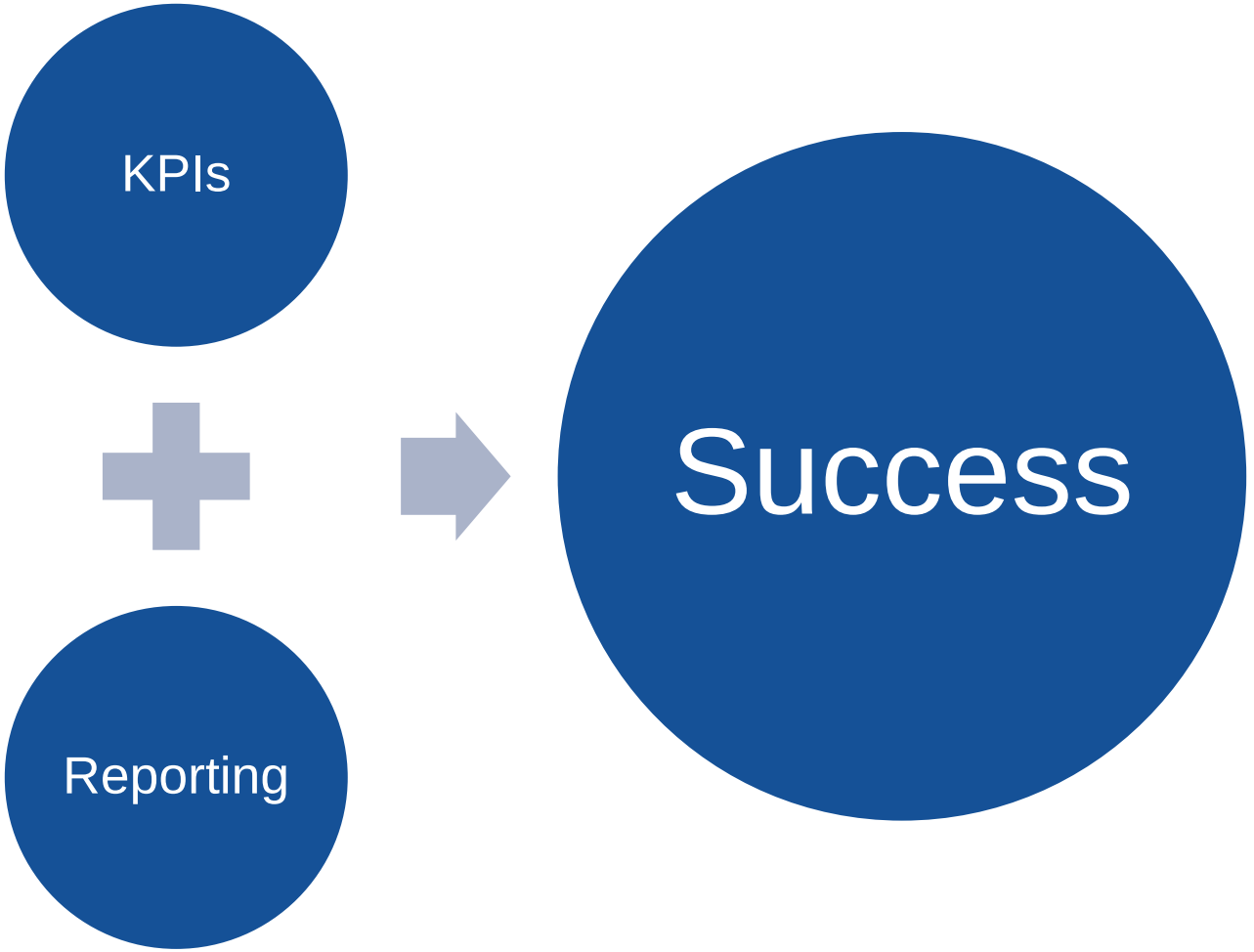
ASPR Ready Solutions



- Automated processes
- Email & text notifications
- Improved processing speed
- Programmed Internal controls
- InCEP integration
- Expanded reporting capability

Measuring & Assessing Collaborative Success

What Does Success Look Like?



What Does Success Look Like?

Key Performance Indicators

- Mission Assignments accepted within 1 hour
- Travel Vouchers submitted within 5 days of return
- FEMA bills submitted every 30 days
- Mission Assignments closed out within 180 days

Transparent Reporting

- Status of funds
- Status of caches
- Personnel accountability
- KPI results

So What?


Typhoon Mawar


Hurricane Helene


Hurricane Irma


Hurricane Sandy

Takeaways

- Define problems in meaningful ways
- Think creatively
- Employ a “best idea wins” strategy
- Set everyone up for success
- Don’t give up!

Questions?

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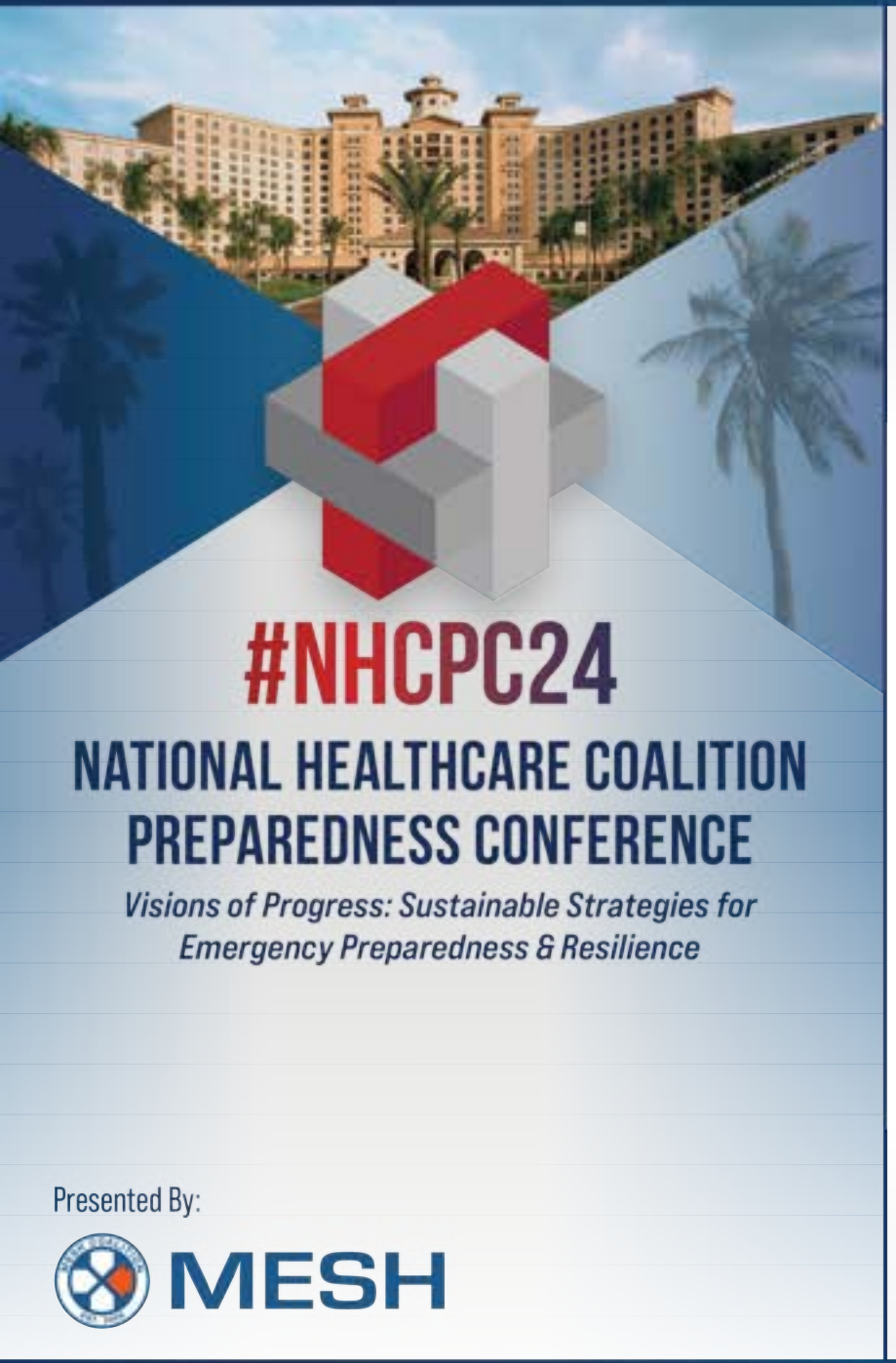


Healthcare Coalitions and EMS

Leveraging new alliances with old partners

Greg Santa Maria, DHSc, MA, NR-P

Housekeeping

- My opinions are my own and are based on
  - Case studies and other research
  - Operational experience
- If while I am making observation you feel like I am picking on you
  - I probably am, but know I am also picking on me
- You are free to disagree

Background

- Paramedic for 30 years
- Masters in EM
- Doctorate in Health Science
- Research interests in crisis decision making and EMS response
- Healthcare Preparedness SME
- ED for South Dakota HCC

EMS

- Originated as a hospital-based response model
- The first healthcare professionals that disaster patients interact with
- Is inappropriately included in the same category as Fire and Law Enforcement while it has much more in common with healthcare and hospital service

Why should HCC's focus on EMS as a primary partner?

- Fire and LE move from dispatch to scene to available
- EMS moves from dispatch to scene to hospital
- EMS operates within the healthcare discipline daily
- In large scale events, EMS may assist with decompression
- In mass casualties, EMS is the extension of the ED

Ongoing case study

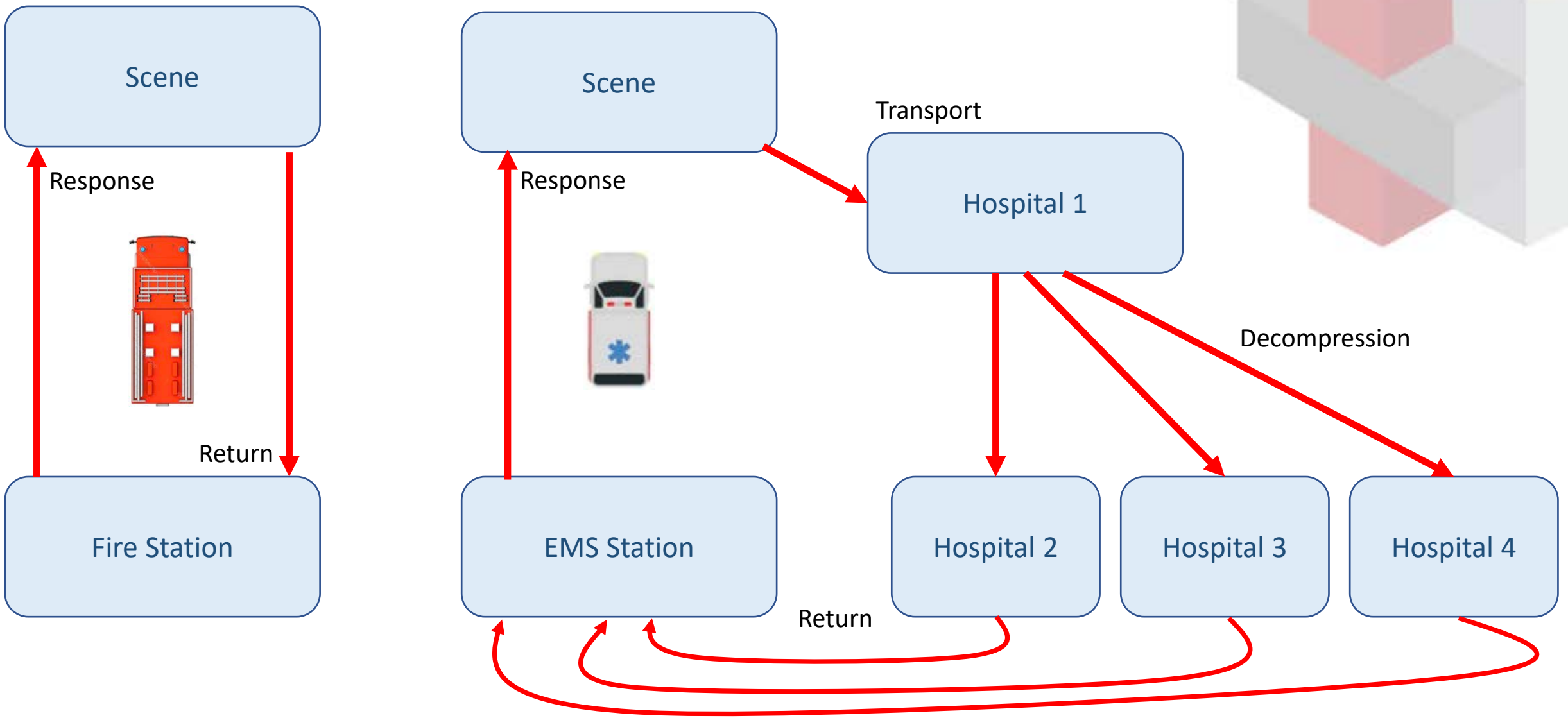
- Research large event responses
- Identify similarities in response issues
- Determine causative factors
- Implement change

- 1993 WTC
- 1995 OKC
- 1995 Tokyo
- 2001 WTC
- 2003 Toronto
- 2003 Jerusalem
- 2004 Madrid
- 2004 Beslan
- 2005 London
- 2013 Boston*
- 2017 Las Vegas

Case study findings

- EMS encounters a mostly dynamic situation
  - Patient loads demand immediate action
  - Medical Branch Operations are time consuming
  - Responder stress and the demand for help (victims)
- HCC’s communicate during events
  - EMS Communications with HCC’s may not be existent

Incident life cycle



NIMS

- NIMS doctrine is focused on not changing what we do everyday
- ICS changes EMS operations to an unfamiliar model
- NIMS training and exercises do not prepare EMS providers for large scale chaotic scenes where “organization” may take several hours

Training

- EMS gets minimal training in MCI management
- EMS has a core-based training related to closest hospitals
- MRSE confirms how long it takes to move patients with actual resources
- Regular training may focus on more day-to-day operations and clinical approaches to patient care and not coordination with HCC's, MCI, and facility decompression
  - This is a performance GAP between HCC's and EMS Partners

Exercise inefficiencies

- **EMS is typically not included in healthcare exercises**
- Independent EMS (non-fire based) is typically not included in first responder exercises
- Volunteer and rural EMS have daily staffing issues that prevent exercise participation

Is EMS on our primary exercise invite list?

THE VISION ▸▸▸

Healthcare systems, including EMS, are fully integrated with each other and with the communities in which they operate. Additionally, local EMS services collaborate frequently with their community partners, including public safety agencies, public health, social services and public works. Communication and coordination between different parts of the care continuum are seamless, leaving people with a feeling that one system, comprising many integrated parts, is caring for them and their families.

EMS Agenda for the Future - 2050

Healthcare coalition exercises

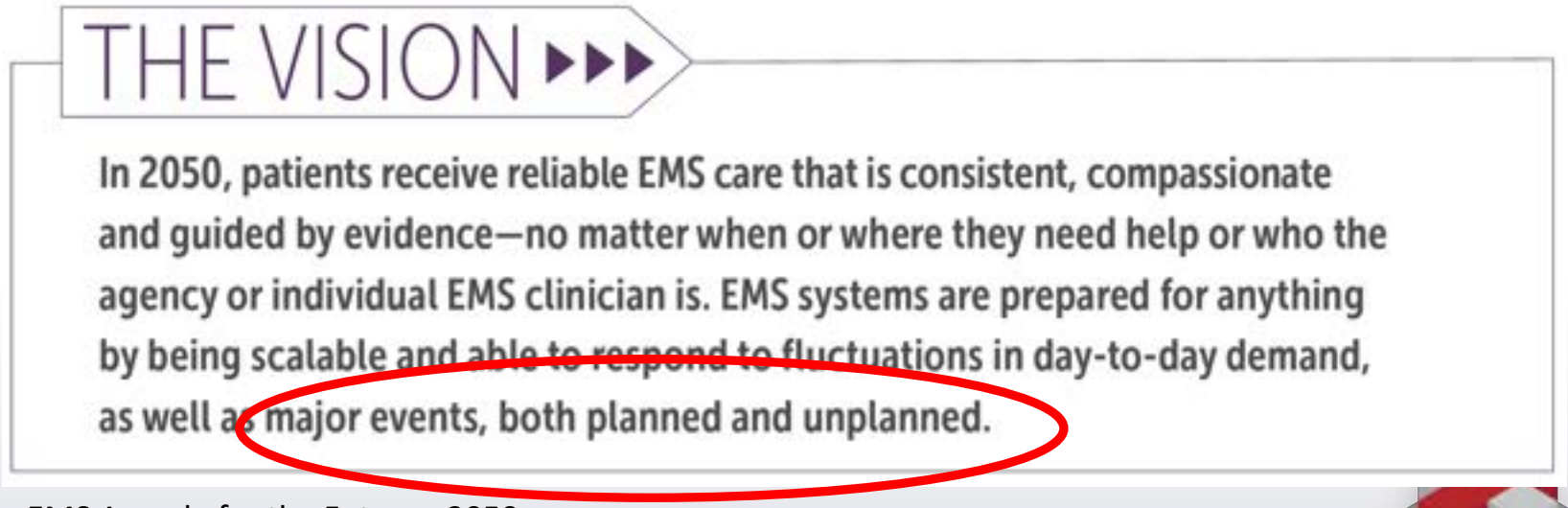
- EMS is not a typical participant in healthcare exercises
- Hospitals “discuss” expectations and assumptions related to EMS
  - Assumption based planning is regularly skewed
  - Often overestimate EMS capabilities
- Local providers are rarely at the planning table
  - Especially in overtaxed areas

New cycle expansion

- What is the ratio of membership?
  - Appendix Z partners
  - **EMS partners**
  - EM partners
  - Public Health partners
  - ESF-8 Partners
  - At-Large partners
- EMS has leadership roles and clear voice
  - EMS comes in many forms

HCC Planning

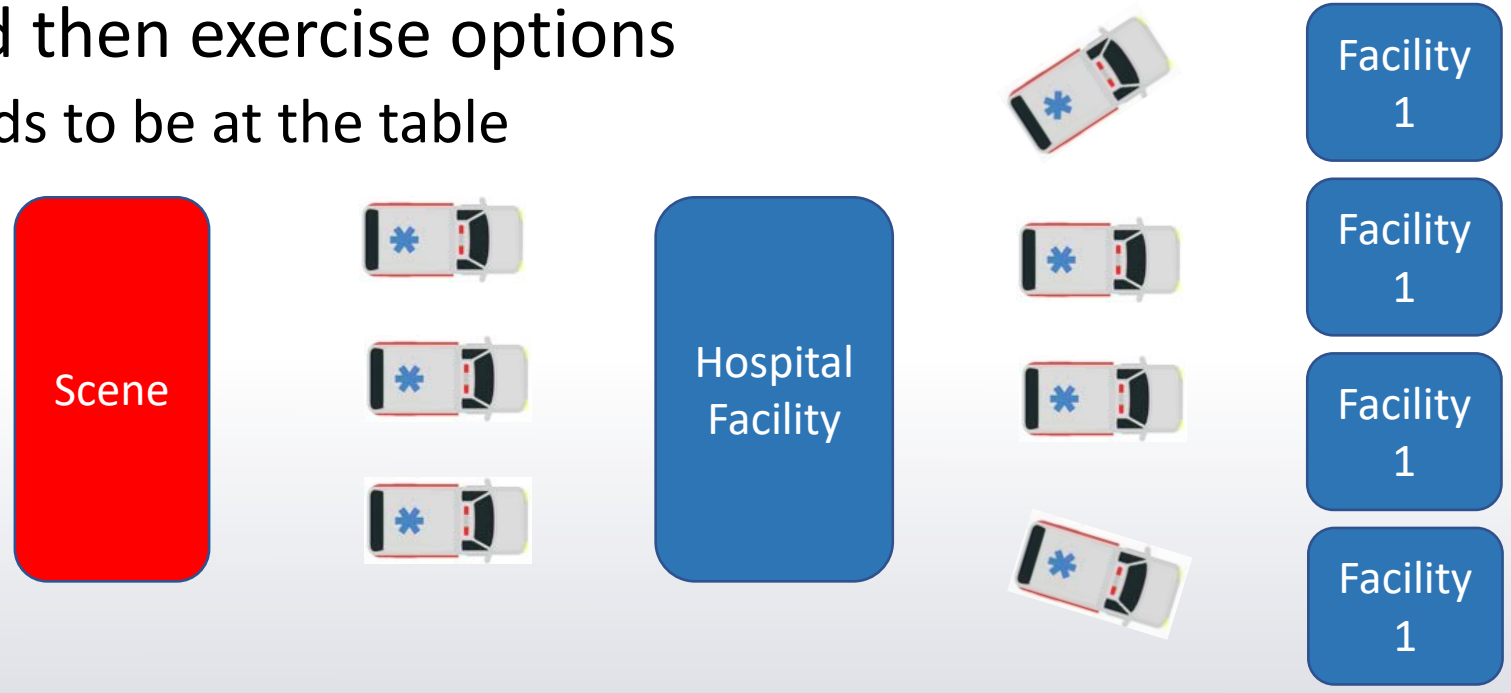
- Is there EMS representation on planning committees?
  - Threat assessments
  - Involvement in plans and annexes
  - Response structure
    - Ability to activate coalition during crisis
  - After action reporting



EMS Agenda for the Future - 2050

Modification of response processes?

- Do we reconfigure the response structure to the geography?
- Are there alternative options for EMS response?
  - If Medical Branch Operations are cumbersome, what isn't?
  - Especially true in rural and frontier
- Define, and then exercise options
  - EMS needs to be at the table



HCC involvement

- EMS coalitions and memberships
  - SDAA and SDEMA
  - Transportation plan
  - EMS involved in Ebola and other specialty planning
    - No continuity after that
    - COVID?
  - Some positive examples
    - Decon training in SD
      - Decon-triage-transport cross training

Gap analysis

- Big gap in knowledge between coalitions and EMS
  - In planning priorities
  - In regulatory issues
  - In C-Suite awareness
  - In healthcare communities

Have we asked our EMS partners what they need?

Adding a second floor

- EMS advisory group
  - Paid ALS service
  - Volunteer ALS service
  - Hospital Based ALS Service
  - Hospital Based BLS service
  - Fire Based service
  - State EMS Director
  - SDHCC Executive Director
  - Volunteer BLS Service

Goals of EMS advisory

- EMS – Healthcare Summit
  - Rural EMS
  - Healthcare planners
  - C-Suite execs
- Adding tiered membership positions for EMS leadership
  - SDEMSA
  - SDAA
  - EMS-C

New concept

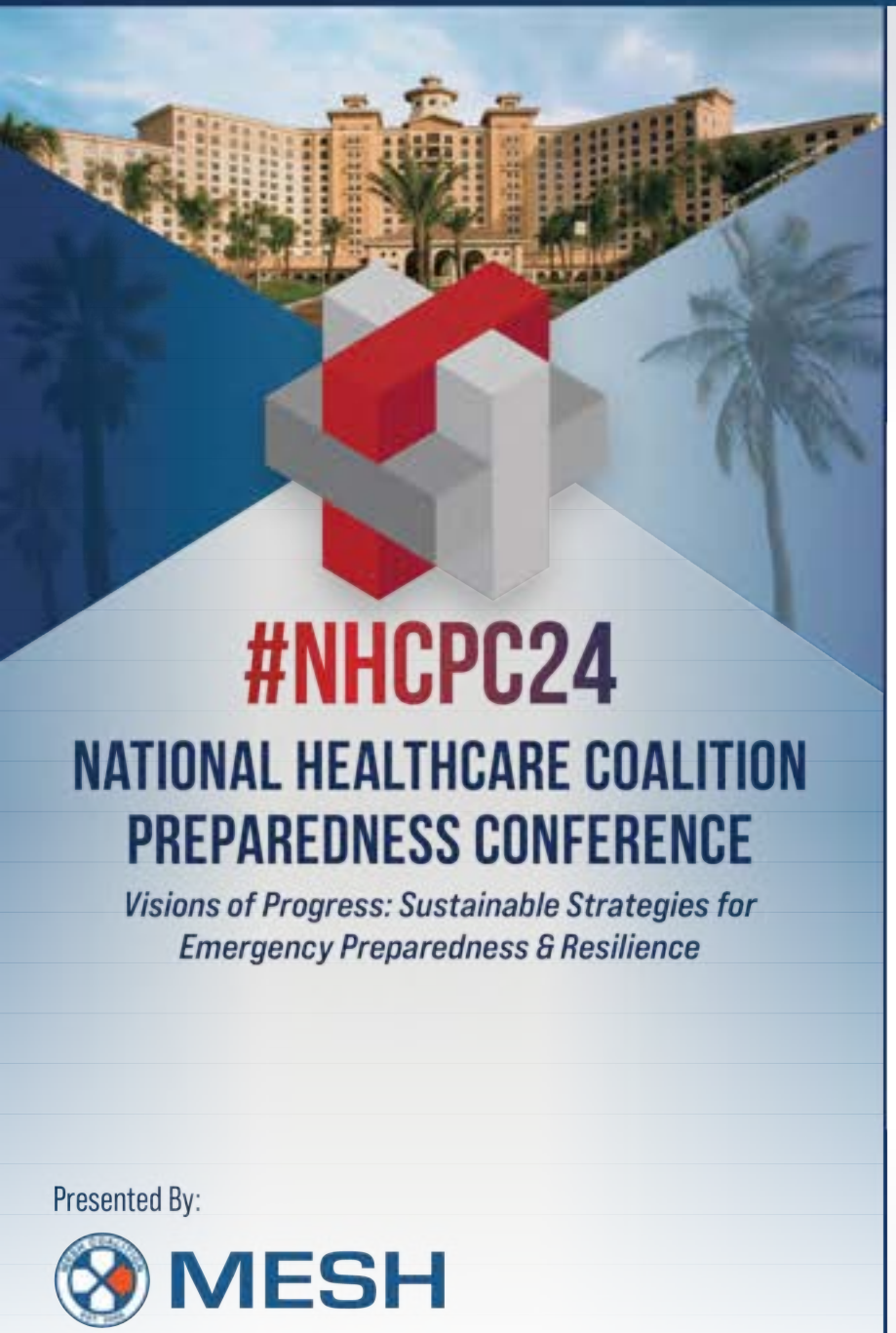
- HAVBed
  - Facilities report staffed beds
  - Can EMS report staffed units?

Final thoughts – Combining goals

- ASPR HPP Cycle (work plan)
- National Healthcare Security Strategy
- EMS Agenda for the Future
- ASPR NACSD/NACCD/NACIDD
- Appendix Z
- Joint Commission

Questions


SOUTH DAKOTA HEALTH CARE COALITION
SD
Partners in Preparedness



Healthcare Coalitions:

Ready to Respond

Luke Aurner MS, CCEMT-P I/C, CHEC-I, PEM
MI Region 6 HPP Coordinator

Julie Bulson DNP, MPA, RN, NE-BC, HcEM-M
Director, Business Assurance, Corewell Health

Speaker Introductions

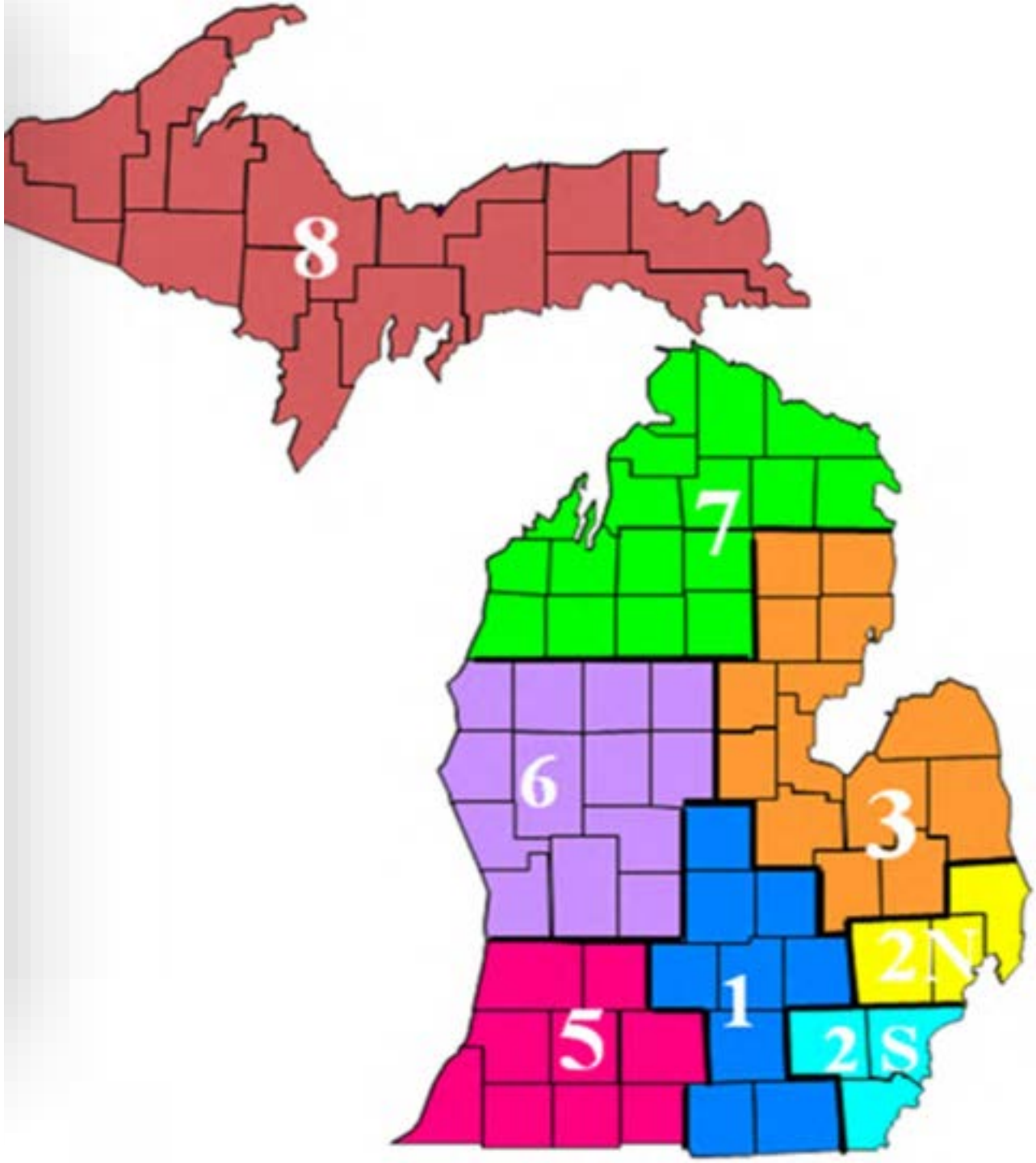
- Luke Aurner MS, CCEMT-P I/C, PEM, HcEM-M
  - Michigan Region 6 Healthcare Coalition Coordinator
- Julie Bulson DNP, MPA, RN, NE-BC, HcEM-M
  - Director, Business Assurance, Corewell Health
- We have no conflicts of interest to acknowledge

Organization Overview – Corewell Health

- 21 hospital facilities
  - 1 children's hospital
  - 2 level 1 trauma unit with burn capability; 4 level 2 trauma units
  - 1 regional emerging special pathogen unit; 1 level 2 special pathogen unit
- 300+ Ambulatory / Outpatient locations
- 1 Insurance company
- 5,000+ licensed beds
  - 264, 179 inpatient admissions; 949, 658 ED visits
- 65,000+ team members
  - 12,000+ affiliated, independent and employed physicians and APPs
  - 15,500+ nurses
- 1.3+ million health plan members
- 9,000+ employers contracted by Priority Health

Organizational Overview – MI Region 6

- Population – 1,550,418 9,671 square miles
- 77 miles of Lake Michigan shoreline
- Major tourist destination events
- 22 Hospitals with Emergency Departments
- 1 Children's Specialty Hospital
- 11 Medical Control Authorities
- 10 EMS Agencies
- 63 Long Term Care Facilities
- 40 Assisted Living Centers
- 7 Public Health Departments
- 1 Federally Recognized Sovereign Nation
- 14 Emergency Management Programs
- 8 Homecare/Hospice Agencies
- 11 Community Mental Health Agencies



Objectives

- Describe the evolution and current state of the Healthcare Preparedness Program including Healthcare Coalitions and their role in emergency response.
- Identify the key functions and capabilities of the healthcare coalitions in facilitating situational awareness, surge management, resource allocation, and alternate care site establishment during complex incidents.
- Analyze real life examples of successful responses by a Midwest Healthcare Coalition and apply the lessons learned to their own coalition context.

Introduction

- Since the inception of Healthcare Coalitions in 2002, there has been some level of response engrained in the overarching framework as designed by HRSA and then ASPR.
- In the beginning, coalitions had the core functions of preparedness; provision of situational awareness; facilitation of surge management; allocation of scarce resources; and establishment of alternate care sites.
- As the preparedness front became more demanding and more complex due to an increase of large health systems and more complicated responses (e.g., cyber, etc) the healthcare coalitions have evolved to meet the demand of complexity.

Evolution of the Healthcare Preparedness Program

- After 9-11, a need was identified for better coordination and cooperation between hospitals, EMS, and public health.
- Northern Virginia Hospital Alliance (NVHA) was formed in 2002 as both a planning and response entity with an initial focus place on creating a real time information sharing and management system.
- Intent of the HPP funding is to ensure connectivity continues to be developed and planned for with all partners within the healthcare sector.
- Healthcare coalitions serve as the convener!

Hanfling, 2013

Healthcare Coalitions as a Response Entity

- It is critical the healthcare coalition is tied into the local emergency management structure.
- Healthcare coalitions organized to form regional networks can improve communications of resource needs and provide situational awareness enhancing the response management of arriving patients.

Hanfling, 2013

Healthcare Coalitions as a Response Entity

Capabilities of HCC during complex incidents

- Facilitation of situational awareness
- Ensuring continuity of health care service delivery
- Surge management
- Resource coordination and allocation
- Alternate care sites

Coordination of this magnitude allows for healthcare leaders to focus on the clinical response required to support the victims of the incident.

Healthcare Coalitions as a Response Entity
Responses

COVID

Newaygo County Ice Storm / Power outage (2022)

Tornado Response- Belmont (2023)

Tornado Response- Region 5 (2024)

Civil Unrest (2023)

Baxter Fluid Shortage (2024)

Healthcare Cyber Attack- Multiple (2024)

Best Practices and Challenges

- Communication is Key!
  - Must have an open line with your partners
- Trust
  - Partners need to know they can trust you.
- Cooperation with partners and neighbors
  - Foster a collaborative environment. Ask for help when needed.
- Understanding of your partners priorities and needs

Future Direction
Goals

- Enhanced Regional Situational Awareness
- Adaptive Resource Allocation
- Comprehensive Training and Credentialing Pathways
- Advanced Crisis Communication Systems
- Data Analytics and Predictive Modeling

Future Direction
Lessons Learned

- Strengthen Inter-agency Communication
- Streamline Resource and Asset Management
- Increase Workforce Preparedness and Cross-Training
- Develop Unified Cybersecurity Response
- Enhance Data Collection and Utilization
- Integrate behavioral health in planning
- Enhance Training and Exercising

Conclusion

- Hospitals and other healthcare response agencies must work together under the framework of a healthcare coalition to ensure collaboration, coordination, and consistency using a systems approach to disaster planning and response.

Conclusion

“Strong, robust, and well managed healthcare coalitions will play an important role in enhancing the response to any catastrophic event and may be uniquely positioned to be able to coordinate key response actions that cross jurisdictional lines” (Hanfling, 2013).

Questions

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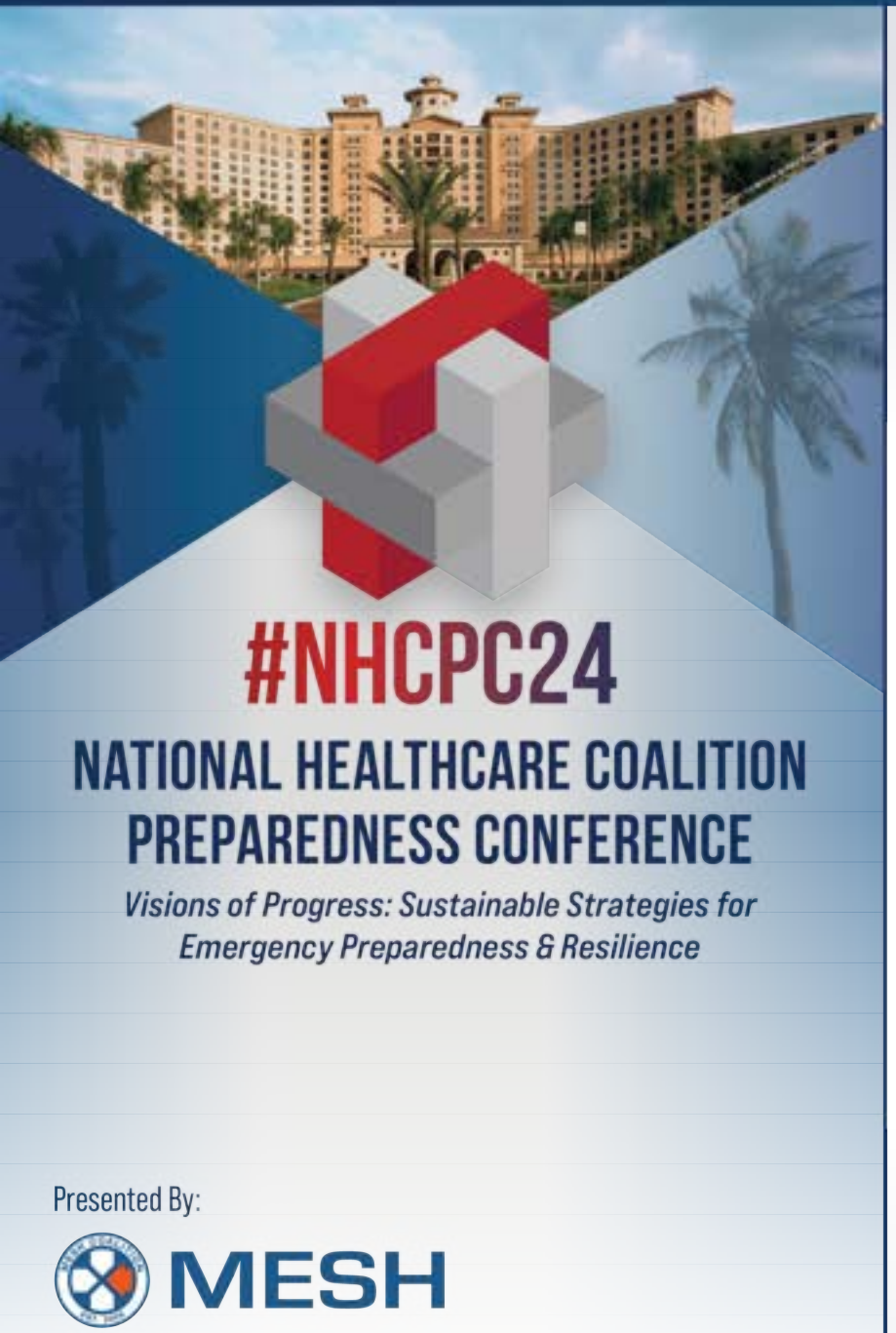
- Julie Bulson DNP, MPA, RN, NE-BC, HcEM-M
- Director, Business Assurance, Corewell Health
- Julie.bulson@corewellhealth.org

References

- Hanfling, D. (2013). Role of regional healthcare coalitions in managing and coordinating disaster response. White paper for workshop on National Response to an Improvised Nuclear Attack, National Academy of Science, Institute of Medicine.
- Harvey, M., Hunt, R., Hick, J. & Hanfling, D. (2017). Letters to the editor. *Annals of Emergency Medicine, 70*(1), 106 – 107.
- Upton, L., Kirsch, T. D., Harvey, M., & Hanfling, D. (2017). Health care coalitions as response organizations: Houston after hurricane Harvey. *Disaster Medicine and Public Health Preparedness, 11*(6), 637 – 639. doi: 10.1017/dmp.2017.141



Long Term Care Facilities and HCCs: Increasing representation and participation

Long Term Care Transformation Office –
Pennsylvania Department of Health

Andrew Zechman, PHPM, MBS, EMT
Eric Laumer, PHPA, BS

Agenda

- Background on COVID in Long-Term Care Facilities (LTCFs) in Pennsylvania
- Formation of foundational programs: Regional Response Health Collaborative Program (RRHCP) & Long-Term Care Resiliency, Infrastructure Supports, and Empowerment (LTC RISE)
- Discussion of parallel, collaborative COVID-19 response efforts
- Formation of Long-Term Care Transformation Office, inspired by collaboration and resiliency building efforts
- Partnership with Health Care Coalitions (HCC)

Learning Objectives

Learning Objective #1:
"The learner should be able to describe the value of a multidisciplinary team collaborative efforts in fostering emergency preparedness, response and resilience."

Learning Objective #2:
"The learner should be able to evaluate how effective partnerships improve preparedness planning and response capacity in their organization on multiple levels."

Learning Objective #3:
"The learner should be able to discuss best practices for building/maintaining partnerships to promote resilience/heighten capacity for efficient crisis response."

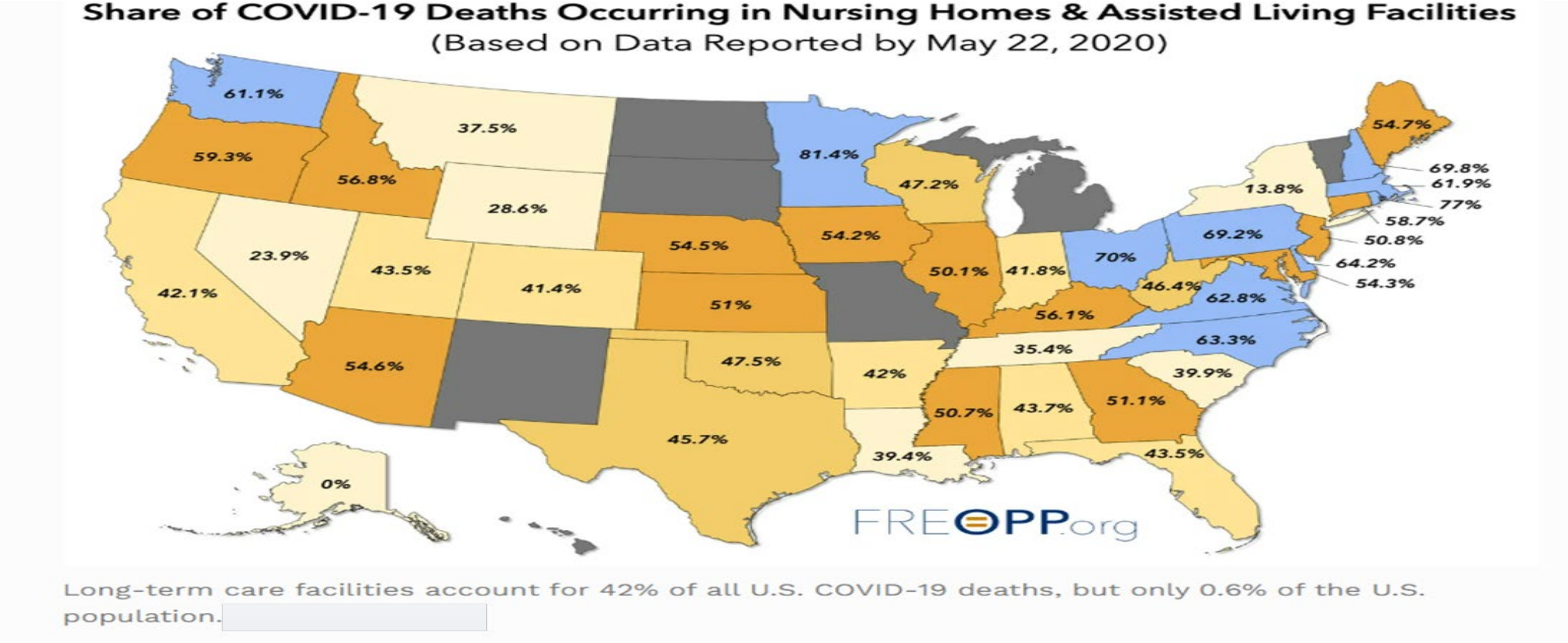
Background/Purpose: COVID-19 and its impact on Long Term Care in Pennsylvania

The COVID-19 pandemic disproportionately impacted long-term care facilities (LTCFs), leading to significant morbidity and mortality. The devasting impacts led to unprecedented crisis response involving active collaboration of multi-sector stakeholders. It is imperative moving forward:

- LTCF's ***NEED*** to have strong representation with respective healthcare coalitions (HCCs).
  - By being "at the table" (Long Term Care Subcommittees) they are better situated to understand what resources may be available from HCCs, partner to produce more efficient operations and better outcomes for residents.

United States Long Term Care and COVID-19 Pandemic

COVID-19 disproportionately impacted long-term care facility residents and staff, leading to disparate mortality and morbidity.



Source: [The Foundation for Research on Equal Opportunity]

#NHCPC24

Discussion: PA Immediate Response to COVID in LTC Facilities – Spring 2020

Formation of LTC Task Force (LTC-TF)*

- PA Department of Health (DOH)
- PA Department of Human Services (DHS)
- Pennsylvania Emergency Management Agency (PEMA)
- PA Department of Military and Veterans Affairs (DMVA)
- PA National Guard (PANG)

***The LTC-TF guided COVID-19 response efforts in LTCFs from March 2020 - January 2023**

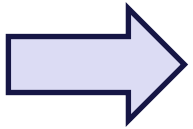
Formation of RRHCP

Through the procurement and direction of the LTC-TF, 7 health systems across PA provided immediate COVID-19 outbreak response support through staffing resources, testing, PPE, and onsite consultation

Discussion: Determining the future of LTC support involved leveraging strong existing foundations

LTC Support & Response Tactics

As Pennsylvania rebuilt from COVID, DOH has the opportunity to leverage its LTC facility (LTCF) COVID response tactics **to improve residents' quality of life** through creating a sustainable and enduring LTC support strategy that focuses on enabling **rebuilding** and **resilience in LTCF.**

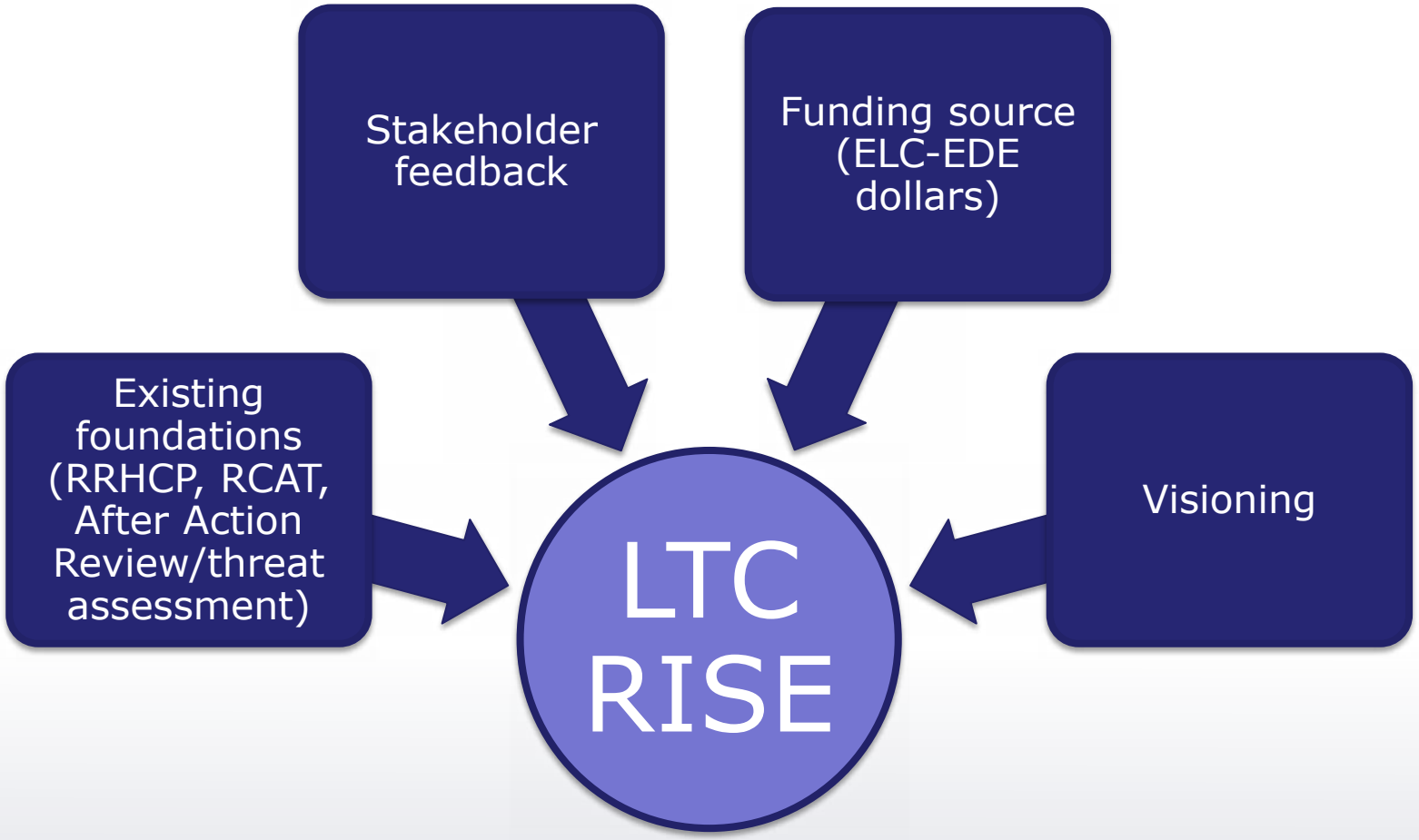


Leveraging Existing Foundations

Regional Response Health Collaborative Partnership (RRHC)/ Regional Congregate Care Assistance Teams (RCAT)

Long-term Care Task Force (LTC-TF)

In May 2021, leveraging existing foundations, stakeholder feedback, funding, and visioning exercises PA began to shift from response focus to resiliency building



Long-term care resiliency, infrastructure supports, and empowerment

LTC RISE is Focused on resiliency with response component

Resiliency

Resilient LTC workforce

Promote **professional development and a resilient long-term care facility workforce** through improving LTCF staffs' physical and psychological well-being.

Resident centered care

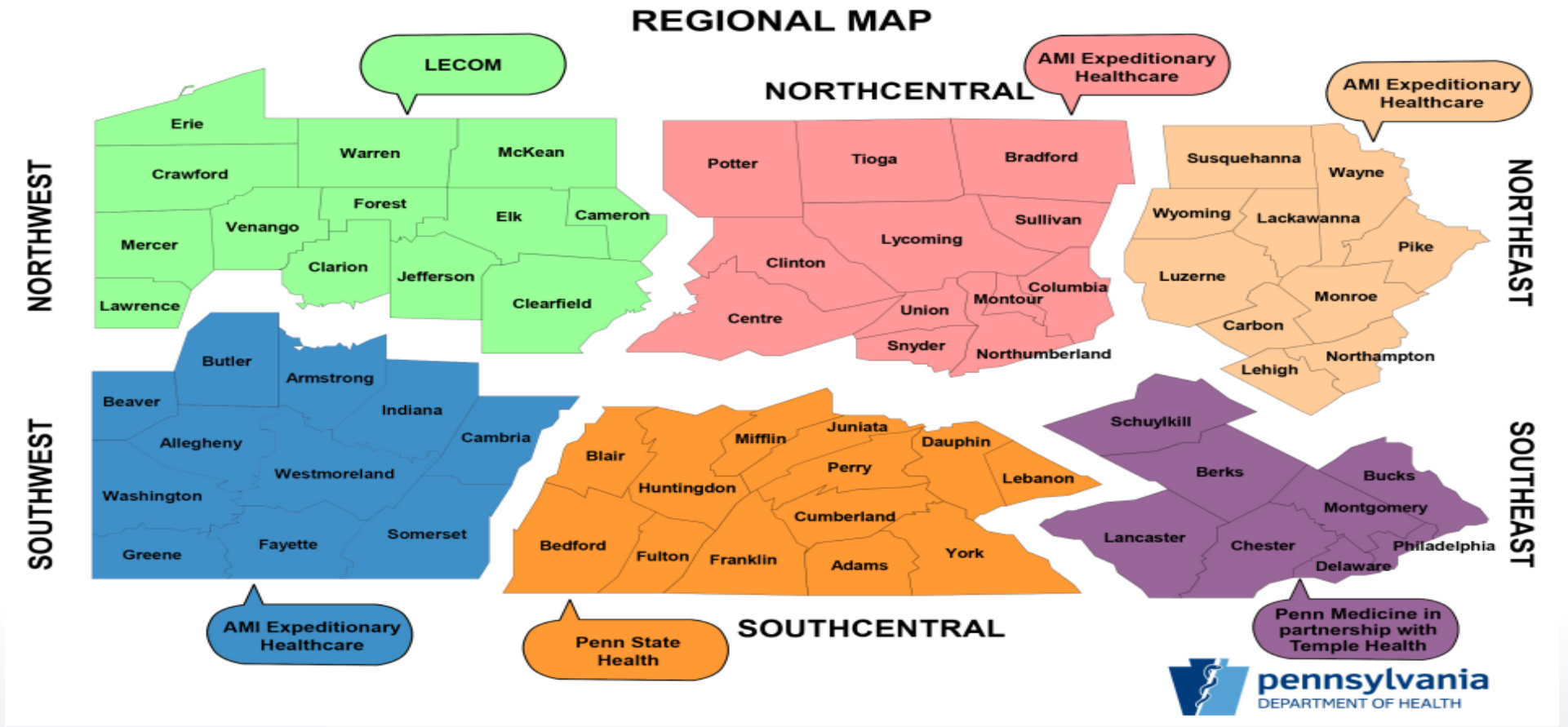
- Implement **infection prevention and control and emergency preparedness** best practices to optimize, and minimize disruption of, **resident-centered care** through quality improvement projects focusing on:
  - **1.What matters** to residents and families – acting on resident's specific health outcome goals and care preferences
  - **2.Mobility** – ensuring residents move safely each day to maintain function
  - **3.Mentation** – supporting cognitive and psychological well-being
  - **4.Other infection and prevention control measures**, including evaluation of, and providing recommendations for, engineering and administrative controls to prevent COVID-19 and other emerging infections

Rapid response construct

- Develop a **sustainable and self-reliant outbreak response construct** through:
  - Engaging region and local community
  - Coordination of resources and sharing of best practices among LTCFs and others in the field

pennsylvania
DEPARTMENT OF HEALTH

The following organizations cover six regions across PA to support outbreak response and quality improvement work



#NHCPC24

LTC RISE parallel COVID-19 response efforts: Collaboration is key!

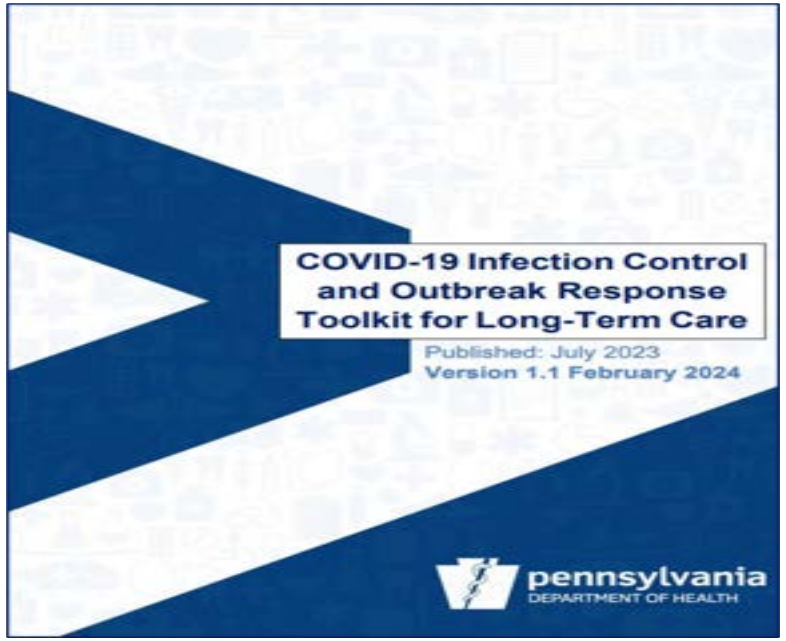
COVID-19 Parallel Response Efforts

•In collaboration with the following agencies, LTCF crisis support requests were handled by the LTC-TF between **March 2020 and May 2023**

- Pennsylvania National Guard
- Bureau of Emergency Preparedness & Response
- Bureau of Epidemiology
- Bureau of Laboratory
- Bureau of Community Health Systems
- Healthcare Coalitions

Crisis Support Category	Request Received
Staffing	502
Personal Protective Equipment	848
Testing Supplies	2,336

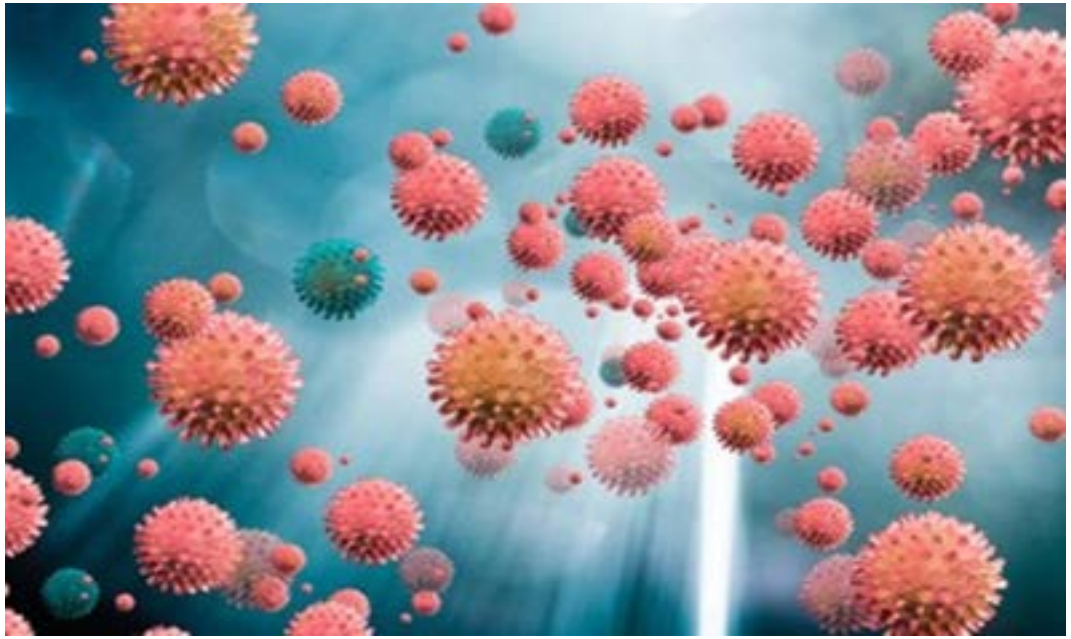
Collaborative Effort: COVID-19 Toolkit for LTC



- Provides guidance, tools, and resources to aid LTC facilities before, during, and after a COVID-19 outbreak
- Creates facility readiness for other disease events

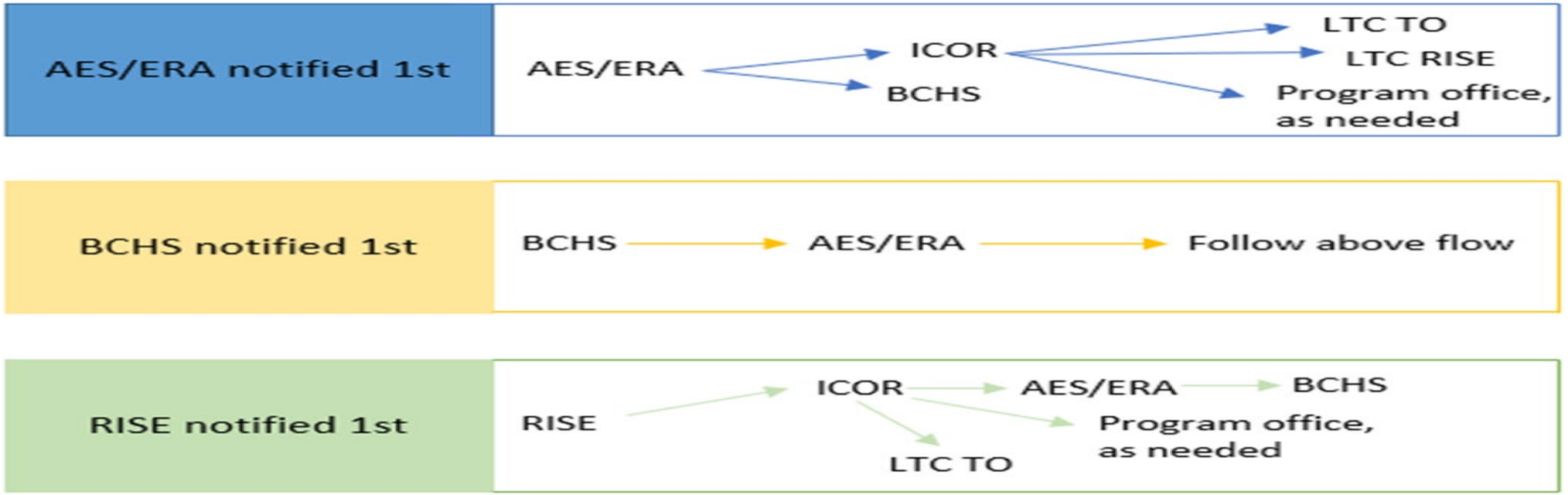
COVID-19 LTC Toolkit.pdf (pa.gov)

Collaborative Efforts: Multi-pathogen Outbreak



- COVID-19 outbreak plus an outbreak of at least one additional pathogen (e.g., Flu, RSV)
- Protocol for a standardized collaborative response

Multi-pathogen Outbreak Collaboration



Acronyms

AES=Associate Epidemiology Specialist
BCHS=Bureau of Community Health Systems
ERA=Epidemiology Research Associate
ICOR=Infection Control and Outbreak Response
LTC RISE=Long-Term Care Resiliency, Infrastructure Supports, and Empowerment
LTC TO=Long-Term Care Transformation Office
Program office=Various departments/offices with regulatory oversight to LTCFs

Outbreak Documentation Collaboration

- Developed guidelines for incident management, information sharing, and documentation in JUVARE for COVID-19 LTC outbreak response

Collaborative Effort: Juvare Outbreak Incident Reporting Development and Training

In Collaboration with Infection Control Outbreak and Response (ICOR) from the Bureau of Emergency Preparedness and Response, the Long Tern Care Transformation Office developed Standard Operating Guidelines for Documenting Long-Term Care outbreaks and response.

- Juvare training was offered to all Long-Term Care Facilities and RISE partners from the Healthcare Coalitions

- From December 2023 until present time, 949 incidents/responses have been recorded in eICS within Juvare

Juvare Outbreak Incident Coordination

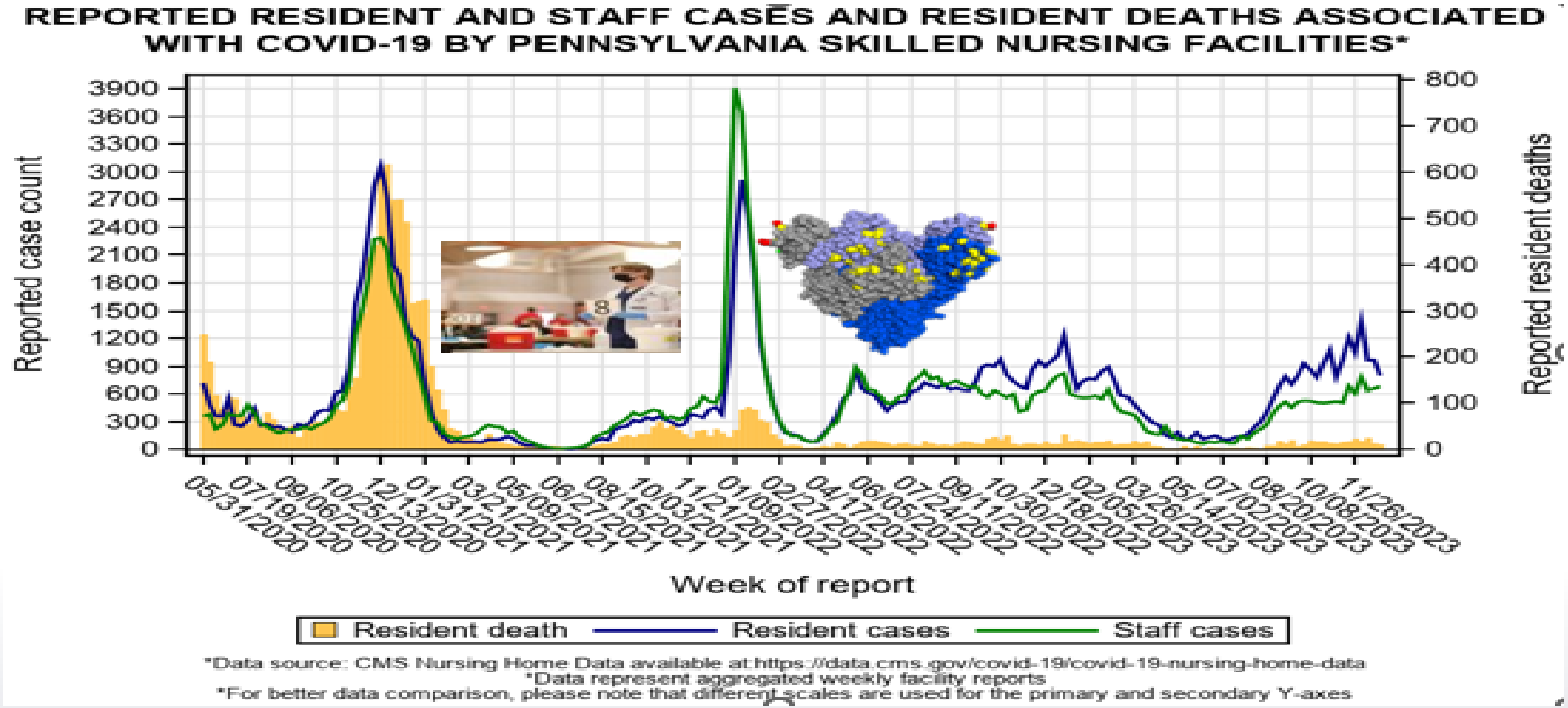
ICOR is notified first of outbreak → ICOR opens outbreak incident in JUVARE *within 1 business day* → ICOR sends immediate notification to LTC RISE using JUVARE messaging

-OR-

LTC RISE notified first of outbreak → LTC RISE opens outbreak incident in JUVARE *within 1 business day* → LTC RISE sends immediate notification to ICOR using JUVARE messaging

JUVARE

Light at End of Tunnel: COVID-19 PA SNF and Case Mortality Data



Permanent Transition from Response to Resiliency

Shift from Response to Resiliency: DOH Initiatives Timeline

Jan 2022 | Mar 2022 | May 2022 | July 2022 | July 2023 | July 2024

Type of support

LTC RISE:
COVID response & resiliency

January 2022 – July 2025

Response:
- Dedicated phone line
- Consultation and technical assistance
- Assessment and feedback
- Training to address issues found in consultation and TA
- Incident management coaching

Resiliency:
- Promote professional development and a resilient LTCF workforce
- Implementation of infection prevention and control and emergency preparedness best practices
- Develop sustainable and self-reliant outbreak response construct

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Quality investment Pilot

March 2023 – July 2024

Resiliency: LTCFs who meet certain predetermined criteria, including specified quality metrics, are eligible to receive funding to be invested in key areas, including workforce development and retention, infection prevention and control, and emergency preparedness. Other facility characteristics affecting a facility's ability to achieve certain levels of the predetermined metrics, including zip code and financial resiliency, to ensure the funding is reaching facilities who are in most need.

Crisis staffing + direct clinical care

Jan 2022 – January 2023

Response:
- Crisis staff: LPN, CNA, RN, medic, general purpose (PANG may provide flu support)
- Direct clinical care: Vax & monoclonal antibody administration, fit testing, testing
- Consultation & assessment support

PPE, testing supplies & support

2020 – March 2023

Response: Provide PPE & outbreak testing support (surveillance in limited circumstances)

The Long-Term Care Transformation Office

- In January 2023, the LTC Transformation Office was established to build resiliency in LTC facilities following previous years' struggles
- Leverage critical lessons learned from LTC COVID response and established programs to inform and drive future long-term care work
- Administer ***LTC RISE***, the Long-Term Care Quality Investment Pilot and other LTC programs developed under the auspices of the Office
- Serve as a coordinating body amongst different bureaus within DOH who have a role in long-term care and amongst sister agencies who work in the LTC space including DHS, Aging, PEMA and DMVA
- Work with Governor's Office and legislature to support long-term care priorities
- Liaise with national stakeholders, including CMS to discuss, promote, and receive feedback on Pennsylvania's long-term care efforts

The Long-Term Care Transformation Office took into consideration multiple authoritative sources when developing priority areas

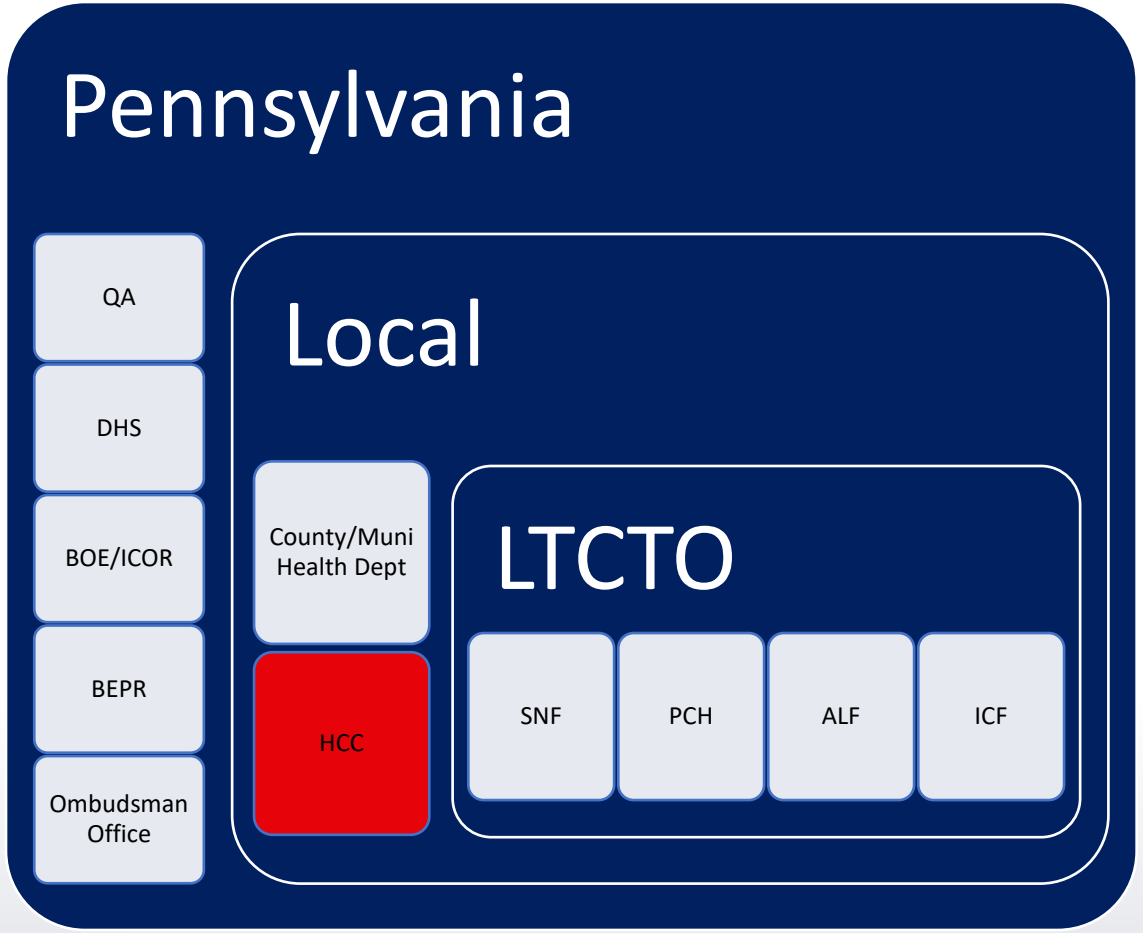
Considerations

- NASEM report
  The Quality of Care in Nursing Homes | National Academies
- Nursing Home Reform Strategy
  FACT SHEET: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes | The White House
- Addressing Health Worker Burnout: U.S. Surgeon General's Advisory
  Health Worker Burnout | HHS.gov
- Separate and Unconscionable: Report on Racial and Ethnic Disparities in PA's Nursing Homes with Recommendations for Immediate Action
  Racial-Disparities-in-LTC-Facilities-Report-and-Recommendations-8-4-21.pdf

Priority areas

- Resident-centric Care
- Emergency preparedness
- Workforce development
- Infrastructure
- Infection prevention
- Facility engagement

The LTCTO collaborates heavily with other agencies and external stakeholder partners



Quality Assurance (QA) & PA DOH
- •Connections LTCTP to facilities

Infection Control Outbreak Response (ICOR)
- •Provides outbreak support

Ombudsman Office
- •Advocacy and Resident Surveys

Bureau of Emergency Preparedness and Response (BERP)

Department of Human Services (DHS)

County/Municipal Health Departments
- •Local health department support

Health Care Coalitions (HCC)
- •Long-Term Care resources and support

Discussion: LTCTO – Quality Investment Pilot Grant

- QIP is an LTC RISE complementary program that is allocating $14.2 million directly to facilities to invest in interventions that have proven value to improve resident outcomes (workforce development and retention, infection prevention control, emergency preparedness, and infrastructure enhancement).

- There is a special focus on disadvantaged facilities. Social vulnerability index (SVI) measures, percent Medicaid or Supplemental Security Income (SSI) resident days was used to prioritize investment funding for the most-needy facilities

- Awarded 125 facilities (7% of all facilities in PA) from March 2023 - May 2024

Discussion: LTCTO – QIP Workforce Tracks

Track 1.A: Identify managers for training in key business enhancing areas

Track 2.A: Identify existing staff for clinical skill certification training

Track 3.A: Identify an Infection Prevention Champion

Track 3.B: Hire a certified full time Infection Preventionist

Track 4.A: Identify an Emergency Preparedness Champion

Track 4.B: Hire a full time Emergency Preparedness Coordinator

Discussion: LTCTO – QIP Infrastructure Tracks

Track 5.A: Telehealth kiosks
Track 5.B: Improved internet access or Wi-Fi connectivity
Track 5.C: Cellphones or walkie talkies
Track 5.D: Call bell system
Track 5.E: Software
Track 6.A: Purchase HEPA filter
Track 6.B: Upgrade HVAC system
Track 6.C: Improve circulation and airflow opportunities
Track 6.D: Airflow Analysis
Track 7.A: Install handwashing stations
Track 7.B: Install hand sanitizer stations
Track 7.C: Divide non-single occupancy rooms
Track 7.D: Create or improve biocontainment units
Track 7.E: Upgrade visitation spaces

QIP Rural SNFs Workforce ROI Data

Total rural QIP SNF funding

- Total awarded funding for these facilities = $3,302,673.99
- Total workforce awarded = $2,658,904.99
- Average workforce award = $132,945.25
- Average total award = $165,133.70

Average ROI realized within 2.8-4.5 months

Cost per agency hour-per-day saved

- Average savings per month, per facility, including increased in-house RN = $6,315 - $14,295
  - 3.8 fewer agency staffing hours and had 1.7 additional in-house RN hours.
- Average savings per month, per facility, including increased in-house LPN = $6,450 - $9,030
  - 4.3 fewer agency staffing hours and had 3 more LPN in-house staff hours
- Average savings per month, per facility, including increased in-house CNA = $16,737 - $23,262
  - 8.7 fewer agency staffing hours and 6.4 additional in-house staff hours
- Total average savings per month, per facility, of between $29,502 and $46,587

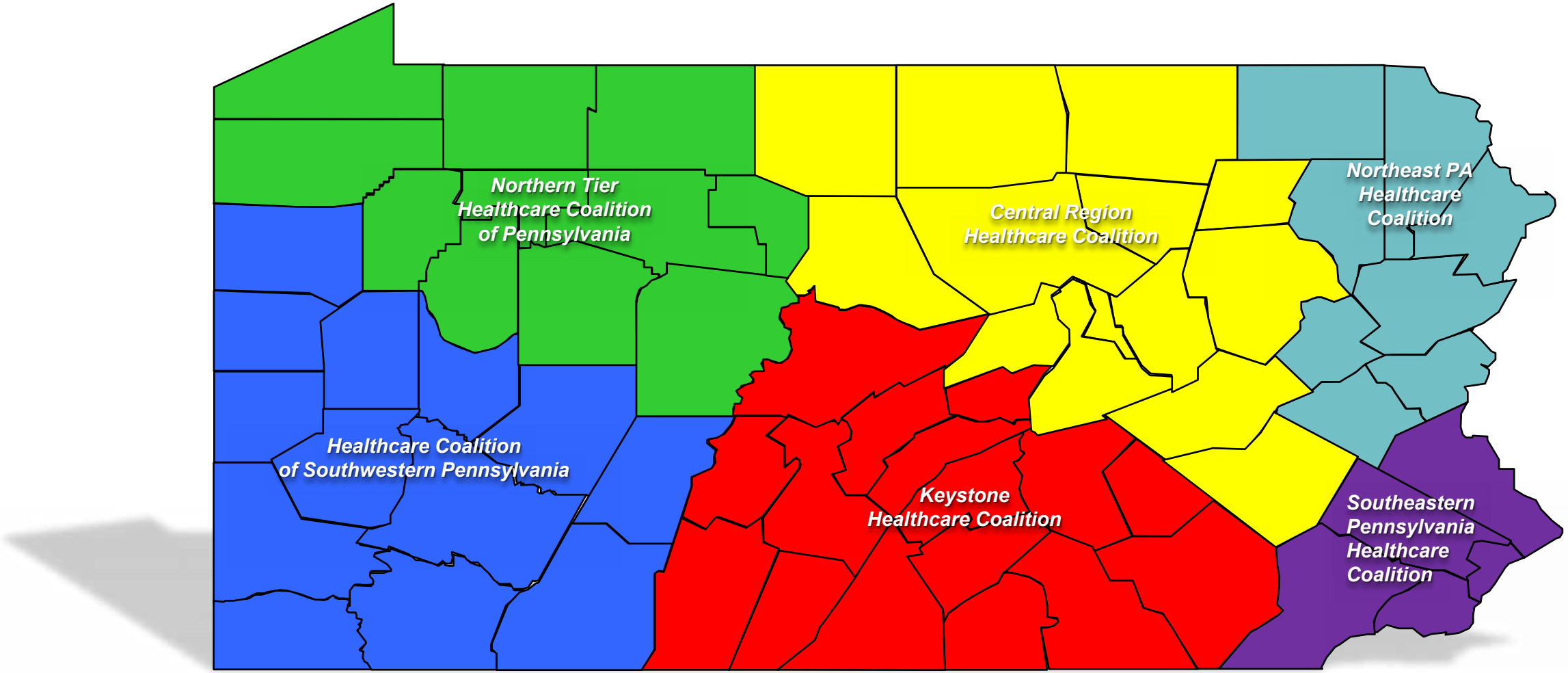
Savings calculation

((Contract hours difference * Contract Rate) + (Staff hours difference * Staff rate))*30

Remaining Resilient Post Public Health Emergency (PHE)

With the ending of PHE, it became clear that LTCFs were still reeling. Support is needed to help LTCFs remain resilient post-pandemic and partnering in greater numbers with their HCC's can aid them to this end.

PA Healthcare Coalition/Mighty.com Linked



Pennsylvania Regional Healthcare Coalitions

Healthcare Coalition of Southwestern Pennsylvania

Keystone Healthcare Coalition
Plan • Prepare • Respond • Recover
Serving Central Pennsylvania

Health Care Coalition NE PA

Southeast Healthcare Coalition Pennsylvania

Central Region Healthcare Coalition
Collaboration Preparedness Response

Northern Tier Healthcare Coalition of Pennsylvania

#NHCPC24

Healthcare Coalitions (HCCs) in the Commonwealth of PA

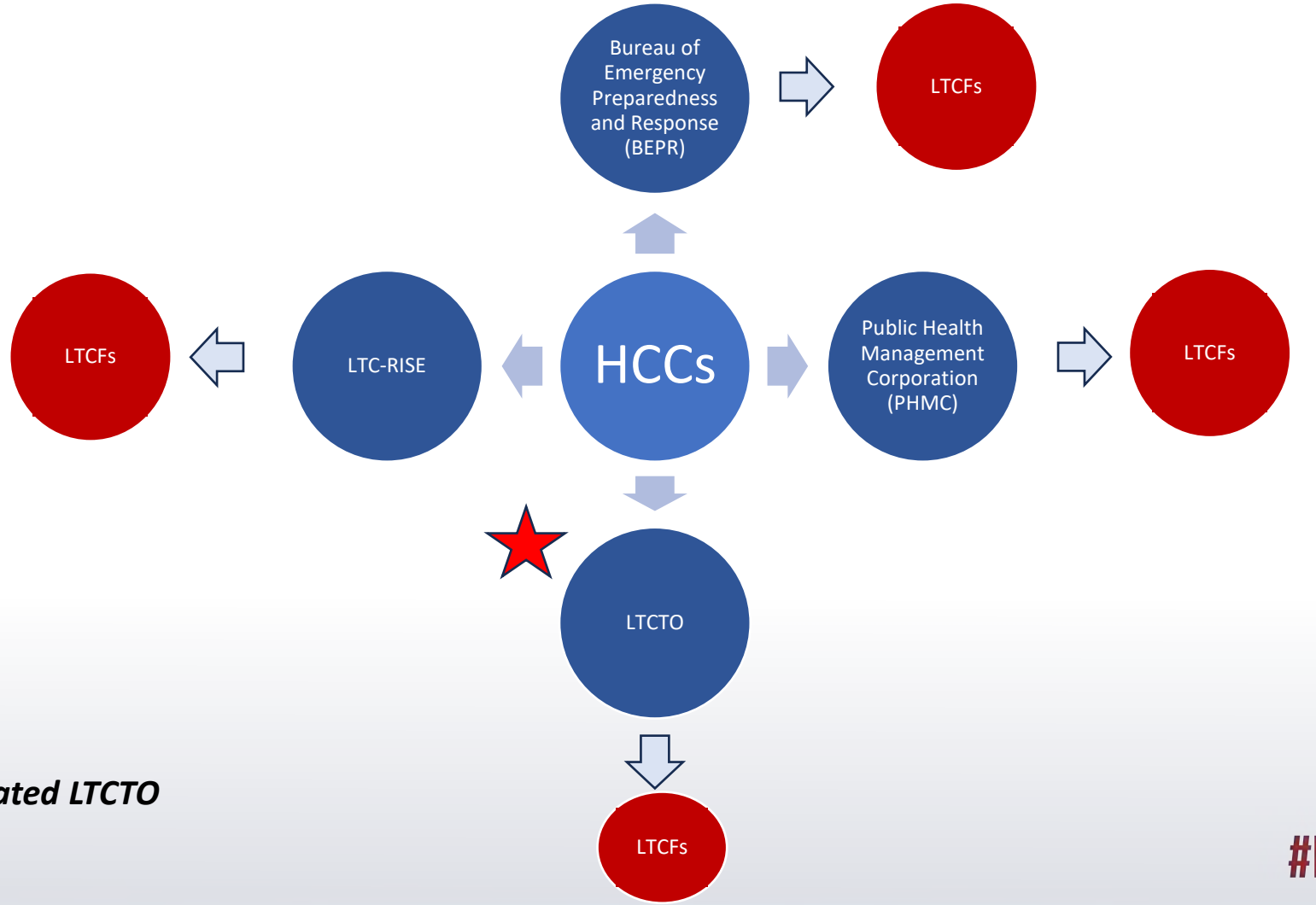
- What is a Health Care Coalition (HCC) in Pennsylvania?
- The Healthcare Preparedness Program falls under the Bureau of Emergency Preparedness & Response and defines HCCs as:
- "A formal collaboration among healthcare organizations and public and private partners that is organized to prepare for, respond to, and recover from an emergency, mass casualty or catastrophic event."

Healthcare Coalitions (HCCs) in the Commonwealth of PA

Key Components

- Comprehensive healthcare membership with four core entities
- Regional presence developed within the state to cover larger geographic areas
- Preparedness capability operationalization through plans, exercises, trainings, response and after-action reports.

HCC LTC subcommittee membership is lacking: multipronged recruitment efforts underway



Each HCC has a dedicated LTCTO liaison

Question for discussion

What strategies can be employed to create a more cohesive collaboration among the various healthcare coalitions?

Question for discussion

How did healthcare coalitions assist Long Term Care facilities in your state during the pandemic/public health emergency?

Value of Collaborations with HCCs for Long Term Care Facilities

HCC benefits

- Access resources and assets
- Know who to call in an emergency
- Gain support for Emergency Preparedness prior to and during a disaster
- Connect with fellow Long Term Care facility peers
- Access trainings and exercises
- Review survey preparedness
- Gain regional emergency situational awareness
- Increase visibility and credibility within the community

Long Term Care Subcommittee

The Long-Term Care Transformation Office encourages nursing facilities of all levels: SNFs, PCHs, ALFs, ICFs, to join their respective HCC regions Long Term Care subcommittee. This offers the opportunity to meet with your peers in your region to discuss best practices and how to navigate the ever-changing landscape of long-term care.

Value of Collaborations with HCCs for Long Term Care Facilities

HCC benefits

***WHY* join the HCC?** To enhance the collective surge capacity and disaster response capabilities among healthcare facilities through information sharing, resource support, response coordination, networking, facilitate Mutual Aid and meet regulatory and accreditation requirements.

WHO joins the HCC?

Healthcare Facilities and Providers, Local Health Districts, Long Term Care entities**,** EMS Organizations, Emergency Management, Behavioral Health, Social Services, Home health, Hospice, Dialysis and more.

Conclusion:

The LTCTO continues to maintain these partnerships to build resilience for both staff and residents of all levels of nursing facilities within the Commonwealth of Pennsylvania.

Key strategies to consider in building a stronger relationship between HCC's and LTCFs include:

- Consistently engaging HCC members to develop and grow Long-Term Care Subcommittees
- Implementing memoranda of understanding to share resources
- Utilization of spectrum of subject matter experts for development of cohesive multi-jurisdictional response plan across HCCs, county and public health departments.

Question for discussion

What strategies can be employed to create a more cohesive collaboration among the various healthcare coalitions ***AND*** Long-Term Care Facilities post Public Health Emergency?

HOW to join the HCC?

Please review the HCC map to
find your respective region.
You can join that region
by scanning the QR Code below

#NHCPC24

One Bite at a Time: Testing Pieces of Your Plans with Virtual Drills & Progressive Exercises

Steven Lerner, Seminole County Emergency Management

Hunter Zager, Tampa Bay Health & Medical Preparedness Coalition

Learning Objectives

- Describe effective strategies for leveraging exercise participation as a tool to build engagement within the healthcare community and recruit new members to healthcare coalitions
- Recognize the advantages of conducting short, focused exercises in testing small pieces of healthcare emergency plans within a community setting
- List practical tips and strategies for planning and executing these exercises efficiently, even with limited time and resources

Exercises….

- can be time-consuming, intimidating and expensive
- are required by CMS and licensing entities
- are essential for testing plans and ensuring readiness
- should be high impact, low cost and easy to conduct in a short time period

The Solution?

- Healthcare Coalition-based virtual drills!
- These exercises are simple and effective
- Meet the requirement for community-based exercises
- Allow facilities to test specific plans
- Are a great way for Healthcare Coalitions to recruit new members and engage existing members!

The Origin

- The first virtual drill, Operation Protect & Secure, was developed by Seminole County Emergency Management in 2017
- Launched during National Preparedness Week, the goal was to allow facilities to practice their lockdown plans
- Central Florida Disaster Medical Coalition partnered with Seminole County Emergency Management to take the drill region-wide
- The drill was a resounding success, with more than 220 organizations registered and more than 120 completing the exercise!
- The drill brought in almost 50 new Coalition members!

Expanding the Drills

- Operation Protect and Secure has been repeatedly annually, with increasing participation each year
- The formula was used to create other virtual drills
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- In 2022, TBHMPC borrowed this virtual drill format, beginning with a generator drill in June, Operation Power Play
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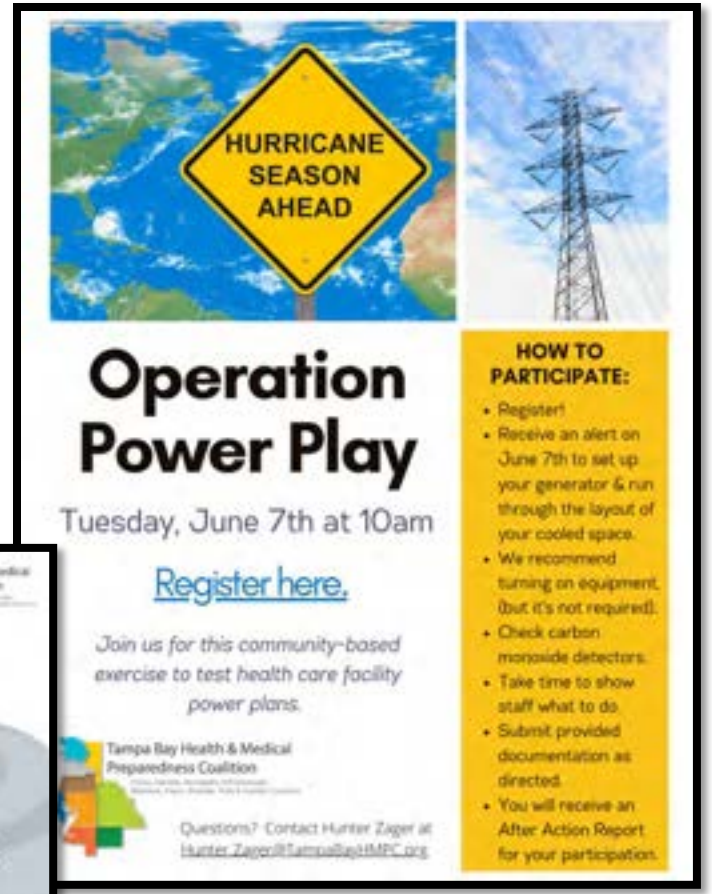

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- In December, the Watchful Workplace Drill focused on workplace violence response plans
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- The 2024 Great Tornado Drill had over 200 registrants, so numbers are growing!

How to Conduct a Virtual Drill

- The Coalition partners with EM across the region to identify and plan for each drill
- A flyer is developed, providing details and allowing organizations to register
- Instructions on how to participate in the drill are provided in advance
- On the day of the drill, an alert is sent out to registered facilities
- The drill takes place at the individual facilities
- Following the drill, organizations submit a survey with a description of their exercise, what went well, and what can be improved
- The Coalition produces an AAR (with regional themes and individual facility information), including an improvement plan with instructions
- This meets CMS and licensure requirements for community-based drill with emergency management

Progressive Exercises

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- TBHMPC has 9 counties, each holding a county-level coalition meeting every other month
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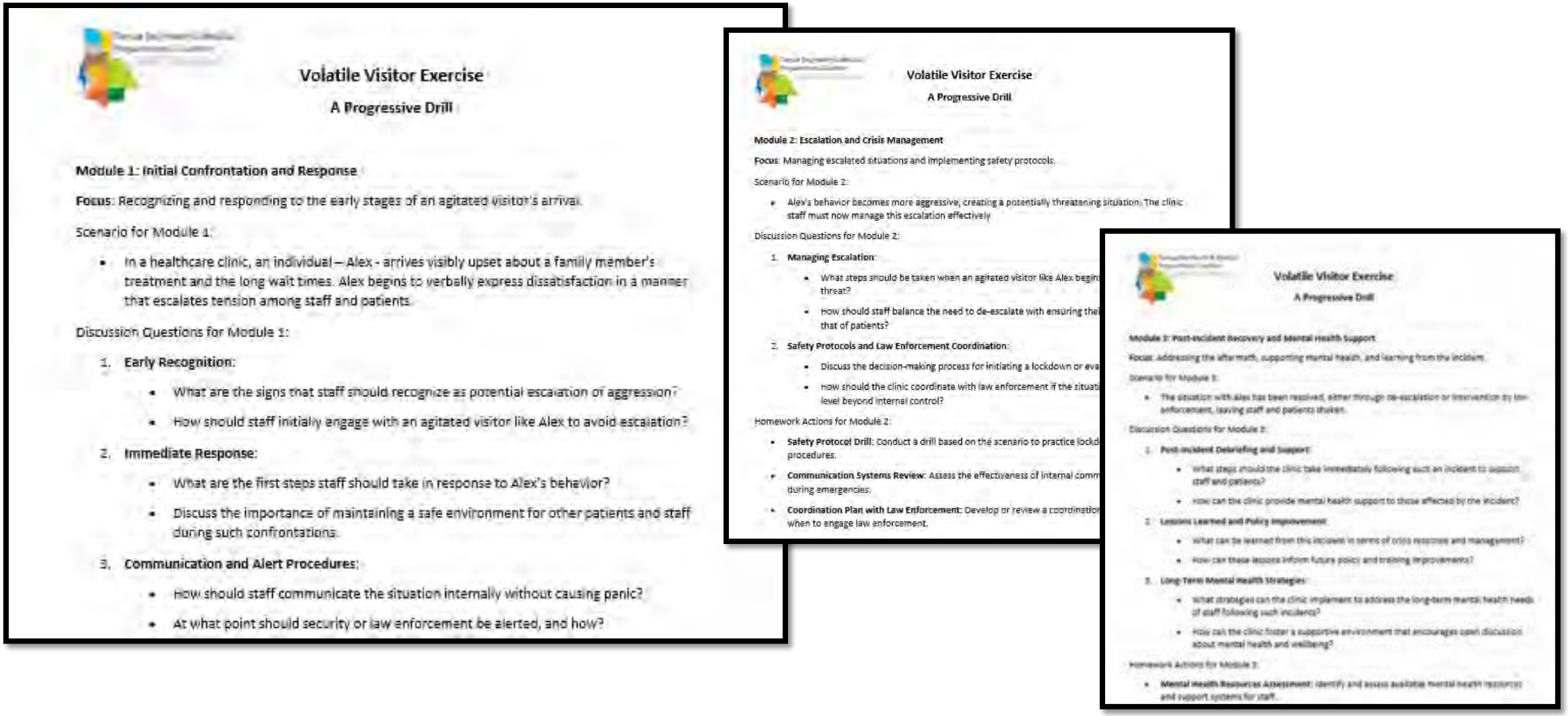
Volatile Visitor Progressive Exercise



Volatile Visitor Exercise

A Progressive Drill

Module 1: Initial Confrontation and Response

Focus: Recognizing and responding to the early stages of an agitated visitor's arrival.

Scenario for Module 1:

- In a healthcare clinic, an individual—Alex - arrives visibly upset about a family member's treatment and the long wait times. Alex begins to verbally express dissatisfaction in a manner that escalates tension among staff and patients.

Discussion Questions for Module 1:

1. **Early Recognition**:
   - What are the signs that staff should recognize as potential escalation or aggression?
   - How should staff initially engage with an agitated visitor like Alex to avoid escalation?
2. **Immediate Response**:
   - What are the first steps staff should take in response to Alex's behavior?
   - Discuss the importance of maintaining a safe environment for other patients and staff during such confrontations.
3. **Communication and Alert Procedures**:
   - How should staff communicate the situation internally without causing panic?
   - At what point should security or law enforcement be alerted, and how?

Volatile Visitor Exercise

A Progressive Drill

Module 2: Escalation and Crisis Management

Focus: Managing escalated situations and implementing safety protocols.

Scenario for Module 2:

- Alex's behavior becomes more aggressive, creating a potentially threatening situation. The clinic staff must now manage this escalation effectively

Discussion Questions for Module 2:

1. **Managing Escalation**:
   - What steps should be taken when an agitated visitor like Alex begins
   - threat?
   - How should staff balance the need to de-escalate with ensuring the
   - that of patients?
2. **Safety Protocols and Law Enforcement Coordination**:
   - Discuss the decision-making process for initiating a lockdown or eva
   - How should the clinic coordinate with law enforcement if the situat
   - level beyond internal control?

Homework Actions for Module 2:

- **Safety Protocol Drill**: Conduct a drill based on the scenario to practice lockd
- procedures.
- **Communication Systems Review**: Assess the effectiveness of internal comm
- during emergencies.
- **Coordination Plan with Law Enforcement**: Develop or review a coordinatio
- when to engage law enforcement.

Volatile Visitor Exercise

A Progressive Drill

Module 3: Post-Incident Recovery and Mental Health Support

Focus: Addressing the aftermath, supporting mental health, and learning from the incident.

Scenario for Module 3:

- The situation with Alex has been resolved, either through de-escalation or intervention by law enforcement, leaving staff and patients shaken.

Discussion Questions for Module 3:

1. **Post-Incident Debriefing and Support**:
   - What steps should the clinic take immediately following such an incident to support staff and patients?
   - How can the clinic provide mental health support to those affected by the incident?
2. **Lessons Learned and Policy Improvement**:
   - What can be learned from this incident in terms of crisis response and management?
   - How can these lessons inform future policy and training improvements?
3. **Long-Term Mental Health Strategies**:
   - What strategies can the clinic implement to address the long-term mental health needs of staff following such incidents?
   - How can the clinic foster a supportive environment that encourages open discussion about mental health and wellbeing?

Homework Actions for Module 3:

- **Mental Health Resources Assessment**: Identify and assess available mental health resources and support systems for staff.

Benefits

- Both types of these simple, short exercises build engagement with healthcare organizations, emergency management, community partners, and Coalitions
- They attract all types of organizations, especially those not traditionally involved in larger community-based exercises
- They meet exercise requirements
- They are simple to plan and execute, and are virtually no cost
- They provide an opportunity to engage healthcare organizations in the need for preparedness (move them out of the “meet the requirement” mentality and into the “we must be ready” mindset)
- They are guaranteed to increase Healthcare Coalition membership!

Resources

For each of these exercises, CFDMC & TBHMPC will share:

- Flyers/registration process
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- Scenarios
- Participation Surveys
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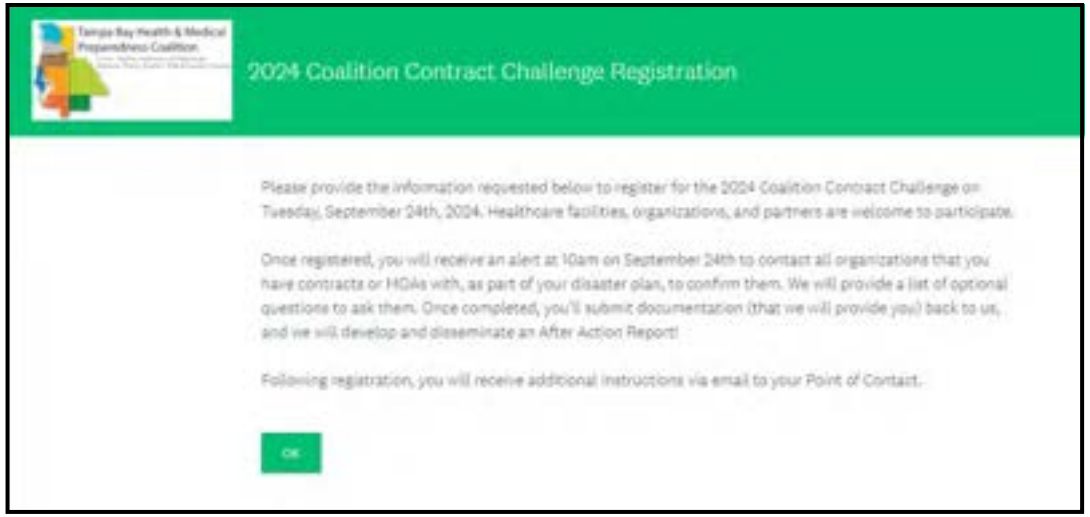

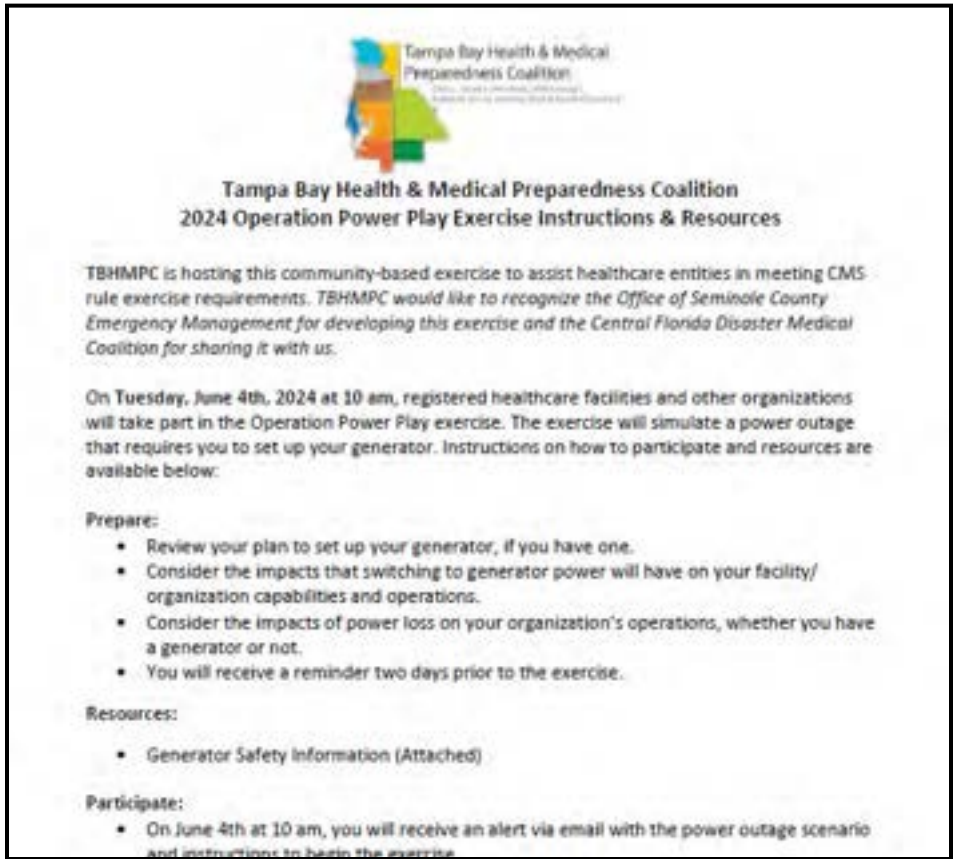
Tampa Bay Health & Medical Preparedness Coalition

Tampa Bay Health & Medical Preparedness Coalition
2024 Operation Power Play Exercise Instructions & Resources

TBHMPC is hosting this community-based exercise to assist healthcare entities in meeting CMS rule exercise requirements. *TBHMPC would like to recognize the Office of Seminole County Emergency Management for developing this exercise and the Central Florida Disaster Medical Coalition for sharing it with us.*

On **Tuesday, June 4th, 2024 at 10 am**, registered healthcare facilities and other organizations will take part in the Operation Power Play exercise. The exercise will simulate a power outage that requires you to set up your generator. Instructions on how to participate and resources are available below:

Prepare:

- Review your plan to set up your generator, if you have one.
- Consider the impacts that switching to generator power will have on your facility/ organization capabilities and operations.
- Consider the impacts of power loss on your organization's operations, whether you have a generator or not.
- You will receive a reminder two days prior to the exercise.

Resources:

- Generator Safety Information (Attached)

Participate:

- On June 4th at 10 am, you will receive an alert via email with the power outage scenario

Questions?

For additional information contact:

Steven Lerner
slerner@seminolecountyfl.gov
407-665-5121

Hunter Zager
hunter.zager@tampabayhmpc.org
727-580-22431

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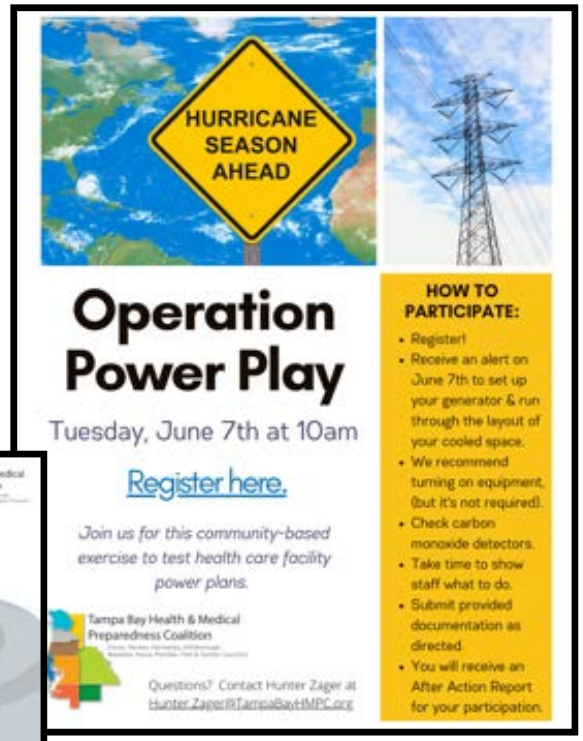

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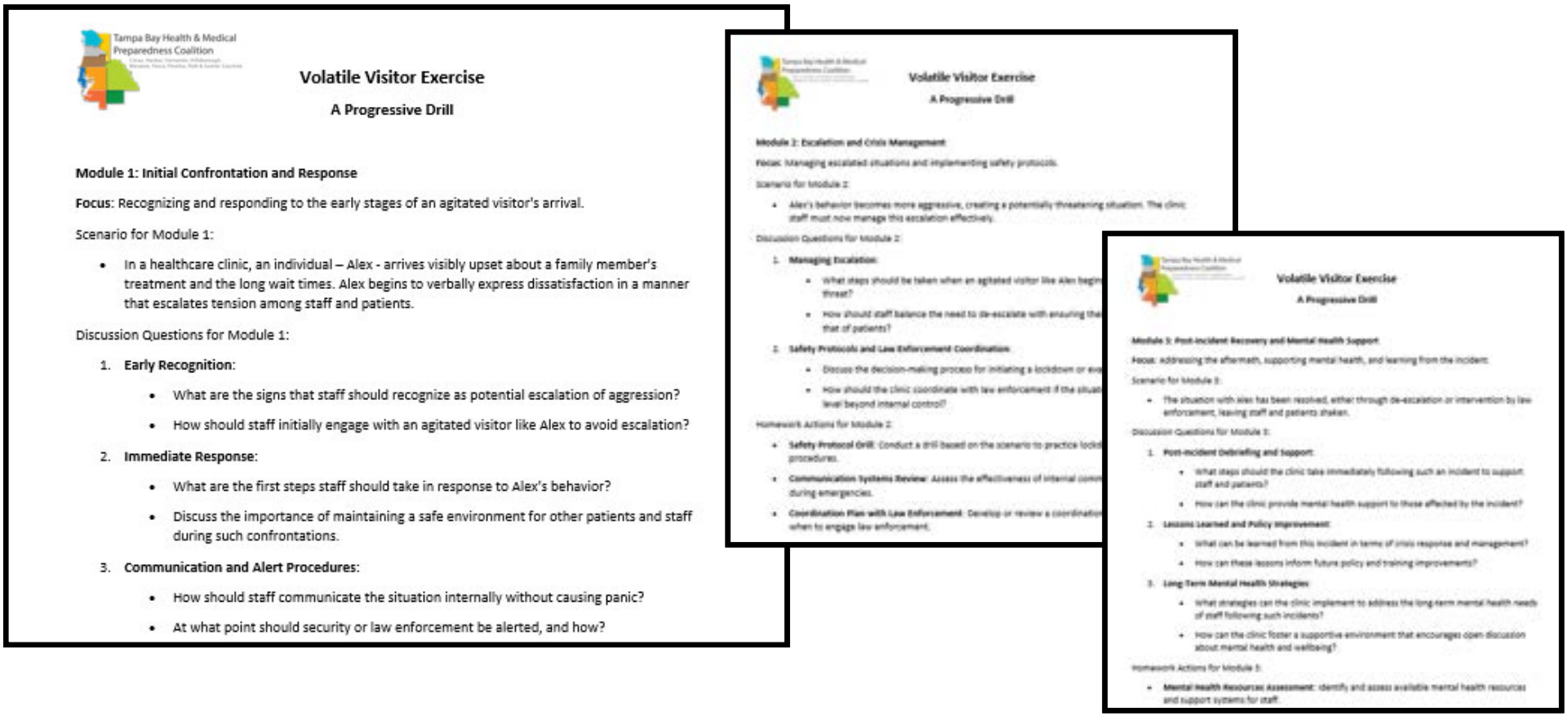

Tampa Bay Health & Medical Preparedness Coalition

Volatile Visitor Exercise

A Progressive Drill

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Volatile Visitor Exercise

A Progressive Drill

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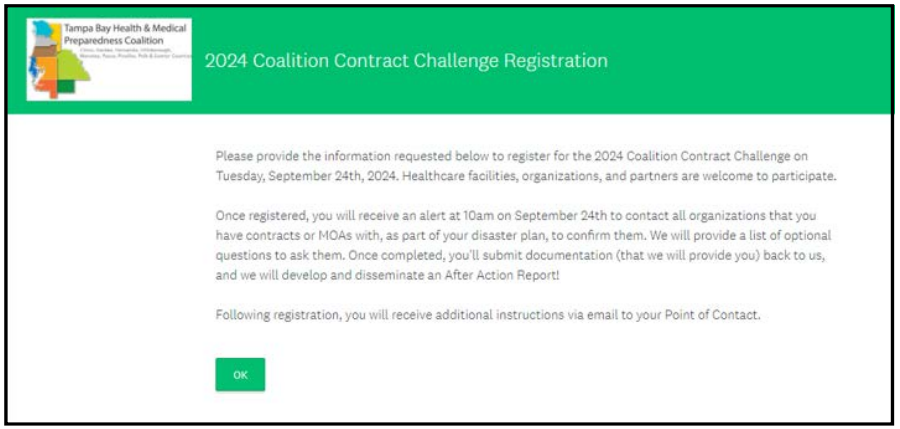
- Participation Surveys
- After Action Template/Improvement Plan



Questions?

For additional information contact:

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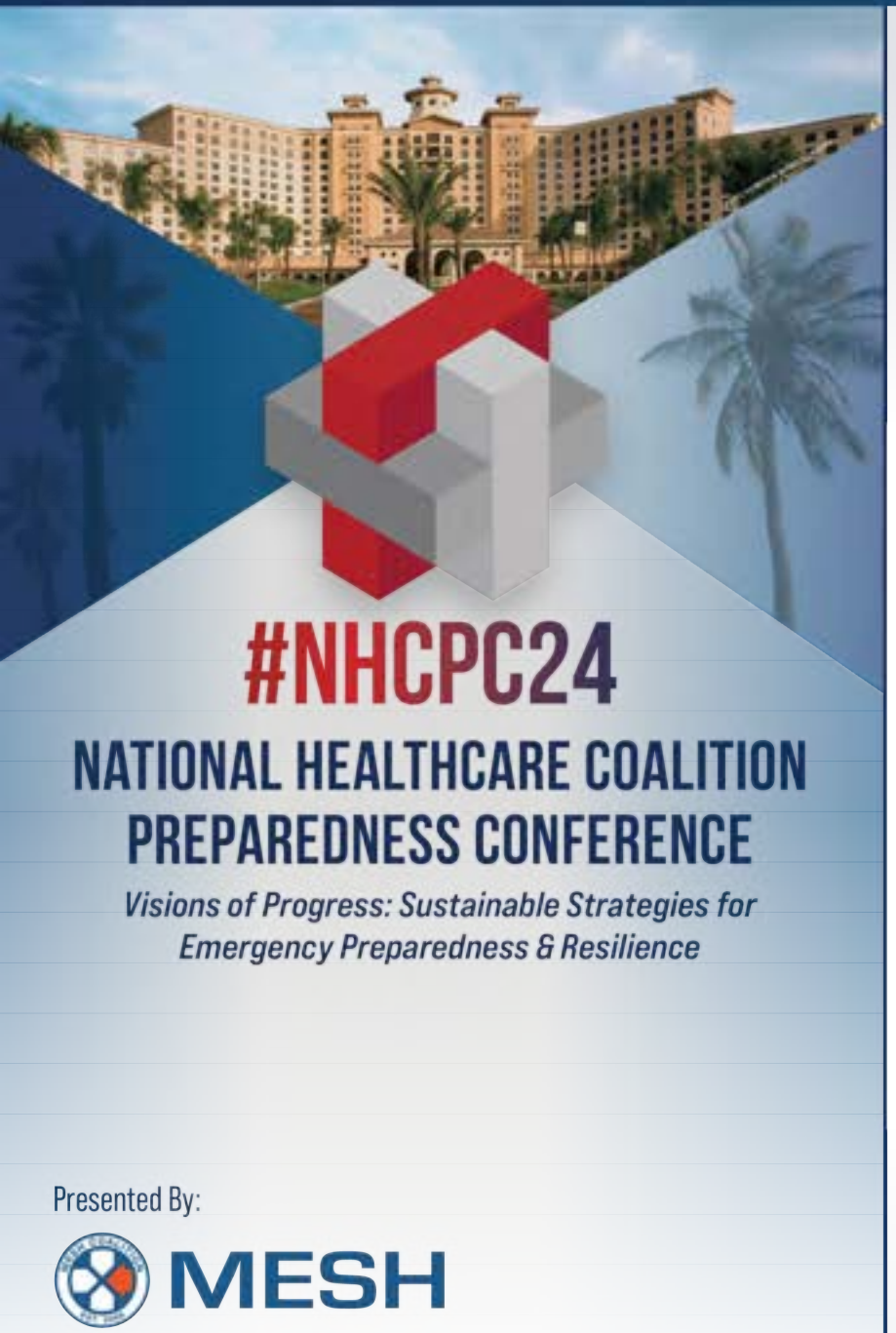
Hunter Zager
hunter.zager@tampabayhmpc.org
727-580-22431



Strengthening Emergency Response

Vital Role of Interstate Collaboration in Hospital Evacuation

Jordyn Marchi, MPH
Kim Stine

Learning Objectives

1. Identify the strategies for enhancing situational awareness and synergy among stakeholders during interstate coordination, particularly for patient evacuation.
2. Assess the resilience of healthcare systems in different regions based on their level of cross-state coordination for patient evacuation.
3. Learn tools to structure a cross-state hospital evacuation workshop.
4. Analyze the potential barriers to effective interstate coordination and propose solutions to overcome them.

Poll Question

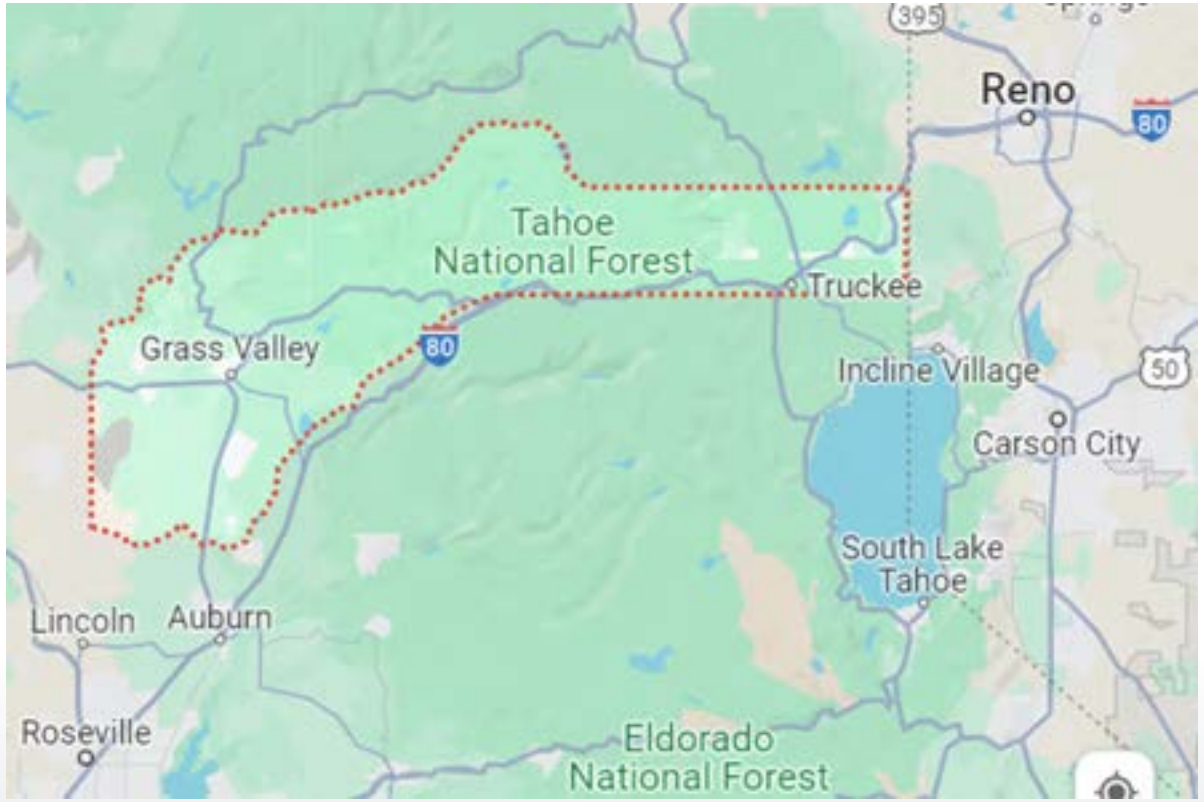
What is your greatest asset during an emergency?

An Introduction To Us

Nevada County

- Rural community tucked into the foothills of the Sierra Nevada mountains
- Approximately 103,000 people over 970 sq. miles
- Highest elevation is 9,152 feet
- 1 general acute care hospital on the west side, 1 critical access hospital on the east side, in Truckee CA
- Truckee is a tourist destination. Their population can quadruple during peak winter and summer seasons. They received 507,000 overnight visitors in 2023 alone.

A narrow but critical boarder line…



Interstate 80

2023 I-80 statistics:

- In 2023, chains were required on 78 days
- Total snowfall: over 60 feet
- Full highway closures: 15 days

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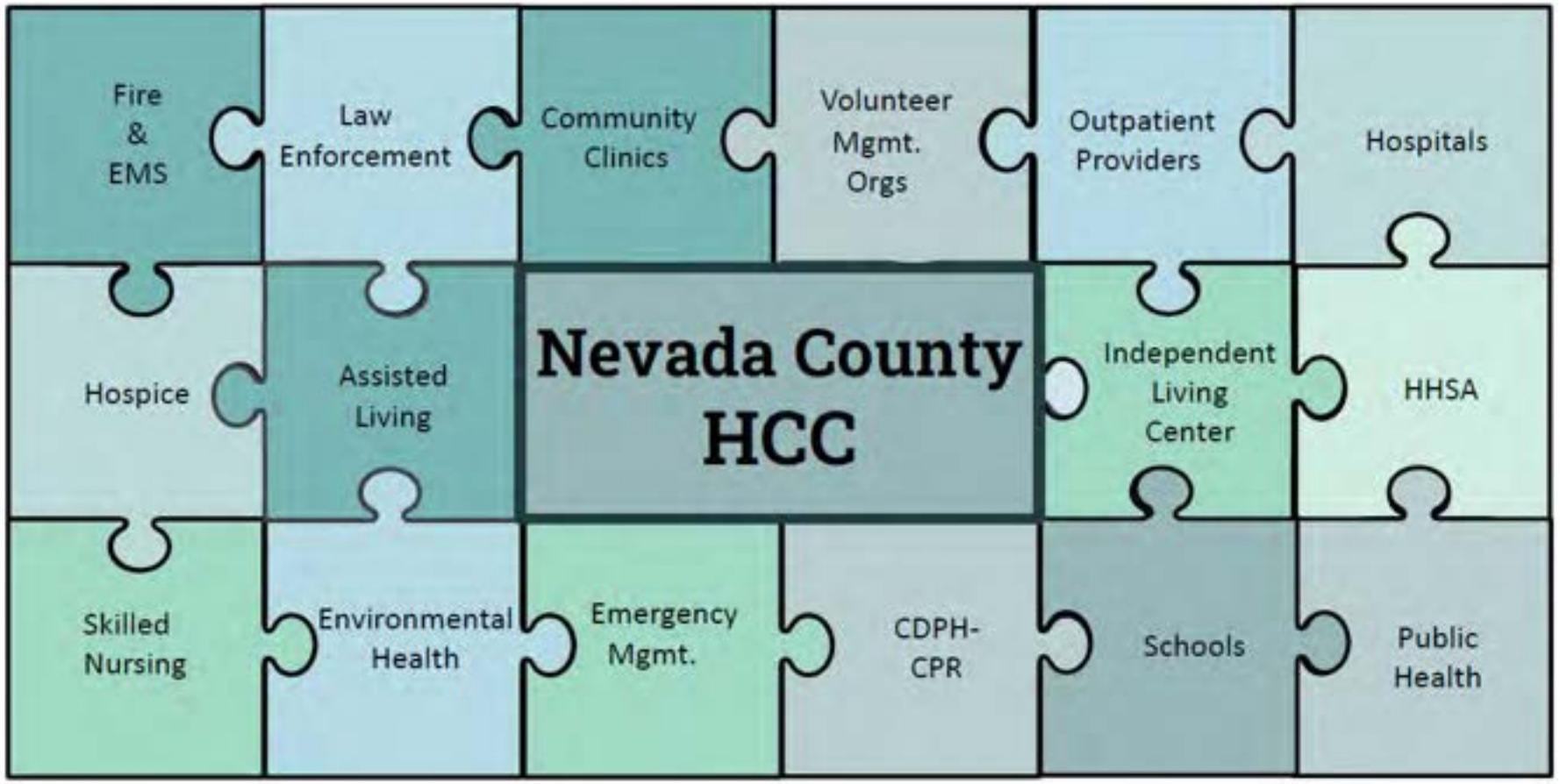
Yes, that Donner Summit…

Hazards-
Nevada County

#NHCPC24

Nevada County Health Care Coalition (HCC)

EPIC is Nevada County's healthcare coalition. We are a cross-sector group of individual healthcare and response organizations with a common mission. We build disaster resilience amongst Nevada County's healthcare network through collaborative planning, joint exercises, resource sharing, and communication. This coalition is grant funded, County managed, and relationship driven.



Washoe County

- Borders California and Oregon
- Located on the eastern slope of the Sierra Nevada Mountains
- Approximately 497,000 people over 6,316 sq. miles
- Highest elevation is 10,785 ft.
- Tourists
  - In 2023, 3.9 million people visited the Reno-Tahoe area
- Hospitals:
  - 7 acute care hospitals
    - 1 Level II Trauma Center
    - 1 Level II Pediatric Trauma Center
    - 1 Level III Trauma Center
  - 3 Free-Standing Emergency Departments

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Hazards-
Washoe County

#NHCPC24

Inter-Hospital Coordinating Council (IHCC)

Began as a partnership in 1985
Officially became a coalition in 1994

Partners include EMS/Fire, healthcare facilities, school districts, emergency management, public health, and law enforcement

Purpose: Collaboration, allocation of resources, information sharing, community resilience

IHCC
Inter-Hospital
Coordinating Council
Est. 1994

Cross-State Collaboration = Regional Resiliency

The Need for Cross-State Collaboration

- There are no boundaries with emergencies
- Resource and information sharing
- Disaster-prone regions
- Critical care facilities may be unevenly distributed across states

Impact

- Minimize disruptions in care delivery
- Optimize resource utilization
- Equitable access to life-saving interventions

Partnership Matters

- If your county or parish is along a state border, a relationship with your neighboring state is imperative.
- If you are a rural community and within two counties distance from a state border, a relationship with your neighboring state is imperative.
- If you are a county or parish that shares tourists with another state or has a major interstate running through your jurisdiction, a relationship with your closest neighboring state is imperative.
- **Valuable to EVERYONE!**

Strategies for Enhancing Situational Awareness

Partnerships

Cross-Training

Exercises

Debrief
&
Optimize

Hospital Evacuation Workshop: 9 Steps For Success

1. Invite the right partners
2. Call it a "workshop"
3. Review your independent jurisdiction's med/health systems
4. Be candid about your assets and your gaps
5. Discuss the "bridge"
6. Learn from your experiences
7. Formalize the process
8. Exchange contacts
9. Make a plan for continued partnership opportunities

Invite The Right Partners

Call it a Workshop

Review Your Independent Med/Health Systems

CA Medical & Health Disaster Response System Overview

Washoe County Mutual-Aid Evacuation Agreement (MAEA)

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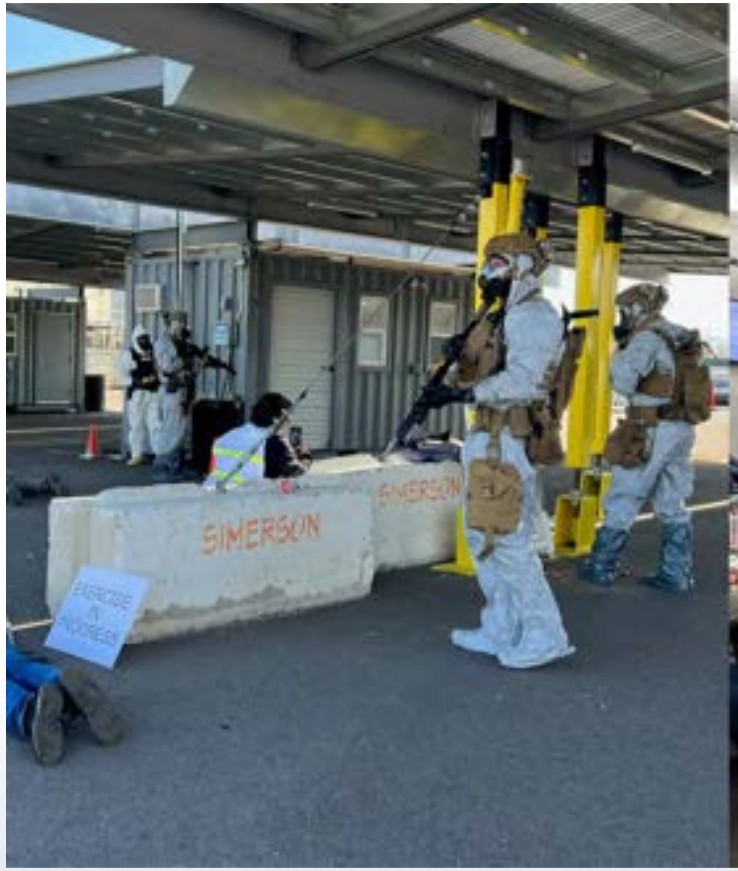
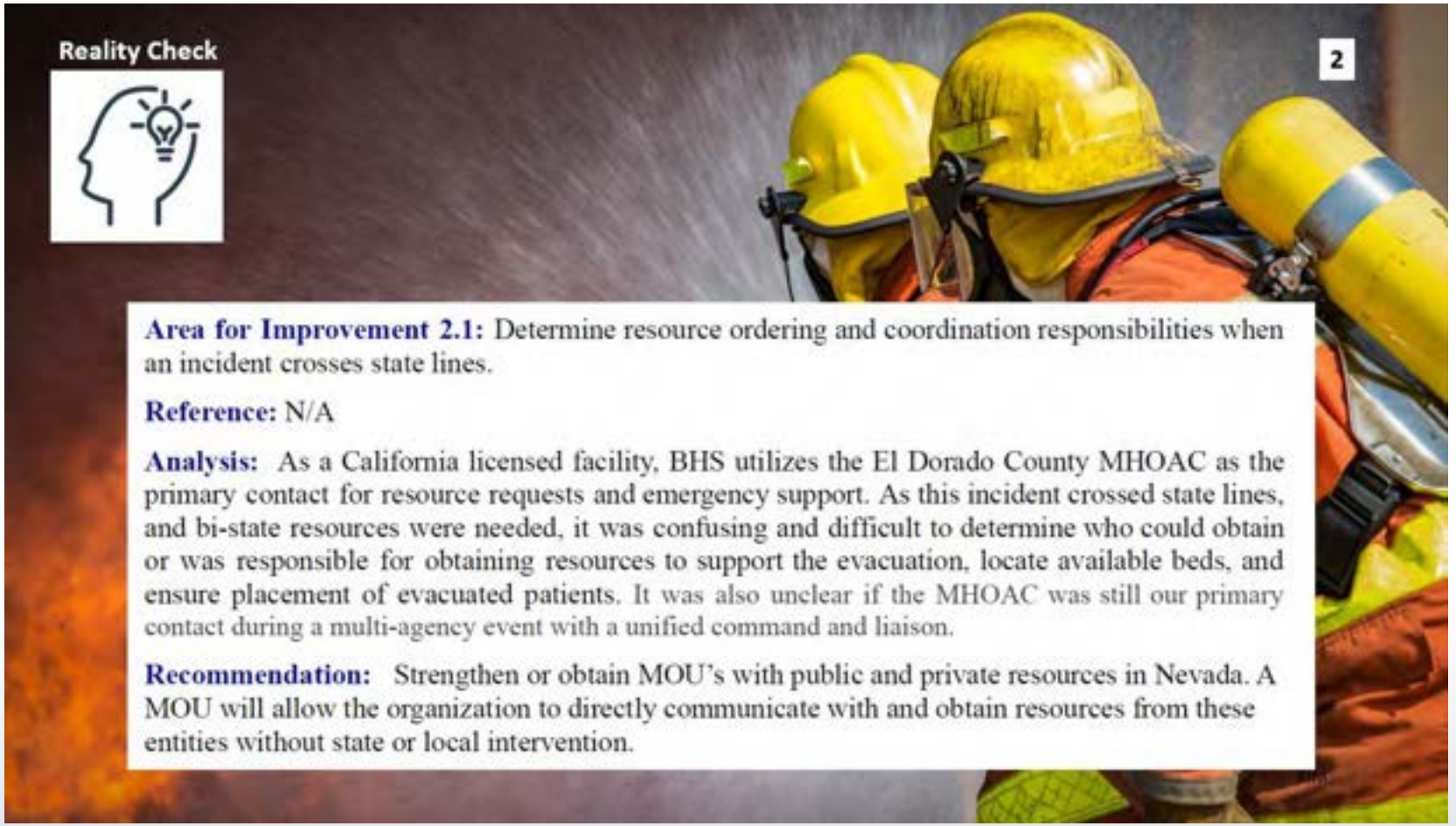
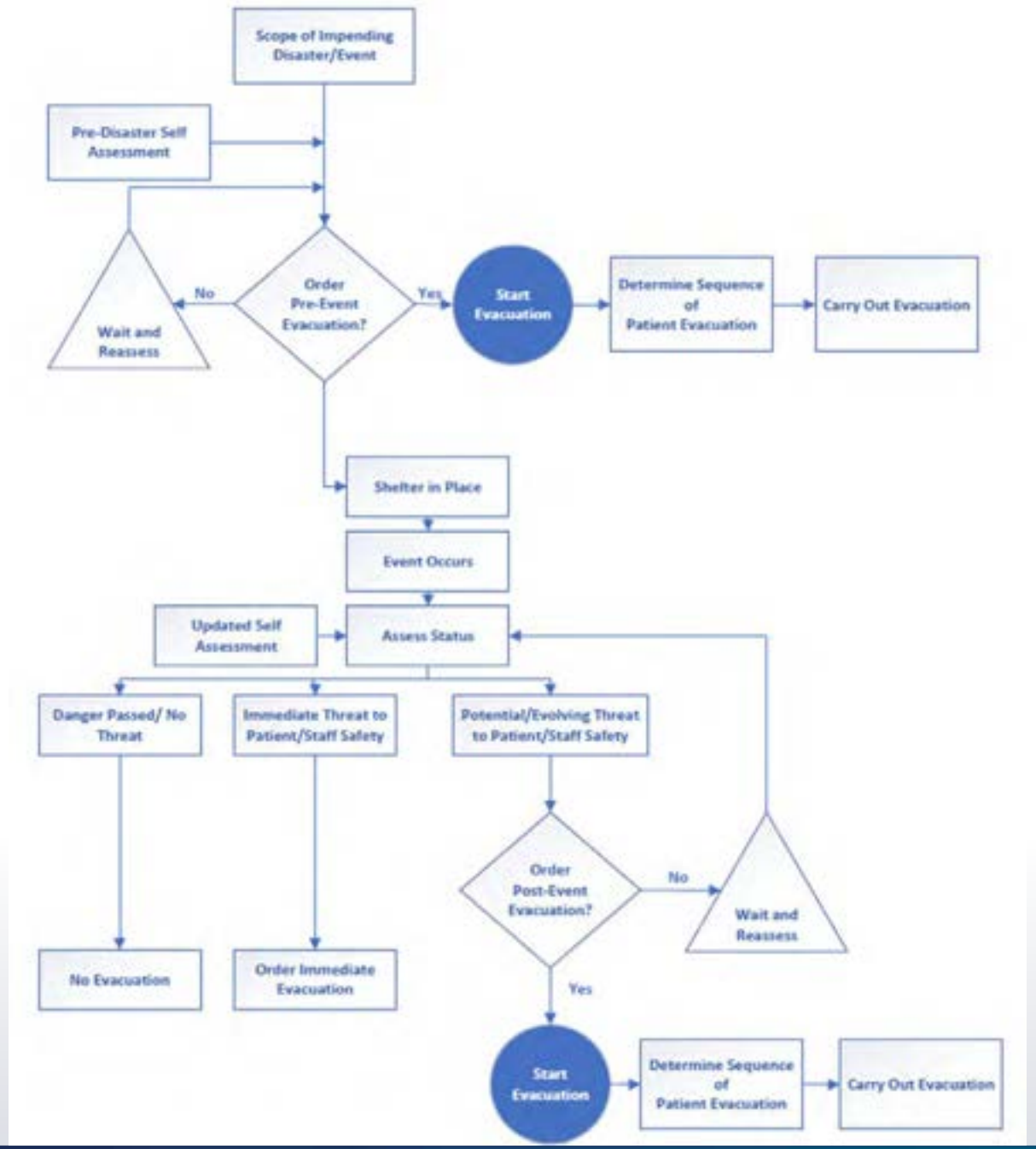
Be Candid About Your Assets & Gaps



Learn From Each Other's Experiences



Formalize the Process



Evacuation Algorithm

Microsoft Word - Hospital Evacuation Guide FINAL051410.doc (calhospitalprepare.org)

Exchange Contacts

Make a Plan for Continued Partnership

Poll Question

What are some barriers to building relationships acr

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Nobody has responded yet.

Hang tight! Responses are coming in.

Overcoming Barriers to Interstate Coordination

Challenges:

- Funding
- Time management
- State-specific processes/procedures
- Legal frameworks and liability concerns

Solutions:

- Cost-Sharing Agreements
- Pre-established Protocols
- Trainings and Exercises
- Cross-State Communication Platforms
- Mutual Aid Agreements
- Emergency Licensing Protocols
- A commitment to the marriage

Call to Action: 5 Steps to Interstate Synergy

1. Start with the relationships. In person matters.
2. Extend invites and embed into exercises with frequency.
3. Promote each other's strengths.
4. Communicate frequently and help often.
5. Reflect and grow.

Thank You!

Jordyn Marchi

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Emergency Preparedness & Response Coordinator

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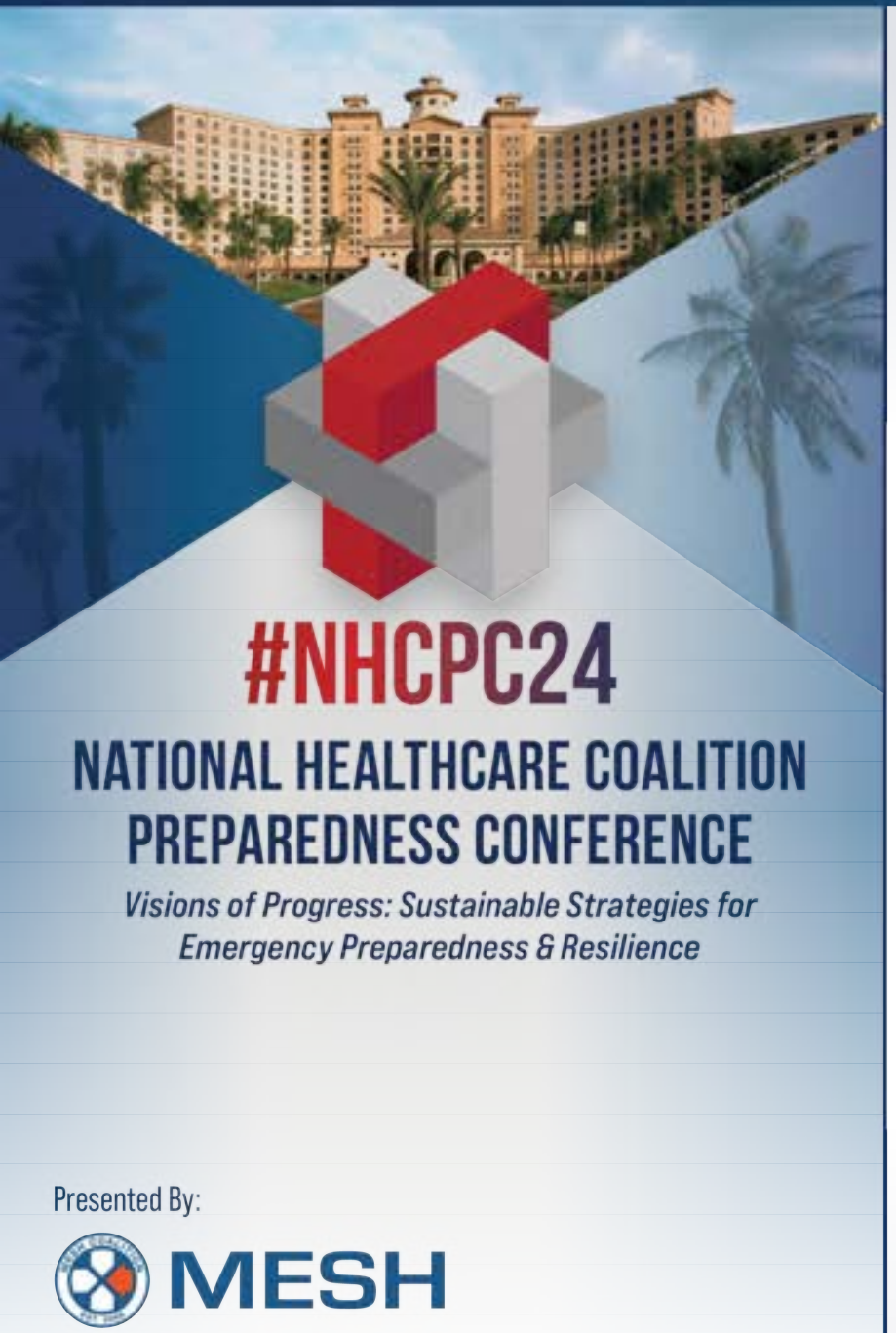


Stuff vs. Staff: The Dilemma

Prioritizing Staff Over Supplies for Effective Preparedness

Luke Aurner, MS, CCEMT-P I/C, PEM, HcEM-M

Rick Drummer BS, MBA, MS, CHEP

Outline

Disclosures

History of our HCC's

Why we are speaking about this

Responsibilities to NOFO and workplan

Challenges

Technology

Response

Training

Presenters

Rick Drummer

Michigan Region 2
North Healthcare Coalition
Coordinator – 16 yrs

BS is Accounting, MBA, and MS Manufacturing Management

CHEP

Luke Aurner

Michigan Region 6 Healthcare Coalition Coordinator – 6 yrs

BS and MS in Emergency Response and Risk Management

CCEMT-P I/C – 25 years

Professional Certs: PEM, HcEM-M, CHEC-III, NDLSF-I, ICS Instructor, HERT-I

Disclosures

Both presenters are funded exclusively by the HPP grant.

Who are You?

Mentimeter Survey

Questions could include:

- Are you a:
  - HCC Coordinator or staff
  - Public Health
  - CMS provider type
  - Other
- How long have you been on the job?
  - Less than one year
  - 1-3 years
  - 4-7 years
  - > 8 years
- What is your background?
  - Healthcare (nurse, physician, EMS)
  - Public Health
  - Emergency Management (no healthcare degree)
  - Business
  - Other
- Add others

Raise your hand if you are a:

Who are You?

- HCC Coordinator
- Public Health
- CMS Provider Type
- Other

Who are You?

Raise your hand if you have been on the job:

- Less than one year
- 1-3 Years
- 4-7 Years
- > 8 Years

Who are You?

Raise your hand if your background is:

- Healthcare
- Public Health
- Emergency Management
- Business
- Other

History of Michigan HCC's

- Funds from Congress through Department of Health and Human Services – 2002
- Michigan Department of Health and Human Services Office of Public Health Preparedness (OPHP)
- Michigan established eight Healthcare Coalitions aligned with the Michigan State Police Emergency Management Districts
- Used an established semi-governmental organization, Medical Control Authority, to serve as fiduciary
- Bylaws and governance established (still used today)
- Partnerships have expanded greatly with CMS conditions of participation

Michigan HCC Members Include

Work with local partners to prepare hospitals, emergency medical services (EMS), and supporting healthcare organizations to deliver coordinated and effective care to victims of terrorism and other public health/healthcare emergencies.

Coordinate medical response during an incident or event, as necessary

- Hospitals
- Emergency Medical Services
- Emergency Management Organizations
- Public Health Agencies
- Specialty patient referral centers
- Behavioral Health Services and Organizations
- Dialysis Centers
- Home Health
- Primary Care Providers
- Schools, Universities, etc.
- Skilled nursing and long-term care facilities
- Others….

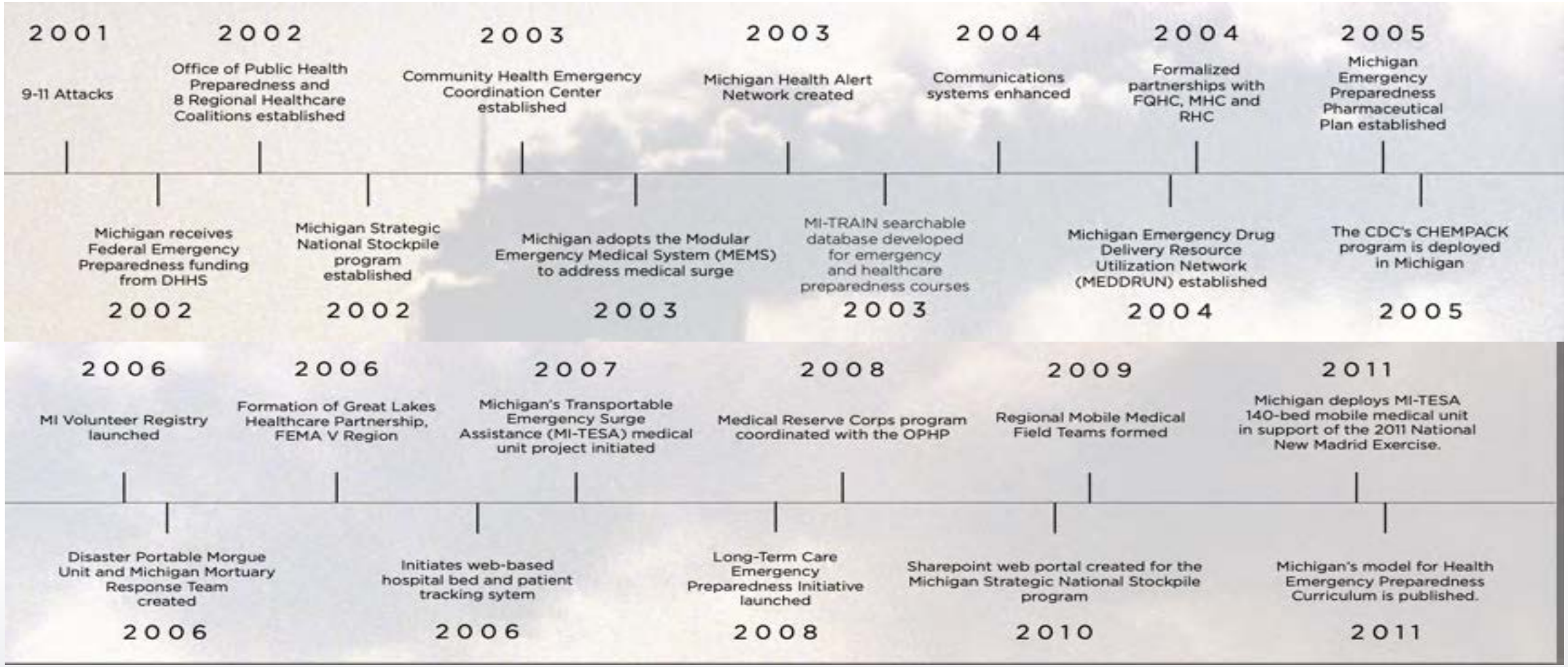
Current Paid Healthcare Coalition Staff

Picture from 10th year brochure:

Only 6 of 21 people in picture still involved in HCCs (29%)

- Regional Healthcare Coalition Coordinator
- Assistant Regional Healthcare Coalition Coordinator
- Regional Medical Director (mostly ER Physicians working part time)
- A few have additional staff for warehouse management or special projects

First 10 Years Established Groundwork



Since Beginning - Threats are Evolving and Increasing

Terrorism

Katrina

Zika

Mass Shootings

Anthrax

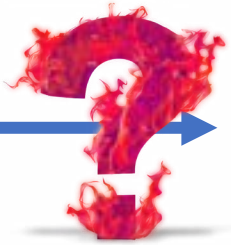
Cyber

Local Floods

IV Shortage

2002

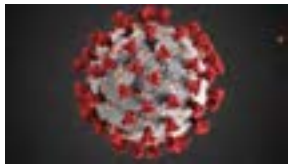
2024



Power Outage

H1N1

Opioids



Pandemic

Water Main Breaks

Meningitis

Political Unrest

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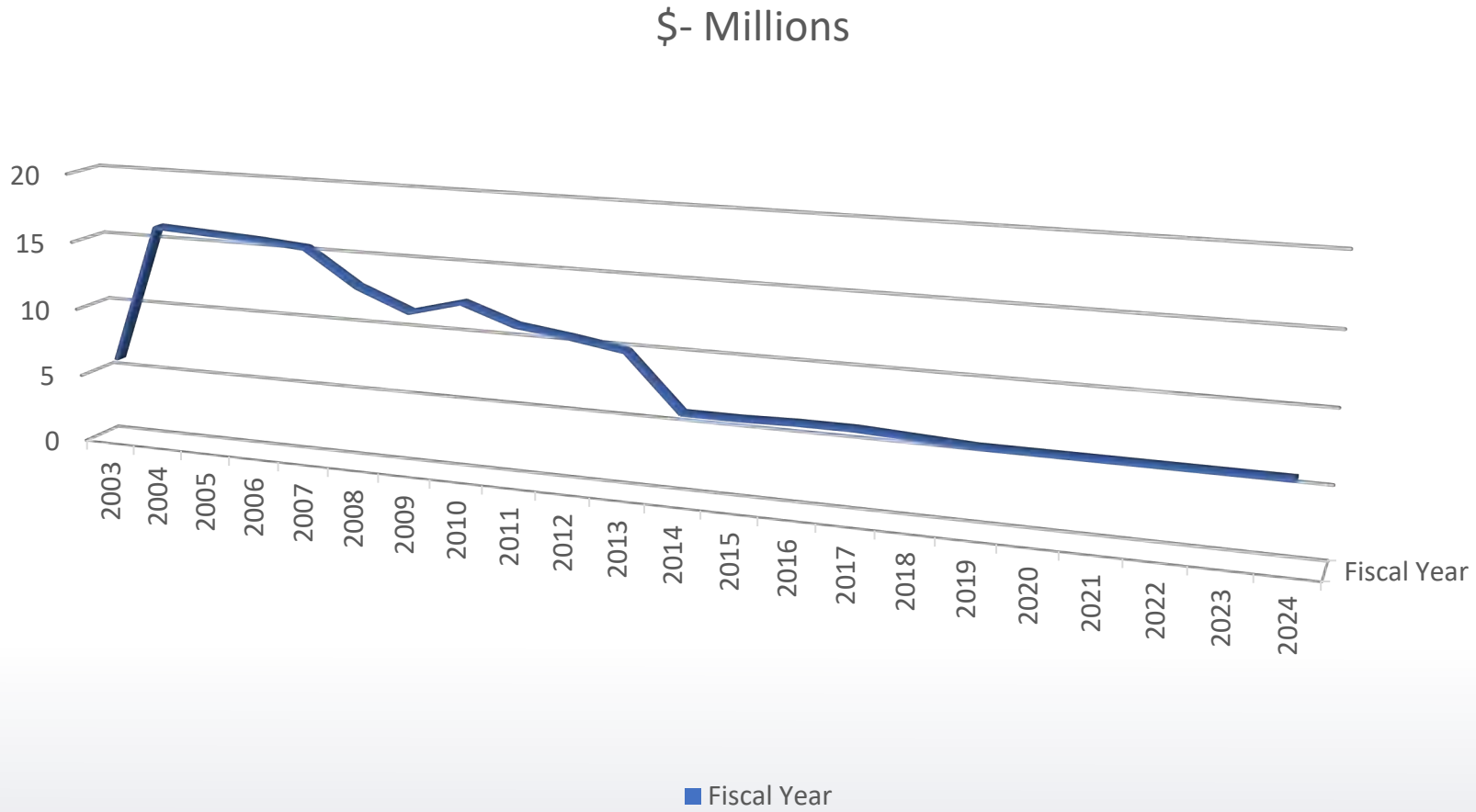
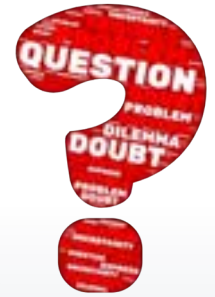
Funding History in Michigan – Includes HCCs, Michigan Staff, Projects, etc.



Future Years



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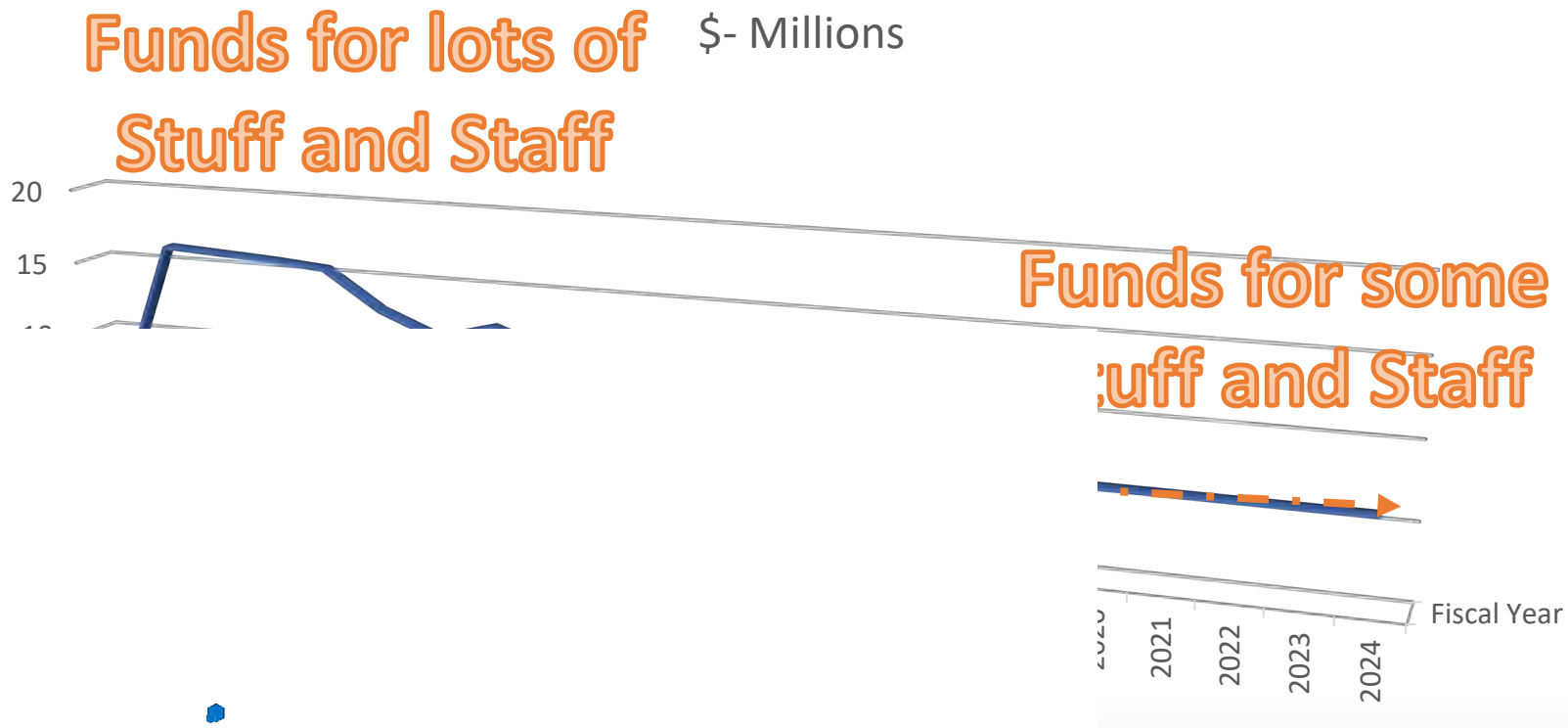
Funding History in Michigan



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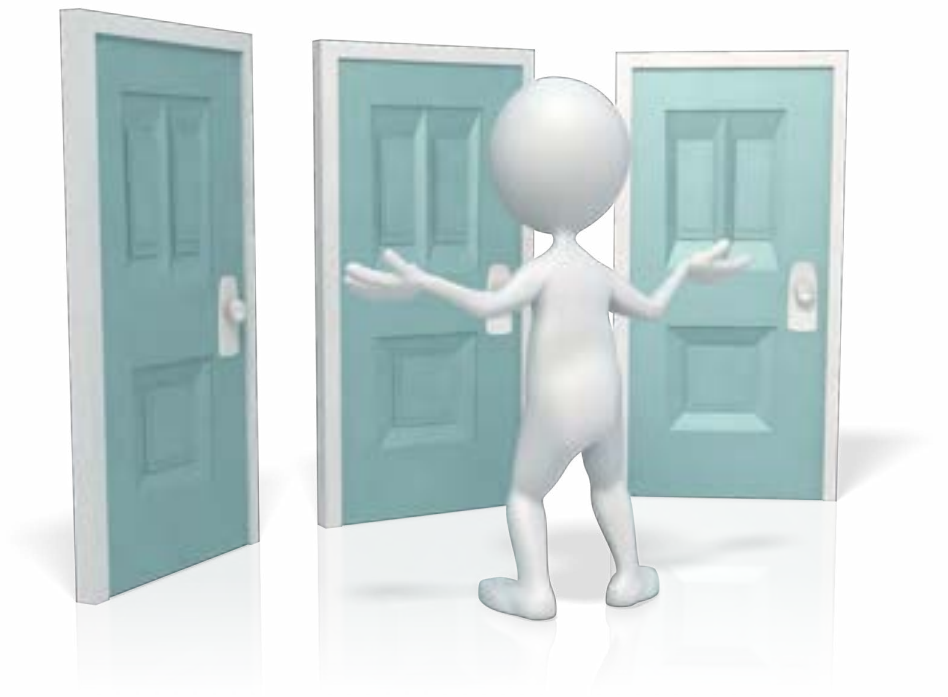
Delighted we still get funding!

Partners have told us that the only reason the Healthcare Coalitions function and exist, is because of the staff:

- Regional Coordinators
- Assistant Regional Coordinators
- Medical Directors
- Office Space and Equipment
- Travel Funds
- Michigan Support Staff
- Fiduciaries
- Etc.

The Dilemma



With Limited Resources

Do We:

Purchase tangible assets (stuff)

or

Invest in Human Resources (staff)

Not necessarily an either or thing, but requires thoughtful thinking and dialog

Why are we up here?

- Decreasing funding
- Increasing responsibilities
  - More partners
  - Evolving risks
  - More requirements
  - More responses
- Replacement and maintenance of legacy spending

Deanne Criswell
FEMA Administrator

Remarks during a recent podcast

She's talking about FEMA, but they could also apply to Healthcare Coalitions

- Role is to help people
- **Invest in emergency mangers and their growth**
- Focus on equity – can't have a one-size-fits-all approach
- **How do we get to them vs. Forcing them to come to us**
- Shift to mitigation and preparedness vs. Response and recovery
- Systems based approach
- Shift focus – good at solving complex problems before, during, and after

HCCs are Partnerships

Making a Partnership Successful

While needs, capabilities, and two-way communication are the basis of a public-private partnership, a partnership should have several characteristics in order to be successful. You can remember these characteristics by the mnemonic device PADRES. A partnership should be:

- **P**ublicly **A**ccessible: Partnership includes the private sector
- **D**edicated: Partnership is managed by a liaison
- **R**esourced: Partnership has funding, facilities, and tools
- **E**ngaged: Members of partnership are actively participating
- **S**ustainable: Partnership is supported by strategic plans, funds, and resources
- https://emilms.fema.gov/is_0660/groups/63.html

Strategies Going Forward

Does your coalition work with partners to plan for the future?

- Funding allocations or additions
- Reduce legacy costs
- Decide what ”stuff” should be provided by the HCC
- If your partners are doing it, don’t try to ”take it over” – leverage them
- Have the right staff with the right education and training
- Leverage 501(C)(3) status

Evaluating Everything!

Since Staff is Most Important:

Looking at staff training, education, support, numbers

Looking at stuff we have with legacy costs and also if we need new stuff:

- Warehouses
- Expiration Dates
- Maintenance
- Consolidation
- Having partners take it over
- Sharing expense

Warehousing

Challenges

Warehouse

Manpower

Expiration dates

Partners have same storage issues

Response Capability

Michigan Healthcare Coalitions are more than planning and preparedness; We are response HCCs:

- Power outages
- Flooding
- Tornados
- Mass Shootings
- Pandemic
- Medical Equipment Needs
- Multi Agency Communications and Coordination (MAC)
- IV Shortages
- Cyber Attacks
- And More...

- Evaluating the Regional Medical Coordination Centers constantly:
  - Right people
  - Right equipment
  - Mobile capabilities
  - Sharing between regions
  - Working with MI Community Health Emergency Coordination Center
  - 24/7 Contacts
  - Redundant communications
  - Letting partners know we are there to help

Staffing

What are you doing in your Healthcare Coalitions in the staffing area?

- Benefits of more staff
  - Interns
  - Administration
  - Support across regions
- Education and Training
  - Conferences
  - Courses
  - Certifications

Training

- Training our staff
- Using staff to provide training to others:
  - Hazards Analysis
  - HERT
  - ICS
  - Michigan Systems
  - BDLS, ADLS, CHEC
  - Crisis Standards of Care
  - Burn Surge
  - Medical Surge

Audience Participation

What is your experience?

Are your HCCs in a similar situation?

What didn't we cover that you want to hear about?

What questions do you have?

Moving forward

"If I had six hours to chop down a tree, I'd spend the first four hours sharpening the axe."

Abraham Lincoln

- Continue to:
  - Evaluate and Make Decisions On:
    - What we do and why we are doing it
    - Future funding and impact on priorities
    - Future HPP requirements
    - Look for opportunities to collaborate to leverage all skills and abilities
  - Train and Educate the HPP staff
  - Train and Educate with our partners
  - Look for other funding sources if appropriate

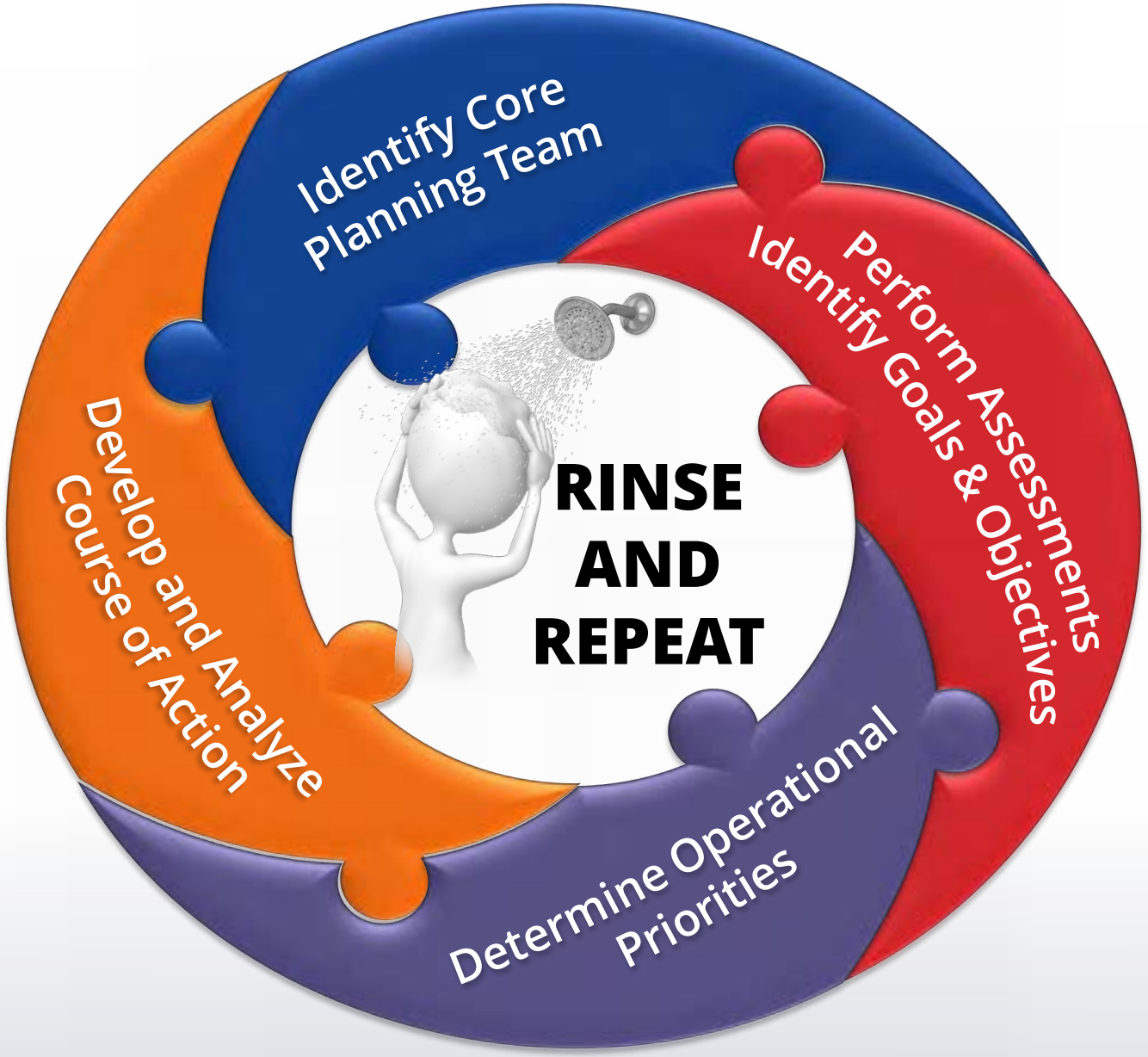
Presented By:

MESH

The "How To"

Creating and Sustaining Essential Multi-Disciplinary Groups

Amanda Hite, CEM, M.Ed
Tabitha Hobson, MPH


Identify Core Planning Team
Perform Assessments Identify Goals & Objectives
Determine Operational Priorities
Develop and Analyze Course of Action
RINSE AND REPEAT

Identify Core Planning Team

- ✓ Recruit:
  - Subject Matter Experts
  - Leaders
  - Potential Champions
- ✓ Determine Expectations:
  - Time Commitment
  - Scheduling
  - Workload
- ✓ Develop Mission and Vision
- ✓ Identify Modes of Communication and Information-Sharing

Perform Assessments
Identify Goals and Objectives

- Risk
- Community Needs
- Threats and Hazards
- Legal Requirements
- Legal Ramifications

- Increase Resilience
- Fill Unfunded Mandate Gaps
- Community Coordination

Determine Operational Priorities, Necessary Skills, and Disciplines

- Operational Priorities
  - Set 3-5 operational priorities

- Necessary Skills and Disciplines
  - Review your current team and determine if additional recruitment is necessary to meet priorities
  - Determine if any additional disciplines should join the team to meet priorities

Develop and Analyze Course of Action

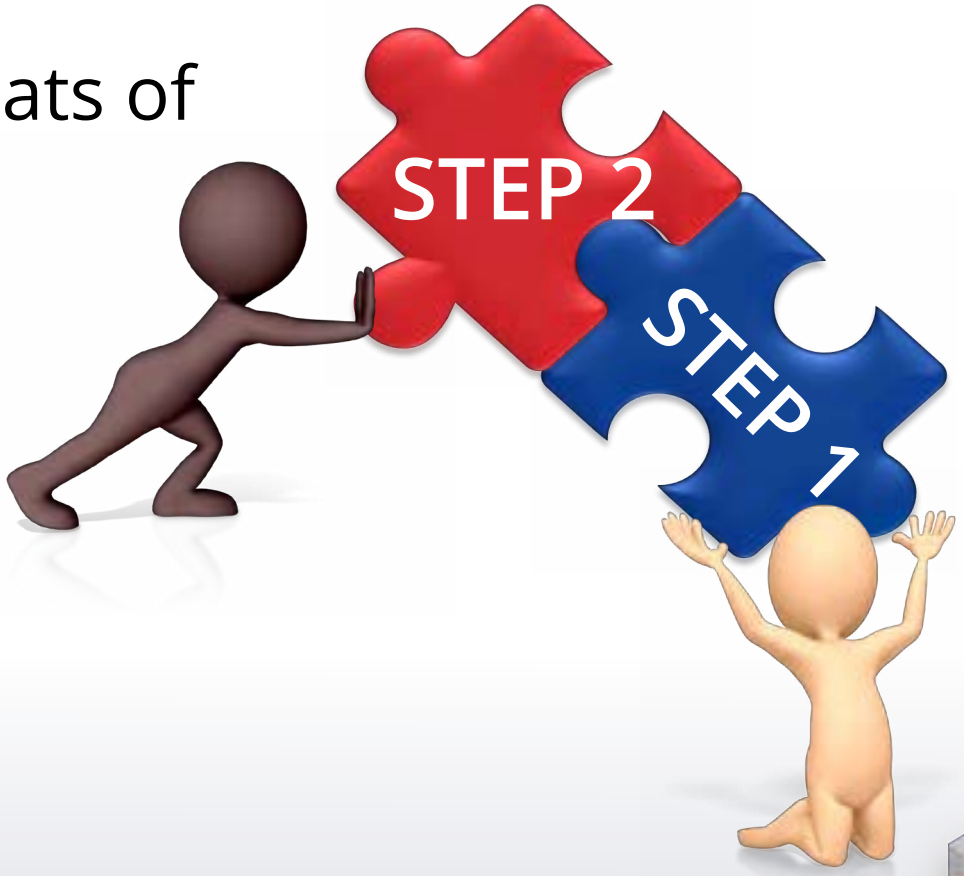
- Strategic Planning
  - Write the plan
  - Develop timeline of actions
  - Assign responsibilities
- Identify:
  - Resources
  - Information
  - Intelligence Needs

Identify Core Planning Team

- Elected state, local, and tribal officials;
- Law enforcement, fire, civil defense, and emergency management;
- Public health professionals; healthcare entities, and emergency medical services;
- Environment, education, and transportation;
- Private industrial partners; and
- Representatives from community civic groups, access and functional needs groups; cultural leaders, and the media.

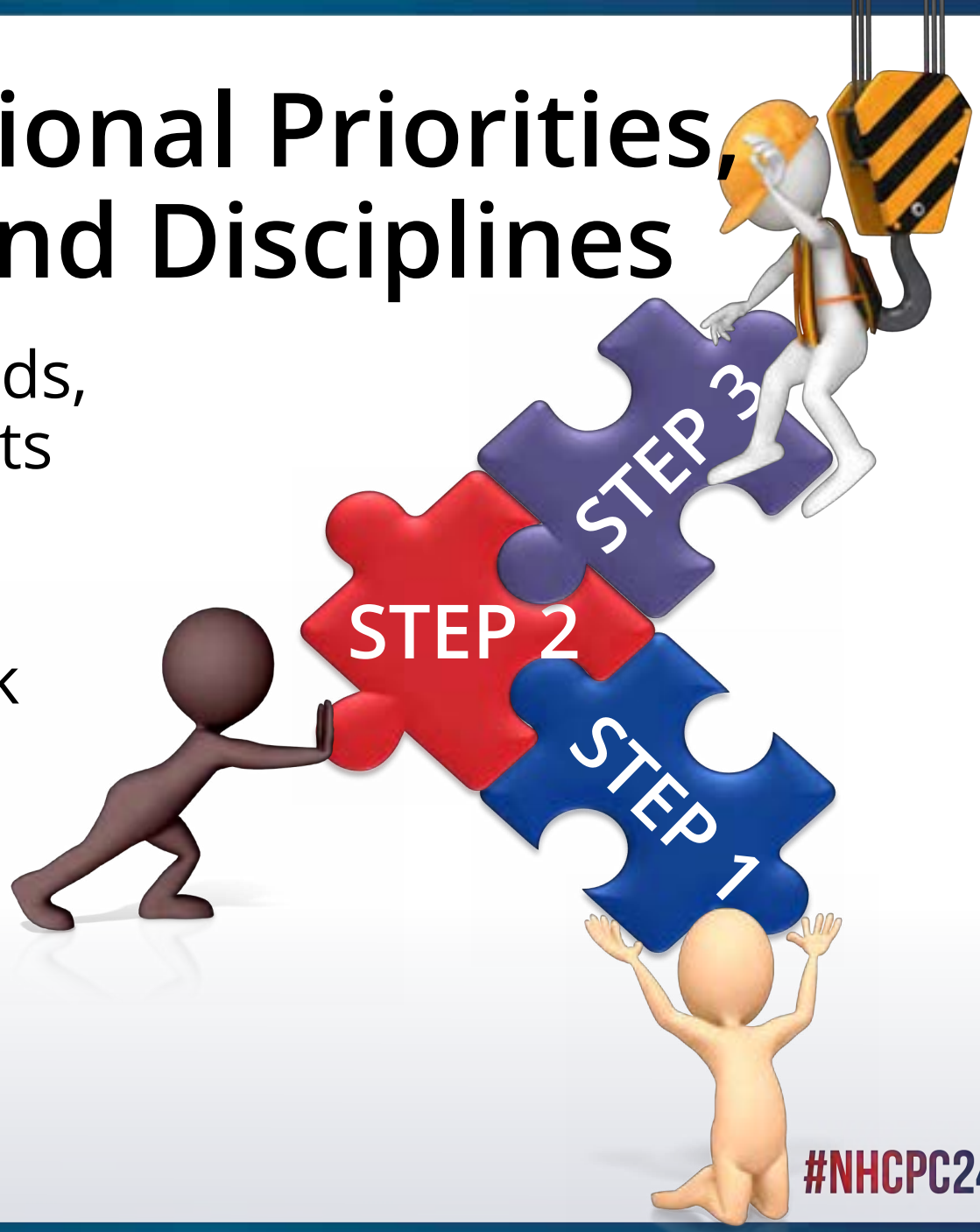
Perform Assessments
Identify Goals and Objectives

- What are the common needs/threats of the group?
- Can one organization fill the unfunded mandates of others?
- Are there legal requirements that can be met?
- What will increase community resilience/preparedness?



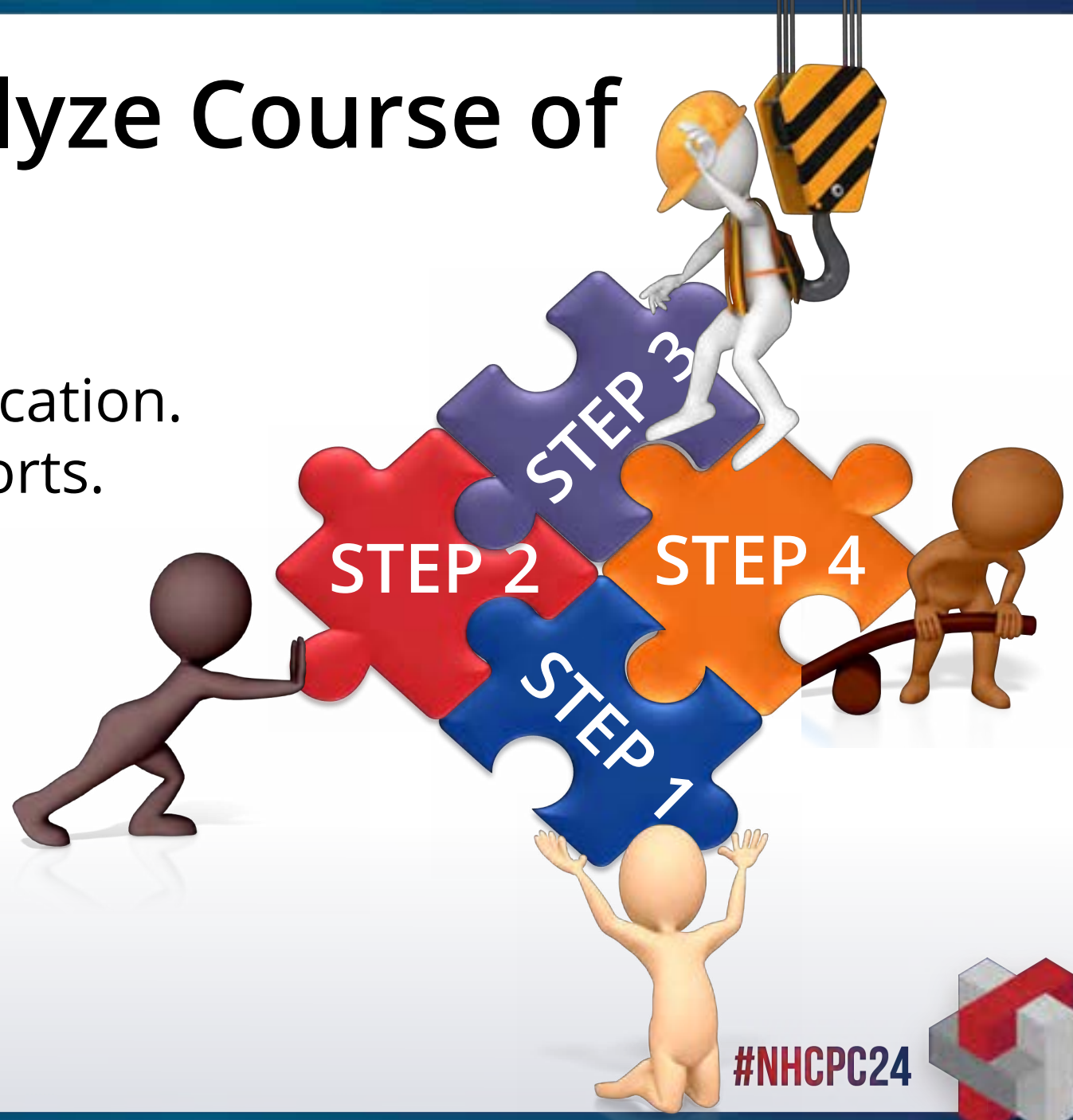
Determine Operational Priorities, Necessary Skills, and Disciplines

- Now that we know the needs, risks and legal requirements what are we going to accomplish?
- Create a schedule and stick with it!
- Identify your champions!



Develop and Analyze Course of Action

- Develop strategic plan.
- Provide effective communication.
- Ensure coordination of efforts.
- Identify your resources.

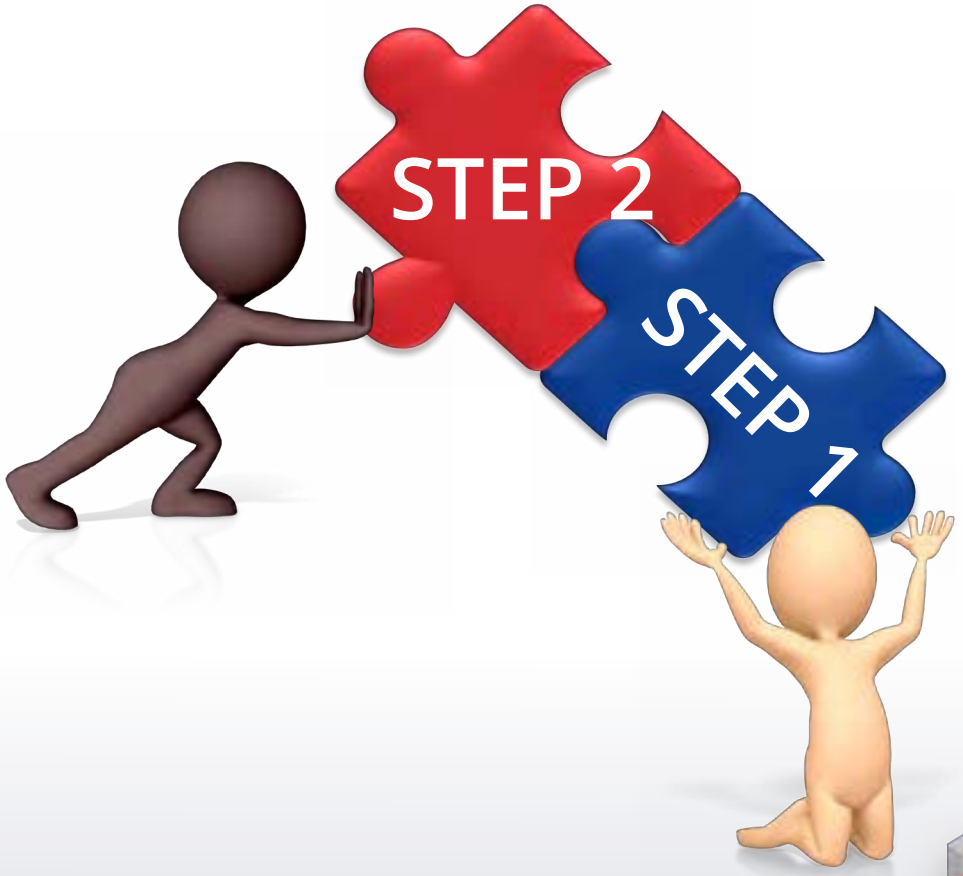


Review the Core Planning Team

- Is your group maturing at an acceptable rate?
- Are we meeting the needs/expectations of the members?
- Re-evaluate core planning team and determine if rotations or breaks need to occur to maintain a healthy work-life balance.

Review Assessments
Identify Goals and Objectives

- Re-evaluate the risk and assessments.
- Were group needs left out of the original goals?
- Were the objectives too easy, too hard, or just right?
- If goals and objectives were met, what now takes their place?

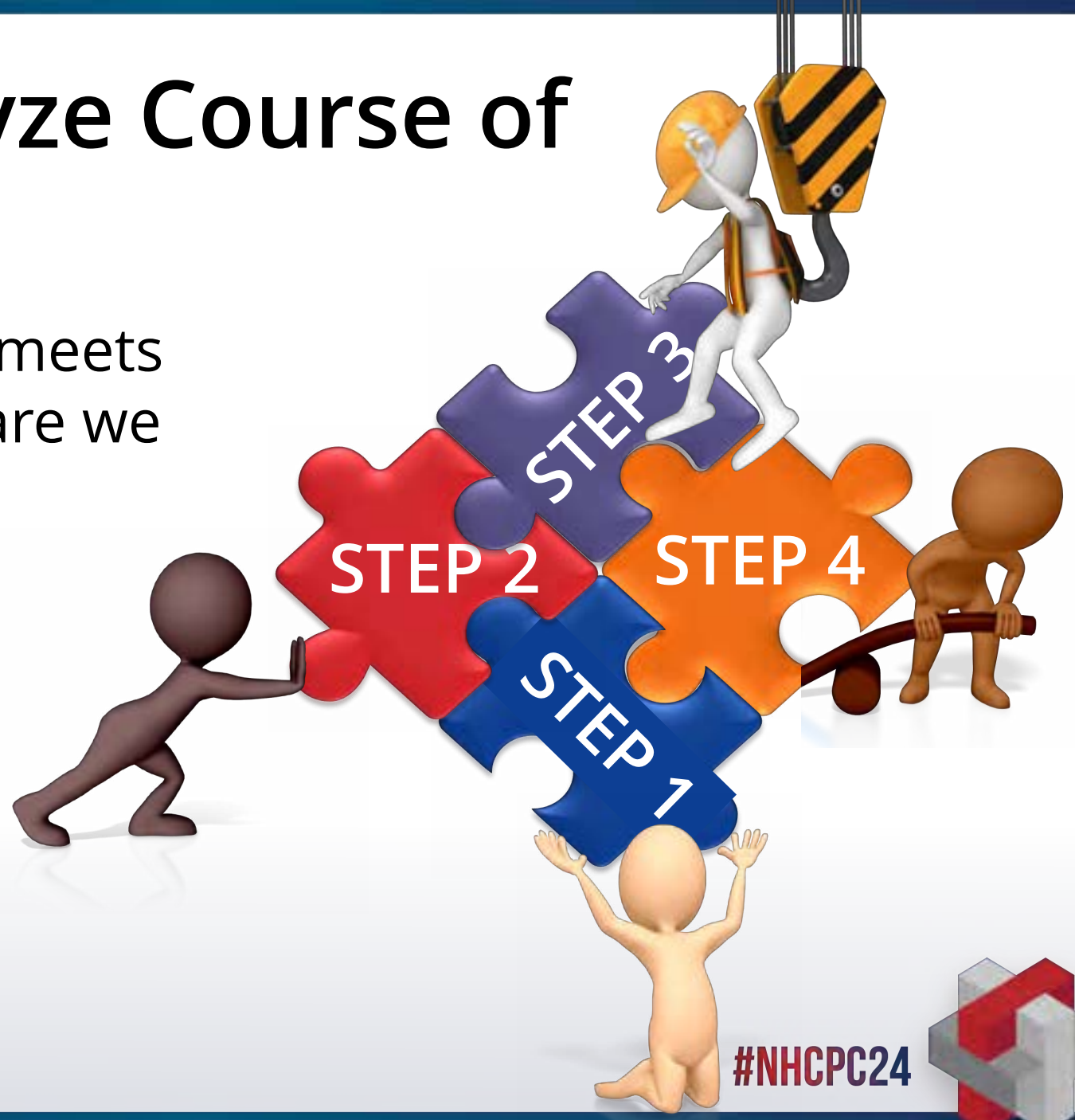


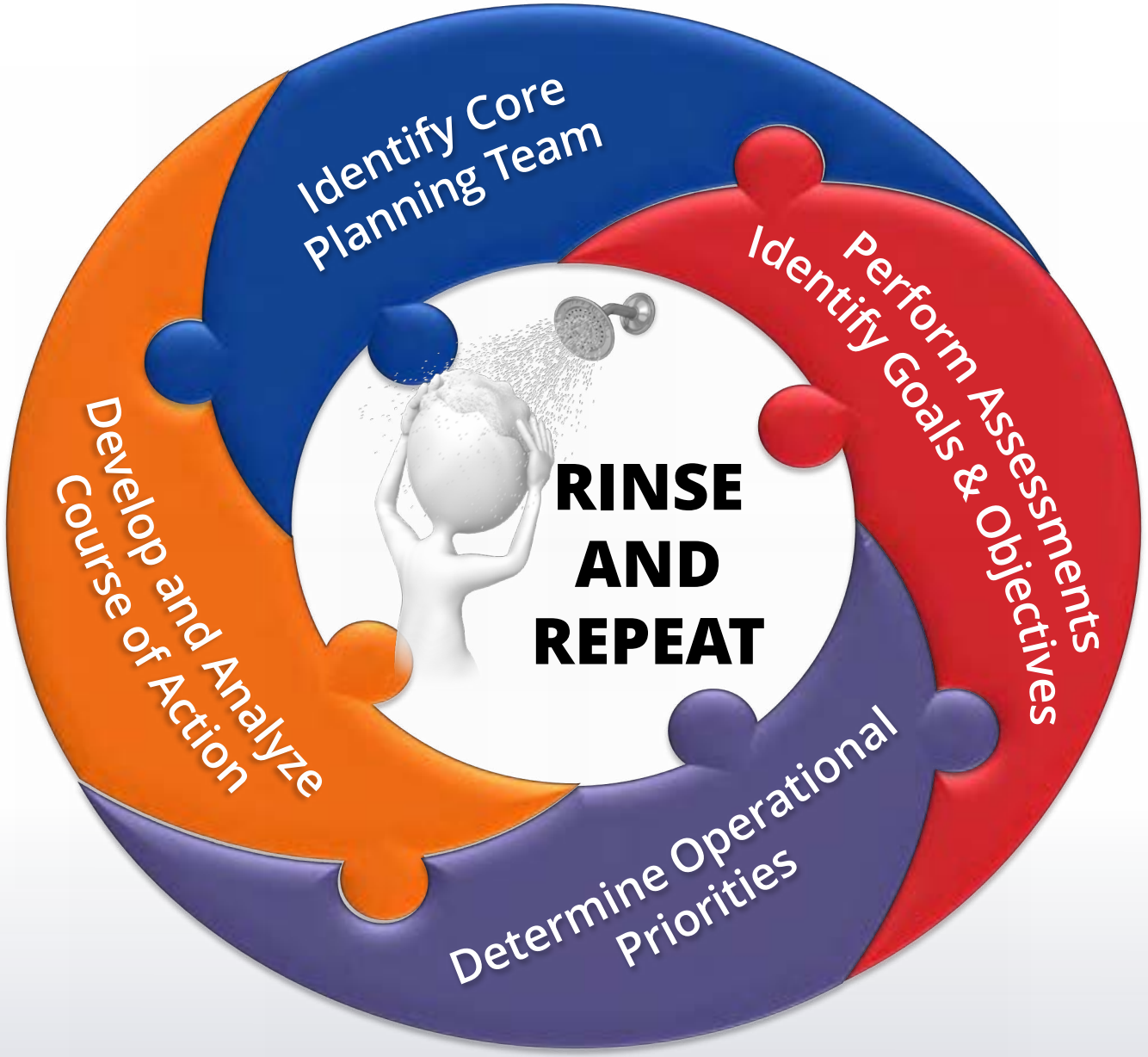
Review Operational Priorities, Necessary Skills, and Disciplines

- Review and update your strategic plan!
- Do you need additional subject matter experts to accomplish your goal?
- Do you have a work-life balance established for your champions?

Review and Analyze Course of Action

- This is where the rubber meets the road; what and how are we going to “do”?
- What do we need to "do" differently?
- Do we have adequate resources?

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DOCUMENTS

CONTACT US:

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WRITING A TABLETOP EXERCISE BUILDING BLOCK STYLE

A STEP-BY-STEP APPROACH TO WRITING A TABLETOP EXERCISE

THE PRESENTERS

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THE BUILDING BLOCK APPROACH

HOMELAND SECURITY EXERCISE & EVALUATION PROGRAM

Why do we exercise?

- Exercises play a vital role in preparedness by enabling whole community stakeholders to:
  - Test and validate plans and capabilities
  - Identify capability gaps and areas for improvement
  - Meet grant or licensing requirements

WHY USE HSEEP

- Guiding principles for exercise and evaluation programs
- Common approach to design, development, conduct, evaluation and improvement planning
- Flexible, scalable, and adaptable
- Applicable to all mission areas: Prevention, Protection, Mitigation, Response, and Recovery
- Based on national best practices
- Supports the National Preparedness System

TYPES OF EXERCISES

- Discussion Based
  - Seminar
  - Workshop
  - Game
  - Tabletop
- Operations Based
  - Drill
  - Functional
  - Full Scale

TABLETOP EXERCISE (TTX)

- Generate discussion of various issues related to the scenario
- Gain understanding of a concept or plan
- Identify strengths and areas for improvement
- Players apply their knowledge and skills to a list of problems/issues
- Discuss problems as a group
- Enhance general awareness and understanding of roles & responsibilities
- Validate (TEST) plans and procedures
- Recommend revisions to current plans, policies, and procedures

THE HSEEP CYCLE

- The Foundation
- Planning
  - Meetings
  - Team Members
- Exercise Design
  - Purpose
  - Scope
  - Objectives
  - Evaluation Parameters
  - Scenario
  - Documentation

- Exercise Conduct
  - Exercise Play
  - Hotwash/Debrief
- Exercise Evaluation
  - EEG
  - AAR
  - Improvement Plan

THE FOUNDATION

- The basis or groundwork of anything;
- The natural or prepared ground base on which some structure rests.

THE FOUNDATION OF YOUR EXERCISE

What is the overarching goal for the exercise?

- What are your preparedness priorities?
  - Risk assessments
  - Integrated Preparedness Plan
  - Grant requirements
- What plan, skill, policy or procedure do you need to test or develop?
  - Current plan, policy or procedure
  - New plan or plan update
  - Capabilities (FEMA Core Capabilities, HPP, PHEP)

THE PRE-BUILD PLANNING PROCESS

- Exercise Planning Team Positions
  - Exercise Director
  - Facilitator/Controller
- Leadership
- Stakeholders
- Plans
- After Action Reports & Improvement Plans

EXERCISE DESIGN

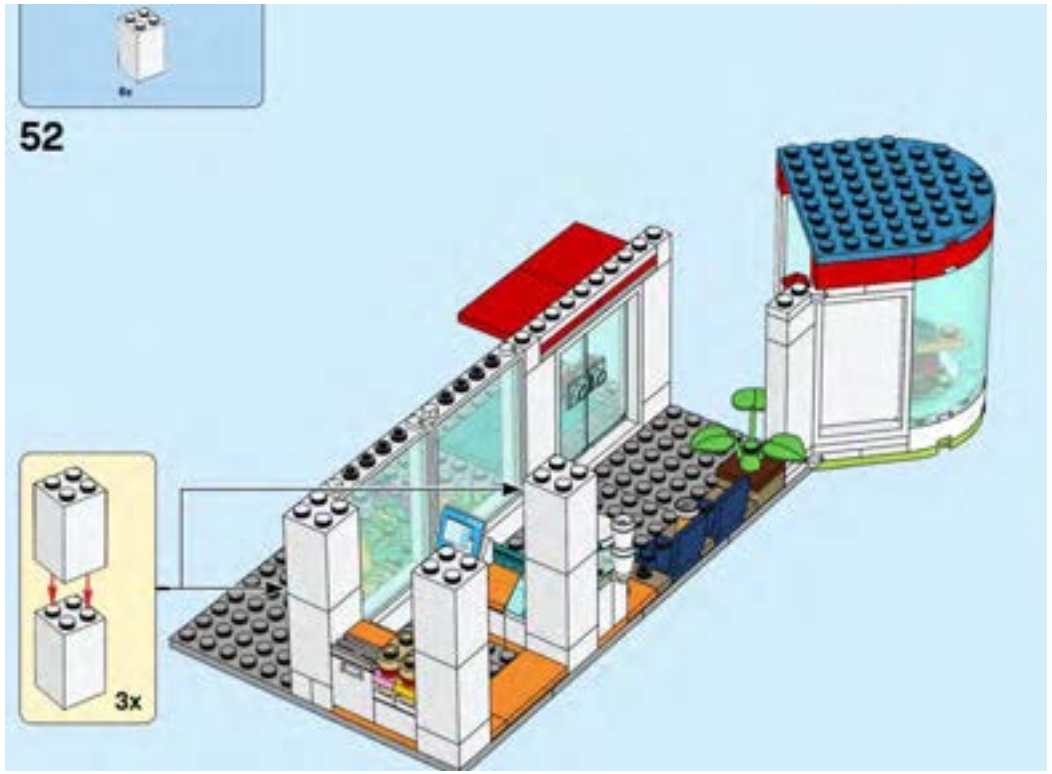
- Purpose
- Scope
- Objectives
- Parameters
- Scenario
- Documentation

PURPOSE AND SCOPE

- **Purpose**
  - Multi-Year Integrated Preparedness Plan
  - Existing plans, policies, and procedures
  - Threat, hazard, or risk assessments
  - Past exercise or real-world AAR/IPs
  - Grant requirements

- **Scope**
  - Exercise Type (Discussion, Functional, Full Scale)
  - Participation Level (Facility, County, Region)
  - Location
  - Duration

THE WALLS - OBJECTIVES SHAPE THE EXERCISE



Limit objectives to most useful, best practices, etc.

Tied to FEMA, PHEP or HPP Capabilities

HVA, THIRA, etc.

What do partners want to test?

New equipment to test

MISSION AREAS AND CORE CAPABILITIES

Prevention	Protection	Mitigation	Response	Recovery
Forensics and Attribution	Access Control and Identity Verification	Community Resilience	Critical Transportation	Economic Recovery
Intelligence and Information Sharing	Cybersecurity	Long-term Vulnerability Reduction	Environmental Response/Health and Safety	Health and Social Services
Interdiction and Disruption	Intelligence and Information Sharing	Risk and Disaster Resilience Assessment	Fatality Management Services	Housing
Screening, Search, and Detection	Interdiction and Disruption	Threats and Hazard Identification	Infrastructure Systems	Infrastructure Systems
	Physical Protective Measures		Mass Care Services	Natural and Cultural Resources
	Risk Management for Protection Programs and Activities		Mass Search and Rescue Operations	
	Screening, Search, and Detection		On-scene Security and Protection	
	Supply Chain Integrity and Security		Operational Communications	
			Public and Private Services and Resources	
			Public Health and Medical Services	
			Situational Assessment	

All Five Mission Areas

- Planning
- Public Information & Warning
- Operational Coordination

MAKE THEM S.M.A.R.T.

- Specific – Who, What, Where, When, Why
- Measurable – Numeric or descriptive measures that define quantity, quality, cost, etc.
- Achievable – Within the control, influence, and resources of participants
- Relevant – Instrumental to the mission of the organization
- Time Bound – Specify a reasonable timeframe into all objectives

THE WALLS - OBJECTIVES HELP SHAPE THE EXERCISE

- Tie your objectives to PHEP/HPP Capabilities or to FEMA Core Capabilities

"Demonstrate the ability of County staff to receive, develop, and disseminate a public alert utilizing the county's notification system regarding a HAZMAT train derailment within 15 minutes of initial notification, in accordance with the Risk Communications Annex in the Emergency Operations Plan."

Is this objective SMART?

- ❑ Specific?
- ❑ Measurable?
- ❑ Achievable?
- ❑ Relevant and realistic?
- ❑ Time-bound?

FEMA Core Capability: Public Information and Warning

EVALUATION PARAMETERS

- Develop the evaluation parameters early in the process
  - Guides the development of the scenario
  - Guides the development of discussion questions and timeline
- Align exercise objectives to capabilities
- Identify the linked capability targets and critical tasks

Exercise Objective 1: **Evaluate the ability to share medical-health information horizontally within the OA (with pertinent partners) and vertically with the region and State. (SITREP).**

Organizational Capability Target	Associated Critical Tasks	Observation Notes and Explanation of Rating	Target Rating
Intelligence and Information Sharing	Hospital A to contact MHOAC within 1 hour of activating their Hospital EOP		
Intelligence and Information Sharing	Hospital A to submit a Sitrep to MHOAC within 2 hours of activating their Hospital EOP		

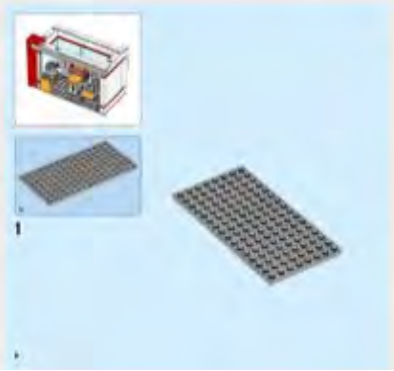
THE SCENARIO

Plausible, realistic, and challenging

Relevant to participants

THE "BLUEPRINT": YOUR INSTRUCTION GUIDE

DOCUMENTS	ROLES
Situation Manual (Sit Man)	Exercise Director
Master Sequence of Events List (MSEL)	Facilitator
Exercise Evaluation Guide (EEG)	Players
After Action Report (AAR)	Evaluators
Improvement Plan (IP)	Observers



SAMPLE SITUATION MANUAL

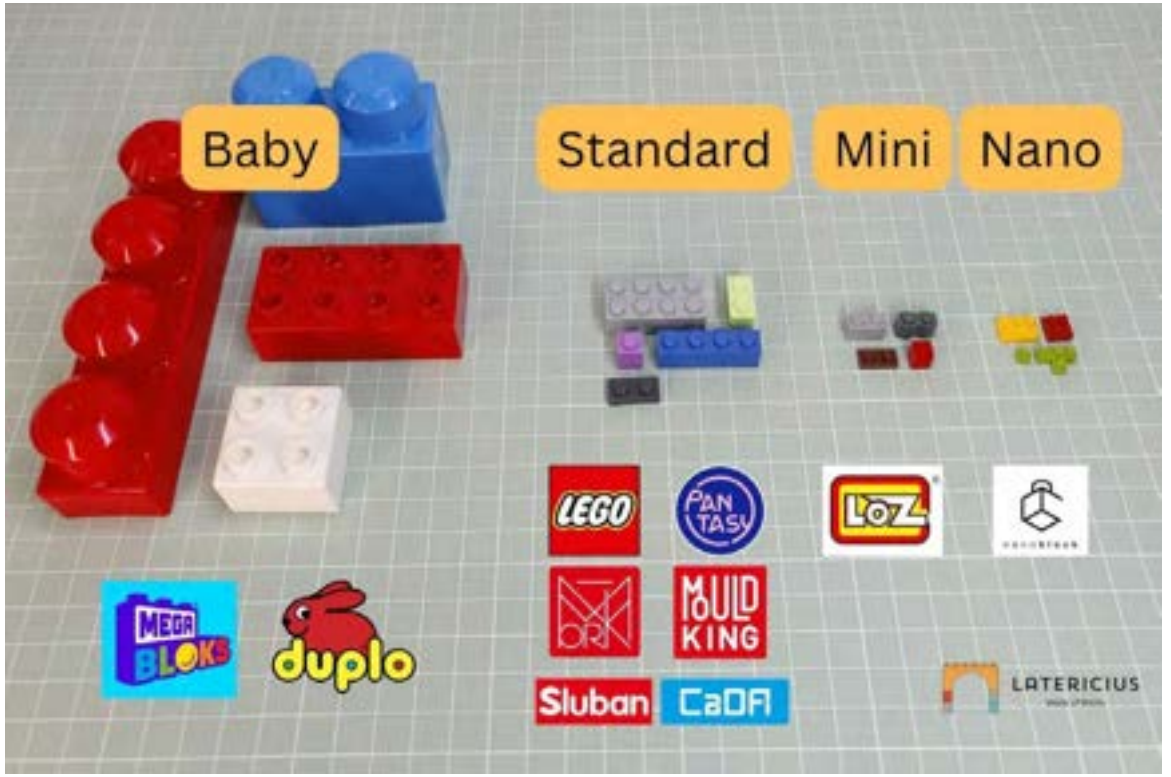
EXERCISE OVERVIEW

Exercise Name	2019 California Statewide Medical and Health Exercise (TTX)
Exercise Date	October 1st, 2019
Scope	This is a TTX planned for the Emergency Prepar coordination with the local public health depart 1st, 2019, at the Hospital A Conference Center.
Mission Area(s)	Response
FEMA Core Capabilties	Operational Coordination Public Information and Warning Public Health and Medical Services
Grant Capabilities	Emergency Public Information and Warning (PH Information Sharing (PHEP) Medical Surge (PHEP & HPP) Healthcare and Medical Response Coordination
Objectives	1. Coordinate with key partners to determin community needs during a medical surge 2. Discuss how the the HCC will ensure coord ability to monitor media utilizing the publi 3. Discuss how the HCC will activate and utili Preparedness and Response plan to comm partners and the flow of information. 4. Discuss how the HCC will activate and utili Preparedness and Response plan to asses capacity of the operational area during an
Threat or Hazard	Emerging Infectious Disease
Scenario	Emerging infectious disease with pediatric medi
Sponsor	Emergency Preparedness Healthcare Coalition
Participating Organizations	Office of Emergency Management Local Public Health Healthcare Coalition Members (List all member California Department of Public Health Local Emergency Services Agency Regional Disaster Medical Health Specialist Prog Health and Human Services Agency

NOT A ONE SIZE FITS ALL SITUATION

Scenario will play out differently in different jurisdictions

TTX can be adapted to fit needs of partners



EXERCISE PLAY

- Facilitator
  - Leads a discussion based on the scenario and objectives
  - Presents the scenario and keeps the discussion on track
  - Ensures that all issues are explored
  - Introduces injects
- Players
  - Actively participate in the discussion and work to problem solve
- Observers
- Evaluators
  - Complete the EEG

INJECTS

- An event introduced to a player(s) by the control staff, representing non-playing entities, to build the exercise environment based on the scenario and to drive exercise play or discussion.
- An inject changes the conditions of the event by adding additional problems or updating current conditions.
- Example Inject: "At 0800 a broken water pipe is discovered in the Med Surge wing; it becomes unsafe to house patients in the area."
- Injects should trigger the need for an action (Sit Rep, Resource request…)

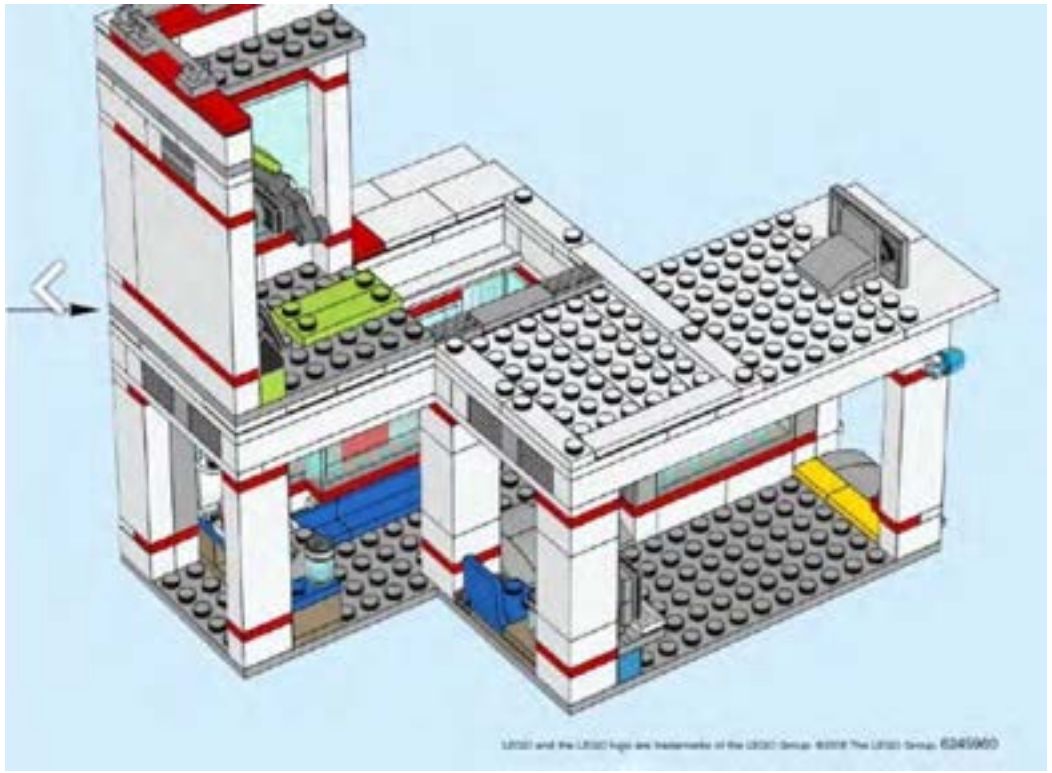
MISDIRECTION

SOMETIMES, AN INJECT IS PLACED AS A "MIS-DIRECT" AND MAY HAVE NO IMPACT TO THE SCENARIO AT ALL

Inject #	Time*	From*	To*	Method	Message/Task*	Expected Action*	Controller Notes/Remarks
Inject #: A numerical ordering of all injects presented.	Time: The time during the exercise at which the inject is supposed to take place and/or be delivered.	From: The sender or source of the inject. Include whether or not delivered by the SimCell or in Exercise Play. Can include specifics on who will deliver this	To: The recipient (person, organization, role) of the inject.	Method: How the inject will be delivered, e.g., verbally, by phone, by an overhead page, through email, etc.	Message/Task: A summary of the event, milestone, or message that is prompted by this inject. OPTIONAL: Include Script: If the Simulation Cell (SimCell) or a Controller is meant to deliver the inject via phone, in person, or through an actor, this column provides a sample script for the Controller/SimCell staff member/actor to use	Expected Action: A list of the expected outcomes based on the prompted inject. Ideally, each responder will have an expected action during the drill.	Controller Notes/Remarks: This optional section leaves space for Controller notes and directions, e.g., evaluation criteria, potential obstacles, or exercise logistics associated with the inject.

MASTER SEQUENCE OF EVENTS LIST

THE NEXT LEVEL – SCENARIO UPDATES (MODULES)

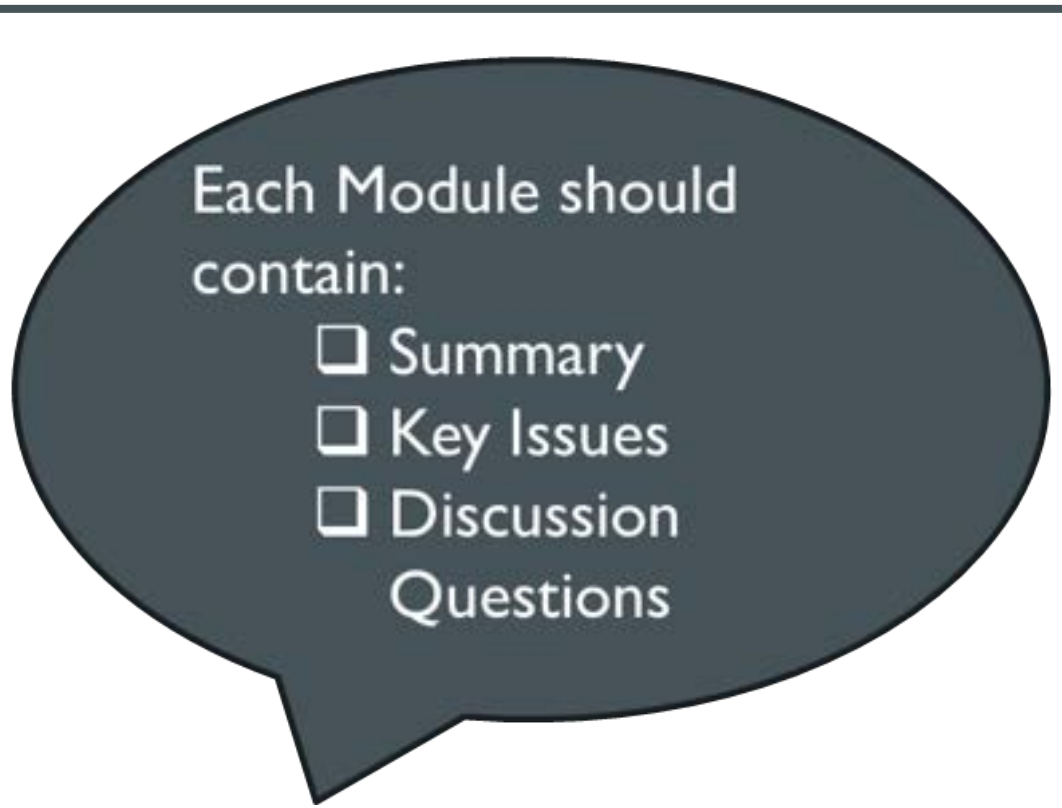


Based on the injects, what is the status of the event?

How has it changed (for better or worse)?

Provide an update to participants

MODULES



Module 1: Initial Response – Scenario Background

Module 2: Ongoing Response and Related Impacts

Module 3: Recovery

Module 4: Hot Wash and Debriefing

DISCUSSION QUESTIONS

- Consider the exercise objectives and capabilities being tested
- Open-ended questions will encourage discussion, reflection, and deeper analysis
- Questions should lead to resource needs or actions
- Start with basic questions
- Move on to more complex questions that address broader impacts, long term considerations and how different stakeholders are impacted
- Use role-specific questions for all stakeholders involved

EXAMPLE DISCUSSION QUESTIONS

- What resources would be dispatched to this incident? Does the jurisdiction have the necessary resources?
- What information would be important to know to develop a Situation Report? What means of communication can we use to get the necessary information?
- What are your major concerns/initial actions?
- What resources would be needed from outside the jurisdiction? How would we order and obtain these resources?

HOTWASH - DEBRIEF

- Identify strength(s) witnessed during the exercise
- Identify area(s) for improvement
- Participant Feedback Form

EVALUATE THE FINAL PRODUCT

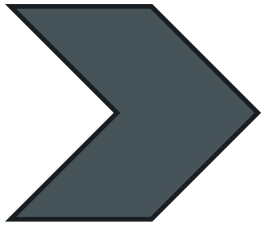
Exercise Evaluation Guide

After Action Report

Improvement Plan

AFTER ACTION REVIEW/REPORT

- Exercise Evaluation Guide(s)
- Participant Feedback Forms
- Notes from Hotwash/Debriefing



- Develop observations for the AAR/IP categorized as "Strengths" or "Areas of Improvement"
- Observation Statement
  - A clear and direct statement
  - Identify the issue
  - Determine the root cause
  - State the impact or result

AFTER ACTION REPORT

- For each objective
  - List the strengths in an observation statement
  - List the areas for improvement in an observation statement
    - Follow with an analysis and recommendations
    - Reference any plans, policies, procedures linked to the issue

Objective 6

Assess healthcare surge capacity of operational area for an MCI.

Strengths

The partial capability level can be attributed to the following strengths:

Strength 1: Clear direction by exercise director and healthcare facility's IC staff.

Strength 2: Surge capacity and ability of healthcare partners to assist with patients' surge, sheltering, and transportation.

Strength 3: Behavioral Health was able to identify staff and begin activation efficiently.

Strength 4: HHSA Care and Shelter management was able to identify a shelter location and begin activation efficiently.

AFTER ACTION REPORT

Assess healthcare surge capacity of operational area for an MCI.

Areas for Improvement

The following areas require improvement to achieve the full capability level:

Area for Improvement 6.1: Staff training in ICS and HICS.

Reference: County EOP and Hospital A EOP

Analysis: Healthcare facilities should continue to train, educate staff, and test through drills and exercises. This is especially critical when there is staff turnover. The hospital would benefit from continued HICS training, drilling and exercising with additional staff participation.

Area for Improvement 6.2: EOP and Healthcare Surge Plans need review and update.

Reference: Public Health & Medical EOP; Hospital EOP; County Healthcare Surge Plan, and Hospital Healthcare Surge Plan

Analysis: The hospital medical surge plan and EOP, as well as the Operational Area Public Health & Medical EOP and Healthcare Surge Plans have been identified as in need of review and update. Updates to partners, staff, and corrective actions from activations need to be incorporated into the plans.

Area for Improvement 6.3: Designate a core team of responders for Behavioral Health for long-term response.

Analysis: County Behavioral Health has the ability to respond immediately and activate an initial team; however, staffing for an extended incident would be difficult. Identification and development of an extended incident staffing model would be beneficial to incorporate into plans.

Area for Improvement 6.4: Behavioral Health does not have clearly defined response

IMPROVEMENT PLAN

- Turn areas for improvement into concrete, measurable actions that strengthen capabilities
  - Prioritize corrective actions
  - Provide input on strategy development and program priorities
  - Suggest a review or new development of plans, policies, and procedures
  - Identify and obtain needed training, equipment, and other resources

IMPROVEMENT PLAN

APPENDIX A: IMPROVEMENT PLAN

This IP has been developed specifically for <Blank> County as a result of 2017 Statewide Medical-Health Functional Exercise conducted on November 16, 2017.

Objective 2 Medical and Health partners complete a Situation Report and submit to the MHOAC Program within 2 hours of request.

Core Capability	Issue/Area for Improvement	Corrective Action	Capability Element[1]	Primary Responsible Organization	Organization POC	Start Date	Completion Date
Core Capability: Operational Coordination	2.1 SitRep were not submitted within the two-hour timeframe.	Retest the SitRep submission with all partners.	Exercise	HHSA-PH	EP Coordinator	01/01/2018	10/31/2018
	2.2 SitRep submission should be primarily electronically to MHOAC email; if faxing, use a cover sheet.	Create a SitRep-only fax cover sheet.	Planning	HHSA-PH	EP Coordinator	01/01/2018	02/01/2018

[1] Capability Elements are Planning, Organization, Equipment, Training, or Exercise.

YOUR TURN TO BUILD

Break into groups.

Complete the exercise planning forms on your table.

Pick a spokesperson and be prepared to report out.

GROUPS

- Public Health
- Emergency Managers
- First Responders (EMS, Fire, Law Enforcement)
- Healthcare Coalition/Healthcare Facilities
- Public Works
- Region or State

INSTRUCTIONS

- Use the forms to develop a Situation Manual for a Tabletop Exercise.
  - Partners to include in planning
  - Partners to include in the exercise
  - Overarching objective – your foundation
  - Scenario
  - Mission Area
  - Capabilities – At least 1
  - Objectives – 3
  - Injects – 3
  - Discussion questions to facilitate participant discussion
  - Scenario update - 1

REPORT OUT

Who wants to share their SitMan?

What were some challenges you encountered?

“A-ha!” Moments?

REFERENCES

Homeland Security Exercise and Evaluation Program (HSEEP), January 2020

California Department of Public Health, Emergency Preparedness Office, Exercise Document Library

THANK YOU

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