Keynote Address

Thad Allen

Thad Allen opening statement regarding his qualifications to address an audience of healthcare professionals and coalition members: “I have been through 5-6 major disasters and I have not been fired”.

Complexity – Every problem has a solution but growing complexity makes it harder getting there. New and novel ways of interacting with each other increases “public participation” (Meaning public’s access and ability to engage not only each other but government). We have the ability to create and implement technology quicker than ever before which has increased public participation. That public participation will challenge current plans/processes. Increased complexity = increased challenges. Main goal is Unity of Effort – uses of diverse resources with a common goal to address the problem, no agendas, and no egos. Co-production of outcomes which cannot be achieved through one single resource. Unity of Effort is not self-implementing. You have to shed parochial interests in order to meet objectives for the common good.

You have to build an atmosphere of trust and confidence.

How do you make something happen when you don’t have the authority to give a legal order? Katrina root issue as he saw it: Weapon of mass affect without criminality, resulting in the loss of continuity of government without actual loss of government officials. No leadership and no Unity of Effort. FEMA was just as lost locals due to ineffectual leadership and no co-production of outcomes.

Ebola – Get it at its source
Transmission/Transportation
We do this every day (these types of responses – media and public participation drove us to respond in ways we don’t normally)
Management of care

Public participation and complexity lead to the breakdown in current practices and processes.

Keys for Region

Unity of Effort easier to achieve during response (we all have a gun to our head); however preparedness efforts lack same Unity of Effort. Concepts of Unity of Effort equally important if not more so during preparedness efforts when those common overarching objectives can be discussed and resultant implementation is easier. Get Ready Capitol Region is a good effort in helping to shape public participation, need to continue to promote site both locally, and with state. Preparedness efforts currently
driven by agency/organizational agendas, personalities, and ego; Region needs to do more to integrate
Unity of Effort and leadership into preparedness efforts.

National Health Security Preparedness Index – Session 1
Dan Hanfling, Chad Priest

NHSPI - first of its kin tool to annually measure and advance our nation’s medical preparedness.
Baseline – determine day to day delivery status = “Healthy Communities” moving to disaster response and
positive health security outcomes.

2014 NHSPI structure has shifted from 2013 surge management transitioned to health care delivery. Part
of a healthy community is public compliance; currently public much more distrustful of government and
government initiatives...worst since Vietnam era.

The NHSPI is not a competitive process but state driven comparative; the NHSPI can be used to develop
areas for improvement. In effect the work is done at the local level but measured (NHSPI) at the state
level. How does this translate into improvement initiatives especially if state does not see the need to
spend time, energy, and resources where locals see a need?

There is no science attached to this tool or other capability measurements that actually indicates or
measures how resilient a community is.

Keys for Region
Region needs to review tool and data for CT, possibly through a workshop environment, crosswalk local
healthcare system objectives, and contract deliverables and then align with where we want to go, who we
want to be.

Healthcare Coalitions and FEMA Reimbursements through Public Assistance – Session 2
Jim Paturas

Quick Guide - FEMA Reimbursement for Acute Care Hospitals – Yale New Haven Health Systems

Most of the players in this arena are typically governmental; private non-profits (PNP), in this instance
acute care hospitals, usually do not have much knowledge about Public Assistance (PA) process and
applicant eligibility.

Intent of PA is to restore affected area to its pre-disaster condition; program and policies are intentionally
gray and subject to a lot of interpretations. Not unusual for applicants to engage consultants to serve as
their advocate, portions of this cost are generally covered under Direct Administrative Costs with the PA
program.

Eligible applicant(s)
Governments
PNPs – Process is open to the general public.
Medical facility means any hospital, outpatient setting, rehab. Centers LTC, centers/offices used for
diagnosis (labs/X-rays, etc.)

Facility must be the responsibility of the applicant located in disaster area; facility cannot be under any
specific federal authority. If facility was used for alternative use prior to disaster it will only be eligible to
restoration to pre-disaster use; e.g. use of clinical space as offices can only be restored as office space.

Eligible “work” can be part of mitigation or restoration efforts and FEMA will usually be the “payer of last
resort, after insurance, etc.
Categories of eligibility for “work” – Cat B Emergency Protective Measures
Cat E – Buildings and equipment
If repair costs exceed 50% of total replacement costs the building will be eligible for total replacement.
Labor Costs have varying criteria for eligible costs to reimburse labor costs.
Contracting – Prepositioned/vetted contracts highly recommended; utilize traditional RFP process prior to disaster as part of mitigation efforts to be used in disaster recovery.

Coalitions – If healthcare coalitions are part of PA application than it is preferred the coalition is in effect prior to disaster declaration:
   – May include non-eligible applicants
   – Can include government and government agencies (State/Local/Tribal)

Have systems in place prior to a disaster – helps streamline reimbursements
Systems for tracking labor and materials for disasters; isolated from normal operating expenditures.
Track all activities performed immediately prior to an event, both normal and disaster related.

Examine lease agreements for off-site locations – who is responsible for what; disasters usually not addressed specifically within lease agreements.
Review insurance policies; it may be more cost effective in the long term to have specific insurance coverages in place than rely upon PA program and/or FEMA reimbursements.

Appoint dedicated person(s) to coordinate and maintain all disaster related expenditures.
PA reimbursement will be reduced based on actual or anticipated insurance proceeds.
Appeals – Applicant can appeal any FEMA PA eligibility or funding determination.

Keyes for Region
Determine if there is a role in assisting R-3 stakeholders in this process. If so develop work plan to meet the mission, if not, at a minimum have basic knowledge of components for PA Program and how it applies to PNPs. Review FEMA policies e.g. 9500 series; FEMA guidance, e.g. 321, 322, 323 and Stafford Act.
Region can also consider working with DEMHS to establish a PNP workgroup to assist with process guidance.

The Present and Future Structure of HCC – Session 3
ASPR HPP representatives – Melissa Harvey – Acting Director –Division of National Healthcare Preparedness Programs – Office of ASPR
   – A 30% reduction in the Hospital Preparedness Program (HPP) funding from 2013 to 2014
   – Budget Period (BP) 2 of Cooperative Agreement – 24,000 healthcare coalition members nationwide; target is to build membership by 48,000 in 2017.

   Per ASPR there are currently 496 Health Care Coalitions (HCC) nationwide – this represents a 47% increase from BP 1 to BP 2.
   – HCC membership is not about in person attendance, membership equates to participants in specific disciplines or organization types which function in sub-committee setting; e.g. LTC is a section under RESF-8, all LTCs are considered coalition members with work done through LTC steering committees/ RESF-8 workgroups. The HCC needs to have a true sub-committee structure that gets pushed up to the overall/parent group HCC. Membership does not begin or end with meeting attendance.
   – ASPR sees the key focus of HCCs on hospitals, local public health, EMA, and EMS.

Community and population health planning is baseline to healthcare system preparedness, response and recovery. ASPR “If you can’t do it day to day, you can’t do it on game day”; day to day systems will be relied upon during a crisis. Are HCC thinking about healthcare preparedness on a day to day basis vs. only when something bad happens?
Office of the National Coordinator for Health can provide specific access to care information, can map coalition borders/processes through Center for Medicare/Medicaid.

**Keys for Region**
Review HHS Cooperative Agreement in conjunction with RESF-8 stakeholders; develop a better understanding of HCC process and structure. What does CT-DPH consider HCC in CT, how does it report to HHS. What do “we” think a HCC is and how is the work done?

**Executive Actions During an Emergency - Session 4**
David Whitaker, Paul Black, Lacey Vowell

Louisville Miss – 4/28/2014 – Tornado strike
Review of events in response to a tornado. Attached LTC evacuated 178 patients in 12 hours, placed in 24. Preparedness efforts and planning made response on the day of the event easier/less traumatic. *(In Moore OK preparedness efforts assured staff was not laid off during limited/no operational status).*

Winston Medical Center in Louisville was closed for one month and had to lay off some staff based on ability to provide services. Inter hospital communications and pre-established relationships were key and aided in decision making during the event.

**Keys for Region**
LTC and Hospital Mutual Aid Plan is key to preparedness and planning efforts leading to more successful intra-inter facility response AND recovery.

**Region 1 HHS Special Meeting**
ASPR project officer – Patti Pettis; Melissa Harvey
Review of HCC status in New England. Governance varies throughout , NH states they have coalitions but they are non-functioning or limited in scope. Maine DPH uses their 3 coalitions as the fiduciaries responsible for HCC contract deliverables. **CT uses ESF-8 structure for HCC, however no connection to DPH deliverables as a coalition, all contracts are with local public health or hospitals.**

**Community of Interest – EMS/Trauma**
Moderated session – Centrella
Discussion focused on EMS issues. Infectious Disease and Ebola preparedness questions; local response varies from treating an “Ebola” call as a hazardous materials incident, and the science surrounding current CDC guidance. Kansas DPH has a website with PPE justifications for their tiered level of Ebola activity: [www.kdheks.gov](http://www.kdheks.gov).

EMS hampered by having DOT/NHSTA as its “national parent”. That may have been appropriate in the 1970’s but EMS and para-medicine has evolved far beyond the scope of NHSTA as a non-medically based hierarchy. Scope of practice includes integration into health care and systems delivery directly tied to “healthy communities” much more aligned to HHS than DOT/NHSTA.

**Keys for Region**
Work of RESF-8 important to EMS stakeholders; explore strategies for larger EMS participation either through monthly RESF-8 meetings, or quarterly EMS section meetings/webinars. Continue participation in state and national dialogue regarding EMS issues.

**Session 5**
**Affordable Care Act – Healthcare Coalitions and Community Health Resilience**
Kevin Horahan, Onora Lien

Examination of the Affordable Care Act and not for profit status of hospitals: Tax exempt hospital has to show a “community benefit” either through free access to medical care/uncompensated care for at need community, or contributions to address community health needs (can be financial but doesn’t have to be).
IRS Tax Code Sec 501 (r)
What Counts:
- Address community health need
- Improve access or community health
- Has to have provide benefit to community than to hospital
- Not required for licensure or accreditation
- In more detail “Activities or Programs that...Strengthens community health resilience by improving the ability of a community to withstand and recover from public health emergencies” (Line 7e of Part 1 of 990 schedule)

**Keys for Region**
Explore accessing CRCOG 501 (c) (3) and generating financial support from not for profit organizations with specific Tax Exempt requirements; Internal Revenue Service “990 filers” needing to demonstrate “community benefit” to maintain tax exempt status. This can provide economic sustainability for RESF-8 activities that benefit both the “community” served, and with that, hospitals. This approach can lend stability not only to RESF-8 but to CREPC as well.

**Closing Session**
Jeff Upperman, Doug Smith, James Robinson

Review of Utah hospital systems, University of Southern California Children’s Hospital, and Denver EMS. Nothing new for Regional consideration other than never letting a good disaster go to waste, meaning being able to leverage previous disasters to help build and/or support your healthcare system preparedness efforts.

Panel discussion regarding competing interest seen at the hospital C-Suite level:
Posed scenario: Hospital A needs more preparedness funds, but the hospital also has a need for a new parking lot. The parking lot takes precedence because we need more patient visits to generate more income which in effect can also grow the hospital’s preparedness program.
Question – How can we address those conflicting needs and get what we need for preparedness.
Panel discussion about using the new parking lot to augment preparedness – open space for alternative care site, made better with installing more lighting, generator connections, tent footings, etc.

Panel also discussed how to engage the C-Suit; far beyond current capabilities in R-3 ESF-8.

How do you de-conflict geographical healthcare coalitions and integrated healthcare systems, (e.g. CT Region 3 and Hartford Healthcare Systems?)
Respondents feel it depends on maturity of healthcare coalition; the more mature the easier to assign specific functions to assist those healthcare systems regardless of borders and boundaries.

**Keys for Region**
In this point in case it is all about hospital preparedness, R-3 ESF-8 role is not as robust as those described by presenters as such R-3 ESF-8 may never have the ability to assist in the nuts and bolts of hospital preparedness, acknowledging current role of information sharing and resource coordination. R-3 hospitals will need to be much more engaged in overall regional preparedness efforts before a more robust role can be assumed by R-3 ESF-8.
Conclusion and Recommendations

This was another good conference which highlighted the potential benefits that can be realized within a healthcare system of a well-organized and supported Healthcare Coalition. The Region 3 ESF-8 Public Health and Medical Services is diverse in membership with certain sections within RESF-8 more active than others in producing a value to stakeholders and the Region. If the Region and the State are to be successful in HCC endeavors than a more open and trusting relationship is needed from the start with acknowledged areas of functional responsibility or supporting roles.

Although all stakeholders seemingly want to work together there are undoubtedly still undercurrents of specific organization or agency agenda needs driving the outcomes. This does not mean that we should necessarily abandon the specific organization’s needs, but in fact that we should acknowledge in an open forum what our needs are and how can we collectively work to that state of co-productive outcomes.

Although the Region 3 ESF-8 has promulgated and maintains a “Strategic Planning” document it is imperative that the R-3 ESF-8 work beyond the four corners of that document by first agreeing upon what it is exactly the stakeholders need and want from a healthcare coalition. There are vast differences in “just” the sharing of information and coordination of resources, to a regionally based planning and response system with more defined functional regional roles and responsibilities that benefit the healthcare system during a surge, or disaster.

Recommendations:

1. RESF-8 examine initiatives that shape the function(s) and course of this Healthcare Coalition
   a. Engage RESF-8 members in a “needs assessment”
   b. Align any such initiative with ASPR HCC guidance and standards where appropriate
2. RESF-8 use the next month to review ASPR HCC guidance documents and work with HHS Region 1 Project Officer to provide comment where appropriate
3. Determine the role of MMRS funding in meeting the needs and work for the RESF-8
4. Develop an appropriate work plan aligning the needs of the RESF-8 Healthcare Coalition with State and Federal deliverables or guidance

Respectfully Submitted,

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