

Healthcare Coalition Statewide Working Group

Meeting Summary

Dates: June 19-20, 2013

Location: Florida Hospital Association Regional Office, 307 Park Lake Circle, Orlando, FL 32803

Members Present:

- Eric Alberts, Orlando Health Inc.
- Brenda Atkins, Wellington Regional Medical Center, Palm Beach Healthcare Emergency Response Coalition (HERC)
- Connie Bowles, Lee Memorial Health System
- Paul Ford, Tampa General Hospital
- Otis Gatewood, Bay Medical Center
- Dr. John Lanza, Escambia County Health Department
- April Henkel, Florida Health Care Association
- Christie Luce, Florida Department of Health, Medical Surge Unit
- Matt Meyers, St. Lucie County Health Department
- Jeanine Posey, Florida Department of Health; Medical Surge Unit
- Mary Russell; Boca Raton Regional Hospital, Palm Beach Healthcare Emergency Response Coalition (HERC)
- Terry Schenk, Florida Department of Health, Medical Surge Unit
- Tony Suszczyński, Shands Jacksonville, First Coast Disaster Council
- Wendy Wilderman, DeSoto County Health Department
- John Wilgis, Florida Hospital Association
- Dr. Jim Shultz, The Center for Disaster and Extreme Event Preparedness, University of Miami
- Thomas Knox Jr., Florida Association of Community Health Centers
- Dr. Christopher Hunter, Associate Professor Emergency Physicians, Orange County EMS

- Gail Stewart, Leon County Health Department
- Jennifer Jensen, Florida College of Emergency Physicians, Emergency Medicine Learning & Resource Center (EMLRC)
- Paula Bass, Florida Hospital Orlando
- Dr. Brad Elias, Baptist Jacksonville Hospital, Florida Department of Health, Medical Surge Unit
- Dan Simpson, Polk County Department of Health
- Makeshia Barnes, Florida Department of Health; Medical Surge Unit
- Kay Croy, Florida Department of Health; Bureau of Preparedness and Response
- Ben St. John, Florida Department of Health; Training and Exercise Unit
- Sara Cox, Florida Department of Health, Training and Exercise Unit

Meeting Goal: Continue to develop recommendations for the design, structure and purpose of healthcare coalitions in Florida.

Meeting Objectives:

- Review and consolidate initial recommendations from ‘Kick-Off’ meeting in March.
- Review Florida Department of Health (FDOH) work plan key objectives, milestones and budget considerations.
- Review and address ‘Action Items’ from March meeting.
- Review and discuss outstanding issues not yet resolved.
- Discuss feedback from local healthcare organizations on the development of healthcare coalitions.
- Determine framework for FY13-14 pilot projects.
- Establish a call and meeting schedule for FY13-14.

Healthcare Statewide Working Group (HCCWG) Summary of Information:

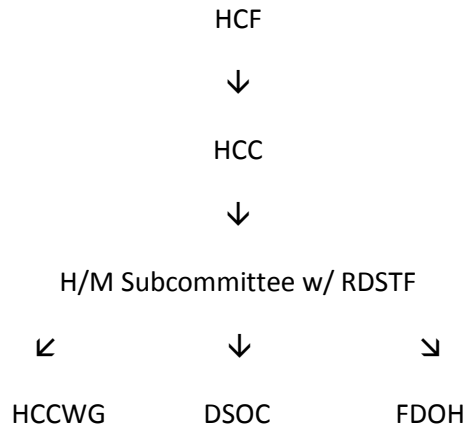
- Year 2 of the U.S. Department of Health and Human Services, Assistant Secretary for Preparedness and Response (ASPR), Hospital Preparedness Program (HPP) 5-year grant cycle runs from July 1, 2013 to June 30, 2014.

- Need for Trauma and Pediatric Representation - Dr. Lanza will reach out Drs. Mulligan and Northrup for Pediatric representation and Kay Croy will make contact with Patricia Stadler for Trauma.
- Integrate beyond the hospitals and involve Long Term Care, Mental /Behavioral Health, and other stakeholders that have not been involved in the past, but are considered “required members” per the ASPR Funding Opportunity Announcement (FOA).
- Encourage local communities to determine Healthcare Coalition (HCC) boundaries, not the state. They should be based on existing partnerships and may include normal referral patterns and other considerations.
- Funding and allocation methodology (included in handouts) is a bureau priority that Kay Croy and the Medical Surge Unit (MSU) will work on over the next year.
- Funding methodology has to be considered up front – definite need for transparency in the allocation process. On June 17, the Regional Co-Chairs adopted the proposed methodology.
 - Regional allocations are based on their percentage of total statewide hospital beds
 - Recommendation from HPP Project Officer to adopt a uniform, statewide allocation methodology. Resulting approach incorporates HCC membership and identification of gaps through risk assessments.
 - Discussion about a funding process with HCCs.
 - FDOH is working to develop risk assessment tool for Regions and Coalitions.
 - Discussion about HCCs creating a tax structure like a 501(c)3 or like structure and FDOH’s use of the Healthcare Exemption for contracts.
- Organizational structure with documentation is needed, (Palm Beach County Healthcare Emergency Response Coalition is one example).
- April Henkel briefed the group on her involvement with an ASPR funded project involving a “core planning group” that considers Long Term Care across continuum of care. Who are the stakeholders? Where do they live within the community? Are they inpatient or outpatient? Do they utilize hospice, meals on wheels, home healthcare, pediatric long term care? During an event, where do they go? There must be a plan. This group has to be brought into the equation for preparedness.
- Ben St. John explained the training and exercise requirements in the ASPR grant. Each coalition must conduct a full-scale exercise within the 5-year grant cycle. Region 3 has agreed to be the first HCC to complete this requirement in November 2013. Each HCC’s exercise objectives should be tailored to identified risks. Ben also explained that there is a community calendar for training and exercise. Regions and HCC’s can post upcoming trainings and exercises. This is accessed through the Florida Department of Health web site. Please feel free to contact Ben St. John or Sara Cox for more information on the website.

- Integration of required plans:
 - Continuity of Operations Plan (COOP)
 - Comprehensive Emergency Management Plan (CEMP)
 - Federal Emergency Management Agency's (FEMA) Threat and Hazard Identification and Risk Assessment (THIRA)
 - Florida Agency for Health Care Administration (AHCA) Emergency Operations Plan requirements
 - Hazards Vulnerability Assessment (HVA) / Risk Assessments
 - Accreditation requirements
- Discussion of Regional Needs/Challenges:
 - R1
 - Evolution
 - Augmentation of HCC with Health and Medical (H/M) Co-Chair and Regional Domestic Security Task Force (RDSTF)
 - County Health Department (CHD) Education / Info
 - Organized Structure
 - 1 point-of-contact for administration
 - Regional Planner / Regional Emergency Response Advisor (RERA) Integration
 - Question - Contract Management
 - R2
 - Redevelopment and expansion of Leon Co. Disaster Healthcare Coalition
 - Challenges – Rural Counties
 - Organized Structure
 - Increase membership
 - 1 point-of-contact for administration
 - R3
 - RDSTF is heavy on Law Enforcement
 - Expanding to Regional HCC includes a broad regional area and members
 - Gaps: Inclusion of entire region; Gainesville/Ocala may want their own HCC; Consider county based structure outside of FCDC

- Regional vs. Hybrid model
- R4
 - No regional group
 - Consider county based – To Be Determined
 - Increase information sharing about HCC to counties
 - RDSTF H/M Committee integration and engagement & guidance
 - Integration with Planners / RERA
 - GAPS: required members; who owns the responsibility (point-of-contact for administration);
 - Need evolution
- R5
 - Lots of existing groups (15 in 9 counties)
 - Don't have formal organization or required members
 - Question - RDSTF structure w/ sub-groups
 - Need to formalize with consideration of 501(c)3 and lead / point-of-contact for administration
 - Question - Administration of funding
- R6
 - Meeting in July with counties and partners
 - Some small existing groups
 - Question - Rural involvement
 - Question - RDSTF structure
 - Question - Ownership and point-of-contact for administration
 - Need Evolution
- R7
 - 3 very formal groups (Question - Monroe)
 - Need sustainment
 - Need transition/evolution to include required partners
 - Question - day-to-day partners with referral patterns

- After each region discussed their current challenges, it was unanimously decided that each region could most effectively begin work on meeting the requirements of the ASPR grant by funding a position to integrate and coordinate all necessary members into a functional HCC.
- There is needed integration within Florida’s Domestic Security structure. This includes outreach to the Domestic Security Oversight Council (DSOC), each RDSTF and the RDSTF Health and Medical Committees. It was also suggested that a representative of each HCC attend local RDSTF Health and Medical meetings. There was discussion that this integration may assist with membership and that some RDSTF’s may explore developing a regional HCC. Integration with RDSTFs could enhance activity around boundaries/gap areas, administration, marketing and communications planning and risk assessment. It was mentioned that engaging the regional Special Agent in Charge would also be a good idea. A regional structure could also support a tiered structure of integration as indicated below,



- FY 2013-14 Regional Goals:
 - Existing HCCs
 - Assessment (Risks and Resources)
 - Operational Planning
 - Training / Education >>> Exercises
 - Regular Meetings
 - Development (Identity for gap areas / Expansion for existing areas)
 - Organizational Structure
 - Engagement of Required Members
 - Sustainment planning

- Documentation of activities
 - Public Relations, Marketing and Information tools
- New HCCs (and members)
 - Assessment Risks and Resources
 - Training / Education >>> Exercise
 - Point-of-contact ⇔ Integration with HCC
 - No supplanting
 - Involvement with Disaster Cycle planning
 - Multi-Year Training and Exercise Plan (MYTEP)
- Overall
 - Invite and brief all required members
 - Develop a Marketing Plan
 - Develop a Communications Plan
 - Define Performance Measures
 - Develop Tier 1 Regional Coalitions
- Hospital contracts will probably still exist, but funding for individual facilities will reduce as HCC participation grows.
- Jennifer Jensen from the Florida College of Emergency Physicians briefed the group on the extensive Chemical, Biological, Radiologic, Nuclear and Explosive (CBRNE) training offered by Emergency Medicine Learning & Resource Center (EMLRC).
- FDOH MSU will establish an information sharing website with links to resources, templates, and existing HCC's that have an active website.

Review of 5 year Work Plan:

FY 2013-14 Goals

- **NIMS** – Will be captured in the Hospital Assessment & Monitoring System (HAMS). This system will be available August 2013.
- **COOP** – For hospitals, COOP plans are required and are usually contained within the hospitals CEMP. The First Coast Disaster Council full-scale exercise in November will incorporate a COOP objective. Tom Knox stated he has access to a template and is willing to send out to anyone interested. Annual hospital surveys are going away. Coalitions will be responsible for reporting on performance measures. A fully implemented COOP Plan is not due until year 5. FDOH will work to come up with an

easier way for HCC's to address COOP. FDOH will also ask ACHA to revisit their requirements and possibly make reporting to both entities easier and more timely. Recommendations were to have a webinar to make reporting more understandable and functional. This too will be taken into consideration by FDOH. Remember that most facilities already have a CEMP/COOP plan. Christie Luce reminded the group that HCC development is a process - they do not have to be fully developed by the end of FY2. Start with end result in mind and develop goals for each year. It is important to remember that communication to the small 'mom and pop' places is essential to ensure there is COOP in place. FDOH will work diligently to make sure regional and HCC Risk Assessment tools are acceptable and user friendly.

- **Education and Training** – Web board will be implemented within HAMS and each region will be able to see and post educational training that is upcoming and available. Training has to be done with other entities and may be offered through the counties as well as hospitals. Remember that Coalition training must be based on identified gaps and risks within the community. First goal is to educate the community on HCC's (their purpose and the federal requirements).
- **Exercises, Evaluation and Correction Action** – Reminder: These are not FDOH requirements, but Federal requirements. The purpose of this requirement is to create exercise programs that build on the Homeland Security Exercise and Evaluation Program (HSEEP) components. Exercises should involve ESF 8 along with other ESF partners (4, 9, 16 and 6). Keep in mind the goal is to work together prior to an event. Healthcare Coalitions can educate members; HSEEP recognizes workshops as an acceptable exercise. Invite all partners to the table. Real events meet the performance measure goal. It was decided that the goal for FY2 will be (at least) a Tabletop exercise conducted by each HCC involving all required members.
- **Needs of At-Risk Population** – FDOH will check into getting tools from a university group doing a GIS project involving mapping of vulnerable populations. ASPR wants HCC's to provide education to locals on situational awareness of vulnerable populations – ASPR does not expect HCC's to take the lead for pre-registration of at-risk populations. HCC's should identify local capacity and capabilities for accommodation of this population. EM has not been able to address this population thus far – decision that EM needs to take a more active role at the HCC meetings and identify gaps. Lots of work ahead to meet the goal for this population. Goal for FY2 is to engage local EM in planning for the needs of at-risk populations during a disaster.
- **Interoperable Communication Systems** – Establish a mechanism for monthly communication checks. By the end of FY2, each HCC will participate in monthly communication roll calls. (Drills are considered an HSEEP acceptable exercise and keep everyone involved). Primary and back-up communications need to be tested.
- **HAvBED** – HAvBED drills will be conducted each quarter. EM Resource has made excellent progress over the last six months and will be used for bed reporting next hurricane season. ESS will be going away. Coalitions need situational awareness; the big picture is bed availability during an event.
- **ESAR-VHP** – Group suggested including MRC's in HCC development. All MRC's should register in SERVFL. HCC's should encourage MRC and other volunteer participation in HCC exercises. Goal for FY2 is to engage MRC for participation in HCC's and HCC exercises.

- **Fatality Management** – This area is a national issue and Florida is ahead of most states with their fatality management process. The Group requests that Jason Byrd join the HCC State Working Group, as he is taking over for Larry Bedore when he retires. It will be important to engage FEMORS in HCC exercises. Goal for FY2: engage local Medical Examiners in HCC. It was suggested that more training needs to be done on fatality management. There is a big concern/need to establish where to take the deceased during an event as most local capabilities for storage are extremely limited. Dan Simpson reported that Region 4 has plain steel truck available to them in case of a mass fatality event.

Mental / Behavioral Health Support:

- Strike Teams
- Florida Crisis Consortium
- Disaster Behavioral Assessment Teams
- Request through local ESF 8 (EM Constellation)
- Medical Reserve Corps
- Lee County has strong mental health component
- Pastoral Care/Chaplains
- Federal Strike Teams

Dr. Haney leads behavior health teams for FDOH and any area in need can contact him for assistance. In order to request help during an event, local emergency management must submit a mission request to activate a statewide team. HCC's can develop their own teams and request state assistance if local capacities are exceeded. Much more training needs to be done on local and state level in this area.

Dr. Jim Shultz explained that training, exercise, response, and recovery for mental health starts right away and goes beyond recovery-post impact. The key is to triage people quickly, not only for medical needs, but for mental/behavioral needs as well. Physiological recovery is post impact, does not happen right away, and can vary depending on the situation. Goal for FY2: Each HCC will conduct behavioral / mental health training with local partners. Dr. Shultz is trying to implement a rapid analysis/assessment for a variety of disaster scenarios. Dr. Shultz has also written an article on Psychological First Aid in Disaster Health journal, this publication can be downloaded from the internet. He is also looking for an article on HCC's if anyone is interested in writing one.

Planning Goals:

1. Compare COOP with CEMP
2. Coordination of MYTEP (Local and State)

3. Leverage Training / Education and Exercise across HCC
 4. Year 1 - HSEEP Exercises
 5. Consideration/Improvement of At-Risk planning with EM and Provider
 - a. HCC integration
 6. HAvBED reporting and awareness
 - a. IBA and HCC role
 7. Engage / Integrate MRCs and FEMORS
 - a. Consider MRC training
 - b. FM tools and resources needed
 8. Integration with Behavioral Health
 - a. Disaster Behavioral Health Teams
- Desired result at the end of Year 5: The entire state is covered by HCC's that incorporate all the required members identified by the ASPR grant guidance. This requires thinking beyond the hospital and focusing more on engaging healthcare partners to be involved this upcoming year.

HCC Project Development, Milestones and Deliverables:

The group voted to fund each domestic security region at \$100,000 with allocated FY 2013-14 HPP grant funds and that an established HCC Regional Coordinator will work with local partners to use the funding to assist in HCC development and sustainment with each participating group meeting all required FY2013-14 deliverables by 6/30/2014. Deliverables are defined below:

Deliverable 3.2.4b – Develop, Refine and Sustain Health Care Coalitions

Key Milestones

Coalition Coverage Areas

1. By 10/30/13 – define Healthcare Coalition (HCC) community boundaries.
 - a. Establish HCC working group points of contact (POC) for each region.
 - b. Identify existing coalition boundaries by providing documentation of counties involved in the coalition.
 - c. Identify coalition coverage gaps and their respective geographic areas.

Coalition Assessment

1. By 12/31/13 – identify existing HCC members using provided template.
 - a. Establish existing coalition membership through documentation.

- b. Determine gaps in required 'essential members' through documentation.
- 2. By 6/30/14– identify existing HCC members using provided template.
 - a. Establish existing coalition membership through documentation.
 - b. Determine gaps in required essential members through documentation.
- 3. By 12/31/13 – conduct an assessment of HCC development status.
 - a. Complete template to include “stages” of coalitions and develop a comparison of existing coalition’s statuses.
 - b. Establish strategies and tools to address gaps & areas for improvement.

FY 2014-15 Project Development

- 1. By 1/31/14 – establish milestones and deliverables for FY 2014-15 based on the assessment.
 - a. HCC Statewide Work Group determines funding needs for FY 2014-15 activities.
 - b. HCC Statewide Work Group defines milestones and deliverables for grant funding.
- 2. By 12/31/13 – conduct two (2) statewide meetings of the HCC working Group (\$20,000 for both meetings).
 - a. HCC Statewide Work Group will provide recommendations for organizational structure, documentation maintenance and meeting coordination.
- 3. By 6/30/14 – conduct two (2) statewide meetings of the HCC working Group (\$20,000 for both meetings).
 - a. HCC Statewide Work Group will provide FY 2014-15 program requirements and criteria.
- 4. By 6/30/14 – participate in the planning and development of education and training programs for 2014 Governor’s Hurricane Conference.

HCC Required Elements

- 1. By 3/31/14 – Determine and refine HCC structure and organization requirements.
 - a. New and existing HCC will submit documentation requirements of HCC structure.
 - b. New and existing HCC will submit minutes of HCC meetings.
 - c. New and existing HCC will submit demonstration of quarterly meetings (minimum) to include a minimum of two (2) face-to-face meetings.

2. By 4/1/14 – Provide elements necessary for completion of ASPR performance and/or outcome measures.

FY 2013-14 HCC Regional Coordinators:

- Region 1: Dr. Lanza
- Region 2: Gail Stewart
- Region 3: Tony Suszczynski
- Region 4: Dan Simpson
- Region 5: Matt Meyers
- Region 6: Wendy Wilderman
- Region 7: Brenda Atkins

Subcommittees:

The following subcommittees were identified by the HCC Statewide Work Group to further develop HCC guidance and recommendations for FY 2013-14. These are listed with their identified volunteer leads.

- LTC/Home Health Integration
 - Chair(s) – April Henkel
 - Members – Matt Meyers and Dan Simpson
- Risk Assessment
 - Chair(s) – Brenda Atkins
 - Members – Paul Ford, Tony Suszczynski, and Eric Alberts
- Funding
 - Chair(s) – Kay Croy
 - Members – Otis Gatewood , Paula Bass, Dan Simpson, Matt Meyers, Ashley Lee, and John Wilgis
- Public Relations, Marketing and Communications
 - Chair(s) – Kay Croy and John Wilgis
 - Members – Christie Luce and Makeshia Barnes
- Fatality Management
 - Chair(s) – John Wilgis (& Larry Bedore/Jason Byrd)
 - Members – Mary Russell, Jim Schultz, Paula Bass, and Paul Ford

- Mental / Behavioral Health
 - Chair(s) – Dr. James Schultz
 - Members – Dr. Lisa Brown, Mary Russell, and Wendy Wilderman

HCC Statewide Work Group Meeting Schedule:

- **Regular monthly:** Calls will be the third Tuesday of each month from 0900 to 1000 ET. A meeting invite will be sent out by the Med Surge Unit.
- **Quarterly meetings:** The HCC Statewide Working Group will meet in person once each quarter. A tentative schedule will be sent out soon.