MARY CLARK: GOOD AFTERNOON AND THANK YOU FOR JOINING US FOR THIS HEALTH AND MEDICAL COORDINATING COALITIONS WEBINAR. WE WILL HAVE 3 PRESENTATIONS TODAY AND AFTER THEY ARE ALL COMPLETED WE WILL HAVE A Q AND A. THE RECORDING AND TRANSCRIPT FOR THE WEBINAR WILL BE AVAILABLE ONLINE BY SEPTEMBER 30.

WE HAVE SOME INSTRUCTIONS FOR PARTICIPANTS THAT WE WILL GO THROUGH. TO AVOID ECHO AND FEEDBACK, PLEASE TURN OFF YOUR COMPUTER SPEAKERS IF YOU ARE CALLING IN. WE ARE AWARE OF SOME GROUPS PARTICIPATING IN THE WEBINAR. IF YOU ARE IN A GROUP, PLEASE HAVE ONLY ONE DEVICE AND ONE PHONE CONNECTED. IF YOU HAVE A TECHNICAL QUESTION DURING THE PRESENTATIONS, PLEASE USE THE QUESTION BOX TO LET UP KNOW AND RAISE YOUR HAND. WE HAVE A SCREEN SHOT TO SHOW HOW YOU CAN RAISE YOUR HAND AND WHERE THE QUESTION BOX IS. WE DO HAVE LIVE CAPTIONING AVAILABLE. YOU CAN ACCESS THIS BY OPENING ANOTHER BROWSER WINDOW. THAT LINK WAS IN THE EMAIL MESSAGE THAT WENT OUT THIS MORNING.


>>THIS IS A MAP OF MINNESOTA LOCAL PUBLIC HEALTH REGIONS. FORTUNATELY THE LOCAL PUBLIC HEALTH AND EMS REGIONS OF A STATE CORRESPOND VERY CLOSELY. THERE ARE ONLY TWO COUNTIES NOT THE SAME FOR THE EMS REGIONS AS THEY ARE FOR PUBLIC HEALTH. THE HOSPITALS BASICALLY FOLLOW THESE SAME REGIONAL BOUNDARIES OF THE ESF 8 THEY'RE ALL ORGANIZED BY THE SAME GEOGRAPHIC AREAS. FORTUNATELY THESE GEOGRAPHIC AREAS TEND TO REFLECT TO A REASONABLE DEGREE PATIENT REFERRAL PATTERNS. IT'S IMPORTANT FOR A FUNCTIONAL COALITION FROM THE MEDICAL CARE STANDPOINT. SO, WE HAVE TRIED TO CONSTRUCT THESE ACCORDING TO BARBERA AND MCINTYRE STRUCTURES. NO HEALTHCARE FACILITY IS AN ISLAND. EACH HEALTH CARE FACILITY IS ORGANIZED AS A COALITION MODEL. BUT THE HEALTHCARE FACILITIES
ARE A SMALL PART OF THE
COALITION.
AS THESE ELEMENTS INTERSECT WITH
JURISDICTION MANAGEMENT AND
PUBLIC SAFETY WE HAVE TO HAVE
APPROPRIATE AVENUES, WE HAVE TO
UNDERSTAND THE INTERSECTION AT
A JURISDICTONAL AND STATE LEVEL
AND FEDERAL RESPONSE IF THAT’S
NECESSARY.
HOW THOSE PIECES WORK TOGETHER
DURING RESPONSE IS REALLY
IMPORTANT.
WE HAVE DONE OUR BEST TO
NEGOTIATE THE POLITICS OF THOSE
THINGS BETWEEN LOCAL EMERGENCY
MANAGEMENT AND STATE’S.
THE METRO HOSPITAL PACT IS ONE
OF THE MOST OPERATIONAL
FUNCTION -- THAT IS THE ACUTE
CARE, IN-PATIENT SIDE OF
THINGS.
30 HOSPITALS 2-RBGs THOUSAND
BEDS TOTAL.
IT WAS FORMED PRIOR TO THE
GRANT.
IT WAS AN OUTGROWTH OF THE
RECOGNIZING WE NEEDED A MORE
INTEGRATED APPROACH THAT NO ONE
HOSPITAL WOULD BE ABLE TO
PROVIDE SOLUTIONS TO THE
CHALLENGES WE FACE ON A MASS
CASUALTY OR PANDEMIC EVENT.
THERE IS A PACT OF SIGNATORIES AND BY LAWS.
THE EXHIBITS DETAIL SPECIFICS OF
STAFF SHARING OF INSTITUTIONS
AND THE OBLIGATIONS.
THIS IS ONLY ONE POSSIBLE MODEL
OF MANY, MANY.
EVERYONE WILL APPROACH THINGS A
LITTLE DIFFERENTLY.
SOME OF THE THINGS THAT
DOCUMENT DETAILS ARE THE
EXPECTATIONS FOR COMMUNICATIONS
BETWEEN HOSPITALS, STAFF AND
SUPPLY SHARING EXPECTATIONS.
WHAT THE REGIONAL HEALTHCARE
RESOURCE CENTER DOES AS A
COORDINATING ELEMENT,
OPERATIONALLY THEN THE
MANAGEMENT FUNCTIONS WITH THE
EXHIBIT.
SO, OUR PARTNER ORGANIZATIONS
WITHIN THE COALITION AT LARGE ARE THE METROPOLITAN HOSPITAL CARE AND IN PATIENT SIDE. -- 13 LOCAL PUBLIC HEALTH BOARDS UNDER AN UMBRELLA OF MPHAA.

THEY HAVE A PUBLIC HEALTH EMERGENCY PREPAREDNESS WORK GROUP WITH A CHAIR TO THE COALITION.

THE METRO 911 BOARD.

THERE IS A JOINT POWERS AGREEMENT THAT GOVERNS 911.

A SUBSET OF THAT, THERE IS A EMS SUB COMMITTEE.

THE CHAIR OF THAT GROUP REPRESENTS EMS ON A COALITION AND TAKES INFORMATION BACK TO THEIR MEMBERS AND WORKS ON MEMBER ISSUES BETWEEN COALITION PARTNERS AND THE 24EMS AGENCY THAT'S WE HAVE.

THE METROPOLITAN ENERGY MANAGERS ASSOCIATION IS A GROUP OF JURISDICTIONAL EMERGENCY MANAGERS AND THE STATE PERSON.

THEY HAVE DESIGNATE TWO PEOPLE TO REPRESENT EMERGENCY MANAGEMENT TO THE COALITION.

THAT'S BEEN BASICALLY ONE PERSON AND THEN ANOTHER GROUP, SLIGHTLY DIFFERENT COMPOSITION AND PURPOSE FOR PURPOSES OF THE GRANT DECIDED THEY NEEDED TO HAVE SOMEONE AT THE TABLE AS WELL.

WE HAVE TWO PEOPLE REPRESENTING EMERGENCY MANAGEMENT.

OTHER PARTNERS AND ELEMENTS EUPT GRATED BUT DON'T NECESSARILY HAVE SPECIFIC REPRESENTATION ON THE EXECUTIVE GROUP ARE LONG-TERM CARE CLINICS.

NOB GOVERNMENTAL ORGANIZATIONS AND OUR LIAISON.

NOW ALL OF THOSE FOLKS ATTEND MEETINGS AND THE COMPACT MEETING, COALITION MEETINGS.

THEY PROVIDE INPUT AND WE WORK WITH THEM AS PARTNERS.

THEY'RE NOT NECESSARILY POLICY
FORMERS AT THE EXECUTIVE LEVEL OR DICTATE AGENDAS AND MANAGE MEETINGS.
LONG TERM CARE AND CLINICS, BY AND LARGE THOSE EFFORTS ARE LEAD BY GRANT STAFF.
I WILL TALK ABOUT THAT IN A MINUTE.
A LOT OF THE WORK DONE WITH THE LONG-TERM CARE AND OUR OUTPATIENT KWREPT CLINICS IS GREATLY FACILITATED BY STAFF MEMBERS WHO ARE PAID TO DO THAT.
WE HAVE A NUMBER OF CLINICS AFFILIATED WITH HEALTH SYSTEMS.
THOSE TEND TO BE MORE TIED IN WITH THE EMERGENCY PREPAREDNESS SYSTEMS WITH THE PARENT SYSTEMS.
WE HAVE UNAFFILIATED CLINICS THAT RO HARD TO CAPTURE.
HUNDREDS IN THE METRO AREA ALONE.
>> WE DON'T LOOK TO GET A HUNDRED PERCENT PARTICIPATION OF THOSE ENTITIES.
WE'RE LOOKING TOGETHER WITH MOMENTUM AND MAKE SURE WE HAVE ACTIVITY WITH THE GROUPS IF WE NEED THAT DURING A RESPONSE.
THERE ARE A NUMBER OF WORK GROUPS THAT ARE VERY ACTIVE.
THE EXERCISE WORK GROUP WORKS TRYING TO CONDUCT EXERCISE THAT'S ARE CALENDARED.
WE HAVE A JURISDICTIONAL RAN EXERCISE ONCE A YEAR MEETING EVERYBODY'S NEEDS FOR PUBLIC HEALTH AND EMERGENCY MANAGEMENT NEEDS.
SOMETIMES THAT GETS TOUGH.
WITH SOME OF THE GRANT REQUIREMENTS FOR THE DIFFERENT ENTITIES BEING WHAT THEY ARE.
THERE IS COMPETITION IT COVERS WHAT SCENARIOSES NEED TO BE DONE.
IT DOESN'T WORK PERFECTLY TO HAVE ONE EXERCISE A YEAR FOR EVERYONE.
THIS YEAR WE JUST COMPLETED A RADIOLOGIC DISPERSION THAT WAS REQUIRED COAST GUARD AND HOSPITAL MANAGEMENT.
SOME OF THE HOSPITALS
PARTICIPATED IN THAT.
ALL OF THE HOSPITALS WILL
PARTICIPATE THIS FALL WITH A
MEASLE EXERCISE.
EMERGENCY MANAGEMENT WOULDN'T BE
INVOLVED IN THAT ONE.
LOCAL MEDICAL WORK GROUP IS
PLANNING FOR MOBILE TEAM FOR THE
METRO AREA.
OUR TEAM AND A TEAM OUT TO THE
WEST.
THEY HAVE A COMPARATIVE WORK
GROUP.
OUR BEHAVIORAL WORK GROUP IS
QUITE ACTIVE AND WORKING HARD ON
A LOST BROAD BEHAVIORAL HEALTH
TRAINING, PSYCH LOGICAL FIRST
AID TRAINING, WORKING WITH TOOLS
AND WORKING WITH THE HOSPITALS
DIRECTLY ON THEIR BEHAVIOR
HEALTH RESPONSE RELATIVE TO
FAMILY SUPPORT CENTERS AND
INTEGRATION OF FAMILY ASSISTANT
CENTERS AT JURISDICTION OR STATE
LEVEL.
ALTERNATE CARE SITES WE APPROACH
FROM THE REGIONAL STAND POINT.
WE HAVE LARGER CARE SITES TO
PROVIDE OVER FLOW HOSPITAL CARE.
THAT WORK GROUP HAS DONE A LOT
OF WORK WITH THE LOCAL
CONVENTION CENTERS.
WE HAVE HAD EXERCISES AT THOSE
SITES AT WELL.
OUR COMPACT CRI AND MRS TO BE
HONEST WAS THE FIRST HEALTHCARE
COALITION IN THE AREA.
WHEN THE FUNDING WENT AWAY AND
WITH THE GRANT REQUIREMENTS WE
HAVE HAD TO RENAME THINGS.
THAT'S A GROWING PROCESS.
THE ERI IS A CHALLENGE TO MAKE
SURE WE'RE MAINTAINING ADEQUATE
PLANS AND RESOURCE POLICIES TO
KEEP THOSE EMMENTS OPERATIONAL.
SO, WHAT THE HPP GRANT DOES IS
SUPPORT COMPACT ACTIVITIES.
IT DOESN'T REPLACE THE HOSPITAL
COMPACT.
IT ISN'T THE COALITION ITSELF.
IT SUPPORTS THE COALITION
PROVIDING PERSONNEL AND PROGRAM
SUPPORT.
WE HAVE ADMINISTRATION, .3 BEING
A manager who puts in significantly more time than that.
Some of that is -- and .2 an administrative support person
for the coalition
handing the typing of minutes
and things like that.
Program support is two positions.
Long term care and the clinic position.
Although both of those have other responsibilities.
One is predominantly responsible
for exercise planning.
The other deals with special populations planning.
Like working on the regional pediatric plan.
Doing the education and hosting
the meetings with developing
those two documents.
On the program side we have an annual preparedness conference.
We bring in speakers of national events that occur to discuss
their weaker points.
There is a local panel of personnel if that happened here.
What are the current plans, the gaps, what to work on.
That's a good opportunity to bring in a broader spectrum personnel.
Get people engaged on a topic that they're interested in and expose a larger number of people to the coalition activities.
We usually draw about four hundred people to that practicum each year.
There is a lot of training that goes on.
The behavioral health ones.
Continuity of operations planning, crisis care with table tops on vaccine and ventilator allocation, radiation response,
we coordinate a number of exercises that I mentioned.
We also do those exercises with long-term care.
We can't exercise with every long term care facility.
WE PROVIDE GRANT FUNDING FOR APPLICATIONS FOR LONG-TERM CARE FACILITIES INTERESTED IN DOING A EXERCISE WE FEEL HAS VALUE TO ALL LONG-TERM CARE FOR LEARNING POINTS AND EXPERIENCES. THEY WILL GET FUNDED WITH A SMALL AMOUNT OF MONEY TO SUPPORT THE EXERCISES. WE WILL HELP THEM PREPARE A BEFORE AND AFTER TO SHARE WITH LONG-TERM CARE PARTNERS. THE GRANT AS I MENTIONED DESIGNATES PERSONNEL RESPONSE I BELIEVE FOR REGIONAL PLANNING WITH PARTICULAR FUNCTIONAL AREAS. EVACUATION, PEDIATRIC AND BURN. THOSE PERSONNEL CAN SERVE AS RESOURCES AND ARE PART OF THE ACCESS FOR THE PLANNING ACTIVITIES. WE CAN HOLD THOSE FOLKS ACCOUNTABLE FOR THE GETTING THE WORK DONE. WE DO DEVELOP A REGIONAL EFS-8 PLAN. WE HAVE HAD A PROBLEM WITH THAT PLAN BEING TOO LONG. WE ARE RESTRUCTURING THAT NOW. IT'S MORE OF A EXECUTIVE SUMMARY, POINTS OF CONTACT, FUNCTIONAL BASED. WITH APPENDICES. THAT'S IN REDRAFT AND EASIER FOR THE EMERGENCY MANAGERS TO WORK WITH. THAT WAS A COMPLAINT THEY HAD WORKING ON A COALITION LEVEL AND FORMALIZED. MOST OF THE PLANNING IS FUNCTION SPECIFIC WE DO WITH MEDICAL SUPPORTIVE SHELTER NEEDS, POINTS OF DISPENSING, HEAT RELATED HEAT WAVES AND HEAT RELATED PLANNING FOR THE JURISDICTION. IT'S A GOOD PLACE TO COME TOGETHER TO DO THOSE FUNCTIONAL PLANS. I THINK THAT'S REALLY THE BIGGEST THING. I REALLY TRY TO EMPHASIZE THE FUNCTION. IT'S MORE IMPORTANT THAN THE
THE FORM AND HOW YOU STRUCTURE AND ORGANIZE YOUR COALITION IS IMPORTANT.
WHAT IT REALLY COMES DOWN TO IS DO YOU HAVE THE RIGHT PEOPLE AT THE TABLE TO GET THE DISCUSSIONS AND GET THE WORK YOU NEED TO GET DONE.
IF YOU DO IT WILL SUCCEED.
IF YOU GET TOO HUNG UP ON THE SEMANTICS PEOPLE SHY AWAY.
THEY ARE UNHAPPY HOW THINGS ARE GETTING PIGEON HOLED, ETCETERA,
IF YOU HAVE FOLKS WITH FUNCTIONAL TOPICS THAT'S A NUMBER ONE WAY TO MOVE COALITION FORWARD.
SOME OF THE CHALLENGES, DECREASE FUNDING A CHALLENGE GOING FORWARD.
JURISDICTIONAL, MEANING REGIONAL NEEDS IS AN ISSUE THERE ARE PAROCHIAL ATTITUDES WITH COALITION PARTNERS WE NEED TO WORK THROUGH.
PAROCHIAL THINKING- THE VIEW THAT EVERYTHING MOVES FROM ONE JURISDICTION OUTWARD IS NOT A REALISTIC VIEW POINT.
WE NEED TO KEEP MAKING SURE THAT WE EMPHASIZE ON A DAILY BASIS WE'RE WORKING ACROSS JURISDICTIONAL BOUNDARIES FOR EMS, HOSPITALS AND PUBLIC HEALTH.
HOPEFULLY THAT HELPS TO CONTINUE AND FACILITATE THE ACTIVITIES.
MAKING FORMAL WRITTEN COMMITMENTS HAS BEEN A LITTLE SCARY FOR SOME OF THE JURISDICTIONAL ENTITIES. WITH MMRS THEY DIDN'T HAVE TO DO THAT.
WE GOT A TON OF WORK DONE WITHOUT HAVING ANYTHING ON PAPER.
WE ARE STRUCTURING THINGS PRETTY LOOSELY TO GET THE BUY IN AND CONTINUED COMMITMENT TO THE PROCESS.
THAT HAS BEEN A LITTLE GROWING PAIN.
WE WILL GET THERE.
COMPETING EXERCISE
REQUIREMENTS AND PRIORITIES.
I MENTIONED GRANT ALIGNMENT.
THE REQUIREMENT OF CERTAIN
GRANTS MAY CONFLICT OR NOT
REALLY ALLOW, YOU KNOW ONE
EXERCISE TO MEET THE NEEDS OF
ALL OF THE PARTIES EVEN IF THEY
WANT IT TO, JUST THE PROCESS OF
HAVING DOCUMENTS.
ALL OF THE GRANT ACTIVITIES.
THE AUDITS AND EVERYTHING ELSE.
IT TAKES TIME THAT COULD BE USED
FOR PLANNING AND SOMETIMES FOR
OPERATIONS.
SOMETIMES THE GRANT CAN BE A
DISTRACTION AS MUCH AS A
FACILITATOR GETTING THINGS
DONE AND MAKING SURE YOU HAVE
STAFF TIME ALLOTTED TO KEEP THAT
OFF THE BACKS OF THE COALITION
PARTNERS AS MUCH AS POSSIBLE IS
CRITICAL.
THEN PLANNING VERSUS OPERATIONS
I THINK A LOT OF COALITIONS TEND
TO REVOLVE ONLY AROUND
PLANNING.
WHEN THE OPERATIONAL SITUATION
COMES UP IT'S NOT REALLY CLEAR
WHERE THE INTERSECTS ARE.
IT'S IMPORTANT TO DOCUMENT THIS
AND PRACTICE IN ADVANCE.
WE USE A SYSTEM THAT HELPS US
SHARE INFORMATION BETWEEN
FACILITIES.
IT'S USED ON A DAILY BASIS TO
MANAGE OPEN AND CLOSED BED
STATUS. DURING AN EVENT WE CAN USE IT TO
REQUEST RESOURCES WHICH YOU SEE
HERE.
THIS IS A EXERCISE WITH CROSSING
VENTILATORS.
WE HAVE BASICALLY A INCIDENT
MANAGEMENT FUNCTION WE CAN THEN
SHARE INFORMATION, PUT UP SPREAD
SHEETS.
PUT UP DOCUMENTS AND HOWEVER
ELSE WE NEED TO SHARE
INFORMATION DURING AN EVENT
ACROSS ENTITIES, JURISDICTIONS
AND BETWEEN REGIONS EVEN.
THAT'S BEEN A HELPFUL ENTITY.
ESPECIALLY THE NIGHT THE BRIDGE
WENT DOWN.
OUR MEDICAL RESOURCE SYSTEM
CONTROL CENTER PUT UP 24 UPDATES
ON THE SYSTEM TO KEEP HOSPITALS
UP TO SPEED ON WHAT WAS
HAPPENING AT THE SCENE.
WE DID PATIENT TRACKING AND
SHARED INFORMATION ABOUT FAMILY
REUNIFICATION ON A FAMILY
CENTER.
OUR REGIONAL HOSPITAL RESOURCE
CENTER IS THE REPRESENTATIVE FOR
EFS8.
SORRY IT'S REPRESENTATIVE FOR
THE MEDICAL CENTER TOO AND
EFS8 -- IT'S USUALLY VIRTUAL.
IF WE HAD A LARGE EVENT AND
NEEDED TO GET FACE-TO-FACE AND
HAVE DISCUSSIONS ON STAFFING AND
THOSE THINGS WE HAVE A LOCATION
SET FOR THAT.
THE JURISDICTIONS THAT ARE
AFFECTED FROM THE EMERGENCY
MANAGEMENT PERSPECTIVE WOULD HAVE
REPRESENTATION THERE.
WE WOULD SOLVE PROBLEMS
GENERATED BY THE EVENT.
?>> -- A REALLY GREAT PLANNING
EXPERIENCE.
ONE I HOPE I DON'T HAVE TO
REPEAT ANYTIME TOO SOON.
THIS WAS THE MULTI AGENCY
COORDINATE CENTER FOR THAT
EVENT.
WE HAD THE ADDED CHALLENGE OF
SITUATIONAL AWARENESS AND WIDE
VARIETY OF FEDERAL STAKE HOLDERS
AND LOCAL PARTNERS.
IT WAS A BIT OF A CHALLENGE.
ESPECIALLY MAKING SURE
INFORMATION WAS SENT AND
DEVELOPING POLICY THAT WOULD BE
APPLICABLE ACROSS A RANGE OF
FEDERAL PARTNERS AND LOCAL
PARTNERS.
H1N1 WAS PROBABLY THE SINGLE
LARGEST TIME THE RHRC WAS OF
BENEFIT.
WE NEVER CONVENED A PHYSICAL
PRESENCE.
WE WERE ACTIVE DURING THE EVENT.
CONFERENCE CALLS, COMMON
MESSAGING WITH PUBLIC HEALTH,
ADJUSTING CALL LINES AND PHONE
TRIAGE ACCORDING TO STANDARD
SCRIPTS.
MAKING PHONE AVAILABLE ANTIVIRAL AVAILABLE -- DEVELOPING REUSE POLICIES AND PRACTICES FOR PPE BETWEEN THE COMPACT AND CONJUNCTION WITH THE DEPARTMENT OF HEALTH.
THAT WAS VERY HELPFUL A COUPLE OF HOSPITALS HAD NURSES THAT'S CALLED OSHA AND REPORTED VIOLATIONS BECAUSE THEY DIDN'T HAVE ACCESS TO STANDARD N 95S. WHEN OSHA LOOKED AT IT BECAUSE OF THE SHORTAGES WE EXPERIENCED THEY SAID YOUR HOSPITALS HAVE AGREED TO A COMMON PRACTICE ACROSS THE REGION.
PROMOTING THE BEST POSSIBLE SAFETY OF THE WORKERS.
THAT WAS QUITE HELPFUL.
CAPACITY MONITORING.
WE HAD SITUATIONS WHERE WE WERE OUT OF ICU BEDS.
THEY KEPT INCOMING TRANSFERS FOR A BRIEF PERIOD AND MAINTAINED SITUATIONAL AWARENESS.
ALTERNATE CARE SITES AND WITH A PORTABLE OXYGEN SET UP.
THEY CAN SERVE 674 PATIENTS.
THESE ARE HOUSED IN A WAREHOUSE HELP SYSTEMS MEDICAL HEALTHCARE STAFFED THESE.
THERE ARE A LOT OF HEADS WITH CLINIC LONG TERM CARE AND HOME CARE PLANNING.
WE WELCOME THESE.
THEY HELP THE ENTITIES TO ENGAGE.
I THINK THERE ARE OPPORTUNITIES FOR TRAINING AND CHALLENGES THERE.
THE INTEGRATION AND WHAT LEVEL WE ENGAGE ON AND IF WE CAN DO THAT.
I THINK WE'RE REINVENTING THE COALITION AS WE GO.
THE PARTNERS IN IT HAVE CHANGED.
THE STRUCTURE HAS CHANGED.
WE WILL NEED TO ADAPT A LITTLE.
AS PART OF THAT, I KNOW, I THINK WE SEE THIS IS A OPPORTUNITY TO TRY FOR SOME ADDITIONAL FUNDING AND HAVE PEOPLE PAY FOR TRAINING TO OFFSET COSTS AND COALITION
OPERATIONS.
IT WILL PUT US IN COMPETITION WITH THOSE SEEKING DONATIONS AND IT'S A BIT OF A SWITCH AND PARTNERS MAY BECOME COMPETITORS.
BUT WE NEED TO CONTINUE TO LOOK AT THIS AS A SYSTEM THAT IS LIKE A TRAMPOLINE.
THE BIGGER AREA YOU HAVE THE BIGGER THE BOUNCE.
THE BETTER COORDINATED WE ARE.
LEADERSHIP DEVELOPMENTS.
TO BE HONEST THE COMPACT WAS FOUNDED BY A COUPLE OF PEOPLE WITH A LOT OF ENERGY AND A LOT OF PASSION AND A LOT OF VISION.
AS WE MOVE FORWARD WE NEED TO MENTOR FOLKS TO TAKE OVER THE REGIONS TO ALLOW US TO MOVE IN A CONSTRUCTIVE FASHION.
IT IS MAINTAINING THE ENERGY TO CONTINUE THE GOOD WORK DONE.
LOOK FORWARD AND SAY WHAT REMAINS TO BE DONE FROM HERE ON OUT.
HOW CAN WE ACCOMPLISH THAT TOGETHER RATHER THAN DO IT SEPARATELY.
AGAIN I APPRECIATE THE TIME I HAVE HAD TO TALK THIS MORNING.
I LOOK FORWARD TO ANSWER QUESTIONS AT THE END.
I WILL TURN IT OVER TO THE GREAT STATE OF UTAH AND KEVIN.
>> GOOD MORNING, EVERYONE.
LET'S SEE IF WE GET OUR -- OKAY.
CAN YOU SEE MY SCREEN OKAY?
I HOPE SO.
KEVIN MCCULLEY PUBLIC HEALTH AND MEDICAL PREPARENESS MANAGER UTAH.
I WILL TALK ABOUT THE MODEL WE USE IN UTAH.
THERE ARE A COUPLE OF TAKE AWAYS.
YOU GET THESE FROM PARTICIPATING IN THE WEBINAR.
>> WE HAVE A LOCAL HEALTH DEPARTMENT MODEL.
IT MAY NOT BE THE MODEL MOST APPROPRIATE FOR EACH STATE.
A LOT OF FACTORS WENT INTO OUR DECISION TO PURSUE HOSTING THROUGH LOCAL HEALTH
DEPARTMENTS.

AS I NOTE LATER AND NOTE NOW IT ACTUALLY DID NOT WORK IN ONE OF OUR SEVEN REGIONS.

IT'S NOT A PERFECT MODEL BUT IT'S ONE WE HAVE SEEN GOOD GROWTH AND GOOD IMPROVEMENTS ON.

SECONDLY YOU SHOULD BE ABLE TO TAKE AWAY THAT THERE IS GREAT VARIANCES BETWEEN OUR URBAN CENTER MODELS AND MORE RURAL AND FRONTIER MODELS.

I WILL COMPARE AND CONTRAST THOSE TWO MODELS.

THIRDLY, I HOPE TO SHOW HOW HOSTING REGIONS HELP TO INCREASE ALIGNMENT BETWEEN THE CDC AND HPP GRANTS AND OUR EMS SYSTEMS AND OUR EMERGENCY MANAGEMENT GRANTEES IN THE STATE.

FINALLY I HOPE TO REINFORCE THAT, AT LEAST IN OUR EXPERIENCE TO MAKE THIS WORK APPROPRIATELY IT TRULY DOES NEED AN INVESTMENT IN IT.

IT CAN'T BE AN ASSIGNMENT OR ANOTHER DUTY ASSIGNED AS A PERSON.

YOU NEED IN ADDITION YOU NEED FUNDS.

I WANTED TO PROVIDE A BACKGROUND.

AS YOU CAN SEE THE STATE OF UTAH HAS 29 COUNTIES.

FOUR OF THEM ARE URBAN COUNTIES.

THOSE ARE CONTAINED IN THE RED OVAL.

THAT'S ABOUT 70% OF UTAH'S POPULATION.

THEN EXTENDING OUT WE HAVE 12 RURAL COUNTIES AND 13 FRONTIER COUNTIES.

THEY'RE FEWER THAN 7 PEOPLE PER SQUARE MILES.

ALSO BY WAY OF HOSPITAL DENSITY WITHIN THE THREE NORTHERN REGIONS.

THAT'S NORTHERN, SST AND UTAH WASACH THAT'S WHERE 80% OF THE BEDS ARE LOCATED AND 86% OF THE POPULATION.

OF A GREAT CONCERN TO US, IS SHOWN BY THE YELLOW LINE NORTH
TO SOUTH.
THAT'S THE PRIMARY FAULT LINE
FOR THE WASACH FAULT.
THAT IS THE AREA THAT WE
REASONABLY ANTICIPATE SOME TIME
IN MY LIFETIME TO HAVE AN
EARTHQUAKE EVENT TAKE PLACE.
BASICALLY WE HAVE OUR EGGS IN
ONE BASKET WITH REGARDS TO
POPULATION AND HOSPITAL BEDS.
I WANTED TO DO A LITTLE CONTRAST
WITH THE COALITION.
WITH THE SEP REGION AND THE
SOUTHEAST REGION.
THE SEP REGION IS THREE
DIFFERENT HEALTH DEPARTMENTS.
SALT LAKE.
THEN TO THE EAST AND WEST SUM
AND THE TAWILLA.
THERE ARE OVER A HUNDRED MEMBERS
THAT PARTICIPATE REGULARLY IN
THE COALITION ACTIVITIES.
THAT INCLUDES ALL 17 HOSPITALS
IN THE REGION.
ALMOST 40 LONG TERM CARE
FACILITIES.
MANY OTHER PARTNERS, FIRE, EMS,
EMERGENCY MANAGEMENT,
PHARMACIES, DIALYSIS, OUTPATIENT
CARE.
MANY OTHER FOLKS THAT ARE PART
OF THESE ACTIVITIES.
LET'S CONTRAST THAT WITH THE
SOUTHEAST REGION.
THEY HAVE SUSTAINED A MEMBERSHIP
OF ABOUT 12 PEOPLE
INCLUDING ALL FOUR HOSPITALS,
THE LONG TERM CARE, FQHC
OUTPATIENT CLINIC, EMS AGENCIES,
AND I CONTINUE TO USE THIS
ACRONYM TO DESCRIBE OUR RURAL
ACTIVITIES.
WHAT THIS MEANS IS IT'S USUALLY
THE SAME TEN PEOPLE THAT ARE
CONDUCTING THE ACTIVITIES.
IF WE LOOK OVER ALL OF THE STATE
WE CAN SEE THAT WE HAVE SEVEN
TOTAL COALITIONS WITH TWELVE
LOCAL HEALTH DEPARTMENTS.
THE EAST AND SOUTH PART, THE
RURAL ONES TEND TO MATCH THE
LOCAL HEALTH DISTRICT
BOUNDARIES.
THE THREE IN THE NORTH COMBINE
EITHER TWO OR THREE LOCAL HEALTH DEPARTMENTS.
THEY JUST ALLOW ONE LOCAL HEALTH DEPARTMENT TO BE THE PRIMARY HOSTING ENTITY.
SO BRIEFLY FACTORS WE CHOSE TO PURSUE THIS MODEL.
WE LOOKED BACK AT HISTORIC ACTIVITIES CONDUCTED IN UTAH.
THAT INCLUDES OUR SALT LAKE CITY AREA HOSPITALS THAT PARTICIPATED IN THE CHEMICAL STOCK PILE PROGRAMS.
WE DID THE ELIMINATION OF NERVE CASES JUST ABOUT 25 MILES OUTSIDE OF SALT LAKE.
HOSPITALS HAVE A PRETTY FORMAL REGION TO ADDRESS THE THREAT THAT MAY COME FROM -- FROM INCINERATING THE EMISSIONS.
WE HAD EXPERIENCE DURING THE 2002 WINTER GAMES HOSTED IN SALT LAKE CITY.
MANY OF OUR HOSPITALS WERE ENGAGED IN PLANNING WITH STATE AND FEDERAL PARTNERS TO INSURE THAT IF SOMETHING BAD HAPPENED THEY WOULD COVER IN A COORDINATED FASHION.
THAT WAS CRITICALLY IMPORTANT. AS YOU RECALL THE OLYMPICS OCCURRED SOON AFTER 9-11.
ALSO SOON AFTER THE ANTHRAX ATTACKS ON OUR NATION.
THERE WAS A LOT OF ENERGY PUT INTO FORMALIZING THESE RELATIONSHIPS.
THEN THE CITY'S READINESS INITIATIVE OR THE CRI.
INCLUDING SALT LAKE, SUMMIT AND TAWILLA FORMING THE SST REGION.
WE CONDUCTED AN ASSESSMENT OF EXISTING REGIONS INCLUDING THE HOME LAND SECURITY REGIONS.
THE BIO TERRORISM REGIONS FROM THE EARLY DAYS OF HPP GRANT AND OUR GEOGRAPHIC BOUNDARIES.
WE CONDUCTED ASSESSMENTS OF HOSPITAL CACHEMENT AREAS.
NORMAL PATIENT ACCESS AND TRANSFER PATTERNS WITH EMS AND HOSPITALS.
THEN LOOKED AT GEOGRAPHIC BARRIERS THAT ARE QUITE PREVALENT
IN OUR STATE INCLUDING MOUNTAINS AND IN SOME PARTS OF THE STATE ROADS THAT ARE RENDERED IMPASSABLE OR CHALLENGING BY THE WEATHER, PARTICULARLY DURING THE WINTER TIMES.

SO, WE ARE SETTLED ON LOCAL HEALTH DISTRICTS AS THE OPTIMAL HOST MODEL.

>> BY EVIDENCE IF WE LOOK AT THE SST REGION MOST OF THE RESIDENTS DRAIN INTO SALT LAKE FOR THE MEDICAL CARE.

>> AS LOCAL HEALTH DEPARTMENTS HAVE ADVANCED IN THEIR SKILLS AND FUNDING WE HAVE SEEN A INCREASED ROLE PLAYER BY FULFILLING THE EIGHT SEATS IN JURISDICTIONAL COMMAND CENTERS.

ADDITIONAL SUPPORT IS SEEN WITH EMERGENCY RESPONSE COORDINATORS IN ASSISTING.

THAT IDEA MEANS THERE MAY HAVE ONLY BEEN A PUBLIC HEALTH ROLE FOR THE EMERGENCY RESPONSE COORDINATORS.

AS RESPONSE SHOWS ESF-8 CAN BE BROADER THAN JUST PUBLIC HEALTH. IT INCLUDES HEALTH CARE AND EMS. THAT'S A BROAD PIECE OF A COMMAND CENTER FOR A SINGLE INDIVIDUAL OR HEALTH DEPARTMENT TO COVER.

WE HAVE A LOT OF REQUESTS FOR GRANTS WE PROVIDE WITH LOCAL HEALTH DEPARTMENTS.

WE HAVE ON GOING RELATIONSHIPS WITH THE FOLKS.

WE SAW A LOT OF DEFICIENCIES WITH GRANT PROCESSING, BUDGETING AND WORK PLAN.

FROM OUR PERSPECTIVE THAT EASES THE BURDEN OF GETTING THE GROUPS ACTIVATED.

WE BELIEVE WE NEED TO USE LOCAL PEOPLE TO SERVE LOCAL AGENCIES AND TAKE ADVANTAGE OF EXISTING RELATIONSHIPS.

ALL OF OUR LOCAL HEALTH DEPARTMENTS, REGIONAL COORDINATORS ARE FROM THE COMMUNITIES THEY SERVE.

MOST OF THEM HAVE A LONG HISTORY OF WORKING WITH THE HEALTH AND MEDICAL FOLKS IN THEIR AREAS.
2008 was our pilot region. By 2004 we were moving and 2010 we were completely regionalized. Acute elements I want to discuss again. I will compare and contrast with urbanized model and a frontier model.
The structures are the same. Both hosted by a local health department. Both receive funding that is for staffing, training, equipment and exercises. In terms of the stats, urban is over a hundred members. It's quite a bit more formalized and has more activity. We actually have that fully staffed with one FTE plus administrative support for the coordinating. Where in the rural and frontier areas with four hospitals and ten or twelve members it's not as demanding on a day to day basis. Most of our frontier coordinators are half time to two-thirds FTE.
As -- because they're employed by the local health department that's also given them a opportunity to fill the rest of that FTE by conducting other grant response activities. Just by way of a comparison of funding that is for training equipment, exercises -- training, equipment, exercises and supplies. Approximately 45 grand for the coalition to leverage during the year to build their regional, provide training and conduct required exercises. That contrasts with the rural. There isn't as much agencies and not as much funding is needed to support the activities. In terms of meetings, our urban had a full coalition meeting bimonthly and executive committee meeting on the
OPPOSITE MONTH.
FRONTIER THEY HAVE A COALITION
MEETING QUARTERLY.
BECAUSE OF THE DISTANCES
INVOLVED AND THE AMOUNT OF
TRAVEL AND THE FACT THAT MOST OF
THE EMS AGENCIES ARE VOLUNTEER-BASED WE REQUEST THESE
COORDINATORS GO MONTHLY AND
ATTEND EXISTING LEPC, EMS,
HOSPITAL MANAGEMENT MEETINGS OR
WHATEVER MEETING MAYBE RELATED
TO PREPAREDNESS AND RESPONSE
THAT GOES ON IN THOSE
COMMUNITIES.
IN TERMS OF KEY DOCUMENTATION
OUR URBAN ONES HAVE BYLAWS, RESPONSE PLANS, A
COMMUNICATION PLAN.
ALTHOUGH THE FRONTIER HAVE A
CHARTER, RESPONSE PLAN AND A
COMMUNICATION TREATY WHAT WE CAN
SEE IS STILL IN OUR RURAL AREAS
IT IS PROBABLY NOT AS FORMALIZED.
I THINK AS DR. HICK MENTIONED IF
YOU TRY TO IMPOSE A STRUCTURE
TOO STRINGENTLY ON PEOPLE THAT
ARE USE TO DOING THINGS IT
CREATES BARRIERS.
WE ALLOW THEM TO LEVERAGE THE
NATURAL RELATIONSHIP, THE
HANDSHAKE, THE AGREED UPON
SHARING ACTIVITIES TO MEET THE
NEEDS OF THE PROJECT.
PRIORITY THREATS ARE A KEY ISSUE
TO THE COALITION.
WE DON'T THINK THEY SHOULD
RESPOND FOR EXERCISE AND
TRAINING.
EVERY OTHER YEAR THEY CONDUCT
REGIONAL HAZARD ASSESSMENT.
AS YOU CAN SEE FOR THE URBAN
AREA, PANDEMIC, EARTHQUAKE AND
HOSPITAL SITUATIONS COME UP AS A
KEY THREAT IN THE URBAN AREA.
IN THE RURAL AREA THINGS SUCH AS
A BUS CRASH, RECEIVING EVACUEES
FROM UTAH VALLEY OR PANDEMIC ARE
NOVEL EVENTS THAT COME UP AS THE
HIGH ONES.
THEY BUILD THEIR TRAINING,
CACHES AND EXERCISES ABOUT WHAT
IS MOST REALISTIC.
IN TERMS OF 24/7 ACCESS WE ARE
STILL IN THE PROCESS OF RAMPING
UP TO BE READILY AVAILABLE TO
SERVE.
The reality is at the multi disciplinary coordination center each goes through the coordinator. Each member has the coordinator cell phones. They can contact them at anytime of the day or night to let them know something is going onto require the activation of regional resources. In terms of governance there is - behavioral health, public health, trying to broadly represent the groups that are engaged in the coalition activities because they're such small groups it really doesn't benefit them to have a sub section of a small group to serve as a executive committee. Rather they just work on the activities together when they have to make decisions about funding, exercises, training things like that. Some of the ways we get efforts and work out of the coalition include in the urban area. They have used work groups or committees to develop specific outputs such as communications plan, a mass fatality plan or a pediatric response plan. Where the rural ones, the coordinator has been empowered to do the majority of the written plan development, then shares or uses the meeting time to share with members to improve and refine the plans to make sure they work for everyone. Some of the barriers we face through the years include communication gap between some entities. There is limited local health department, long term care planning that goes on in the community. One way we improve that is rotate the meeting between the different regional member sites. Often include a tour and presentation by the host.
SO EACH OF THE PARTNERS BEGIN TO UNDERSTAND WHAT THEIR STRENGTHS AND WHAT THEIR LIABILITIES MIGHT BE AS A INDIVIDUAL FACILITY.
WE DO HAVE A LOT OF RURAL CHALLENGES. UP TO 150 MILES BETWEEN SOME FACILITIES IN OUR RURAL AREAS. ALSO THE RESPONSE IN THAT BROAD OF A REGION IS COUNTY-BASED. AS I NOTED BEFORE WE SEND THE COORDINATOR TO TRAVEL TO THE PARTICIPATING ENTITIES AND DO ONE TO ONE MEETINGS.
INSURE THAT THE COORDINATOR ATTENDS RELATED MEETINGS AND MAYBE JUST GET A OPPORTUNITY TO DO A FIVE OR SEVEN MINUTE UPDATE TO THAT GROUP ON THE ACTIVITIES OF THE COALITION.
THERE WAS AN IMPRESSION INITIALLY THAT THE COALITION WALKED OVER THESE EXISTING GROUPS.
MANY WHICH HAVE BEEN IN PLACE FOR A LONG TIME.
WE HAVE BEEN PROVIDED A OPPORTUNITY TO CLARIFY WITH ALL OF THE RESPONSE PARTNERS THE COALITION IS AN ASSET.
WE ARE DEVELOPING RESPONSE CACHES THAT ARE FACILITY BASED.
COMMUNICATION AND REDUNDANT RADIO SYSTEMS.
WE HAVE PLANS IN PLACE TO SUPPORT IMPACTED HEALTHCARE FACILITIES.
WE WORK TO INSURE THE MEETING CONTENT AND GOALS ARE SYSTEM-BASED RATHER THAN FACILITY-BASED.
MORE LATELY AS JOHN MENTIONED WE HAVE A OPPORTUNITY RIGHT NOW TO LEVERAGE THE COALITION TO INSURE ALL PARTICIPANTS CAN ADDRESS THE A PENDING CMS RULE ON EMERGENCY MANAGEMENT.
WE HAVE FOUND THERE HAS BEEN A DIFFICULTY IN COMPLETING THE WRITTEN PLANNING TARGETS. MANY PEOPLE MYSELF INCLUDED ARE NOT NATURAL PLAN WRITERS.
MANY OF THE COALITION LEADS TRY TO DEFER SO MUCH TO THE COALITION FOR PROGRESS THAT THE MEETINGS ENDED UP BEING A PLAN UP ON THE POWERPOINT TRYING TO WORDSMITH AND IT WAS LIKE
PULLING TEETH.
INSTEAD WE HAVE EMPOWERED OUR COORDINATOR TO TAKE EXISTING TEMPLATES FROM OTHER STATES OR HIGHLY FUNCTIONING COALITIONS, DEVELOP THE CONTENT FOR THEIR REGION AS SEEN, AND THEN TAKE THAT TO THE GROUP TO SEEK, EDIT, AND GIVE THEM THE COPIES OF THE PLAN TO GO BACK AND TALK ABOUT IT WITH STAKEHOLDERS. SO, THAT'S BEEN A GOOD SUCCESS. A GOOD RESPONSE TO THAT BARRIER THAT WE HAVE HAD.
YOU KNOW WHEN WE LOOK AT SHORT AND LONG TERM EXTERNAL SUSTAINABILITY WE STILL ASSUME WE WILL BE GRANT FUNDED TO SUPPORT THE COALITIONS AS WE MOVE FORWARD. PRIMARILY THE HPP GRANT.
I AGREE WE CONTINUE TO INVEST IN THE PROCESS AND THE PEOPLE. TODAY OUR HPP GRANT IS 40% GOING TO COALITIONS DIRECTLY TO SUPPORT ACTIVITIES.
WE BELIEVE THAT SUSTAINING A REGIONAL CACHE, TRAINING AND EXERCISE FUND IS A CRITICAL COMPONENT. NOT ONLY TO GET PEOPLE AROUND THE PRIMARY NEEDS BUT TO REALLY GIVE THEM A OPPORTUNITY TO BUILD THOSE REDUNDANT SUPPLY CACHES THAT WILL SUPPORT THEIR NEEDS IN AN EVENT.
>> WE BELIEVE THE REGIONS WILL BE SUSTAINED BY BEING THE VEHICLE AT WHICH A YEARLY EXERCISE IS CONDUCTED IN WHICH ANY MEMBER CAN BE PART OF THE EXERCISE PLAY.
>> -- PARTICULARLY FOR THOSE WITHOUT THE BENEFIT OF FUNDING THROUGH THE YEARS. SUCH AS DIALYSIS, HOSPICE, LONG TERM CARE.
WE ARE LOOKING AT INCREASING OUR INTERSTATE COALITION. WE HAVE A VIGILANT NATIONAL GUARD EXERCISE COMING UP. WE'RE LOOKING AT REGIONAL PLAY. WE MEET WITH THE REGIONS DEVELOPING IN IDAHO, COLORADO AND OTHER PARTS HERE IN THE
INNER MOUNTAINS AND WEST.
WE WILL DEVELOP REGIONAL
HOSPITALS PARTICULARLY FOR BURN
AND PEDIATRICS.
IN SALT LAKE COUNTY THAT'S OUR
ONLY PUSH CENTER AND PEDIATRIC
SPECIALTY HOSPITAL.
>> IF THAT GOES DOWN WE WILL
HAVE A PROBLEM GETTING PEOPLE TO
CARE.
ONE EXAMPLE OF A CLOSE
CALL, THERE HAVE ABOUT MANY,
THIS SHOWS A INFORMAL BENEFIT OF
THE COALITION.
OUR SITE COORDINATOR GOT A CALL
FROM THE VA MEDICAL CENTER
EXPERIENCING A ISSUE WITH THE
TRANSFORMER ON THE CAMPUS.
IT WAS LEAKING COOLANT AND AT
RISK OF EXPLOSION.
IT WASN'T DIRECTLY ON THE
BUILDING BUT IN THE VICINITY OF
THE VA HOSPITAL.
THE VA INITIATED THE FIRST STEPS
TO PREPARE FOR A FULL FACILITY
EVACUATION AND CONTACTED SITE.
THE SITE COORDINATOR WITHIN
30-45 MINUTES LOCATED
IMMEDIATELY AVAILABLE BEDS FOR
ALL TWO HUNDRED PATIENTS AND WAS
STARTING TO PREPARE TRANSPORT
OPTIONS FOR THE FOLKS.
FORTUNATELY THE DANGER PASSED.
THEY GOT THE POWER OFF ON THAT
TRANSFORMER AND WERE ABLE TO
ROUTE, ABLE TO ROUTE AROUND IT
AND STOOD DOWN.
HOWEVER THAT'S WHAT WE HOPED
FOR.
ALL OF THIS TOOK PLACE IN 30
MINUTES.
IT WAS TOO SHORT OF A TIME TO
ACTIVATE A COMMAND CENTER AND
FORMALIZE THE PROCESS.
BECAUSE OF THE RELATIONSHIP WE
WERE ABLE TO SEE SUCCESS WITH
THIS NEAR MISS.
IN TERMS OF AVAILABLE RESOURCES
I'M MORE THAN HAPPY TO SHARE
WITH THE STATE OR INDIVIDUAL
COALITIONS ALL OF THE WORKBOOKS
INCLUDING RESOURCE ELEMENT
ASSESSMENTS, PROGRAM MEASURES,
TRACKER, DISCUSSION ABOUT HOW WE
PRIORITIZE OUR YEARLY RESOURCE, OUR YEARLY GRANT TASKS.
TALK ABOUT HOW WE DEVELOP AND LOOK TO BUDGETS FOR SHARED REGIONAL EQUIPMENT TRAINING AND EXERCISES AND MANY OTHER ACTIVITIES.
AS A KEY TAKE AWAY WE NEED TO WORK TO FIT THIS PROJECT TO THE COMMUNITY NOT TRY TO FIT THE COMMUNITY TO A NARROWLY DEFINED PROJECT.
I THINK THAT'S A CRITICAL PIECE FOR SUSTAINABILITY AS WE MOVE FORWARD.
SO, YOU'RE WELCOME TO CONTACT ME AT ANYTIME.
I APPRECIATE THE TIME I WAS GIVEN.
I WILL PASS THE BALL ONTO OUR NEXT PRESENTER>>
GOOD MORNING.
THIS IS LINDA SCOTT FROM MICHIGAN.
I WANT TO THANK YOU FOR THE OPPORTUNITY TO PRESENT ON HEALTHCARE COALITIONS.
I WANT TO BE CLEAR THERE ARE HUNDREDS OF PARTNERS THAT MAKE THIS WORK AND DEVELOP IN MICHIGAN. THE COST EFFECTIVE AND RESPONSE ORIENTATED HEALTHCARE -- ESTABLISHED IN 20002.
MICHIGAN EMBRACED THIS

>> YES.
>> LINDA, I'M SORRY WE CAN'T SEE YOUR SLIDES.
DO YOU NEED TO SHOW YOUR SCREEN?
>> SORRY.
>> THAT'S OKAY.
>> MY TECHNICAL PERSON HERE IS HELPING.
>> MINE TOO.
>> CAN YOU SEE IT NOW?
>> NO, WE CAN'T.
DO YOU WANT ME TO RUN YOUR SLIDES FROM HERE?
I ONE MORE TIME WE WILL TRY.
>> SORRY.
>> NOW?
NO.
>> HOW ABOUT NOW?
>> SORRY.
CAN YOU RUN MY SLIDES.
I'M SORRY.
>> ABSOLUTELY.
>> OKAY.
>> SO I'M ON THE MSCC HANDBOOK SLIDE.
DO YOU HAVE THAT UP NOW?
>> YES, THAT'S UP.
>> OKAY.
GREAT.
SO, I APOLOGIZE FOR THAT.
THE HANDBOOK REALLY DICTATES A FRAMEWORK THAT IS CRITICAL TO THE COALITIONS BECAUSE YOU HAVE TO HAVE A BASE LINE OPERATIONAL CAPACITY AND CAPABILITY THAT'S ALWAYS AVAILABLE, SUCH AS DEDICATED STAFF AND PROCESSES TO RECEIVE THE INFORMATION ABOUT AN EMERGENCY AND RAPIDLY NOTIFY COALITION ORGANIZATIONS.
THEM THEN MOBILIZE AND ACTIVATE USING A MULTI AGENCY COALITION SYSTEM.
IN MICHIGAN WE CALL THE MEDICAL COORDINATION CENTER.
THAT SUPPORTS THE INDIVIDUAL HEALTHCARE ORGANIZATION.
THE JURISDICTIONAL AT TIER TWO.
I WILL TALK MORE AS WE GO FURTHER IN THE PRESENTATION AND TALK MORE ABOUT THAT TIER 2 RESPONSE.
NEXT SLIDE, PLEASE.
THIS IS THE BIG PICTURE VISION OF THE TIERED CAPABILITIES IN MICHIGAN.
WE KNOW ALL DISASTERS START LOCALLY WE HAVE LOCAL EMERGENCY MANAGEMENT CENTERS AND OUR KEY MEMBERS.
THE NEXT STEP WE HAVE IN MICHIGAN IS EACH EMERGENCY MANAGEMENT PROGRAM HAS A DISTRICT COORDINATOR.
THEY ARE STATE POLICE.
MICHIGAN STATE POLICE IS EMERGENCY MANAGEMENT AT THE STATE LEVEL.
THEN WE HAVE DISTRICT COORDINATORS HELPING TO SUPPORT THAT EMERGENCY MANAGEMENT RESPONSE IN THE DEFINED JURISDICTION.
THAT IS REALLY TIER 2 FOR BOTH EMERGENCY MANAGEMENT.
RESPONSE.
NEXT SLIDE, PLEASE.
>> BOTH THE CDC AND ASPR FUNDS COME TO OUR OFFICE TO THE MICHIGAN COMMUNITY DEVELOPMENT OF EMERGENCY HEALTH.
AS THIS SLIDE INDICATES THE FUNDING STREAMS ARE DEDICATED TO COORDINATED STATE AND REGIONAL PLANNING EFFORTS.
WE HAVE ALWAYS HAD THE TWO GRANTS COMING IN BEING DISTRIBUTED WITH THE PLANNING.
MICHIGAN ESTABLISHED A FUNDING ALLOCATION PROGRAM SPECIFIC TO THE HPP FUNDS USED SINCE THE ONSET OF THE HOSPITAL PREPAREDNESS PROGRAM.
WE HAVE A BASE AMOUNT THAT ALL REGIONS RECEIVE.
WE KNOW THERE ARE CORE MEASURES THAT EACH REGION MUST ACCOMPLISH REGARDLESS OF THE POPULATION DENSITY OR HOSPITALS OR EMS AGENCIES.
THE REST OF THAT REGIONAL ALLOCATION IS BASED ON POPULATION.
WE HAVE WORKED THE NUMBERS SEVERAL WAYS OVER THE YEARS TO LOOK AT IF POPULATION OR DENSITY ARE MORE IMPORTANT. SHOULD WE LOOK AT THE NUMBER OF ER SYSTEMS OR EMS RUNS.
WE FOUND IN THE END THAT THE AMOUNTS USING DIFFERENT FORMULAS WERE SO CLOSE TO THE FORMULA WE ORIGINALLY DEVELOPED WE CONTINUE TO USE THAT SAME FORMULA TODAY.
BASE FUNDING AND A PERCENT BASED ON POPULATION.
APPROXIMATELY 62% OF FUNDS GO OUT TO THE EIGHT REGIONAL HEALTHCARE COALITIONS.
15-20 GO TO THOSE SUCH AS PATIENT TRACKING AND BED TRACKING.
THE REMAINING 18% IS KEPT FOR STATE WIDE HPP MANAGEMENT.
NEXT SLIDE.
>> THIS IS CERTAINLY A IMPORTANT OVER VIEW OF THE HEALTHCARE COALITIONS.
MICHIGAN HAS 8 HEALTHCARE COALITIONS.
THESE WERE FORMED NEAR THE STATE DEVELOPED EMERGENCY DISTRICTS.
WE WERE FORTUNATE IN THE
BEGINNING WHEN WE LOOKED AT THE DIFFERENT WAYS THAT REGIONS WERE ALLOCATED IN 2002.
WE THOUGHT THIS WAS THE BEST WAY TO LEVERAGE A RESOURCE THAT WAS ESTABLISHED FOR EMERGENCY PREPAREDNESS AND RESPONSE.
DURING THE COURSE OF THE RESPONSE OUR STATE TRAUMA REGIONS ARE BEING CONSISTENT.
THIS REALLY DOVE TAILED THE PROCESSES VERY NICELY INTO EACH OTHER IT WAS IMPORTANT FOR MICHIGAN WHEN WE LOOKED AT HOW TO ALLOCATE THE FUNDING AND TRY TO IDENTIFY AN ENTITY TO SERVE AS A FIDUCIARY WE DIDN'T WANT ONE LARGE HOSPITAL SYSTEM TO SERVE AS THE FIDUCIARY.
WE WANTED TO MINIMIZE THE COMPETITION FACTOR.
WE HAVE SOMETHING UNIQUE IN MICHIGAN.
A ORGANIZATION CALLED A MEDICAL CONTROL AUTHORITY.
THIS IS A QUASI GOVERNMENTAL AGENCY.
EACH HOSPITAL WITH AN EMERGENCY DEPARTMENT DOES BELONG TO A MEDICAL CONTROL AUTHORITY.
EACH YEAR OUR OFFICE ESTABLISHES A CONTRACT WITH THE FIDUCIARY MEDICAL CONTROL AUTHORITY.
WE CALL THEM MCA.
WE ESTABLISH THE CONTRACT FOR THE FUNDING.
IT MAKES IT EASIER FOR US MANAGE THE FUNDS AND CAPTURE INFORMATION FOR REPORTING.
THESE AUTHORITIES HIRE A MEDICAL DIRECTOR.
A EMERGENCY PHYSICIAN CONNECTED TO THE EMS WORLD.
THEY HAVE A FULL TIME COORDINATOR AND AN ASSISTANT COORDINATOR.
WE DIDN'T START WITH AN ASSISTANT COORDINATOR.
IT BECAME EVIDENT WE NEEDED HELP AND IT WAS MORE ABOUT STAFF THAN STUFF.
THIS AGAIN HAS BEEN VERY IMPORTANT IN RESPONSE.
WE HAVE REDUNDANCY.
EACH OF OUR HEALTHCARE COALITIONS HAVE A SET OF BY-LAWS
That guide the actions and processes of the coalition. These have been in place since 2003. They were reviewed in 2013 to make sure there was consistency among the coalitions. Over the course of the project, the coalitions grew and changed, kind of growing bigger and it was important for us to try to keep that constant set of by laws within each coalition that recognizes the nuance that could be there in addition. In the by laws was the need for an advisory committee and planning board. I will expand on that shortly. This is the core infrastructure of each region. Structure is the same with a great deal of flex.

This is important because as we know from our health perspective patients don’t stop as a divide line between one jurisdiction and another. I want to mention we’re a diverse state. We have the mitten and the upper peninsula. Our Michigan region to south is urban, the Detroit area. It houses the highest population density and the largest number of hospitals of all of our coalitions. This is our major international border. A lot of coalition special event planning takes place we have lots of headquarters for the auto industry and other businesses. It’s a very populated busy region. Next slide. Contrast that to our region 8, the upper peninsula. That is a very rural area with a large geographic area to serve including the tourist attraction Makinaw Island. There was over 300 inches of snow last year.
WHICH IS WHY I'M IN THE LOWER PENINSULA. IT HAS ONE LEVEL TWO TRAUMA CENTER. THE REST ARE SMALLER CRITICAL ACCESS HOSPITALS. IT HAS A INTERNATIONAL BOARDER AND UNIQUE CHALLENGES FOR PLANNING AND RESPONSE. I SHOW YOU THESE TWO REGIONS TO SHOW OUR SYSTEM IS ASSISTED TO THE DEMOGRAPHICS OF THE REGIONS WITH THE SAME INFRASTRUCTURE. EACH REGION HAS REPRESENTATION SIMILAR TO ORGANIZATIONS LISTED ON THIS SLIDE. FROM THE BEGINNING OF THE PROGRAM MICHIGAN NEVER FOCUSED ONLY ON HOSPITAL PREPAREDNESS BUT THE BROADER SYSTEM. WE CALL "ALL HAZARD PREPARENESS" FOR PREPAREDNESS AND RESPONSE. OBVIOUSLY KEY TO EACH REGION'S COALITION IS THE ROLE OF PUBLIC HEALTH AUTHORITIES. EACH LOCAL HEALTH DEPARTMENT DOES HAVE FUNDING OF THE CDC FUNDS FOR ONE EMERGENCY PREPAREDNESS COORDINATOR. EACH COALITION HAS A REGIONAL EPIDEMIOLOGIST THAT WORKS WITH LOCAL PUBLIC HEALTH DEPARTMENTS AND THE COALITION THAT IS FUNDED UNDER CDC FUNDS AND OBVIOUSLY LOCAL PUBLIC HEALTH ALSO HAS A PERSON RESPONSIBLE FOR STRATEGIC NATIONAL STOCK PILE ACTIVITIES. THOSE FOLKS ARE CRITICAL TO THE COALITION. IN ADDITION EMERGENCY MANAGEMENT IS A IMPORTANT ROLE, AS WE HAVE HEARD FROM OTHER PRESENTATIONS. WE HAVE LOCAL AND DISTRICT COORDINATORS THAT ARE PART OF THE PLANNING BOARD AND ADVISORY COMMITTEE. THE IMPORTANT PIECE IN THIS IS FOLKS THAT ARE PARTICIPATING ARE MEMBERS THAT BELIEVE IN EMERGENCY PREPAREDNESS AND FIND VALUE IN ATTENDERRING THE MEETINGS. NEXT SLIDE. THE HEALTHCARE COALITION ADVISORY COMMITTEE IS ONE OF TWO COMMITTEES WE HAVE ASKED EACH COALITION TO MAINTAIN.
THEY HAVE TO CONTINUE THE COMMITTEES TO BE CONSISTENT WITH OUR COALITION FRAMEWORK.
THE HEALTHCARE COALITION ADVISORY COMMITTEE IS THE WORK HORSE OF COALITION ACTIVITIES.
THIS IS WHERE WORK TAKES PLACE THROUGH SUB COMMITTEES AND WORK GROUPS. IT'S THE LARGER GROUP.
ALL MEMBERS INTERESTED IN MEDICAL AND HEALTH PREPAREDNESS.
>> COMMITTEES ARE ESTABLISHED ON CAPABILITIES, DISCIPLINES AND AREAS OF INTEREST FOR THE HEALTHCARE COALITION.
>> SO ALL OF THEM GENERALLY HAVE AN ALTERNATE CARE SITE COMMITTEE. SOME HAVE PUBLIC HEALTH COMMITTEE. SOME ARE CAPABILITY BASED.
THEY MEET REGULARLY TO GUIDE COALITION ACTIVITIES.
NEXT SLIDE..

>> EACH HOSPITAL AND EACH MEDICAL CONTROL AUTHORITY WAS GIVEN A VOTE AT THE PLANNING BOARD MEETING.
IT WAS CRITICAL PLANNING THE LARGEST HAD ONE VOTE. NO ONE MEMBER'S OPINION HAS MORE IMPORTANCE THAN THE OTHER.
REMEMBER THE MEDICAL CONTROL AUTHORITIES THEY ARE FOR EMS AGENCIES. FROM THE BEGINNING EMS WAS IMPORTANT AND PART OF THE VOTING STRUCTURE.

THE GOAL IS TO IDENTIFY THE NEEDS OF THE ENTIRE REGIONAL HEALTHCARE STRUCTURE AND BE CONSISTENT WITH STATE GUIDANCE AND FEDERAL GUIDANCE.

>> IN THE BEGINNING THE STATE REQUIRED ONE VOTING MEMBER FROM EACH HOSPITAL.
AFTER THAT AND OVER TIME THERE ARE LOCAL HEALTH AND THOSE OF THE PLANNING BOARD.
OTHERS ADDED AS WELL BASED ON THE ROLE OF THE COALITION.
SOME COALITIONS WITH LONG TERM CARE WORK GROUPS HAVE LONG TERM CARE REPRESENTATIVES ON THE PLANNING BOARD.
THE PLANNING BOARD FUNCTION IS CONSISTENT WITH THE BY LAWS.
SOME HAVE EXECUTIVE COMMITTEE TO
MOVE PROJECTS FORWARD.
AGAINLY THESE ARE MORE
HEAVILY POPULATED AREAS.
OTHERS DON'T HAVE AN EXECUTIVE
COMMITTEE.
EACH MUST SUBMIT AN ANNUAL
APPLICATION FOR FUNDING AND MUST
COMPLETE A END OF YEAR STATUS
REPORT TO THE STATE TO DOCUMENT THE GREAT PLANNING
WE HAVE DONE AND TO KEEP THE MONEY COMING.
I KNOW THIS IS A LOT OF INFORMATION IN A SHORT TIME.
I WANTED TO SKETCH OUT A PROCESS
OF A DECISION. YOU MAY THINK IT
SOUNDS LIKE A LOT OF COMMITTEES
AND REGULATIONS.
ACTIVITY STARTS AT THE ADVISORY
BOARD.
IDENTIFYING PROJECT X FOR
ACTIONS.
THE WORK IS THEN REFERRED TO THE
PLANNING BOARD AND LOOKING FOR
SUPPORT.
THE REGIONAL LEADERSHIP TEAM AS
WE CALL THEM OR THOSE HIRED
UNDER THE FUNDING ARE AVAILABLE
TO ANSWER QUESTIONS OF THE
BOARD.
GENERALLY THEY'RE NOT VOTING
MEMBERS OF THE BOARD.
THEY'RE THERE TO COORDINATE.
ONCE THEY'RE APPROVED IT GOES TO
THE FIDUCIARY WHICH DOES A
CHECKS AND BALANCES ASSESSMENT TO BE SURE IT'S CONSISTENT AND CAN LINK TO
THE CAPABILITIES AND PRIORITIES.
WE HAVE TO LINK BACK TO OUR
EIGHT CAPABILITIES.
>> WE ACTUALLY HAVE A FORM THAT'S CALLED A IMPLEMENTATION
APPROVAL PROCESS.
IT'S SUBMITTED TO OUR OFFICE.
THE REASON IT'S BENEFICIAL IS A LOT OF TIMES WE
HAVE A REGION LOOKING TO DO A
ACTIVITY THAT IS ACCOMPLISHED IN
ANOTHER COALITION.
WHILE THERE ARE OPPORTUNITIES TO MEET, YOU
CAN'T TALK ABOUT WHAT EVERY
COALITION IS DOING.
BY HAVING THE CHECKS AND BALANCE
IN THE OFFICE WE CAN SAY YOU
DON'T NEED TO HIRE A CONTRACTOR
FOR THIS EXERCISE.
WE KNOW THE COALITION IN SIX DID
IT LAST YEAR.
WE WILL GET IT FOR YOU AND
YOU'RE GOOD TO GO.
THAT'S WHERE GETTING IT BACK TO
THE STATE IS EFFECTIVE OF THE
GREEN LIGHT.
IT GOES TO THE FIDUCIARY,
APPROVED AND THEN MOVES FORWARD.
THIS IS ALL DONE ELECTRONICALLY
AND QUICKLY.
IT WASN'T ALWAYS THAT WAY BACK
IN THE DAY BUT IT IS NOW AND
MOVES FORWARD.
>> NOW THE STRUCTURE, AN
IMPORTANT PART OF OUR COALITION
IS THE TWO TIER SUPPORT
PROVIDED.
THIS IS THE MULTI AGENCY SYSTEM.
THE GOAL IS TO USE
STANDARDIZATION.
>> THIS IS A 24/7, 365 ANSWERING
POINT WITH THE COALITION BEING
THREE DEEP FOR EACH ROLE.
MANY OF THE FOLKS COME FROM THE
COALITION BUT WE RECOGNIZE IT
COULD COME FROM OTHER REGIONS IF
THE INCIDENT IS ISOLATED TO A
CERTAIN REGION.
EACH COALITION HAS A SITE THAT
IS VIRTUAL TO MEET THE NEEDS OF
THE INCIDENT.
>> NEXT SLIDE.
THIS IS INFORMATIONAL.
THIS IS PART OF MICHIGAN
COMPILED LAWS AND PUBLIC HEALTH
CODE. THE MEDICAL CONTROL AUTHORITY SERVE AS A FIDUCIARY AND
ARE VALUABLE FOR HOSPITAL CARE
AS A KEY PLAYER IN EACH
COALITION.
ONE OF THE QUESTIONS I THINK
ALWAYS COMES UP WHEN WE THINK
ABOUT COALITIONS HAVING A ROLE
IN RESPONSE IS WHAT AUTHORITY
DOES THE HEALTHCARE COALITION HAVE.
WE STRUGGLED WITH THIS FOR MANY
YEARS.
IN THE PREVIOUS DISCUSSION WE
HEARD ABOUT THE IMPORTANCE OF
LEVERAGING PUBLIC SAFETY AND
RECOGNIZING HEALTH CARE IS A
DIFFERENT ENTITY MOVING IN A
DIFFERENT DIRECTION.
WE HAVE ALWAYS FELT THE
COALITION HAS A RESPONSIBILITY
TO REPRESENT THE HEALTHCARE
PARTNERS.
The authority issue can be a challenge. Next slide.
I recognize that you can't read this slide.
It's here to let you know that in Michigan like most states each EMS agency functions under protocol.
In Michigan a Med Control Authority protocol must be as least comprehensive as the State protocol.
We were able to write the regional coalition into the Mass Casualty protocol.
What that does is it gives protection, liability protection for anyone who functions in the Medical Coordinating Center.
That Mass Casualty Incident protocol spells out the roles of the Medical Coordinating Center and how they function in an emergency and link to the State Health Emergency Coordination Center.
That was huge in getting that authority issue resolved in Michigan.
Next slide.
>> So, we have talked a little bit about sustained activity.
I will touch briefly on 501c3.
That is the way we are working to help sustain the health care coalition.
We embarked on a project which each healthcare coalition will be a 501c3.
Next slide.
This project was started in Budget Period Two in anticipation of decreasing HPP funds.
Not all coalitions were happy with this direction.
We used this to talk about it, lay ground work, take information back to coalitions.
When the BP3 funding came out and Michigan was cut, this was more attractive and folks understood that we had important
WORK TO DO.
The infrastructure we have created is so valuable we agree we need to find a way to financial sustainability. That is with this model.
The next slide.
This is just a snapshot of our timeline to complete the important sustainment activity. It's our goal that each healthcare coalition will have all of the paper work completed by budget period three.
We are not saying they will all be there.
It's a multi-year project.
There are legal things, working with the current coalition, current board.
Who wants to be part of the board.
There is a lot of mechanics that need to happen.
This is what we're doing during BP3.
I was happy to report our Region Eight was the first to get the paper work submit to the state and the IRS to be a 501C3.
When we think they're too rural, don't have the infrastructure.
Our most rural coalition is the first one to tackle this, this project.
We're pretty proud of them.
Next slide.
So with the limited time I have left I want to briefly highlight how the coalitions have and continue to support response.
I know your state was heavily impacted by the steroids that cause the mortality for many.
Unfortunately Michigan had the highest number of cases including death.
One of our large tertiary hospitals was the point of patient care.
At one point a third were linked to the contaminated medications.
This hospital did an awesome job of surging resources, opening up previously closed units, it became a sustained effort.
AGAIN THIS WAS THE FACILITY OF A SUSTAINED INCIDENT. THEY REACHED OUT TO THE COALITION. THAT COALITION WORKED WITH NEIGHBORING COALITIONS. OVER THE COURSE OF SEVERAL MONTHS WE HAD WEEKLY WEBINARS, ROUNDS, ADDITIONAL PERSONNEL AND MOVED PATIENTS NOT ASSOCIATED WITH THE OUTBREAK TO OTHER FACILITIES TO GET CARE. THEY WERE EXPERTS ON THE MANAGEMENT OF THE PATIENTS. IT WAS COMPLEX. I COULD GO ON AND ON WITH THAT RESPONSE. THAT'S A TALK FOR ANOTHER DAY.

WE GET SIGNIFICANT WINTER STORMS WHERE POWER CAN BE OUT FOR DAYS OR WEEKS. THE COALITION WAS CALLED ON BY A LOCAL HOSPITAL WHICH HAD TO RELOCATE THE EMERGENCY DEPARTMENT. THE HOSPITAL HAD QUESTIONS OF STATE LICENSING OR REGULATORY ISSUES WHEN THEY RELOCATED OPERATIONS. THEY PUT THE QUERY TO THE COALITION. WORKING WITH US AND OUR COORDINATION CENTER, WE WORKED THROUGH THE STATE SYSTEM AND A RESPONSE WAS GIVEN BACK IN LESS THAN ONE HOUR. THERE, INSTEAD OF THE HOSPITAL TRYING TO FIND SOMEONE AT OUR DEPARTMENT OF REGULATORY AFFAIRS WHILE MOUNTING A RESPONSE, ONE PHONE CALL TO THE COALITION HELPED TO TRACK DOWN THE INFORMATION THEY NEEDED TO ANSWER THE QUESTION. THEY COULD CONCENTRATE ON RESPONSE AND CONTINUE THE OPERATION.

ALSO ONE HOSPITAL HAD SIGNIFICANT DAMAGE TO THE EMERGENCY DEPARTMENT. ALL OF THE PORTABLE CARDIAC MONITORS WERE OUT. THEY CONTACTED THE HEALTHCARE COALITION TO IDENTIFY MONITORS TO RELOCATE TO THE HOSPITAL. WITHIN SEVERAL HOURS THE COALITION WORKED WITH THEIR HOSPITALS AND THEIR NEIGHBOR COALITIONS IDENTIFYING OVER 30 MONITORS TO TRANSPORT TO SUPPORT THE HOSPITAL.

IT'S A SMALL THING BUT IF YOU'RE THE ONE HOSPITAL THAT NEEDED HELPING THE COALITION CAN REALLY PAY
FINALLY OUR COALITIONS REALLY HAVE BEEN INTEGRAL WORKING COLLABORATIVELY WITH TRADITIONAL RESPONSE MANAGERS FOR EVENT PLANNING. THEY HAVE SUPPORTED THE SUPER BOWL AND ALL-STAR GAMES, THE AUTO SHOW. THEY HAVE EQUIPMENT, SUPPLIES AND SUBJECT MATTER EXPERTS THAT NOT ONLY HELP IN PLANNING BUT RESPONSE IF NEEDED.

>> NEXT SLIDE.

SO, I THINK THE IMPORTANCE, THE LESSON LEARNED IS THAT IF WE CAN CONTINUE TO DEMONSTRATE VALUE IN PLANNING AND RESPONSE WE CAN CONTINUE TO NURTURE OUR COALITIONS, CONTINUE TO PARTICIPATE. MANY ELECTRONIC TOOLS AND PLATFORMS SUPPORT BOTH OF THE LOCAL JURISDICTIONS OR THE FACILITY, AS WELL AS STATEWIDE.

I THINK THIS IS WHERE THE VALUE-ADD IS FOR THE INDIVIDUAL ORGANIZATIONS FOR THE COALITIONS AS WELL.

LAST SLIDE.
I HOPE IN THIS SHORT TIME AND TALKING RATHER QUICKLY I HAVE CAPTURED THE SIGNIFICANT INFRASTRUCTURE OF OUR EIGHT HEALTHCARE COALITIONS.

THE IMPORTANT ROLE NOT JUST FOR THE CATASTROPHE BUT REGIONAL INCIDENTS.

WE LOOK FORWARD TO THE OPPORTUNITY WHERE HEALTH CARE COALITIONS WILL BE A IMPORTANT SUPPORTING ROLE AS CMS ROLLS OUT THE EMERGENCY PREPAREDNESS CONDITIONS OF PARTICIPATION.

WITH THAT I WILL END AND TAKE ANY QUESTIONS.

AGAIN I APOLOGIZE FOR THE SNAGS ON MY SLIDES.

>> MARY CLARK: THANK YOU, LINDA AND JOHN AND KEVIN FOR THREE EXCELLENT PRESENTATIONS.

WE ARE GOING TO MOVE INTO THE QUESTION AND ANSWER PHASE OF THE WEBINAR NOW.

SO I WANT TO GO THROUGH THE INSTRUCTIONS WHICH YOU SHOULD SEE ON THE SCREEN.

FOR THOSE WHO WANT TO ASK THE QUESTIONS BY TELEPHONE OR
HEADSET YOU SHOULD ENABLE YOUR AUDIO BY PRESSING POUND YOUR AUDIO PIN NUMBER AND POUND. PLEASE USE THE CONTROL PANEL ICON TO RAISE YOUR HAND AND BE PLACED IN QUEUE. THERE IS A SCREEN SHOT ON THE SCREEN TO SHOW HOW TO RAISE YOUR HAND ON THE SCREEN. PLEASE LISTEN FOR YOUR NAME TO BE CALLED. WHEN YOU HEAR THAT YOUR LINE IS UNMUTED PLEASE ASK YOUR QUESTION. FOR THOSE WHO WANT TO ASK A QUESTION BY TEXT TYPE YOUR QUESTION INTO THE QUESTION BOX. THERE IS A SCREEN SHOT THERE SHOWING YOU THAT. LISTEN TO HEAR YOUR QUESTION BEING READ ALLOUD AND THEN IT WILL BE ANSWERED. I THINK WHILE WE GIVE FOLKS A CHANCE. WE WILL POSE ONE QUESTION THAT WAS SUBMITTED EARLIER.

TO CLARIFY I'M GOING TO ASK EACH SPEAKER IN THE ORDER THEY PRESENTED TO CLARIFY WHETHER ANY PHEP FUNDING IS USED TO DIRECTLY PAY HEALTHCARE COALITION STAFF OR TO COVER THE COST OF OPERATING EXPENSES OR HOW YOU COORDINATE WITH THAT AND HPP FUNDS. CAN I TURN TO YOU, JOHN, TO START WITH THE QUESTION. >> JOHN HICK: THE FUNDS ARE USED ON THE PUBLIC HEALTH SIDE FOR THE METRO LOCAL TO SUPPORT THE ACTIVITIES OF THE LOCAL EMERGENCY PREPAREDNESS. >> MARY CLARK: THANK YOU.

JOHN HICK: HOPEFULLY YOU CAN HEAR ME. THE FUNDS CONTRIBUTE TO THE PUBLIC HEALTH AWARENESS WORK GROWTH FOR PUBLIC HEALTH. THEY'RE WORKING THE PUBLIC HEALTH SIDE WITH THEIR FUNDS. THEY USE HPP FUNDS THROUGH THE COMPACT. >> MARY CLARK: THANK YOU, JOHN. KEVIN.
>> KEVIN MCCULLEY: YES. ALTHOUGH THERE AREN'T DIRECT
ALLOCATIONS IN THE GRANT OF FUNDS TO THE COALITIONS AS JOHN
KIND OF MENTIONS YOU KNOW THERE
ARE MANY OPPORTUNITIES FOR
SUPPORTED STAFF AND PROJECTS TO
CROSSOVER INTO THE REGION SURGE COALITION. A COUPLE OF EXAMPLES:
ONE, EACH OF THE EMERGENCY
RESPONSE COORDINATORS ARE ACTIVE
PARTICIPANTS IN THE COALITION.
THEY OFTEN SERVE AS THE
LEAD IN COMMAND CENTERS THEY
INSURE THE HEALTH AND MEDICAL
TEAM ARE COVERED TIMELY. SOME OF OUR PROJECTS THAT
ARE SUPPORTED LIKE THE NATIONAL STOCK
PILE THESE FOLKS HAVE A DIRECT
LINE OF ACCESS FOR THE HEALTH
AND MEDICAL FACILITIES WITHIN
THEIR JURISDICTION.
THEY CAN DO THINGS LIKE DEVELOP
CLOSED POD AGREEMENTS WHERE IN
THE PAST THEY HAVE DONE IT ON A
INDIVIDUAL BASIS WITH FOLK THEY
DIDN'T REALLY KNOW.
IT'S NOT DIRECT FUNDING BUT WE
HAVE SEEN REALLY STRONG
BENEFITS.
LOOKING AT THE PROJECTS IN ALIGNED MANNER.
THAT'S ALL.
>> MARY CLARK: THANKS, KEVIN. LINDA?
>>LINDA SCOTT: YES, AT THE COALITION LEVEL
THERE HAVE BEEN FUNDS SUPPORTING
THE COALITION ACTIVITIES.
NOT TO A HIGH DEGREE IN ALL
COALITIONS.
BASICALLY IT'S MORE ABOUT
LEVERAGING RESOURCES OR
ACTIVITIES.
>> IF LOCAL PUBLIC HEALTH IS
DOING A CRI EXERCISE THEY
PARTICIPATE SOMETIMES THEY HAVE
EDUCATIONAL CONFERENCES.
MORE IT'S THE PARTICIPATION OF
FUNDED PERSONNEL TO ATTEND
COALITION MEETINGS AND SUPPORT
COALITION ACTIVITIES.
AT THE STATE LEVEL FUNDS DO
SUPPORT OUR OVERALL
INFRASTRUCTURE OF THE OFFICE TO
PROVIDE CDC AND ASPR STAFF.
>> MARY CLARK: THANK YOU, LINDA, JOHN AND
KEVIN.
I WILL GO TO A COUPLE OF
QUESTIONS COMING IN.
THE FIRST QUESTION IS WHAT ROLE DO
College Health Services play if any. Can you talk about the level of involvement with the services. Let's -- can we start back in the order we presented. Start with John.

>> John: Sure. I will say that's relatively limited. Our College Health Center is represented through the Academic Health Center. It's fairly limited participation.

>> Mary Clark: Thanks John. Kevin.

>> Kevin McCulley: Yes. I would concur with Dr. Hick. The activities have been limited to some extent but we actually will benefit of a lead Hospital Emergency Management folks who left employment with the hospital and became the emergency manager for a college. Based on that, as I mentioned before sometimes it does take a champion in one of our regions. We have been able to enhance the interaction between the college campus emergency management and the health services and the region.

>> Mary Clark: Thank you, Kevin. How about Michigan, Linda?

>> Linda Scott: Actually it varies by coalition. Our region one coalition - Michigan State is actually part of the coalition. They are involved in the coalition. They have participated in exercises. Coalition leadership does emergency preparedness and programs for the medical students and nursing students. Some of the coalition utilize university health centers as alternate site locations. There is a large Grand Valley State University. As a huge training facility. It's like a hospital for the health care professional program. They have signed as an alternate care site if needed. It has medical gases and everything in it. It varies by region.

Mary Clark: Thank you, Linda.

>> I would say if there is one thing that stands out for us
UNFORTUNATELY THE THOUGHT THIS DAY AND AGE AN ACTIVE SHOOTER EXERCISE THAT HAS BEEN CONDUCTED AT SOME OF THE COLLEGE CAMPUSES HAS BEEN A OPPORTUNITY TO REALLY MAKE THE HEALTH CARE SYSTEM WORK TOGETHER WITH THE COLLEGE BECAUSE OF THE CONCERNS FROM PRIOR EVENTS.

>> MARY CLARK: THANKS.
I'M GOING TO GO TO ANOTHER QUESTION.
IN MASSACHUSETTS WE HAVE A NUMBER OF MUTUAL AID PROGRAMS.
ONE IS A MUTUAL AID SYSTEM ACROSS THE STATE FOR LONG-TERM CARE FACILITIES.
CAN YOU TALK A LITTLE BIT HOW YOUR COALITIONS MAY INCORPORATE EXISTING MUTUAL AID AGREEMENTS OR DEVELOP THOSE.
LET'S START WITH YOU, LINDA, IF WE CAN.

>> LINDA SCOTT: WE HAVE DONE QUITE A BIT OF WORK WITH LONG TERM CARE STARTING MANY YEARS AGO.
WE DIDN'T HAVE STATE WIDE AGREEMENT.
WE STARTED TO USE THE CMS RECOMMENDATIONS WHERE THEY DEVELOP AN MOU WITHIN 50 MILES AND OUTSIDE OF 50 MILES.
THEY ALL WERE WORKING WITH THE PROCESS.
WHAT WE EXPERIENCE WITH THE WINTER STORMS IS DEMONSTRATION THAT THE LONG TERM CARE NEEDS MORE, MANY MOUs.
GENERALLY A FACILITY OF A DESCENT SIZE, NO LONG TERM CARE ORGANIZATION HAS A HUNDRED BEDS TO GET CLIENTS FROM ANOTHER AGENCY.
WE'RE WORKING HARD.
UNFORTUNATELY WE DON'T HAVE A STATE WIDE MUTUAL AID.
THEY'RE ESTABLISHING THOSE 50 IN, 50 OUT.
MARY CLARK: THANK YOU, LINDA. KEVIN OR JOHN?

>> KEVIN MCCULLEY: SURE. THIS IS KEVIN.
WE HAVE HAD A LONGSTANDING MUTUAL AID AGREEMENT BETWEEN THE HOSPITALS IN THE STATE.
IT'S BEEN IN EXISTENCE SINCE ABOUT 2006.
IT'S COORDINATED AND UPDATED BY THE UTAH HOSPITAL ASSOCIATION.
THAT'S BEEN A BENEFIT TO GET
PEOPLE TO THE TABLE AND WORKING AROUND THE SAME IDEAS OF SUPPORT FOR IMPACTED ENTITIES. HOWEVER WHEN WE START TO DEVELOP REGIONS WE FOUND A HOSPITAL-ONLY MAA OBVIOUSLY DOES NOT INCLUDE ALL OF THE PARTNERS WE HOPE TO GET TO THROUGH THE REGION. SO USING THE MASTER MUTUAL AID AGREEMENT OF THE HOSPITALS THAT'S SUSTAINED AND REMAINS IN PLACE AND IN EFFECT, WE USE THAT AS A TEMPLATE AND OTHER TEMPLATES AVAILABLE FOR EACH REGION TO DEVELOP A REGIONAL MUTUAL AID AGREEMENT MORE INCLUSIVE OF THE ENTITIES THAT PARTICIPATE. THAT'S ALL.

>>MARY CLARK: THANKS, KEVIN. JOHN, ANYTHING FROM MINNESOTA?
>>JOHN HICK: YOU KNOW I THINK THERE HAVE BEEN SITUATED LIKE WITH EMS MUTUAL AID AGREEMENTS IN PLACE TO A DEGREE SOME OF THE OTHER COALITION DISCIPLINES. WHAT WE HAVE FOUND ONCE WE GET THEM TO THE TABLE IS MOST OF THOSE ONLY ADDRESS A SMALL SLICE. THIS IS A LOT THAT COALITION PARTNERS CAN BRING TO THE TABLE. WHETHER IT'S ORGANIZING THE EMS ASSETS TO HELP EVACUATE A NURSING HOME. REALIZING WE NEED MORE OF A TEMPLATED RESPONSE PLAN. THE EXPECTATIONS ARE NOT COMMON OR THERE ARE LEGALITIES THAT PREVENT THE MOUs FROM WORKING. IF THEY'RE SMOOTHED OUT, IT'S A GREAT PROCESS TO HAVE FOLKS BRING EXISTING AGREEMENTS TO THE TABLE AND TALK ABOUT WHAT THEY DO AND DON'T DO, WHERE WE CAN SUPPLEMENT THEM. SOMETIMES WE NEED TO SHAKE THOSE DOWN A LITTLE BIT. MAKE SURE THEY DO WHAT THEY'RE INTENDED TO DO. IF SO IT'S FANTASTIC AND A PIECE OF THE PUZZLE IN PLACE.
>>MARY CLARK: THANKS, JOHN. NEXT QUESTION THAT I SEE ON THE SCREEN. DO YOUR HEALTHCARE COALITIONS ROUTINELY SUB CONTRACT WITH OTHER AGENCIES OR ENTITIES FOR THE SERVICES OF PLANNING OR FOR EXERCISES.
CAN WE START WITH KEVIN?

KEVIN MCCULLEY: SURE. THAT WOULD BE FINE.
ROUTINELY SUB CONTRACT FOR OTHER SERVICES? THEY, THEY DO TO THE EXTENT THERE ARE SOME IDENTIFIED GAPS IN THE REGION. WHAT I MEAN IS IN OUR MORE FORMALIZED, MORE URBAN AND DEVELOPED REGIONS WE HAVE PLENTY OF MASTER EXERCISE PRACTITIONERS THAT PUT TOGETHER EXERCISE EVENTS FOR EXAMPLE. HERE WHERE THERE ARE MANY EXPERTISES AND RESOURCES THOSE FOLKS CONTRACT WITH A CONSULTANT AT THAT POINT OR SOMEONE DOING TRAINING AND HE CAN CONDUCT EXERCISES WITH THOSE ACTIVITIES.
BEYOND THE TRAINING AND EXERCISES AND NEED TO FIND EXTERNAL SUBJECT MATTER EXPERTS MOST OF THE REST OF THE ACTIVITIES ARE CONDUCTED EVEN BY THE COORDINATOR OR WITH A GROUP OF COALITION MEMBERS OR WITH WHATEVER SUPPORT THE DEPARTMENT OF HEALTH PROVIDES TO EACH REGION. WE'RE MORE THAN HAPPY TO SEND EXPERTS AND OUR PLANNERS AND OTHER FOLKS DOWN TO ASSIST WITH WHATEVER IS NEEDED. WE KEEP THAT DOOR OPEN.
OF COURSE THAT'S NO COST TO THE COALITION IT'S WHAT WE DO.

MARY CLARK: THANK YOU, KEVIN.

LINDA OR JOHN?

JOHN HICK: I WOULD SAY -- AS THE FUNDING HAS DECREASED OVERTIME THERE IS LESS OF THAT. -- A PLANNING BOARD MEMBER OR SOMEONE WHO IS MAYBE A HAZMAT THAT CAN DO TRAINING ON DECONTAMINATION, THEY MAY STIPEND SOMEONE TO HELP THEM OR OFF SET COSTS WITH MILEAGE OR COMPENSATE TRAINING. SOME WILL USE AS KEVIN SAID MORE EXERCISE DEVELOPMENT OR COMPLETE THE AAR -- I WOULD SAY LESS THAN THERE USED TO BE.

KEVIN MCCULLEY: IF I COULD GIVE ONE MORE FOLLOW-UP. SORRY TO CUT JOHN OFF. SOMETHING THAT'S A CRITICAL POINT FOR US IN UTAH, WE STILL RETAIN SOME OVERSIGHT IN THE DEVELOPMENT AND TRAINING FOR THESE REGIONS. IF WE SEE THREE OF THE SEVEN REGIONS WITH THE SAME TRAINING
NEEDS WE WILL TAKE IT AND MAKE IT HAPPEN INSTEAD OF HAVING THIS DUPLICATED EFFORT THAT EACH REGION HAS TO DO THEIR OWN THING AT ALL TIMES. IF WE CAN GET VISIBILITY THAT CREATES A OPPORTUNITY FOR EFFICIENCY BY DOING A STATE LEVEL TRAINING.
THAT'S ALL.

>>JOHN HICK: THANK YOU, KEVIN. I WOULD SECOND KEVIN AND LINDA'S COMMENTS. IN GENERAL WE DO IT WITH THE OPERATIONAL PERSONNEL, PLANNING PERSONNEL. ON GAME DAY WE DON'T DON'T HAVE A OUTSIDE CONTRACTOR.
IF WE HAVE A CONTRACTOR IT'S A LOCAL PERSON REAPPROPRIATING THEIR TIME TO DO EXERCISE DESIGN OR SPECIFICS. IT'S VARIABLE BETWEEN THE REGION DEPENDING ON THE NEEDS AND EXPERTISE AVAILABLE TO THEM.

>>MARY CLARK: THANK YOU, THANK YOU, VERY MUCH.

>> ANOTHER QUESTION THAT CAME IN. THE PRESENTATION FROM EACH OF YOU TALK ABOUT THE WORK OF THE COORDINATING COALITIONS IN FOSTERING A MORE COORDINATED RESPONSE IN EMERGENCIES, PLANNING ACROSS THE DISCIPLINES. BUT THE PUBLIC HEALTH AND THE HOSPITAL FUNDING REMAINS THROUGH SEPARATE STREAMS. CAN YOU TALK ABOUT WHETHER THAT HAS PRESENTED CHALLENGES OR AND HOW YOU HAVE ADDRESSED THOSE IN YOUR COALITION. HOW ABOUT LINDA?

>> LINDA SCOTT: SURE. OUR OFFICE -- IT'S TRUE THE FUNDS GO OUT TO THE LOCAL HEALTH DEPARTMENTS, THEY GO TO THE LOCAL HEALTH DEPARTMENTS. IT'S A COMPREHENSIVE FUNDING. THE LOCAL HEALTH DEPARTMENTS GET FUNDING FROM THE STATE FOR ALL KINDS OF PROGRAMS. THAT FUNDING IS PUT INTO THE LOCAL HEALTH DEPARTMENTS THROUGH THE MORE BROAD BASED SYSTEM. THAT MAKES IT DIFFERENT FROM THE HEALTHCARE COALITIONS. WE, WE COORDINATE AT THE STATE LEVEL.

IT'S DEFINITELY TWO FUNDING STREAMS. IN MANY WAYS THEY HAVE A UNIQUE DELIVERABLE THAT THEY LEVERAGE THE RESOURCES TO WORK TOGETHER. IT'S STILL TWO FUNDING STREAMS. IT GOES TO TWO DIFFERENT
>> MARY CLARK: THANKS LINDA.
KEVIN?
>> KEVIN MCCULLEY: SURE IN OUR CASE IT'S A BIT DIFFERENT. WE ACTUALLY OUT OF OUR OFFICE WE JUST DO ONE AGREEMENT WITH LOCAL HEALTH DEPARTMENTS WITH MANY DIFFERENT PROVISIONS DEPENDING ON THE FUNDS.
FOR EXAMPLE, 7 OUT OF 12 RECEIVED THE HPP FUNDS.
ALL 12 RECEIVE MEDICAL RESERVE CORP FUNDS. SOME RECEIVE SNS.
THREE RECEIVE CRI. ALL RECEIVE -- FUNDS.
SO, SO YOU KNOW WE HAVE A OPPORTUNITY EVEN THOUGH THE PROGRAM FUNDING TARGETS ARE DISTINCT BECAUSE OF THE FACT THEY HAVE SHARED CAPABILITIES THERE ARE OPPORTUNITIES TO SEEK OVERLAP EVEN IF IT'S NOT EXPRESSLY LAID OUT IN THE GUIDANCE. WHAT I WOULD HOPE FOR FUTURE YEARS IF THAT IS SUSTAINED AND HPP IS AT A LOW LEVEL OF FUNDING OR DECREASED WE WOULD HOPE TO SEE IMPROVED LANGUAGE IN THE CDC GUIDANCE THAT IS MORE INCLUSIVE OF COALITIONS TO INSURE THAT REGARDLESS OF THE FUNDING STREAM THAT IT'S A SUPPORT FOR COALITIONS. THAT IT'S MAINTAINED IN THE AREAS.
>>MARY CLARK: THANKS, KEVIN.
JOHN, ANYTHING FROM MINNESOTA?
>> JOHN HICK: YA, I THINK THE SEPARATE FUNDING STREAMS ARE A BLESSING MORE THAN A CURSE.
I SEE THE END OUTCOMES FOR BOTH GRANTS AS COMPLIMENTARY AND YET DIFFERENT.
THERE ARE NUMEROUS OPPORTUNITIES FOR US TO COST SHARE BETWEEN STAFF AND HPP ON EXERCISE PLANNERS, ON WORK SHOP HOSTING FEES, A NUMBER OF OTHER THINGS WHERE THERE IS GREAT PARTNERSHIP AND JOINT ACTIVITY.
YET, AT THE SAME TIME THERE ISNT THE DISPUTE HOW FUNDS WILL GET UTILIZED.
EACH HAS THEIR OWN STREAM TO WORK WITH. SOME COMPLIMENTARY AND NOT YET EXACTLY THE SAME GOALS.
SO, IT'S WORKED OUT ACTUALLY
Mary Clark: Thanks John.

Next question that has come in. So, system hospitals, hospitals that are profit or not for profit but may have a more traditional business model, that can be looked at differently from local governmental health department and the primary activities they have. Can you talk about whether there is a conflict if you're working through funding and/or priorities often from those two models. Working with healthcare partners that are for profit or not for profit. Could we start with you, John, on that?

John Hick: Sure. I don't know we have really seen that much conflict in that. You know the hospitals even though they tend to be private entities. When you look at the goals of the grant there is a lot they share in common. Because they're working off of a business model they need to maximize investments. When we help out at a regional level with exercise design support, communication, policy support you know a lot of that development work is taken out of their hands. They're actually quite glad of that to have the ability to reach out to subject matter experts to get drafts, policies from partners. It can save tremendous work for hospital management, security, safety, infection control and other personnel. I think they see this as a big win win. I think there are some issues sometimes of focusing on the hospitals here - there are questions for emergency management of their ability to compel the entities to do certain things. How are they able to obtain resources during event. There are different rules on reimbursement and different statutory language for the situations. Definitely it needs to be looked at ahead of time. In general the hospitals are willing participants this is a good return on investment for them.

Mary Clark: Thanks, John.
LINDA?
>> LINDA SCOTT: YA, WOULD I ECHO WHAT DR. HICK SAYS. I THINK EARLY ON WE SAW THE TREPIDATION OF HOSPITALS AND PRIVATE EMS AGENCIES AND SHARING INFORMATION AND RESOURCES. REALLY FOR THE PURPOSES OF PLANNING AND RESPONDING THAT REALLY HAS GONE BY THE WAYSIDE. THINK THERE IS A NEW RESPECT GAINED BY EMERGENCY MANAGEMENT PUBLIC HEALTH AND HOSPITALS, AND EMS FOR THEIR ROLES AND RESPONSIBILITY. ALTHOUGH WE ARE ALL IN ORDER IN RESPONDING MEDICAL AND PUBLIC HEALTH WE HAVE OUR SPECIALTIES AND AREAS OF EXPERTISE AND FOCUS. WHEN EACH DISCIPLINE KEEPS THAT IN MIND AND DOESN'T GO INTO THE LANE OF THEIR SERVICE PROVISION, THAT MAKES IT WORK MORE SMOOTHLY. I THINK THROUGH EXERCISING, PLANNING AND THIS PROGRAM THAT IS STRENGTHEND IN MICHIGAN.

MARY CLARK: THANK YOU, LINDA.

>> KEVIN, FINAL COMMENTS ON THIS?

>> KEVIN MCCULLEY: YOU KNOW I HAVEN'T SEEN A BIG DISTINCTION FOR PROFIT AND NON PROFIT. WE HAVE HOSPITALS SUPPORTED BY SPECIAL TAX DISTRICTS. YOU KNOW THEY HAVE HAD THE BENEFIT OF HPP FUNDS SINCE 2002. IT'S REALLY TO SUPPORT THE THINGS THAT ARE NOT GENERALLY DAY TO DAY REQUIRED OF THE HOSPITAL. SO, REALLY WHAT WE'RE DOING IS ASSISTING THEM REGARDLESS OF THE CORPORATE SETUP TO BE OF ASSISTANCE TO THE JURISDICTION IN A RESPONSE. WHETHER WE LIKE IT OR NOT, FOLKS ARE GOING TO SHOW UP AT A MEDICAL FACILITY. IF WE HAVEN'T DONE OUR DUE DILLIGENCE REGARDLESS OF THE FOR- PROFIT OR NON-PROFIT IT WILL BECOME A ISSUE DURING AN ACTUAL RESPONSE EVENT. I THINK ONE OF THE KEY ISSUES MAYBE THAT WE HAVEN'T APPROACHED FULLY NOW HAS TO DO WITH SOME OF THE REIMBURSEMENT ISSUES THAT SEEM TO DRAW A DISTINCTION BETWEEN NON PROFIT AND FOR
PROFIT SYSTEMS.
THAT IS A TOPIC OF ON GOING AND
FUTURE INVESTIGATIONS.
MARY CLARK: I THINK SO THANKS.
>> SO GETTING CLOSE TO THE END
OF OUR TIME. WE HAVE A FEW QUESTIONS.
IF WE DON'T GET TO EVERYTHING I
WILL FOLLOW-UP WITH THE SPEAKERS
AND WE WILL POST ADDITIONAL
INFORMATION ON THE BU WEBSITE
FOR QUESTIONS WE DON'T GET TO.
I WANT TO ASK --WE HAVE A QUESTION ABOUT WHETHER
THE COALITIONS HAVE BEEN ABLE TO
PARTNER WITH HOMELAND SECURITY
AND GET ACCESS TO THOSE
ADDITIONAL RESOURCES FOR FUNDING
FOR THINGS SUCH AS SUPPORT OR
EQUIPMENT OR TRAINING.
JOHN, HOW HAS THAT WORKED IN
MINNESOTA?
>> JOHN HICK: I THINK THE HOME LAND
SECURITY FUNDS ARE ALLOCATED
BEFORE THEY TRICKLE DOWN.
HOWEVER THERE ARE GREAT
OPPORTUNITIES TO PARTNER WITH
EXERCISES AND TRAINING PROGRAMS.
WE HAVE BEEN ABLE TO ACCESS
THE TRAINING PROGRAM WE SEND
PERSONNEL TO TAKE THE COURSES
DOWN AT ANNISTON THROUGH HOMELAND SECURITY
FUNDING IT'S A TREMENDOUS VALUE.
WE HAVE GREAT EXERCISES GREAT TO
PARTNER WITH, TRAINING, ALL
BROUGHT IN BY HOMELAND
SECURITY. WE HAVE PARTNERS ON THEIR
NUCLEAR POWER PLANT EXERCISES.
THERE IS NOT DIRECT OPPORTUNITY
TO APPLY FOR AND RECEIVE FUNDING
DIRECTLY TARGETING TO HOSPITAL
OR EMS WE SEE A LOT OF AREAS WE
HAVE A GREAT OPPORTUNITY TO
ENGAGE WITH THEM ON ACTIVITIES
TO MOVE FORWARD THAT WE PIGGY
BACK ONTO.
>>>MARY CLARKK: THANK YOU, JOHN.
HOW ABOUT KEVIN?
>>KEVIN MCCULLEY: SURE. AT LEAST IN OUR EXPERIENCE PRIOR
to this HPP cut the division of
emergency management suffered a
severe cut. From my perspective that is not
a case for our entities, coalitions to look for
sustaining funds for their project.
That being said we recognize a
couple of critical factors.
ONE IS THAT IF YOU HAVE
EMERGENCY MANAGEMENT ACTIVELY
REPRESENTED IN THE REGIONAL
COALITION AS DR. HICK SAID THERE
BECOMES AN AWARENESS THAT THERE
ARE SHARED NEEDS AND THREATS
WITHIN THE AREAS.
THAT THERE ARE OPPORTUNITIES TO
DO JOINT TRAINING AND EXERCISES
THAT ENGAGE MORE OF THE STAKE
HOLDERS.
YOU CAN LOOK ACROSS THE WHOLE
SPECTRUM OF RESPONSE.
THEN FINALLY, OR SECONDLY YOU
KNOW BEING GOOD GRANTEES IN UTAH
WE DEVELOPED A STATE LEVEL
ADVISORY COMMITTEE THAT IS BOTH
PHEP AND HPP. HOWEVER WE HAVE SIGNIFICANT
INVOLVEMENT BY THE STATE
EMERGENCY MANAGEMENT PARTNERS IN
THE STATE LEVEL ADVISORY
COMMITTEE. WE CAN DO THINGS SUCH AS SHARING
MULTI YEAR TRAINING PLANS WITH
THEM. LEVERAGING THE NATIONAL MOA
BETWEEN CDS, ASPR AND HOMELAND SECURITY.
LOOKING AT IT FROM BOTH LEVELS.
THE GROUND LEVEL, GRASSROOTS
LEVEL AND THE TOP LEVEL OF STATE
EMERGENCY MANAGEMENT TO INSURE
THAT THEY UNDERSTAND WE ARE
REMOVING THE BURDEN FOR
JURISDICTIONAL EMERGENCY
MANAGERS IF WE HAVE HEALTH AND
MEDICAL TAKEN CARE OF DURING AN
EVENT.
>>MARY CLARK: THANK YOU, KEVIN.
LINDA, ANY FINALS FROM MICHIGAN?
>>LINDA SCOTT: YA, I THINK ACTUALLY WE HAVE
SEVERAL HEALTHCARE COALITION
THAT HAVE BEEN RECIPIENTS OF
HOMELAND SECURITY FUNDS.
SOMETIMES YOU KNOW THINGS THAT
HOMELAND SECURITY CAN BUY LIKE
THINGS WITH AN ENGINE, STEERING
WHEEL AND WHEELS CAN BE
PURCHASED. PHARMACEUTICAL THAT CAN'T BE
PURCHASED CAN BE PURCHASED WITH
THE OTHER FUNDS.
BASED ON RELATIONSHIPS
ESTABLISHED AND HARD WORK WE DO
HAVE COALITIONS THAT HAVE
RECEIVED SPECIFIC FUNDING TO
SUPPORT SOMETHING THAT WAS
UNABLE TO BE PURCHASED WITH HPP
FUNDS. AS DR. HICK SAID WE HAVE DONE A TON OF EDUCATION, TRAINING AND LEVERAGING THOSE EXERCISE OPPORTUNITIES. 

>>MARY CLARK: THANK YOU, VERY MUCH. WE ARE RIGHT AT 1:00 O'CLOCK. SO, I WANT TO FIRST THANKS OUR THREE PRESENTERS. JOHN, KEVIN, LINDA, A GREAT JOB PRESENTING ON THE COALITIONS IN YOUR STATES AND ANSWERING QUESTIONS. WE STILL HAVE A COUPLE OF QUESTIONS WE HAVEN'T GOTTEN TO. WE WILL PROVIDE INFORMATION ON THOSE ON THE WEBSITE. WE WILL PUT THE QUESTION AND INFORMATION REGARDING THE QUESTION ON THE BU WEBSITE. AS A REMINDER THE WEBINAR HAS BEEN RECORDED. THE RECORDING AND THE TRANSCRIPT WILL BE REPORTED ON THE WEBSITE AS WELL FOR THOSE WHO WEREN'T ABLE TO PARTICIPATE ON THIS. THE WEBSITE IS WWW.BU.EDU/SPH-COALITIONS THE RECORDING AND TRANSCRIPT WILL BE POSTED THERE. I WANT TO THANK EVERYONE FOR BEING ON THE WEBINAR TODAY. WE WILL CONTINUE TO PROVIDE INFORMATION AND ADDRESS QUESTIONS AS THEY COME IN FOR BU OR DIRECTLY TO US. THANK YOU VERY MUCH. THANK YOU, JOHN, LINDA AND KEVIN. HAVE A GREAT AFTERNOON, EVERYONE.