COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HEALTH

OFFICE OF EMERGENCY MEDICAL SERVICES

IN RE: EMERGENCY PREPAREDNESS & RESPONSE COMMITTEE MEETING

HEARD BEFORE: MARK DAY

CHAIR, EMERGENCY PREPAREDNESS & RESPONSE COMMITTEE

FEBRUARY 8, 2019

CONFERENCE ROOM

EMBASSY SUITES HOTEL

2925 EMERYWOOD PARKWAY

RICHMOND, VIRGINIA

8:00 A.M.

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APPEARANCES:

Mark Day, Presiding
Chair, Emergency Preparedness & Response Committee

EP&R COMMITTEE MEMBERS:

Patrick Ashley

Sam Bartle, MD

Ron Clinedinst

Michelle Cowling

Keith Dowler

Michael Feldman, MD

Dan Gray

Robert Hawkins

Erin Nowlin

Kelly Parker

Robert Truoccolo

VDH/OEMS STAFF:

Wanda Street

David Edwards

ALSO PRESENT:

Walter Soto

Kelley Rumsey

Tanya Trevilian

ALSO PRESENT (con't.):

Kate Challis

Khaled Basiouny, MD

David Long

Gordon Thomas Schwalenberg

Richard Szymcyk

James Giebfried

Kelly Brown

Erin Nowlin

Michel Aboutanos, MD
TAG and EMS Advisory Board

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(The Emergency Preparedness and Response Committee meeting commenced at 8:00 a.m. A quorum was present and the Committee's agenda commenced as follows:)

MR. DAY: Hello, my name is Mark -- Mark Day. I'm the chair for the Emergency Preparedness and Response Committee, and Kelly is the vice-chair.

So you see on there that we're going to be selecting a vice-chair. That has been selected. It was selected a long time ago. So we are not -- we are not going to be doing that today.

I am the trauma program manager for Virginia Beach General Hospital down in Tidewater, Virginia. I'm at the beach. And with this -- we are -- this is really the first time we've had this many people in the room.

It's very nice to have this many people here. We've been here for two days now, and sitting through a couple of the other meetings. This has been a long time coming for those of us who have been

working at this for years now. Two, almost three years now. Three years now to put this program together. So the Emergency Preparedness and Response Committee for the trauma side of this.

And -- and you'll see you've got some things in front of you. We're going to be working on the trauma side. All right, not -- some of you coming from other areas like EMS and stuff, we're -- we're not working from the EMS side.

We're working with EMS, but we're not working from the EMS side of that. We're working on the trauma plan. We're trying to bring a cohesive group together. All right?

So we're not going to be approving any previous meeting minutes because really, this is our first true meeting. And our agenda you have in front of you.

Unless anybody has any heartburn, Kelly kind of already fixed the agenda. And our Chair report, we don't have a Chair report because this is really our

first meeting. So what we're going to do today, as you can see, we're going to go over -- we're going to have our coalition overview.

We're going to talk about our burn assets. We're going to talk about ASPER, which is near and dear to my heart. Thank God for ASPER. And we're going to talk about the selection of our crossovers.

One of the thing that we have to do is -- and two of our crossovers are here today. And I'll have them introduce themselves. But we have -- we actually have multiple other sub-committees.

Acute Care and -- and Post-Acute are here. There's Pre-Hospital Committee. And we have to cross over and sit on their committees as well.

And we are -- I'm going to not burden you with two of those. So I will cross over and sit with Acute Care and the Pre-Hospital. And then we will be asking or being told who will be sitting on the Post-Acute Care. So with no further ado, if you would like to --

MS. PARKER: Do you want to do introductions?

MR. DAY: Yes. I'd like to do introductions with everybody, so we can start with the end of the row. Yes, sir.

MR. GRAY: I'm Dan Gray. I'm the regional health care coordinator for the far southwest region.

MR. TRUOCCOLO: I'm Rob Truoccolo. I'm from UVa Health System emergency management.

MR. CLINEDINST: Ron Clinedist, northwest region, Health Care Coalition.

MS. NOWLIN: Erin Nowlin, Central Virginia Health Care Coalition, training and preparedness coordinator.

MR. HAWKINS: Robert Hawkins, Near Southwest Preparedness Alliance.

MR. DOWLER: Good morning. Keith Dowler, system director of emergency management for the Inova Health System, but representing the northern Virginia Hospital Alliance.

MR. ASHLEY: I'm Patrick Ashley. I'm the state hospital coordinator with the VDH office of Emergency Preparedness.

MS. PARKER: I'm Kelly Parker. I'm the director of emergency preparedness at Virginia Hospital and Health Care Association. It's a bit of a -- yes.

MS. STREET: Wanda Street, Office of EMS.

MS. COWLING: Good morning. Michelle Cowling. I'm the new -- new program manager, program coordinator for eastern Virginia Health Care Coalition. So I don't really quite know what my title is yet, obviously. Because I'm transitioning from the V -- MVP role.

MR. DAY: We'll change it on here.

MS. COWLING: I know. That's what -- that -- I've seen it written three different ways in the last week, truly.

MS. BROWN: I'm Kelly Brown. I'm the trauma program manager at Central Lynchburg General Hospital. And I am from the Acute Care Committee, representing them.

MR. GIEBFRIED: I'm a liaison member from the Post-Acute section. I work presently at Sentara Home Health Care. And also as requested by the State who applied for the position through our association, I'm a physical therapist.

And just a comment to you from our association. I asked is this something that's common throughout the United States. And as far as they knew, Virginia was the only in the trauma programs that she investigated to include the therapists. So our appreciation for listening to our voice. I'm here to learn as well as work.

MS. PARKER: In the back.

MR. DAY: You guys in the back.

MR. SZYMCYK: Richard Szymcyk. I'm with Life Care Medical Transports.

MR. SCHWALENBERG: Gordon Tom Schwalenberg with Tidewater EMS Council. I'm the chair for the Emergency Management Committee for the Governor's Advisory Board.

MR. LONG: I'm David Long with Tidewater EMS Council. I serve as the executive director there.

DR. BASIOUNY: Kal Basiouny, trauma medical director at Chippenham Hospital.

MS. CHALLIS: Kate Challis, trauma program manager at Johnston-Willis.

MS. TREVILIAN: Tanya Trevilian, pediatric trauma program manager at Carilion

Children's of Roanoke.

MS. RUMSEY: Kelley Rumsey, pediatric trauma program manager at Children's Hospital of Richmond, VCU.

MR. SOTO: And Walt Soto, peds manager at -- emergency management for Children's Hospital in Norfolk.

MR. DAY: Okay. Before we go over the coalition --

MS. STREET: We have [inaudible].

MR. DAY: Do you agree? Before we go over the coalition presentations, I want to take out this form that you guys all have in your sheets.

It's the Emergency Preparedness and Response Committee goals and objectives. Every committee meeting that we've been to, we're talking about just going over the goals. So those of you on the committee who do not have the -- the

whole plan, let me know and we'll give it to you. And that is what we'll be working off of -- but right, you don't have it. So we'll -- we'll get that to you.

So right now, I'm just going to go over the -- we're going just go over the goals and objectives. Goal one, make sure that the trauma system is engaged in the State disaster plan process.

Wow. Believe me, when we first started this, we were like, well, of course. And then we got into the, maybe not. So what we're looking at is -- what we -- we have been charged to -- these are our goals.

We have to -- we have to get to here. Creative words, is an existing -- awareness of existing coalition preparedness and response capabilities. What are talking about today?

We're going to listen to the coalitions. Ensure appropriate stakeholders within the coalition are adequately represented. And I think that southwest has been a key theme in the last two days.

Ensure comprehensive trauma system is inclusive in the State disaster preparedness and management plan. Again, remember we wanted to bring people together and work together.

Goal two is collaborative with the OEP, Office of Emergency Preparedness. And ensure that the provision of Disaster Preparedness education is -- to -- preparedness education to trauma centers, regional councils and local emergency medical service providers.

And I can speak to the Tidewater region. We're -- Tidewater region does a very good job. Tom, I think you can speak to that.

And -- and -- we can -- we do a lot down there. But I can't speak to any other region. So thus, the room that we have in here.

So we're going to contribute to the State Emergency Preparedness plan, collaborate with the OEP to evaluate and modify a disaster preparedness guide for EMS and trauma systems together, not silo'd.

And then goal three is collaborate with the OEP to assess and maximize the use of ASPR to insure -- to enhance the medical service capabilities of the State's trauma centers.

And I can tell you that what -- again, what we do, I can tell you. But I can't tell you what other people are doing. So contribute to the assessment of each region's annual via collaboration with VDH and VHHA.

So that's what we have been -- that's our goals. And then bringing you all together to help in that reaching of goals. We used the HRSA document to get -- to get through this.

And like I said, if anybody does not have the State plan, let me know. We'll get that to you so you can digest what the Emergency Preparedness -- oh, look -- document looks like.

And then go from there. Does anybody have any questions on this document? Wow, no questions.

MS. PARKER: No questions at all.

MR. DAY: No questions at all. I see my peds people over there, Dr. Bartle's not here. He has pediatric questions.

So that's one of the things that I know he wants to look at early on in the process is the pediatric -- and that's new to us in the Tidewater region because we just got a pediatric trauma center.

In the -- in the past, we've been working without that for years and years and years. And now we're -- we're now bringing this whole concept of a pediatric trauma center into our trauma care and disaster care.

So that's one of the things I know he wants to work with in this -- in this -- with this sub-committee. He did bring that up to me. So, no questions. Then I'll let you --

MS. PARKER: Awesome.

MR. DAY: -- take that, Kelly.

MS. PARKER: Good morning. So one

of the things you saw on the objectives is really getting the awareness of what our health care coalitions do around emergency preparedness across the Commonwealth.

We have six health care coalitions that cover the entire geographic landscape of the State. And what they really are -- are designed to do is kind of prepare and respond to disasters for the health care industry.

So you know, we're hoping that we can kind of better align the -- the trauma aspect of the trauma system with what our health care coalitions currently do. Good morning.

MS. STREET: Good morning.

MR. DAY: We were just using your name.

DR. BARTLE: In vain?

MR. DAY: No.

DR. BARTLE: Sorry I'm late.

MR. DAY: That's okay. Just here in time for the presentation.

DR. BARTLE: Great.

MS. PARKER: So the Virginia Health Care Emergency Management Program was started between a partnership -- so exists between a partnership with the Virginia Department of Health and the Virginia Hospital and Healthcare Association.

Started in 2002 as a way to, you know, bridge the gap between silo'd health care facilities, to be able to prepare and respond to disasters. So it started after 9/11.

ASPR, the Assistant Secretary for Preparedness and Response -- it was HRSA at the time -- created some federal funding to help fund this initiative. And we're still funded here 17-18 years later. This is a break up map of our regions. You can see we have six coalitions, which they are

all going to kind of give you an overview on their operations. I'm here in just a couple minutes. We really look at this as a partnership between all of our coalitions.

We primarily started working with hospitals. That was kind of the directive at the beginning of our -- our program.

And as we've coordinate and communicate with all of our hospitals now daily, regularly and have really good 100% participation, we expand into other health care entities.

So we've expanded to long term care, dialysis, specifically those type of facilities that could place a significant amount of surge on a hospital during any type of an event.

We've also expanded membership to include some of our local -- locality partners. So EMS, emergency management and public health as they -- they play a different but key roles depending on what the disaster is to their [unintelligible] level. So they said a health care coalition

is kind of the make up to bring everybody together in real time, to break down those silos, to break down corporate boundaries.

And to kind of be the non -- you know, the non-competing interest in each region. These are the typical make ups of the health care coalitions as I just stated.

And we have five of them that are prescribed and they have to be core members of each of our coalitions. And we require membership from long term care hospitals, EMS, public health and emergency management.

So what the folks in our coalitions will talk to you about today and what you'll hear from them is that they really work to identify those partners, to bring those partners together and understand how they can have a working relationship to respond to the health care system.

In addition to that, we work -- like I said -- with Dallas -- dialysis, not Dallas, Texas. We also have done some work with home health and hospice and some of the other entities that were affected by

the CMS emergency preparedness rule that went into effect a couple of years ago. So each of our health care coalitions is going to go -- go over an overview of kind of their operations.

We're really going to talk about their risk assessment planning and what the threats are in their geographic areas with their surge planning, it looks like in their region.

If they have their own surge plan that's with the hospitals. If they're included into the EMS Councils, MCI guides, etcetera.

They're going to talk about the RHCC, which is the Regional Health Care Coordination Center. That is -- each coalition has one.

It's a 24/7 activation hub that is activated for health care or any type of disaster to be able to coordinate and communicate during response. We also have a lot of stuff. So each of them are going to highlight what caches they have and resources they have available in their

region, what type of MOU's they have. And if the coalition support for any tele-medicine capabilities in their region.

And we're going to go in alphabetical order, so I will turn -- can you pass that down -- turn it over to Erin Nowlin.

MS. NOWLIN: I'm Erin with Central Virginia Health Care Coalition. I'll give you a brief overview of those mentionables for our region itself. Our HVA, our risk assessment is a modified Kaiser Permanente hazard vulnerability assessment.

And it's modified so that it doesn't just look at one facility, but really the region as a whole. These are our top five regional risks for this year.

And of course, they're reviewed annually and can be changed at any time based on new and emerging threats or events. So electrical failure, pretty prominent in our -- our region. Specifically, we had a bout of long term care facilities that were going through some

electrical failure issues. And we've worked to increase our cache of generators and quick connects to those facilities and our acute care hospitals so that we can help mitigate and then respond quickly to those needs.

Severe thunderstorms, MCI's, communication interruptions and then winter storms also hit pretty high on our risk assessment. Search planning and our response planning, we've been lucky over the last two years to really bolster this.

We had Russell Phillips Association come and do a full assessment of all of our long term care facilities in our coalition in 2017, identifying spaces that were available for search.

Transportation needs showed that facility to evacuate and items that were needed to harbor or bring in patients that were surging into facilities.

We conducted that across our acute care facilities in 2018. So all 17 -- 16 of our hospitals also had that done last year. So that allows us to have some

pre-planned space over awareness in our facilities and what our needs might be from transportation to equipment. Our RHCC is staffed 24/7.

We have a 1-800 activation number that is answered by 911 communications center and is then sent over to a duty officer who's on call 24/7. We rotate about six to seven staff members through that per month.

And at any time, we can virtually activate our RHCC or respond to our downtown physical asset of the RHCC, which is a large style command room with the technology and equipment so that we can coordinate and communicate with any of our facilities and members.

That does allow us to get coordination started with all of our facilities and a -- a nice situational awareness.

Our goal is always to conduct and be able to provide a common operating picture so that if an event is happening at one facility, another facility is able to

understand the -- the situation as it is and prepare for what any outcomes might be. We do also have a -- well, a[n] originally large supply of regional cache items. It may be a common theme you'll hear today.

But moving away from things that are expire-able to education and -- and long term plans, we do still have physical assets. And so, we had one stabilization and treatment in place system.

And for anyone who's not familiar with that, it's a military-type tent system that can be set up and conduct into a -- an emergency room, an operating room -- whatever the needs may be.

We have utilized that in the region several times for things like the vice-presidential debates that were held. And it's the deployed and set up annually.

We have three 600 kilowatt trailer-mounted generators, and the fuel to go along with those. And transportation MOU's should one of our facilities need it. Now if we're looking at a Level I trauma or a Level II trauma, most likely the 600

kilowatts are not going to power that whole hospital. But it, at least, gets some very critical areas opened up and -- and powered.

Adult and pediatric critical care ventilators, something we've added over the last year. We have 40 currently for deployed. That's 10 at four different hospitals in our region.

And those do come in handy during the Chippenham power outage when their ICU was affected. Search cots, so that we may have patients in cots in that stabilization and treatment place.

And additionally, deploy those to shelters or wherever they may be needed. Portable suction, large cache of PPE for chemical radiation and biological. We do have a unit called the MERC unit, the mobile morgue system.

And that can hold and refrigerate 28 deceased patients in there as well. We do have a large cache of box stands. And those came out of a need from long term care facilities who oftentimes lose either power or HVAC and require some

necessary air flow. Privacy screens and tap bells items identified that would be needed should be set up [unintelligible].

Here's a picture of some of those assets in the top left, that white tent that's the -- the SICPS tent going down the trailer that its housed in and can be deployed in.

And some pictures of the inside of that there. The MERC unit to your right and the screen's left is that DRASH tent at the top, that brown tent. It is also housed and transported in a trailer.

And then you see one of our staff members who is very much still alive. Just showing you how those -- how those [inaudible] goes.

We do have regional memorandums of understanding and this is an agreement that we started with our acute care facilities stating the relationship we would have with them, and really outlining what we are here to provide and what we expect from our members. We've extended that to our long term care facilities, our

dialysis members in the region. And those areas continue to grow. With the CMS guidelines that changed last year, we've had a huge increase in participation and have really grown those relationships through home health, hospice and dialysis.

Our tele-medicine capabilities currently are really facility and health system based. We don't house or fund any additional -- other then utilizing the VHASS platform for communications. That's not mine, so I don't want to go into it.

MS. PARKER: Okay. Oh, wait.

MS. NOWLIN: No, it's me.

MS. PARKER: Oh, okay. Now I can draw pictures, Robert.

MS. NOWLIN: I wouldn't be a meeting if we didn't have technology issues.

MS. PARKER: Thank you.

MS. COWLING: Again, I'm Michelle Cowling with the Eastern Virginia Health Care Coalition. The newbie, so hold your tomatoes to the end. And Kelly, please correct me if I'm incorrect, okay?

Just like Erin, we have very -- very much similar things. Obviously our HVA that is coordinated each year with our community-based partners, those core members and partners, come together.

That includes our hospitals all the way down. We've had home health at the table, hospice, certainly nursing facilities, our acute care facilities.

Really working together as a community to determine what our regional risks might be. Obviously, if I'm in eastern Virginia, hurricane and nor'easters are a number one.

We're very -- very low with sea level, and so we flood quite often. And then we have IT system outage, power outage, snow, blizzard and ice. And it -- I know it's amazing to see that in our top five, but as you all can imagine, we are in

southern Virginia. We don't have a lot of good drivers when there's snow and ice. And we --

MR. DAY: Cheers to that.

MS. COWLING: We have impacts, you know, with staffing trying to get in to work, which has made us really become more innovative and work with four-wheel dirt drive clubs and what not to assist our health care providers.

And then certainly mass-casualty incidents being the fifth, that's more on the hospital side because that -- they -- they really want to see that as the top five so that they can continue to exercise and have robust -- robust policy for that.

With regard to our surge plan, again, similar to that of central. But what we do have, even though we have our -- our surge plan as part of our regional health care coordination center guide, operational guide. We also have what's called the

pre-hospital Hampton Roads MCI response guide. And that was developed in partnership with Peninsula EMS and certainly Tidewater EMS as well as fire, us and EVHC and RHCC, air medical, hospital and our military community partners.

Again, as you can imagine sitting in Tidewater, we have a huge military population or presence. So we always try to have them at the table. And they continue to remain very active with us.

Then we have, with regard to our RHCC mobilization, a Tier I, II and III level activation. So obviously, Tier I is virtual and monitoring.

So really, we can monitor the Virginia Health Care alerting and status system from wherever we sit, whether it's on our phone or on our lap top surfaces, whatever device.

And then Tier II is where we are physically primary sitting in an RHCC, one of our two. And it is going to be staffed -- this is normally for a full regional event effecting multiple health

care facilities. So like with Hurricane Florence where we did have the mandatory evacuation of Zone A, certainly we were round the clock -- very, very active as you can -- can imagine in Tidewater.

And then certainly, Tier III, this is a regional event effecting multiple health care facilities where we would stand up for multiple days or even weeks.

Again, Hurricane Florence, another example where we weren't in there for just 24 hours. We literally were around the clock sitting in -- in the RHC -- RHCC.

But I would be remiss without saying this, is that again, this type of activation requires a lot of man-hours. And we are still a very small staff.

So I do -- I don't want to over-sell our capabilities, if you will, because we get very tired very quickly, especially through the -- the Hurricane Florence event. Regional cache of items, we certainly have -- obviously -- a huge cache. Again, I don't want you all to think that we have all this stuff stored in a warehouse by

any means. It is strategically placed throughout both central -- or south side in Tidewater. You know, we have bodies of water that divide us.

So we have the peninsula side and then we have the south side. So we want to make sure that we have similar or like items or things or assets placed on both sides of the river, in the case that are bridges or our tunnel systems are knocked out.

So I don't want to go over in detail because Erin's covered many of those things. But you can see where we have -- we have mobile regional health care coordination centers, as well.

We have a full comps trailer and then burn kits, peds kits, the ventilators as well. 48 portable heater/air conditioner units.

And I know I don't have fans up there, but much like what Erin was talking about. Those things -- the heaters, air conditioning units and fans are certainly bourne from a number of our, I'll

say new partners, long term care facilities having needs and wants. We've had several loss of heating and air conditioning systems, back-up generators going down.

Some patient movement, and then we've had a couple of fires where smoke has been in the building. And obviously, we love our firefighters.

But they can't just leave us all these fans to ventilate these facilities. So we need to quickly deploy. Portable patient D-CON systems at the 19 acute care facilities, those are certainly aging.

And we're looking at some alternatives now. Our -- our SICPS system, we -- just like Erin, we have one. It sits with Sentara Virginia Beach Hospital. That's been a recent acquisition, thank you, Central.

And we are making that most robust at this time with the last two purchases of hopefully ultrasound and an x-ray -- a portable x-ray machine. And then 11 -- we say 11 mass casualty incident

buses. Again, EVHC has two of those. The remaining of those are with our public safety folks.

So though we all play in the same sandbox, I just want to be clear, that -- that two of those we have based at two hospitals, our Riverside partner as well as our Sentara partner.

Again, on each side of the river. Surge tents, portable emergency lighting, medsleds are among some of those. But again, just reiterating that we do not have a warehouse.

Regional MOU's, we obviously take great pride in our partnership with many of our health care facilities. Those that have newly come on.

228 signed MOU's to date and that includes every one from our six -- 68 nursing homes, 19 hospitals, transitional care hospitals, intermediate care facilities, dialysis, home health, hospice -- I think I've said hospice. Sorry about that. And then, as you all well know, our health care partnerships continue to grow,

especially in the behavioral health area. As I was told just yesterday at our coalition meeting, we had several of our community service board partners there who really want to begin working very closely with us.

So tele-medicine capabilities, and Mark, you might even be able to expand on this. Sentara does utilize this for disasters. They have developed a trauma disaster triage plan.

They exercised that plan. Riverside Health Systems has some limited capability with regard to tele-medicine. So that's a stay tuned item for them. So I -- I do see that it's coming. Mark, did you have anything you wanted to add?

MR. DAY: We -- we just -- it's new. We're -- we're going to be testing that this spring in a few minutes. Stay tuned. That's -- I mean, there's no reason why we can't do it. We've been doing it in the military for years and years and years.

MS. COWLING: Okay.

MR. DAY: So there's no reason why we can't -- we can't be doing it. I mean, literally years we've been doing this in the military. So -- for long distances. So there's no reason why we can't do this.

MS. COWLING: Okay. And that's it for Eastern.

MS. PARKER: All right. Dan.

COMMITTEE MEMBER: Dan.

MR. GRAY: Yeah. And I'm Dan Gray, the regional health care coordinator for the Far Southwest. And Robert's in Southwest Virginia. We're even further west than that.

I go all the way to Tennessee and all the way to Kentucky and North Carolina. So my region's pretty unique with borders. So -- and again, you're going to hear a lot of the same stuff from my region,

as you will from all six of us. But we use the same HVA. And these are our top five. And in our region, weather is typically the big one.

And -- and the new one for us is kind of information systems failures at the hospitals. One of our -- one of our big health systems in that region covers a lot of our facilities in far southwest.

And it also covers northeast Tennessee, which we work really, really close with. We have to because all of the facilities in my region -- there are 12 -- they're very rural, very small facilities.

So they all get -- all of the trauma is transported over to Tennessee. So they have a big -- they've had some issues with their information systems failures. So how we attack our risk assessment, we -- we talk about it in our coalition meetings.

But we let the hospitals do their risk assessment. And then, they submit them to us at RHCC. Then we sit down as a staff, the entire HCC, and we analyze all their risks and look at them and see --

it's interesting to look at those over the years and how they'll fluctuate and how they'll change with what events is happening throughout the country.

It's very interesting to watch that. So we'll -- we'll look at all of those and then we'll -- we'll combine them. And then we make a regional HVA. And typically, it turns out that -- this is how ours come out on our regional one.

So you go down and you look into individual hospital ones, they're going to be pretty consistent, but they might be flip-flopped a little bit, you know.

Snowfall, for example -- you know, it's very mountainous down there. We -- we split our region into -- into two. This side of the mountain and this side of the mountain.

Over here, they get a lot of snow. So theirs is going to be pretty high. So that's how we kind of handle our HVA. We -- we just do the total assessment and then we do it at the RHCC. Surgeon response, I think Erin kind of hit the nail on the head

with that one pretty well. And again, I think we all do it about the same. We might use a little different terminology how we do that.

So I'm typically not a big fan of hearing things because in emergencies, disasters change so much. So when you check a box, soon as you did it, you got to uncheck it and go check a different box.

So -- but when it comes to surge, I like that approach because, you know, we have our set-up. Our Level I surge is just -- we went to get that activated in zero to four hours.

And that's -- just to try to get these hospitals to be able to provide rapid in -- inpatient intake. And you know, that could be just, you know, quick discharges.

You know, anybody who you can discharge pretty quick, get them out the door. Again, with the Level II surge, that's when things get start -- interesting. We want to try to be able to do that in a four to 24-hour. And then that's when we

start looking at different locations within the hospitals of where we can actually put people and what resources were needed.

I think Erin and my region's basically are the only two that's had -- with -- the entire state had the Russell Phillip assessment as she mentioned in long term care world.

Central and my region, I think, had been the only other two that we -- we took that out into the hospital world. So that was very, very interesting.

We've got this much information from that assessment, which we've got a lot of work to do on. We just completed that. It's not a year and a half ago.

So what they did, they went in to these -- all of our hospitals and looked at each room and they -- and seen where -- where we could surge. Where they could surge other rooms, how they could make those rooms from semi-private to private -- or -- or -- that was backwards, sorry. Private to semi-private. Other locations within the

hospital, where we could put people. So -- and again, what equipment, you know. And then the big thing with that is staff. You got to be able to maneuver staff around.

No matter what the resources and space you have, you got to have the staff to pull it off with. So -- and they addressed that as well. So that's kind of how we've done our surge plan.

Our RHCC mobilization, we actually -- we've had this for a while. But I don't have it up there -- no. I've got a pretty detailed -- kind of a 14-point checklist for the RHCC mobilization.

And we look at more of -- we look at the event, see what the event is telling us we need to do. But this sheet here is just a very quick guideline to make sure you're mobilizing everything you need.

Tell me who this, virtually -- like Michelle talked about and -- and Erin talked about. We can do a lot of this from mobile. And then, do we need to come in, what resources do we need when we have the folks in. So this is just a check box,

because you go through this real quickly. And if it's an event, or even when we do an exercise, you get kind of heightened when you do an exercise.

So this sheet is designed, you -- you get the thing rolling and you come back and you go, okay. And we actually have yes or no, did I complete that task. So we check that box.

And this really stemmed from -- because Michelle hit the nail on the head when we're talking about RHCC mobilization. I can only imagine how tired you guys got during Florence.

Because we're over on the other end of the state. Just having to watch what she's doing and be in support if we needed to be -- support for her -- it was exhausting on our end.

So I come up with this concept years ago. And it's starting to come into play now. We realize, you know, this event goes 48 hours, three days, four days, five days. There's just no way -- I mean, how many people you have on staff?

MS. PARKER: I have three.

COMMITTEE MEMBER: [unintelligible].

MS. PARKER: I have three staff currently. But then I have two heart team folks. But I only have two and a half staff qualified to manage the RHCC. So I manage the nursing home piece, so --

MR. GRAY: Well Michelle, maybe you can -- the staff the people you can pick from time to time. So you have an event for 48 hours. You can't do that. So we've hacked into our medical reserve corps folks.

And we strategically hand picked some of those folks and we call them our RHCC strike team. So we can send this form to them at home and alert them through our system.

And they can fill this out and let us know. Hey, I can come into the office or I can't. I can stay at home. I can monitor things. And then also, this is

why we really come up with this sheet because those volunteers need as much help along the way, you know, along with us.

COMMITTEE MEMBER: I worked that.

MR. GRAY: So I'm real proud of how this element has taken off. Those -- those medical reserve corps folks have been excellent.

And -- excuse me -- we've been having a quarterly meeting with them probably over the past year and a half, getting them trained to be able to come in and help us at the RHCC.

Regional cache items, again, it's just ditto to everybody else pretty much. We have a mobile morgue unit as well. It's located at one of our hospitals.

And it's also in a trailer, so I mean, we can hook to it and take off, you know, with whoever requests or needs it. We have four disaster trailers. They have minimum supplies -- same day supplies, per se. But that's to help us if we have to

implement some of the surge and move out into shelters and so forth. That's kind of what the disaster trailers are really meant for is to help supplement those folks at shelter locations or alternate care sites so they're not flooding the hospitals.

Our infectious disease isolations stretchers, we've gotten those with the Ebola funds. And we have a MOU with one of our big hospital -- hospital -- EMS providers in the region.

They have stations kind of throughout southwest Virginia, so they are keeping -- we've got two of them. One on one side of the valley and then one on the other.

And they -- they house those for us. And we have an MOU with them there that we have to pull them out and if we need to do a transport or whatever.

Those are our go-to guys. They manage that for us. Our burn kit supplies, we just did that, upgraded last year with our ASPR funds. We've got like a big portable tote of burn supplies. And one

of the interesting things, I think, we did with our kits is -- I mean, we're real proud of, we get the least amount of money out of all of these regions, just because we're a small region.

We don't have a lot of ED visits, so we've got to really pay attention to what we're spending. So I noticed on these burn kits, they were outrageous.

And the reason was for the burn creams that they supplied with them. So how we kind of mitigated that was we bought the kits without the burn cream.

But we made the hospitals responsible for the par level on the burn cream. And so we got way more bang for our buck on supplies.

COMMITTEE MEMBER: Smart idea.

COMMITTEE MEMBER: Very smart.

MR. GRAY: I mean, they want an outrageous amount of money for -- when you buy those kits for that Silvadene cream.

And we're just like -- and then it expires.

COMMITTEE MEMBER: Mm-hmm.

MR. GRAY: So then are people going to do? A lot of people throw the whole tote out. And --

(Several committee members began speaking at once.)

MR. GRAY: Yeah. And some facilities don't even use that. They use different cream. So that's one of the things -- and we have a -- a pharmacy work group and -- and a[n] ED work group from each facility.

So those were the driving committees in helping us make that decision. So I -- I like what we did with the burn kit.

Evacuation chairs and medsleds, we've had them. We just did kind of an upgrade and made sure we had it more. And that's one of the things that came from

the Russell -- their assessment. They come in and they counted what you have. How many medsleds you need and how many evacuation chairs you need to be -- to have a reasonable evacuation plan for that facility.

So we took that information and that -- made that one of our regional projects. We want to buy -- make sure that each facility had those amount of evacuation supplies.

Hand radios, I think that's just pretty common. Everybody's got radios for communication. Regional MOU's, you know, we have them all with our hospitals. We have strategic MOU's.

Like I said, with -- with the ambulance service for our isolation stretchers. And the only other MOU's that we have with other facilities -- like dialysis, long term care -- is if they happen to have any supplies. If we have supplies for them, then we have an MOU with them. Because we have [inaudible] with the long term care folks, some medsleds as well.

Especially the ones that are just two floors. The single floors, we've given them one or two. But the other ones, they have multiple -- multiple bed sleds.

So we've got MOU's for the beds. Tele-medicine capabilities, we -- we kind of surveyed them in the past and that stayed consistent after Kelly sent this out to us and wanted to know if we're using tele-medicine.

And the most we use tele-medicine for in our region, every hospital does. But for the most part, it's for pediatrics. And I saw David sneak in a little earlier.

David and I worked together on a pediatric project in my region. And then he's kind of calling it a pilot project. We have kind of set up an inventory of all our pediatric supplies and we've done just -- just awareness is really what is.

We make sure that all the ED's go through and make sure their inventory is correct. Make sure everybody's kind of got the same thing across the board. We look at

education and training opportunities. One of the little things we did was badge attachments. I think those are Browselow. We made those badge attachments.

So all the staff members can look real quickly and see what type and percent of medicines they need to give them and kilograms and compared to the pounds and so forth.

So just little things like that that we're doing in the pediatric world has really made our pediatric perform and awareness a lot better.

We're going to kind of steer off -- still in pediatrics, but we're going to kind of look into the autism part of it, get the list part moving.

Because we want to -- we want to do something every year with that pediatric project. So the autism folks is kind of where we're going now.

And that's just not only autism children, I mean, it's any special needs. But that's a big one in emergency preparedness today, special needs. So we're

trying to hope that we can kill a bunch of birds with one stone, do the children and then also move that over into the adult plane as well. Okay.

MR. DAY: [unintelligible] just now picked that up.

COMMITTEE MEMBER: Yeah.

MS. PARKER: If you have anything different, let's finish --

MR. HAWKINS: We'll talk about a few. So one of the conversations on the HVA is we -- we look at it as a conversation. So we attend the HVA's of our partners. We give a regional perspective so they may use that input, specifically for the clinical staff who aren't always emergency management. We've been using several for this fiscal year. This is -- for 2018, for our region, we are going to conduct our regional one in two weeks at our coalition meeting. Cyber attack, that's

also going to be synonymous with information systems technology loss for any -- any means. Infection disease operate, hacked computer, work place violence.

There's been a conversation there about even evolving that term to a hostile event. So it's going to be lumped in with a couple other things.

Blizzard, severe weather, tornado severe weather -- great summer to everyone else. And we see those as being the most feared issues. Our surge plan, it's essentially the same thing.

It's -- we're -- we're co-housed with our EMS Council and we work closely with the other EMS Councils in our areas. So their regional MCI plan, we're very much a part of that process.

We expound on it. I'm not going to go through that process. Our mobilization for RHCC is based on where we receive an activation through our call center most often. And this can be from any partner, not just health care. We receive quite a few from Emergency Management. We

hear of situations with them in their jurisdictions. We -- our most frequently is infrastructure concerns, how we get them for surge or potential evacuations.

We have on-call part time staff who answer 24/7 thanks to a partnership with Carilion. And then we all have active duty officers who are going to answer those calls and get information, provide information or give some guidance and coordinate the pieces.

Cache items, very similar to everyone else. The one thing that's not listed here that I do want to talk about that's fairly different.

And maybe it's going to be synonymous with everyone else is our communication redundancy. We have a very interesting geographical split.

We have some rural, we have some metropolitan areas. Our communication assets include satellite phones, wi-fi packs that we provide knowing that the loss of information particularly for our integration into VHASS and getting situation reports is

a big key. So we allow our partners to have wi-fi hot spots so they can still communicate with us through those means. We obviously have the RIOS radio system.

And we have an upcoming regional dedicated radio system that we're looking to pursue this year, which would have a dedicated radio net for RHCC activities with our partner hospitals so that it -- and -- and the key to this is it's actually completely outside of any internet infrastructure.

Knowing that's a distinct vulnerability between operating systems and platforms that things change. If you have just one conflict with the software bundle, you lose a system.

We're trying to go old school. And I know that Dan said that it's pretty anonymous -- you know, pretty synonymous with everybody else. But not everybody has that same capability. So it's something we're pursuing this year. MOU's, 15 of our 16 hospitals. We're still waiting for the Salem VA. We also have two free-standing

ED's we have MOU's with as well. 88 with -- within the long term care, dialysis, behavioral health, home -- home health -- home care hospice.

And we also have MOU's with our local emergency management. 21 of the 23 jurisdictions represented in our region have MOU's with them as well.

As for our tele-medicine capability, there's nothing intrinsic to our regional capabilities alone and would be within -- within our partners.

MR. DOWLER: Again, Keith Dowler for Northern Virginia Hospital Alliance. I think the hazard vulnerability analysis is an interesting thing that we need to think more about while -- it sounds like we have really robust ideas across the coalitions.

I would argue that there are probably a way we can standardize that approach, use a little more science, a little bit more procedure. And maybe come up with something that's, you know, something we can all come together with.

Now granted, this is what ours looks like. Keep in mind that one, two, three, four, five -- there's a combination of hospitals and the non-hospital community.

However, the hospitals all face the -- about the five same things. So patient surge, major network outage, utilities, active violence and emerging disease.

We have thrown in everybody outside the hospital environment, and this is -- this is what we look like as a huge picture. Like I said, I think I am certainly interesting in better data collection there.

So our surge and response plan across our 17 hospitals, skilled nursing facilities, etcetera, is the goal of 20% immediate bed availability.

That's been the -- the going one-liner from ASPR and HPP for a long time, and that still remains our target goal. And now we're including skilled nursing facilities. And they're really stepping up to be a part of our surge plan, and with --

want to make space in their facilities including the home health folks. And so, being a part of the hospital -- and now -- and now that we're all required to be in community exercises is forcing everybody to really take a critical look and that's great.

Our RHCC is much like everyone else's. I would say the one major difference is all of our hospitals and partners have RHCC radios, we call it, the medcom channel.

It's a 800 megahertz repeated system throughout Northern Virginia. And I think all of our long term -- our skilled nursing facilities now have them as well. Of course, we use VHASS and we have trained staff.

The regional cache items are all pretty much the same. I will point out that because we have Dulles, we are -- many of our hospitals are in a rotation to receive emerging disease patients and patients with potentially highly infectious diseases. So we have these cool Bioquell

units which are hydrogen peroxide units. You just put -- you seal it up -- seal the room up, put it in the room and it just -- it -- it kills everything the log seven.

That's what the scientist tells me anyway. And we have some other neat things, too, but not radically different.

As far as MOU's, all of our hospitals, our -- our partners, all of our long term care groups are a part of a mutual aid compact to help each other. That is in no small part to a young lady by the name of Mary Laurel Hayborn [sp].

She's been an incredible resource for us at Northern Virginia EMS -- or excuse me, Northern Virginia Emergency Response System and now Northern Virginia Hospital Alliance.

We do have MOU's in place with pharmaceutical distributors and we employ a part time pharmaceutical tech to rotate out a stockpile of drugs that is essentially just an addition to the par levels at each of the hospitals. And she has privileges to

go in to each of the facilities and rotate those stocks out. And we have -- we get a monthly report that she sends which is just brilliant of everything that we have in that stock.

And that really is -- when we start look -- talking about stuff that -- expire-ables, that's our approach. And our direction moving forward is less stuff in warehouses.

Let's just add to the par level of the facilities with that initial bolus of funding. You keep it up. That adds to our capability -- our capacity just to where we go.

Tele-med capabilities, I am incredibly fortunate to have my office in the Inova EICU, which is the hub of our tele -- our regional tele-med capabilities.

All member hospitals have at least one -- I think most have two, I could be wrong -- two-way video, audio, wireless carts that they can with the push of a button reach our EICU center. And we can activate a physician we call the regional

triage officer. Which is a medical doctor who is typically an emergency medicine doc that we can stand up, either at her residence or she can come in.

Or -- when I say she, that's the primary one we have. And they rotate that role out. I do think we have some opportunity there to roll that out, formalize that as a process, and really exercise it.

And if you've heard me talk before, I think -- it's our opinion to fully measure and I want to measure it. And so we do exercise it and it's used during all of our regional drills to connect not only to the EICU center, but also to connect hospital to hospital.

So I want to -- I need a peds specialist because we're not a peds ED. We don't treat those kind of patients traditionally.

So we can just -- that hospital will hit the button, they'll get connected to the EICU. And the EICU can transfer them to somebody that is a peds

specialist. And that goes for not just peds, but any specialty we need.

MR. CLINEDINST: Ron Clinedinst. I'm going to make this fairly brief. The reason being, you've heard a lot of this from the same thing from everyone.

The regional risk assessments, although you've heard everyone talking about Kaiser Permanente, that's the same one we currently use.

However, we are going to transition to the new redesigned Kaiser Permanente. The reason why I highlight that, not only does it indicate what your vulnerabilities are, it also indicates how many activations you've had -- both at the hospital level and the regional level.

Excuse me. Our surge plans, you see on the screen it talks about within 30 minutes if we have an MCI, mass casualty incident. We've actually tested that, actually have done it with a bus crash. Where we were able to get the bed numbers to the local responding agencies, less than 30

minutes for that response. That is one of our highlights that we'd like to point out. Additionally, for next year for our surge -- excuse me -- next funding year, we're going to look at a surge assessment.

Same thing that you heard Dan talking about. Additionally, we're going to look at transportation plan. Excuse me. One of the things that we've noted is transportation assets.

They are not available. Anybody that has seen emergency management develop over the many, many years, transportation are our weakness. We've got to figure out how to get to that trauma.

No question, that is a weakness that we have. Along with that is pediatrics. We do have one of our staff members that is actually on a national emergency management pediatric membership, if you will, that they're looking at how, nationwide, how we can look at pediatrics in disasters, especially with trauma. That is a huge, huge gap. Mobilization, you've heard everyone talk about that 24/7, the 800

toll free number. We have a rotating staff that man that each month. Everybody's on call. All over, we're training.

Additionally, we're looking at the same thing Dan talked about where we have the medical reserve corps that are going to help supplement us. Regional cache items, same thing that you see on the screen.

A lot of the same stuff that you saw from others. However, what I do want to highlight or review, that are stabilization treatment in place.

If those that are unfamiliar what that is, I'll go through it real, real briefly. Stabilization treatment in place, think of your ED suffers a catastrophic disaster. You're no longer able to use it.

This is what a STIP will do. The problem being, it's not staffed. It's equipment, no staff. Mobile morgue, I think we're one of the largest within the State. We actually have three mobile morgues. People were holding 84 bodies. Hook it up to a trailer, it's self-contained. Move it

wherever you got to take it. They are strategically placed throughout our region. We have three of those.

Surgical masks, gowns, other PPE that you see on there, what I want to do is highlight the -- the ViroGuard 2's. Think about a highly, highly infectious disease.

Just because highly infectious disease hit you place -- meaning your hospital, long term care, whatever it may be -- trauma still occurs.

If you have a highly infectious disease patient comes in that has suffered trauma, you need to be properly protected. We purchased the ViroGuard 2 -- ViroGuard 2's to do that.

They actually cede CDC's requirements for PPE level. The medsleds, you've heard a lot of people talk about that. The adult, pediatric and bariatric.

We also have infant capability. We are nursing -- take down six infants at one time down a stairwell. I think we're probably the ones that actually

have that. That is a huge, huge benefit, especially 40, which sitting my -- my right -- my colleague here, Robert from UVa. Our trauma one and our trauma Level II both have those.

Decontamination showers, obviously if there's a trauma -- just to give an example. We've had a couple different plane crashes recently. If you're familiar with jet fuel, it's a very hazardous condition.

We've had trauma associated with that. So obviously, they got to be decontaminated before they enter the hospital. Look at the very bottom, talking about Base-X tent, generators, heating/cooling system.

Base-X tent, you saw a picture of earlier when Erin -- the very first presentation -- had the Base-X tent. It was the yellow one. That's what that's for.

Every hospital in our region has that capability. It's just an extension, if you will, of an emergency room. Regional MOU's, you've heard the same

thing talked about from everyone else. All of our hospitals have the MOU's that are signed. We recently acquired a 14th hospital, and they have actually signed one with us as well.

You'll notice the number of long term cares is 29. We actually have 42 long term care facilities that are separated. What we're working through is the legality issues that come up.

We have signing of MOU's, if you're familiar with how lawyers work, it's not a fast process. But we are confident we'll be able to get all of those signed.

Tele-medicine capabilities, you notice again, 13 of the 14 hospitals. Reason being that is that 14th hospital that we recently acquired.

That is a -- and actually the only children's -- it's called Children -- Commonwealth Center for Children and Adolescents. CCCA is what we call it, real short. Trying to spit that all out at one time. They are the only children's behavioral unit in the State of Virginia,

which is pretty big for our region. We have taken them on. They've always been a big partner with us with their behavioral health, right across the street which is Western State.

However, they're getting heavily involved now. They understand the need for HRSA management.

MS. PARKER: So you know, death by PowerPoint, but -- you know, part of this -- our first objective here is to really get familiar with what the health care coalitions are.

As you can see, I mean, we have a lot of assets. We do have a lot of partnerships. We plan a lot. And that goes beyond just trauma. As we stated, we do a lot of work with our long term care folks.

I think that came out of 2012 when we found out long term care's plans for evacuation were to go to hospitals. And we said, that's probably not the best place to go. So that's where some of our work started with all of our non-acute care

partners. So you know, that was a kind of down and dirty quick overview of all of our six health care coalitions.

So specifically for the folks on -- on the committee and our burn and trauma -- burn and heat folks. If you guys have any questions or anybody in the back has any questions for coalitions, we'd be happy to entertain.

MR. GIEBFRIED: I had a question. Again, I'm new so I have some questions. Moving of some of the equipment. In the military, we would use a -- almost like a trailer complex, simply have a cargo trailer.

And you could take it by helicopter and move it and drop it into an area where you needed that material quickly. I -- many disasters, we can't get in.

People are isolated. And being in the medical reserve corps they've always told us, you have to be able to take care of yourself for 72 hours. And I'm just wondering if, one, moving that equipment and

then, two, when I was listening to the tele-medicine kind of concept, I was thinking of the police mobile unit -- command unit, some of the State mobile units, of whether or not we have brokered with them an understanding.

And if they got into the area or were able to get into the area and help us with the shelters or the triage capabilities, or responding to some of the quick medical needs.

Do we have that capability to use that medicine with it, or other disciplines that are out in the field.

MR. CLINEDINST: Okay. I'll go ahead and take that. Yes, tele-medicine actually is currently used daily. I'll give you an example. Again, my colleague here to my right. UVa does consults constantly.

The tele-medicine capability, again, provides -- and I'll even take it one step further in a minute. But the tele-medicine capability -- let's take it for trauma. If there's something on the scene that -- or at a facility -- that someone

needs to talk about. Do we need to transfer on base -- on the scenario you just gave? They will consult with a trauma with a trauma doc.

They say, okay, is it a viable option? The other thing about tele-medicine, what it does for highly infectious disease, for example, where UVa's actually tested it multiple times.

They actually have a team -- a[n] EMS unit as well where they're enroute, they can actually talk with -- to the trauma doc or the doc on call about what the scenario is, what's going on.

What's the best course of action. So that capability is there. It's all over the internet. That would be the gap, that it's internet-based.

So if you have a major earthquake -- and I'll take what happened in Mineral, for example. The internet crashed. That's where you gap is. But as far as the capability of tele-medicine, if you've got a two-way communication device that has a camera on it, you can connect in.

MR. GIEBFRIED: I noticed that some of you talked about partnerships with some of the distributors of pharmaceuticals. And also looking at the storage of what we have. So I'm a damn Yankee, I came from Boston down.

And there's a couple of scenarios we could talk about, but we had it in our understanding that Boston -- if it was isolated -- and couldn't get any -- any services for whatever reason, had three -- three days of really fuel, food and medication needs.

So the -- the medical [unintelligible] again, they say 72 hours, okay. So how have we, if it lasts longer, planned for dealing with food needs? We've talked about medicine. I didn't hear anything about food.

COMMITTEE MEMBER: Yeah.

MR. GIEBFRIED: Fuel needs, didn't hear that.

COMMITTEE MEMBER: Right.

MR. GIEBFRIED: So I was just wondering how we were doing with our memorandums of understandings for all the businesses that we're going to need. Whether or not it's Home Depot, because we need batteries. Or fuel, whatever.

COMMITTEE MEMBER: So to answer -- to answer that question, you're going down -- just for your awareness. All hospitals have to meet a 96-hour requirement.

So we have to have whatever it takes in place to be able to continuously operate and provide the essential functions and services we do for 96 hours.

After that, then yes, we started to look at extended contracts and we look at our -- personally I like MOU's. They're cool, but contracts are better --

COMMITTEE MEMBER: Mm-hmm, that's right.

COMMITTEE MEMBER: -- because they have to take the --

COMMITTEE MEMBER: That's right.

COMMITTEE MEMBER: And on -- for events where we have a head's up, which is most of the time for the long events, we'll front -- I don't think there's any hospital in the Commonwealth that won't front load supplies, food, enough pharmaceuticals.

And now, I'll say that since we've been probably all adding business continuity to our repertoire, we are enforcing and contracting that they have to -- that they're -- that all of our vendors have to, not only provide us with their business continuity plans to be an eligible vendor of our facilities.

But also, explain to us very clearly how they plan on providing services even when the roads don't work, supply chain's broken, etcetera. There's still opportunity there, don't get me wrong. But I think we've made pretty good steps. I

defer to my colleagues for --

MR. ASHLEY: I think bringing -- bringing this back up through the trauma net system so we don't stray too far away from that. But the -- the real purpose of coalitions is about sharing.

And I don't just -- we should be sort of sharing information. But it's really helping to understand what the situation is and helping partners who share amongst themselves.

And so, some of the partners might have more supplies that they could contribute. Whether that's, you know, nurses, staff, food, whatever the -- the necessity is.

That's really what the coalitions are there for is to help share those assets and resources and information. Whether it's trauma-related or weather-related or -- or what have you.

MS. PARKER: And even --

MR. GRAY: And I just want to add --

MS. PARKER: Oh, I was just going to say --

MR. GRAY: Well, I think I'll add to what Patrick said is like, when we do exercises, our hospital will lean on those other hospitals --

MS. PARKER: Right.

MR. GRAY: -- that you -- when we have to do an evacuation tool. And it's a table top exercise. So the -- the ones that are receiving are like, yeah, I can take them.

But I need your supplies and your staff to go along with them. So that's the piece that goes with it. And then, if the emergency is just not contained to our southwest region and if those resources start to get exhausted, then I'm going to reach out to Robert which is near me. And

then I also have relationships with West Virginia Coalition, northeast Tennessee Coalition. So it's just not kind of a boundary thing.

And that kind of, I think, it added on to what Patrick said there. So we -- we've got a lot of avenues to reach out. And I think, you know, if I run out of resources, Robert will be able be able to help me.

MS. COWLING: And I also want to take that from the hospital scenario to also our long term care facilities as well.

MR. GRAY: Right.

MS. COWLING: Because in Tidewater, again, they -- their 96 hours out as well and very prepared in trying to order -- if it's a known event, trying to order things ahead of time. And -- and we certainly have shared a number of sheets and linen and things in the last few incidents we've had because generators have failed and they

couldn't keep up with the demand.

COMMITTEE MEMBER: The coalition also serves to bridge the gap between a local need and State resources if it's available at that time.

So leveraging those relationships and being able to connect with proper needs should we have to escalate it I think is a -- is a main key thing that helps our -- our facilities as well.

MR. GIEBFRIED: I was -- one further on that. You sort of mentioned about transportation also. People using some of the buses, whether it's school buses or whether it's city buses or whatever.

I would -- thought back on something Homeland Security was teaching us. And they were talking about situation in Moscow and a computer, where the Russian troops put in gas and knocked everybody out. And they didn't bring in ambulances because they didn't want to alert what was going to happen. And they instead had buses. And

they then quickly ferried people out into the buses. But there was no one supervising the people on the buses.

And the nerve gases -- many of the people died because they closed off their airway. And they lessened that capability on the buses.

So I -- I wasn't sure what when you were talking about transportation and the other people were talking about having staffing enough to do it, or medical reserve corps being brought in.

Were there any consideration was in regards how are you going to manage those people that you're moving in either military trucks or in -- in bus situations if you have them available to assure that they're not dying in route.

COMMITTEE MEMBER: So --

MR. GIEBFRIED: I think that's part of that trauma.

MS. PARKER: It is absolutely.

That is a bit out of the purview of what our health care coalitions do. We can help find the assets and provide a contact for -- to the facility that's affected and say, this person has some ambulances.

You need to contact them. But we do not direct patient distribution. We -- we don't kind of step into that -- that realm.

So we can help find the assets, we can help coordinate the assets, get your assets there. But it is still the -- the facilities' responsibility.

COMMITTEE MEMBER: Can I ask a question real quick because we have everyone here. When I was involved in this a few years ago, we were really trying to work on being able to support different regions.

So if something happens in the Tidewater region, Northern Virginia can step in and provide the support. One of the problems that we ran into were the legalities. So for example, we talk a lot about tele-medicine. But the problem is, is

there a very distinct legality issues with me, as a physician, sitting in a hospital giving orders about a patient in a different health care system.

And those were issues that really had to be addressed because it's late in a disaster event when we kind of talk about suspension of care. But a lot of these things actually come up in a little bit more robust discussions outside of those kind of events.

So have we -- are there systems in place right now outside of within your coalition, or even within your coalition, that will allow something like a regional triage officer to reach out to the Tidewater region that may be overwhelmed and provide burn support, or provide critical care support and things like that.

COMMITTEE MEMBER: So I'll take that. I think the answer is yes and no, as it always is. We -- we work very hard on trying to streamline some of the administrative processes. Some of that

comes down to policies and procedures at the system level. Some of that comes down to whether or not it's declared or just a[n] undeclared emergency.

And so I don't have a -- a good answer for you, except for that I think -- within your specific case that sort of consultation with another physician who would have those privileges.

And really they're just taking your advice. And you're not actually giving the order is the work-around there that we've seen work before.

It's more of that -- that sort of professional conversation. And then that other physician is giving the order. But I don't have a good answer for you on that.

MS. COWLING: But I think, you know, maybe part of that is Hurricane Florence, for instance, where in Tidewater we received so many patients and nursing home residents from North Carolina. You know, this may be getting off a little bit. But again, with regard to credentialing, we

certainly had a process in place that was affected very quickly so that when those patients were transferred or those residents were transferred, they could quickly be triaged and treated in those receiving facilities, whether they were nursing homes or hospitals.

I'm not going to say the receivers didn't balk a little bit at the credentialing documents that had to be filled out and -- and verifications taking place.

But I can assure you of the almost 500 residents and patients that we assisted with the transfer of, we had no negative impacts.

Certainly, we had a number of gaps identified and a robust after-action. But I think it was very well handled, in my opinion, certainly.

COMMITTEE MEMBER: And you make a good point. From the crossing of state lines credentialing, we've done a lot to streamline that. There's -- there's some

barriers that are just always going to exist. And largely what we see within a state is -- is not so much the legal barriers more than it is the policies and procedures within the system.

MS. COWLING: Mm-hmm, exactly.

COMMITTEE MEMBER: But we were able to mitigate that in a -- in a recent revision, at least within a health system by -- and I know you're talking outside a health system -- by -- by revising medical staff bylaws and presenting the traditional policies to allow for emergency credentialing that didn't require verification.

It was, do you have an ID? Do you have someone that can vouch for you, and that -- that truly is the -- the bar we have to meet and can -- we come as a standard, at least. And say, okay, Virginia, the State's not going to be able to help us here. And there's no offense. What can we -- what language can we all agree to in our -- in

our own internal policies. And I know that's not a solution.

COMMITTEE MEMBER: And we -- we sort of even, for example, recently with our old disaster with the power going out. We were able to put nurses on buses and get them places and things like that.

My bigger concern is, for example, what happened with Michael is actually one of my hospitals. So when Michael couldn't come on [unintelligible] it actually wiped out the two major facilities there.

Completed decimated them. They lost all surgical and trauma capabilities. And they literally -- you got to count on your finger, you were getting a helicopter ride.

This was the problem that you were running into. And so, we were crossing state lines. There were really limited abilities to provide care, so there was some tele-medicine involved in this. But it -- it really became kind of very sticky legal

ground once you started getting into the power restore. We can now get communication, but now we're a week out or two weeks out or things like that.

And this went on -- I mean, there's still upgrading their capabilities. So just -- these are conversations that the alliances are actually fantastic for dealing with.

Because it's not just saying I can get equipment and supplies, but if I need to reach out to VCU when I'm in, you know, the Tidewater region because we're so overwhelmed, how do we do that? How do we get those conversations going? So -- or pediatric support.

COMMITTEE MEMBER: The -- I have some questions, basically fundamental, some background. What are -- the MOU's, you know, they throw specific -- and you can get cover over in general.

COMMITTEE MEMBER: It -- it depends on -- on which one. So our hospital ones

are -- are standard. And it's pretty much, you're going to report your statuses, you're going to share stuff -- space.

I mean, that one is actually -- it's -- it's prescribed, but not really. It kind of is open for some flexibility. Our long term care MOU is -- is very prescribed.

But that one is a little bit different in the sense that the long term care MOU is an MOU for a long term care facility to a long term care facility.

So it is an agreement between the long term care facilities to be able to transfer payments, staff, stuff and all of that.

So that one was at -- was a large statewide project that is -- is a little bit different than how our hospital one is structured.

And then some of the other MOU's that we have with all of our other health care partners are -- are essentially sharing their information. You would agree to provide support and provide stuff and

staff and space if you can. And stay in constant communication with your regional and local partners.

COMMITTEE MEMBER: That comes with the next question. How is this triggered? I mean, who -- you have days where you're busy.

COMMITTEE MEMBER: Mm-hmm.

COMMITTEE MEMBER: And we can't get the hospital person on the phone.

COMMITTEE MEMBER: Yes.

COMMITTEE MEMBER: Mm-hmm.

MS. NOWLIN: So I can help with that. They've asked specifically. A hospital emergency manager contacted the RHCC, activated the phone -- the hotline. I was the duty officer on. Took the call. He said, hey, we have our command center up. We're trying to figure out where we're going

to put patients. We don't want to go on diversion, but we probably should be. But there's some administrative issues right now with pulling that trigger.

And that's not where the RHCC comes in to aid. That -- the ability of the RHCC and the coalition was to say, okay, well what would help you during this time?

What would help your administration make that decision. And he said, if you could activate a roll call and see what other hospitals are dealing with, specifically in the metro region right now.

So we did a roll call and found out we were pretty saturated everywhere. We tied neatly with ODEMSA's, MCI and diversion plans for central region.

And so, had that hospital gone on diversion, it would've been our -- our fifth in the region and put us into a code red, which would've made all patient transportation go through the communications room at VCU for all EMS. Unfortunately, a lot of these patients were self-admitting, so it wouldn't have even assisted in the

situation we were incurring. But the knowledge that each hospital was suffering from the same kind of surge at the same time from an unknown, no one incident cause allowed -- from what I saw -- administration at each of those facilities -- St. Mary's, St. Francis, Henrico Doctors', Chippenham-Johnston-Willis and VCU -- all sit in their own areas and say, we had to -- we had to push discharges, we need to open up rooms.

And so while one facility was doing that, activating the RHCC, allowed us to share that, hey, I know you're diversion, diversion, diversion. You're -- you're doing what you need to do.

But these other hospitals, they're going to start getting overwhelmed because you're on diversion. And now, we're going to get to a city situation.

So I think it was really offering the common operating picture that we're all heading into this situation together. What can you guys do individually to help out?

COMMITTEE MEMBER: And -- and just to give you an example of how that worked in real life, when 9/11 hit, two major facilities -- Inova Fairfax and Hospital Center -- were both able to with just a handful of hours get rid of about 300 plus inpatients at each facility.

And they had -- at Inova where -- we had 19 teams on standby. So by just getting communications to the RHCC, that can be disseminated and the individual systems will trigger that response when they know it's a true mass casualty event of some type.

So the -- the flexibility of this, the surge capacity of that is really enormous. But it's really about communications.

So yes, every health care system in the trauma world, every time any hospital goes on diversion -- no matter what it is -- it's very clearly scrutinized. And it doesn't matter what system you are, there's always a work-around of how we can make sure we're meeting the needs. But the

reality is in events like this, it doesn't really matter at that point. Because now we're instituting a system-wide recourse.

COMMITTEE MEMBER: What about in areas where the, you know, special populations -- pediatrics, burns, geriatrics -- something that not all facilities can take care of. So --

MS. NOWLIN: In Central, we've worked over the last year to come together with a list of pediatric-specific beds available in the State. So outside of just our region.

And the coalition worked to provide those and kind of liaison, provide the contact number for your call center to your call center.

And that there's common verbiage between the two so that, you know, if you're a hospital and you call another hospital, sometimes they're not willing to give up information --

COMMITTEE MEMBER: Right.

MS. NOWLIN: -- because it's -- it's competitive. If you're a coalition, you're saying, hey, I would -- you know, this hospital's asking to contact you and discuss this.

Can we work out a way where nobody's compromising their -- their business values. But we're serving the patients, which is what we're all here to do.

And I think we come with that unbiased ability to link people together. So we have done that in the pediatric world. I know we've done a roll call several times throughout the State, even once for pediatric beds specifically.

And now, there's a process in place that it doesn't have to be so high alert alarm those 'P' bed needs. But it's a core group of people that can function to contact each other.

MS. COWLING: And I'd like to add

to that, too, Erin. In Eastern, we're in the early stages of looking at that as well. And as a result of Hurricane Florence, what we found is we had an escalated number of bariatric residents or patients that needed to be placed as well as secure memory care.

We simply found out we don't have a lot of available memory -- secure memory care beds available. So now we're trying to identify where those resources simply would be.

And in fact, I don't know if David Long or Tom Schwalenberg could talk to even the bariatric trailer asset we've now built and -- you know, so that we can insure that the bariatric population is also tended to. David, did you want to add anything to that aspect?

MR. LONG: I'll just say briefly, it was one of those things when Tom and I spoke on the phone and experience, we recognized that the bariatric population is growing. And the -- the primary challenge is always the resources to manage the

bariatric patient. So we were fortunate to leverage a couple different grant programs and be able to put two bariatric trailers together.

It's not a -- it's not a resource that was designed to essentially pre-stage equipment. It was a resource that was designed to -- when you have an identified need -- say you had somebody checking in or you've identified somebody that's going to be moving to a shelter that does meet the bariatric guidelines, then we can deliver the assets and resources.

So it's a 1000-pound rated bariatric bed. Whirlpool, [unintelligible] shower chairs. All the -- all the tools that you'd need to effectively manage and protect both patient and the staff members from -- from moving and injury.

MS. PARKER: So in the interest of time, I was going to see, Dr. Feldman, if you had any questions or Dr. Bartle, Khali, anything else?

DR. FELDMAN: It's -- it's not really questions but, speaking to our burn capabilities --

COMMITTEE MEMBER: Mm-hmm.

DR. FELDMAN: -- there -- there are local, regional and state plans that have been discussed. Right now, the -- the local plan centers around communication between Jay Collins, myself, Jeff Young where we would coordinate burn care in the Commonwealth.

We are part of the Southern Region Burn System, so there's a number that we can call and activate additional burn resources if needed. And -- and then we do rely on the burn cache that -- that is distributed throughout the Commonwealth.

So if we -- if we are going to have a large scale burn incident, you would need access to that medication because a [unintelligible] those dressings are only going to get you so far and then you have to start worrying about infections. So even

though they expire and they have an expense, they're going to be necessary if you have that situation arise. So that's something we'll have to talk about.

We have transfer agreements that are set up between hospitals that are all capable of -- of dealing with burn patients. So if anyone is interested in updating transfer agreements, I think -- I think now is the time.

And we should establish those relationships because right now I know that VCU has reached out to UVa and EBMS. And I think we -- we have all the local hospitals as well.

And then some of our colleagues up north and south of us. But we should have a list of everybody and what agreements we have in place.

MR. GRAY: How often is that list updated for your burn centers? Is that annually or --

DR. FELDMAN: Probably every three

years or so.

MR. GRAY: I want to make a recommendation that it's a little sooner than three. I don't -- I mean, the reason I say that because we did an exercise at one of my facilities.

And we -- we tested the burn supply kit that we had purchased that was part of our exercise. One of our hospitals -- I can't remember what -- I think it was Buchanon County that they actually had transferred over to Highpole [phonetic] or Lexington.

And during that exercise, they learned that there -- that hospital no longer took burn patients. And we learned that during an exercise. And that's -- well, that's a good time to learn it, but you don't want learn it during an event.

COMMITTEE MEMBER: When you have to practice for it, yes.

MR. GRAY: I mean -- do you get my

point?

DR. FELDMAN: So -- so there aren't that many places that are verified or certified or designated to take care of burns.

It doesn't mean that -- that in a -- in a -- in a time where our resources are stretched thin that people can't take care of burns.

It's more -- if you're looking for where those resources are, they are kept up to date on the American Burn Association web site. And -- and that's fine. We can chat more about all that stuff.

But the -- these transfer agreements, there's a lot of legal issues involved with that. So to -- to get all of that yearly would require a lot of attorney involvement. Anyway --

COMMITTEE MEMBER: Can I ask you a question? How is the connection -- or is there a connection with the National Guard?

COMMITTEE MEMBER: That's a good question, yeah.

DR. FELDMAN: What -- can you clarify what you mean by that?

COMMITTEE MEMBER: You always hear the National Guard's held out in an emergency.

DR. FELDMAN: Yeah. So --

COMMITTEE MEMBER: How do y'all work together? Do y'all work together or is it they come in, they can all go home?

COMMITTEE MEMBER: Yes, I can -- I can cover that a little bit, I guess. And so the programs really, you know, comes through VDH.

And -- and with VDH being the lead, I think we said at -- at the emergency operations center next door to the National Guard, a few -- few bays down. And so, we advocate on behalf of our coalitions to get

any type of resources that they need. That relationship also exists at the local emergency management agencies. So every jurisdiction, by the Code of Virginia, has a local emergency management agency.

And they have the power to also request resources. And so many times what we see is if there's a request for National Guard, that it'll go both through the local EOC and then also up to the -- through the state level.

And they sort of meet at the middle. Most times, what we also find out by commentary on this is that the resources can be met by things other than the National Guard. The National Guard is very slow and very expensive.

COMMITTEE MEMBER: Very slow.

COMMITTEE MEMBER: And so lots of times what we end up doing is triaging and saying -- reaching out through all of our other partners to say, here's the capability that we need. And then what -- how else can

we need this. And sometimes, the only capability is the National Guard helicopters or a big one that National Guard plays a role in. High water vehicles as well.

And so we do have that, but there's -- there's not that many National Guard resources that just come pouring out of the barracks during an emergency, either.

COMMITTEE MEMBER: 10-second funny anecdote. I have to -- physicians ended -- when I was working at Inova Fairfax before I transferred to the system office. Physicians were calling 911 asking for National Guard transport to work during Blizzard Jonas.

And I talked to the PSAP over at the 911 center. And I said, any future one you call -- you forward the call to me. And they started doing that and -- because that's insane.

MS. PARKER: So on the topic of pediatrics and burns and kind of the direction that our health care coalitions

are going and the direction that ASPR, you're going to see as kind of going to -- kind of push us.

I think this might give us the ability to kind of open the discussion, especially on those -- those kind of specialty surge events that we definitely need to plan more about. So I'll turn it over to Patrick if that's cool. And he can go over --

MR. ASHLEY: Sure. Yes, I'm going to -- like Kelly said, I'm going to talk about sort of the hospital preparing for and sort of where we see it going where -- whereas the Assistant Secretary Preparedness and Response, with both the agency and a person sees it going.

But I think I can sum up my eight slides. And what's on the right is that partnerships are key. And that's really -- regardless of whether we're talking about health care preparedness or health care in general, or emergency management. It's all about the

partnerships. And -- and that's really the direction where we're going is that everybody's better integrating with each other. So just a couple points of -- sort of items of interest here and some commentary on them.

We believe that some of the topics du jour are going to be complex -- coordinated attacks, terrorism, active shooter -- whatever you want to call it. We believe that that's going to be a challenge as we move forward.

The coordination of health care during these events is very difficult. We saw during things like Las Vegas where we have spent a lot of time working on ambulance diversion policies and ambulances, where they do during trauma events.

But we see that lots of times patients self-present. And -- and so how do we get a hold of making sure that patients don't overwhelm a hospital and create a second disaster. On that topic as well as what role does first responders have to play at the front door of an emergency room to

help control that disaster before it moves inside your emergency room. So that's a -- that's a big topic of conversation as we move forward.

This goes without saying, cyber security is -- is massive. And many of our health care systems -- all of our health care systems are so dependent on technology.

We're also dependent on technology, whether this is a planned or unplanned outage. This is huge. This will cripple our entire systems.

And if it's -- it's some type of regional disruption where we're looking at some of our backbone providers for IT infrastructure, some of our fiber providers, some of our core telecom providers.

That just makes that problem so much worse if it's not just an isolated health care system or even an isolated hospital. Highly infectious disease, we saw during Ebola, going back about five years ago, that this is a major topic of interest that is also not going away. As -- as

you've seen before, diseases can jump the continents very easily. And so we -- we're constantly worried about just preparation awareness and -- and how we respond to that is a big topic that we believe is going to be important moving forward.

Increased systemization of health care, this is -- this presents a set of opportunities and challenges in the fact that it makes the health care systems have a lot of resources.

But it also introduces some artificial silos as well within that. It -- it really is just something to really watch for and how we develop partnerships and making sure that partnerships aren't just within systems, but are also with next door neighbors.

And so sometimes we'll see systems have facilities that are very far apart. And that's really their -- their redundancies. But there's also the need to have partnerships with the hospital next door or the long term care facility next door. Other items of interest here as we

move forward is really home based care. You guys are all aware of this, it's where we start seeing patients that are discharged out of a hospital earlier, moving to long term care facilities sooner.

And -- and that presents a set of vulnerable patients and vulnerable populations in the community that we have to think of that during an emergency whether they're evacuated or they're having some type of other issue.

Whether it's that highly infectious disease we're talking about, a pandemic that's going to cause continual challenges as they re-present back to the health care systems, or moved to another area.

Tele-medicine is just a -- an item of interest here that we believe is -- has a big role in all of this. And again, that technology is a huge -- it presents an opportunity, but it also presents the challenges that we've talked about before. And then finally, technology dependency is -- is really one of the things to watch is

that our -- as -- as citizens, we're so dependent on technology to decide what hospitals we're going at, where the closest hospital is. How to make appointments with our doctors, and so that presents both an opportunity and challenges.

And one of the commentaries here is about Las Vegas again, where dependent on whether you used Google maps or Apple maps on your phone about which hospital in Las Vegas that you presented to.

One of them you went to a trauma center, one of them you didn't go to a trauma center. The -- the map applications, how we leverage those in terms of providing care, I think that's a huge potential.

And it's just conversations that we have to have with those technology providers about how do we get folks to the most appropriate level of care during emergencies. So one of our focuses, moving forward -- this has been our focus for a while -- is increasing our engagement. Whoops, I am clicking on my computer and I'm

not there for things. In that basically, 93% of all the trauma hospitals in the US or the TCA members belong to a health care coalition. This is nationwide, this is not just Virginia data. You want to click again for me --

COMMITTEE MEMBER: Mm-hmm.

MR. ASHLEY: -- because I'll forget. But the problem is, is that when we look at that, 72% of the respondents of that survey didn't know -- did not know that they were in a health care coalition.

So if you can click one more time, Gilly. So what we see lots of times is that health care coalitions are great. We have a lot of engagement with a number of facilities.

But many times, that engagement doesn't go very deep within the facility because everybody has their own competing priorities. And so one of the areas of engagement that we really need to work on is engaging those folks other than

the emergency managers, other than the emergency rooms. Our trauma programs obviously here, our clinicians, our executives, our administrators.

Our pharmacy and our infection prevention is. And really, just increasing the bench that understands that there are resources and relationships out in the community that they can leverage during disasters.

And so, that goes on to sort of increase our membership as another priority. We'll -- you put --

COMMITTEE MEMBER: No?

MR. ASHLEY: Too fast. Is really increasing our membership, and that's really moving away from -- you've seen the move of the hospital preparedness program, which used to be just hospitals to now it includes the long term care facilities, our other health care providers to really looking at the full spectrum of health care. And understanding that a hospital can't operate

without their supply chain. Understanding a hospital and health care facilities can't operate without their pharmacies and laboratories.

Many of these services are outsourced these days. And so we also see with supply chain just how quickly that can be disrupted with, say, a simple warehouse fire, icy roads that prevent transportation into the region.

And so that's -- that's the big picture of how do we leverage these relationships. Some of these relationships are best leveraged locally and some of these are regionally, some of these are state level.

And some of these are bigger, you know, engaging things on sort of US region level. And so how we engage those relationships is so important.

Finally, specialty care centers, burns and peds, that huge understanding. Not every region's going to have these specialty assets. And so understanding how you access those during an

emergency and what your stop-gap provisions are. I like this. And so some of the things that -- that the ASPR is concerned about and we've added some as well, so you'll see the ones in stars up there is the ASPR's concerns.

But we're very concerned about the high consequence of beds and the specialty care that comes along with that. And so we're very concerned with trauma. We think that we have a pretty good system, but there's always room for improvement.

Pediatrics is huge. And -- and there's not a lot of capacity there. Burns, also, as well. Just an anecdote, I saw -- has anybody seen the boiled water challenge where you throw the water up in the air --

COMMITTEE MEMBER: Yeah.

MR. ASHLEY: -- because it's been freezing cold. So eight people went to the University of Chicago Burn Center because of that. And so it's not just all about the --

the explosion that's going to cause these types of surges. It's going to be people doing stupid things as well.

Infectious diseases, how we take care of those folks that, you know, have some type of very highly infectious disease, and also the folks that don't have something that's quite as severe but just as infectious, say, measles for example, and how we take care of those in the surges.

COMMITTEE MEMBER: Yeah.

MR. ASHLEY: Radiation and chemicals are two of the things that people don't like to talk about a whole lot because that's very hard, very specialized. And so that's another thing that we want to look forward as how we deal with that.

And that may not be dealing with it in Virginia, that may be dealing with it in Virginia. But having that access to care and that subject matter expertise when the -- the event happens. And then finally, as you all know, mental health is a

huge issue. The number of beds for mental health in the health care system in general is very fractured. And so that presents its own challenges during these high consequence events and on a day to day basis.

And so that's something that we're hoping to get more engaged with. So we think that each region of the Commonwealth has a pretty good established trauma plan, and that's really the baseline.

And the reason I have this slide here is about -- you know, again, that's for of very initial response. And where we move forward to, Kelly, is how we move and build that capacity as we look forward from the initial event response and building out and saying, all right, we've taken care of the immediate.

We stopped the bleed. Where do we go from this? So this is one of the ASPR slides and one of his priorities is that at a regional and coalition level, we have very established, defined trauma systems in most regions that can take care of things. And as we start to look at

specialty care, how we build these networks within our health care systems is so very important. And understanding how we access the care is so very important as well.

To your point earlier about legal implications and how do we cross state lines is very important as well. And so, that's the understanding because I know that I might have specialty capabilities in North Carolina, Washington, DC, Maryland, whatever.

But can I legally transport that patient there and what do I need to do in terms of insurance and all of the other moving parts there. So this is really just a notional map.

None of these locations on the map actually exist. They don't exist and the stars don't mean anything. And this is really the ASPR's vision of what a regional disaster health response network looks like.

And this is what we're really looking to sort of build our system around. Notionally in that, there will be specialty sort of centers of excellence that take care

of some of this very high consequence, very threat-specific events. So for example, you see like Nebraska has the highly infectious disease as part of their NETEC program out there.

And so really understanding how we fit in and how we transfer care amongst these systems is so important for us. So they -- they started two pilot projects here.

They did aware two $3M grants to Massachusetts and Nebraska to really study about how this looks like. And what does it look like when we start looking at things on not just a regional level or a state level, but really looking at US regions for that specialty level of care.

Building a good foundational base amongst our health care communities to deal with the day to day issues, our small MCI's, our traumas.

And then moving up to where we have specialty care at the state level that's coordinated amongst all those specialty care providers. And then moving

up to those sort of ultra-specialized care levels for things like Ebola, our burn centers and -- and those types of assets.

So that's really -- the -- the ASPR vision is really about bringing all of these assets, resources and relationships together in a partnership.

And understanding one of the things we often say in our program is that, you know, we're competitors on a day to day basis, but during emergencies we're colleagues.

And so that's what's so very important to us is about how do we fit in together. And how do we institutionalize and systemize those relationships so it's not dependent on Keith and I having a relationship and understanding that, you know, it's institution to institution relationship.

And those -- when Keith quit or I quit, that those relationships stay -- stick around. So that's really the vision. I'm happy to take any questions.

COMMITTEE MEMBER: Call it cooperatition [sp].

MR. ASHLEY: Cooperatition?

MR. GIEBFRIED: Just comments. There are some contacts, regional contacts for licenses. And there are some that are moving forward and -- and Virginia's, we're coming up for vote on that.

But the other one, I had -- had a question about was the criminals, the individuals who are in jails or in prisons.

MR. ASHLEY: Sure.

MR. GIEBFRIED: In responsing -- responding to those from other facilities have handed special facilities that have locked wards.

They could manage some of these. But in a large event, I'm just wondering -- I haven't heard anybody talk about how that population will be managed.

MR. ASHLEY: That's -- that's a really good question that I don't have an answer for with regards to the general prison population.

That's -- that's historically been a challenge of how do you deal with a mass evacuation of a number of locked individuals.

With regards to our health care systems that have some of those locked, those are a little easier because there are so few patients within our health care system.

But we see some of the same challenges within our long term care facilities with their dementia units. And some of our psychiatric units within our hospitals, they need that same sort of level of supervision, albeit not quite the same. But that is a challenge that I'll -- I'll recognize but don't have an answer for.

COMMITTEE MEMBER: I -- I actually could take a small snippet at that --

MR. GIEBFRIED: Sure.

COMMITTEE MEMBER: -- because in my previous life, I did manage juvenile detention populations for many, many years. And we had a very robust plan in place, especially in southeastern Virginia.

But as part of the requirement under the Department of Juvenile Justice -- and we regularly practiced full scale evacuations of the detention center to an alternate location site, undisclosed, of course, as you can imagine.

But we not only had one, but also a secondary. So again, that was not the adult population that I managed, it was certainly the juvenile.

And very similar to schools, as well, that continued to be -- well, as active shooters became more popular and things like that, we simply had to continually practice. Especially with the transition or turnover of staff in -- in a detention or prison setting, the turnover of staff is alarming. And it is constant

retraining, if you will, and in-service. So I hope that helps a little bit.

MR. GIEBFRIED: I had one further question from working in the medical observatory, setting up shelters. The Red Cross, initially, wouldn't allow service to animals or pets to be in shelters and that changed after Katrina.

What happens as we're in a shelter situation, these people come in with their affected animals, bringing them in when they're transported into the hospital.

How do you manage that population of these both pets and sheltered animals, and assist animals?

COMMITTEE MEMBER: Sure. You know, I think that's on a case by case basis. Many times, just from my own experience, the local animal control take -- takes a role in that coordination. They aren't seizing the animal or anything like that, but they'll take custody of the animal in the shelter situation where -- and we're not talking

service animals, if they have an animal within a shelter. And then ultimately, that's a conversation with the hospitals.

And I'm not very well read on that, but I would look to other people in their room of how you would deal with a service animal that presents at your hospital. But I'm not that familiar --

COMMITTEE MEMBER: Yeah. That's -- that's --

COMMITTEE MEMBER: It's not trauma-related and it's -- it's hospital-related. So each individual hospital deals with that.

MR. GRAY: The only thing I can add to that, I can't remember the actual name of the group. But it's a statewide group and it's a national group.

But we've engaged -- they have one regionally as well. So we've engaged them and talked to them about during a disaster, they'll actually bring trailers and so forth.

COMMITTEE MEMBER: Yeah.

MR. GRAY: And they can help with pets.

COMMITTEE MEMBER: And that's in every jurisdiction. I mean, again, it's jurisdictional based.

MR. DAY: All right. So let's finish this up. It's almost 10:00 o'clock. So we -- we've gone over the coalition overviews. We've talked about burns. We've talked about -- a little bit about pediatrics.

And what I do want to tell you I want to do is we want to offer up for everybody to think about, we need one more crossover to sit on the Post-Acute Care Committee. So does anybody have a burning wish to sit on that from our group?

MS. NOWLIN: I don't mind and I'm local, so...

MR. DAY: All right, Erin.

MS. NOWLIN: I think you win.

MR. DAY: Thank you.

COMMITTEE MEMBER: Erin's going to be key, and nobody else on here.

(At this time, several committee members began speaking all at once.)

MR. DAY: So we have a lot of information today. And what we -- the other thing we found out over the course of the last two days is that a lot of this work is going to be hard to get done in -- every three months.

So we -- in a couple of the other meetings, we've talked about getting together every six weeks. Is that something that people think that they can -- because we can't do this work outside of -- you know, we can't talk to each other because of State rules. We can't get all -- get

together on a flat screen TV and work. So we're kind of constrained by that. So is everybody think they can -- they can get together two ways.

All as a whole every six weeks. Or we can break some of this up into smaller sub-groups that can meet differently. I'll take ideas.

COMMITTEE MEMBER: I think it needs to be a bigger group until you can divide them up.

MR. DAY: Yes.

COMMITTEE MEMBER: You have to know what to divide up with.

COMMITTEE MEMBER: Do you rotate a -- the location can be in -- in a coalition's post meetings or does it have to be --

MS. PARKER: Fortunately, because it's an Office of EMS-run meeting, it's

wherever they decide the meetings are going to be. I think they're all going to be based --

MR. DAY: Pretty much based in the Richmond area.

MS. PARKER: -- in Richmond. If we do decide to meet outside of this meeting -- the already established ones -- I mean, we could potentially look at other locations. But that would have to be run through OEMS and it has to be publicly announced. And then you have to open up to the public wherever that location is. And so --

DR. ABOUTANOS: And then you have to make --

MR. DAY: Yes, sir.

MS. PARKER: Yeah.

DR. ABOUTANOS: So we can work

without EMS and meet in different place. It does not have to be where the Office of EMS is. We did that throughout the trauma system. It's a -- they prefer to all meet in, you know, and they just say in the Office a lot.

It's cheaper than that's going to be like in this location. But you could host and in this way, you would be kind of there where you want to meet.

But what's happening in every committee now is that every committee's coming to recognition that three months is not adequate. And there's no way we could move forward.

Even the trauma system plan took us two and a half years to put together because of these -- these restrictions. And so most committees, I think almost every committee now, wants to meet at six -- the six-week interval.

So what that does is that it creates -- if that happen, the Office of EMS can have this event come -- like today, central location, everybody else meet. So

the crossovers can also meet in the other -- with the other committees who are also decided to meet half way. Because this is one of the biggest aspect of -- of this committee is decide the phenomenal work has happened today, is to look at the trauma perspective.

Trauma system plan, look at the pre-injury part. What are we doing with that from disaster aspect. When the, you know, Pre-Hospital, Hospital and the Post-Acute, we make sure every one of those are covered.

But also be the liaison for those various committees and make sure that they're -- you know, they're covered. You know, so for example, like even in the Post-Acute Committee when I was there, they were discussing a lot -- you know, how can the post-acute help in emergency preparedness.

But there's an additional part of recovery, how long does it take. So there is -- I think having integration and being able to be in a place where the other committees are there, it would serve the

function of -- of the plan.

MR. DAY: Okay.

COMMITTEE MEMBER: Do we have to have our meeting every six weeks or does it make sense to?

COMMITTEE MEMBER: Mm-hmm.

MS. PARKER: Yeah, we just tag onto that, if everybody's in agreement to meet.

MR. GRAY: To tie it down, you know, another meeting that we have works usually prompt --

COMMITTEE MEMBER: Yeah.

MS. PARKER: Yeah.

MR. GRAY: -- between six hours.

MS. PARKER: That's what we tried to do.

MR. DAY: And that post -- Post-Acute Care, I mean, that's -- we talked a lot about the long term care facilities and all that.

So that would -- that -- you would bring a lot to that. All right. So we bring that back to -- we're meeting later, so we'll bring --

DR. ABOUTANOS: Yeah, you bring it back to the TAG Committee. Say this is request of this committee, we need to meet more often.

MR. DAY: So both of you, I have tele-medicine questions for. But I'm going to keep to each individual stuff --

COMMITTEE MEMBER: Sure.

MR. DAY: -- for future -- to bring back. Dr. Aboutanos, do you have -- I know you came in kind of late. I'm going to have this presentation sent to you personally so you have all of that. Can you -- can you

send that, please, Kelly? Do you have any questions or any comments to the group?

DR. ABOUTANOS: No. That was kind of just my -- my comment of -- of what I just mentioned earlier that the function of extra -- of this committee can not -- remember, this committee is made for the trauma system plan.

MR. DAY: Right, right. We kind of -- we steer that. But --

DR. ABOUTANOS: Yeah, because it's very easy. And then if you go -- if any of you are involved with -- in a hospital disaster plans, you could see how a lot of the trauma part is something you have to fight toward, fight the -- the infectious disease, working to -- set up the -- have something the most common -- there's a lot of presumption that -- that this is known. So as we develop -- when we develop a strategy not initially of all the committees, disaster was kind of -- was an

add-on. And it just shows you how bad that -- that one is. It's sort of like being a function integral for the use existing trauma system advanced -- you know, I think the best example Katrina, etcetera.

But the -- the big aspect, I would just say from this committee is how to truly make the units that are not part of the system be part of the trauma system, you know.

And -- you know, what is trauma? How does trauma effected in disaster planning? And is that being addressed adequately in trauma system plan, you know. And so this is -- so you're going to get into doing a lot of us are already doing.

COMMITTEE MEMBER: What?

DR. ABOUTANOS: Which is the coalitions together talking about overall preparedness. And so we have -- we have to be very cognizant of this fact. And there are some big things like burn. That does

belong naturally in the -- in the -- doing trauma system plan. That's the easy task. And you know and -- but that -- that part becomes very important. So addressing with the [unintelligible] part, the adequate hospital preparedness part.

One day we also find out, you know, I mean, you can comment. A lot of people in the hospital committees, the disaster preparedness in their own hospital are not aware of the -- that the system.

So the question, for example, that Sam was asking, those are basic questions that everybody asks. And just tell you the -- a lot of us who deal with disaster know these things.

But that the ones who are responding, especially within the hospitals, they have a different knowledge of it than the Pre-Hospital person.

So understanding the gap of what this committee -- so there's a lot of work for this committee. That's why I'm very happy that the -- you're thinking of me more often. This being an initial

presentation of what -- what exists. And it shouldn't just be sent to me. See, that's the whole point. It should be sent kind of literally -- I would send it --

MR. DAY: I'm going to send it to all the -- all the heads.

DR. ABOUTANOS: Yeah, all the chairs do not have that.

MR. DAY: But I -- want you to have it, too. Because you -- you didn't --

DR. ABOUTANOS: Send it to all the chairs. And let them send to the -- communicate with their committees and ask the question, is this -- does this -- how does this work from your committee, from your aspect, you know. And so...

MR. DAY: Absolutely.

MR. SOTO: Doctor, Walt Soto from Children's Hospital. As a planner, I spent

quite a bit of time in discussion with our trauma doctors. And I think it's valuable for us to know what's important for you to know. Because there's a lot of information that we can -- that we can communicate.

But -- I mean, it's -- is -- is valuable. And we don't want to overload our -- our trauma caretakers with too much information.

So it's what are the essentials that you need to know about this larger plan, as opposed to, you know, the PowerPoint.

You know, death by PowerPoint and too much information that isn't really relevant, you know, to your scope of specialty.

DR. ABOUTANOS: I mean, this -- this is a great question. And I would just bring it back to this committee and ask it -- ask it that way. What is the community's knowledge of what -- our trauma responders. And I won't limit it to the physician. You know, does the physician -- but the

providers and nurses, etcetera. And maybe create -- this committee comes out with a certain understanding what the hospital need.

What you ask is -- if I answer you, I'm going to give you one person's opinion. We do it from a -- from a committee aspect.

MR. SOTO: And see, that has value to it.

DR. ABOUTANOS: We have -- I mean, I tell you very quickly what we have found out that most disaster committees and hospitals are logistics.

COMMITTEE MEMBER: Mm-hmm.

DR. ABOUTANOS: And most providers in hospitals are very much disconnected because they -- and the whole point is that can you bring the content of -- of medical management to the -- and -- and expertise development to the content of logistics.

Can you learn from other aspect -- and don't -- I mean, they go together, you know. So -- and make quick example. We take the, for example, the burn patient. We know the burn patient can travel within 24 hours.

But after that, huge amount of resources comes in to burn patient. A lot -- a mob comes in with explosions and most of -- of -- orthopedic injury, for example.

Huge, huge cost to the hospitals. And they stay significantly for more than two -- two months sometimes. And so this is different extreme.

That this -- these kind of details comes to trauma and not very well known to combine logistics with trauma. But I think what you have said is very important.

We must take that, let's ask the various hospitals who's involved in your committee? Where are you at, and so this thing can function in this -- in this manner. But today is just a -- this is inaugural day. You know, preliminary --

getting to know the -- the lay of the land, what already exists. Don't reinvent something already there.

But the only thing I'm asking is we -- is we start getting more focused on what the function of this committee within the trauma system plan.

COMMITTEE MEMBER: Okay.

MR. DAY: Okay. So we'll get -- we'll send out regarding the next meeting for sure, whether it be the next EMSC meeting. But I'm -- we're going to look at the next six-week. So do we have any questions? We'll adjourn. Thank you.

(The Emergency Preparedness and Response Committee meeting concluded.)

CERTIFICATE OF THE COURT REPORTER

I, Debroah Carter, do hereby certify that I transcribed the foregoing EMERGENCY PREPAREDNESS AND RESPONSE COMMITTEE MEETING heard on February 8, 2019, from digital media, and that the foregoing is a full and complete transcript of the said committee meeting to the best of my ability.

Given under my hand this 6th day of April, 2019.

Debroah Carter, CMRS, CCR
Virginia Certified
Court Reporter

My certification expires June 30, 2019.

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