# Building Collaborative Disaster Planning Processes Between Hospitals and Emergency Management

## Northern New England Webinar Transcript

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Subject Matter Experts: Jeremy Damren, Curtis Metzger, Deborah Yeager, Robert Gougelet, Dan Manz, Kathy Knight

Moderator: Dustin Benac

Dustin Benac: Well good morning and welcome to the Northern New England webinar for the Building Collaborative Disaster Planning Processes between Hospitals and Emergency Management. This is actually a regional webinar featuring participants and subject matter experts from Vermont, New Hampshire, and Maine and we will be discussing regional collaboration notably not collaboration between hospitals and emergency management, so thank you for joining us today. It really is a privilege to have everybody on the line. I know both the participants and the subject matter experts are all very busy so we really do appreciate you taking time to join us today. So I did want to, just thank everybody once again, and thank the subject matter experts, and along those lines, we do have a number of subject matter experts on the line with us today, and I did want to take a few moments to introduce those individuals and their respective positions and agencies. They are Jeremy Damren from the Maine Emergency Management Agency where he is the State Exercise Coordinator. Curtis Metzger from the Department of Health and Human Services and Emergency Services where he is the Hospital Preparedness ESAR-VHP, MRC Coordinator, excuse me, we got a little head of ourselves. We also have Deborah Yeager from the New Hampshire Hospital Association where she is the Director of Emergency Preparedness and Dr. Robert Gougelet from Dartmouth Medical School where he is an Assistant Professor of Medicine, specifically, Emergency Medicine, the Director of Northern New England MMRS, and the Acting Team Coordinator of NH-1 DMAT. Additionally, we also have on the line with us, Dan Manz from the Vermont Department of Health where he's the Director of Office of EMS and Injury Prevention and then finally, we have Kathy Knight on the line with us today, and I'm actually going to post her information in a different manner. One moment, excellent, there's Kathy's information and as it indicates, Kathy is the Director of the EMHS Center for Emergency Preparedness for the northeastern Maine Regional Resource Center. So thank you to all the subject matter experts for joining us today. It truly is an honor and a privilege to have you on the line. Well, as I mentioned, this is a webinar to discuss regional collaboration throughout Northern New England and I would like to begin reviewing some basic material, which I will use to stimulate conversation. This material is derived from ACEP's Building Collaborative Disaster Planning Processes between Hospitals and Emergency Management, and I will, and this material will be applied specifically to regional collaboration. Notably not just collaboration between hospitals and emergency management, and I'm also doing this as I believe some of you may have completed this course a significant time ago while others may have just registered to participate in this webinar, either way, I will briefly review this material. And then I will invite SMEs to respond, if at any point in time you

do have questions, I would ask you to submit those through the Question Dialog Box at the bottom of your screen, as we will have a conversation, a Q&A session following the discussion by SMEs, so to the modules. Module 1 discussed mitigation and noted that mitigation occurs by jointly exploring a community's vulnerabilities and existing response plans, in doing so it emphasized that collaboration, collaborative planning is critical to mitigating a community's risks and encouraged the development of a community plan by conducting a Hazard Vulnerability Analysis, and updating the Emergency Operations Plan. Module 2 discussed preparedness by noting the importance of formulating agreements between response partners before a disaster occurs, it is imperative that these agreements one, delineate resource sharing. Two determine how to manage information flow, and three, plan ahead for response needs. Module 3 of four discussed response emphasizing that one's reaction to unknown risks and circumstances is just as important as one's actions in response to known risks. This response includes actions taken in anticipation of an event, as well as during an event, this module also noted the importance of effective communication with the public both before and during an incident and knowing how to request resources and track patients. Finally, it was noted that during incidents HIPAA and EMTALA regulations are sometimes relaxed. Finally, we discussed recovery, and provided some suggestions for improving one's community for the next disaster. These suggestions included model documentation as it helps with tracking and transfer of resources, personnel, and patients, protocols for credentialing and fatality management, which should be developed prior to an event, regular collaborative exercises, which follow the Homeland Security Exercise and Evaluation Program and a commitment to a sustainable emergency management program that requires permanent staff, well excellent. Well, as we have just covered some of the basic core material for this conversation, I would actually like to, now enter into a, open discussion involving the SMEs. So at this point, SMEs could you provide some response to some of this material and discuss a particular aspect that you found noteworthy, beneficial or particular applicable in light of regional collaboration throughout Northern New England. The floor is yours.

Kathy Knight: Hi, this is Kathy Knight, Northeastern Maine Regional Resource Center, just Dustin I think you had a lot of very important information in the presentation that you just gave, I think it's very; much of it is very true. We do hospital preparedness with 21 hospitals and started out at a ground floor level with developing trust and then moving forward with much of the information that you've just provided such as developing a template. We used Kaiser's template and we have changed it and developed something that's more appropriate for and delineates out in a much better fashion the important format or pieces that for emergency preparedness for hospitals. We've also worked with hospitals on after action plans and corrective action plans. Developing templates for their emergency preparedness planning and MOUs and directions on how to develop MOUs and we do a lot of exercises and trainings as well and. Those are all very important for the hospitals but it's very difficult for hospitals right now, because of the economic pressures on each and every one of them and especially in the state of Maine where rural hospitals in my region are experiencing a great deal of difficulty making their finances float. The day-to-day operation flow [INAUDIBLE] Emergency Preparedness Program.

Dustin Benac: Thank you Kathy...

Robert Gougelet: This is Rob Gougelet. I mean. I think we have two structures that I feel are very important the Northern New England MMRS, which is a regional collaboration between Maine, New Hampshire and Vermont and then also, the newly formed New Hampshire 1 DMAT, which also has team memberships from Maine, New Hampshire, and Vermont so I think. One of the big issues up here is that we're primarily rural states and we need to really, rely on each other and so regional collaboration I think, is essential, there's also a history of regional collaboration here, so. I think that we have a longer experience working together and I think that collaboration has been tested many times over the years but I think the most important part is both the MMRS and the DMAT, there's individual team members that are trained in incident command. Familiar with hazard vulnerability assessments and all of the basic planning and response activities, they take, participate in HSEEP exercises, they participate within their own region and. Then we do cross border exercises and trainings, and things like that, so I think operationalizing the concepts presented in the ACEP work is one of the strengths of having tangible assets doing these things.

Dan Manz: This is Dan Manz and I'd like to piggyback on Dr. Gougelet's comment, I think that MMRS initiative for those who may not be intimately familiar with it, it really is a cooperative venture among healthcare providers, and others. Among the three Northern New England states, which creates a capacity that none of the states individually would've been able to make on their own, and I think from a preparedness perspective it represents a resource that could be deployed to an incident in any one of the three states or conceivably beyond the three Northern New England states. That doesn't rob any one of the states of so much capacity that they can't continue day-to-day operation, but just as a concept. It sort of speaks to the level of willingness to participate in mutual aid kind of arrangement, willingness to share resources, willingness to cross borders that's necessary because as a Dr. Gougelet said, at least in the northern side, the rural nature of all three of those states just requires it [MISCELLANEOUS TALKING] [CROSSTALK]

Deborah Yeager: Well I just wanted to chime in on that as well because in New Hampshire we have MOUs between all of our own hospitals where they. They'll assist each other with, we call it staff, stuff, and services but we found, in real events, such as H1N1, that the benefit of cross border collaboration is really important to explore because we have one. Well, Dartmouth, our largest hospital, is right on the border and many of the patients come to that hospital, so we have made some strides in sharing information and forming partnerships across the border. We'd like to do more of it with Maine but I think that that's very important. Because they're going to be regionally, it makes more sense for Dartmouth to work across the border into Vermont, and it makes more sense for Portsmouth Hospital to work across the border into York and so I think one thing going forward is that we should try to explore those cross border MOUs, similar to what exists within the state.

Dustin Benac: Thank you very much, just a quick follow-up question for Dan and Dr. Gougelet, you were mentioning the Northern New England MMRS, has that been deployed or and, if it has not what are some possible incidents in which it might be deployed.

Unidentified Male: Well first of all it has been deployed within states to support H1N1, the major fire, the ice storms, the, I forget what, they were the New Hampshire ice storms a few

years ago. They're deployed regularly for mass gatherings up in Maine for the Brunswick Air Show, the Dempsey Challenge in New Hampshire for the Peace Boston air show, up in Burlington Vermont, they've deployed for the Phish concert awhile back and things like that. We haven't deployed interstate but. We have exercised as recently as this past September where we set up a medical surge facility at the Barry auditorium, which is a community owned auditorium to support one of the hospitals that would have been surged out for a chemical event, and so a community based medical surge capacity was set up within Barry. Full scale functional exercise this past September, previous to that we did a large scale exercise supporting surge capacity for Dartmouth Hitchcock Medical Center and so we are actually very experienced and we feel confident that we could deploy if there were a major incident to a hospital anywhere in the three states.

Kathy Knight: This is Kathy Knight again, Dr. Gougelet has done great work, along with the three states to develop the MMRS and the strike teams, in each of the states; we don't want to forget the Medical Reserve Corps as well. I'm the Director of the Northeastern Maine Medical Reserve Corps and as such, we've also been working on a great many of the topics that Dr. Gougelet touched upon, his resources as an MMRS, they have the training, and the education as well as the resources. Physical resources are much greater than the Medical Reserve Corps but we were utilized greatly during the H1N1. We provided more than 18,000 vaccinations, over a period of three vaccination, mass vaccination clinics and vaccinated most of the schools in the greater Bangor area, so the Medical Reserve Corps was fulfilling a great role there; all of us combined then it's a tremendous resource for all three states.

Robert Gougelet: This is Rob, I really agree with Kathy I mean, the MMRS is really a backup for the local communities, and the MRCs with statewide teams and so we really don't have the capacity obviously to cover every community, which makes the hospital preparedness and local community preparedness the most essential component of this.

Dustin Benac: Could we probe that final comment a little bit further with the panel, the hospital preparedness, and the community preparedness, what does that look like in light of the current demographics in Northern New England and what are some steps that are currently being taken within your facilities to do so.

Kathy Knight: Kathy Knight, again. In my region, I have the eight most northern counties in the state of Maine. Our population is, for that entire area, is slightly less than the lower four counties all pulled together so, we have a lot of moose and deer and squirrels up in my region and our hospitals are very widespread, or spread apart and they're very small. Most of them are critical access and so what we see in our region is that, if something should happen to the state at large then most of the resources, of course, and we expect it to happen. Will go to the economic support of the eight areas, such as Portland, Bangor, Lewiston Auburn, Waterville, Augusta, those areas, southern portion of the state of Maine, which keeps our state alive and also, has the greatest population area, so my northern hospitals. They're the ones that are trying to make sure they've always understood that, they would probably have to make do just as they did in parts of Mississippi following Katrina where no resources came their way, because there just wasn't enough to go around and so our northern hospitals understand that they have to be prepared. And ready to go, in the event of a very large scale incident where most of the resources are going

to the southern portion of the state, and therefore, they do work very hard with us on making sure that they are prepared and, working on their plans with us and being very collaborative. They travel, these folks travel almost 5 hours once a month to our collaborative meeting, front, and back, forward and back, and they're very dedicated.

Unidentified Female: I just want to add to that Kathy. We have a very collaborative process here in New Hampshire as well, and some of our people. Maybe not five hours but at least three, are coming to meetings and ever since the beginning, we've been working together. Giving our smaller hospitals, we have 13 critical access hospitals. Same responsibility as the bigger hospitals yet [INAUDIBLE] scale and I think the success of the program in making all hospitals prepared here is the collaborative nature and their commitment to working together and sharing resources and sharing lessons learned. Not reinventing the wheel, we've had a couple of incidents that are specific to the hospitals that may not get to emergency management, to that level and we've seen how they can rise to the occasion even the smaller critical access hospitals to help out a bigger hospital in need, I'll just give you a quick example. In as Southern New Hampshire Medical Center, which is a larger hospital in Southern New Hampshire, they were beginning to lose their capacity for vacuum. They were losing suction capability as the hospital people on the line know that's quite a disaster for a hospital. It may not rise to the level of emergency management and our partnership that was created was able to provide that hospital, Southern New Hampshire, with the resources they needed to mitigate that event, so it never rose to the level of an emergency, but the reason it didn't rise to that level was because of the commitment to assist each other in an emergency.

Dan Manz: This is Dan Manz and yeah, I think, sort of a central point [INAUDIBLE] in all of these comments is that most of these incidents or events, really do happen at the local level and we sort of think about statewide emergencies, and national emergencies. Like a pandemic flu. That sort of thing, but much more numerous are the events, like, losing suction at a local hospital and so it does seem to me that the planning and the partnerships and the evaluation, the drills and the testing and so forth, you cannot overstate the importance of assuring that all of that is in place at the local level. The resources from a state perspective, the resources from a multistate, region perspective, the resources from the Federal perspective, I'm more and more coming to believe those things are real, they're there, they can be mobilized, they don't get mobilized in 5 minutes. And I think, hospitals and communities, really have to be thinking, all the time, about how do we survive the first few hours with nothing more than what we have in this community and then what can we realistically expect for help from our neighbors, from our adjacent facilities, from the resources that we can best mobilize locally.

Kathy Knight: I think this is Kathy; I think you're right on targets both you and Deb. In the state of Maine we have as you folks do we have a statewide MOU between all hospitals to share resources, staff, space, and stuff, so I think we're all going in the same directions. Our hospitals also understand that their success and their failure is very dependent on their partner organizations, what we do is, in a disaster situation, even if it's a very localized event with an individual hospital. Then we will put together a telephone conference call with all of our regional hospitals as well as the two other regional resource centers in the other parts of the state of Maine and we will discuss. We'll have that individual organization discuss its problems that it's encountering and state. What its needs are, and then the hospitals... We're sort of a

membership and a great partnership. And then the hospitals will start offering up their resources, so everybody's getting the information at the same time, offering up resources, we know what's going on and then we continue to plan for those additional telephone conference calls to keep up to date, and make sure that our partner hospitals have what they need. Additionally, some of these things that we're working on to make sure that there's sustainability in the rural communities, is hospitals even though they're very small, and they're critical access hospitals, they sincerely want to make sure that they can offer some resources to partner hospitals in an event, that they are a valuable member of the team. And so what we're looking at is developing modules of healthcare volunteers so to speak so we for instance we have Emergency Department personnel, and we decide what that module of personnel is going to look like, what the equipment and supplies would look like. And we'd say for instance that it's 3 team, four team members, an Emergency Department Physician, a PA, NP or and a nurse and a Tech and, they have this equipment. They can treat this many people, and their turnaround time is this amount of time and that way, an individual at a hospital has 100 people and this module of people, so to speak treats 50 of them, and, they know they need three modules of those. But we can get them from different hospitals as long as we know what the resources are that are available, if you get my drift in regards to building that modular system, so a hospital. Eastern Maine Medical Center for instance, says well we can send three modules, we have three modules available, another one, a local hospital, a small critical access says well we only have one module and we can't get it up and running for 2 hours. Those kind of things, so we know what we assessed the resources available using a modular system, and then it's almost like a checklist or an order form for what's necessary, which we at the Regional Resource Center can try to locate those, and get them into the area of need.

Dustin Benac: Excellent, thank you very much Kathy... At this time, I would like to invite any of the participants who have called in to begin submitting questions you have for the SME panel. Because I do want to allow for that because that is one of the primary goals of this conversation, so begin submitting those now and, you can submit those through the Q&A dialog box at the bottom of your screen. When they are received we will present them to the panel, and discuss accordingly, as those are coming in, I did want to just pose one further question for discussion to the panel, and that is in response to something you mentioned, Deb, you talked about how because of the geographic nature of Northern New England. There are many localities, which are either on the border or are in close proximity to other jurisdictions, so could you talk about a little bit further. What are some of the policies and procedures that are enacted when an incident does occur at the local level but that jurisdiction is either, neighboring another state or maybe occurs in both states and across state lines?

Deborah Yeager: Well I think that my point was that I think more work needs to be done in that area, on policy level, I think that in an event, a real event, there's. Normal procedures are going to be followed, so let's just take Dartmouth for example. They have patients that are in Vermont that live in Vermont and cross the border to get their services and I think that's just going to happen. I think that a New Hampshire hospital is not going to turn away a Vermont patient if they show up at their door but. There are things such as credentialing and. Rob maybe can jump in on this, credentialing and licensing of physicians and providers that may not have the same impact on both sides of the border or it may not transfer over, things such as protection for volunteers from both sides of the border, it's more a legal issue than it is practical issues. I

think, so that's where I would like to see more work be done and to just sort of open up the virtual border, say and allow for these easy transitions from state to state, because I think it happens naturally but then when you get into legal aspects it's dicey.

Dustin Benac: Are there other thoughts in response to that, SMEs.

Curtis Metzger: Yeah, this is Curtis and of course. I'm the ESAR-VHP, and MRC Coordinator in New Hampshire and these areas, of course, have been the bugaboos across interstate planning, which has been going on for a good while here in New England and through the Hospital Preparedness Program. I know that from the beginning days, Tony [INAUDIBLE] and I, Dr. [INAUDIBLE] in Rhode Island. We used to do a lot of interstate meetings to try to get at these cross border issues. They've sort of fallen off a little bit now partly because of dwindling funds and people. That workloads but because we're in New England and we're also close. It's something definitely we have to pay attention to. I think the so the defining thing here, is that, as Deb was saying, when it comes to patient services and clinical care, that just sort of happens, without regard to border for the most part, and people just kind of, are on autopilot about that. Where we stumble is that because the money that comes to us through the Hospital Preparedness Program Federal grant and the PHEP Grant is state based. It sometimes we have a hard time breaking out of the shell of our responsibility is to plan for the state, and so I think that's sort of the nexus of the challenge is. How do we make sure that in our robust planning within the state, we also think the way the hospitals and clinical services are provided near border areas so that there's an easy transition and the biggest problem, of course, is the credentialing of staff, which is of course, what ESAR-VHP is supposed to be about. Building in every state is we have some kind of a mechanism so that we can credential people and hopefully, deploy them effectively; ESAR-VHP's not a first responder organization. It's kind of a backfill and when things are going on for an extended period of time, to get resources but that's definitely the challenge and I think, as we're talking, I think one of the things that will be good for us to focus on. I know here in New Hampshire is just having conversations with the people here in New Hampshire who are responsible for EMAC, so that they understand, and we understand how we would deploy people, resources, is fairly easy, but how we would deploy people across borders using EMAC, which is definitely, what we would think about for our ESAR-VHP System. So I think that's the real challenge there is that we kind of at the state planning level keep continuing to challenge ourselves to think of ways to erase the borders as it were the way clinical services are provided.

Dustin Benac: Thank you Curtis, I appreciate that perspective, excellent, any further comments from SMEs on this topic.

Unidentified Female: I just wanted to throw in there that also in the state of Maine we also have our Canadian neighbors that are very important partners with us and, there have been long running Relationship Building meetings and planning sessions with our Canadian partners. Maine Emergency Management Agency has recently initiated planning for cross border communication including the healthcare organizations in that planning sessions, which are very important. Because really the hospitals as was pointed out earlier, hospitals really don't care about borders whether it's international or it's state borders and patient care is not that important. Although there are still barriers especially on the Canadian border for us but, there's a lot of

leeway there that otherwise wouldn't be and so that planning to smooth out those rough edges has been very important.

Dan Manz: This is Dan Manz, I think Curtis touched on kind of an important point, a challenge, in collaborative cross border ability to work together, which really is the Federal model, under the PHEP program pretty much everything that's described and everything that the Feds are willing to support and pay for really is state based initiative. And it sort of forces you to think, internally, within the silo that are our individual states well I think, New England is just replete with examples of how people cross border. They cross political jurisdictions to receive their healthcare all the time. I mean. The whole eastern side of Vermont looks to Dartmouth as a tertiary referral center and the same is true all over the rest of New England. There's many examples of that and so. I think we in New England sort of, get schizophrenic on this in some cases. Because we're, on the one hand having to develop plans to satisfy Federal requirements and to follow Federal guidance that tend to look uniquely within the state but. The reality of it is the patients are going to go where they normally go to get healthcare, and in many cases, that means just crossing a border that to them is invisible and irrelevant in terms of how they actually access service.

Robert Gougelet: Yet, this is Rob, I definitely would agree with both your and Curtis' comments on that.

Dustin Benac: Excellent, thank you SMEs and as we do have a few more moments, I would invite any questions to be please submitted and I do have one that we will present to the panel, so, if you could discuss this accordingly. Subject matter experts and how this will work, is I'll actually read it for anybody that is calling in and just has the audio capacity or for anybody who listens to this as a web archive and the question is what interstate MOUs have been developed and what should disaster planners consider when developing these agreements, SMEs.

Curtis Metzger: Well, this is Curtis. I think the biggest MOU really is EMAC, which is the Emergency Management Assistance Compact that all the states have signed, which is a mechanism based in the emergency management offices of each state, to be able to transfer staff, and things, to assist another state. I mean, I think that's the essential MOU that everybody relies on, and it's certainly something that we look to in terms of in healthcare response as well, other than that, I imagine that there are MOUs. Deb maybe you could clarify this but I think southern I don't know if they've officially southern and Saint Joe's entered an MOU with some of their Massachusetts border hospitals.

Deborah Yeager: Yes...

Curtis Metzger: Yeah, they did.

Deborah Yeager: Yeah, I think that there's hospital-to-hospital MOUs across borders, there, I know for sure in Massachusetts I think there are, maybe between Portsmouth Hospital in New York... I'm not positive but I know that Steve [INAUDIBLE] at Dartmouth has been working a lot with the border hospitals in both New Hampshire and Vermont to try and get some plans

together, whether they're official MOUs or not I'm not sure but yes, southern definitely has been proceeding along those lines.

Unidentified Male: Yeah, and I think, a lot of hospitals have really extensive day to day operations between each other, so the first impact of a disaster would be to rely on those mutual aid type activities that occur on a day to day basis and expand those.

Unidentified Female: It's a natural partnership.

Unidentified Male: Excuse me.

Unidentified Female: They're natural partnerships that they already have in place.

Unidentified Male: Right and then the MMRS does have an MOU between the three states to coordinate and cooperate in terms of our regional planning and response activities as well as the utilization of the strike teams.

Dustin Benac: Excellent, thank you SMEs, as we have a few more moments, we can discuss a few more questions, or SMEs, if you have another direction you would like to take this conversation, please do that as well...

Dan Manz: Dan Manz here again let me go back to that previous question about the interstate MOUs because I think it makes another sort of important emergency planning. Emergency operations point, which really is following the Incident Command System, that EMAC as it was described really is this process that's been worked out between the states on how they could share resources across borders. And who's responsible for real world questions like money and liability, and what if people get hurt and that kind of stuff, so that's a framework that's in place but. You only get to EMAC through your State Emergency Management Agency and so using the Incident Command System to follow this logic of we manage the incident locally until it exceeds the capabilities of what we're able to do locally and. Then we start reaching upward and going to the state and if the state can provide additional resources, great, if the resources exceed what the state's able to get, then the state can go shopping through EMAC to adjacent states or anywhere else in the country to help bring in the resources that are necessary. But I think it all begins with everyone speaking the same language, everyone understanding the Incident Command System, and that's really what has to be in place, as sort of an overarching capability to be able to make effective use of interstate and other Federal resources that might be necessary.

Dustin Benac: Excellent, thank you very much Dan and I mean this has been a very beneficial conversation and unfortunately, as we are running out of time, we do have to begin closing the call and before we do so however, I did just want to present one quick request to participants who have called in, and that is. If you are calling in from a centralized location, and you have more than one individuals participating in this call at your location, please submit the total participants from your location through the Question Dialog Box at the bottom of your screen. That will assist us as we track participants and numbers. Well, as we close this call I did want to invite any of the participants who still have lingering questions to, please contact the SMEs at their contact information listed on your screen or, you can also contact myself, and I also wanted

to post Kathy Knight's information as did previously and that will appear on the screen briefly and just in closing, I did want to thank everybody for participating in this regional discussion. We had just excellent discussion surrounding collaborative disaster planning. If you're interested in reviewing some of the additional information I would encourage you to review the Building Collaborative Disaster Planning Course that is found on the Vcall community site, and, if you need additional information about that, you can contact me directly and finally, just a very special thanks to the SMEs who participated in this call. You truly provided some very valuable discussion and perspective, and appreciate your time, and investment, and commitment to emergency management within your region... Before closing, I would like to give SMEs just a final opportunity for closing remarks so we have about a minute and a half for closing remarks, if you have any, excellent, well, as it seems there are no further comments or questions, we will officially close this call. Thank you for your time and your participation today.