

Welcome

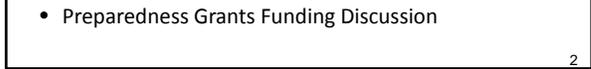
ADHS Public Health Emergency Preparedness & Hospital Preparedness Program All Partners Meeting

This meeting was supported in part by the CDC Cooperative Agreement, Catalog of Federal Domestic Assistance (CFDA) 93.069 and the Hospital Preparedness Program (HPP) Grant CFDA 93.889. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC or the Department of Health and Human Services.



Agenda

- Welcome
- NDMS
- Red Cross/Sheltering
- AMR/FEMA Ambulance Contract
- Region Breakout Session I
- Working Lunch 11:45 with CSC Presentation
- Region Breakout Session I continued
- Breakout Session II – County/Tribal and Healthcare
- Brief Back from Breakout Sessions
- Preparedness Grants Funding Discussion



Welcome

Don Herrington
Arizona Department of Health Services
Assistant Director Public Health Preparedness



HAPPY



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Arizona Department of Health Services All Partner Meeting

Kerry Reeve
Area Emergency Manager
February 11, 2016

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National Disaster Medical System



A public/private sector partnership
DHS DHHS DOD DVA




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Components of the National Disaster Medical System



I. Medical Response:

- Personnel, teams and individuals, supplies, and equipment
 - Disaster Medical Assistance Team (DMAT)
 - Disaster Mortuary Operational Response Teams (DMORT)
 - National Veterinary Response Team (NVRT)

II. Patient Movement

- Patient evacuation: primarily DoD, new alternate modes of movement – Dual Use Vehicles
- Medical regulating: DoD/VA
- En-route care: transport providers
- Patient tracking/in-transit visibility: DoD/VA

III. Definitive Medical Care

- Treatment provided by participating NDMS medical facilities

7
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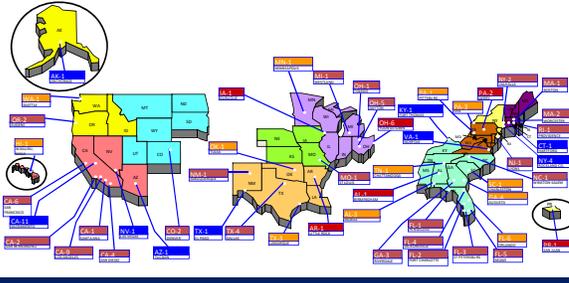
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DISASTER MEDICAL ASSISTANCE TEAMS (DMATS)





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Federal Coordinating Centers



- A Federal Coordinating Center (FCC) is a facility located in a metropolitan area of the United States and Puerto Rico, responsible for day-to-day coordination of planning and operations in one or more assigned geographic NDMS Primary Receiving Areas.
 - VA currently has 50 FCCs nationwide and in Puerto Rico
 - VA FCC functions are coordinated by VHA OEM Area Emergency Managers
 - Medical Center Directors are the FCC Director
 - Facility Emergency Managers train/operate FCCs

9
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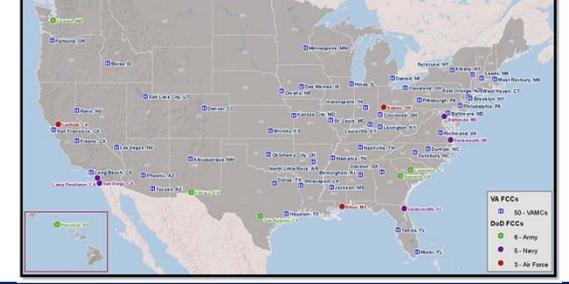
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Current Federal Coordinating Centers





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Arizona Based FCC's



Federal Coordinating Center's (FCC)

- ❑ Two in Arizona Phoenix and Tucson
- ❑ Arizona Air National Guard PRC – Phoenix
- ❑ Davis Monthan AFB PRC - Tucson
- ❑ Hospitals with MOA's
- ❑ MMRS support
- ❑ Other Partners
- ❑ Patient movement (throughput) via FCC (24 hours)

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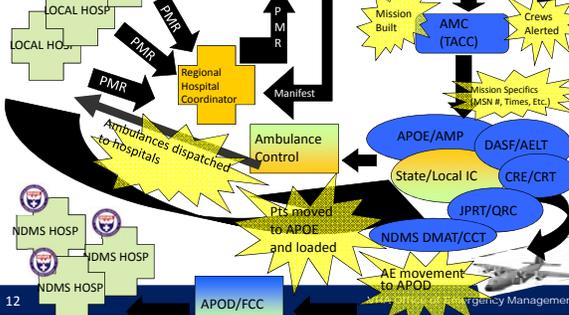
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AE System Overview





12
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Federal Medical Station (FMS)



- Cache of medical supplies and equipment
- Temporary non-acute medical care facility
- Requires Harden Bldg.
- Treat & hold 250 people for 3 days
- Inventory = 67



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Dual Use Vehicles





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DUV Function



- Develop an internal VA capability that could function, if necessary, independent of local, State, Federal or private-sector capabilities during disasters or emergencies.
- Support routine transportation requirements for VA Medical Centers and Community Based Outpatient Clinics.
- Support patient evacuation and regulation during disasters or emergencies.

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DUV's Specifications



GENERAL SPECIFICATIONS	28' DUV (SHORT Platform)	36' DUV (LONG Platform)
OVERALL LENGTH:	28'	36'
BODY WIDTH:	102"	102"
OVERALL HEIGHT:	12'10"	12'10"
GVWR:	26,000 LBS.	32,000 LBS.
ENGINE:	DIESEL 6.7L	DIESEL 6.7L
TRANSMISSION:	AUTOMATIC	AUTOMATIC
MAXIMUM PASSENGER SEATING:	14	30
MAXIMUM LITTER POSITIONS:	9	15
MAXIMUM WHEELCHAIR POSITIONS:	6	10

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Dual Use Vehicle



- Nationwide
 - 118 Production Large
 - 208 Production Small
- Arizona
 - 2 Large
 - 17 Small

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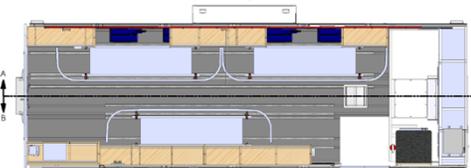
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Small DUV



- 14 ambulatory, 4 wheelchairs or 9 litters
- 10 - 12 Years or 700 - 800,000 miles



18
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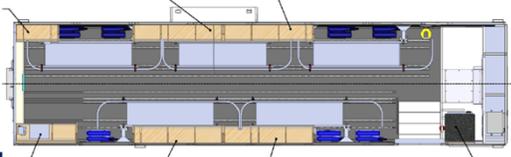
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Large DUV

- 30 ambulatory, 6 wheelchairs or 15 litters
- 10 - 12 Years or 700 - 800,000 miles



19

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DUV w/loadout



20

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DUV/Combination Loadout



21

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Stretcher



22

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Wheelchair

- Litter stanchions (stored on board)
- Wheelchair tie downs
- Shore power cables
- Privacy curtains
- L-track "D" and "Pear" rings
- Crash-tested wheelchairs
- NATO litters
- Vehicle First Aid Kit
- Electrical extension cords
- Cargo tie down straps



23

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Questions

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24

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American Red Cross

Mass Care Sheltering

ADHS Annual HPP-PHEP All Partners Meeting
February 11, 2016

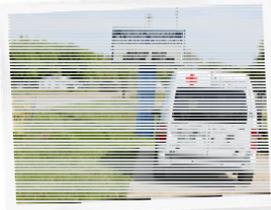
Mass Care Shelters & Emergency Planning

- Selection
- Surveys
- Information sharing
- Supplies
- Training




Partners in Preparedness

Shelter Selection



Shelters must be **safe** & accommodate all the activities of shelter life.



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27

Shelter Surveys



Shelter facility surveys should be conducted with emergency management partners – include general facility and ADA accessibility information.



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Information Sharing



Most shelter data **CAN** be shared with emergency management partners.



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Shelter Supplies



Shelter supplies are staged across Arizona and more can be quickly deployed from neighboring states.



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Shelter Training



Red Cross disaster relief training is FREE and open to our partners. Classes include shelter operations, management and serving people with Access & Functional Needs.



31

Mass Care Shelters in Response

- Determining Need
- Selecting Location
- Notifications
- Opening
- Operations
- Reporting



Determining Need



- Emergency Mgmt Recommendation
- # of families affected
- Nature of the disaster



33

Selecting the Facility



- Prefer facility with a current survey & signed agreement
- Safe location
- Nearby affected area
- Accessible



34

Notification



- Press Releases
- Social Media
- Red Cross Website & Apps
- Email to stakeholders



35

Opening a Shelter



- Open within 2 hours of notification
- Supplies may arrive after opening
- Safety & Comfort



36

Shelter Operations



- The shelter is HOME for a while
- Immediate focus on Recovery
- Partners are essential



37

Closing the Shelter



Shelters remain open until the threat subsides and/ or everyone has a safe place to stay



38

Mass Care Shelters in Recovery

- Shelter residents may have fewer resources available for recovery
- Focus on transitioning folks to more permanent lodging



39

For more information

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40

Breakout Session I

Topics may include:

- Strategic Planning
- Capability Planning Guide/Gap Assessments
- Training and Exercise Discussion
- Financial Considerations/Concerns to Support Regional Priorities



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Breakout Session I - Locations

- Central Region – Solana H
- Southern Region – Solana I
- Western Region – Cira A
- Northern Region – Cira B



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Arizona Crisis Standards of Care Plan:
A Comprehensive and Compassionate Response

Andrew Lawless, MBA, PMP
 Emergency Response and Communication Coordinator
 Bureau of Public Health Emergency Preparedness
 Arizona Department of Health Services



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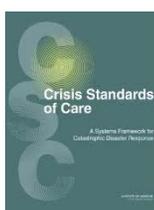
What are crisis standards of care (CSC)?
What type of disaster would be CSC?
How was the AZ CSC Plan developed?
What would a CSC response look like?
What are the indicators?
What are some tactics?




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IOM - Crisis Standards of Care
A Systems Framework for Catastrophic Disaster Response

VOLUME 1: Introduction and CSC Framework
 VOLUME 2: State and Local Government
 VOLUME 3: EMS
 VOLUME 4: Hospital
 VOLUME 5: Alternate Care Site Facilities
 VOLUME 6: Public Engagement




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What are crisis standards of care?



The level of care possible during a crisis or disaster due to limitations in space, staff, and/or supplies.



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Crisis standards of care will usually follow a formal declaration or recognition by state government during a **pervasive** (pandemic influenza) or **catastrophic** (earthquake, hurricane) disaster which recognizes that contingency surge response strategies (resource sparing strategies) have been exhausted, and crisis medical care must be provided for a **sustained** period of time. Formal recognition of these austere operating conditions enables specific legal/regulatory powers and protections for healthcare provider allocation of scarce medical resources and for alternate care facility operations...

(IOM, *Crisis Standards of Care*, 7-1 – 7-2)



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Five Key Elements for all CSC Plans

1. A strong ethical grounding... based transparency, consistency, proportionality, and accountability
2. Integrated and ongoing community and provider engagement, education, and communication
3. The necessary legal authority and legal environment in which CSC can be ethically and optimally implemented
4. Clear indicators, triggers, and lines of responsibility
5. Evidence-based clinical processes and operations



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CSC Pillars

Hospital, Public Health, Out-of-Hospital, EMS, Emergency Mgmt. & Public Safety

CSC Assumptions

- Resources are unavailable or undeliverable to healthcare facilities
- Similar strategies being invoked by other healthcare delivery systems
- Patient transfer not possible
- Access to medical countermeasures (vaccine, meds, antidotes, blood) likely to be limited
- Available local, regional, state, federal resource caches (equip, supplies, meds) have been distributed- no short term resupply

(IOM, Crisis Standards of Care, 1-10)

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Does this qualify as a CSC Incident?

Gabrielle Giffords Mass Shooting

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Not a CSC Response

Gabrielle Giffords Shooting

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Does this qualify as a CSC Incident?

Boston Bombing

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Maybe not a CSC Response

Boston Bombing

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What types of disasters are we talking about?




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Catastrophic Disaster Attributes

- 1) Most or all of the community's infrastructure is impacted.
- 2) Local officials are unable to perform their usual roles for a period of time extending well beyond the initial aftermath of the incident
- 3) Most or all routine community functions are immediately and simultaneously disrupted
- 4) Surrounding communities are similarly affected, and thus there are no regional resources

(IOM, Introduction and CSC Framework 1-15)


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Chemical – Bhopal India

- December 3, 1984
- Union Carbide plant leaked 32 tons of toxic gas including methyl isocyanate
- 5,000 immediate deaths
- 18,000 deaths w/in 2 weeks
- Many more sickened
- World's worst industrial accident




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Pandemic Influenza

- 50 million deaths worldwide
- Major pandemic like 1918 "Spanish Flu" was a global catastrophe




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Madrid Bombing

- March 11, 2004
- Fatalities - 191
- Wounded 1,800 – 2,000




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Flood – Natural or Technological Failure

Previous Dam Failures

China 1975 – 175,000 fatalities, dam failure from severe rainfall after typhoon



Earthquake

- Nearly half of Americans live in earthquake prone areas
 - San Andreas Fault
 - Cascadia Subduction Zone
 - New Madrid Fault
- Impact from quake– neighboring states may receive thousands of evacuees with medical needs



Northridge, 1994

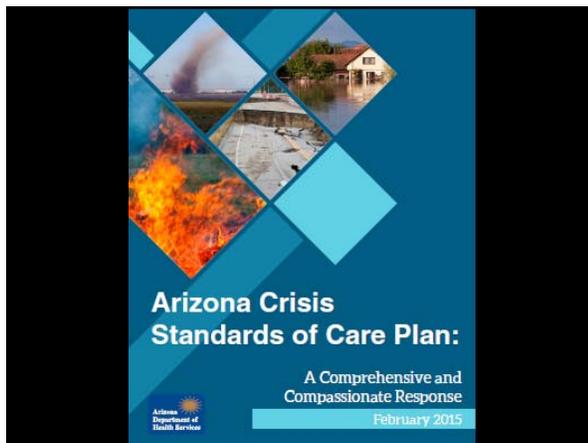


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How was the AZ CSC Plan Developed?




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Arizona Crisis Standards of Care Plan:

A Comprehensive and Compassionate Response

February 2015



ADHS Planning Approach for CSC

- Integrate IOM Framework & Core Functions with:
 - Comprehensive Planning Guidance 101
 - Standard format for response plans
 - Existing plans (e.g., ERP, CERC, HEOC SOP, SERRP)
 - Previous planning efforts (e.g., Disaster Triage)



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Project Milestones & Events

- Initial Planning Meeting – January 2013
- Mid Planning Meeting
- Workgroup Sessions
- Public Engagement
 - 9 public meetings (2 hours each) across the state
 - Online survey
- Proof of Concept Meeting
- Clinical Proof of Concept
- Finished Plan – February 2015
- Tabletop Exercise - May 2015



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CSC Workgroups

- Legal/Ethical
 - Ethical code, legal sections of plan
- Clinical
 - Triage protocols, inclusion criteria
- Public Engagement
 - Developed public engagement tools
 - Conducted 9 public meetings & online survey
- EMS
 - Validated existing plans & standards for transport



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What would a CSC response look like?




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State Disaster Medical Advisory Committee (SDMAC)

The SDMAC will convene to develop incident-specific **priorities and guidance** for the delivery of healthcare and use of scarce medical resources.




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State Disaster Medical Advisory Committee (SDMAC)

Supports existing EOCs and ICS structure within the response.




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SDMAC Members

- ADHS Director, Policy Advisor, Committee Members
- Partner Agency Committee Members (local/state agencies, medical boards, associations, federal)
- Healthcare Coalition Committee Members
- Subject Matter Expert Committee Members

Plan contains Job Action Sheets for SDMAC Members



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SDMAC guidance may address

- Triage for emergency medical services (EMS);
- Primary, secondary, and tertiary triage for healthcare facilities;
- Expanded scopes of practice, as approved by regulatory authorities;
- Priorities for medical resources including space, staff, and supplies; and
- Considerations for healthcare access points, including hospitals, out-of-hospital facilities, and alternate care sites.



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What are the indicators?




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Indicator: A measurement, event, or other data that predicts a change in demand for healthcare. This often requires further monitoring, analysis, information sharing, and/or emergency responses.



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What Do Indicators Tell Us?

- Indicators may serve as triggers to change from one standard of care to another.
 - Conventional
 - Contingency
 - Crisis



See Appendix B (pp. 103 – 106) for complete list of indicators

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Conventional Indicators for Healthcare

RESOURCE	Indicator
SPACE	Usual patient care space fully occupied
STAFF	Usual staff called in and utilized
SUPPLIES	Cached and usual supplies being used

Adapted from IOM, p 1-41

Contingency Indicators for Healthcare

RESOURCE	Indicator
SPACE	Patient care areas re-purposed (e.g., PACU or monitored unit used for ICU-level care)
STAFF	Staff extension in place (brief deferrals of non-emergency care, supervising broader groups of patients, etc.)
SUPPLIES	Conservation, adaptation, and substitution of supplies with selective re-use of supplies for an individual patient

Adapted from IOM, p 1-41

Crisis Indicators for Healthcare

RESOURCE	Indicator
SPACE	Facility damaged/unsafe or non-patient care areas (classrooms, etc.) used for patient care
STAFF	Trained staff unavailable or unable to adequately care for volume of patients even with extension techniques
SUPPLIES	Critical supplies lacking, possible reallocation of life-sustaining resources

Adapted from IOM, p 1-41

Conventional Indicators for the State

- One or more counties/regions at capacity
- Patient transfer may be impacted



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Contingency Indicators for the State

- Local jurisdictions initiate resource requests
- Medical countermeasure availability declining
- One or more hospitals on diversion or damaged
- Patient transfer across all or part of state is limited



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Crisis Indicators for the State

- One or more counties/regions request CSC
- Medical countermeasures depleted
- Patient transfers insufficient or impossible statewide
- Local jurisdiction resource requests unfillable or undeliverable
- Multiple healthcare access points impacted



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What are some tactics?



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Scripted Tactic: A tactic that is **predetermined** and is quickly implemented by frontline personnel with minimal analysis.

Non-Scripted Tactic: A tactic that **varies** with the situation, based on analyses of multiple or uncertain indicators, recommendations, experience, and expertise.



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Conventional Tactics for Healthcare (Proposed)

- Place facility Incident Command staff on standby
- Notify county PHEP and/or emergency management partners of conventional surge conditions



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Contingency Tactics for Healthcare (Proposed)

- Activate incident command and Emergency Operations Plan/Emergency Response Plan
- Notify county PHEP and/or emergency management partners of contingency surge conditions
- Notify ADHS Licensing



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Crisis Tactics for Healthcare (Proposed)

- Notify county PHEP/emergency management partners of crisis level
- Consider alternate care sites
- Implement facility CSC plans and procedures
- Re-use and repurpose supplies
- Assign primary, secondary, and tertiary Triage Officers, as needed



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Conventional Tactics for State

- Place emergency operations/incident command staff on standby
- Notify statewide partners of surge conditions



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Contingency Tactics for State

- Activate state EOCs
- Participate in unified command with on scene operations and local EOCs
- Process space, staff, and supply resource requests from local jurisdictions
- Notify SDMAC committee of possible activation
- Notify federal partners of medical surge



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Crisis Tactics for State

- Activate SDMAC to develop and implement CSC
- Participate in statewide public information activities
- Activate state medical countermeasure, medical materiel, volunteer management, and alternate care site/system plans



CSC DEACTIVATION

- SDMAC works with response partners to monitor situation and identify appropriate time to return to contingency standards of care
- When impacted healthcare facilities are able to return to contingency care, or patient transfer/evacuation becomes possible, statewide CSC can be deactivated.



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Next Steps

- First CSC Plan revision will start in May
- Link to plan: <http://www.azhealth.gov/emergencyplans>
- Link to provide feedback at top of page
- Feel free to review and provide feedback on other plans as well
- Currently a link up for the Draft Volunteer Management Plan



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Questions ?




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Breakout Session I continued


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Brief Back Breakout Sessions


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Central Region Brief Back

- Priority 1: Exercise synchronization/crosswalk of requirements
- Priority 2: Access to training
- Priority 3: Mentor program and partnership
- Action Step: Develop an outline for the mentor program.


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Northern Region Brief Back

- Overarching Goal: Reviewing, updating, and exercising the plans
- Priority 1: Incident Management
- Priority 2: Information Management
- Priority 3: Community Resilience
- Barriers (to goal): Participation
- Strategy 1: Use one format WebEOC to provide training and increase participation
- Strategy 2: Create a workgroup evaluate the plans
- Strategy 3: Increase access to WebEOC or other communications platforms


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Southern Region Brief Back

TOPIC:				
Overarching Goal: <small>(Desired Destination in BPS)</small>	To Enhance partner agency capabilities and develop coordinated and effective medical and public health system partnerships to manage all hazards.			
Objective: <small>(Attainment in BPS)</small>	Membership increased in the coalition's base on whole community representation (more partners) Health resource coordination plan 96 hours sustainability plan Communication plan exercise Strategic Planning Regional Training and Exercise based on regional annual HVA			
Potential Barriers:	Cost of replacement of MSA. Travel costs.			
List the Strategy/Activity	Action Steps	Who? Key Persons	When? (Completed)	Resources Needed
Regional HVA ICS Training for all partners and integration with ESFB partners Inocce equipment and training and build teams (equipment out of date) Complete the disaster credentialing process New CMS rules changes BP 5 funding strategies Business analysis plan	Build out the web site to increase partner participation Build a marketing plan/ compiling metrics			
96				

Western Region Brief Back

- Priority 1: Regional exercise
- Priority 2: Group unified training
- Priority 3: Resource inventory program-educational sustainability



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Group A – County/Tribal Brief Back

- Priority 1
- Priority 2
- Priority 3



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Group B – Healthcare Brief Back

- Priority 1
- Priority 2
- Priority 3



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Preparedness Grants Funding Discussion for BP5/Next Steps & Closing Remarks

Teresa Ehnert, ADHS



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