



Health Care Access for All

**Clinic Emergency Preparedness Task Force Meeting Agenda
California Department of Health Services
Joint Emergency Operations Center Tour
1615 Capitol Avenue, Sacramento
July 25, 2006 10:00am – 3:00pm
Chair: June Levine, CCALAC**

1. Welcome and Introductions- June Levine
2. Approval of April 25, 2006 Meeting Notes
3. Clinic Emergency Preparedness Expansion Project Reports
 - a. Consortia Reports- All
4. Emergency Preparedness Peer Profiles/Skills Inventory- Christina Wildlake
5. Emergency Preparedness Planning Funding Opportunities- Nora O'Brien
 - a. Alternate Care Site Workgroup Report- June Levine and Daniel Albano
 - b. HRSA/CDC Grant Deliverables
 - c. Regional CDC Pandemic Influenza Planning Grant
6. Emergency System for the Advanced Registration for Volunteer Health Professional (ESAR-VHP)- Lisa Schoenthal, EMSA
7. CEPTF Retreat Planning Report- Planning Committee Members
 - a. Status of Clinic Emergency Preparedness of CA Consortia - June Levine
 - i. Finalize Consortia Status Survey
 - b. Finalize Clinic Emergency Preparedness Task Force Retreat Agenda
8. Statewide Disaster Exercise Plan Committee report – Linda Kehoe
9. Adjourn

Updates

UCSF Center for Health Policy Studies Emergency Preparedness Issue Brief
NACCHO Emergency Preparedness 2007 Summit Call for Presentations



Health Care Access for All

**Clinic Emergency Preparedness Task Force Meeting Minutes
RCRC, 801 12th Street, Sacramento, CA
April 25, 2006**

Participants: June Levine- Chair, Daniel Albano, Carla Alexander, Adrienne Bowes, Evelyn Brown, Diana Concannon, Kathryn Hall Susan Huffman, Linda Kehoe, Jeff Larson, Ambrocia Lopez, Kathy Michaud, Theresa Nitescu, Jim Perkins, Tim Rine, Tonya Robinson, Kirstin Ruf, Raul Salazar, Leah Strevralia, Maeve Sullivan

CPCA Staff: Nora O'Brien, Christina Foncree

Guest: Susan Fanelli and Amanda Loveless, California Department of Health Services

Call to Order

Chair June Levine brought the meeting to order at 10:05am.

Welcome and Introductions

The Chair welcomed the Clinic Emergency Preparedness Task Force (CEPTF) members and asked that everyone introduce themselves.

Approval of January 24, 2006 Meeting Notes

It was decided that Christina will send out the previous meeting notes before the next meeting so that they may be reviewed by the CEPTF members prior to being approved.

The minutes were approved as written. **The motion carried.**

Clinic Emergency Preparedness Expansion Project Reports

Consortia Reports

The consortia members each gave an update on the progress in Emergency Preparedness of the clinics. The main focus areas are implementing customized EOP's for clinics, developing relationships with the county to become more involved in their plans, securing pharmaceutical caches, applying for grants, participating in drills, assessing clinics on their emergency preparedness needs, assisting with hazard vulnerability analysis and identifying supply needs.

HRSA Local Contract Extension

CPCA received the new HRSA contract and the scope of work was revised this year. The deliverables were changed slightly so as to not appear that the same work is being done as last

year. The checks and MOA's will be mailed out once received from the California Department of Health Services.

Department of Health Services Surge Capacity Survey Results and Surge Planning

Susan Fanelli presented a Surge Capacity survey results and asked the task force to review it and make suggestions on the results. The survey will be sent out again in December and the Task Force will discuss further at the July meeting to discuss definition of terms and give input to DHS on how to better capture the data from the clinics.

Governor's Budget on Emergency Preparedness Planning

The Governor has allocated \$5.5 million specifically for Surge Capacity planning. The Surge Planning survey has helped to identify where and how the funds should be spent and CPCA will be asking for at least \$1 million in order to enhance clinic emergency preparedness capacity. The Governor may propose additional funds in his May Revision. CPCA will analyze the May proposal and seek Clinic Emergency Preparedness Task Force input when needed.

CEPTF Retreat Planning Report

"Status of Clinic Emergency Preparedness of Consortia" Survey

June presented a survey to the Task Force on the Status of Emergency Preparedness within Consortia for input from the group. The survey will be sent out and completed prior to the Retreat and the results will be presented and discussed at the Retreat. Once results are analyzed, a document will be published that highlights the type of work being done by Consortia in emergency preparedness. This will also serve as the Progress Report for that time period.

Review Draft CEP Task Force Retreat Agenda

The draft agenda was presented to the Task Force for input on timing and issues being covered. It was suggested that the Retreat start at 12:00pm instead of 2:00pm and end at 6:00pm on the first day and some structural changes were made. The Task Force also decided to have the Retreat in Sacramento. A Clinic Emergency Preparedness Retreat Planning call will be scheduled prior to the July 2006 Task Force meeting to finalize the agenda and start the planning effort.

DHS Pandemic Influenza Report

Alternate Care Site Workgroup Report

Nora attended the March Alternate Care Site Workgroup meeting and the main focus of the discussion was looking at different types of health care facilities and alternate care sites, such as school gyms, shelters, evacuation centers, etc., and identifying the level of care needed by each patient and what type of facility would be best suited to provide that care. The main point made by Nora and other members of the Work Group was that it is not enough to designate health centers and clinics as Alternate Care Sites, they would also need funds, resources, training, etc. to really be able to fulfill that role. The Workgroup will prepare report recommendations (best practices guide, worklists, and decision trees) to the DHS Joint Advisory Committee on Public Health Preparedness for approval.

Assembly Budget Committee Hearing on Pandemic Influenza

The Assembly Budget Committee had a hearing in regard to the Federal Pandemic Influenza Plan. June testified on behalf of CPCA insuring that clinics would be at the planning table and able to secure resources. This was joint hearing with the Assembly Health Committee. Assemblyman De La Torre has actually read the plan and asked many relevant questions during the hearing. Coca's testimony was based on comments submitted to DHS on the Pandemic Influenza Plan.

HHS California and Los Angeles Pandemic Influenza Summit

June attended the HHS Pandemic Influenza Summit and gave a brief description on the events that occurred. She will make a packet of the materials that were given out available for distribution. There were about 1500 attendees, including Governor Schwarzenegger and Secretary Leavitt, who both presented. The majority of discussions were in regards to Pandemic Influenza Readiness Plans for all types of situations.

CDC Pandemic Influenza Planning Guidance

The \$100 million CDC Pandemic Influenza Planning funds Guidance was released and the money must be spent by DHS by August 31, 2006 by the California Department of Health Services and the local health departments. The some portion of next round of \$250 Million for Pandemic Flu planning could be going to clinics. Once the guidance is released, CPCA will analyze the guidance to develop an advocacy strategy on how to secure some of the funds for clinics.

Statewide Disaster Exercise Plan Committee Report

Linda Kehoe gave an update on the Statewide Disaster Exercise Plan Committee. They have met twice since the last Task Force meeting. The committee has recommended that both of the next statewide exercises be done on the same day in November as the Golden Guardian drill to avoid confusion and encourage more participation. They have also requested someone from the Public Health and Environmental Health departments, as well as, a Medical and Health Liaison from the Emergency Operation Centers to participate on this committee.

The committee is also using the JACHO Standard Environment of Care for Ambulatory Health Care Facilities as a checklist for developing EOP's so that the objectives for the statewide exercises coincide with the JACHO Standard Environment of Care.

Action Item:

- Nora to email the Task Force last year's guidebook and the Clinic After-Action Report form
- Task Force to review and submit input via email back to Nora
- Nora to add to July agenda for discussion

Bureau of Primary Health Care Public Information Notice re: Health Center Emergency Preparedness Expectations

Nora reviewed the Bureau expectations of FQHC's regarding emergency preparedness that will be released in a new PIN in June 2006. The PIN will not provide any new funding to meet any new expectations. A resource document is being developed to provide guidance on how to

create EOP's, developing local relationships with local health departments and hospitals. Nora was given the opportunity to give feedback on this document before it is released.

On the National level, Nora has been working on developing specific language designating health centers to get a portion of the funds in the HRSA National Bioterrorism Hospital Preparedness Planning Grant Guidance. PCA members and members of NACHC will be meeting with Commander Melissa Sanders of the HRSA National Bioterrorism Hospital Preparedness Planning Program to provide guidance specifically on what PCA's and NACHC would like to see as far as securing resources for Health Centers and PCA's.

Hurricane Katrina

Kathryn Hall from The Birthing Project gave a personal account on the aftermath of Hurricane Katrina from a trip she recently made to New Orleans. She brought up various issues and problems being experienced in the affected areas, such as: devastation of buildings, including hospitals, schools, homes, clinics; work force and client populations diminished due to lack of transportation and personal matters, such as locating family members, alcoholism, depression; grant funds are being recalled; total breakdown of infrastructure, such as plumbing, electricity and roads; and other difficult issues. Kathryn's moving presentation gave gravity to the emergency preparedness efforts of CA clinics.

Adjourn

The Task Force meeting adjourned at 3:01pm.



Health Care Access for All

CPCA Clinic Emergency Preparedness Budget Request

In light of the Governor's strong financial commitment to emergency preparedness planning, coupled with the restructuring of the Health Resources and Services Administration's (HRSA) National Bioterrorism Hospital Preparedness Program (NBHPP) grant, which places a greater focus on emergency planning, the California Primary Care Association (CPCA) is requesting funds to enhance our own emergency preparedness and response capacity. CPCA represents over 630 non-profit community clinics and health centers (CCHCs) which provide primary and preventative health services to 3.4 million low-income, ethnically diverse patients- of which nearly half have limited English proficiency. Overall, CPCA is seeking to increase our own organization's preparedness capabilities so that we can better assist the CCHCs as well as our local, state, and federal partners in time of emergency.

CPCA is requesting the following budget items from the California Department of Health Services:

Statewide Emergency Preparedness Communications and Tele-Medicine Infrastructure

CPCA is a statewide organization linking community clinics/health centers throughout the state. CPCA is in a unique position to coordinate and serve as the statewide communication hub for CCHCs in case of an emergency. Not only would CPCA link the CCHC community, CPCA would link to other state and federal organizations. To facilitate this role, CPCA is proposing to advance a statewide tele-medicine and video conferencing infrastructure with Regional Consortia serving as disaster resource centers and alternative tele-medicine sites. Also, CPCA plans to coordinate CCHC drills and exercises to test the CCHCs' Emergency Operations Plans and develop stronger ties with their disaster planning partners. Our counterparts involved in the Hurricane Katrina-affected states sought support from CCHCs in non-affected areas for disaster response and the state Primary Care Associations responded by serving as information centers. CPCA will explore using technology for developing a statewide emergency preparedness communication system utilizing the Regional Consortia as points of access that would allow CCHCs throughout the state to support their colleagues when a disaster strikes.

Communications Equipment - \$10,000

In order to increase CPCA's internal emergency preparedness capacity, we are requesting equipment that would allow CPCA to better communicate with our members, colleagues, and local, state, and federal authorities in times of emergency. Currently, due to our limited redundant communications capacity, CPCA is requesting three satellite phones and four walkie-talkies. CPCA is also requesting three additional computers to assist CPCA with our overall technological infrastructure.

CPCA Video Conference Equipment - \$100,000

This budget request is for CPCA to advance the tele-medicine and videoconferencing capabilities throughout the CCHC network. This technology would be used for the provision of tele-medicine, which will be crucial in a disease outbreak. That capacity would be useful especially during a pandemic influenza outbreak for those CCHCs that because they could serve patients without physical contact therefore preventing the risk of influenza transmission to the provider. Also, when a local or regional disaster occurs and local health care systems are overwhelmed alternative medical sites can be set up to provide tele-medicine services. Also, this technology would be used for meetings, trainings and planning as well as for communication and statewide collaboration during a disaster. In this role, CPCA needs video conferencing ability as well as the ability to be the “bridge” to other videoconferencing sites. CPCA would be the hub site along the existing hubs of the Northern Sierra Rural Health Network (NSRHN) in Nevada County, and the Council of Community Clinics (CCC) in San Diego. The Community Clinic Association of Los Angeles County (CCALAC) has secured funding from their HRSA emergency preparedness grant to create a videoconferencing network for the clinics in their county. The video conference network of these four hubs would add to CPCA videoconference redundancy in case of disaster. CPCA would also ask NSRHN and CCC to serve as mentors as we develop the statewide communications network. CPCA requests the telephone connection charges needed for CPCA to make the connection via the video conference equipment. CPCA would work in partnership with the California Telemedicine and eHealth Center on the statewide analysis needed to determine CCHCs that have telemedicine capacity.

Emergency Preparedness Training and Planning - \$150,000

Currently, CPCA is working to identify the strengths and gaps in CCHC emergency preparedness planning via our Status Report which will be developed in fall 2006. One of the expected gaps that will be identified will be training needs of CCHCs. Once the specific training needs are clearly determined, CPCA will research, develop, pilot, evaluate, and disseminate additional training curriculum and tools. Given provider shortages in many areas of the state, one of the major issues for CCHC staff is access to training and their limited ability to physically leave the CCHC and attend a training. The equipment purchased to develop the emergency preparedness communication infrastructure, noted above, will also serve as a modality for providing virtual training. CPCA is looking to develop a comprehensive “Distance Learning Institute” focused on emergency preparedness planning. This would involve developing a comprehensive training and technical assistance curriculum and developing technology-based tools to disseminate the training materials. The distance learning options would include, but not be limited to: downloadable web casts, audio clips (including pod casts), video conferencing programs, etc.

Another key to enhancing CCHC’s emergency preparedness capacity would be to increase the ability of CPCA, the regional clinic consortia, and CCHCs to increase planning efforts with disaster planning partners at the state, regional, and local levels. Efforts will include the development of a pandemic influenza plan that assesses and enhances the capacity of CCHCs to serve as alternate care sites. With the increased focus on alternate care sites and surge capacity planning in the HRSA NBHPP grant, as well as the Governor’s budget, CCHCs who will serve

as alternative care sites will require the training, supplies and equipment necessary to serving patients. As part of the planning effort, CPCA will provide input on the alternate care site selection criteria to ensure that CCHCs are considered as providers in that capacity.

CPCA Staff - \$130,000

This budget item would cover the partial staff salaries of the Senior Regional Advocate, a information technology coordinator to assist with our additional technological needs, and an administrative assistant. In addition, this budget item would cover the entire salary of an Emergency Preparedness Coordinator who would be responsible for coordinating training, drills and exercises, and pandemic influenza planning.

Clinic Emergency Preparedness Task Force Meetings and Annual Retreat - \$55,000

This budget item would allow CPCA to move from a quarterly to a bi-monthly Clinic Emergency Preparedness Task Force meeting schedule. In addition, CPCA would be able to fully fund the Clinic Emergency Preparedness Task Force Annual Retreat which would offer an additional opportunity for a CCHCs to attend emergency preparedness training. This budget item would also allow CPCA staff and/or members to travel to the Clinic Emergency Preparedness Task Force meetings and emergency preparedness trainings and conferences to increase our overall knowledge base and planning efforts. In addition, this budget item would cover the costs for the conference calls and materials for the Clinic Emergency Preparedness Task Force and Retreat Planning Committee.

Consultants - \$25,000

This budget item would allow CPCA to complete grant deliverables without expending additional staff time and resources. Consultant projects may include assistance with the best practices publication, facilitation for the Clinic Emergency Preparedness Task Force Retreat, and assistance with other emergency preparedness planning efforts.

Clinic Emergency Preparedness Best Practices Publication - \$10,000

CPCA seeks to share our clinic emergency preparedness best practices with the disaster planning community. This budget item would cover the costs of editing, printing, and disseminating the best practices publication.

Website/Help Desk Maintenance - \$10,000

This budget item would cover the costs of updating CPCA's website and Clinic Emergency Preparedness Help Desk library. CPCA is requesting the following funds for the regional clinic consortia for emergency preparedness planning efforts from the California Department of Health Services:

Regional Clinic Consortia Clinic Emergency Preparedness Expansion Project – \$40,000 x 13 = \$520,000

This budget item of \$40,000 for each regional clinic consortia would build on the previous work of the Clinic Emergency Preparedness Expansion Project. CPCA would add deliverables for the project to incorporate new HRSA grant deliverables such as pandemic influenza planning, development of hospital Memorandums of Understanding (MOU) agreements with alternate care

sites, Emergency Operations Plan customization, and National Incident Management System (NIMS) compliance process.

CPCA Clinic Emergency Preparedness Budget Request Summary

Budget item	Amount
Statewide Emergency Preparedness Communications Infrastructure <ul style="list-style-type: none"> ▪ CPCA Equipment ▪ CPCA Video Conference Equipment ▪ Regional Clinic Consortia Video Conference Equipment ▪ Telephone connection for Video Conference Equipment 	\$110,000
Emergency Preparedness Training and Planning <ul style="list-style-type: none"> ▪ Drills and Exercises ▪ Pandemic Influenza Planning ▪ Alternate Care Site Selection 	\$150,000
CPCA Staff Salaries <ul style="list-style-type: none"> ▪ Emergency Preparedness Coordinator - 100% ▪ Senior Regional Advocate - 50% ▪ Information Technology Coordinator - 25% ▪ Administrative Assistant - 25% 	\$130,000
CEPTF Bi-monthly meetings & Annual Retreat	\$55,000
Consultants	\$25,000
Best Practice Publication	\$10,000
Website/Help Desk Maintenance	\$10,000
Overhead -18%	\$-+
	3+++ +-83,700
Clinic Emergency Preparedness Expansion Project - Regional clinic consortia planning and technical assistance funding	\$40,000 x 13 = \$520,000
Total	\$1,093,700

DRAFT



**JOINT HRSA/CDC ADVISORY COMMITTEE (JAC)
SUBCOMMITTEE ON ALTERNATE CARE SITES (ACS)**

May 9, 2006 / 10:30 am – 3:30 pm

Present: E. Anderson, L. Angell, D. Boyd, M. Codeglia, S. Goldmacher, A. Loveless, E. Moyer, N. O'Brien, R. Richter, D. Stratman, J. Tritten.

AGENDA ITEM	DISCUSSION						
Accept Agenda/Minutes	<ul style="list-style-type: none"> D. Boyd presented agenda overview and meeting goals. Previous meeting minutes accepted. 						
Review of Conceptual Algorithm for Triage	<ul style="list-style-type: none"> Group reviewed ACS triage algorithm drafted at last meeting with the Neighborhood ACS (NACS) document which was developed to complement SEMS. Similar in concept to the mass. prophylaxis model. Use of the ESI (Emergency Severity Index) was suggested as a well-known 'concept' to assist with routing patients to available ACS. Influenza (or suspected) patients could be triaged with similarly developed support criteria (? ISI – influenza severity index). 						
Site Selection	<ul style="list-style-type: none"> Discussion of funding model for development of the neighborhood ACS. Who would fund these? L. Angell reported that a disaster medical services facility activated through SEMS can get reimbursement from FEMA. S. Goldmacher reported meeting with C. Starling and managed care reps. to address multiple topics including funding stream. Group discussion led to how supplies would be acquired and stored before ACS activation. J. Tritten reminded basic supplies similar - differ depending on level of care provided. NACS manage level 3, 4 and 5 patients. One to 20 ratios with no ventilator patients. Reviewed revised Cantrell site selection matrix documents. Discussion some local area planners suggest each hospital develop 6 potential ACS – then narrow down to 3 most suitable. Then develop MOUs with these. Seems 25,000 SF a minimum. N. O'Brien suggested development link with clinic EOPs. Schools seem to frequently rank near the top as optimal ACS. 						
Site Activation/Deactivation	<ul style="list-style-type: none"> Group reviewed realistic timeline for opening a developed ACS. Agreed 48 hours too fast – 72 hours more realistic. Discussion as to what incentives would foster clinic participation as expanded ACS. Some thought a model similar to FQHC funding might be developed for clinics to commit to active role in the local disaster plan (based on improved reimbursement structure). A. Loveless reminded HRSA grant will require MOUs to receive funding – require HVA. Further discussion about challenges of sustained response with ACS (recent LA experience). Discussion that closure of ACS may be triggered by: increased hospital capacity, increased ease of placement to higher LOC from ACS, lack of specific supplies/personnel. 						
Triggers	<ul style="list-style-type: none"> Group reviewed indicators of increased census: total % of admissions, increased inpatient LOS, # of ED patients admitted, ED/Clinic influenza-related visits, LHD surveillance. In general, # of casualties exceeds # of treatment spaces or equipment available and relief is more than 24-48 hours away. Discussed using existing hospital communication systems (i.e., ReddiNet, EM Systems). Triggers should be agreed upon at the local level with State oversight. Brief discussion on logistics for opening ACS. Local PHO should designate ACS and work with the local EOC coordinator and city/county OES on activation. Need local law enforcement partnership. D.Boyd to forward recent articles on ED-based scoring tools developed for more objective capacity/capability measurement (i.e., EDWIN score). Group agreed there would be value in use of similar measurement tools across the State. 						
'Unfinished' Issues/Summary	<ul style="list-style-type: none"> Discussion on issues requiring attention. Need clarity from PHO perspective on site selection for ACS. How is this being organized & coordinated Statewide with CA DHS leadership? What model for coordination we should be using? Align with SEMS. Locally activated, regionally supported. Link with key community resources (Red Cross, CalMets, etc.). 						
Next Meeting	July 13, 2006, 10:30 a.m. to 3:30 p.m., Sacramento, location TBD. Topics: ACS Staffing/Security						
Action Items:	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:60%;"></th> <th style="width:20%;">Target Date</th> <th style="width:20%;">Who?</th> </tr> </thead> <tbody> <tr> <td>Present group progress report to JAC</td> <td>06/14/06</td> <td>TBA</td> </tr> </tbody> </table>		Target Date	Who?	Present group progress report to JAC	06/14/06	TBA
	Target Date	Who?					
Present group progress report to JAC	06/14/06	TBA					
Present group progress report to JAC	06/14/06	TBA					

Site Evaluation Tool

County/City:	Evaluators:
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	Facility:		A		B		C
Factors:	Rating:	Comments:		Rating:	Comments:		Rating:
Ability to lock down facility							
Adequate building security personnel							
Adequate lighting							
Air conditioning							
Heat							
Water							
Electrical power backup							
Communications (phones)							
Two-way radio capability							
Wired for Internet Access							
Equipment storage area							
Loading dock							
Ambulance Access							
Biohazard & other waste disposal							
Door sizes/accessibility							
Floors & Walls							
Patient Decontamination area							
Patient Showers							
Staff Showers/locker area(s)							
Lab specimen handling area							
Pharmacy area(s) incl. Refrigeration capability							
Food supply/prep/delivery							
Temporary Morgue area							
Family Area							
Proximity to Hospital							
Laundry Facilities							
Staff Parking							
Patient/Visitor Parking							
Office Space							
Adequate space for 50 bed pods							
Oxygen delivery capability							
Total Rating:							

Like a hospital	Not like a hospital
5 4 3 2 1	0

Site Evaluation Tool



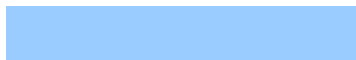
Comments:



Site Evaluation Tool



Comments:



(County)

MEMORANDUM OF UNDERSTANDING (MOU) FOR USE OF FACILITIES
IN THE EVENT OF A MASS MEDICAL EMERGENCY

(County), and (name of facility) agree that:

In the event of a mass medical emergency in the State of California, local and state health and medical infrastructure and associated resources will be quickly committed to providing the necessary treatment and/or prophylaxis to effectively respond. Resources from the state, federal, and private sector will be mobilized and deployed to augment local medical and health resources as soon as possible. Such an event may require a facility to support the activation of an Alternate Care Site (ACS). The ACS will serve as a site where supportive care can be provided to victims of a large-scale mass casualty or bio-event.

Deleted: Whereas, Section (?) of the Michigan Public Health Code (?) allows MDCH to enter into agreements with other government entities, the private sector, and non-profit entities to ensure an expedient, effective, coordinated response to any natural or man-made disaster; and

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(County) and (name of facility) enter into this partnership as follows:

1. **Facility Space:** (County) ACSepts designation of (name of facility) located at (address of facility) as an Alternate Care Site (ACS), in the event the need arises.

2. **Use of the Facility:** Request to use facility as an ACS will occur as soon as possible through the local Emergency Operations Center. Designation and use of (name of facility) will be mutually agreed upon by all parties to this agreement.

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3. **Modification or Suspension of Normal Facility Business Activities:** (name of facility) agrees to alter or suspend normal operations in support of the ACS as needed.

4. **Use of Facility Resources:** (name of facility) agrees to authorize the use of facility equipment such as forklifts, buildings, communications equipment, computers, Internet services, copying equipment, fax machines, etc. Facility resources and associated systems will only be used with facility management authorization and oversight to include appropriate orientation/training as needed.

5. **Costs:** All reasonable and eligible costs associated with the emergency and the operation of the ACS that include modifications or damages to the facility structure, equipment and associated systems directly related to their use in support of the ACS facility operations will be submitted for consideration and reimbursement through established disaster assistance programs.

6. **Liability:** Emergency Management Public Act 390, as amended (part 30.4 | 1, Sec. 11 (2), (6), addresses immunity from liability for services rendered voluntarily and without compensation in support of emergency operations during an emergency or disaster declared by the Governor.

Comment [JST1]: Need to ensure reflects CA statute

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7. **Contact Information:** (name of facility) will provide (County) the appropriate facility 24 hour/7 day contact information, and update this information as necessary.

8. **Duration of Agreement:** The minimum term of this MOU is two years from the date of the initial agreement. Subsequent terms may be longer with the concurrence of all parties.

9. **Agreement Review:** A review will be initiated by (County) and conducted following a disaster event or within two years after the effective date of this agreement. At that time, this agreement may be negotiated for renewal. Any changes at the facility that could impact the execution of this agreement will be conveyed to the identified primary contacts or their designees of this agreement as soon as possible. All significant communications between the Parties shall be made through the primary contacts or their designees.

10. **Amendments:** This agreement may be amended at any time by signature approval of the parties' signatories or their respective designees.

11. **Termination of Agreement:** Any Party may withdraw at any time from this MOU, except as stipulated above, by transmitting a signed statement to that effect to the other Parties. This MOU and the partnership created thereby will be considered terminated thirty (30) days from the date the non-withdrawing Party receives the notice of withdrawal from the withdrawing Party.

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HRSA National Bioterrorism Hospital Preparedness Program (NBHPP) FY06 -07 Grant Guidance Overview

Emergency Preparedness Funding Background

In response to September 11th and the anthrax attacks of 2001, Congress recognized the need to improve the disaster preparedness of the health care and public health systems throughout the country. The U.S. Department of Health and Human Services created two key funding mechanisms under the Office of Public Health Preparedness for state and local bioterrorism preparedness. First, the Centers for Disease Control funding (CDC) was allocated to improve public health preparedness. Second, the Health Resource and Services Administration (HRSA) funding, the National Bioterrorism Hospital Preparedness Program (NBHPP), for a) developing and implementing regional plans to improve the capacity of the health care system, including hospitals, emergency departments, outpatient facilities (specifically community health centers), emergency medical services (EMS) systems, and poison control centers; and b) responding to incidents requiring mass immunization, isolation, decontamination, diagnosis and treatment in the aftermath of terrorism or other public health emergencies. Since Fiscal Year (FY) 2002, Congress has appropriated \$3.5 billion to the CDC to fund local and state public health preparedness and \$1.6 billion to HRSA for health care system preparedness throughout the country.

HRSA Funding Focus FY 2002- 05

The focus of the HRSA NBHPP grant since its inception has been to largely provide medical supplies, pharmaceutical caches, equipment such as decontamination units, generators, communications such as satellite phones and radios, and Personal Protective Equipment (PPE) to health care facilities such as hospitals and community clinics and health centers (CCHCs) to enhance their preparedness and response capacity. During this time period, HRSA requirements concentrated on critical benchmarks that asked states to meet minimal levels of readiness in ten key areas that included medical surge capacity, surveillance, trauma and burn capacity, and communications.

Hurricane Katrina's Impact on HRSA NBHPP FY 06 Grant Guidance

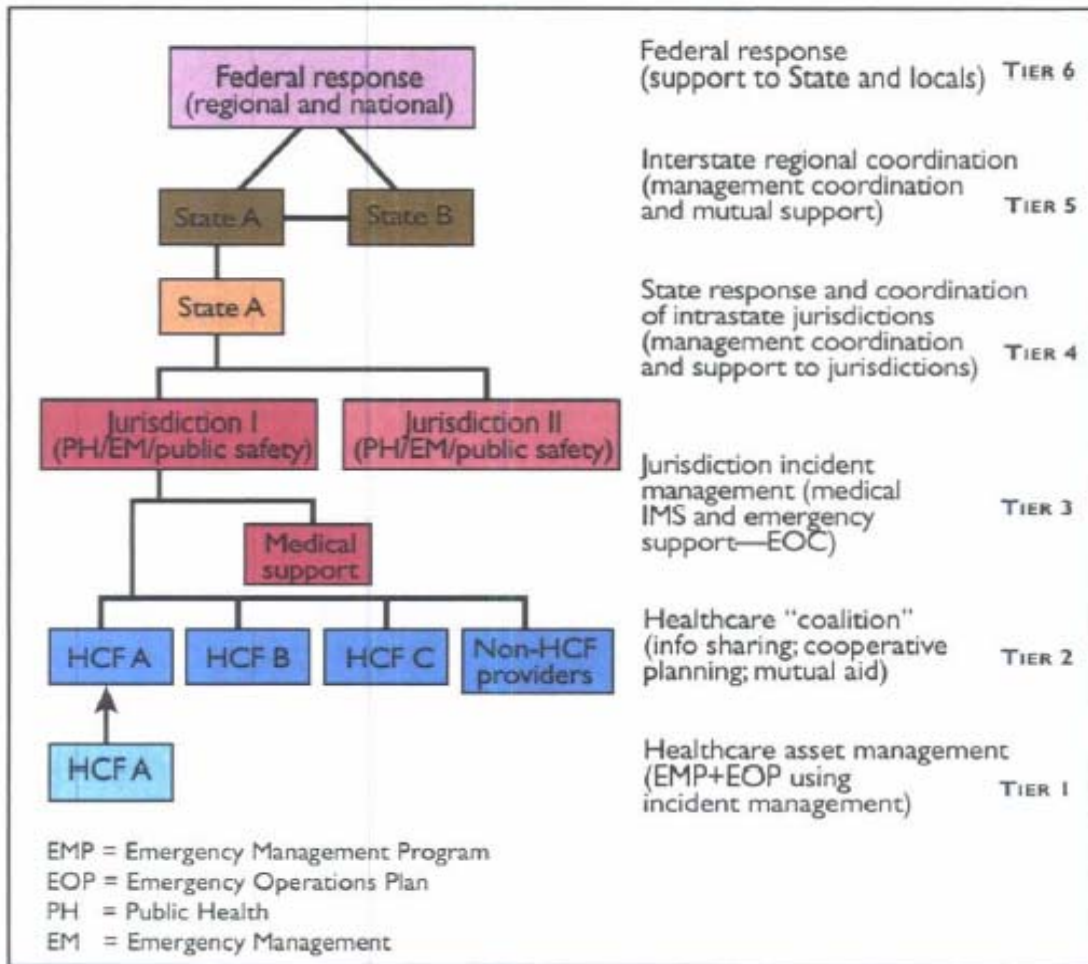
When Hurricane Katrina hit the Gulf Coast states in August 2005, the national response plan was severely challenged because the key focus of the previous HRSA NBHPP grant was to purchase stuff rather than focused on training and planning of health care facilities and public health departments. Those facilities, like many CCHCs that were not integrated in the local and state response plans, were ill-equipped to serve the large influx of patients because the lack of resources and they were not seen as a viable medical assets. The result of the Hurricane Katrina response fiasco is that HRSA completely restructured the FY 06- 07 grant guidance to concentrate on planning, training, vertical and horizontal response integration, and data collection.

HRSA NBHPP FY 06 Grant Guidance Overview

The main change of the HRSA NBHPP is the new focus on Tiered Response Systems. Each state must identify each health care facility including CCHCs that can provide medical response in a disaster. Please also see Figure 1-2 below that outlines the Medical Surge Capacity and Capability (MSCC) Management Organizational Strategy. Description of the Tiers includes:

- *Tier 1:* Management of Individual Medical Assets which include CCHCs
- *Tier 2:* Management of Healthcare Coalitions which organizes individual healthcare assets into a single functional response unit. The coalition can “include hospitals, rural healthcare facilities, private physician offices, clinics, health centers and any other health or medical asset that can be brought to bear during a major medical response”. California Department of Health Services has recognized the regional clinic consortia can also serve as a “health care coalition”.
- *Tier 3:* Jurisdictional Incident Management
- *Tier 4:* Management of State Response and Coordination of Intrastate Jurisdictions
- *Tier 5:* Interstate Regional Management Coordination
- *Tier 6:* Federal Response

Figure I-2. MSCC Management Organization Strategy



Another important change to the HRSA NBHPP Grant Guidance is the concentration on capabilities- based planning that seeks to identify the preparedness strengths and gaps in order to prioritize each state’s preparedness goals and objectives. There are five elements of capabilities that each state must address in their application. They include:

- *Personnel*: Identifying medical personnel to join the volunteer disaster registry system. It is called the Emergency System for the Advanced Registration of Volunteer Health Professional (ESAR-VHP) which is a system that credential providers prior to an event so that they can be deployed in a disaster. CCHC medical personnel will be asked to join the California ESAR-VHP registry.
- *Planning*: Designation of alternate care sites to provide the medical surge capacity. For pandemic influenza planning, states must identify health care facilities that serve patients outside the hospital. CCHCs along with long-term care facilities and nursing homes are identified as potential alternate care sites. In addition, the guidance highlights the role of mobile medical facilities. The February 2006 CCHC Surge Capacity Survey results indicated that there were 92 mobile medical and/or dental vans that can be deployed for medical response.
- *Equipment and Systems*: HRSA will require each state to develop a bed tracking system that would allow for the determining the bed availability of hospitals during a disaster. The grant guidance also will require states to have interoperable communication systems that link “hospitals, emergency medical service agencies, and other health care entities with public health and other first response partners”.
- *Competency-Based Training*: The HRSA NBHPP requirement is that the training that is developed must be based upon the expected functions during an emergency. Examples of training activities that may be used for competency-based training include “oral presentations, distance/online learning or other forms of asynchronous learning”.
- *Exercises and Drills*: The HRSA grant guidance asks each state to indicate “how many hospitals, rural health facilities, health centers, etc will participate in the state, local, and/or regional drills and exercises”. The more that CCHCs participate in drills and exercises, the more likely that they will be included in the response plans.

Overall, the HRSA NBHPP FY06 -07 Grant Guidance does a better job than previous years of identifying CCHCs as emergency responders. CCHCs can serve in those roles if they are included in the local planning process as well as given the resources to effectively respond.

Consortia Survey

Consortia Name _____

County/Counties _____

1. Number of clinic corporations represented by your consortia.

2. The number of clinic sites represented by your consortia

3. The number of medical/dental mobile vans in your consortia clinics

Medical _____

Dental _____

4. Do you have a disaster preparedness work group?

_____ Yes _____ No

5. If you answered yes to question 4, Please answer the following 6 questions

a. How often does it meet _____

b. How long has the committee been established? _____

c. Who by position leads the meeting? _____

**d. What level of person represents the member clinics
(Indicate type of positions)**

e. How many clinic corporations are represented on the committee? _____

f. What agenda topics predominate your meetings?

g. Other comments

6. If you answered no to question 4, how do you accomplish your activities?

7. What are your goals for your disaster preparedness work?

8. What percentage of your clinic corporations are actively engaged in the following activities?

- _____ attending DP consortia meetings
- _____ updating EOP
- _____ conducting trainings
- _____ attending trainings
- _____ conducting non-fire drill drills and exercise
- _____ has a cache of medical surgical supplies
- _____ has a cache of non-medical/surgical supplies
- _____ has a cache of pharmaceutical supplies
- _____ completed a hazard vulnerability assessment
- _____ completed CERT trainings (please indicate the total number of people at a total number of clinics)
- _____ completed on-line NIMS training 100, 200 or 700
- _____ other activities (please specify) _____
- _____ other activities (please specify) _____

9. Has your consortia identified a standard medical surgical supply cache list? ___yes, ___no If yes, Please attach

10. Has your consortia identified a standard non- medical surgical supply cache list? ___yes, ___no if yes, please attach

11. Has your consortia identified a standard pharmaceutical cache list? ___yes, ___no If yes, please attach

12. What supplies/equipment has been purchased/distributed by your clinics using disaster preparedness funding.? Please provide numbers. Needs to be better formatted and I cannot seem to do it.

- medical surgical supplies
- _____ surge tents
- computers
- _____ servers
- _____ 800 Mhz radios
- _____ cots
- _____ cell phones
- _____ decontamination units
- _____ PDAs
- _____ generators
- _____ Other _____
- _____ Other _____
- _____ Other _____
- _____ Other _____

14. How has the Clinic Emergency Preparedness Task Force influenced your work in helping your clinics to prepare for emergencies? _____

15. Overall, how would you describe the current preparedness of your clinics that are engaged in Disaster Preparedness activities? Please place a percentage number next to each category.

__ Not prepared __ Somewhat prepared __ Prepared __ Very prepared

16. Do you feel that the percentages you assigned in question 15 is reflective of improvement in disaster preparedness since you began working with the clinics?

_____ yes _____ no

Clinic Emergency Preparedness Task Force Retreat Agenda
 October 25 and 26th
 Sacramento

Time	Topic/Event	Potential Speaker
12:00 -1:00	Lunch Welcome and Introductions Ice Breaker Next steps built into all topics	June Levine
1:00– 1:15	History of CEP Task Force	June Levine
1:15- 1:30	Strategic Planning Process Overview	June Levine/Nora O’Brien
1:30- 2:30	The role of consortia/clinics/CPCA in emergency preparedness	Task Force discussion
2:30 – 2:45	Break	All
2:45- 3:45	Report of consortia survey	Task Force discussion
3:45 –5:00	Develop Strategic Priorities- small groups then report out- give us what they wrote Next steps	Task Force discussion
5:00	Debrief and Adjourn	All
6:00pm- 8:30pm	Networking dinner	All

Wednesday, October 26th

Time	Topic/Event	Speaker
8-8:30	Breakfast	All
8:30 – 10:00	Communication- brainstorming EOP update- breakout or whole committee	Task Force discussion
10:00 – 10:15	Break	
10:15 – 12:00	EOP update Including pandemic influenza template	Task Force discussion
12:00 – 1:00	Lunch	
1:00- 2:30	Drill – earthquake Tabletop exercise – Train the trainer format	Cheryl Starling
2:30- 3:00pm	Debrief, Next Steps, and Adjourn	Task Force discussion

CEPTF Retreat Planning Conference Call Meeting Minutes
May 30, 2006
10:00-11:30am

Participants: June Levine- Chair, Adrienne Bowes, Susan Huffman, Maeve Sullivan, Paulette Carpenter, Judy Silva

Staff: Nora O'Brien and Christina Foncree

Welcome and Introductions

June opened the call by welcoming the participants and asking them to introduce themselves.

Review of Consortia Survey

June explained that the purpose of the survey is to give an overview of the work being done by Consortia in Emergency Preparedness. The group reviewed each question and provided feedback. June and Nora will make changes to the survey based on responses, redistribute and request comments back from the Task Force before the July Meeting. The data collection period will be between July and August 2006.

Review of Draft Agenda

June went over the draft agenda and asked for feedback on subject matter and timing issues. Nora will make changes to the agenda to be presented at the July CEP TF meeting for input from the larger group.

Adjourn

The call was adjourned at 11:30am.

May 22, 2006

Clinic Objectives

2006 Medical & Health Statewide Exercise Planning Committee

Linda Kehoe, cal-PEN Coordinator; California Preparedness Education Network

Objective I:

Identify clinic personnel responsible for establishing communication with external medical emergency contacts and communication the facility's response capability for managing a surge of walking wounded and worried well patients to the Medical and Health Officer Area Coordinator, County Medical Operations Center, or Incident Commander from parent facility utilizing appropriate communication systems.

Objective II:

Identify clinic personnel responsible for activating the clinic emergency operations plan and assess clinic status including staff availability, approximate surge numbers, resources, and overall facility functionality.

Objective III:

Determine the appropriate course of action based on your facility's status and recommendations from the MHOAC, Medical Operations Center, or parent facility incident commander, and discuss the basic actions your clinic will take upon activation of the facility's emergency operations plan utilizing an incident based command system (See glossary for SEMS and Incident Command System).

Objective IV:

Communicate the appropriate course of action to the clinic section chiefs or department leaders.

Objective V:

Coordinate response efforts with local city public works, police, fire, ambulance, HAM, and emergency response teams as available (e.g. MRC, CERT, and DMAT).

Objective VI:

Assess the facility's response capability for managing a surge of walking wounded and worried well patients and communicate that capability to the MHOAC, Medical Operations Center or parent facility incident commander.

Objective VII:

Conduct an after action briefing and identify gaps and weaknesses in emergency operations plan. Establish revised policy and procedures for addressing those gaps.



CALL FOR PRESENTATIONS

**February 19 – 23rd, 2007
Hilton Washington
Washington, DC**

PROPOSALS DUE AUGUST 31st, 2006

The 2007 Summit Planning Committee is currently accepting proposals for the upcoming 2007 Public Health Preparedness Summit to be held February 19th through 23rd in Washington, DC. The 2006 Summit attracted over 1500 public health preparedness professionals from local, state, and Federal health agencies, public health associations, academic institutions, and corporations. The 2007 Summit is expected to be even larger, involving public health professionals from across the country and around the world.

Presenters are asked to share material that will provide Summit participants with public health preparedness strategies and solutions, including both “lessons learned” and “things to avoid” from a local, state, and/or Federal public health perspective. All presentations are required to adopt an interactive, participatory format to engage session participants in the material presented.

Presenters are asked to select a preferred session type, a programmatic topic or “track,” and indicate if the material to be presented is “basic/introductory” or “advanced.” Presentations that are accepted will be asked to prepare learning objectives in accordance with the standards set by national CEU administering organizations. All details and further information are available at the 2007 Summit website www.phprep.org, including contact information if you have a specific question. Please complete the submission form on-line at:

www.phprep.org/present