Region 6  
FY 2013-2014 HHS Round 2 Meeting Minutes  
CHRISTUS St. Frances Cabrini, Alexandria  
April 9, 2014  
11:30 A.M. to 2:00 P.M.

**Hospitals:** 12 of 26 hospitals (46%) attended.
- Avoyelles Hospital, Mike Johnson
- Bayne Jones Army Community Hospital; Sharaell Treloar
- Bunkie General; Terry Riche
- Byrd Regional Hospital
- Central LA State; Kelly LaCroix
- Central LA Surgical Hospital
- Christus Dubuis Hospital
- Christus St. Frances Cabrini; Mary Tarver, Brenda Bennett
- Compass Behavioral of Alexandria
- Longleaf Hospital (Crossroads Regional Hospital)
- Veteran’s Affairs Medical Center;
- Doctor’s Hospital at Deer Creek;
- Hardtner Medical
- Healthsouth Rehab of Alexandria, Michael Gallagher, Bryon Stansell
- LSU-Huey P. Long
- LaSalle General Hospital: Brenda Smith, Jennifer Mason
- Leesville Rehab Hospital; Jack Causey
- Oceans Behavioral of Alexandria
- Promise Hospital of Miss-Lou
- Rapides Regional Medical Center; Patty Carlock, Chuck Butterfield
- Riverland Medical Center, Maryrose, Billy Rucker, Jeannie Couture, Sam Ellard
- Riverside Hospital of LA
- Specialty of Winnfield
- Tri Parish Rehabilitation Hospital; Paul Boisseree
- Winn Parish Medical Center; Todd Teal
- Woodlands Behavioral Center

**EMS:** 4 of 7 EMS Providers (57%) attended.
- Acadian Air Med Services; Jacob Andries, Jeff Pogue
- Acadian Ambulance Services; Jacob Andries, Jeff Pogue, Dustin Ethridge, DRC
- LaSalle Ambulance dba Hardtner Medical
- LaSalle Ambulance dba LaSalle Parish Hospital; Brenda Smith
- Med Express Ambulance Service
- Miss-Lou Ambulance Service, Jim Graves
- Vidalia Fire & Rescue

**Other Partners:** 3 of 3 Partners (100%) attended
- Office of Public Health, Rebecca Beaman, David Holcombe, Patricia White
- GOHSEP; Teresa Boscoe
- LHA Grant Staff; Allyn Whaley-Martin

**Facilitators:**
Brenda Bennett, Region 6 ADRC; Mary Tarver, DRC; Frances Arledge, HHS/LHA; Dustin Ethridge, EMS DRC

**Other Partners:**
Steve Philippe, Deputy Director, BEMS; Wymon Dawson, CCP/OPH

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**Welcome and Introductions**

Brenda Bennett welcomed the group and introduced Frances Arledge and Allyn Whaley-Martin as the newest LHA Grant Staff coordinators. The group was then asked to go around the room and introduce themselves by providing their name, title/role, and home facility/provider.

She then turned the meeting over to Frances Arledge, the hospital and ems grant coordinator for the Hospital Preparedness Program (HPP) for the state of Louisiana.
Grant Management System Phase 2 Training: Documentation Submission for Reimbursement
A twenty-minute demonstration was given of the New Grant Management System Phase 2 training for uploading invoices and supporting documentation. The mandatory requirements for reimbursement were revisited; proof of payments details, survey, grant summary worksheet, and expenditure report. There was a review of the deadlines and emphasis was placed on the importance meeting those deadline dates, including timely submission of the survey. The group was shown where to access the Grant Summary Worksheet, hard copies (PDF format) of the Needs Assessment Survey – hospital and EMS along with the links to the Survey monkey sites for completing the surveys on the LHA website.

Review of Capability Planning Guidelines (CPGs): Shifting from BP2 to BP3
Frances Arledge began with a review of Capability Planning Guidelines by discussing how we are already meeting the CPG’s across the state/regions and at the institutional or provider level by participation in the HPP program and the regional meetings. Introduced the new items and the CPG’s that will be in focus going into the next year. Capabilities two and ten in particular, regional Continuity of Operations Planning and Crisis Standards of Care planning will be the focus moving into the new grant year. Shifting out of the current grant year and into the next grant year, the grant program encourages participants to develop Healthcare Coalitions (HCCs). Therefore, there will be a heavy emphasis on the HCC level planning activities around these and all capabilities.

HCC Development and Strengthening
The BP2 performance measures are on COOP and Med Surge Crisis Standards of Care planning. We currently are getting a baseline to see where our regions/coalitions stand on preparing to develop these plans. A formal definition of HCC according to the Program Measures Manual was shared with the group. ASPR specifically mentions incorporating Behavioral/Mental Health professionals into the coalition and planning activities. This is not only to assist with planning to meet the needs of the mental/behavioral health population that already exists, it’s also a strategy to bring the subject matter experts to the table to help in planning for a response to the needs that will result from a crisis or large scale disaster in which it is anticipated that a demand for mental Health service post event will present itself. This level of coordination is why we open our meetings and encourage EMS, Public Health, and other health organization representatives. In Louisiana, we already have established HCC’s, nine regions across the state and one state level coalition. We will continue to encourage other organizations to join coalitions even if they do not participate in the HPP grant program. Moving into BP3, the objectives of our HCC’s is to 1) Develop HCC level Continuity of Operations Plans, 2) HCC’s and their member institutions adopt a uniform Crisis Standards of Care Plan, and 3) Work toward formal/proper HSEP compliant After Action Reporting.

CPG 2 – Healthcare System Recovery: COOP
The group was provided the formal definition and purpose of COOP according to ASPR and the HPP Measure Manual for BP2. It was mentioned a good starting point for regional COOP development would be to identify the PMEF’s for a Region by including input from institutional level partners. Continuity of Operations planning components were reviewed as a way to show hospitals that they may already have institutional level plans to address some of these components, but they may not call it a “continuity of operations plan”. Med Surge and Crisis Standards of care plans exist at the state level. Regional coalitions must work toward adopting Crisis Standards of Care plans within their regions, using the state plan that already exists. Future meetings may be held to discuss challenges specific to individual regions and ways to incorporate these factors into their planning. These plans should be all encompassing for med surge events. Not only for Pan-flu events but also for sheltering in place, evacuation planning, etc.

HSEP Exercises – After Action Reports
The final area of focus moving into the new grant year was HSEP compliant exercises and drills especially as they pertain to after action reporting (AAR) activities. Applying HSEP principles to exercise/drills and after action reporting for exercises and real events provides us with an idea of how well we are prepared for and can respond to incidents. There are many helpful templates that can be searched on the web. Some of these can be found in the ESF 8 portal and on the LHA website. It’s important for us to identify gaps and lessons learned as we continue to build our plans and provide accurate capabilities for future grant years. HSEP AARs are the most accurate way to collect the critical information we will be looking for in state and regional level reporting. Each individual hospital
may not need to have HSEEP compliant training as much as they will need to know how to capture critical information for sharing as it relates to the HSEEP fundamentals.

**CMS Revised Emergency Preparedness Checklist**

Included in the handouts was a current copy of the CMS Revised Emergency Preparedness Checklist. New or updated items are in red. This checklist is not only for Tier I and II hospitals that participate in the grant, it’s for all healthcare providers including specialty hospitals, LTACs, Nursing Homes, Home health and hospice, etc. In reviewing a lot of the items on the checklist and how it pertains to our expected preparedness activities within facilities, a lot of the activities we work toward in our coalitions and the requirement for participation in the grant program. The last CMS guideline encouraging participation of institutions in healthcare coalition development and planning, reiterates the importance of this activity outside of the HPP grant program requirements. The Joint Commission also has their own guidelines that must be followed by its identified accredited hospitals. A lot of these guidelines and requirements (HPP, CMS, TJC) overlap. Coalition developed and coordinated exercises are encouraged to provide the most realistic depiction of capabilities as regional and institutional plans and responses blend.

**Upcoming Exercises: Hurricane and Chempack**

A state level Hurricane Planning exercise took place the first week of April. The exercise was organized by GOHSEP and the Louisiana National Guard and involved other various key players and ESF’s at the state and local levels. In order for ESF 8 to play an effective role in the exercise and practice operations with real-time data, hospitals were asked to enter bedpoll information into the ESF 8 portal at the beginning of the exercise, April 2. The participation results from across the state were presented. Region 6 had the highest percentage of participation in the bedpoll reporting.

Another exercise is being planned at the state level to test the effectiveness of communications in an incident in which a Chempack must be deployed to hospitals across the region(s). A recap of the basics of a chempack was provided, reviewing its purpose and capabilities in a nerve agent or organophosphate incident. These assets are prepositioned across the state in each of the nine regions, at specific pre-identified hospitals and EMS Providers. These packs are positioned and if a real event warrants activation, the packs can be deployed to hospitals requesting the medications through the formal channels and process. The standard hospital chempack can treat a large quantity of patients (up to 1000) and EMS can treat a large number in the field (around 450). Buffer packs are also positioned at the same sites for use in an event where then number of patients needing the medication may be unknown or smaller. These packs are very expensive and therefore, avoiding moving and opening them if there is only a need to treat a few patients (up to five) for about twelve hours. This buys time to assess the need to deploy the standard size chempack or collect medications from caches at other locations within the region or across the state. Hospitals and EMS providers are reminded that their first contact should be with the Louisiana Poison Center. Wymon Dawson with CCP assisted in providing some of the details of the exercise and the phases. The exercise will be over the span of three days, December 9-11, 2014. It will begin in the CRI Regions and then expand into other regions, one at a time. Injects of specific regional details will be added. As we move further into the planning phases (according to HSEEP MPC, FPC) and developing regional plans, the expectation for play of Hospitals will be shared. The exercise is functional, therefore there will be no movement of physical assets. A spreadsheet with hospital and EMS provider participation (reflecting documented exercises through December 2013) was passed out to show facilities/providers needing to participate in an exercise. Those not listed are strongly encouraged to participate in this exercise to meet the exercise participation requirement for the grant. Everyone is asked to consider participating in the exercise and should contact LHA (Stephanie Hull) or their DRC to get their name on the list. The deadline to decide to participate is May 23, 2014.

**Comprehensive Needs Assessment Survey**

The comprehensive needs assessment survey for both Hospitals and EMS is posted on the LHA website for PDF hard copies. The content of the survey is mostly the same this year. CPG 1, we still would like to capture the details of drills and exercises. Please add additional comments for lessons learned and gaps identified. CPG 2, COOP question on if you have a COOP or any plan that may be similar, or a component of a continuity of operations plan. CPG6, EPI Sharing and CPG 14, Responder Safety and Health are questions framed to gather
information for other Public Health and DHH emergency preparedness partners who may need to collect information for their records. CPG 10, Med Surge uses the same calculation for surge beds. Use last year, 2013 average staffed bed count, to calculate surge numbers. Vents have also been added to the survey again this year.

**Hospital and EMS Site Visits Spring 2014**
Hospital and EMS site visits are coming up in May 2014. About 55 hospitals and 11 EMS providers are going to be visited this year. DRC’s will receive a list of those expecting a visit in April 2014 and will notify upon receipt of that list. This will be the third year of site visits, so those who have not had a visit have a higher likelihood of being visited and should therefore begin to prepare for the possibility. The visit will be more comprehensive and some of the areas being reviewed in addition to the grant purchases will be NIMS compliance, survey responses, compliance with participation agreements, surge plans, pharmaceutical and PPE caches, etc. A DRC from another Region will conduct the site visits again this year.

**Other Announcements**
A brief review of the report released from the American College of Emergency Physicians published in the Advocate was shared with the group. Of the five categories ranking Louisiana, the state was ranked at no. 3 in Disaster Preparedness. Coalition efforts and individual hospital participation are the critical components to keeping this rating high.

**Emergency Medical Services (EMS) Update**
Steve Philippe, Deputy Director of BEMS, provided State Surge Update to the group. New BEMS staff members include the Director, Donnie Woodyard; Deputy Director/EMSCC, Stephen Phillippe; Manager, EMS-Children, Rose Johnson; Manager, EMS Education, Bob Brankline. Rose Johnson comes from a hospital background as an emergency room nurse and is bringing a new set of ideas and approach to BEMS. New DRC’s have been added to all of the regions but there are still gaps in some regions, particularly in Regions 7, 2, and 1. These regions need at least 2-3 DRC’s to fill the gap.

A surge operations overview was provided discussing the primary use of surge units to support community evacuations, augment local 911 responses, support Search and Rescue operations, and during the repatriation of communities and facilities. A full coastal evacuation will still require an estimated need of over 600 surge ambulances. This is a figure that will be adjusted according the scenario and needs specific to individual events. A chart was presented showing the breakdown of the needs summary estimates based on each region, unit type for the event response function activity – Evacuation and Shelter/Triage. Currently, under contracts and agreements, the breakdown of units we have access to is 70% ALS and 30% BLS mix. Under the State Surge Ambulance contract, we have up to 100 ground units with limited aviation assets available. This contract is up for Rebid this month, March 2014. The additional assets we are accounting for in planning will come from EMAC and Federal/AMR Contracts. EMAC can provide 100 units and Federal contract can provide 300-400 units. We also have access to 3,500 to 4,000 Federal Para-transit Seats. The state also has shelter support contracts in place. A chart was shown of the breakdown by regions for shelter support. The support comes from mostly private ambulance providers as well as RSI Inc. BEMS holds as staff augmentation contract with Response Systems Inc (RSI) to provide staff in support of several operations; EMS Tactical Operations Center (TOC), ambulance processing sites, EMS DRC support, and Bus Triage in Baton Rouge on the LSU campus. The continued mission of BEMS and surge operations planning, is to utilize the support of the EMS DRC’s in order to continue to strengthen Regional EMS plans and capacity building, State EMS surge networks and systems, and the Regional EMS CRC and support network.

**RSI Staff Augmentation Contract**
Frances Arledge presented on behalf of RSI, the State Staff Augmentation Contract. She discussed that Medical Special Needs Shelters are a large component of medical surge planning in Louisiana. Opening up these shelters relieves some of the pressure that we would otherwise experience in our community hospitals. The optimal plan has been identified as one that provides contractual support as well as community support. The Primary Gas which have been identified in the MSNS are personnel with key clinical skillsets that are normally provided in the hospital setting including ER, med surge, wound care, trach care, and respiratory care. RSI is a contractual vehicle that has
the ability to bring out-of-state providers in to fill this gap. Additionally RSI provides the opportunity for local providers to obtain paid shifts and compensation for the time worked at the identified Regional MSNS. The purpose of the visit at the Rounds meetings are to get the message of this opportunity out into the field through the local channels of professionals and clinical providers. The Standard Operating Procedure (SOPs) and clinical care guides for the shelter have already been developed. It can be expected that some shelterees may not have any caregivers accompany them to the shelter as advised, or they may have multiple caregivers or family members. Most shelterees are elderly and homebound individuals. The RSI contract provides liability protection and coverage for those employed. Shifts are twelve hours only, and compensation will be according to the twelve hours shift schedule, therefore you must be able to work an entire shift. The type of clinical positions they are looking to fill are physicians, nurse practitioners, registered nurses, licensed practical nurses, respiratory therapists, licensed clinical social workers, EMT’s and paramedics. Two disciplines have the greatest need for Louisiana citizens, Nurse Practitioners because of specific state licensing regulations and LCSW’s who can serve as discharge planners because of their breadth of knowledge and contacts of healthcare systems and networks across the state. All individuals must possess an active, unencumbered license or certification at the appropriate level for the position in which they are filling. There are also non-licensed positions available. This includes nurse aids, clerical/administrative support, and supervisory staff. Nurse aids don’t necessarily have to be licensed as CNA’s, the job can be filled by an EMT or someone who possesses extensive experience caring for the sick. While there is only limited identified need for the clerical and supervisory positions, it is important that those interested in the supervisory position have extensive experience in disaster medical sheltering. If called to work for an event, RSI will covered all expenses. This includes housing/billeting, meals and transportation (direct pay if possible). DHH will require all equipment and supplies, but responders are encouraged to bring their own personal equipment such as stethoscopes. It is expected that employees dress professionally and comfortably as they would for a regular work shift. RSI will provide marked vests to identify contracted workers. All positions are paid and rates will be based on position and experience. Bonus pay may be available for those who can respond quickly and stay extended periods of time. After signing up, pay specifics and salaries can be discussed with RSI leadership. The salaries are per day and in line with disaster response wage averages. There is a four day minimum deployment request, but smaller deployment durations by those responding from within the state will be acceptable. RSI maintains insurance and worker’s compensation policies for all of the contracted staff. In order to join the strike team, you must present an active unencumbered license or certification as appropriate for your specific clinical skillset, pass a background check, and be in reasonably good health. Good health means capable of working 12 hour shifts, standing for long periods of time, assisting with patient movement, and managing personal medications or health without assistance. Additional courses and certification requirement include AHA CPR for Healthcare Professionals and ICS 100, 200, 700, and 800. These can be obtained after the initial application and can be accessed online. The website and contact information was shared to the group and contact cards are available. More materials or discussions can be obtained upon individual request if desired.

**Regional Updates**

Ms. Bennett provided the group an update on the Regional re-allocation of grant funds totaling around $13,000. She noted to the group that approximately $7,000 will go towards the Olla Shelter. If there are any ideas on how to spend the rest or any facility/provider has a need for it, they can reach out to her to discuss.

The group was also provided with a date for the upcoming regional HazMat Training held by Major Wright. Scheduled for May 16, 2014, anyone can attend as long as they bring their own equipment to train and practice with.

**Adjournment**

The meeting ended at 1:30 p.m.