

MCH/CSHCN Director Webcast

February 9, 2006

PETER VAN DYCK: Good afternoon and welcome to the MCH/CSHCN Directors Webcast, coming to you from HRSA Maternal and Child Health Bureau in beautiful downtown Rockville. I'm Peter van Dyck the director of the Maternal and Child Health Bureau. We really have a very interesting program for you today, but before I introduce today's speakers, I'd like to review some technical information about the webcast. In response to your suggestions which we do listen to, the speakers' PowerPoint presentation is available on mchcom.com website, so you can download the slides before the webcast. So please make use of that and save yourself some time.

Slides will appear in the central window and should advance automatically. Slide changes are synchronized with the speakers' presentation. You don't have to do anything to advance the slides. We may need to adjust the timing, however, of the slide changes to match the audio by using the audio control. We encourage you to ask questions at any time during the presentation. Simply type your question in the white message window on the right side of the interface. Select question from speaker, or question for speaker from the drop down menu and hit send. Please include your state or organization in your message so we know where you are participating from. The questions will be relayed on to the speakers at the end of the broadcast.

Because we have a number of speakers today, we'll save the questions for the end.

Please ask questions, as they arise, type them into the queue and we'll answer them at the end of the broadcast. On the left of the interface is the video window, you can adjust the volume using the volume control slider by clicking on the loudspeaker icon. Those of you who selected accessibility features when you registered will see text captioning underneath the video window. At the end of the broadcast, the interface will close automatically and you'll have the opportunity to fill out an online evaluation. Please take a minute or two to do that, because it does help us to plan future broadcasts and it helps us to improve our technical support, as well.

Now, about today's webcast. We'd like to update you on the lessons learned from the national disasters that devastated the gulf coast last fall, particularly as they affect our MCH population. The mchcom.com webcast will use these events as a backdrop for a more general issue of emergency preparedness response. Today speakers will address emergency planning and training and the MCH roles in a disaster. Many state programs and staff participated in a round table and town hall discussions as a part of a partnership meeting last October. And today's speakers were selected to provide the perspective from state programs that faced these recent incidents. Speakers today will address what their states are doing to be better prepared for the next emergency they face and the steps they're taking to ensure that the healthcare needs are being met in the aftermath disaster. We have several speakers today representing different states that had to respond to the emergencies that started last September, including Louisiana, Texas and Florida. We also

had the manager of the HRSA emergency operation center with us today. Beginning our program today will be Jeff Lobas. He is a pediatrician. Jeff, start us off.

JEFF LOBAS: Thank you, Peter. Welcome everyone. The twin natural disasters in September of 2005 have caused us all to focus on this emergency preparedness and response. As Peter mentioned, we discussed this at length at the partners meeting. The purpose of this program is to describe those lessons learned from the perspective of those of you who are most directly affected by the hurricanes that devastated the gulf shore in September. Designing effective solutions to deal with lessons learned from these experiences is critical to saving lives and ensuring well-being of families affected by future disasters. We present these experiences of these states as a starting point to help us all better deal with the public health affects of disasters on family. This webcast will focus on emergency planning and communication and training and the federal and MCH roles in a disaster. Each speaker will address a specific set of lessons. As a matter of format, I will introduce all the speakers first and then the individual speakers will pass the baton to the next speaker at the conclusion of their presentation. At the end of the presentation Dr. Chris DeGraw will introduce and coordinate a question and answer period.

The first of our presenters is Tim Miller, who is the director of HRSA operation center. He has worked in a variety of positions at HRSA since 1980. He was responsible for developing grants for immediate response program that provided \$175 million to help for financial losses attributable to 9-11. Tim will be providing an overview of the HRSA emergency operation center, both before the events of last September and afterwards.

Next, Gina Lagarde, child health medical director of Louisiana maternal and child health program will discuss lessons learned communications during before and after Katrina. She is a certified pediatrician, and has practiced medicine for over 12 years. She was newly appointed to her position right before hurricane Katrina struck. Our next presenters are from the state of Texas. Doctor Fouad Berrahou was named Title V MCH director in 2002 and he holds his Ph.D. in health planning from Texas A & M university. Hurricanes Katrina and Rita were his first disasters to deal with. -- coordinates departmental efforts with the governor's division of emergency management. John's background in hospital disaster planning. Doctor Berrahou and Mr. Huss will discuss workforce and personnel issues for maternal and child health as well as for Children with Special Health Care Needs including the roles of volunteers in disaster preparedness. Finally, we will hear from the state of Florida, a state for many years has had numerous hurricanes and other situations. Annette Phelps is with the Florida Department of Health. She has worked with C.D.C. on rapid needs assessment following recent storms in Florida and is co-author of a publication following hurricane Ivan. She will address the process of emergency preparedness planning involved in these activities. Mary Hooshmand is the regional nursing director for children's medical services, which is a lead title agency in the state of Florida for Children with Special Health Care Needs. Miss Hooshmand has over 24 years of nursing experience, including state government positions in New York and Florida and a master of science with a major in community health nursing in New York. Currently a 2004 Robert Johnson executive nurse fellow, she will discuss planning for emergency response Children with Special Health Care Needs. Our first speaker, Mr. Tim Miller.

TIM MILLER: To start off by going over a little bit of background on HRSA's emergency operations center. By way of history, it was created several years ago shortly after the 9-11 disasters, about the same time that H.H.S. established the secretary's operation center, which some of you may have seen featured on C.N.N. or some other news shows. It's the set of 30 or so consoles in a room surrounded by a lot of plasma screens where a lot of information flows through. So we started it shortly after 9-11. The responsibility resided in our office of planning and evaluation. And it largely amounted to staff from throughout HRSA that would convene at a point in time where a disaster would -- or when a disaster would happen. It operated largely in an ad hoc manner, and it was primarily reactive. Okay. It established reporting requirements and data collection efforts that were developed in response to the disaster and may change during the disaster.

During Katrina and Rita, it became evident that we had some shortcomings in our ability to respond in a time and effective manner to disasters. And there was a large demand placed on a lot of HRSA personnel in scrambling about trying to meet our requirements. As a result, the administrator of HRSA, Doctor Betty Duke created an office that would focus on supporting the agency's response to hurricanes and other disasters on a year-round basis. So where we're at right now was on October 1st, the emergency operation center was established as a year-round organization in HRSA, and it was moved into the healthcare systems bureau. And it makes sense to be in that bureau, because that bureau also has the national bioterrorism hospital preparedness program and the advanced registration for voluntary health professionals and both of those organizations can have roles in disasters and emergencies.

The expectation is that there will be increased interaction and planning with all HRSA bureau and offices throughout the year. It's a work in process. We currently have representatives from all of our offices and bureaus that participate in a work group that convenes by-weekly and is working to develop policies and procedures for us to use in our emergency response. At the immediate time of an incident, we will still activate a command center and that will bring in people from throughout the bureaus and offices in HRSA, but we would hope that there's a much clearer role for what each bureau and office is responsible for during then. We're also responsible for continuity of operations and planning, but that's separate from emergency operations. It's important that one thing that isn't handled in emergency operations center in HRSA is policy issues. A lot of grantees and providers will be interested in those issues such as grants management issues, malpractice, tort claims. That will be handled separately in a policy section that continues to reside in the office of planning and evaluation.

If we go to the next slide. What does HRSA EOC do? What's our major role? I think of it as the communications and reporting hub for emergencies and disasters. We coordinate and facilitate the information. We communicate with H.H.S., the secretary's office operation center that I referred to earlier. The SOOC, that's located in D.C. in the Humphrey building. We interact with the secretary's response team at H.H.S., and that is typically located at FEMA and they will also have secretary's emergency response teams closer to the disasters. We interact with the public health emergency preparedness which is staffed down at H.H.S. central office also in HRSA. We interact with FEMA and the

states largely in the emergency support function number 8, D.S.F.8. That's the mechanism by which most resources and assets flow out to people that need them. We interact with HRSA's administration, which then carries forward the message to the H.H.S. secretary, surgeon general and other interested parties that can also impact on resources. We obviously interact with HRSA's bureaus and offices, and try to provide information and collect information from them that can be disseminated and shared with people that want it. Grantees hopefully we are not interacting with them unless nobody else is available. One of our goals is to have one person interacting with the grantees and that would be the project officer as the prime and only point of contact. But we will serve as a backup in that role.

Next slide. During an emergency, what do we do? Well, before the emergency what we do, actually, is we try to assess what might happen. But aren't working largely. We have patient surge that can happen to facilities that haven't had damages, but can get swamped with patients that are moving out from the disaster area. We determine what resources are needed to provide or restore the patient service delivery. So we've been hurt with our services, we've assessed that. We try to provide assistance to acquire and restore the resources that they need. We can't directly provide resources typically. We don't have authority and don't get funding to do that. But we can try to impress upon ESF8 secretary's office operation center, other people that can bring resources to bear. And afterwards, we assist in recovery efforts to some extent.

Moving on to lessons learned. Improved communications and coordination and clearly define roles and responsibilities. Every lesson I've looked at from every organization as a result of this disaster has those in it. It seems to be a common theme among everybody. One of the things that we want to move to in this area is, again, who contacts the grantee and what do we get from them? We want to work towards a single point of contact and make sure that there's a clear dissemination of information to the other people that need it, so we don't have multiple people calling and asking for the same thing. Standardized reporting requirements. We want to figure out in advance what are we going to collect? Who we're going to collect it from? When we're going to collect it, and how often? And how we're going to collect it? Phones, paper, Internet. Most importantly, we have to work with in the off season those people we're going to collect it from so in an emergency we're ready to go. Educate staff, all of the policies and procedures that we developed have to be disseminated to the staff or it doesn't make any sense. Deployments we had a number of issues. Some of them related to core deployments that will not be of interest to you. There is disability and volunteers and the deployments of that didn't go smoothly and we'll be working with the department in that area.

Finally, we need to establish clear guidance for the grantees. Our policy section will play a major role in that in letting you know basically what happens to the grants which a lot of people are interested in for sites that are shut down and what's happening with tort claims and all of that. That will be carried on by policy. A lot of the clear guidance that will come out of the emergency operation center is what data are we going to collect and what

reports do we need. That in a nutshell is the emergency operations center at HRSA. That's where we are and where we're going. I will turn it over to Gina Lagarde

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GINA LAGARDE: Hello. Can you all hear me?

PETER VAN DYCK: Yes.

GINA LAGARDE: Okay. This is -- I'm Gina Lagarde. I'm the Louisiana child health medical director for Louisiana. I would like to speak to you all today about the issues surrounding communication. As it pertains to disasters. As you all know, Louisiana had a double whammy. On August 29th, Katrina blew in, devastating the southeastern portion of our state. Just when we were just starting to recover from Katrina, Hurricane Rita came in devastating the southwestern portion of our state. And basically, we did have pretty much a collapse of southern portion of our state. I hope to relate to you today the information relating to the challenges facing communication systems during disasters. I hope to illustrate Louisiana's public health response during this time of disaster and the successes that we had with communication. And then I also hope to offer some recommendations for improving and expanding communication capabilities.

Next slide. With respect to Hurricanes Katrina and Rita, they were truly what we call equal opportunity destroyers. They came in. It mattered not your race, your sex, your job, your neighborhood. It pretty much destroyed things across the board. Hurricanes Rita and Katrina also demonstrated the many challenges and complications arising from disasters

of large magnitudes. This was the first large magnitude disaster that the U.S. had faced, so for some of the issues surrounding Hurricanes Katrina and Rita, we learned as we went along as well. It illustrated the vulnerabilities in our Infrastructure. I'm talking about across the board, whether it was healthcare infrastructure, transportation infrastructure, et cetera. The vulnerabilities were there and not just in our state, but across the U.S. The storm illustrated the gaps in our disaster plan. Most disaster plans are designed around impact infrastructures, as was ours in Louisiana. But what the storm showed us was that we were not prepared to respond well to the disaster when we do not have a communication system intact or your healthcare system intact. So that's the one thing I want people to definitely take away from this is plans must be made for both impact and collapsed infrastructure.

Next slide. As for the aftermath challenges, we did face many. And I just basically categorize it into three general areas. First, capacity, which is basically the ability of the public health system to rapidly expand beyond its normal services to meet the demand for the services in a large scale public health emergency. And for us, we were not prepared for the full surge that we had gotten from the southern part of our state during the storms. Basically, public health role and what we found is that we had to provide all of the services that were lacking. People did turn to public health for direct services, and we did provide medical coverage for search and rescue. We opened up triage centers. We opened up treatment centers in non-traditional settings, like airports, hotels, police stations. We provided pharmaceuticals, because we did lose medical records and providers. More than 6,000 providers had evacuated the state.

The other issues and challenges surrounding the aftermath was basically resources, insufficient manpowers as I stated over 6,000 people left. We had limited workforce. But in a public health system, we had to close down our public health unit to provide the medical services for the special needs children, which is the primary role of the Office of Public Health. And so that meant that other services could not be done as a result of that. And the other issue surrounding manpower is that those that did come in, like the volunteers, not all of them were trained for the level of expertise that we needed to provide healthcare. And specific to M.C.H. issues, many of them were not trained in pediatrics. As I already stated, we needed materials and the other service that we found was lacking was mental health services. And finally one of the other challenges was communication, which is what I want to talk to you today about.

Next slide. Basically, communications, you must address the who, what, where, when, how, and why of communications to be the messenger or central leader. The what being the message. And the message -- the language of a message itself. Where, a specific site to deliver the message. When can this message be delivered, like before, during, or after a disaster. How to choose and the mechanism. You must know why you deliver certain messages.

Next slide. With respect to communication, the issues that we faced surrounded infrastructure capacity, equipment and tools that we used and the logistics. Also, with respect to communication, I'll go on and talk about our response to the issues, as well.

Next slide. With respect to the infrastructure and equipment, what we found was collapse of our communication system. Due to the storm itself. And basically, most communications in the direct path of the storm, which was most of the southern portion of our state, lost power. There was destruction of base stations and there were downed towers. So really, we were not able to communicate in certain areas regardless of what types of tools we had. Now, with respect to the tools, we had an array of tools ranging from cellular phones, satellite phones, using 800 megahertz wavelengths, both of which were very unreliable and pretty much non-functioning in some of the hardest hit areas. We did use computers, Blackberrys, text messaging, any possible way to get information out. And as some of you may have seen on television, it wasn't until someone came out with a megaphone or bullhorn in front of the super dome that they were able to communicate to the crowd. If your tools rely on electricity, then there is a problem. And we also found that the airways or the networks were overwhelmed. So oftentimes when you tried to use the cell phone, the lines were busy. So most high-tech equipment was pretty much unreliable during, before and after the disaster. As for the logistics issues.

Next slide. We had inadequate backup plans for failed communications. Again, our plans were designed around intact infrastructure. There were issues surrounding poor communications. What we found was we needed to bring more people to the table when planning a disaster, because we did call upon people in the community, such as federally qualified health centers, school-based health centers, private practitioners, faith-based community, to assist us in delivering services. But they were not involved in the planning

process, so there was a communication gap there. We also had the issue around the volunteers where hundreds upon hundreds of volunteers showed up in our state. It was very difficult trying to coordinate their efforts, as well. We were not expecting such an influx of volunteers. And because we could not find the Louisiana state board of medical examiners, we also had to credential the volunteers and to verify their credentials and to assign them and then to try to track them. That became very difficult in and of itself, when you do not have an intact communication system.

There was also miscommunication of information. To give you an example, in one of our cities there was miscommunication with respect to pregnant women going to the American Red Cross shelters, therefore a special shelter had to be opened as a result of that to allow pregnant women to come in until the issue was solved. Again, the issue surrounding the tracking of people. And also tracking our information. When even though we relied on computers, when the systems were down, we could not access information about our special needs population. And also, during a time of a disaster, if you are overwhelmed with a surge of patients or evacuees, you may not have the time to enter everything into the system and sometimes it's a lot easier to do it by paperwork. And the other thing that I found was that the language was not -- [INAUDIBLE]. It's okay to use terminology day-to-day, but in time of a disaster, a simple word like missing becomes an issue. And early on in this disaster, you heard about thousands of missing children. But in essence, that wasn't really true. Yes, we did have separation issues. But how the national center for missing and exploited children stated they were missing was different than what we were saying.

Language for disasters must be standardized. As for some of our successes -- next slide please -- we did have training in July right before Katrina. So we were prepared for running our special needs shelters. Unfortunately, that preparation was for 72 hours. In reality, we had to run special needs shelters for months. So again, we were not prepared for the longevity of our services. We were successful in incorporating computer information technology. This did evolve during the aftermath. We were able to have volunteers sign in on a web data bank. We were able to have access to pharmacy and allergy information to help the healthcare providers and pharmacists have access to medicine and allergy information. We also allowed access to the community of our missing database where you can also call for reporting missing people and then you can also access a list on the Katrinamissing.com website. The family national call center was collecting information about missing people.

One of the big successes about the information technology is the innovation program has a computerized system called Links, where we were able to access over 30,000 requests for immunization records. And we managed to still retain some communication with our collaborative partners and we were still able -- and that enabled us to get important medical information out such as partners for healthy babies, continuing to provide information and referrals for prenatal care and services in the upper portion of our state. The other thing that I found -- next slide -- which was very important was we did have a centralized organizational infrastructure. And that exists even on a daily basis. That enabled us to have communication not only internally, but same messages, unified

messages across communities and also we at the local level would be able to deliver information to the state level and from there to the federal level effectively. We had a centralized command site, we had an identifiable leader and we called in about three or four times a day at specific times throughout the first four weeks and then twice a day for the next four weeks for information exchange. And that was crucial in making sure we understood what was going on across the state and even on the federal level. And we were also able to credential over 400 people from the centralized command center and to assign them to specific jobs.

Overall, next slide, what I do recommend to other states and communities for state and local level is to create a unified message, an identifiable message. It is important to speak with one voice during a disaster, and to identify your chains of command. And that will help to create a smooth delivery of services. And I do recommend creating a centralized administration and command center. Again, this helps to centralize your information, as well as to create a unified message. It also gives the community one identifiable person and source of reliable information that they can turn to at all times during a disaster. And you want to create a community and infrastructure that is seamless and flexible. Flexible meaning being able to move from daily operations to disaster mode in a drop of a hat. And it must be coordinated and it must be interoperable. Mobile communication command centers will help when you have downed towers and the communication center must have an array of communication devices. You want to make sure that you utilize reliable communications tools that are functional without an intact infrastructure.

We are looking into utilizing HAM radios and we did also utilize a courier system. So these are things to help us with communication. And to also make sure you have a generator backup. Because you can't plug in your cell phone to charge when you don't have electricity. The other thing is to include all the entities that you will call upon at the time of a disaster. We did have a gap in including our local doctors in the plan, some of our business leaders, and some of our faith-based community. And definitely I recommend incorporating information technology, electronic medical records is of value, but again just keep in mind the more you rely on high-tech information, we found the more likely it was to fail. But again, a good system to put in place especially for tracking your evacuees, the employees, and your volunteers. And you definitely want to build in some accountability in performance measures into your disaster plan. And use best practice models for planning and training.

As for my recommendations to national programs and to federal agencies as well, is what we need is really an assessment of our wireless communication network capabilities. Since we now know that they can be beneficial, we're not sure what other space may not have the capability or the capacity as we found out. We need to possibly create a national shared communication frequency that can only be used in a time of a disaster. And can only be used by first responders, public health entities, and governmental leaders. Again, I told you that we did have an overload of the network, so it made communication very difficult. Also important, creating policies that maximize response and service delivery during disasters. And what we have found that would be of benefit is creating an accessible and compatible across state lines, a national database of information, whether

it's trained volunteers, medical information. But definitely some means of having a national database to access information. And that may also mean for reporting the -- [INAUDIBLE] people.

And finally, to sustain an appropriate funding stream to enable us to plan, train, maintain, and upgrade our current communication systems. So in conclusion, I will just say to achieve an appropriate level of preparedness for future events, adequate planning, training, and communication of staffing are required, along with improved policy at all levels of government. With that said, I will conclude. And the next speaker will be Dr. Fouad Berrahou.

FOUAD BERRAHOU: Good afternoon. The first part of the presentation focus on Texas workforce experience with back-to-back hurricane impacting the state in 22 Texas counties. Because of time limitation, the workforce in this presentation refer to primarily to state employees deployed in emergency center, local shelter, and the Department of State Health Services patient locator assistance for the location of evacuated hospital and nursing home patients. Next slide please. Next. For the Texas response to hurricane Katrina and Rita were defense in a way that Katrina occurred outside Texas, did not impact the Texas infrastructure. Staff were fresh and were about to take the challenges presented. On the contrary, with Rita, several east and southeast Texas counties were impacted and as a result the local infrastructure in the affected area was damaged. In addition, staff were aware physically and mentally tired and experiencing Katrina-related stress.

Next slide. The following are a few critical issues regarding the -- [INAUDIBLE] validation. Matching skills, for health and health-related professionals to special needs situations. In Texas, during the Katrina and especially Rita, we had a little bit of time to define the needs in some of the shelters, so we can respond appropriately. For example, defining the need between specialty care and chronic needs. Another issue has to do with unlicensed volunteers. The unlicensed volunteers that were eager to help and learn, at the same time, but there were some issues in terms of liability that we had to face. Another issue is at the health department, we have a great number of nurses and clinical staff, but we have -- [INAUDIBLE] simply because many of the clinical staff have not used the clinical skills for years. And many of them never acquired the skill needed in disaster settings in terms of triage or clinical cares.

Next slide please. Other critical issues were identified in the leadership and assignments, where the roles and responsibilities that weren't clear in the chain of command in the command center and the other assignments. In Texas also we did not have an effective systematic process for ensuring that personnel were given sufficient rest and were rotated appropriately. In some cases, we didn't have adequate staff or volunteers to allow for rotation. Next slide. During the deployment of state employees and volunteers, we faced some logistic problems such as housing, food and other essentials. Safe and reliable transportation for deployment and moving those teams from site to site, or even they weren't even aware of the length of time they're going to stay at one site or for how long they're going to be away from their families. In terms of another critical issue was security

in terms of safe places. And also, the staff employees that were deployed, they weren't aware of different responses from patients or co-workers as a result of stress and frustration. Like I said, the roles and responsibilities, they weren't effective and weren't delineated. And that causes debriefing that was not adequate.

Next slide. Another issue which was really important in a way to provide clinical staff into affected areas was that they have families behind and they didn't have any plans for their family, how to be taken care of when they were deployed. Access to mental health services was another issue. Seems our state employees and the other volunteers, they were really greatly exposed to stress. And also, as you know, Rita did affect only the east and southeast counties in the state. So basically, the other part of the state, generally they weren't impacted, so business was as usual. For example, the -- [INAUDIBLE], they were still expecting services in the local areas. And we had a lot of state employees, that they were in the region, but they were deployed, so we need to have a plan so that we can ensure that continuity of care.

Next slide. In the next few slides, they are like a few lists of response to issues that I just mentioned. And those in any kind of disaster readiness plan, we need to include the -- [INAUDIBLE] and establish team in advance, well in advance. There was some suggestion about teams that can be an M.D. and a couple of nurses or an M.D. nurse and social worker and so forth. And we need to provide -- [INAUDIBLE] required some staff to get continuing education in triage and further clinical skills. And ideally the team should be bilingual, especially in California, Texas, Florida when we have a larger Hispanic, Latino

population. In addition, like I said, the teams, the adults who are going to be deployed in affected areas, they need -- they're required to establish emergency plans for their own family members that were left behind. Next slide please. Regarding the leadership and assignment, like Gina said, that it is really, really important to delineate clearly the roles and responsibilities through the chain of command. And also, to identify national, state, local and private partners and finding out how they will interface. Meaning, that you need agreements in place with trade associations such as nursing associations, medical associations, hospital associations, and so forth, so that everybody knows what to do in case of disaster.

Another problem that we learned the hard way in Texas is that you need to, before any kind of -- [INAUDIBLE], you need to establish effective mechanisms to -- [INAUDIBLE] to related needs. The purpose of this is two-fold. It will help you with the skill sets needed where you need to deploy some clinical staff and so forth. And also, -- that will be a lot easier to do. Another -- Jon is telling me that my four minutes are over. But the last point is and basically I think it's very, very important. And that's what was lacking in our experience here in Texas, is that we didn't have or we didn't establish a proactive learning team. And this team should not be involved in day-to-day problems and areas, but always look ahead and prepare for the next step. And another thing is that some of our staff were from many different areas, so I think it would be really a good idea to have a job description for critical functions and positions, including disaster preparedness response. And I think a couple of other things that need to be mentioned is that we need to ensure access to mental health counselors as needed to our volunteers and employees. And

also, to train some staff in critical stress management so that they can provide the support to each other.

And I think the last slide I have are these are ongoing -- [INAUDIBLE] in Texas. After March 21, we will have an after-action report that will capture this and hopefully -- and that will be comprehensive. And not that you need to work towards anything. But comprehensive. That will be available to all of the state. And now Jon Huss will present.

JON HUSS: Good afternoon. My name is Jon Huss and I'm the director of the community preparedness section for the Department of State Health Services. My principal responsibilities are to oversee the administration of the C.D.C. and HRSA preparedness grants. And a corollary to that is to coordinate the emergency response capability of the Department of State Health Services in coordination with our department of emergency management in the governor's office. I want to speak very briefly, because some of these subjects have been covered in detail, but the component that we struggled with the most, besides some of the workforce issues that Doctor Berrahou has mentioned and focusing in or drilling down on the communications issues, but specifically relates to the inter-agency communication process. And I use that in a broad way to include what you may be familiar with what is called VOADS. Some of the professional associations that at least in Texas came to the floor offering their services. In the background before Hurricane Katrina and Rita, the Governor of Texas, Governor Perry requested in late 2003 following an active hurricane season, but not a particularly destructive one along the coast of Texas, that a task force be formed to do an analysis of the response and risks that still

remain along the coast of Texas. That was issued to him in a report to the governor dated October of 2004. That report indicated for the first time, at least the first time in Texas emergency management x the special concerns of what were termed special needs population. Those are populations that are also defined in the C.D.C. and HRSA grants. But for the state of Texas, it was broadly defined principally around transportation issues, people who were unable for whatever reason, be it medical needs or being homeless, lacking resources, having mental conditions which would prevent them from accessing transportation, or home health and meals on wheels are the people with assistive living needs to remove themselves from harm's way. And the publishing of that report was in October and it was a sizable delay. But in July of 2005, the department of emergency management determined that that rightly belonged in emergency support function 8, which is the responsibility of D.S.H.F. As we prepared for special needs, not knowing of course that there were hurricanes coming up, we began to put procedures and training in place to address the communication needs between the agencies in the state and presumably that a system that the federal partners would fold into.

In Texas, the special needs -- the agencies that deal with the special needs populations are decentralized. There are at least five and we are focusing on seven as being the number that we need to fully integrate with. The hurricanes obviously hit us fairly quickly after the determination that the Department of State Health Services would be the agency responsible for coordinating the response. And we learned some very valuable lessons. First of all as pointed out in Louisiana, the infrastructure had significant problems in maintaining itself in Louisiana. In Katrina, we were very fortunate. We had an intact

communication structure, an intact public health structure and the stresses on the system were due principally to understanding command and control. We had not practiced or trained enough to know who was actually responsible for accumulating data, disseminating data, and handling issues such as logistics, supplies, volunteers, those sorts of things.

We found that the various agencies had various databases developed on different architectures that could not communicate with each other. A very specific example that we received over and over again in our after-action reviews is that hospitals in particular felt overwhelmed with numerous phone calls, as many as 60 a day requesting identical information from the various agencies who needed to know what their surge capacity was, what their equipment capacity was, and what their patient load was. It has been noted in several presentations that command and control is an issue. We have a mantra in Texas that says the way you practice is the way you're going to play. We obviously did not have an opportunity to practice for long or consistently so that our play was uncoordinated. We do have actions that we have taken subsequent to the fallen late fall hurricanes. The governor has established a special task force on evacuation that will have recommendations related to improvements to the way we handle and identify special needs populations. Both before, during and after an event and then as Doctor Berrahou noted on repatriation. The department is conducting a review where we expect to have significant and valuable input on all aspects of the delivery of services across the spectrum of the S.F.8 activities to include mental health and mental retardation.

Some of the specific things that we expect to come out of this are standardized software, particularly in databases so that we have the ability to data share and data mine efficiently. To combine databases wherever possible. We need to refine our communication protocols so that, for instance, hospitals are receiving one or perhaps two phone calls during the course of a day and that information is shared by the lead agency. We are looking for quick wins in the field to build relationships among our field staff who report to different central agencies. For instance, our epidemiologists in the Department of State Health Services working hand in hand with the regulatory folks from long-term care to identify special needs shelters and the requirements for staffing and supplying those. We expect that the agency responsible for regulating long-term care facilities and hospice and home health will tighten their requirements related to disaster planning and reporting.

We also expect to engage the state P.C.P.s and pharmacy providers, home health agencies, and other people in direct contact with the home health and meals on wheels population to help us pre-identify and pre register the folks, particularly along the coast of Texas so that we know who they are and it will be far more efficient for us to locate them and get them out of harm's way well in advance of the hurricanes. Please take to heart the information that was given to you from Louisiana. I certainly don't intend to repeat that. But as Doctor Berrahou noted, there were 24 counties in east and southeastern Texas that were directly impacted by hurricane Rita. The communication structure partially collapsed in many of those communities. And as you would expect, in the rural communities, the outages were most prolonged and ultimately the impact was most serious in the rural communities. Redundancy and interoperable ability of equipment

systems and training of staff so that they know what those redundancies are critical. And the next slide is my contact information if you have any questions. I believe the next speaker will be Annette Phelps from the state of Florida.

ANNETTE PHELPS: Thank you, Jon. Like most states, Florida has faced many threats and events and certainly none of them have come up to what Katrina brought. But we still talk about hurricane Andrew and that happened over a decade ago. Every single disaster that we've faced is different, but a prepared workforce certainly makes the chaos less. I tried to focus on the core concepts that relate to ESF8 approaches. The infinite command system or I.C.S. training are vital components of our efforts. [INAUDIBLE SPEAKER] All responder agencies can use this system to clean up confusion over who is in charge and how to respond. We use something of a project ready model. We staff, we equip, we train, we test and modify as needed so that we are ready. Next. You've already heard that it's not enough just to be trained. It's important that you practice. .C. -- practice makes the language familiar. That's the simple common language you've heard talked about and provides for a greater depth of training for our overall workforce.

Next. Continuity of operations planning is another component of our preparedness. We develop our plans based on the kinds of events that we might face. This includes source supply, plans for shelter and be ready to evacuate. Staffing is a direct impact -- [INAUDIBLE]. Other things to consider you've already heard about was communications. You have to plan for steps to take. Things like rally points and times you're got to meet. I have contingency plans and agreements in place. Our lead staff and their alternates have

information stored on memory sticks and other important information stored off site so we can retrieve that. Staff has to be equipped and prepared.

On this next slide, I've given you an example of the C.O.O.P. organization chart for my division. You have to look at this on your own computer to be able to read it. It's basically showing you that you have to have a team set up with the information and the type of things that they will be doing so that they know ahead of time and are like a well-oiled machine in place.

Next slide. Keeping your staff ready and able is very important. Or you won't have them to call upon when you have repeated events, like we've faced in Florida. As you can see, the conditions that people have to work and live in during a disaster are really a challenge. You need to make plans for what is reasonable shifts. For example, in one shelter situation, staff sometimes are in place 72 or more hours before you can get new staff in there to help them. Colleagues want to help each other, but errors increase and moral decreases if staff don't take rest periods that they're given. Behavioral health, you've heard a little bit about today. Managing that in and after periods of crisis and plans for staff to return to normal is very important. Some suddenly staff's view of what is important is very different. They find that people who are laughing and smiling offend them. How can they laugh when things are dire in other places? The celebration of success and a hero's welcome back helps them move toward recovery and it's very important in getting them back into routine. We value our employees' contributions through certificates, recognitions and celebrations.

The public is another important component to think about. Materials for the public need to be available prior to and after the event. Frequent messages through the media can help reassure and inform. Risk communications and training and practice is integral to the process. Working on mechanisms prior to an event or communicating them to trusted community members seems to work best. But they may be the victims themselves. So having a network ahead of time and teams from other communities ready to deploy to the disaster site is important, too. One local E.M.S. director in Florida begins a weekly news column in May each year by offering hurricane preparedness tips in manageable chunks. Our populations have manageable lives and are vulnerable. He talks about what to do week by week, so forth, until he gets a full kit equipped for those families.

Next, you heard how important it is to work with departments. Knowing who your key players will be for a variety of events is essential. And having memorandum, agreements in place ahead of time, smoothes the way for the response. This includes planning an exit strategy plan following your intervention from the beginning. Finally, how do we look to the future? What we do immediately, as people have been talking, a hot watch or after-action report. We review the event by gathering data from as many of the participants as we can get. What opportunities there are for improvement, we post them on internal websites for our staff. We post a lot of downloadable materials on our website that can be forwarded easily for others to use. We've shared them with a lot of other states. We do things like hold public Summits.

Next week, we'll be having a flu pandemic Summit and focusing on needs. We have developed MCH work loads that meets with the disaster response provision and exploring further areas that we need to think about in times of disaster.

Next Mary Hooshmand will talk about special needs shelters for Children with Special Health Care Needs.

MARY HOOSHMAND: Thank you. I'll be talking today about disasters and Children with Special Health Care Needs specifically in the south Florida region. As Annette so well said, since hurricane Andrew, Florida has prepared for disasters. In south Florida, we've been deployed in the last couple of years or we've had five storms with unique personalities come to Florida. Those storms have caused us to have different experiences and from our regional perspective, we have six counties where we have had different experiences regarding shelters for Children with Special Health Care Needs. The most important lesson is disaster plans, not only from the employee's perspective, but ms family and that individual child with special healthcare needs. From an employee's perspective, I think we look at the work plan, continuity of operations, disaster training.

Over the last couple years, we've focused on their home individual family plans. Again, looking at how much time do they need to prepare, giving them that time before disasters to prepare their homes, prepare their families and do what they need to do. Again, with family disaster plans, we really start actually now at the beginning of the year really reinforcing the importance of that family disaster plan, particularly for Children with Special Health Care Needs. Looking at it not only for the period of the disaster, but looking at

transition options after disasters. What other plans in terms of if they're home, if they have no home to go back to. I think over the last two years, we've learned that is a possibility. It is a critical need to plan for what are the options for these families.

Another issue again in disaster plans is transportation. And I think we've all seen this year what happens when families don't have transportation. So those are part of offer plans with our partners. We have identified all the children in our community that need transportation and our families, so that that is actually incorporated into the disaster plan for them, as well as for us as an organization. A keyless lesson learned in south Florida has been that there is an extremely important to designate special needs shelters for the pediatric and youth populations. Families we have found are more likely to register and more likely to come to a special needs shelter for Children with Special Health Care Needs versus an adult population. We have seen that in our census. In our county, we have a pediatrics special needs shelter that is full for hurricanes.

In other areas of our region, we see families not accessing the special needs shelter, preferring to stay home for various reasons. Those include the fact that the family center care that they need addressing their medical healthcare needs, while keeping the family intact, it's important to these families, most of the special needs shelters require one individual and one caregiver. Our pediatric special needs shelter allows the family, plus if they have a nurse caregiver or a home health aide, that person, an individual can come with the family to the special needs shelter. Again, it's logistically difficult to place pediatric populations mixing with senior populations. In fact, we've heard at different shelters move

the children into a corner. At the pediatric shelter, you can design the shelter for the Children with Special Health Care Needs and their family. It's focused on their issues. Again, safety is a huge issue. If you look at the adult special needs shelters, they're different versus the pediatric special needs shelter. And again, a lot of families prefer to stay home with home generators.

What we have found in south Florida is that there are very difficult situations, particularly with generators during a disaster. That they themselves can become the danger during the disaster. We encourage the families to be sheltered during the disaster, versus having problems and coming in the middle of the storm or disaster, which we had seen happen in south Florida. So we encourage them to come to the shelter prior to the disaster. Once the disaster is over, they can assess their home and then utilize their home generator.

Advantages again include on site healthcare support. The pediatric shelter is staffed with pediatricians, nurses from children's hospitals and partners in our community. Our children's medical services, Department of Health staff. All of the providers that come to the shelter are experienced in pediatrics. We have respiratory therapists. We have staff from the school, nutritionists right down to the diet and food is focused on the children. We have seen a reduction in the number of hospitalizations before and during the disaster and even after the disaster, especially this year. We saw families rerouted to the pediatrics special needs shelter that might otherwise have been in the hospital. It's definitely facilitated our post disaster planning and recovery for our Children with Special Health Care Needs.

While we are in the shelters this year, we were able to transition families either to homes with portable equipment or to other alternative settings for a period of 30 or 60 days, or further if needed. But we were able to do that transition planning with social workers, nurses, and teams at the shelter, versus having them to go anywhere else to work with Red Cross, or other individuals. Again, I heard the other speakers talk about planning. There's a definite need to identify your needs in your community in advance. What we have done is identify the number of medically fragile children, children in medical foster care, children who are technology dependent, children with transportation needs, and we are able to -- these children are all pre registered so that before disaster, we are able to contact those families and they are routed to the pediatric special needs shelter, or hospitals. We actually have worked with a hospital for our ventilator-dependent children to place them in settings that are safe. Key partnerships are critical, particularly with Children with Special Health Care Needs. We have reached out to our partners, the school board, Red Cross, our Children's Hospitals. Even our paramedics who will work with us at the shelters. Medical agencies have supported staff at the shelter. We have worked with skilled nursing facilities, as well as pediatric extended care programs to plan for transition and back into the community after the disaster has occurred.

Next slide is on developing disaster plans for the pediatric special needs shelter. What we have done is look at roles and responsibilities of our community partners and our shelter teams. What we found originally was that D.O.H., and I heard many people talk about the exhaustion and limited supply of Department of Health nurses. We saw that and we were able to reach out to partners over the last couple of years to develop shelter teams that

not only involve nurses from the department, but also nurses from the Children's Hospitals and the skilled nursing agencies that work with us routinely in the community. That has helped to promote safe staffing, as well as relief for the people working in the shelter. Again, disaster readiness for families. We found registering people throughout the year was updating those plans to be critical. Logistics include looking at your shelter structure. We saw problems with shelter structures I know throughout Florida. We look at using schools, estimate the electrical needs. We have had to have our shelters retrofitted, looking at the electrical needs and making contingency plans for the generator backups.

I heard a lot discussed right now about communication and I would only say that I would reiterate that. That we became dependent on -- we have been dependent on our cellular, satellite communications, which don't always work. I will say that the HAM radio operator was critical for us during many of these storms. He was our link with the emergency operation center. And when other communications fell through, we were able to communicate back to the E.E.O.C. and other desks through that HAM radio operator. Medications were a real issue. I heard this expressed. I think one of the most helpful things in Florida was after some of the earlier storms that families, some of the rules were changed so that people could get refills of prescriptions for 30-day supplies. That was extremely helpful to many of our families so we encourage that they bring extended supplies of medications. Not just a one-week supply of medication and equipment, but more 30-day supplies. Again, oxygen and D.E.N. equipment. Most insurance companies do not approve battery-powered equipment.

One of the things we found was that our biggest problem was that we may have had structures intact and ready for families, but they would not have electricity for 30 days or more. And we were able to work with our D.N.E. companies to ship in battery-powered feeding pumps and nebulizers and other equipment which was helpful in terms of transitioning families back to homes. And again, shelter supplies in a pediatric facility, we were able to focus on the pediatric needs. We looked at mats versus cots so there were family pods versus cots that could collapse and cause injury to children and families. Again, shelter staffing was critical and we were able to utilize our community partners in promoting safe staffing patterns in the shelters. I think some of the things, just to sum up, is that it is critical to have ongoing development of your care plans and that means individual and family disaster plans.

Contingency planning is absolutely critical. We began, and I think Annette you said it well, we had many post meetings after the different storms at all levels, regional and local. Debriefing and developing contingency plans and what-if scenarios with a goal to hopefully keep children safe in the storm and transition them back safely to their communities and homes. And I can't stress enough the planning. That drilling, clinical drills, training at all levels was absolutely critical in terms of planning for the storms as one came right after the other in the last two years. Many times we hear I think after the storm, caring for the caregivers also became critical. We saw many people who had worked in shelters week after week, and not only our families, but our staff. And we found ourselves doing significant debriefing and offering counseling and employee assistance programs for our staff as we moved forward over the course of the last couple years.

Lastly, I think that I've heard many people say, well pediatric special needs shelters are nice, but not possible in our communities. And I would say never doubt that a small group of committed citizens can change the world. Indeed, it's the only thing that ever has. It can be done and we are working across our region to make it possible for our families, because it has been deemed a critical need for our children. And I'll turn it back to Jon Nelson.

PETER VAN DYCK: Well, what a wonderful set of presentations around the events that occurred last fall. We regret that we do not have a time for a question and answer period for this news cast. But encourage the listener to communicate directly with the speakers. I think all of them gave their email addresses and you all know one another besides. So communicate if you have specific questions. Download and save the slides. You can go through those at your leisure again if you wish. I really want to thank the speakers for today, Jeff Lobas, Tim Miller from HRSA, Gina Lagarde, Fouad Berrahou, and Jon Huss. Annette Phelps, Mary Hooshmand, and John Nelson and Chris deGraw, here, who were prepared to answer your questions. Thank you for participating in the webcast. I'd like to thank our contractor, the Center for Advancement of Distance Education at the University of Illinois, Chicago. Today's webcast is with all of our mchcom.com will be archived and available in a couple of days on the website, www.mchcom.com. We encourage you to let your colleagues also know about the website and hope they will find it useful. We would like to make these webcasts as responsive to your information needs as possible. If you have suggestions, please let us know. If you have ideas for future webcasts, let us know

or if you even have comments in general, let us know. And you can email those ideas, requests, or suggestions to info @ mchcom.com. Again, thank you for your participation. Have a wonderful rest of the week and weekend and we look forward to sharing our ideas with you and our participants' ideas with you next month. Goodbye.