

**HEALTH AND HUMAN RESOURCES SUB-PANEL
GOVERNOR'S SECURE COMMONWEALTH INITIATIVE
Henrico County Tuckahoe Library, Henrico, VA
Meeting Notes, April 12, 2012**

Review/Overview of Secure Commonwealth Panel/Subpanel Structure

- Del. John M. O'Bannon, III, MD, Chairman of Health and Medical Sub-Panel Committee
- Karen Remley, MD, MBA, FAAP - State Health Commissioner

The strength of our preparedness is only as strong as the people who stay engaged in working with VDH on making our commonwealth prepared. Today's afternoon session will be a discussion about where we need to go from here, understanding the challenges before us and how we need to continue to move forward.

As we look at plans that have been developed, some over ten years ago, we find that we now are integrating more communications and more aspects of our clinical communities in our responses. The best example of when preparedness works is the recent jet crash in Virginia Beach. What happened was that everyone knew what to do and had exercised what they needed to do, including citizens. What we need to do now is tell the story so others know how the funding we have brought us to this point, and to discuss what the impacts could be as the future of our funding changes.

Updates

- Public Health and Healthcare Capabilities and Performance Measures
PHEP and HPP Grant Consolidation – Dr. Marissa Levine, Deputy Commissioner, VDH

Handouts provided at registration included a summary of the new health care preparedness capabilities. Handouts will be used as a reference in the afternoon discussion. There are 15 Public Health and 8 Healthcare capabilities.

The last four years of grant funding and a corresponding trend chart of funding since program inception shows the drop off of funding over the past years.

The capabilities started with DHS target capabilities and represent an intersection of emergency management, medical services and public health services. We expect to see continued evolution of these capabilities and development of methods for measuring progress toward achieving each capability.

Think of capabilities in terms six domains: community resilience, biosurveillance, countermeasure and mitigation, incident management, information sharing and surge management. Special emphasis will be placed on these capabilities in the upcoming year. Challenge is to sustain capabilities achieved as well as expanding community recovery capabilities.

- Influenza - Dr. David Trump - Director, Office of Epidemiology, VDH

The message on influenza this year is that it is not very exciting. What OEpi does – get data from EDs and urgent care centers, receive lab info, and investigate outbreaks. In summary, this 2011-2012 was late, short and mild flu season. Virginia was late reaching a widespread level for flu. The season was only 9 weeks in length, and the highest percentage of ILI visits reached only 2%. And, there were only 4 confirmed outbreaks this year (last year had 33 outbreaks).

We still saw a variety of strains of flu virus including the H1N1 virus that was so prevalent in 2009-2010. We have had the same vaccine composition for the past two seasons. WHO and FDA are recommending some changes to the vaccine for the upcoming flu season. H5N1 is still affecting some countries associated with handling of poultry. This virus is still not being transmitted person to person. We had a good match between our vaccine and presence of virus this past year, but flu remains unpredictable.

It is difficult to say if the mortality rate for those infected by H5N1 would be similar in more advanced countries with better medical resources compared with under developed countries where the mortality rate is 65%.

Dr. Remley reported that Virginia (in 2010-2011) was number 4 in the nation for adult influenza vaccination rates. This speaks volumes for the clinical community who has assisted in making this happen, along with schools and pharmacists who have promoted vaccination among the citizens of the Commonwealth.

Unfortunately, some populations continue to refuse to accept (get) vaccinated. This is a big barrier to even better vaccination rates. Providers are documenting clearly when patients refuse to get vaccinations.

We cannot yet make a correlation between our vaccination rates and the drop in prevalence of flu this past year.

A lot of the basis for the increase in vaccination rates is because providers have been able to get more vaccine in a timely manner, which resulted from pressure put on manufacturers by public health to make more vaccine and deliver it earlier.

- **Emergency Transportation Update – Jason Eaton, Logistics Chief and Mutual Aid Coordinator, VDEM**

VDEM has been working on transportation Initiatives for several years. In 2010, they awarded a large scale contract to TMS logistics to provide emergency transportation serviced. This contract will allow for impacted localities with emergency transportation if needed during locally declared emergencies. The contract makes available 1200 evacuation transports including 1140 motor coaches arranging from 45-55 persons capabilities for pets and transportation dependent citizens. Another 60 Para transit vehicles can be made available for transportation of citizens who have mobility restriction.

Statewide Mutual Aid Agreements would allow the state to request emergency transportation support from other jurisdictions. There is also a National Ambulance Transportation Contract, and Emergency Management Assistance Compact (EMAC) allows VA to request assistance from other states if additional transportation assistance needed. VDEM has access to 100 buses to assist with emergency transportation of people, i.e. to pick up stranded vehicle participants. VDEM has worked with FL and TX to make our operation and contract with TMS a turn-key operation. There is a phase-delivery concept of transport vehicles as well as phase out procedures. The contract includes a command concept, i.e. TMS will have seat at state EOC to participate in planning, deployment and re-entry of resources during an event. TMS has GIS capabilities; TMS can track vehicles and will also provide security on each vehicle.

Bill Zeiser, DMAS transportation unit - handles the coordination of Medicaid patients on a day to day basis. 9.4 million trips were arranged by him/his office last year for Medicaid patients. DMAS has a provider network of 250 providers and a call center to take requests from individuals to call for transports. Their network providers are trained to deal with mobility restricted patients as well as HIPPA laws. DMAS has 1500 ambulatory vehicles, 800 wheelchair vans, 390 ambulance providers. The objective is to not re-invent the wheel and use these resources in conjunction with what VDEM has in place and incorporate into statewide plans.

If localities have transportation contracts, they will not be overridden by state contracts. VDEM also has agreements with tow trucks.

- **State Managed Shelters (SMS) and Radiological Nuclear Emergencies/VERTEX Plans – Bob Mauskopf, Emergency Preparedness Director, VDH**

SMS planning is coordinated between VDH and DSS. VDH assists with coordinating care for medically fragile person who will be in state shelters. There are 18 state managed shelters available (lost one when state fair folded). Plan is for MRC staff to assist with manning state shelters to care for medically fragile persons. Costs are not insignificant for opening and running state managed shelters, but the effort has the support of SHHR. VDH has assessed sheltering places among local health districts to ensure minimum consistencies exist. A recent shelter exercise assisted in highlighting and creating an accompanying pet sheltering plan with state managed shelters

The Governor conducted a cabinet level exercise on a dirty bomb scenario. This scenario will also be used for this year's VERTEX. We will be conducting a nuclear power plant exercise this year as well.

The CDC completed a State Technical Assistance Review of the strategic national stockpile plan just yesterday. There was tremendous support from VDEM, representatives from private sector partners, an airport team, and local gov't partners. VDH will conduct a receipt, stage and storage exercise later this year with partners as well.

VDH continues to explore options to ensure we have adequate clinical staffing to support medically needy patients in state shelters though MRC support, contracts with private nurses, communicating with private physicians to work with their respective patient to get them to think about and plan for how they will be prepared.

VDACS is working on a SMS for animals to use in conjunction with human SMS.

- Disaster Behavioral Health Advisory Committee (DBHAC) – Suzi Silverstein, Risk Communication and Education Director, VDH

This group began in 2006 as TADBHAC – Terrorism and Disaster Behavioral Health Advisory Committee, but membership has expanded to include more state agencies, universities, private sector and community members with behavioral health backgrounds to assist with providing guidance on our grant. In addition, DBHAC is assisting with training, educating volunteers, assisting with messaging for VERT and more.

Behavioral health can be considered medically fragile or medically vulnerable, but there is no plan to create separate shelter for behaviorally fragile separate from any other medically needy persons. They will be incorporated into existing shelters.

DBHDS has agreements in place to provide services to in many different settings. They are working with VDH to incorporate their resources into existing state sheltering plans. The issue may be how to staff the state managed shelters to be able to provide services to handle all types of disabilities.

Situational Awareness Activities

- EOC/Fusion Center – Rob Reese, Virginia Fusion Center (VFC), Lead Coordinator

Current international terrorism trends, i.e. what happens overseas can impact what goes on in the U.S.

Open source information – many terrorism activities going on overseas. 2/9/12 was an announced official merger of Al-Qa'ida and al Shabaab. Two large threat organizations. Terrorists groups still interested in targeting US military assets to cause harm and disruption.

Virginia specific incidents - El Khalifi tried to set off bombs in DC as recently as February 2012.

VFC Awareness campaign – know that Virginia is a target. Be aware of suspicious taping and photography. Suspicious behaviors should be reported to VFC as soon as you possible by calling 877-4VA-TIPS (877-482-8477).

Facilitated Discussion – Sustaining Public Health and Healthcare Emergency Capabilities in Virginia

Gov Gilmore initiated Secure Commonwealth Panel, Governor Warner continued it. Now the Panel's work is codified and operates under the direction of Secretary Terrie Suit, head of the new Office of Veterans Affairs and Home Security.

What steps do we need to take to maintain specialized staff? i.e. epis, lab personnel, emergency coordinators

Epis – gather info on who is sick, where they are, what are the risk factors, what were the exposures, try to figure out source of illness with goal of mitigating the source of illness or preventing spread of illness. Success is tied to people and information systems. Epi and surveillance is the “CSI” of public health, but not what people think of as “traditional public health”.

The more we can tell our story about how the dollars have been used to train people that respond, the more we can show the benefit of the funding. We need to weave into a story how we used funding to perform the miracle that we responded to on Friday.

Some of VDH response activities are part of routine public health. We need to demonstrate more how the routine functions of staff relate to emergency response. We need to be candid with our successes and failures resulting from specific ties to funding or lack thereof. If funding is cut, what specific capabilities will be lost?

DHS has received massive cuts in Congress and is tasked with prioritizing programs and what programs are essential. How money is being spent to buy down risk is being evaluated by JLARC. Ask JLARC to conduct a study of preparedness funding to determine what the impacts will be if federal funding is cut. Directly petition GA for more money, which is not necessarily best option because will be passed on to localities or the citizens through increased taxes.

Make an argument of dual role of response participants. Emphasize how long it takes to replace the talent. What are the other capacities that can be met (including outside of Virginia)?

Concerning the Navy jet crash last week, do fire and police get preparedness funding? Yes, primarily through DHS. Preparedness funding contributed to hospital coordination ready to receive injured. Medication provided to people who could not get back to their homes, Vital Records provided birth and marriage certificates to people who lost those.

MMRS grants, UASI grants, and Regional Catastrophic Preparedness Grants funded by DHS will drop from \$50 million to \$5 million in Hampton Roads (HR) area. Much of the equipment and training provided in HR area came from DHS funding. We need to look to regional resources to sharing. HR has assessed a per capita fee to sustain these resources.

Hospital Preparedness dollars have been used to build private/public partnerships, communications, and situational awareness among hospitals, the clinical community, the public safety community and public health. We need to educate people about what we have done and what it would look like if this infrastructure went away.

We need to make sure the money committee staff know more about how current funding is used, i.e. for the training, planning, surveillance as well as response to actual events. It is incumbent upon all of us to make the best possible use of resources we have. Must focus on regional assets as being a good thing to continue. It will be tough to choose between regional infrastructure vs “stuff”, but would chose infrastructure.

VA Beach fire service trained to respond whether there is funding or not. VA Beach dumped 90% of their on duty personnel into responding to the jet crash event last Friday. Who back-filled regular fire and EMS calls during that time? Fire, EMS and Police resources were within several blocks of the event. Funding needed to continue training and provide advanced training and more specialized equipment.

All components of disaster response were in place at the inception of preparedness funding, but it was clear that a response could be better. Federal funding was the only way to get folks at the table to start working on joint planning on how to do things smarter. We must learn how to build an infrastructure that is sustainable with reduced funding.

Important for participants to make folks aware within their respective organizations what the issues are related to loss of funding.

What strategies needed to maintain medical countermeasure distribution?

The first 8 weeks of H1N1 vaccination campaign in 2009, VA was 50% better than rest of the country in getting vaccine in arms. The current systems of communication and distribution of medical countermeasures were fully funded by federal preparedness grants. Also contributing to Virginia's success was the ability to use federal funds to significantly build temporary staff to assist Local Health Departments (LHD) conduct vaccination clinics. It was a benefit to have multiple partners to able to administer vaccine, i.e. LHDs, private docs, pharmacies. We need to find a way to keep partners engaged.

VDH has contracts with private pharmacies to dispense in emergencies if needed. VDH also has an agreement with DMAS to pay dispensing fees for pharmacies to dispense.

How can we leverage the Stafford Act to engage more pharmacy partners? Can the federal gov't work with national large pharmacy chains to get them engaged to assist with dispensing.

The Governor's economic contingency fund may be available to assist with temporary funding during emergencies.

A Governor's emergency executive order or public health emergency declaration could include specific language to waive dispensing requirements to allow pharmacies to dispense when needed.

All the staff that develop the plans for dispensing and managing the stockpile and that provide training are paid for by federal preparedness funds (takes over 60% of total preparedness funds to pay for this VDH staff).

Colleges are very good at planning responses to shooters, or bombs or other traumatic events. But, are not prepared for responding to a disease outbreak among its student body. Will need help with that. That's where public health is needed to play a big role.

How do we sustain mass care sheltering, volunteers, hospital surge capacity?

Need to find alternative private and public sector funding.

Need to contract with private community health care systems to assist with shelter support. Problem is not to obtain the commitment, but how do we provide for the planning and the training and address the liability issues to implement these agreements.

Opportunity to reach out to large corporation volunteer groups/teams that can assist with response efforts.

Problems with MRC is not recruitment or training but keeping them engaged.

Need to leverage VOAD and other entities to assist with volunteer needs.

Of all the things we do in VDH, what are critical activities and what will VDH not be able to do if funding is reduced? What will have least impact?

How do we maintain hospital regional coordinating infrastructure and even expand to other entities (other than hospitals)?

Things to do to make more effective:

1. *Take advantage of newer technologies*
2. *Communications interoperability – RIOS – integrates hospitals, public safety, fire, EMS,*
3. *Improve integration – i.e. of webEOC – facilities each have, but not interactive. Also, long term care partners have EOC but they are not using as much as needed.*

One of tasks in next five year project period of hospital preparedness grant is to further develop health care coalitions.

How to enhance fatality management capability?

Less than 100 OCME employees statewide, so will be important for localities to be able to handle fatalities in a pandemic, i.e. natural disease fatalities. Need to get continue to get localities to think more about what their role and capabilities are and need to be.

OCME looking to Medical Reserve Corps (MRCs) to recruit forensic volunteers and provide training to assist with fatality management and tracking. Trying to integrate with DMORT to get training and use the tools (software and forms) DMORT uses for fatality tracking. OCME trains forensic pathologists through grant funding - \$385,000. This year, the grant has been reduced to \$180,000 for future years. There is a deficit across the nation to fill forensic pathologist positions and with funding being reduced, OCME may no longer be able to hire existing fellows.

Questions from law enforcement, EMS, and localities will come to VDH on how to safely handle certain fatalities and will be a need to find out how to continue to provide that support.

How is regional support working?

From fatality management perspective would be better off if localities would consider regional approaches in dealing with fatality management versus trying to solve it within a jurisdiction.

Concept of coordinating regional resources has been established among hospitals in collaboration with VDH. Regional concept works because there is something to trade when you need to use something from a different area. As funding diminishes, concern will be that hospitals may not have any resources to trade and withdraw from this regional sharing concept.

If someone can provide a concise summary of what the specific impacts will be to our state of preparedness if federal funds are cut, i.e. how can we ensure we will be able to continue to provide the support needed to respond or not, then that message can go forward to legislators. Bottom line, it will not be possible to provide the same level of response currently in place if funding is reduced.

Continued recruitment and training of volunteers will be a great resource.

Health Dept. role is glue to bring together the private sector. How much “glue” will it take to keep the partnerships together that have been built? Does Virginia only want to be good at responding to local emergencies, or do we want to be able to respond to larger, major events involving multi jurisdictions and large events?

Public Comment

The will to collaborate is what will keep us working together.