



the E **X** *CHANGE*

ASPR
ASSISTANT SECRETARY FOR
PREPAREDNESS AND RESPONSE



TRACIE
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

ASPR TRACIE: Looking Back, Looking Forward

A lot can happen in just two years. In early 2015, while ASPR was contributing to the response and recovery effort after the largest Ebola outbreak in recorded history, a mass shooting claimed the lives of 10 people at a community college in Oregon. That same year, a highly pathogenic avian flu virus outbreak affected farmers around the country, emergency health care professionals monitored the spread of Middle East Respiratory Syndrome (MERS), and a multistate measles outbreak was linked to an amusement park in California. In 2016, 50 people were killed at a nightclub in Florida in the nation's worst mass shooting, the Zika virus emerged as a public health threat, and parts of Louisiana experienced catastrophic flooding. Later, ASPR responded to the Flint, Michigan water crisis, and in September, the Centers for Medicare & Medicaid Services posted the final Emergency Preparedness Rule. So far, in 2017, the WannaCry and Petya cyberattacks left health care facilities particularly vulnerable, and wildfires and record heat scorched the western states. Even now, as we go to press, parts of Texas and Louisiana are beginning what will likely be a years-long recovery effort from Hurricane Harvey and the southeastern states and territories are recovering from Hurricane Irma. Our country faces a growing opioid crisis, with close to 100 Americans a day dying of overdoses.

While ASPR staff, and their inter-agency and Emergency Support Function 8 partners, assist with responding to these incidents on a federal level, we know state, local, tribal, and territorial stakeholders are tackling not only these challenges, but also the myriad local incidents and natural disasters they manage with their own resources.

Since its launch in September 2015, ASPR TRACIE has become widely regarded as a source for proven, timely, and vetted information and a place where stakeholders can go for quick technical assistance. Over the past two years, we have created resources either in response to, or in anticipation of, nearly every incident we just mentioned. As visits to the ASPR TRACIE website climbed, so did the number of subject matter experts who agreed to provide help. We developed 47 Topic Collections that provide our audience with links to resources and research they can use in their everyday lives. We created tools that health care coalitions and other stakeholders can use while planning for and responding to disasters, and our Information Exchange allows users to communicate with each other and share tools and other resources in a password-protected environment, in near real time. [Check out our infographic to see how we've grown.](#)

As you know, a critical challenge is the work that must be completed in the days, months, even years before these terrible events occur. It is the painstaking work of preparation that you do every day to ensure that our local, state, and private sector partners are optimally resourced, organized, trained, equipped, and exercised to respond. At ASPR, we understand the importance of being prepared and having evidence-based, operationally focused resources and templates at your fingertips. [ASPR TRACIE](#) serves as a one-stop shop, and this issue highlights how we've evolved to continue to understand and meet your needs, allowing you to be better prepared as you contribute to the resilience of our great nation. As I begin my ASPR experience and as we strive together to improve our readiness, please don't hesitate to reach out to the [ASPR TRACIE Assistance Center](#) to share your story, so others may benefit from your advances. As always, we [welcome your feedback](#).



Dr. Robert Kadlec
Assistant Secretary for
Preparedness and Response,
U.S. Department of Health
and Human Services

Welcome to Issue 5!

In this issue of the [ASPR TRACIE](#) newsletter, The Exchange, we celebrate our second anniversary by looking back at how the emergency health care field has changed and looking forward at what is facing our field from the federal, state, and local perspectives. We feature input from stakeholders (including health care coalition members) who have used our products to plan for and respond to a variety of incidents, and we highlight tools we have prepared that can make your jobs easier. We hope that these real-life experiences shared by subject matter experts help you learn more about what ASPR TRACIE can do for you. We continue to release new [Topic Collections](#) and respond to a variety of [requests for technical assistance](#). Your feedback is what makes us successful—please [contact us](#) with comments, questions, technical assistance needs, and resources to share.

We look forward to our continued collaboration!

Shayne Brannman, Director, ASPR TRACIE

John L. Hick, MD, Senior Editor

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- ▶ As we were going to press, states and territories across the Gulf of Mexico and southeastern part of the country were beginning to recover from the historic damage caused by Hurricanes Harvey and Irma. Our next issue of *The Exchange* will focus on local, state, regional, and federal response and recovery efforts regarding these devastating events.

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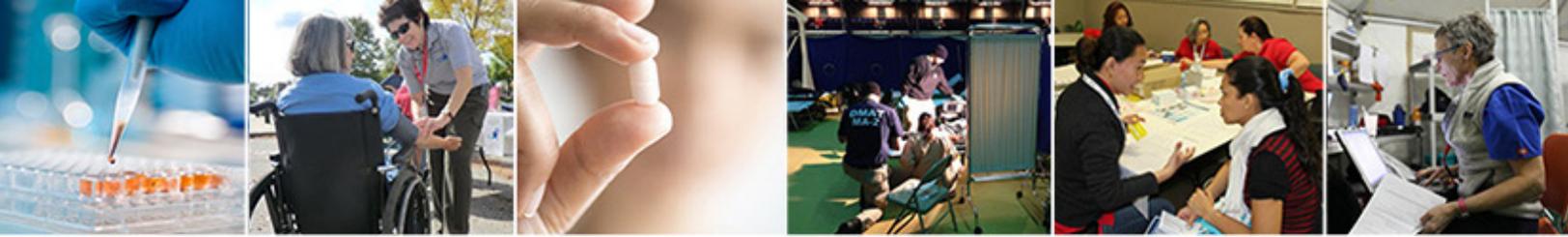


Photo courtesy of HHS ASPR.

What's New With ASPR?

A lot has happened since ASPR TRACIE published the most recent issue of [The Exchange](#), which focused on disaster behavioral health. Dr. Robert Kadlec was [confirmed as the new Assistant Secretary for Preparedness and Response](#) and is currently overseeing the Emergency Support Function 8 [response to Hurricanes Harvey and Irma](#). Dr. Thomas E. Price, Secretary of the U.S. Department of Health and Human Services (HHS), also determined that a public health emergency exists in the wake of the hurricanes in [numerous States and Territories](#). In other news, Combating Antibiotic Resistant Bacteria Biopharmaceutical Accelerator (or "CARB-X", a partnership between UK charity Wellcome Trust, HHS Biomedical Advanced Research and

Development Authority [BARDA], and other life science accelerators) announced [funding for global scientists to research new antibiotics to combat superbugs](#). BARDA and NASA are working together to [study the radiation absorption and related treatments](#) being developed by BARDA and private industry partners. At ASPR, the Office of Policy and Planning's Division of Policy and Strategic Planning released blog posts on the benefits of a [Neighborhood Health Watch](#) and [strategies for increasing national health security](#). Interested in learning more about how ASPR is working to strengthen the nation's ability to prepare for, respond to, and recover from emergencies? Visit the [ASPR webpage](#) and [blog](#)!



ASPR TRACIE: Two Years of Service

Contributed by John L. Hick, MD, Lead Editor for ASPR TRACIE, Hennepin County (MN) Medical Center

Three years ago, as health care coalitions began to mature, National Healthcare Preparedness Program (NHPP) leadership and field project officers noted an increasingly sophisticated need for technical assistance (TA), including the need for coalition-specific plans, tools, and templates, as well as subject matter experts (SMEs) who could quickly respond to questions. This need often resulted in a group email exchange, sometimes connecting with an SME or the right document, and sometimes not.

There was clearly a need for a cadre of SMEs that could be called upon to answer questions, but

more than that, we needed to be able to host a library of resources that the experts already relied on. Although the National Library of Medicine has an extensive disaster database, we needed a curated library of resources that would be geared toward the needs of health care coalition members, disaster responders, and others across the emergency health care response spectrum. This became our [Technical Resources](#) domain.

Questions that were not easily answered with available materials would need a mechanism for rapid TA. Users needed their TA requests acknowledged, and they needed quick, succinct results.

The Coyote Crisis Collaborative and its partners have benefited significantly from the help received from TRACIE. Specifically, TRACIE connected us to subject matter resources who advised us on a framework for the development of a mental health disaster response plan. Numerous disasters have demonstrated there must be a concise strategy with a significant mental health staffing that includes individuals trained to accommodate diverse ages, genders, and other characteristics. This response must be aligned across the state, so resources are used wisely and do not duplicate or flood the scene unexpectedly. Thanks to TRACIE, we have the concept for how to train, register, and build a significant force multiplier of mental health specialists from the community. Congratulations, TRACIE, on your second anniversary.

— Deb Roepke, Executive Director, Coyote Crisis Collaborative (AZ)



Top Technical Assistance Request Topics

CMS EP Rule*	Natural Disaster
Zika	Crisis Standards of Care
Healthcare Coalitions	Radiological/Nuclear
VHF/Ebola	HVA/Risk Assessment
Cybersecurity	Mental/Behavioral Health

*This category overlaps with a variety of technical assistance topics (e.g., emergency and communications planning, evacuation, and exercises).

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Who Requests Technical Assistance

Federal Government	Private Healthcare Entities	HCC/Other	State/HPP Awardee	Local Government
36%	23%	20%	14%	7%

We created an [Assistance Center](#) with the goal of triaging requests, providing rapid response, and tracking requests to closure.

Finally, during the Ebola epidemic, ASPR recognized the need for our stakeholders and partners to be able to privately share information (e.g., unofficial documents and advice specific to current incidents) in real time. As a result, we developed the [Information Exchange](#) to meet our stakeholders' need to freely share information and ideas as well as documents in real time, to facilitate peer-to-peer interactions. Private threads are also available when engagement with a small, limited group is desired.

We created [ASPR TRACIE](#) with the vision that it would be a one-stop national knowledge center for

health care systems preparedness. We knew our audience would be broad, so we built TRACIE to ensure that our resources and SME Cadre members reflected that diversity. However, ASPR TRACIE was not built to replace the excellent work and TA already being provided by ASPR regional staff (e.g., field project officers, regional emergency coordinators, and Medical Reserve Corps staff) or by other federal partners' field staff. Our mission is to augment that effort and provide ASPR's staff and partners with the tools and resources they need to better serve their communities.

We launched ASPR TRACIE not knowing how it would be received, and we have been so grateful that, to date, our Assistance Center maintains a satisfaction rate of nearly 97 percent. This speaks

My colleagues and I have found TRACIE to be of benefit to so many types of people and health care organizations. Whether it's easily finding a variety of published items on numerous important topics in the Technical Resources section, participating in conversations with peers as part of the Information Exchange, or asking SMEs for one-on-one assistance via phone or email requests, TRACIE is where we start looking for information to enhance our Coalition activities and advance the preparedness of our individual health care facilities and organizations.

— Craig DeAtley, Director, Institute for Public Health Emergency Readiness, MedStar Washington Hospital Center

volumes about our staff and the members of the SME Cadre, who are generous with their time and expertise in helping field questions and develop responses. With nearly 150,000 subscribers receiving our alerts and materials, over 3,100 Information Exchange members, more than 2,200 TA requests, and nearly 500 SMEs in our Cadre, we could not be more pleased with how TRACIE has been received and used.

Did you miss the "New Resources to Help Improve Health Care Coalition Preparedness" webinar? [Access the slides and recording](#) today!

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Still, we're just getting started! We've completed 47 [Topic Collections](#), with more on the way. [Several interactive and best practice tools and templates](#) have been released to assist coalitions with gap and resource analysis, pharmaceutical management, pandemic preparedness, and general preparedness and response planning. Hundreds of coalition documents were reviewed, and best practices are highlighted on our [Select Health Care Coalition Resources](#) webpage.

We hope in the coming year to be more aggressive at pushing information to our members in areas affected by natural disasters and human-caused incidents to provide more timely information. And we'll continue to monitor evolving trends and issues and

bring you webinars and resources, as we have with [cybersecurity](#), [Zika](#), [avian influenza](#), and [drug shortages](#), to name a few.

In the end, the success of ASPR TRACIE depends on you. As you encounter resources that you think are best practices, please [submit them to us](#)! As you use resources in the [Topic Collections](#), please take time to [rank and comment on them](#) so that your peers can understand their benefits or limitations. Contribute to discussions on the Information Exchange to seek or share ideas and resources. Recommend ASPR TRACIE to colleagues as a resource for health and medical preparedness and response issues. Take time to visit our website when you need guidance—not only might you find answers, you might also uncover

other interesting information that could enhance your preparedness efforts, make your job easier, and help you serve your community.

As we celebrate our second anniversary, we thank you, our members, for giving us an opportunity to assist you! It is truly a joy and a privilege to work with so many dedicated professionals and to see TRACIE becoming the “commons” where we can work, learn, and share together to enhance our national preparedness. ■

Health care coalitions are encouraged to apply for the Health Care Coalition Response Leadership Course; [check out the course offerings](#) and apply today!

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Two Years of Technical Assistance



While the [Assistance Center page](#) may look simpler than the others, behind the scenes it is complex and consistently busy. Since the inception of ASPR TRACIE, the Assistance Center has served as the primary way for our stakeholders to reach us, allowing ASPR TRACIE to provide the one-on-one direct support that makes us unique and valuable. It is managed and staffed by members of the ASPR TRACIE team, who have the professional backgrounds necessary to provide the assistance needed to our

diverse audience. The Assistance Center is typically the first stop for many of our users if they have questions, need specific support, or cannot find a resource. We customize our responses to the specific needs of the requestors, and while most of our responses are simple, research-based, and provided via a [written response](#), other responses may be more complex and include connecting with an SME, developing a fact sheet or tip sheet, coordinating a webinar, presenting at a meeting, or gathering resources in

anticipation of or in response to an event. Our SME Cadre includes nearly 500 members with a variety of professional backgrounds (e.g., health care, public health, emergency management, academia, public sector) who assist with the development of Topic Collections, TA responses, and special projects. In just two years, our stakeholders made more than 2,200 TA requests in topic areas such as highly infectious diseases, health care coalition development and management, cybersecurity, natural

disasters, crisis standards of care, and the Centers for Medicare & Medicaid Services Emergency Preparedness Rule. We maintain a [summary of select TA](#) requests and include redacted responses in the [Information Exchange](#) (login necessary) to allow you to learn more about what your colleagues are requesting. The Assistance Center looks forward to growing and learning with you and continuing to provide you with excellent customer service for many more years to come!

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Leaning Forward and Responding Quickly



ASPR TRACIE Resources Developed in Anticipation of an Event

Cybersecurity and Healthcare Facilities

WannaCry,
Petya Viruses

Solar Eclipses: Planning Resources

August 2017
Solar Eclipse

CMS Emergency Preparedness Rule: Resources at Your Fingertips

CMS Emergency
Preparedness Rule

EMS Infectious Disease Playbook

Highly Infectious
Disease Outbreaks

Since we launched, our mission has been to serve as a force multiplier for our stakeholders. We pride ourselves in being able to quickly collect or develop new resources that can help you respond to incidents and identify and help you prepare for what's coming next.

Orlando Health conducted several debriefing sessions with their team members and physicians following the Pulse nightclub tragedy. We compiled all of the lessons learned from these sessions and the incident and drafted an After Action Report/Improvement Plan that includes 66 areas for improvement (we are still working on 17 items). ASPR TRACIE provides numerous guidelines and benchmarks, which are great ways for hospitals and health care organizations to implement their building blocks toward preparedness. Besides the Topic Collections, one of the most valuable components is the ability to ask TRACIE for answers to challenging questions or for documents/input from SMEs. We know another incident is inevitable; we are preparing as if it were in our area, just like readers of this article should be, one block at a time.

—Eric Alberts, Corporate Manager,
Emergency Preparedness, Orlando Health

Check out our [recently released tutorials](#) that can help you make the most out of your ASPR TRACIE experience!

Health Care Coalitions—The Past and the Future

An Interview With Andrea Esp and Brian Taylor, Washoe County [NV] Health District

Abstract: Our approach to medical preparedness has changed markedly over the past several years. With fewer resources, integration between agencies and facilities is critical to leveraging resources and expertise to improve capacity and capabilities. Many health care coalitions (HCCs) were created—or formalized—after the 2009 H1N1 pandemic, and they serve as integral components to the disaster planning, response, and recovery phases. ASPR TRACIE interviewed Brian Taylor (Emergency Manager, Regional Emergency Medical Services Authority and Chair, Inter-Hospital Coordinating Council) and Andrea Esp (Public Health Emergency Response Coordinator) from the Washoe County (NV) Health District to learn more about how their HCC has changed over time, how ASPR and ASPR TRACIE have helped facilitate that change, and how they are preparing for future threats.

John Hick (JH): How have HCCs changed over the past few years?

Brian Taylor (BT): Five years back, I was part of the coalition, and while we were very collaborative, we were more focused on our core members, like EMS, hospitals, and public health. We were creating plans and things we thought looked good on paper,



Photo courtesy of HHS ASPR.

and we interacted a bit through exercises, but we mostly “checked the boxes.” After taking the Health Care Coalition Response Leadership Course in Anniston, we are now bringing in plans and tools that are usable from a field perspective and have been tested and tweaked to our region. That’s where ASPR TRACIE has helped us the most—bringing those plans to life and helping us utilize them.

JH: When did you start coordinating between disciplines?

BT: We had a large-scale mass casualty incident (MCI)—the 1985 Galaxy Airlines crash—and we realized that the response wasn’t coordinated to the degree that it needed to be. We all agreed that getting together as a group would be helpful and started

the Inter-Hospital Coordinating Council (IHCC), a health care preparedness coalition. This incident also showed that when working separately, people brought with them different terminology and plans, and those did not necessarily work well together. After that, we began to work on our comprehensive incident action plan.

Andrea Esp (AE): The coalition officially started in 1994, and we pretty much continue to meet on the same day of every month, since we launched.

JH: When did you begin receiving grant support?

AE: When the ASPR/Centers for Disease Control and Prevention cooperative agreement came along in response to anthrax. Prior

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to that there was an EMS program within public health that helped provide MCI-related support for the IHCC.

JH: How did the 2011 Reno Air Races crash affect your coalition?

BT: I ran that scene as the Medical Branch Director, and while the incident was praised nationally because we transported 54 patients in 62 minutes, and the hospitals complimented us on how we distributed patients, there were so many lessons learned. For example, we were given the state-mandated tool for patient triage, transport, and tracking, but it didn't work in this situation. We lobbied the power of the coalition to come back and present and change our entire triage tool. We based this change upon field personnel input—we took a few tools and presented them in a full-scale exercise format, compared them, and made the changes. Now the region is using this tool, and the entire state is considering adopting it. The HCC spearheaded that process, and all the coalition members helped us acquire and pay for the new tool.

AE: We also revised our plan based on lessons learned from the incident. Because we try to engage all HCC partners (not just EMS, fire, hospitals, public health), we wrote and coded our own MCI board for patient tracking. This gives other HCC members situational awareness of where

patients are being transported around the area. From this, we also developed a family resource plan that includes a lot of our nontraditional community partners. We've increased the capacity of the plan, and it really shows how other members play a role. This has also helped with buy-in.

JH: For how long have the more diverse stakeholders been engaged in the work your coalition does?

BT: The recognition that “everyone needs to be part of the group” happened about two years ago. But our Health Care Coalition Response Leadership Course in Anniston spearheaded how we need to involve the other noncore members (e.g., dialysis centers and long-term care facilities). ASPR TRACIE specifically has helped us with resources, plans, and templates that show these providers how they fit into the general emergency preparedness and response picture. This makes our facilities and our response more robust, because all are incorporated into an integrated plan.

JH: It's pretty clear that the nature of your work has evolved to include many more partners who provide input. That's both an opportunity and a challenge—we've covered the opportunities. What challenges are you facing, and what strategies are you using to overcome them?

The more TRACIE is integrated with the boots on the ground and the more our coalition is integrated with the responders is the key to success. It makes the work meaningful to the people who are doing the job—one size does not fit all—it fits one.

—Brian Taylor

AE: I try to manage and bring in the outside partners. The CMS Emergency Preparedness Rule has been a huge help, but our workload has definitely increased (mine has tripled). We have 230 licensed health care facilities in our county, and there is no way you can have everyone at the table (nor do they want to attend every meeting). A challenge is ensuring that our meetings remain productive. We have to determine when there are too many stakeholders in the room, and we are working on recruitment and retention strategies. We also have representatives from hospice, surgical centers, long-term care, and the like who come to our meetings, then take information back to their respective partners.

Having the new rule is a great thing from a government perspective. And while it increased our workload, it has really helped engage some partners and put

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more ownership on these facilities to create their own plans. They still need some guidance; someone showing them how to fill out forms would even be helpful. A big challenge is that the manpower to help them isn't there, and our coalition might not be able to get them all up to speed. At the same time, we don't want to lose the opportunity to be that helpful resource and get the buy-in by November 15. While we can't write their plans for them, we know that if we aren't working closely with them, they may not be able to fully comply with the new regulations. It would have been nice to have a one-year transitional period to allow us to provide our partners with some assistance in developing these plans. This process is brand new to a lot of our facilities, and we don't want them to just hire a contractor to do the work.

BT: Another challenge is answering the question, "Why does it matter to us?" It is very hard for us to explain how this type of collaboration matters to a facility executive managing day to day or hour to hour. One way we've tried to overcome this is by using our hospital evacuation plan to try to illustrate to our partners how this collaboration will play out in an emergency, and we also emphasize the need for training. Once we do that, they are more willing to come to the training and learn about our established systems. We've also put a lot of effort into creating "champions"

in the different areas—identifying someone who is really engaged in this process and can take our information back to their partners can also help us get reluctant players committed.

BT: Funding challenges are also huge; in our region, with nonpaid coalition leadership, we ensure funding is spent to the penny.

AE: I would say that our biggest tool for getting folks on board is the Mutual Aid Evacuation Annex. Our plan has pre-identified how many patients a facility can take without us needing to call and ask. We capitalize on the real-life incidents we've experienced lately, such as this year's flooding events, to show how incidents can affect our nontraditional partners, how the plans actually work, and to highlight their roles in the plan.

BT: Our plan has become a regional plan—it's being used by seven counties in northern Nevada. Getting everyone to speak the same language and emphasizing how these plans are integrated is key to effectiveness.

Does your HCC need help developing plans? Conducting a gap analysis? Preparing for a pandemic? Access our new [tools and templates that can help improve HCC preparedness](#) located on our [Select Health Care Coalition Resources](#) page.

JH: Did you use any kind of strategic process for the coalition to determine priorities?

AE: Not at the beginning. We used to just ask the group for input on what we should work on. We became more motivated when we began receiving scores related to the HCC Development Assessment Factors and the Jurisdictional Risk Assessment (JRA). The JRA looked at behavioral health, public health, and the rest of the health care system and tied scores back to the coalition, which really highlighted gaps and helped us determine what to work on and how to demonstrate our annual growth. Now, for the first time, we are going to have a coalition hazard vulnerability assessment (HVA) that we can provide to our health care partners so they can incorporate it into the development of their own HVAs. This will then feed into our next level of jurisdictional assessment at the beginning of the year, so we can strategically plan out what needs to be accomplished and what can be added to our scope of work. We'll be developing graphics to illustrate how all of these are connected and how the CMS rule applies throughout the process.

JH: If you had to look forward 5 years, what are some areas you'd like to make progress in?

BT: Making sure that everybody knows that if we have a disaster,

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Photo courtesy of HHS ASPR.

we are going to share the burden. Long-term care facilities have to play a critical role and take patients. Hospitals would have to open their surge capabilities, and our coalition would really become a “complete community response coalition.” We would all respond and be flexible.

AE: We’re working toward that point where all of our health care system partners understand their role. We’re working on a joint exercise with all surgical centers and letting them determine their role, how they would support the system, and how communication would work with public health or ESF-8 and emergency operations centers. It’s really developing the educational mechanisms that help partners understand their

roles, depending on the incident. That way, as a system, we will all have the same expectations, we won’t inundate our hospitals, our community will be more resilient, and there will be less chaos and confusion in the response phase.

John Hick Commentary: The Washoe County HCC has the benefit of strong relationships and a degree of integration—which began prior to 2001—that is not found in many communities. Building these strong relationships has been a critical element to its success. As partners get broader, it can become more difficult to establish these types of core partnerships. For coalitions facing these challenges, a strategic approach is key, as is determining what can be moved

forward, by whom, and with what resources, as current funding is insufficient to support the broad range of possible activities. At the same time, there are so many interdependencies between health care services and therefore many gaps and opportunities to address. Washoe is doing a great job of recognizing these gaps and opportunities and channeling the energy of core partners and new partners as they continue to try to figure out what is possible in their area with their resources and stakeholders. Some coalitions are as mature as Washoe, and others are just starting, but all can benefit from looking forward and looking back to see how much progress has been made or can be made! ■

Hospice and Emergency Preparedness: Tales From the Field

An interview with Sheryl Pierce, Therapy Health Services

Abstract: In many areas of the country, homecare and hospice agencies—while providing critical services to patients and their loved ones—have not traditionally been part of the emergency preparedness landscape. The CMS Emergency Preparedness Rule, combined with recent events requiring these providers to evacuate patients, prioritize care, or provide health care volunteers, is changing this notion across the United States. Dr. John L. Hick (ASPR TRACIE's senior editor) interviewed Sheryl Pierce, RN, MS, who currently serves as the corporate quality assurance performance improvement director for Therapy Health Services (Texarkana, TX) to learn more about the changing role of homecare and hospice agencies in community resilience.

John Hick (JH): Please describe your current role, and explain how long you have been in the hospice field.

Sheryl Pierce (SP): I am a registered nurse and have been in nursing since 1967. Before joining Serenity, I worked in a 500-bed hospital, which had an affiliated 120-bed skilled nursing facility with a hospice unit. I have been with Serenity/Therapy Health Services since 2010—in a more local

position for six years, and now in a corporate role. When I was in Texas, I conducted an award-winning disaster drill with two states—Texas and Arkansas—and many counties regarding infection control.

Members from both state departments of health and the American Red Cross also participated in the drill. Since then, I have been traveling to our corporate hospices across the country getting their emergency preparedness programs off the ground.

JH: Congratulations on the award! Can you tell us more about the lessons learned from the drill and how your hospices are addressing them?

SP: In 2014, when two nurses in Dallas contracted Ebola, both of them stated that they hadn't received enough training to deal with a highly infectious disease. At the same time, a hospital in one of the smaller communities we serve in Arkansas was experiencing a meningitis outbreak that also sickened some staff. Had they been trained in the proper use of personal protective equipment (PPE), they could have gotten a



better and quicker handle on the outbreak. I reached out to my FEMA contact in Dallas to see if I could do an infectious disease exercise based on FEMA's *PrepareAthon!* methodology (and funded by our corporation), and my request was granted. I invited community partners to do the drill, and we went through the proper donning and doffing of PPE.

In 2016, Sheryl Pierce accepted the Federal Emergency Management Agency's (FEMA) Individual and Community Preparedness Award for outstanding efforts in disaster preparation.

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During the exercise, we practiced with the PPE we would use in the event of another meningitis case, since we agreed that was a more likely scenario. We were all pleasantly surprised that 400 invitees participated in the exercise! Since then, I have been traveling to local community health care agencies, especially extended care facilities, to work on similar planning and exercises. I have also set up a group that travels and does similar training for private home care and hospice providers. I have had the privilege of going to all our corporate hospices and setting their programs up and doing drills with them.

JH: Is there better integration between hospice and emergency management now?

SP: Absolutely. In January 2017, Biloxi, Mississippi, was hit by a tornado. The following June, a tropical storm spawned another tornado in the same area, and we were so pleased to see how many changes had been made between the two incidents. In January, shelters admitted our home health and hospice patients, but they put them with the general public. This was problematic for two reasons: one, our patients typically have compromised immune systems. And two, while shelter staff assigned our patients shower times, they didn't realize that many of our patients needed a different way to maintain their hygiene because of mobility and other

challenges. In June, the shelters actually had a separate area for home health and hospice patients so they weren't exposed to the general public. They stocked the area to be sure there was enough electricity, oxygen concentrators, and similar equipment for those patients. They had also set up a more mobile and private bathing system.

JH: Can you explain your experiences with the new CMS rule? For example, how are you meeting your requirements? Are you using specific resources or tools?

SP: Our agencies across the country are on pace to meet the requirements. In Chicago and Costa Mesa, California, nursing homes and hospices have been invited to join health care coalitions. In Hawaii, they are invited to be part of the exercises. In Mississippi, our agencies must have their communications plans finished before the deadline—we are using their plan as a template for our other states and agencies. I'm grateful I learned more about ASPR TRACIE at a workshop.

Access the [Homecare and Hospice Topic Collection](#) for reports, toolkits, and guidance specific to providers and patients.

We've used and shared [ASPR TRACIE's Evaluation of Hazard Vulnerability Assessment \(HVA\) Tools](#) and the [Hazard Vulnerability/Risk Assessment Topic Collection](#) a lot. All of our plans and policies are based on information we found at this site!

JH: Do you provide your clients with any emergency preparedness materials or education?

SP: We give our clients a complete set of emergency preparedness plans, and we go over the materials with them. In Texas, we focus on tornadoes. In California, we focus on earthquakes. In Hawaii, we focus on nuclear disasters, hurricanes, and tsunamis.

JH: What about patients who use durable medical equipment at home?

SP: Realistically, we know that 2–4 hour battery backups are not going to cut it during an emergency. If our patients have oxygen and a concentrator, our durable medical equipment company has to furnish a 12-hour battery to ensure that we have enough time to evacuate them. Everything is electronic, but the city has a backup database of patients in the community with needs and intensities. They are prioritized and the teams know who to go to and when.

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JH: What’s the best part about the CMS regulations and related activities?

SP: The fact that homecare and hospice are finally recognized as being just as medically important as hospitals. These agencies have been left out for many years for no reason. Our nurses can be excellent resources in disaster shelters, for example.

John Hick Commentary:
When hospice and homecare agencies fail to plan for disasters, both staff and consumers may be challenged by the response and, in some cases, patients may wind up in unfamiliar hospitals or

shelters. These agencies must help consumers, their caretakers, and the staff who serve them understand what they need to do in emergencies and work with the community to ensure that shelters are prepared for their unique needs. Sometimes, shelters are unable to provide the type of support these consumers require (or may be unaware of how to provide it), but trained staff, proper equipment, and appropriate shelter space can go a long way toward keeping consumers safe and comfortable until a better destination can be identified. Also, having a plan to triage services provided is important

when staffing and access are compromised or the demands on the agency increase during a disaster. Though not addressed in this interview, the ability of homecare to accept new patients can be a critical component of hospital surge capacity, as it allows safe discharge of patients that might otherwise have to remain as inpatients. ■



Most Frequently Searched Terms (past two years)





Our Subject Matter Experts

Healthcare	Federal	S&L Govt.	Private/ Non-Profit	EM/First Responder	Academia
37%	35%	15%	6%	4%	3%



The ASPR TRACIE SME Cadre

Contributed by Shayne Brannman, Director, ASPR TRACIE

Words like “intelligent,” “diverse,” “selfless,” “dedicated,” “passionate,” “responsive,” and “generous” quickly come to mind when I think of ASPR TRACIE’s SME Cadre. One of the cornerstones of our accomplishments resides in the ability to attract and retain knowledgeable professionals who willingly share their expertise and experiences so others might benefit. The contributions of our SMEs are as diverse as their

backgrounds and work settings: improving Topic Collections; supporting TA requests; providing one-on-one consulting; participating in webinars; writing articles; and developing or reviewing work products like templates, playbooks, or white papers. Simply put, ASPR TRACIE would not be able to help our diverse stakeholders without the direct support of our SME Cadre members, who willingly lend their

talents and time (often at the end of their own demanding work days) so others might benefit. We unabashedly thank and acknowledge our growing bench of SMEs who, on a daily basis, are helping us realize TRACIE’s vision to be a premier health care system preparedness information gateway. If this has sparked an interest and desire within you, please [submit an application to join our SME Cadre](#). ■

The Opioid Crisis—How Can Coalitions Help?

Contributed by John L. Hick, MD, Lead Editor for ASPR TRACIE, Hennepin County (MN) Medical Center

Any disaster that killed 100 people today in the United States would be sustained front page news. And yet, this is an everyday occurrence: 3,000 people will die this month, the same number will die next month, and by the end of 2017 approximately 12,000 additional people will die from opioid overdoses. This fact is somehow overlooked in this sneaky epidemic.

The causes are many. Over-prescribing of narcotics for acute and chronic painful conditions resulted in countless patients habituated or addicted to narcotics. Cheap heroin flooding into U.S. markets and wide availability made it easier to access the drug and get hooked. Severe withdrawal symptoms make it difficult to give up. And synthetic derivatives that are easy and cheap to produce, but can be far more potent than the “original” product (and resistant to usual reversal agents like naloxone), have resulted in a dramatic increase in deaths.

While at press time, no formal declaration had been made, in August, President Trump claimed that the opioid crisis is a “public health emergency.” The question for our disciplines is what does that mean, and to what degree can the tools we use to respond to infectious disease epidemics and conventional disasters be used to mitigate this emergency?

Multiple states and Native American communities have declared public health emergencies. The advantages and the power afforded under these declarations differ from state to state. Often, the declaration involves the ability to shift resources to the problem, change the legal landscape, and draw the attention of lawmakers to the issue.

Historically, use of naloxone was limited to advanced life support providers and hospitals. There has been a major effort to ensure that naloxone is available earlier—providing it to drug users, their loved ones, and first responders, and altering the legal requirements and liability. These interventions have certainly saved lives, although the doses of naloxone may be insufficient to reverse the newer agents and should not be seen as a “safety net.” In addition, stocking, replacement, and other issues continue to challenge these programs.

Controversy surrounds potential dangers to first responders from the new synthetic opioid derivatives. Some law enforcement officers and emergency department nurses have experienced symptoms when handling articles contaminated with powdered narcotics. In many cases, symptoms experienced by these responders are not



Due to the increase in 911 calls in Regions 8 and 9, our first responders exhausted their supplies of PPE, especially their nitrile gloves. I had to make a request to our coalition partners for CPR face shields, adult ambu bags, and other equipment to handle this influx.

—Jackie Campbell, RN,
Health Care Coalition
Coordinator Region 8/9 (KY)

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The opioid crisis has put such a demand on the county coroners in some of the rural communities of northern Kentucky that the Hospital Preparedness Program (HPP) Region 7 coalition acquired this past summer two additional body coolers to add capacity and help deal with the surge in remains until they could be processed. We bought two more for rural county coroners in HPP Region 15 within Central Kentucky for the same purpose. While we are dealing with an unusual surge problem, this enhances the overall capacity of the health care preparedness system, should the next round be associated with a highly contagious disease outbreak or a terrorist event. People assume that all hospitals and communities have a morgue that can store the deceased, but that isn't always the case—particularly in rural areas. Not every county has a hospital, and it may only have the ability to store one body for a short period of time. When the cause of death is undetermined, or needs to be confirmed, the deceased may have to be sent to a state facility for the Medical Examiner to review. The other fact many don't realize is that in some states, the County Coroner could be an elected official, not necessarily an undertaker or someone who is affiliated with a local facility that examines or processes remains.

—Dick Bartlett, Emergency Preparedness Program Coordinator, Kentucky Hospital Association

consistent with those typically associated with narcotic exposure, but intoxication is possible when the substance is inhaled or ingested. Transmission is not possible through intact skin, but the substance can enter a small cut or scrape. During patient care, providers should always be wearing appropriate examination gloves. Although the risk of inhaled powder during patient care activities is not defined, and is likely very low, first responders should be careful not to aggressively brush powders and should strongly consider use of a filtering face mask. Simple masks offer some protection and should

be used if the [recommended N95 or other respirators](#) are not available.

Once the patient is medically stabilized at the hospital and observed to ensure that the opioid effects do not outlast the naloxone effects, the patients are often discharged without specific follow-up plans. Some hospitals do provide Narcan kits, and some share patient education and referral materials. In general, there are too few treatment programs for narcotic addiction and many users live too far from approved programs. Physicians need special licensure and training to provide

addiction services and often do not have the resources or training to address the needs of those addicted. In addition to treatment, major social interventions and support are usually required to help the user avoid relapse, and to navigate the health insurance issues associated with treatment.

A comprehensive look at the threat, programs, information, policies, and stakeholders at the local level is needed if the community or region is to have a unified approach to this problem. Fortunately, HCCs can bring EMS, hospitals, public health, law enforcement, and emergency management together to do just that, as is evidenced by the quotes that accompany this article.

Heroin and Norco use are a major issue in Region 6 (MI). Fentanyl is also suspected in numerous deaths. HCCs are working with hospitals, EMS agencies, and medical control authorities to make Narcan available throughout the region and to give hospitals the education and resources needed to deal with this major issue. Region 6 has included nasal Narcan in all medical first responder vehicles and in the EMS bags carried throughout the region.

—Jerry Evans, MD, Region 6 Health Care Coalition Medical Director

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Potential HCC actions may include:

- ▶ Sharing information and creating situation reports and incident action plans
- ▶ Providing a forum for discussion of the issue among the stakeholders and including legal counsel and political officials
- ▶ Collecting public health, hospital, law enforcement, and EMS data to determine the epidemiology of the problem in the area
- ▶ Collecting information about resources in the area in one place
- ▶ Determining current programs and policy for naloxone use and options to create consistency within the region
- ▶ Ensuring that consistent information is given to overdose survivors at the hospitals to facilitate follow-up
- ▶ Facilitating complementary interaction between social services and treatment programs in the area
- ▶ Developing concise, tailored provider and public messaging around the epidemic in the area
- ▶ Creating a strategic plan outlining the contributions and roles of the involved disciplines
- ▶ Weighing the advantages and disadvantages of emergency powers and declarations
- ▶ Evaluating potential liability and indemnification issues based on local and state laws and ordinances

Coalitions do not have a required role in the opioid crisis. But we do have the tremendous opportunity to showcase how our membership and our structure can be used to benefit the community in an emergency that is insidious and claims far more lives in many of our communities than any recent infectious disease outbreak or mass casualty event. It also affords the opportunity to increase HCC visibility with potential partners, including jurisdiction and political officials. Hopefully, engagement on issues such as these can lead to opportunities to involve the key coalition partners

in other efforts to prevent injury and death in the community.

There are no short-term answers to the opioid problem. Control of the flow of drugs is difficult, reaching the victims in time to intervene is unpredictable, and getting the patients the treatment, follow-up, and resources that they need to quit is complicated, even when it's possible. This crisis will require a dramatic commitment of resources at the federal, state, tribal, and local levels for us to effectively reduce these deaths. We all have a role to play, both as responders and advocates. ■

As with much of Michigan and the nation, Region 5 has witnessed an explosion in nonfatal and fatal opioid overdoses. The coalition infrastructure is well poised to both gather data and push out information to partners, particularly hospitals, EMS, and law enforcement agencies. With the emerging use of synthetic opioids, the 5th District Medical Response Coalition also serves as a clearinghouse of information for responders concerned about safety and proper personal protective equipment for dealing with these incidents.

— *William Fales, MD, FACEP, FAEMS*
Chief, Division of EMS and Disaster Medicine,
Department of Emergency Medicine, Western Michigan University, Homer Stryker MD School of Medicine

— *Medical Director,*
Kalamazoo County
Medical Control Authority
State Medical Director,
Michigan Bureau of EMS,
Trauma, and Preparedness

Access the ASPR TRACIE fact sheet [Opioids: Frequently Asked Questions](#) for more information.

RECOMMENDED RESOURCES

TECHNICAL
RESOURCES

ASPR TRACIE recently released Topic Collections on [Rural Disaster Health](#), [Coalition Administrative Issues](#), and [Volunteer Management](#). Be sure to bookmark our page that includes [all comprehensively developed Topic Collections](#), as it is updated often. You can also learn more about rating, commenting on, and saving resources [in this short tutorial](#).

ASSISTANCE
CENTER

When disasters such as Hurricane Harvey strike, the ripple effects on the entire community can be significant. Access [Tips for Retaining and Caring for Staff After a Disaster](#) to learn more about general promising practices—categorized by immediate and short-term needs—for facility executives to consider when trying to retain and care for staff after a disaster. Our document [After the Flood: Mold-Specific Resources](#) can help residents, business owners, and health care facility executives prevent, identify, and get rid of mold. You can also access a [summary sample of TA requests](#), which range from providing individuals with topic-specific resources to researching and providing individuals with topic-specific resources (e.g., evacuating patients with mental illness in disasters). For assistance navigating the Assistance Center, [check out this new tutorial!](#)

INFORMATION
EXCHANGE

[Register for the ASPR TRACIE Information Exchange](#), where you can click on the [Responder Safety and Health](#) threads and share your opinions and resources with us and your colleagues. Already have an account? Simply log in and share your feedback! Need help registering for the Information Exchange? [Access our quick tutorial!](#)

NEW & UPCOMING 2017 EVENTS

The FEMA Center for Domestic Preparedness, in collaboration with ASPR's Division of National Healthcare Preparedness Programs, has developed a one-day, eight-hour Health Sector Emergency Preparedness Course. The course is designed to provide training to health care providers and suppliers in the achievement of the four core elements outlined in the September 2016 Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers Final Rule. Access [the syllabus](#) for more information.

CMS just launched a new, on-demand Emergency Preparedness Basic Surveyor Training Course. This is a required course for all State Survey Agency (SA) and Regional Office (RO) surveyors and reviewers who conduct or review health and safety or Life Safety Code surveys for emergency preparedness requirements. Non-survey professionals and other SA or RO support staff responsible for ensuring compliance with regulations are also encouraged to take the course. Access [the course](#) on the Integrated Surveyor Training Website. Contact the website's [help desk](#) for technical assistance.

October

October 19–20; New York, NY

[Ebola and Other Special Pathogens Simulation Training](#)

This training is geared toward direct care providers and will provide information and hands-on practice on several essential skills of caring for patients with Ebola and other special pathogens, with a focus on providing safe and effective care in PPE. (The course repeats April 10–11, 2018.)

November

November 2–3; Atlanta, GA

[Emerging Infectious Disease Workshop](#)

This workshop will provide information and tools on the many aspects of managing and maintaining readiness of a facility responsible for assessing or treating patients with a special pathogen.



November 4–8; Atlanta, GA

[American Public Health Association](#)

Attendees will learn more about the health risks associated with climate change and how APHA is using this conference to “mark the cornerstone of the Year of Climate Change and Health.”

November 8–9; Dallas, TX

[Association of Healthcare Emergency Preparedness Professionals](#)

This event gives administrators, emergency preparedness coordinators, directors of public health preparedness, emergency managers, RNs, and individuals in the health care and public health preparedness field the chance to share the latest research and best practices, network, and collaborate on ways to move preparedness forward. Check out ASPR TRACIE's session on November 9 at 2:30 p.m.!

November 9, 2:00-3:00 pm; Webinar

ASPR TRACIE and the [National Ebola Training and Education Center](#) (NETEC) will host the webinar “Highly Pathogenic Infectious Disease Exercise Planning for Healthcare Coalitions.” This fourth in a series of joint webinars will highlight NETEC's free exercise templates for HCCs to test their readiness to manage patients suspected or known to have a highly infectious disease and will feature speakers from HCCs that have already exercised their plans.

November 28–30; San Diego, CA

[National Healthcare Coalition](#)

The National Healthcare Coalition Preparedness Conference is expanding opportunities for learning about the implementation of health care coalitions and coalition activities in our communities.

April

April 17-20, 2018; Atlanta, GA

[Preparedness Summit](#)

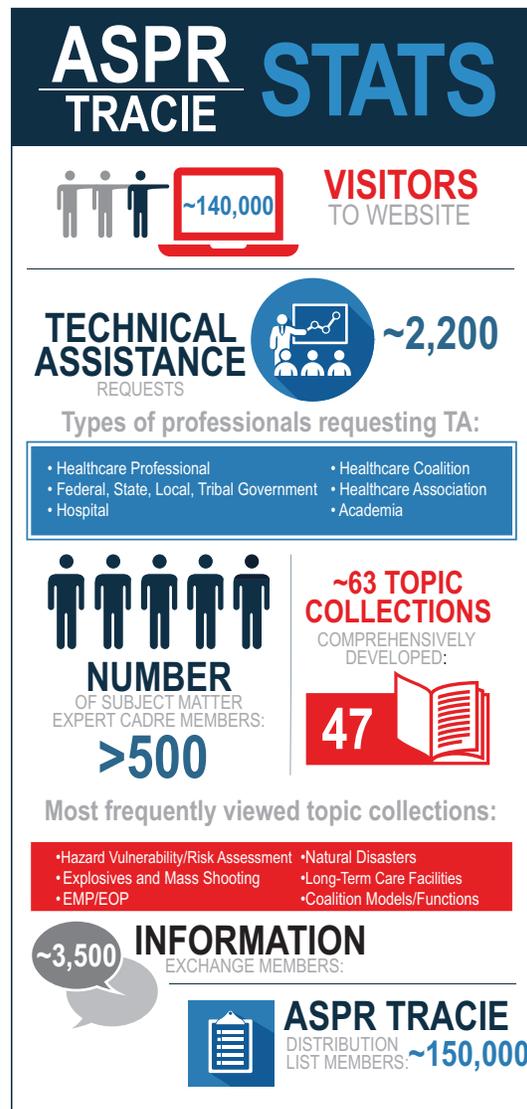
Attendees will learn about and share experiences in public health preparedness. Abstract submissions will open in September 2017.

ASPR TRACIE:

Your Healthcare Emergency Preparedness Information Gateway

The Exchange is produced by the Office of the Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE). Through the pages of *The Exchange*, emergency health professionals share firsthand experiences, information, and resources while examining the disaster medicine, healthcare system preparedness, and public health emergency preparedness issues that are important to the field. To receive *The Exchange*, please go to ASPR TRACIE's homepage (<https://asprtracie.hhs.gov/>), and enter your email address in the "Subscribe to the ASPR TRACIE Listserv" box on the bottom right.

ASPR TRACIE was created to meet the information and technical assistance needs of ASPR staff, healthcare coalitions, healthcare entities, healthcare providers, emergency managers, public health practitioners, and others working in disaster medicine, healthcare system preparedness, and public health emergency preparedness. The infographic illustrates ASPR TRACIE's reach since launching in September 2015.



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