Utah Public Health Emergency Preparedness Advisory Committee Meeting

March 17, 2016

In Attendance: Paul Patrick, Dean Penovich, Suzanne Barton, Kevin McCulley, Marc Babitz, Mike Stever, Judy Watanabe, Jill Vicory, Dave Cunningham

On the phone: Lewis Hastings, Chris Crinch, Linda Emmett, Jay Downs, Lloyd Berentzen

Excused: Hugh Daniels, Bryan Larsen, Jennifer Brown

Approval of Minutes: October 22, 2015 minutes motion made by Jill Vicory, motion seconded by Marc Babitz. All members voted in favor to approve the minutes, none opposed, Dave abstained because he has not read over the minutes/wasn't in attendance. Motion carried to approve the minutes.

Announcement: Dave Cunningham is the new co-chair of the Advisory Committee.

New HPP and PHEP Cooperative Agreement: Kevin and Dean
July 1, 2016 will be year five of five, with this being the last year of the cycle for the current HPP/PHEP cooperative agreement. The budget period is July 1st through June 30th. The funding year is being revised so the PHEP base is going to decrease. There will be a call tomorrow and we are anticipating 5 - 7% decrease in PHEP funding. CDC has been directed to take 50 million dollars off the top for Zika. This will be effective July 1st. A few years ago HPP got a 40% reduction in funding and they have restored some of that. We have a concurrence requirement from our local health departments in our proposal and plan on how to use this funding. There is also a requirement this year that we need to get a letter from our executive director of our health department that we are working with epidemiology, the lab and the Bureau of EMS and preparedness. The purpose is to make sure that we are being prepared for public health emergencies. There is new language about contingency emergency response funding and operationalizing our efforts and making sure we are ready to respond.

The second thing is there is expanded authority to use unobligated funds from year to year for just one additional year as carry over money as long as it was pre- approved in the first year budget approval. The language focus is for response and not just pre-event preparedness efforts; which has really been the focus over the past several years. We need to think about how we can better prepare ourselves this year for response. There is specific language this year about addressing the needs of individuals with chronic medical conditions and an emphasis on coordination with EMS, ensuring cross discipline information sharing between health care coalitions, surveillance programs, communicable disease programs, health care associations and infectious control programs. We have done a lot of this the past year. There is more language on operationalizing healthcare coalitions. There is a requirement in the guidance this year that we purchase equipment for the lab for chemical laboratory for $186,000 and they are getting quotes for that. Kevin is looking at their budget prior to the overall cut in funding. We still have a requirement to sustain our information system such as our surveillance system and our notification system and conducting an annual PHEP exercise. There are some close out requirements and a few new benchmarks.

There are joint requirements for both HPP and PHEP. There are specific requirements for each one. There will be continued interaction with infection control and public health, which they have already been implementing. There is continued reference with continued coordination with partners like DEM starting at the federal level with the joint MOA between the federal agencies that trickles down to the state levels. There is a lot of new language on interaction with infection control and we expect for 2017 - 2022 that the capabilities will be refined and will be similar with some changes programmatically in terms of development of the work plan and they might pull training and exercises out on their own plan. Also they might focus more on work force resiliency.

2016-2017 ASPR Hospital Preparedness and CDC Public Health Emergency Preparedness Programs -
In terms of a general overview, we are still required to do cost sharing, matching and show some maintenance of effort required. The fifth year of the five year project begins on July 1st. In general Utah falls below in funding compared to the other states. Utah is generally 30th in the funding level of the 50 states and Utah gets $2.3

million. The average award is usually $4.1 million. PHEP award is going to be determined on the call with the Fed's tomorrow. The purpose of HPP is about maintaining the health-care systems resiliency, critical infrastructure protection and medical surge response and PHEP supports local and state public health, epi surveillance and lab and preparedness and response. What we have done is there are some aligned capabilities between PHEP and HPP. On the PHEP side of community preparedness we will continue to work on catastrophic earthquake plan and enhance work with at-risk and vulnerable populations to prepare for disasters. On the HPP side we will continue to sustain regional coalitions and address vulnerable, burn and pediatric populations. We will also continue to work on NIMS compliance. There are recovery plans on both sides and that capability has the biggest gap. It's a large challenge for states that don't experience frequent events. The frame work for what recovery looks like will have some progress this year.

On the PHEP side we have been assigned as the lead for DOH to work with the various divisions and buildings to insure they have adequate continuity of operation plans. On the HPP side we continue to try and make efforts to ensure that healthcare organizations are doing their continuity planning recovery plans mainly with access through their administrators. We also have coordination with HHS and FEMA designated recovery coordinators. Emergency operations coordination capability is a joint capability and on the PHEP side we will update command and control plans, improve our job action sheets and SOP's for the Department Operations Center, On the HPP side we will start to train non-preparedness staff to serve in a command and control function and provide assistance when we are operating in incident command. On the HPP side we are working on developing the role for regional coalitions and jurisdictional command and control. It's not clear in some areas and in other areas it is a defined seat at ESF- 8. We want to continue to operationalize how a coalition could support a jurisdiction.

On public information and warning that is really our PIO function. We are looking at real time monitoring with twitter feeds and social media and how do we improve the public messaging overall.

Mike Stever commented that we have created an emergency response team and we don't have enough staffing coverage for over 24 hours. They are asking for department wide interest to help with staffing needs and to get trained. The training will be basic training level. The success of this will basically rest on Just in Time Training and job action sheets. The challenge we have is any new assignment gets difficult and is put on the back burner. Job action sheets in the Department Operations Center are going to be key factor and a functioning knowledge of Web- EOC is going to be a key factor as well.

A larger issue is amateur radio operators and how they become ineffective in a disaster because they serve so many different people. We have purchased radios and will provide training for department staff and this will help with this void if necessary. The FCC regulations states that amateur radio operators can be used in the event of a disaster.

There is fatality management on both Hpp and phep. Lanette Sorenson and the OME office have made great strides in refining the state's mass fatality plan and have been developing templates for locals to eventually adopt and for regional coalitions. They are also working closely with their partners, UTA, and other transportation carriers to deal with the issues of family assistance, victim identification and other critical components.

Information Sharing is a joint capability. UTNEDSS, UNIS, UHRMS, Utah Responds, UTRAIN, 800 Radios, Sat Phone UPATS are the operation communication systems we are using. We will sustain and use with exercises. The biggest gap is the automated patient tracking system. We have adopted the federal system which we call UPATS. We are going to look to see what we can do during this final year to determine if we will have a viable patient tracking system. Other states have bought in to larger corporate patient tracking software systems and it is costing them $100,000 a year and it is only used maybe once in ten years. We took the free federal system which doesn't have a lot of vendor support and we are trying to build it in a way that is more viable given our funding limitations and the frequency of use. For our smaller jurisdictions, patient tracking could be done using a spreadsheet and making phone calls as long as people know who to contact as the point of contact in that jurisdiction that would be assigned to patient tracking function.

Kevin mentioned that he was in South East recently and there were issues with HIPAA with the recent bus crash and one of the emergency managers from the hospital was trying to help an individual locate a missing

family member who had gone to one of seventeen facilities and because of HIPAA nobody would say if that person was there because they were more concerned with HIPAA than about family reunification. There is an issue that we know that HIPAA can create a barrier to appropriate response if people don't understand that things like that can be waived during a large disaster and they may be waived retrospectively and not have to wait for the declaration from the Governor.

Mass care is a PHEP capability. We are trying to continue to expand our partnership with the Utah Red Cross. Brett continues to have a highly placed role with the Red Cross. We did take access of a surplus federal medical station, which is the guts of a 250 bed hospital. It is currently in temporary storage in state surplus. We have an offer from the Weber County emergency manager to store this federal medical station at no cost in a new warehouse that they are building. The medical station is 4,500 square feet of palletized equipment.

Medical countermeasure and medical materials are really strategic national stockpile capabilities that Brett is over. Working on local health departments vaccination dispensing and POD plans and continue to improve our scoring when our Federal partners come out to determine what is called our operational readiness. We get a distribution from the Feds and it comes to Utah and we have to break up that material and then re-distribute to each of our local health department partners. We have many processes that can be improved and streamlined to ensure that goes well.

Medical surge is another joint capability. It's primarily a function of the healthcare preparedness program. We are looking at regional representation and jurisdictional command centers and continued work with our EMS agencies; not only through the development of strike teams but also through engagement of EMS agencies through regional coalitions. Ensure that we are available to fund healthcare organizations directly because there are a lot of regional assets that can be helpful to enhance surge, evacuation and shelter in place needs. Finalize Crisis Standards of Care plans including base, burn, pediatric and pandemic annexes. On the PHEP side refine and enhance the role of UDOH as a member of UT DEM State Emergency Response Team and support ESF-8.

Epi and lab functions are on the PHEP side along with non-pharmaceutical interventions. This is a function of epidemiology that is primarily quarantine and isolation issues including the development and refinement of our Utah infectious disease emergency response plan (IDER). Public Health Lab continues to maintain a certain level of competency for both bio-terrorism and chemical threat analysis and they want to maintain those levels as best as they can. They are quickly working to test for Zika after completing the competency to be able to test for Ebola. They are flexible, mobile and adaptable when these new viruses come down. The lab is a critical partner. Epidemiology wants to improve two critical things, the first one is the GIS analysis and the second one is to acquire an electronic surveillance from healthcare partners across the state. Right now they make a call or fax a handwritten report, and they are really looking at a way to make that electronic so they can start to look at disease trends early and identify areas of concern instead of trying to do catch up.

Responder safety and health deals with maintaining and rotating the current stockpile of PPE. They have a small cache for pharmaceutical for responders and public health workforce.

Volunteer management is a combined capability to sustain Utah Responds state tracking system, continue to support the Medical Reserve Corp units across the state to engage and support agencies that are impacted.

Crisis Standards of Care - Kevin

One of our grant targets is to establish a framework for healthcare providers to operate when they don't have access to all the resources that they normally would. This is when the needs and demands exceed the available resources of the healthcare system. For many folks it's one more patient than they can handle at their facility. What happens when needs exceed the available resources? It means that they are not going to be able to give a CAT scan to every single person. Every person is not going to get 100% of the resources like they normally would. It is moving from individual care to triage care. To address the concerns of the healthcare community, we have been tasked with developing the crisis standards of care plan which is a plan to allocate resources, to appropriately deny care to those that may not benefit compared to other folks and to consider the moral, ethical and legal implications when providers who can't give 100% to every patient. There are a lot of critical issues. Through UHA there is a workgroup of about 35 physicians that have been working on this piece for 3 to 4 years. There are four components to the plan. The first piece is the clinical piece, that is how do we

determine who will likely benefit from care versus someone who if given a lot of resources their outcome and prognosis would not be good. It involves some lab testing, assessment of organ failures scores and clinical judgement has to be put into place.

The clinical piece is pretty well developed. There are pandemic clinical pieces and we have recently developed a trauma response medical surge clinical component to determine how to appropriately allocate resources and assign patients to different categories of triage. This clinical piece will be tested during the Great Utah Shakeout by seven different hospitals in Utah. IASIS and Mountain Star have agreed to distribute the clinical protocols to their providers and they will work through it. It will be presented to a group of 10 patients and they will have to make a decision on which 3 of the patients will get access to an ICU bed based on the clinical application.

There is a moral and ethical component crisis standard of care. Physicians and the medical community are not used to denying care once that person has presented himself or herself at the healthcare facility. To address the moral and ethical issue we have Dr. Jay Jacobson who is a medical ethicist from the U of U will be guiding this group. We have the intention to train at least one senior level physician in every facility across the state to serve as a crisis care triage officer. This is not triage at the door; this is someone who can appropriately review the needs and determine who is going to get to ICU, who is going to get ventilators based on a series of criteria and supported by a team of palliative care and social workers.

The third category of crisis standard of care deals with the legal implications when a provider cannot offer the standard of care. There is a certain expectation with the community and medical practice world that when someone presents with these symptoms that you provide A B C D tests and assessments. In the triage care environment you may not be able to do that and the standard of care is going to drop creating some liability for providers. In our assessment of the current State laws, rules, regulations and codes we found there are many protections in place for governmental workers during disaster events. There is a governmental immunity clause in state law. There are many protections for volunteer organizations and individuals. There is an extension of the Good Samaritan Law, Volunteer Health Practitioner Act; things where people are responding with no expectation of getting paid for their work. There are few protections in place for a group of medical providers at a hospital when a disaster event occurs, they are still on the clock providing care but they are not meeting the standard of care. We found that a few states, specifically Virginia have adopted additional language in their medical code that says it doesn't matter if you are paid or not, if you are not able to provide the standard of care and allocate every resource because there is a disaster or a disaster that causes a shortage of resources, you are still protected to the extent possible for malpractice and immunity for gross negligence, etc. We have been meeting with our legal counsel, Brittany Huff, and the bigger issue that we found with the crisis standards of care group is our legal team is really concerned with protecting the interests of the Department of Health. Whereas the legal issues for this are really an issue of what legal protection is offered to the private medical community when they have to serve as an agent of the government in a defined role in a disaster response. To meet those ends, next week Kevin will be meeting with some of the senior legal counsel from Intermountain Health Care to find out what their concerns are and if there is going to be a push though UHA or some other advocacy group for suggested changes to existing code that would insure adequate protection for the private medical community during disasters. After he meets with this team he will have a good idea about what needs to be done to protect the private sector side.

There are some additional sub components of the crisis standards of care that are unique to populations, including burn. We have a 15 bed burn unit in Utah and if there is one explosive event with 20 people, the burn unit is going off- line. If we have an earthquake, the fault-line runs right under the U of U Hospital and the burn unit is off-line. We are training hospitals and EMS providers how to provide extended care for burn patients in the event the U of U burn center is not available. We have many concerns with pediatric populations because we have 25% more peds per capita than any other state. They are working closely with Primary Children's to look at identifying not only in-state pediatric resources that could be used at Primary's as offline but also to build a Mountain States Pediatric Disaster Coalition which is a group of pediatric hospitals from Utah, Idaho, Montana, Wyoming, Colorado and Arizona to talk about what if you had to offline Primary's. Some could go to a general hospital but those ICU kids could not go to a general ICU. We would work closely together with this multi-state collaborative. We expect increased activity during the final year of the grant.

Ebola Preparedness - Kevin

Ebola preparedness continues and the HPP piece of Ebola goes until 2020. The PHEP piece recently was extended to the end of 2017 and it was originally scheduled to end at the end of 2016. There is an opportunity for Ebola funds that come in to the state to be adopted for other special pathogens and for Zika. We have a planned functional exercise on the 28th of April with many of our partners across the state. We are going to test walk-in patients to healthcare facilities in every jurisdiction in the state. We are not doing active monitoring like we were during Ebola. We have over 10 million international visitors and it's just a matter of time before they walk in and create some concern in the healthcare setting that has a known pathogen. They will be called front line facilities and they will have to be able to identify a person of concern, isolate them and immediately contact public health to determine if this is a person of concern. The second phase of our exercise is the local health departments and state health departments will coordinate around the presentation of these folks to determine a couple of things. One, does this person need to be in bio-containment, are they a danger to the community or to the healthcare workforce and two is testing warranted safe for Ebola for this individual. We are not set up to have someone show up in Richfield and the hospitals are not set up to isolate a patient and provide clinical care. They could temporarily for 6 to 8 hours have them in a single room with a single bathroom, but if we determine we want to test that person, we would actually get them up here to one of our designated Ebola assessment hospitals. They are Primary Children's, University of Utah and Intermountain Medical Center and they have all gone through a CDC, Salt Lake County and DOH site visits and they will repurpose a portion of their ICU's to serve as a bio-containment unit to provide 3 to 5 days of care. This is the 3rd part of the drill is to have the hospitals notified that in three hours they will be receiving a patient that needs to be in a bio-containment unit and in a hour somebody will be in their ambulance bay that will have to be admitted. They are going to test any gaps they find at these hospitals.

They will be coordinating throughout the state the public messaging with Charla as the lead. Our Ebola assessment hospitals are set up for 3 to 5 days of care. We will have Denver Regional in Denver, Colorado that is set up as the designated Ebola treatment unit that is set up for 30 to 45 days of care. If a person is tested positive we are going to have to initiate an interstate move of that person to the designated treatment unit. The state of Colorado department of health is working on the interstate plan. We will test the interstate movement of patients in the fall/into winter.

We have a critical issue with EMS where someone calls EMS and says they are not feeling good and to send police and paramedics to their house we do not an advance notice for suspicion with EMS agencies to a 911 call if this person could have a special pathogen. These agencies would not have any advance notice. They are considering having a travel question in the information asked with the 911 call.

Upcoming Events -

- Disaster Recovery Training (UPHA Pre-conference) April 11th
- Annual Public Health Preparedness Summit April 19th - 21st in Dallas, Texas
- Utah Shakeout & CSC Exercise April 21st
- Statewide exercise April 28th 9am - 12 pm

Next Meeting -

Next meeting will be June 23rd. We will keep having the meetings every 3 months and if there is not a need for a three month meeting, it will be cancelled.

Adjourn