Health Care Coalitions—The Past and the Future

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

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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.

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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, 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

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

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.

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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,

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! ■