ASPR/RHCC Meeting
March 21, 2013
9:30 a.m. – 12:00 p.m.
Carle Foundation Hospital
Pollard Auditorium, Urbana, IL

Welcome/Call to Order at 9:29 a.m.—Jack Fleeharty

Roll Call—Jack Fleeharty

Present: Winfred Rawls, Mark Vassmer, Laura Prestidge, Brian Kieninger, Shannon Wilson, Greg Atteberry, Mike Epping, Irene Wadhams, Linda Angarola, Anita Guffey, Evelyn Lyons, Greg Yurevich, Mike Maddox, Troy Erbentraut, Stephanie Kuschel, Paul Banks, Sue Hecht-Mikes, Sheila McCurley, Mary Connelly, Jill Ramaker, Brian Churchill, Phil Pittman, Jennifer Gorrie (GI Mapping Solutions), Carla Little, Jack Fleeharty, and Laura Harris

Present via teleconference: Carol Bell, Dawn Davis, Jackie Hamilton, Elizabeth Houston, Dan Lee, John Mayer, Don Schneider, Duane Wagner, Lisa Wax, Trevor Herbst (John Mayer's intern), and Juan Ortiz (MCHC)

Absent: Christina Boyd, Billy Carter, Christine Chaput, Mark Edmiston, JoAnn Foley, Sara Fricke, Tsoetsy Harris, Rob Humrickhouse, Lisa Johnson, Ron Meadors, Anu Meka, Bridget McCarte, Tammy Moomey, Karen Pendergrass, Martha Pettineo, Linda Reimel, and Elisabeth Weber (represented by Lisa Wax)

TOPIC/DISCUSSION	ACTION
Review of February 19, 2013 Meeting Minutes Correction made to misspelling of Cori Swiebocki's name on page 2. Motion made by Brian Churchill to approve. Motion made to second by Sue Hecht-Mikes; no oppositions; minutes approved.	*Minutes approved.
HaVbed System Improvements—Dan Lee To meet grant requirements these enhancements will improve the usefulness of the system; not only bed availability, but total beds, as well. Percentages of capacity utilization can be provided this way. Helps to determine margins. Hospitals won't have to do too much more work; extra screen proposed where total staffed beds can be entered; if it stays the same it doesn't need updated. Another enhancement will improve the timeliness and reliability of updates reported to the HHS HAvBED Helpdesk/Secretary's Operation Center, by developing and implementing a web service capability enabling the Illinois and the HHS systems to communicate with each other directly. This change will be transparent to the hospitals and will not require any additional time or effort on their part once implemented. IDPH is requesting feedback. When reports go out showing reliability, a paragraph will be added to update the enhancement status.	

Hospital By-Pass Mapping Functions—Phil Pittman and Jennifer Gorrie (GIS Solutions, Inc.)

Phil: This web-based application for the By-pass System has a map link and tool--the mapping tool needs updated as the software is not supported any longer. The funding is available now to update to modern technology, but he want input from end users regarding what they've used and what they think may need added, etc. Jennifer Gory is working on upgrades.

Jennifer: She is working with Phil and IDPH to migrate the By-pass System to a newer version. The current software (i.e. the mapping component) is out-dated. She's asking what functionality, tool, or utility RHCCs would like to see and/or what they don't use in the current system. She asks how many have used the mapping component; Anita Guffey says she has little experience with the system. Jack Fleeharty says the seasonal influenza situation saw 10-11 hospitals going on the By-pass System. Lisa Wax states that she uses it and states it helps her get a visual in one geographical area during peak census, as well as a glimpse of the statewide and just outside her region areas. Jennifer asks when you click and get more info, what other information would be more helpful? Jack says we're looking for contact names to call and need to know why they're on By-pass, etc. Discussion ensues regarding appropriate contact names and numbers, and that By-pass status justification is required already and shows up on reports. Jack says not everyone utilizes reporting tool. Dan Lee says it won't mean additional work for hospitals—data is already collected; we just want it displayed at a glance. Sue Hecht-Mikes asks if a layer could be added to show aero-medical so they can see helicopter bases/locations. Jack asks Phil to include. Sue recommends that the Temporary Medical Treatment Sites/locations be displayed, as well—Jack confirms necessity of this.   Jack says there is a problem when zooming in or out, whereby you lose the screen. Jennifer says the newer version will remedy this. Elizabeth (Liz) Houston says she's had problems getting a map to come up as the system is slow, making it time consuming--Jennifer says she'll use Liz Houston's area as a testing site. Jack says the map is the main tool he uses and we need to make it more efficient. Phil asks what specifics we want to see while in the mapping interface. Jack says in disaster management we may be looking for pediatric beds, psych beds, etc. and to identify the closest hospitals to take some of the surge. Phil says additional functionality not be able to be done by July 1 (2013), but he will investigate additional enhancements to make it also a disaster management tool. Jennifer asks for all to think about functionality and what questions you ask or need answered while in the map tool. The report-side data is already being collected, but can be incorporated into the mapping tool. All agree that "readily-seen info" is the priority. Don Schneider asks if it's possible to have a layer for surveillance as by December 2014 this info must be automatically submitted per this morning's SIREN alert…can we map syndromic surveillance to layer and link to this mapping tool? Phil says IDPH IT is looking at that now. Don says this is linked through electronic medical records and is sent to IDPH. Dan agrees hospital linkage would be feasible. Mark Vassmer says this data is in a Health Information Exchange and may be possible. Jack thanks Jennifer and Phil for participation and work in these enhancements.

Jack says regarding By-pass, it's controversial. Jack suggests eliminating the diversion (By-pass) and that hospitals would adjust and find more efficient ways to operate. This puts the responsibility on the hospital to find ways to meet impending demands. IDPH would like to explore proposing that we do away with or modify By-pass legislation. Lisa Wax and Rob Humrickhouse found a situation with a considerable number of psych patients being held, waiting for beds—Lisa Wax said they were tied up for five days. Resources used for these "held" patients put other ER patients at a higher risk. She says the burden from hospitals going on By-pass is a daily problem. Dan says he's heard agreement that By-pass ends up being

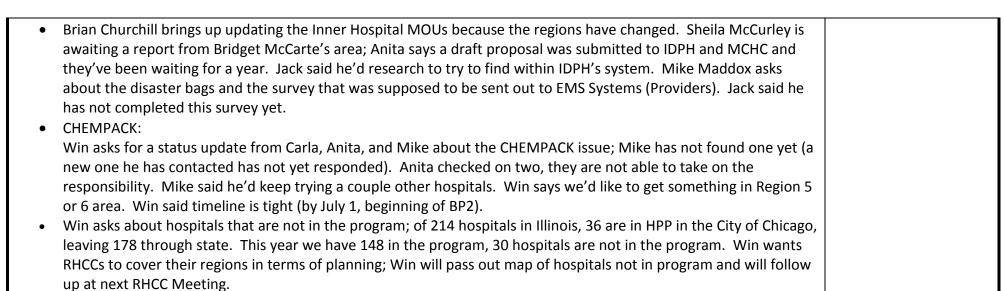|	
a way for hospitals who don't manage things well burden hospitals that do manage things well. Jack says we'll bring up at next EMS Advisory Council Meeting and Trauma Advisory Council Meeting (June 6, 2013). Don says to not forget to include the Illinois Hospital Association (IHA) because they may want an input from the perspective of the CEOs on this topic.	
Fiscal Update—Greg Yurevich Regarding funding amendments, he's getting all the certifications done; all are signed by the director but one; he'll get copies out this week. There's been a change to IDPH *in-house* fund appropriations number to use a different funding source but this doesn't affect funding itself. Greg says the matching fund rate is 10% and he confirms for Troy Erbentraut that they need to document and make sure that it is spent on last year's grant deliverables. He says our funding has shifted: we're losing approximately $544,000 (about a 5-6% hit to our grant). Greg says we're trying to have agreements signed and in place by July 1 (2013). The new online grants management system will improve efficiency, but it may not be available in this cycle.	
CEMP Governance Committee Update—Mike Maddox They met on 3/20/13 and looked at the charter. The Committee is narrowing its focus to governance issues only; looking at standardizing the format and content of CEMP so when they send it to the hospitals it's easy for them to use and understand. Hospital CEMP training is coming up with on-site training locations in the southern, mid, and northern parts of the state focusing on ensuring the end user knows how to perform data-entry into CEMP, complete quarterly reports, etc. Anita states that her region won't be in training till after April; she's concerned. Jack reiterates that IDPH decided to roll out CEMP to all 150 instances and we knew it would be a challenge to get scheduled; they worked with ISC. Three basic tasks expected: each hospital updates their contact information, CHEMPACK if they're a CHEMPACK hospital, and quarterly reports (sent in by REMSCs), which have been loaded into CEMP (with a goal to have hospitals do their 3rd and 4th quarterly reports independently but we're against a deadline now; we may allow them to be a month late due to training needs; quarterly reporting is the law). We're working to de-conflict this schedule, starting with Region 4 and 5 and mid-state since they're easier to train; the northern part of the state has many more hospitals. The training involves a day's training face to face in two sessions (three hour sessions). ISC's goal is that attendees will already have their log ins to be ready for face to face training. At 3/20/13 HPP CEMP training there were many questions. Jack says CPGs only have to be done by the coalition leads. IDPH has to have the coalition CPGs done and back so Jack can submit them by May 1, 2013. Jack gave templates to ISC 3/20/13 and RHCCs need only to log in to your CEMP (for your hospital) and complete the CPGs (i.e. survey monkey type template), work with your coalitions and have CPGs done in CEMP by April 15, 2013 so IDPH and ISC can aggregate data and get to CDC by May 1, 2013. Anita asks when it'll be there, Jack says it's there NOW. They have three and a half weeks; eight capabilities to complete. IDPH is hoping to supplement these training sessions with a webinar for those who can't make it.	
Old Business—Jack Fleeharty • Jack announces that a hiring freeze is still in place. When an HPP Coordinator is hired, the program manager will become Mark Vassmer for the HPP, as well as the PHEP; it'll no longer be Jack. Jack for HPP and Mark for PHEP must write the FOA grant by May 1, 2013; Jack says we'll use last year's capability assessments and will address gaps. We'll identify targets and will continue with unfinished targets.	

• Jack says everyone would like to see HVA in CEMP and it may be added/linked when hospitals become comfortable with CEMP. Sue asks about the THIRA (Threat Hazard Incident Reduction Assessment)…Jack says we'd have to look at that tool to see if it'd be compatible with the healthcare realm. Completing the HVA is a requirement and it's in the grant—it tells where hospitals are strong and where they're weak. In the past, the State could not put its finger on any geographical area to identify this and therefore, where the money should be spent. The HVA helps IDPH identify variances. Discussion ensues about the fact that hospitals already complete and HVA for the Joint Commission (JCO) and how relevant is an HVA completed for the State. Jack says IEMA's focus is different and the State doesn't get the information from IEMA. Jack suggests an HVA is done per coalition, instead of per 150 hospitals. The RHCCs support doing a coalition HVA. Greg Yurevich says he agrees but asks if there will be support if the coalition decides where the money will be spent? Brian Churchill states in the past they didn't have ANY direction. Sue says the HVA lacks a pediatric component. Jack will ask the RHCCs to the table to create an HVA tool that each coalition can complete. Don would like to share the product with the region so each hospital may use it. They have to do one for accreditation anyway and it would be great to have ONE. Win comments that HVAs are Joint Commission on Accreditation of Healthcare Organizations (JCAHO, referred to acceptably as "Joint Commission") requirements and are beneficial; it's a way the federal government can measure progress of hospital preparedness; "No metrics, no money." Win says Illinois is given money to do the HVA and submit the data. Win says we need a standardized tool and the HPP needs to be aligned with "Joint Commission" requirements, with the hope of only having to complete it once. Evelyn says the regional catastrophic planning team up north is working on developing an HVA tool, too. Carla Little says RCPT in Chicago had to develop a public health and medical HVA; the tool they developed was based on Kaiser and the UCLA model, which married the gaps. That group's survey monkey was good in identifying risks, but then measured ability to respond depending on what plan was in place. Mark says the challenge puts burden on the coalition lead and requires standardized data for evaluation. Brian Churchill says these assessments will guide them into what should go into HVAs. Troy asks if data is aggregated and prepares a final document for the RHCC to see in the end; Carla says it aggregates data using survey monkey. Steve Muir's group then did follow-up analysis to determine risk and if sufficient planning was in place. Troy notes this method is singularly assimilated by Steve Muir. Carla says that each local jurisdiction provided info as a group, and then it was aggregated as a survey monkey. Steve Muir took data to the next step. Then as a group they validated the data before the final report was submitted. They tried to be as objective as possible. Carla says she will send it out. Laura Prestidge asked if there was a population assessment; Carla said the pilot was based on PHEP capability Community Preparedness and looks at different populations represented. Jack asks that all consider other facets of the healthcare system that need to be assessed and evaluated, such as special populations, EMS, hospital response, primary care centers, clinics, etc. Jack says we'll plan on pulling together the RHCC group with Carla and Evelyn and others for subject matter expertise.	
New Business—Jack Fleeharty Future Meeting (possible cancellations for May 16 face to face): The group as a whole decides to change the May 16 face to face to a conference call, there'll be a face to face in June at the Summit, and then the face to face in July remains as scheduled. The ESF-8 scheduled for May 16 is cancelled.	

Wrap-up and Call for Public Comment/Closing Comments/Open Discussion/Questions—Jack Fleeharty

- Jack says quarterly reports are burdensome; he is going to work with regional staff using subrecipient monitoring results and may choose which to focus on in upcoming grant period (no need to take on all eight)--we simply have to note which capabilities we'll not be addressing this year. At the end of the five year cycle all MUST be addressed, but as far as for BP2, which CPGs and performance metrics will be addressed will be decided upon by Jack and Mark. The new quarterly reports will be done on CEMP and anything that can be pulled from CEMP will be pulled to reduce the technical burden. Jack says we have Training and Exercise requirements and coalition building to consider, too; will use the report as a guideline for all of this. Greg says we sent Stephanie Howard and Mark Vassmer to coalition building training; Mark, as a designated subject matter expert, said he's started a coalition work group. Jack stated the Federal Site Visit involved an IMERT deployment facilitated by Mary Connelly, Anita Guffey hosted Site Visitors at Carle Hospital to present their preparedness program, Sue Hecht-Mikes presented material and slides regarding drill activity in her region, and Mike Maddox and Linda Angarola presented information regarding the Harrisburg tornado. The Federal Project Officer, Duane Wagner, submitted a report that IDPH is still evaluating. Duane Wagner notes the Site Visit was a great opportunity to see our hard work and all the moving parts in motion. Jack thanks the RHCCs and REMSCs who participated. Mark says that Duane suggested (during the HPP Federal Site Visit) that we emphasize recovery and information sharing capabilities in the future. Win also thanks Anita and Mary for their efforts during the Site Visit activities.
- (HVAs) Win states that MCHC did a survey for us. Duane said he is asking his counterparts if there are regional HVAs out there and he'll share if he finds anything. MCHC survey question, "Does your facility conduct an annual review of HVA, 91.7% said yes, 6.4% said no, 1.8% said unsure." Most widely used tool was the Kaiser Permanente Template (36%), 19% unknown, 17 % Ashley Model (Brian Churchill says it's just like Kaiser), 7% Region 5 Tool, Joint Commission Tool at 4%...
- Open discussion: Don asks the dates of the Summit; Win responds June 18-20; the RHCC Meeting is at 1:00pm on 6/20/13 at The Westin.
- Mike Maddox addresses Mark Vassmer about Twitter comment that hospitals cannot use HPP funds for individual exercises unless it includes partnerships; it seems counterintuitive if hospitals can't use the funds for exercises internally. Mark says this year's grant does have that restriction; the exercise has to be greater than the facility itself. Duane says there is a movement toward exercising across the coalition; the FOA plan is to exercise at the coalition level. Troy Erbentraut asks if we still have to follow HSEEP (Homeland Security Exercise and Evaluation Program)? Mike emphasizes the benefits of developing an exercise and performing it on a smaller scale to plan it out. Duane states that all don't need to be exercising at that same level; maybe some may do table-tops and expanding from there. Jack reiterates we have to follow HSEEP guidance and an AAR must be filed after each exercise. Troy says the plan isn't moved to the coalition level until it's tested; now they have to use their own money/funding to do this? Mark said FOA requirements are going to be amended during a call he's participating in this Friday (3/22/13). Mark says if he (Mike) presents his questions in writing to him, he'll bring them up. Duane said if questions are sent his way prior to the call, it'd be helpful.

• Brian Churchill brings up updating the Inner Hospital MOUs because the regions have changed. Sheila McCurley is awaiting a report from Bridget McCarte's area; Anita says a draft proposal was submitted to IDPH and MCHC and they've been waiting for a year. Jack said he'd research to try to find within IDPH's system. Mike Maddox asks about the disaster bags and the survey that was supposed to be sent out to EMS Systems (Providers). Jack said he has not completed this survey yet. • CHEMPACK: Win asks for a status update from Carla, Anita, and Mike about the CHEMPACK issue; Mike has not found one yet (a new one he has contacted has not yet responded). Anita checked on two, they are not able to take on the responsibility. Mike said he'd keep trying a couple other hospitals. Win says we'd like to get something in Region 5 or 6 area. Win said timeline is tight (by July 1, beginning of BP2). • Win asks about hospitals that are not in the program; of 214 hospitals in Illinois, 36 are in HPP in the City of Chicago, leaving 178 through state. This year we have 148 in the program, 30 hospitals are not in the program. Win wants RHCCs to cover their regions in terms of planning; Win will pass out map of hospitals not in program and will follow up at next RHCC Meeting.	
Adjourn—Jack Fleeharty Jack calls to adjourn the meeting at 12:02 p.m.; motion made by Sue Hecht-Mikes and motion to second made by Troy Erbentraut. Meeting adjourned at 12:02 p.m.	