Anchoring Success

Leadership Models to Strengthen Healthcare Coalitions

Richard W. Lippert

Healthcare Coalition of Southwestern Pennsylvania

- Why coalitions fail even with good people + funding
- Coordination and true coalition leadership
- Anchor vs. Sail concept: stability + adaptability

- The anchor isn't there to stop progress.

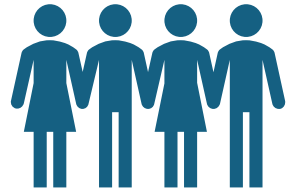- The sail isn't there to replace structure

Let's Be Honest

- Coalitions don't fail because people don't care — they fail because leadership gets fuzzy.

- Most coalition leaders inherit chaos, not clarity.

- You're expected to lead… without authority, leverage… or sometimes even buy-in.

The Coalition Leadership Reality

Unique challenges:

No direct authority

Competing organizational priorities

Volunteer fatigue

Grant-driven survival cycles

The leadership paradox: influence without control

What Coalition Leadership Really Feels Like

- Everyone agrees… until it costs them something.

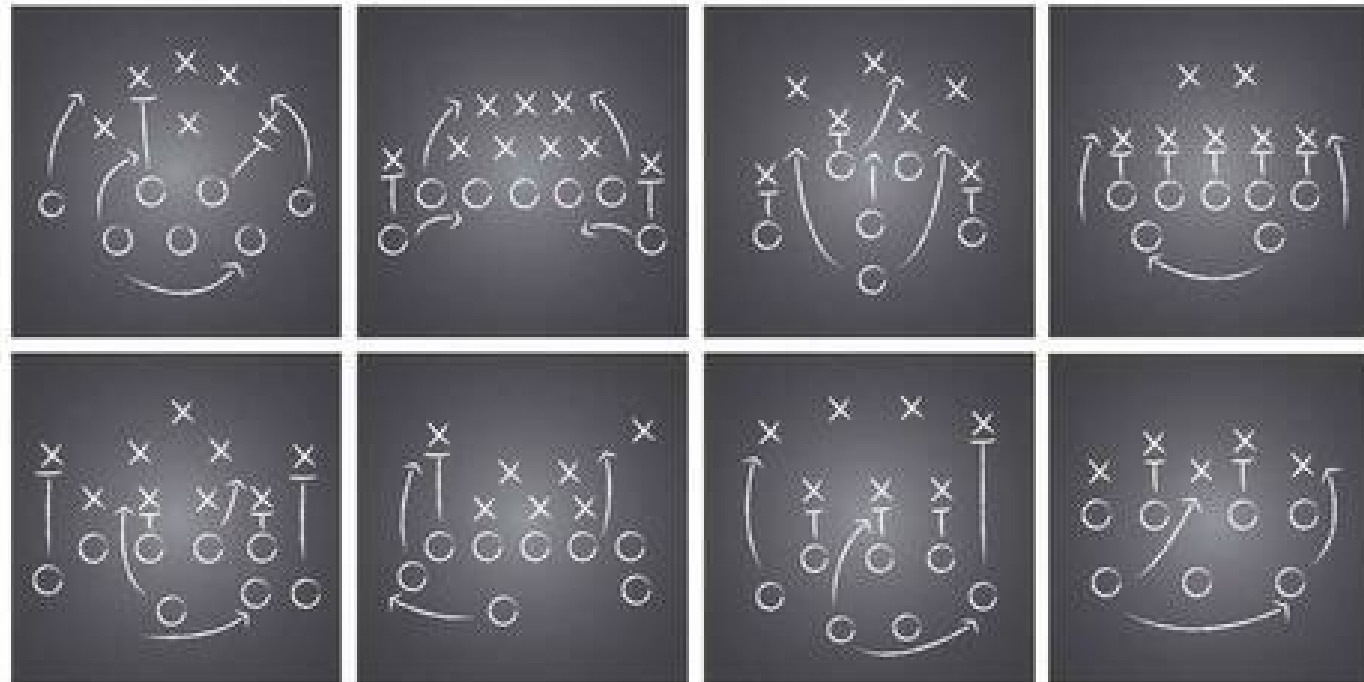- Influence without power is exhausting.

Core Leadership Models That Hold Up

- Adaptive Leadership
- Servant Leadership
- Systems Leadership
- Distributed Leadership

Adaptive Leadership

- Leading people through challenges where there is no clear playbook.

Servant Leadership

- The leader exists to serve the coalition, not control it.
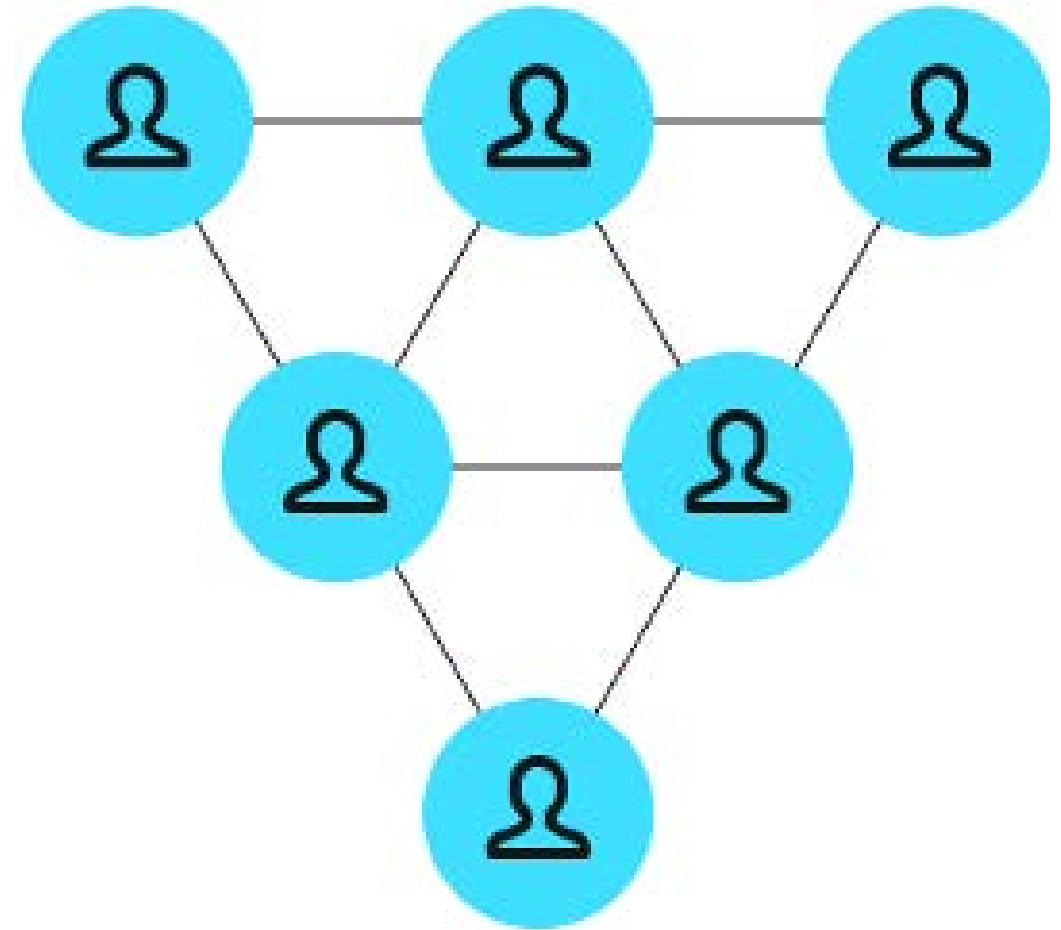 - Translation: You're not the star. The coalition is.

Systems Leadership

- Leading with awareness that everything is connected.
  - If you only fix your own piece, the system still fails.

Distributed Leadership

- Leadership is shared, not centralized.
  - Coalitions don't survive on single heroes.

Strategic Anchors of High-Functioning Coalitions

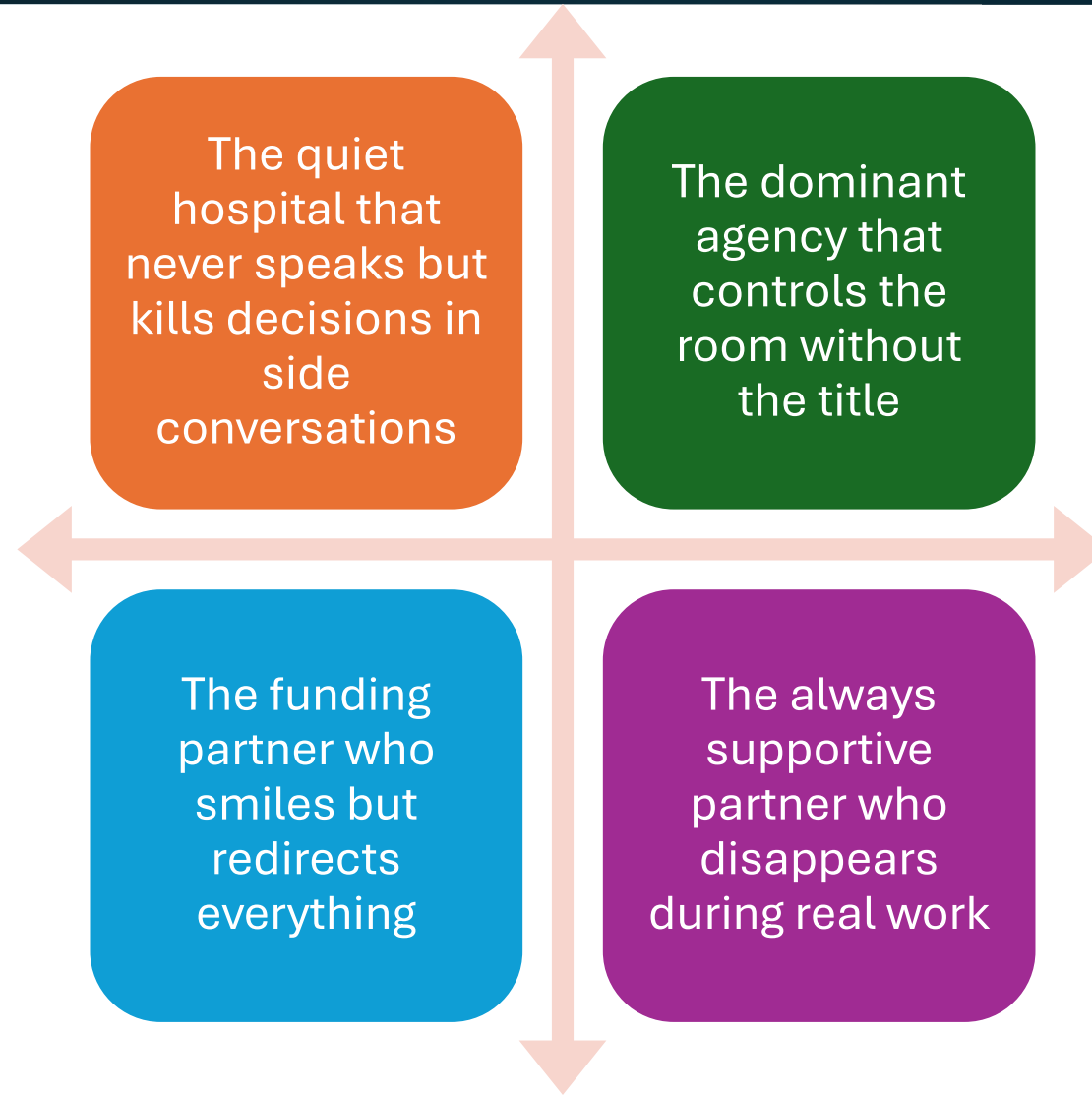**Governance clarity (roles, decision rights, behavioral norms)**

- Decision authority mapping: Who decides vs who advises
- Participation expectations: What active membership actually means
- Role of chair/lead agency: When facilitation becomes leadership
- Accountability mechanisms: How to keep commitments visible

Vision alignment vs. mission creep

Trust economies (credibility = currency)

Decision-making frameworks (consensus vs. command moments)

The Stuff Nobody Warns You About

The quiet hospital that never speaks but kills decisions in side conversations

The dominant agency that controls the room without the title

The funding partner who smiles but redirects everything

The always supportive partner who disappears during real work

Off-the-Wall / Not Often Discussed Elements

Leadership Energy Management → **Coalition Politics & Power Mapping** → **The Quiet Member Problem**

The Expiration Date of Leadership → **Crisis Identity Shift** → **The Myth of Consensus**

Blind Spots

Decision-making rules no one can actually recite

People thinking they have a vote when they don't

Boards/committees with unclear purpose

Governance Reality Check
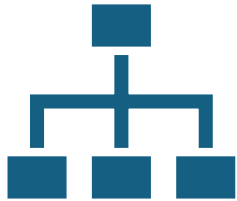
Formal structure is rarely the real structure.

Side conversations can override bylaws.

If the rules aren't clear, the politics take over.

Clarified roles prevented future conflict

Alignment exercise reset the mission

Open conflict → structured agreements

Lessons Learned

Board retreat

Anchors That Keep Coalitions Standing

Clear decision ru

Defined

Succ

Strate

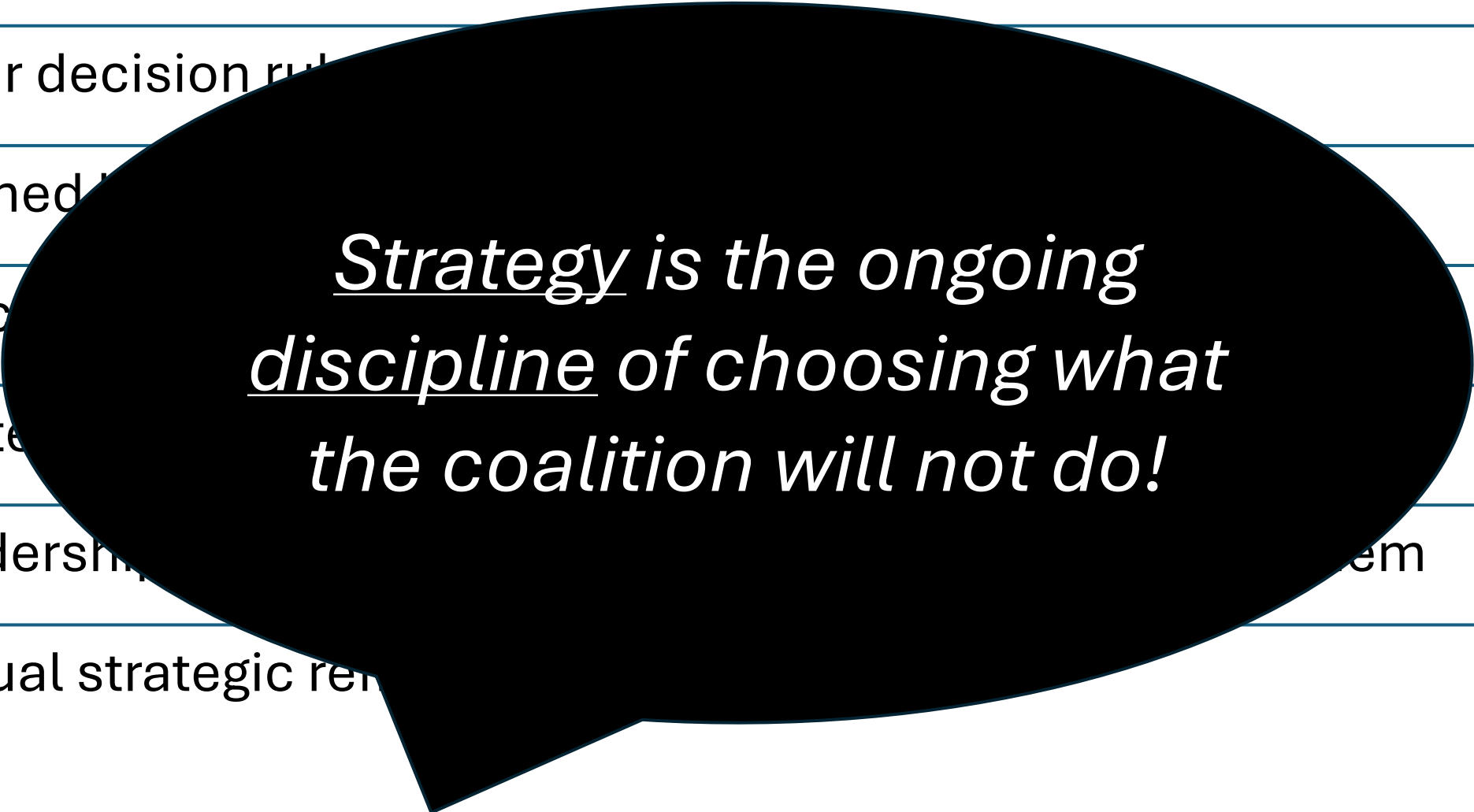Leadersh   em

Annual strategic re

Strategy is the ongoing discipline of choosing what the coalition will not do!

MY MEETING PHILOSOPHY

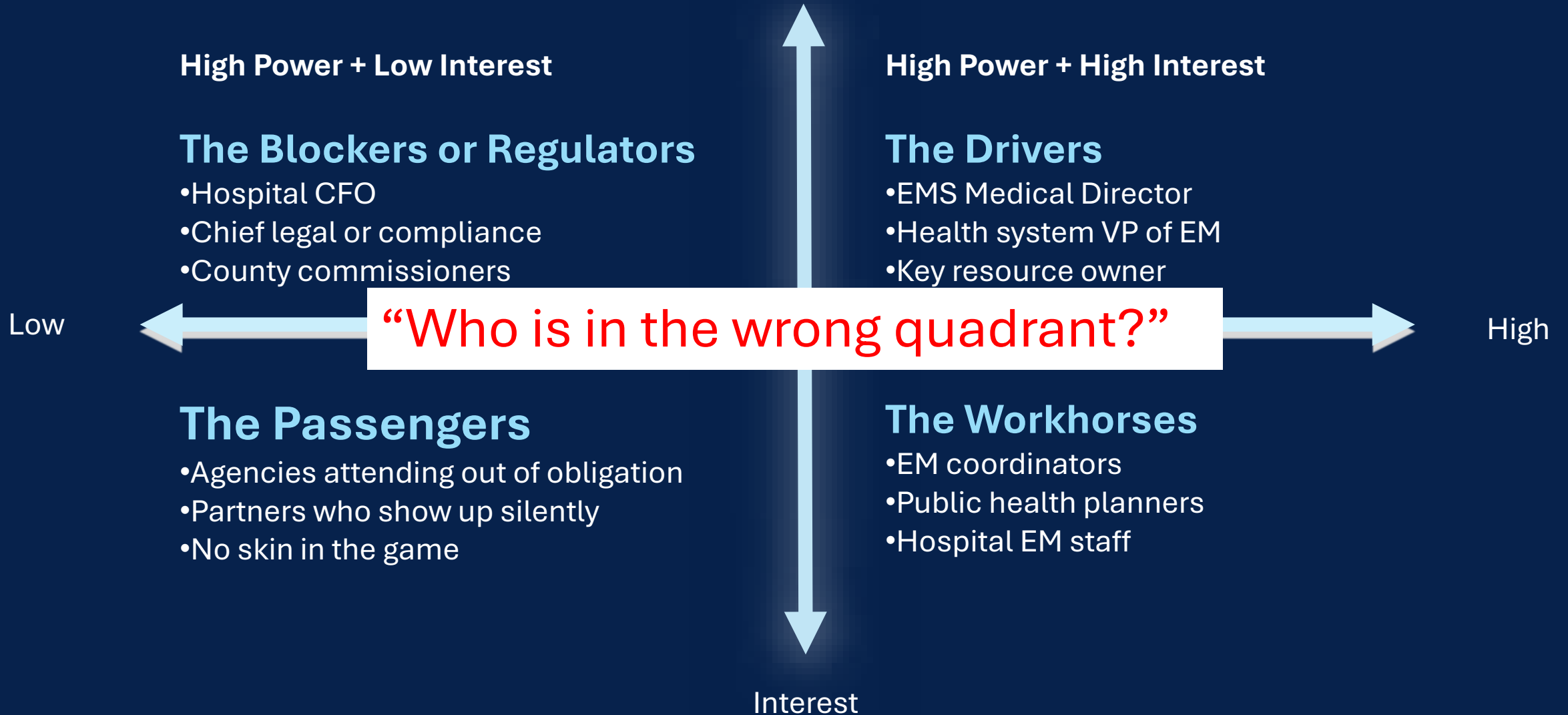**SPEED UP A PROCESS**

UNBLOCK A PROCESS

GET BETTER ALIGNMENT

Leadership Tools That Aren't Sexy — But Save You

- Annual review of bylaws, roles, and meeting structure

- Power-mapping: Who truly influences the room?

- Coalition health check pulse tool

- Crisis vs. stability decision matrix

- Engagement reset strategies

Power-Mapping: Who truly influences the room?

Power-Interest Grid

High Power + Low Interest

The Blockers or Regulators
- Hospital CFO
- Chief legal or compliance
- County commissioners

High Power + High Interest

The Drivers
- EMS Medical Director
- Health system VP of EM
- Key resource owner

Low ← → High

"Who is in the wrong quadrant?"

The Passengers
- Agencies attending out of obligation
- Partners who show up silently
- No skin in the game

The Workhorses
- EM coordinators
- Public health planners
- Hospital EM staff

Interest

Real Stories, Real Lessons

- When collaboration actually worked
- When politics stalled progress
- When a board retreat shifted trajectory
- When trust had to be rebuilt

- This is where leadership becomes credible.

Future-Focused Leadership

- Preparing coalitions for:

  - Funding instability

  - Workforce fragmentation

  - Cross-sector fatigue

  - Digital transformation

  - Scenario Planning

The Future Coalition Leader Isn't a Manager

- A translator between systems

- A mediator of personalities

- A stabilizer in uncertainty

- A driver of uncomfortable progress

The Future Coalition Leader Isn't a Manager

A translator between systems

A mediator of personalities

A stabilizer in uncertainty

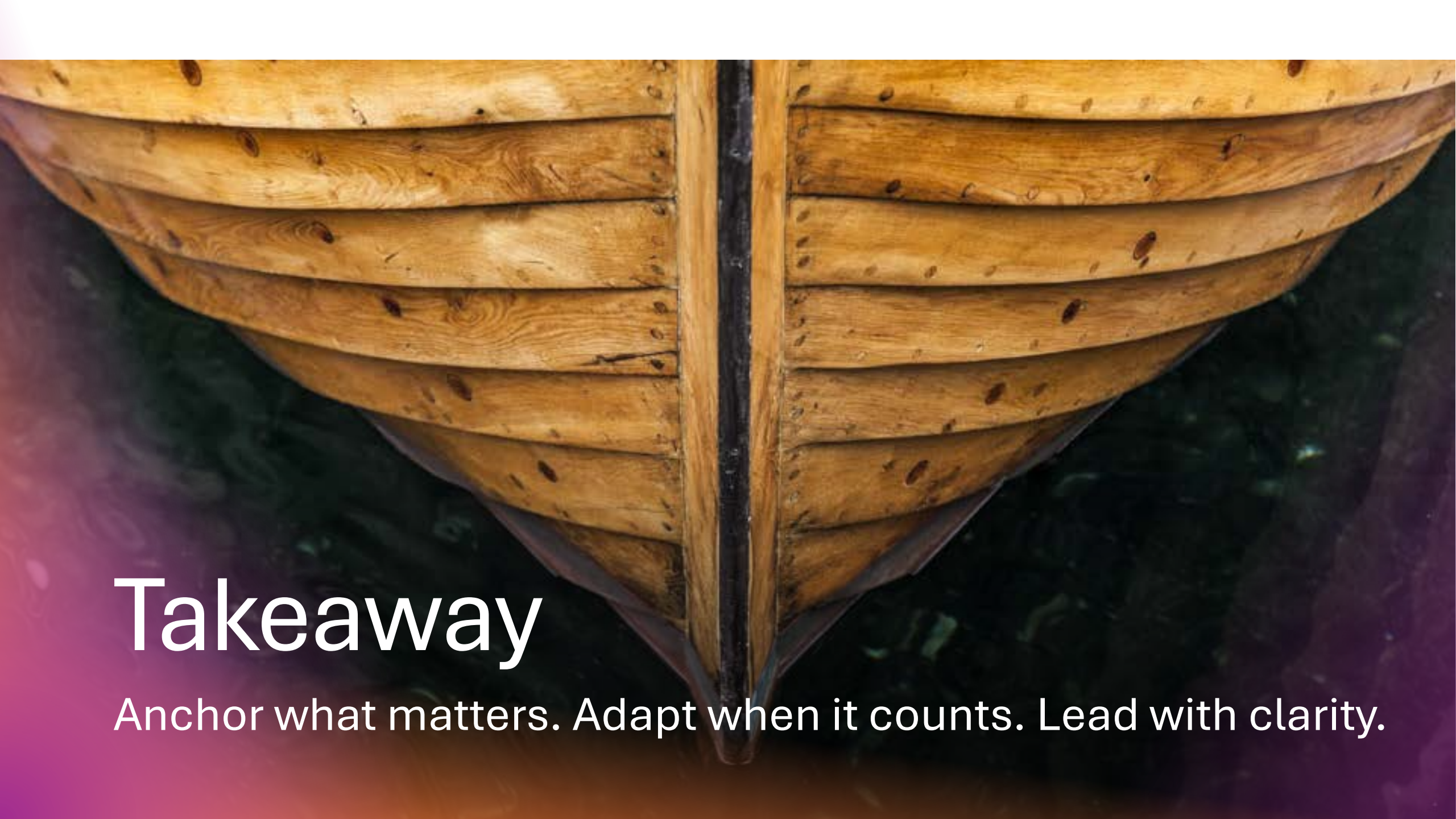A driver of uncomfortable progress

Anchoring the Future

- Redefining success in coalition leadership

- Call to action: Lead with intention, not position

- Strong coalitions aren't built on funding.
    - They are built on courage, clarity, and uncomfortable conversations.

- Leadership isn't about being liked.
    - It's about keeping the anchor steady when the storm hits.

Takeaway

Anchor what matters. Adapt when it counts. Lead with clarity.

Questions

Rick Lippert
Richard.Lippert@getyouthinking.com

Resources (for reading)

Core Leadership Thinkers

Ronald Heifetz – Adaptive Leadership
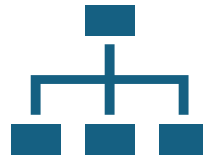
Peter Senge – Systems Thinking

Simon Sinek – Start With Why / Trust & Culture

John Maxwell – Leadership fundamentals

Patrick Lencioni – Team dysfunction & organizational health

Brené Brown – Courageous leadership / vulnerability
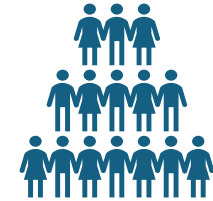
Jim Collins – Level 5 Leadership

Strategy & Decision-Making

Henry Mintzberg – Organizational structure & leadership reality

Gary Hamel – Future of management

Margaret Wheatley – Leadership and systems in chaos

Crisis & Complexity

General Stanley McChrystal – Team of Teams

Atul Gawande – Healthcare systems & human factors

Building Advanced Internal Resources for Resilience

Kimble Richardson, M.S., LMHC, LCSW, LMFT, LCAC
Community Health Network

#NHCPC25

Indianapolis 500 Gordon Pipers

Circle City Sidewalk Stompers

Charlie's Pocket

My Family

Learning Objectives

- Define resilience.
- Understand the difference between Fixed and Growth Mindset
- Identify impact of Adverse and Positive Childhood Events on mindset
- Consider team and leadership influence on mindset
- Reflect and discuss where you personally fall on the mindset spectrum

No Financial Disclosures

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ECHO from the beginning

2003 - Dr. Sanjeev Arora began Project Extension for Community Healthcare Outcomes (Project ECHO®) at the University of New Mexico to demonopolize knowledge, amplify local capacity, provide best practice care for the underserved.

2006 – Additional ECHO programs in mental health disorders, SUD, gestational diabetes and rheumatologic diseases.

2009 - The Robert Wood Johnson Foundation funding. Now across the US and in over 30 countries around the world.

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Doing More for More Patients
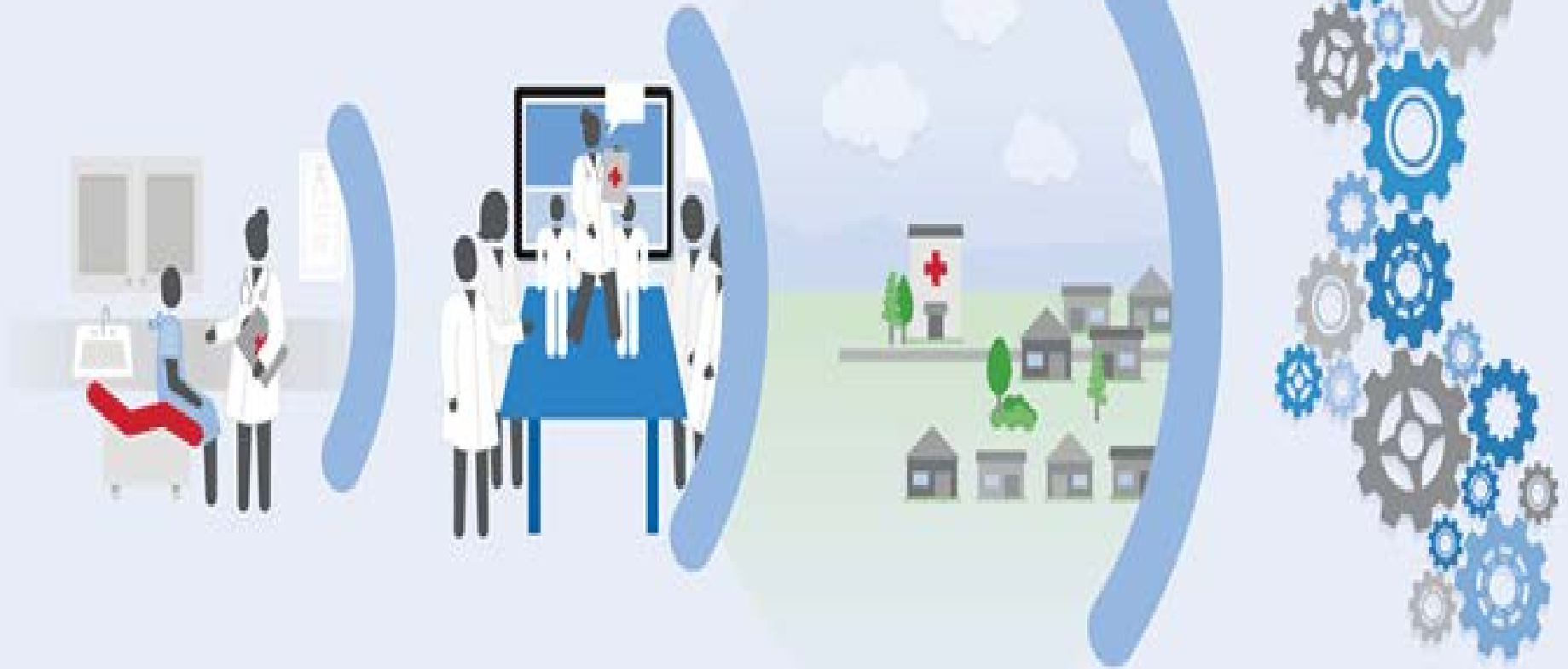
PATIENTS
- Right Care
- Right Place
- Right Time

PROVIDERS
- Acquire New Knowledge
- Treat More Patients
- Build Community of Practice

COMMUNITY
- Reduce Disparities
- Retain Providers
- Keep Patients Local

SYSTEM
- Increase Access
- Improve Quality
- Reduce Cost

https://hsc.unm.edu/echo/what-we-do/about-the-echo-model.html

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ECHO…

2019 - Drs. Jeffrey and Joanna Katzman created an ECHO to support First Responders through the opioid crisis via video TeleECHO sessions. Connects FRs to current best practices, resources and clinicians, and generates discussion on best pre-hospital care.

2020 – At the onset of the COVID-19 pandemic, the ECHO pivoted to supporting First Responders, focused on resilience, and expanded the definition of a FR to include all of those providing direct care in the COVID-19 pandemic.

2021 - Publish results of the First Responder Resilience ECHO

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ECHO Hub Team

- Jeff Katzman, MD
- Joanna Katzman, MD, MSPH
- Pam Arenella, MD
- Ben Bernstein, PhD
- Maria Yellow Horse Brave Heart, PhD
- Lindy Grabbe, PhD, APRN-BC
- Sarah Heines, MBA
- Yasmin Magdaleno, MD
- Jessica Medrano, NRP, NCEE
- Ankit Mehta, MD, SFHM, FACP
- Rebecca Murphy, MEd
- Terra Reed, MSN, RN
- Kimble Richardson, MS, LMHC, LCSW, LMFT, LCAC
- Kristina Sowar, MD
- Randon Welton, MD
- Steve Xenakis, MD

Introduction to Resilience: Building our Internal Resources

- Gives overworked and overburdened health-care providers resources, knowledge, and skills to advocate for their own and their organization's well-being.

- Designed to develop resilience, decrease burnout, and prevent further mental health issues.

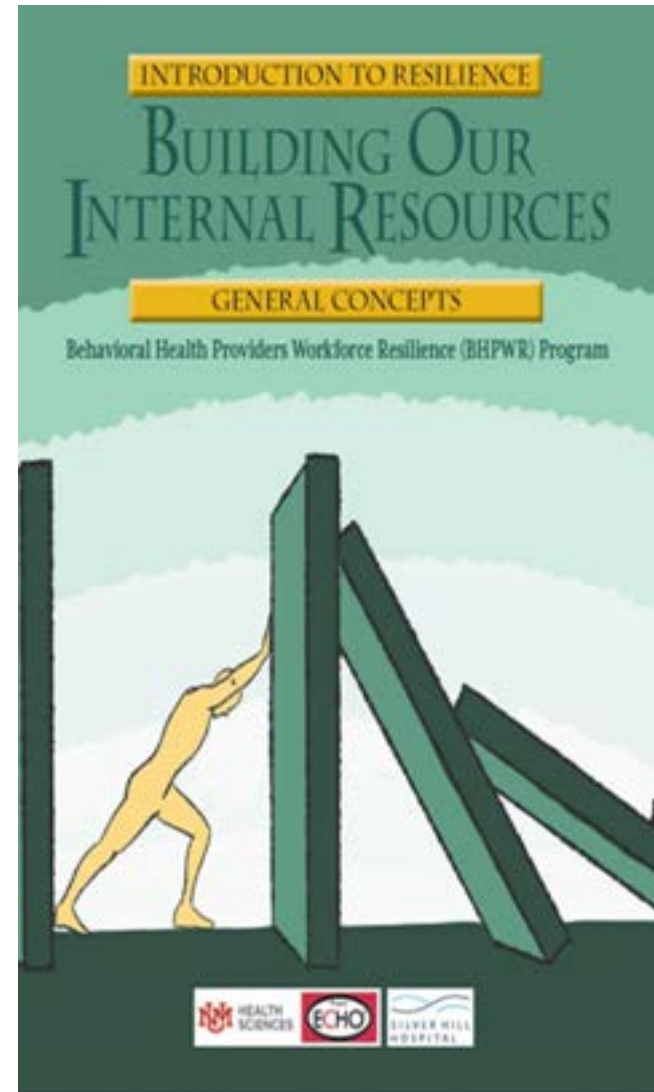- A more resilient workforce better retains its employees.

Free **Workbook**

- Designed by health-care professionals for health-care professionals

- Helps ward off burnout, reduce stress levels, and rejuvenate passion for the profession we love.

- Workbooks are available as a hard copy or a downloadable pdf:

https://sdppublishingsolutions.com/product/introduction-to-resilience-building-our-internal-resources/

INTRODUCTION TO RESILIENCE

BUILDING OUR INTERNAL RESOURCES

GENERAL CONCEPTS

Behavioral Health Providers Workforce Resilience (BHPWR) Program

Chapter	Title	Comments
1	What is Resilience	*Best guide to using the workbook*
2	Self-Awareness	*Self-assessments*
3	Self-Care and Self-Compassion	*4 archetypes, Quick Action Plan, Connecting to community*
4	Empathy and Responsiveness	*Active constructive responding*
5	Growth Mindset	*Growth vs fixed mindsets*
6	Uncertainty and Flexibility	*Applied improvisation training*
7	Connection	*Tips to strengthen connections*
8	Optimism and Play	*Benefits of hope*
9	Concluding Thoughts	*Impact of working on the resilience project from each contributing author*
	Plus…	*Online and chapter resources, references*

Sample Course #1

8 weekly 45-minute sessions

Check in from the previous week

20-30 minutes of interactive presentation

15-20 minutes of discussion

Pre-Course Survey

Session 1 *What is Resilience* | Ch. 1

Session 2 *Self Awareness* | Ch. 2

Session 3 *Self Care & Compassion* | Ch. 3

Session 4 *Empathy & Responsiveness* | Ch. 4

Session 5 *Growth Mindset* | Ch. 5

Session 6 *Uncertainty & Flexibility* | Ch. 6

Session 7 *Connection* | Ch. 7

Session 8 *Optimism and Play* | Ch. 8

Post Course Survey

Sample Course #2

6 weekly 45-60-minute sessions

Check in from previous week

20-30 minutes of interactive presentation

25-30 minutes of discussion

Pre-Course Survey

Session 1 *What is Resilience | Ch. 1*

Session 2 *Self Awareness | Ch. 2*

Session 3 *Self Care & Compassion | Ch. 3*

Session 4 *Empathy & Responsiveness, Connection | Ch. 4 & 7*

Session 5 *Growth Mindset | Ch. 5*

Session 6 *Uncertainty & Flexibility, Optimism & Play | Ch. 6 & 8*

Post-Course Survey

What is Resilience?

...the capacity to adapt, recover, and even grow when faced with challenge.

What Resilience Is	What Resilience Is Not
• A Learnable Skill	• An Immutable Trait
• Emotional Agility	• Imperviousness
• Adaptive Response	• Perfection
• Learning & Growth	• Solo Heroism
• Connection & Support	• Suppressing Emotions
• Self-Care & Boundaries	

Mindset and Resilience

What Is a Mindset?

- Your "mental lens" for interpreting challenges, setbacks and feedback

Key Principles:

- Spot learning opportunities
- View effort as path to mastery
- Use setbacks as feedback

Mindset

↓

Response

↓

Resilience

MINDSETS

GROWTH VS FIXED

GROWTH		FIXED
Continuously developing	**SKILLS**	Can develop to a point
Key to improvement	**EFFORT**	Not helpful
Welcome and accepted	**CHALLENGES**	Avoid
Invited and embraced	**FEEDBACK**	Taken personally
Inspired	**SUCCESS OF OTHERS**	Threatened

Growth Mindset Builds Resilience

- Receptiveness toward receiving feedback
- Increased mental resiliency, emotional intelligence, and perseverance
- Supportiveness for collaborative relationships
- Desire to create safe learning environments
- Improved motivation

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Fueling *Fixed* Mindsets

Limiting belief - an internal conviction – often unexamined – that tells us what we can't do or can't be. These are the "rules" we create for ourselves, usually based on past experiences, others' opinions, or fear of failure.

Self-fulfilling prophecy
- Believing you can't do something makes you less likely to try - so you never prove yourself wrong

Fear of challenge and feedback
- Limiting beliefs magnify the stakes: every challenge or critique seems to confirm "I'm not cut out for this"

Avoidance of effort
- If you see ability as fixed, why put in extra work? Effort becomes a sign of deficiency rather than a path to growth

Limiting Belief	Fixed-Mindset Impact
"I'm just not good with technology."	Deters you from learning new EMR features or digital tools.
"I've never been a public speaker—I'll embarrass myself."	You avoid presenting innovations, stunting leadership growth.
"I failed once, so I'll fail again."	You shy away from trying new approaches or process improvements.
"If I ask for help, I'll look incompetent."	You miss out on collaboration and coaching opportunities.

Breakout #1

Consider a challenge you faced, a mistake that you made, or a time when you received constructive feedback.

Describe how your mindset (either fixed or growth) effected your response to the situation.

Adverse Childhood Experiences

Traumatic Experiences **+** Threatening Environments **=** ACES

"What happens in childhood, doesn't always stay in childhood."

Positive Childhood Experiences

- PCE that promote safe, stable, and nurturing relationships and environments can help children develop a sense of belonging, connectedness, and build resilience (CDC, 2022).
- PCE act as protective factors from ACEs and increase resiliency in the face of trauma.

Thinking back to your childhood, how often did you…

- Feel able to talk to your family about your feelings.
- Feel your family stood by you in difficult times.
- Enjoy participating in community traditions.
- Feel a sense of belonging in high school.
- Feel supported by friends.
- Have at least two non-parent adults who took a genuine interest in you.
- Feel safe and protected by an adult in your home.

Childhood Wiring (Early Neuropathways)	Adult Influences (Ongoing Rewiring)
• ACEs wire your survival circuits for high sensitivity (fight/flight baseline)	• **Feedback Culture:** – *Person-praise* ("You're so smart.") vs *process-praise* ("Great strategy—what did you learn?")
• Forms core self-beliefs ("I must be perfect," "I'm always in danger")	• **Failure Framing:** – Seeing setbacks as threats vs growth opportunities ("What can I try next?")
• 61% of adults report ≥1 ACE • 1 in 6 report ≥4 ACEs	• **Risk-Taking:** – Safe practice zones vs risk-averse routines—stretching your "yet" muscle
• Positive childhood experiences buffer reactivity	• **Ongoing Neuroplasticity:** – Deliberate practice, reflection & reframing build new pathways

Growth Mindset...Teams

- Just as important for teams as it is for individuals
- Teams that grow toget her tend to be higher functioning and more resilient
- Team growth fosters a better sense of belonging which is an important factor of occupational well-being

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Breakout #2

How can you help your colleagues become more resilient by encouraging a growth mindset?

Making the Shift

- Embrace challenges
- Invite feedback
- The Power of "Yet"
- Learn from others' successes
- Praise effort over achievement

Psychological Safety

- Trust in your community.

- A sense of confidence that others will not embarrass, reject or punish you for speaking up.

- A team climate characterized by interpersonal trust and mutual respect in which people are comfortable being themselves.

No One Wants to Look:	How to Manage:
Ignorant	Don't ask questions
Incompetent	Don't admit weakness or mistakes
Intrusive	Don't offer ideas
Negative	Don't critique the status quo

"We're so busy with managing impressions that we don't contribute to creating a better organization."
   Amy Edmonson

Accountability

		LOW	HIGH
Psychological Safety	**HIGH**	**Comfort Zone** Teammates enjoy working with one another but don't feel particularly challenged. Nor do they work very hard.	**LEARNING ZONE** **Here the focus is collaboration and learning in the services of high-performing outcomes.**
	LOW	**Apathy Zone** Teammates tend to be apathetic and spend their time jockeying for position. People fulfill their functions but prefer to curry favor rather than share ideas.	**Anxiety Zone** Teammates fear to offer tentative ideas, try new things, or ask colleagues for help, even though they know great work requires all three.

Summary

- **Mindset matters** – Growth vs Fixed: see challenges as paths to skill-building, not threats

- **Spot and reframe limiting beliefs** – those internal "rules" hold us back; replace "I can't" with "how can I?"

- **Neuroplasticity** – our past experiences shape the brain's default pathways, but through practice and reflection we can rewire circuits to support growth

- **Grow together** – Teams flourish when competence, autonomy, relatedness & psychological safety are nurtured

- **Key actions** – Invite feedback, learn from mistakes, praise effort over outcome
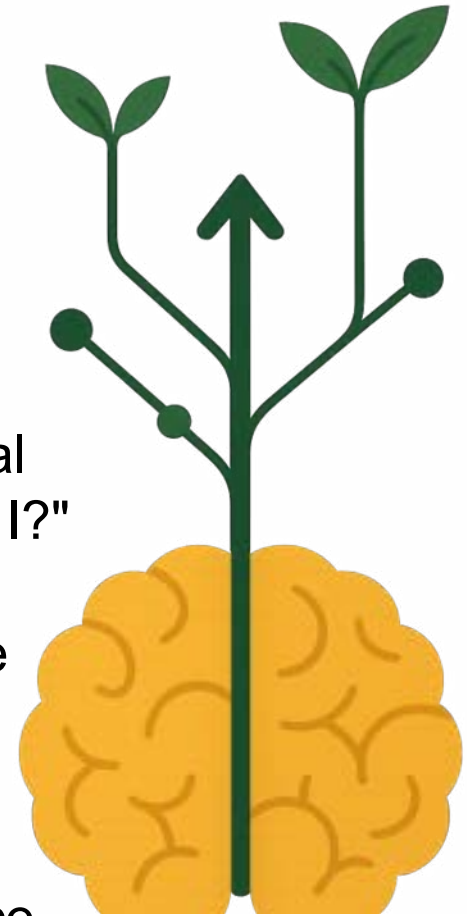
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Katzman, JW; Tomedi, LE; McCoy-Hayes, S; Richardson, K; Romero, E; Rosenbaum, N; Greenwood-Ericksen, M; Medrano, J/ Archer, GRD; Jacoby, MK; Everly, G; & Katzman, J (2021). The project ECHO first responder resiliency program: curriculum development, listening groups and lessons learned to support providers virtually during a pandemic, International Review of Psychiatry, 33:8, 682-690, DOI: 10.1080/09540261.2021.2021867

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"Positive Childhood Experiences as Protective Factors." *American SPCC*, 28 Mar. 2023, americanspcc.org/positive-childhood-experiences-as-protective-factors/.

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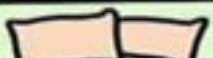
Tzouvara, Vasiliki, et al. "Adverse Childhood Experiences, Mental Health, and Social Functioning: A Scoping Review of the Literature." *Child Abuse & Neglect*, Pergamon, 10 Mar. 2023, www.sciencedirect.com/science/article/pii/S014521342300073X.

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Community Fairbanks
Behavioral Health

Kimble Richardson, M.S.

LMHC, LCSW, LMFT, LCAC

Manager of Business Development |

Community Fairbanks Behavioral Health & Recovery Center

Trainer | **RISE Team**

Coordinator | **District 5 REST Team**

Co-Coordinator | **Caregiver Rehab Committee**

krichardson@ecommunity.com

(317) 418-0988

Disclosures

The speaker has nothing to disclose.

Objectives

- Learn steps to foster the creation of a COP dashboard for a team, agency, or interagency working group.

- Discuss new and innovative methods for COP development and dissemination to stakeholders.

- Explain the benefit of using a COP Dashboard for meetings and briefings.

What is a Common Operating Picture (COP) Dashboard

- Learn steps to foster the creation of a COP dashboard for a team, agency, or interagency working group.

- Discuss new and innovative methods for COP development and dissemination to stakeholders.

- Explain the benefit of using a COP Dashboard for meetings and briefings.

Application of a COP

- Briefing Document

- Meeting Template

- Supports Round Robin Updates

- Broadcast Information Sharing

- Status Updates

Application of a COP Continued

- Handling large-scale incidents or small-scale operations.
    - In emergency management or incident response,
    - allows personnel to monitor the situation, identify potential risks, and formulate plans faster
    - resource tracking and deployment

- In military operations, the COP provides an overall view of an operation's progress,

- 0perational areas, such as logistics or transportation management.
    - User can track their resources visually

- Allows users across different departments or business units to collaborate more effectively and efficiently on projects.

When is it useful?

- Anytime data can be better depicted by graphs, pictures or images

- Updates to recurring information are regularly needed

  - Team learns to expect information in the same format

The goal of Using a COP

- Efficient use of verbal (meetings) and written communication (briefings)

- Saves time for program leads and senior leadership

- Ensures printable, portable, easily accessed preparedness data in a one-page format

- Standardized format to update.

- Can be cost savings if physical documents were previously printed

Process for Development

1. Get buy-in from contributors

2. Background Interviews and Work to garner data display format

3. Enlist graphics personnel, if available

4. Trial run of new data format and get feedback

5. Develop final template

6. Set a cadence for information submission

7. Socialize cadence of publication/dissemination of

Process for Development: Buy In

- Get buy-in from contributors

- Discuss the benefits to moving to a new format for data

- Create any needed agreement between entities about info usage

- Stress the desire to gather more or more detailed information in a streamlined way

Stakeholder Interviews

- Clarify lines of effort

- Determine format for concise presentation of data

- Ensure data could be depicted by graphs, charts, or timelines and ascribe to readiness colors

- *Red (issues, on-hold), Yellow (risks/delays) and Green (ready).

Process for Development: Data Display

- Work with each group to ensure data is properly & efficiently displayed

- Graphs

- Charts

- Color Coding (Green, Yellow, Red)

  - Ensure it is universal to the agency so that all with understand color meanings

Process for Development: Format

- Be open-minded to format ideas, enlist graphics personnel, if available

  - One page PowerPoint format

  - Developed by a graphics team or designers

  - Can allow for more data on the page or overlay of maps on the chart

    - Simple charts

Process for Development: Trial Period

- Complete a trial run of a briefing with new data format and get feedback

- Send Dashboard for review of all stakeholders and get feedback

- Trial the item for a meeting or Briefing

  - Allows for edits to create a stronger product.

Process for Development: Finalize/Cadence

- Develop final template

  - Share the final version

  - Determine submission Cadence

    - Can information be retrieved for an existing database

Process for Development: Socialize

- Socialize cadence of publication/dissemination of final data

  - Share and advertise to other entities who may need the information

Sources of Information

- Government networks and databases

- GIS systems

- Geospatial images and maps

- Communication tools

- Satellite imagery

- Weather information. COPs can also be generated from manual inputs such as reports or observations made by field personnel.
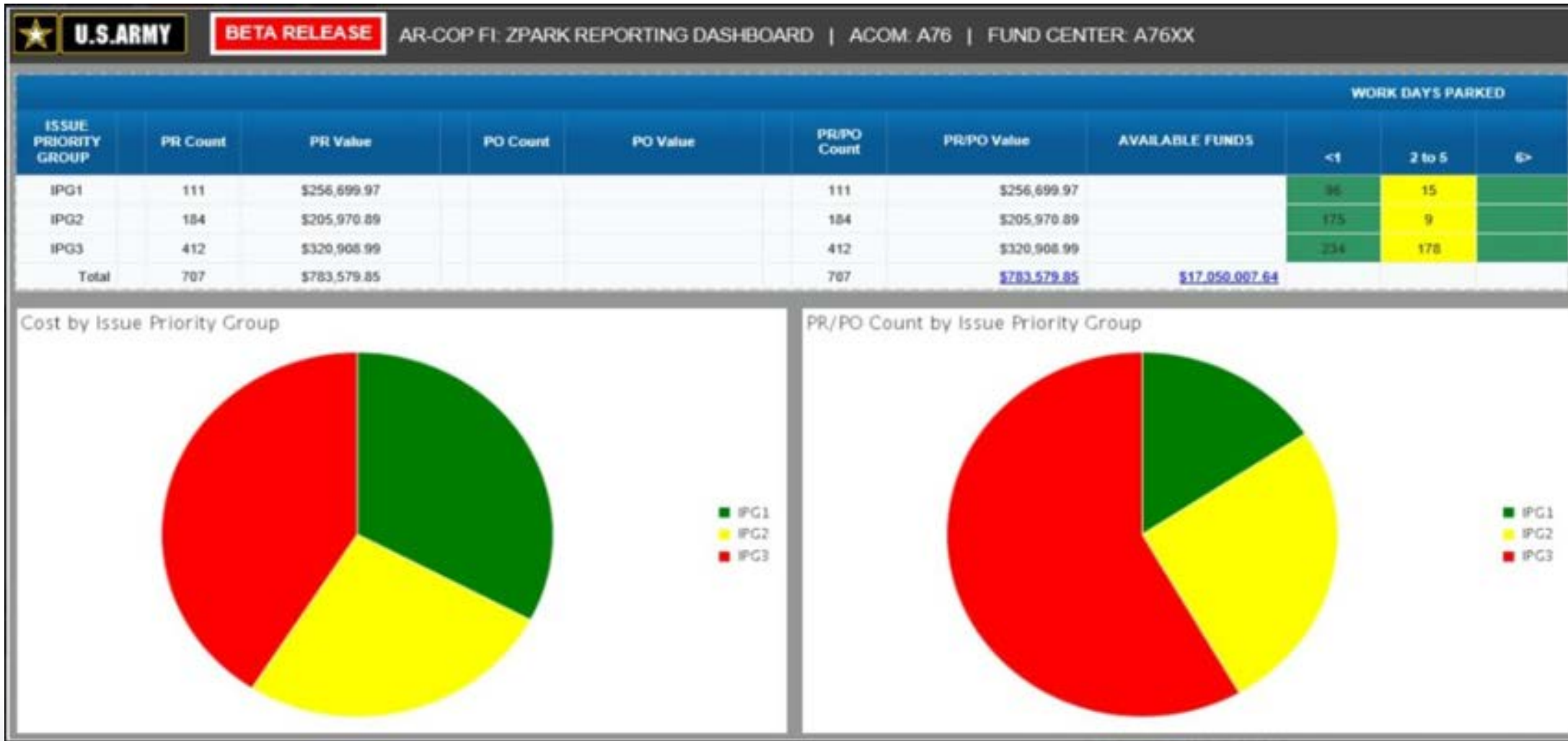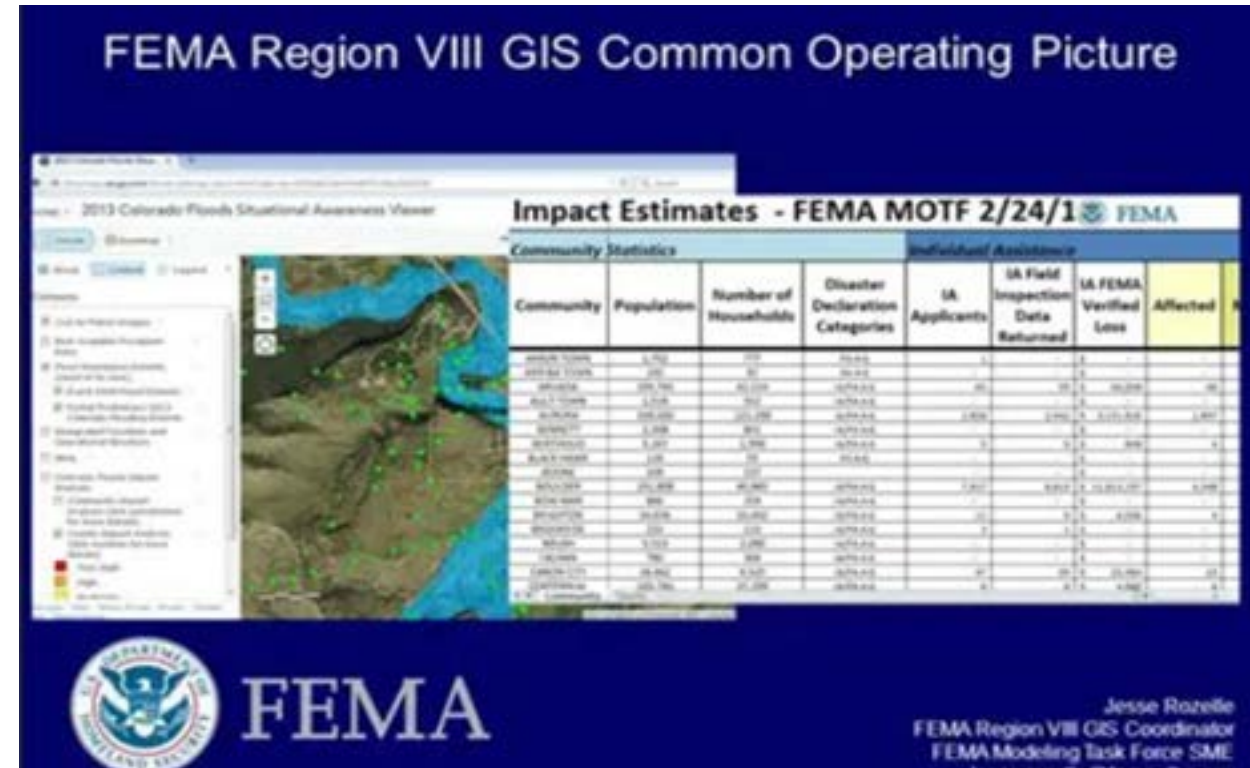
Types of Dashboards

- Pulled from a data source (excel or software)

- Geospatial

- Collaboration of submitted data graphics developed independently

- Artificial Intelligence (AI) Supported

Types of Dashboard: Readiness

Types of Dashboard: Geospatial
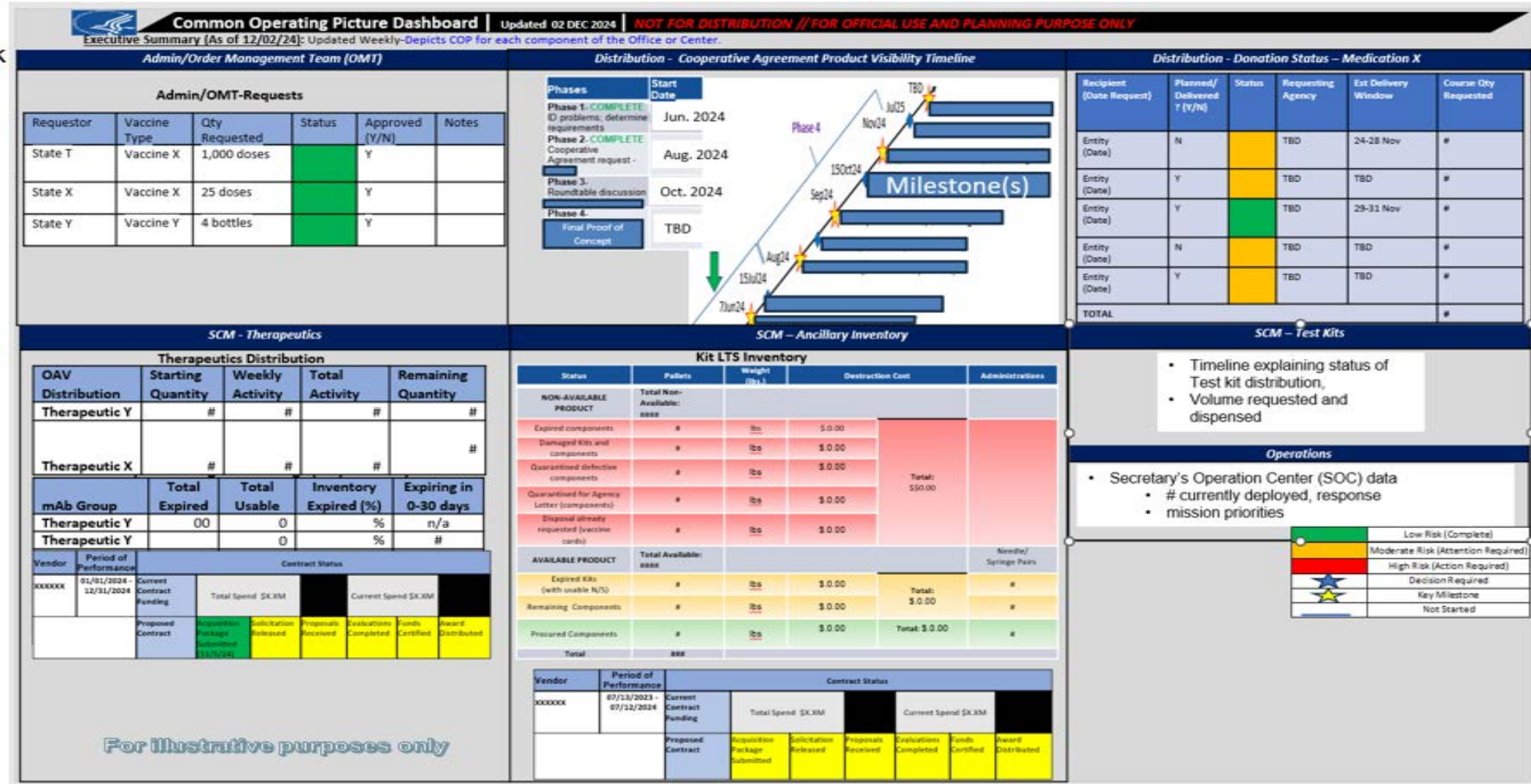
Types of Dashboard: Manual Pull

Types of Dashboards: AI Supported

- Contain dynamically updated with customized software solutions that use artificial intelligence (AI).

- AI-powered COPs can act as operational assistants

  - providing proactive recommendations based on current situations and activities.

  - leverages highly advanced systems

  - teams can make decisions more quickly

Sites/Software to Develop a COP

- Juvare

- Intterra

- GIS Based
  - Esri (ArcGIS) –National-level situational awareness
  - AWS (Cloud)

- DHS National Operations Center (NOC)

Summary

- COP Dashboards provide standardized, streamlined forms for info sharing

- Facilitates enhanced collaboration among teams, departments or agencies

- Saves time regarding presenting and compiling data

- Can aid in decision making by allowing broad information to be presented in a concise manner

Learning Objectives

- Analyze crisis situations quickly and systematically

- Make clear and informed decisions under pressure

- Enhance team communication and collaboration during emergencies

- Apply tools and strategies to improve organizational resilience

Rare, Unpredictable, and Highly Disruptive Events: A White Paper from the Florida Hospital Association

Bottom Line Up Front

- Crisis leadership and decision-making do not follow a linear or predictable path. Instead, they function as complex systems characterized by interdependent actors, dynamic feedback loops, evolving conditions, and nonlinear consequences.

- Leading effectively in this context requires more than procedural knowledge; it demands adaptability, situational awareness, and systems thinking.

- Leadership is less about control and more about coordination, rapid communication, and informed responsiveness within a fluid, high-pressure environment.

- Recognizing crisis leadership as a complex system reinforces the need for ongoing, stress-tested training.

- Building capacity for crisis response is no longer optional; it is a strategic imperative for organizations facing increasingly volatile risk environments.

Crisis Leadership - Background

<u>The Literature</u>

- Much has been written, particularly following Covid-19.

- D'Alessio, O.; Quaglieri, A.; et al. "Leading through Crisis: A systematic Review of Institutional Decision-Makers in Emergency Contexts." *Behav. Sci.* 2024, 14, 481.

  - "The decision-making environment … is characterized by considerable complexity due to changing circumstances, limited reaction time, disparity of information, and inadequate protection of resources."

  - Complex Problem-Solving: dynamic, multifaceted, and lacks straightforward solutions.

  - Dynamic Decision-Making: interdependent decisions that change over time.

Crisis Leadership - Background

The Literature (cont.)

- D'Alessio, O.; Quaglieri, A.; et al. "Leading through Crisis: A systematic Review of Institutional Decision-Makers in Emergency Contexts." *Behav. Sci.* 2024, 14, 481.
  - Computational limits of human cognition: "Managing a lot of problematic information for the decision-maker does not help the human cognitive system to faithfully represent the situations to be faced."
  - "Time pressure combined with the scarcity of information often generates strong emotions and, sometimes, stress in institutional decision makers."
  - Model of Success: 3-Stage Process
    - <u>Assess</u> the severity of the event using various types of information.
    - <u>Determine</u> response <u>options.</u>
    - <u>Evaluate</u> response options <u>before implementing.</u>

Crisis Leadership - Background

<u>Our Research Discoveries</u>

- Calm, non-emotional leadership is critical during crises. Leaders must be truthful, transparent, and confident (but not arrogant).

- During unprecedented crises, the response should be based on values and principles because knowledge and plans may be inadequate or nonexistent.

- Genuine curiosity should be encouraged. Leaders should ask curious questions about the causes, consequences, and possible responses.

- It is essential to look "around the corner continually."
    - How could the incident get worse?
    - What are the secondary/tertiary impacts of these decisions?

Processing Information While Under Duress

Cognitive load tests, like the <u>Stroop Test</u>, can measure a person's ability to process information under duress before a crisis.

Processing Information While Under Duress (Incongruency)

Write the **ink color** in which the word is printed, even when the word names a conflicting color.

RED

BLUE

GREEN

YELLOW

Risk Assessments and Power Law Distributions

Risk = Likelihood * Severity

Risk Assessments and Power Law Distributions

- In risk, surprises often stem from confusing the <u>improbable</u> with the <u>impossible</u>.

  - Planners often use expected values for hazard occurrences.

- Extremes are not as unlikely as they might appear, leaving communities vulnerable to worse-than-usual and so-called Black Swan events.

Risk Assessments and Power Law Distributions

Black Swan Event:

- Rarity: It lies outside the realm of regular expectations – few people consider it possible.

- Extreme Impact: It has severe, widespread consequences.

- Retrospective Predictability: After it happens, people often feel it was obvious or predictable all along.

Nassim Nicholas Taleb, "*The Black Swan: The Impact of the Highly Improbable*" (2007)

Risk Assessments and Power Law Distributions

Normal Distributions (Skinny or Thin Tails):

- Governed by the Gaussian (normal) distribution (standard bell curve).

- Events are predictable and well–behaved, with highly improbable extreme values.

- Examples: Human height and IQ scores.

- **Risk Implication**: Standard statistical models (e.g., standard deviation, mean-variance analysis) work well.

Risk Assessments and Power Law Distributions

Power Law Distributions (Fat or Heavy Tails):

- Governed by the Power Law (non-standard bell curve).

- Extreme events (Black Swans) are more <u>frequent and impactful</u> than expected in normal distributions.

- Examples: natural disasters, financial market crashes.

- **Risk Implication**: Traditional risk models fail; <u>rare events dominate the outcomes</u> (e.g., one market crash erases decades of returns).

Risk Assessments and Power Law Distributions

Application(s):

- Crisis leadership is about preparing for the <u>extreme</u>, not predicting the future.

- Power Law Distributions are <u>highly unpredictable</u> and have no well-defined mean or variance. (You can't extrapolate from the past.)

- Most consequential impacts come from <u>rare, catastrophic events</u> rather than everyday disruptions.

- <u>Small triggers can lead to disproportionately large consequences</u> due to interconnected systems (e.g., surge, utility outages, financial systems, supply chains).

- Embrace <u>rapid decision-making and adaptive leadership</u> in crises.

Crisis Management as a Complex System, and Cognitive Biases

Crisis Management is a complex system involving interconnected, dynamic, and unpredictable elements that interact nonlinearly. It goes beyond simple cause-and-effect thinking and requires an adaptive, systems-oriented approach.

Cognitive Biases are systematic patterns of deviation from rational thinking or objective judgment. They occur when the brain takes mental shortcuts to process information quickly.

Crisis Management as a Complex System, and Cognitive Biases

What makes Crisis Management a Complex System?

- Multiple Interdependent Actors
  - Involves governments, emergency responders, organizations, media, and the public.
  - Actions by one group can trigger ripple effects in others.
- Dynamic and Evolving Conditions
  - Crises unfold in real time and change rapidly.
  - New information can suddenly reshape priorities or strategies.

Crisis Management as a Complex System, and Cognitive Biases

What makes Crisis Management a Complex System?

- <u>Uncertainty and Incomplete Information</u>
  - Information is often scarce, conflicting, or delayed.
  - Decision-makers must act despite high ambiguity.

- <u>Nonlinear Feedback Loops</u>
  - Small actions can lead to big effects, or big actions may have little impact.
  - Delays in system response can worsen the problem.

Crisis Management as a Complex System, and Cognitive Biases

What makes Crisis Management a Complex System?

- <u>Emergent Behavior</u>
  - New, unexpected patterns or behaviors that weren't predicted by individual parts can emerge.

- <u>Conflicting Goals and Perspectives</u>
  - Stakeholders may have competing interests (e.g., public safety vs. economic stability).
  - Cooperation and coordination are challenging under stress.

Crisis Management as a Complex System, and Cognitive Biases

Crisis Management as a Complex System -- Applications

- Linear planning fails in complex crises.

- Agility, flexibility, and communication become more valuable than rigid protocols.

- Leaders need to embrace "systems thinking" – considering:

  - Relationships

  - Feedback Loops

  - Unintended Consequences.

- To manage crises effectively, we must think <u>adaptively</u>, not just <u>reactively</u>.

Crisis Management as a Complex System, and Cognitive Biases

Cognitive Biases

- <u>Confirmation Bias</u> – Seeking data that supports preexisting beliefs.

- <u>Overconfidence Bias</u> – Overestimating one's ability to predict or control outcomes.

- <u>Sunk Cost Fallacy</u> – Continuing a failing course due to past investments.

- <u>Groupthink</u> – Suppressing dissenting opinions due to social pressure.

- <u>Normalcy Bias</u> – Ignoring warning signs because "it's never happened before."

- <u>Availability Bias</u> – Overestimating the likelihood of events or success/failure based on easily recalled examples.

They are used to simplify and save time, but can mislead us in high-stakes decisions, emotional situations, or rapidly changing environments.

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Preparing for a Crisis – as an Individual

- **Be calm and unemotional**
  - Learn real-time stress management techniques (e.g., box breathing, cognitive reframing, self-talk and confidence building, focus and distraction control).
  - Engage the team by looking professional and confident.
  - Be supportive and curious.
  - Exemplify good self-care.
- **Learn mental models to improve your crisis thinking.**
  - Pause, Prioritize, Proceed
  - OODA Loop: Observe, Orient, Decide, Act

Preparing for a Crisis – as an Individual

- **Think systematically:**
  - Identify: What needs to be solved now?
    - What can or should be delayed?
  - What problems should we anticipate in the next 12, 24, 36, 72 hours?
    - How can those be mitigated now?
  - What information do I have, and what information do I need?
    - What do I actually know, and what do I only think I know?
- **Use emergency plans:**
  - When plans do not exist or are not working, focus on values and core principles.

Preparing for a Crisis – as an Individual

- **Learn crisis-decision-making tools and models:**
  - Optimal versus First Available
  - Recognition-Primed Decision Model
    - Relies on experience and pattern recognition to make rapid decisions (mental slide-deck).
- **Treat crisis leadership as a high-risk and low-volume competency:**
  - Regular training and high-fidelity simulations
    - Training with realistic scenarios: rapid choices, tight time constraints, and information gaps.
    - Wargaming under adversarial conditions.

Preparing for a Crisis – as an Individual

- **Communicate frequently and genuinely:**
  - It is almost impossible to overcommunicate in a crisis.

Preparing for a Crisis – as an Organization

- **Think systematically:**
  - Identify: What needs to be solved now?
    - What can or should be delayed?
  - What problems should we anticipate in the next 12, 24, 36, 72 hours?
    - How can those be mitigated now?
  - What information do we have, and what information do we need?
    - What do we actually know, and what do we only think we know?
- **Use emergency plans:**
  - When plans do not exist or are not working, focus on values and core principles.

Preparing for a Crisis – as an Organization

- **Use structured and timely briefings**

- **Develop and execute several tactics** – do not devise and use just one plan.

- **Reverse engineer solutions** – determine the ideal outcome and plan backwards.

- **Conduct pre-postmortems** – identify what could create a negative outcome, and work backwards to mitigate those causes.
  - Force leaders to confront uncomfortable risks.
  - Encourage diverse thinking.

Preparing for a Crisis – as an Organization

- **Treat crisis leadership as a high-risk and low-volume competency:**
  - Regular training and high-fidelity simulations.
    - Training with realistic scenarios: rapid choices, tight time constraints, and information gaps.
    - Wargaming under adversarial conditions.

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Crisis Management Decision Making for Teams and Individuals

Roger Glick, MS, MBA, CEM, FACHE

Market Director: Healthcare + Emergency Management

Jensen Hughes

Roger.Glick@jensenhughes.com

540.521.7996

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So, Who Are You?

Please Raise Your Hand If You Are With:

- A Hospital System

- Government Emergency Management

- Voluntary Organization

- Consultant

- Student

- Public Health

- A Non-Hospital Provider

Disaster Preparedness For Healthcare

What We Will Discuss Today:

- Risk Assessment

- Plans and Policy

- Training and Exercise

- Emergency Management Tools

- Support Tools

INTERACTIVE, DISCUSSION-BASED SESSION

Comprehensive Community Preparedness

- Fits together elements of emergency management into framework
- Before, during, and after a disaster
- All-hazards approach
- Includes all levels of government
- Includes private sector

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Phases of Emergency Management

- Mitigation—eliminate or reduce impact
- Preparedness—planning, training, resources
- Response—provide emergency assistance to victims
- Recovery—return to normal/near normal

Emergency Preparedness Cycle

Risk Assessment

OR – just what the heck are we worried about....

What is a Disaster?

- An emergency of such severity and magnitude that routine procedures or resources cannot effectively manage its consequences.

Introduction

- Dr. Kevin Kitka's observations during the Joplin tornado.
  - St John's Regional Medical Center
  - Joplin, MO
  - Sunday, May 22, 2011

Risk Management Framework

- Dynamic risk
- Static risk
- Inherent risk
- Speculative ris
- Pure risk
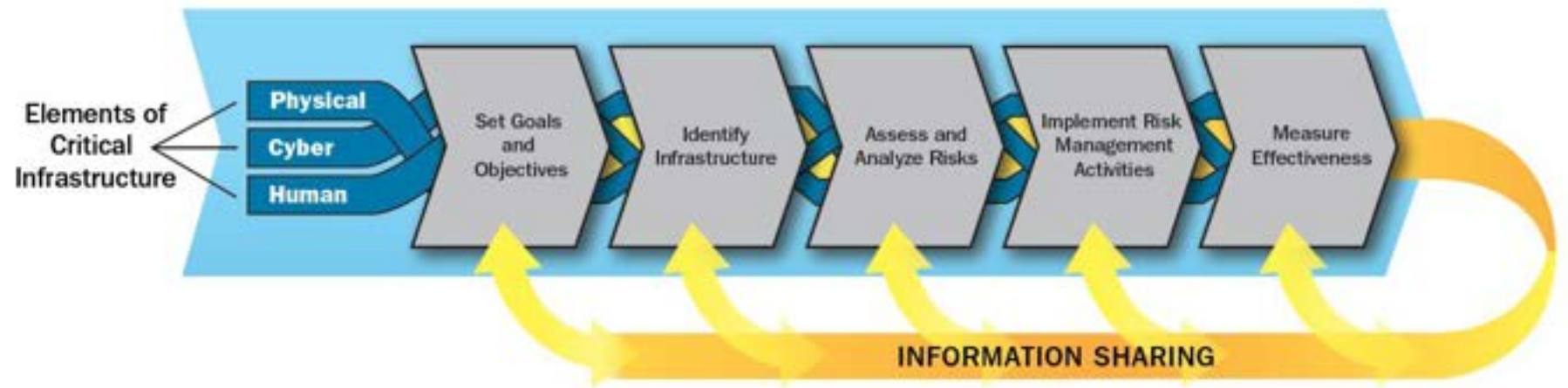
Identify Threats and Hazards

- Natural disasters
- Technological disasters
  - Accidental
- Human-caused incidents
  - Intentional

Additional Medical Issues

- Mental health
- Isolation and quarantine
- Mass prophylaxis
- Disruption of supply chain
- Medical surge

Unique Vulnerabilities of Healthcare Facilities

- Heavily occupied
- Complex buildings
- Supplies are critical
- Dependent on utilities
- Drugs/chemicals/equipment can be hazardous

Healthcare Hazard Vulnerability Assessment

- Identify hazards that affect an organization

- Assess the risk associated with each hazard

- Analyze the data to prioritize vulnerabilities

- Vulnerability determined by:
  - Impact on organizational function
  - Potential increase of service demands created by the impacts of a hazard

HAZARD AND VULNERABILITY ASSESSMENT TOOL
NATURALLY OCCURRING EVENTS

EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK	Notes
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE		
	Likelihood this will occur	Possibility of death or injury	Physical losses and damages	Interruption of services	Preplanning	Time, effectiveness, resources	Community/ Mutual Aid staff and supplies	Relative threat*	
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 - 100%	
Blizzard	0	2	2	3	2	2	3	0%	
Drought	1	2	2	2	2	2	2	22%	
Dust/Sand Storm	1	1	2	1	3	3	3	24%	
Earthquake, >6 Local	3	3	3	3	3	3	2	94%	
Epidemic/Natural	2	3	2	3	3	3	2	59%	
Flood, Local	2	3	3	3	3	3	2	63%	
Hurricane	0	0	0	0	0	0	0	0%	
Ice Storm	1	3	2	3	3	3	3	31%	
Infectious Disease (SARS, etc.)	1	3	3	3	3	3	2	31%	
Landslide	1	1	2	2	3	3	2	24%	
Severe Thunderstorm	1	1	1	1	2	2	2	17%	
Snow/Ice/Hail Storm	2	2	2	2	3	3	3	56%	
Temperature Extremes	1	1	1	1	2	2	2	17%	
Tsunami - Tidal Wave	0	0	0	0	0	0	0	0%	
Tornado	0	0	0	0	0	0	0	0%	
Volcano	0	0	0	0	0	0	0	0%	
Wild Fire	2	3	2	3	3	3	2	59%	
AVERAGE SCORE	1.06	1.65	1.59	1.76	2.06	2.06	1.76	21%	

*Threat increases with percentage.

* Events in Bold have occurred previously

RISK	=	PROBABILITY	*	SEVERITY
0.21		0.35		0.60

Natural Hazards : HVAIDetailedHM.xls

Kaiser Permanente

Hazard Vulnerability Assessment

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Plans and Policy

OR – the guts that'll be audited….

Joint Commission Standards—Six Critical Areas of Emergency Functions

- Communications

- Resources and assets

- Safety and security

- Staff responsibilities

- Utilities management

- Patient clinical and support activities

CMS Emergency Preparedness Rule

- Provider types
  - Hospitals
  - Nonmedical healthcare institutions
  - Hospice
  - Psychiatric residential treatment
  - Transplant Centers
  - Critical Access Hospitals
  - Organ Procurement
  - Intermediate Care for Individuals with Intellectual Disabilities

- Renal Disease Facilities
- Long-Term Care
- Ambulatory Surgical Centers
- Home Health Agencies
- P.A.C.E
- Outpatient Rehab
- Mental Health Centers
- Rural Health Clinics
- Clinics, Rehab, Physical Therapy and Speech-language Pathology

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CMS EP Rule Core Elements

- Risk assessment and emergency planning
- Communication plan
- Policies and procedures
- Training and testing

CMS Emergency Preparedness Rule Critical Areas

- Continuity of operations

- Command and control

- Staffing

- Surge patients

- Medical/non-medical supplies

- Pharmaceuticals

- Security

- Evacuation

- Decontamination

- Isolation

- Power supply

- Water/Sanitation

- Communications

- Medical records security and access

Continuity Planning

- NFPA 1600: Standard on Disaster/Emergency Management and Business Continuity Programs
  - All-hazard approach
  - Program elements necessary for mitigation, preparedness, response, and recovery

Continuity Planning

- Risk assessment

- Incident prevention

- Mitigation

- Facilities

- Mutual Aid/Assistance

- Planning

- Incident Management

- Communication & warning

- Operational procedures

- Resource management and logistics

- Training

- Exercise, evaluation, improvement planning

- Crisis communications and public information

- Finance and Administration

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All-Hazards Emergency Planning

- Plans address hazards that organization may face
- Avoids: duplication of effort, gaps in response, and conflict from divergent approaches
- Organizations must develop, implement, maintain plans
- Address mitigation, preparedness, response, recovery
- Comprehensive Emergency Management Program (CEMP) has multiple plans
- EOP is the centerpiece

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All-Hazards Emergency Operations Plan

- Describes overall response actions
- Details tasks for organizational elements
- Based on objectives, assumptions, and capabilities
- Plans versus Procedures

All-Hazards Planning

- Single emergency plan
- Each disaster is unique, but incident management issues are the same
- Direction, control, communications, and resource management
- Efficient in use of time, effort and money
- Avoids duplication of effort and gaps
- Appendices for unique aspects of incidents

Plan Development

- Broad representation of organization is involved in planning
- Participants must have time/talent or INTEREST
- Utilize local expertise
- Plan toward identified hazards
- Learn from experiences/ plans of others
- Gain support of highest level leadership

Plan Development

- Plan writing team
- Draft plan
- Acceptance by organization and senior leadership
- Train on the plan (all personnel)
- Exercise the plan regularly
- Revise the plan as needed
- Review the plan periodically
- *A Plan is a living document!*

Emergency Operations Plan Components

- Main components (functional format)
  - The Basic Plan—CONOPS, direction and control, logistics
  - Functional annexes
  - Hazard-specific appendices—special response considerations
  - SOPs and checklists

Developing a Continuity Plan

- Basic components include:
  - Applicability and scope
  - Prioritized essential functions
  - Concept of operations (orders of succession, delegations of authority, vital files/records/data)
  - Logistics (alternate location requirements, interoperable communications)
  - Training and exercises

Training & Exercise

OR – how to meet your compliance elements and ACTUALLY GAIN in your program....

Preparedness Training and Exercises Assessing Training Needs

- EP Rule requires training and testing program

- Multi-phase process
  - Determine current skills level versus needed skills level
  - Assess the gap (training need)

- Develop a training plan
  - Who needs to be trained? In what?
  - How, when, where, and by whom?

Assess/Validate

- Policies
- Plans
- Procedures
- Training
- Equipment
- Assumptions
- Agreements

Exercising the Plan

- Clarify roles/responsibilities
- Improve interagency coordination and communications
- Identify gaps in resources
- Measure performance
- Identify opportunities for improvement

After-Action Report/Improvement Plan (AAR/IP)

- Summarizes incidents
- Analyzes performance
- Evaluates achievement of objectives
- Identifies corrective actions and timelines
- Assigns responsibilities

Training and Exercises HSEEP

- Capabilities- and performance-based exercise program
- Provides standardized policy, methodology, and terminology for exercise design, development, conduct, evaluation and improvement planning
- Provides tools and resources
- Reflects lessons learned and best practices

Exercise Types

Homeland Security Exercise and Evaluation Program

- Seminar, workshop, drill, games
- Tabletop (TTX), Functional (FE), Full Scale (FSE) are primary
- Most federal grants mandate exercises use HSEEP guidelines
- CMS recommends HSEEP

TOOLS

OR – How do we actually do more with less....

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SCAN ME

Disaster Preparedness for Healthcare

TOOLKIT

What's in the Toolkit:

- Emergency Management
- Business/Support

Diane Logsdon

REACH OUT:

LinkedIn: linkedin.com/dianelogsdon

Email: diane@logsdon.group

Office: 847-701-5647

Website: www.logsdon.group/healthcare

Agenda

- Review the 2 HCC Regions of COTS

- Discuss the COTS HIL

- The Why?

- The Process

- Training, Coordination & Communication

- Lessons Learned

About Our Coalitions

Mission

- To create and promote a state of readiness and response to protect Central and SE/SEC Ohio's healthcare system during an emergency; through effective planning, exercises, education and collaboration between healthcare organizations, 1st responders, emergency management directors, public health, and other emergency response planners.

- To create a state of readiness and response by promoting better outcomes through collaboration thus achieving quality healthcare delivery during a crisis.

Eight Homeland Security Planning Regions – receive ASPR funding for HCC Coordination
Seven Healthcare Coalitions

Northwest Region
Hospital Council of NW Ohio
RHC: Susan Murphy
President: Hayley Struder

West Central Region
Greater Dayton Area Hospital Association
RHC: Molly Dargavell
President/CEO:
Sarah Hackenbracht

Southwest Region
The Health Collaborative
RHC: Jessica Skelton
VP Clinical Strategies: Tiffany Mattingly

Northeast Region
WellLink
RHC: Christina Fozio
VP of Business Ops and
Administration: Tracy Wise

Northeast Central Region
Healthcare Alliance of Greater Ohio
RHC and CEO: Steven Nuske

Central Region
COTS
RHC: Jodi Keller
President: Sherri Kovach

Southeast/Southeast Central Region
COTS
RHC: Kelsey Blackburn
President: Sherri Kovach
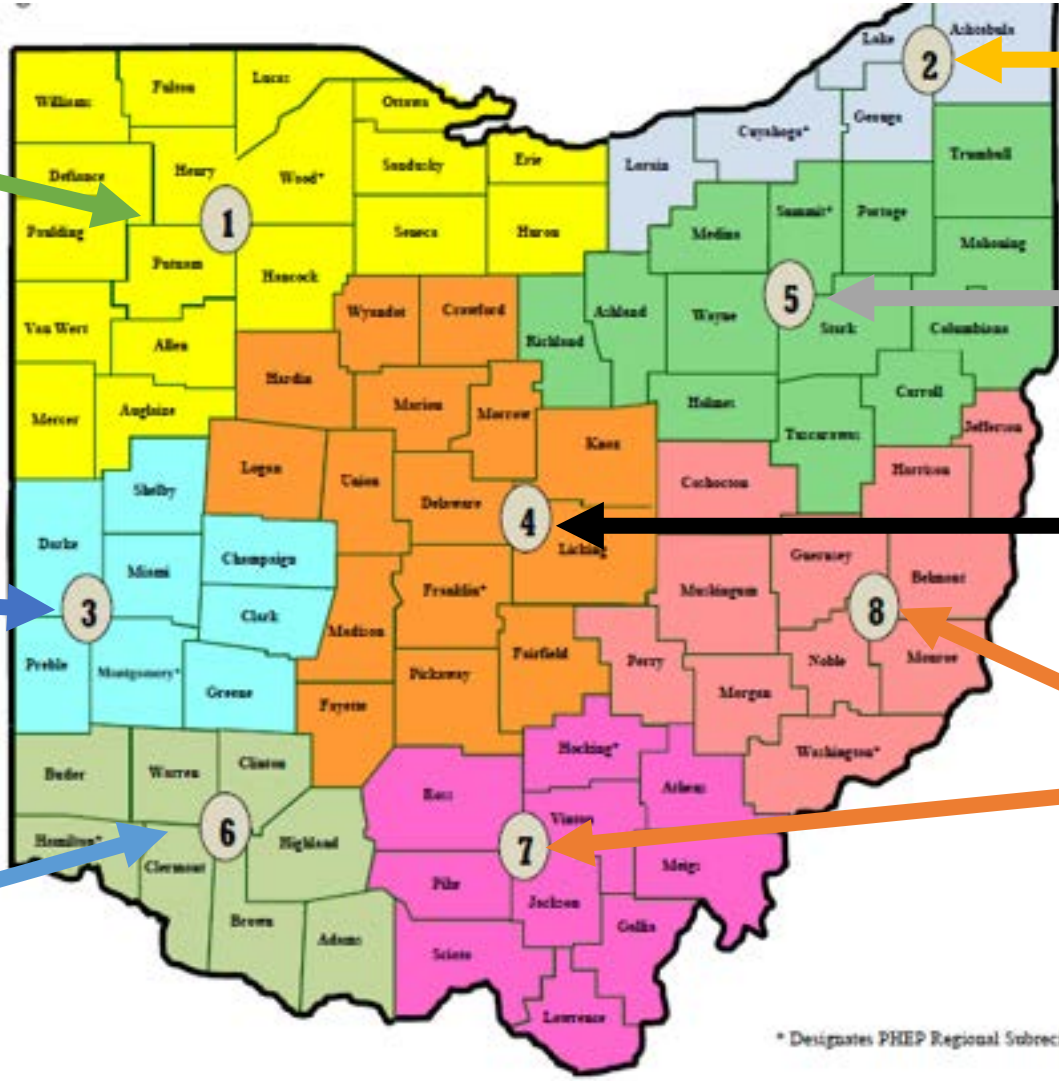
* Designates PHEP Regional Subrecipient

RHEP Coalition- Central Ohio

- 15 counties in central Ohio with Columbus being the Urban center
- 30 Hospitals
- 8 Trauma Centers
- 1 Pediatric Trauma Center
- 14 Acute Care hospitals
- 7 Critical Access Hospitals
- 12 FSEDs
- >600 HCC Members

Ohio Hospital Preparedness Regional Map

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SE/SEC Ohio Coalition

- 21 counties
- 17 hospitals
  - 2 - Level 3 Trauma Centers
  - 6 – critical access hospitals
  - **NO** pediatric or burn hospitals
- 5 free-standing EDs
- 170+ Coalition Members

Ohio Hospital Preparedness Regional Map
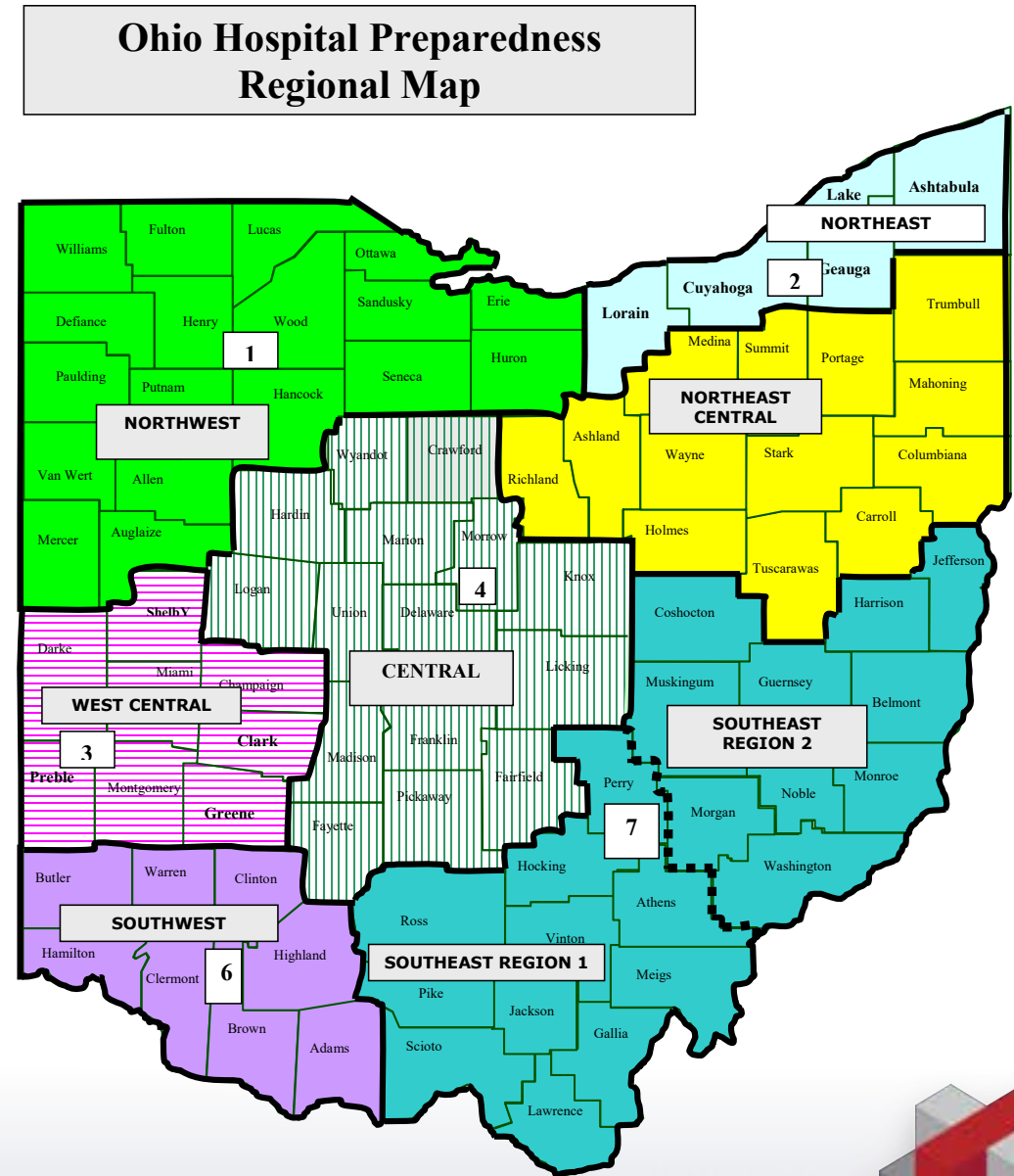
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Local/County Healthcare Coalitions

Central
- 15 county coalitions
- Each has a lead agency

SE/SEC
- 12 Local Coalitions
- Each has a lead
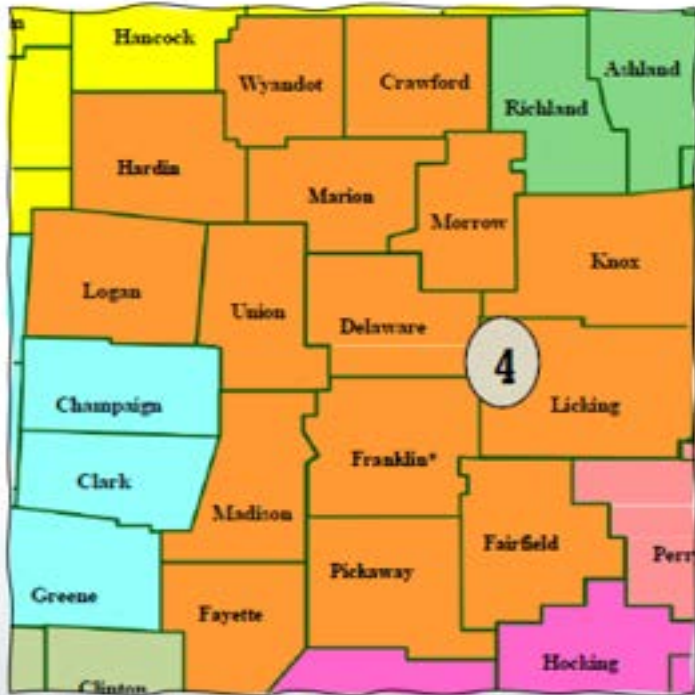
Region or Zone

Coalition Members

Local/County Leads

Disaster response occurs first at the **Local** level. Local governments and voluntary agencies represent the front line when disasters occur.

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Healthcare Incident Liaison (HIL)

- Direct Response to 911

- Hospitals willing to share resources and act collectively in disaster

- Recognition of the value of collaboration in a disaster

- COTS HIL role is written into city, county, regional, and state emergency response plans.

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HIL Role

- On call 24/7

- Coordinates Healthcare Response to Disasters/Emergencies:
  - Collection and collation of regional health information
  - Resource Allocation
  - Situational Awareness
  - Monitoring of health care system performance and capacity
  - Liaison between the region and state agencies
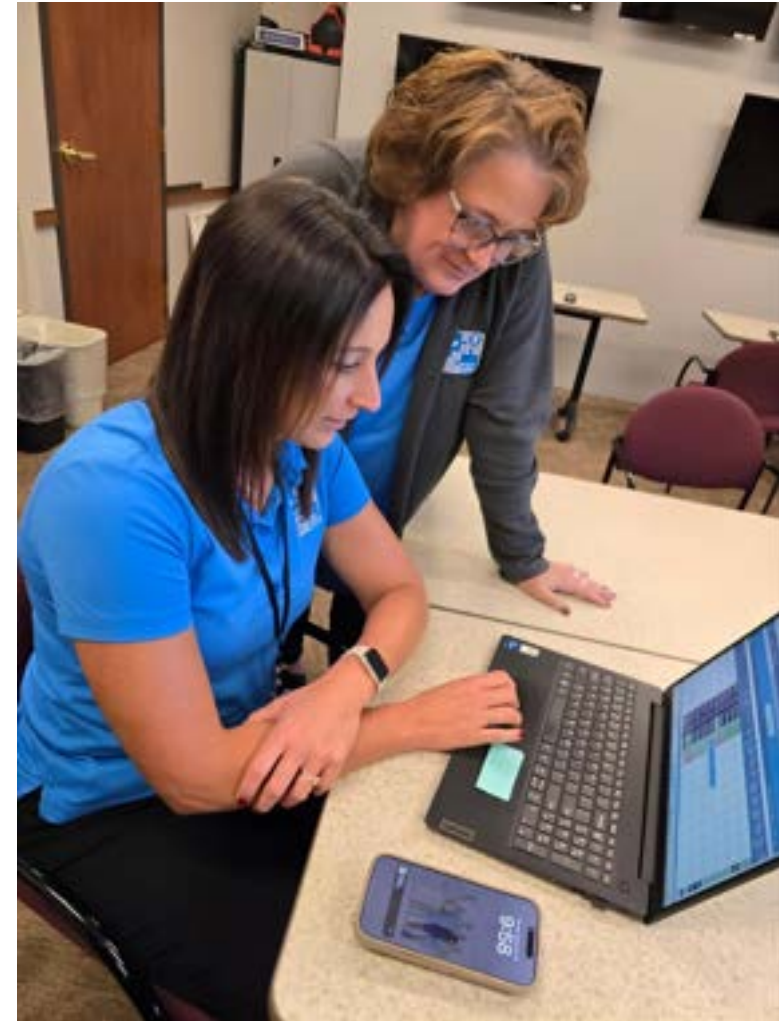
When to Call the HIL

Examples of events in which the HIL should be activated include but are not limited to:

- System-wide communication outages

- No Notice mass casualty incidents

- Facility evacuation

- Hazardous materials exposures (decon)

- Internal hospital emergencies that require absolute diversion of EMS patients, reallocation of patients and/or additional resources
  - With or without an impact to patient care

- An injured suspect fleeing from law enforcement who may present at a Central Ohio emergency department

- Resource request

- An event with anticipated media coverage

Information Sharing and Communication Systems

Background

On March 15, 2024, an EF-3 tornado hit
a trailer park and community in Indian Lake
in Logan County, Ohio.

Logan County has 1 rural hospital (Mary Rutan)
with 19 ED beds, 7 ICU beds and 15 M/S beds

Mary Rutan has an Emergency Management Staff
of 1

    He was out of town at the time of the tornado

Response

Tornado hit at 8:30 p.m.

HIL Activated 8:39 p.m.

EMResource (bed tracking); EMTrack (patient tracking) 8:54 p.m.

Activated the trauma teams at our trauma centers, blood banks at hospitals, SOCC 9:00 p.m.

Notified the other regions and the state- expanded the EMResource event to 2 additional regions

@10:20 HIL requested LPH staff to respond to Mary Rutan Hospital to assist with patient tracking

Hospital conference call held at 11:00 p.m.

LPH created the patient list, and the COTS HIL entered every patient into EMTrack

The Why?

Most of our hospitals have an EM staff of 1

EM staff pulled in multiple different directions during an emergency

They are the ones who know the plans and the partners in the community

Everyone relies on them

High turn over of staff

At the time, we had just implemented EMTrack and training had not been completed at Mary Rutan to enter the patients.

Mary Rutan was extremely busy with the influx of patients they did receive

**NEED to determine a way to FORCE MULTIPLY the emergency management staff at our facilities during a time of crisis

Logan County Tornado: After Action

Strengths (37)
- The Central Region has an established Response Ready Coalition that was able to share and gather situational awareness throughout the event.
- The Logan County Coalition made calls to all of the healthcare agencies to determine their status.
- HIL assisted the hospital with requesting a state asset for a mobile cooling unit.

Area for Improvement (6)
- There is a need to force multiply hospital/HCC emergency management staffing during a crisis.
- Deceased patients that were not transported to the hospital were not entered into EMTrack, making family reunification difficult.
- Additional training needed on patient tracking.
  - Continued tracking to discharge/disposition.

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Call For Volunteers

- Made the presentation/request at our hospital meeting

- Started with 8 Emergency Managers who showed interest

- Initial training included 9 (large trauma center and small rural hospital EMS)

Brainstorming

- In person brainstorming session with volunteers, COTS, Clinical Advisor, and Mary Rutan Hospital EM

- Dr. Bachmann, Clinical Advisor: "This is niche. Need to make it broadly available to all

- Defined the Scope of the team

- No self-deployment! Voluntary decision made by the hospital IC

- Created the request and activation process through the COTS HIL

Brainstorming

- Talked about other strike teams: pediatric, public health

- Set operational period times

- Seeking approval from hospital leadership to participate

- **Bonus Points:** Clinical Advisor is a member of Ohio Task Force One and other volunteers were previous Red Cross staff = familiar with deployment

Scope

- EMStrike Team is an optional resource available to impacted hospitals, FSEDs, and other HCC members
- Requesting the EMStrike Team is a voluntary decision made by the hospital incident commander in conjunction with the EM staff. There will be no self-deployment of the EMStrike Team
- Assist the EM with local, regional or state resource requests
- Assist the EM by becoming a liaison between the facility and the HIL

Scope

- Assist Decon Team as Decon Safety Officer
- EMStrike Team operational period will rotate no longer than every 12 hours
- Serving in a support role with EMTrack and EMResource updates.
- Supporting the EM in the county EOC
- Other duties deemed appropriate by the facility EM, which may include assisting with documentation of action items based on credentials and qualifications

The Annex

Annex

- Defines the Strike Team Structure
- Scope
- Request Process
- Activation
- Go Bag
- Demobilization

Documents

- JAS- EMStrike Team
- JAS-HIL Planning Section Chief
- EMStrike Team Activation
- HICS 204
- HICS 214
- HICS 252

Activation Process

Need identified for EM support for an event
- Requesting hospital pages the COTS HIL
- COTS HIL obtains specific information from requesting facility
- COTS HIL creates an incident in Veoci platform

COTS HIL sends TENS notification to EMStrike team Members
- EMStrike team members report their availability in Veoci
- COTS HIL staff assigns available EMStrike team member – based on specialty needed and proximity to requesting hospital
- COTS HIL staff calls selected EMStrike team member and provides logistic information
- EMStrike team member deploys to assigned location and COTS HIL assigns EMResource and EMTrack access
- EMStrike team member assigned updates arrival in Veoci

Demobilization
- If a second rotation is needed @ hour 9 will restart the process to notify EMStrike team members
- No activation will last longer than 12 hours
- Debrief with EMSTrike team members and requesting hospital
- EMStrike team member will page the COTS HIL when shift is complete and update status in Veoci
- COTS HIL removes access to EMResource and EMTrack

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HICS Forms

HICS Forms to Know

204: Assignment List — Document assignments

214: Activity Log — Document activities completed

252: Section Personnel Time Sheet — Document your time

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Pre-Identified Scripts

- **TENS Script:** This is a real-world message from COTS. The E.M. Strike Team for the central region is being activated for the event occurring in Franklin County. XXX Hospital is requesting additional E.M. resources. If you are available to respond as an EMStrike Team Member, check the TENS alert text or email for the link to provide your availability. DO NOT SELF-DEPLOY!"

- **Text Script:** "The EMStrike Team has been requested. XXX Hospital is requesting additional E M resources. Click the link below to provide your availability. https://veoci.com/v/p/form/bqc8kryxkqyh?c=310496"

- ***Email Script**: "This is a real-world message from cots. The E.M. Strike Team for the central region is being activated for the event occurring in XXXX County. XXXX Hospital is requesting additional E.M. resources. Please click on the link to provide your availability. https://veoci.com/v/p/form/bqc8kryxkqyh?c=310496 Do NOT Self-deploy!"*

Veoci - EMStrike Team Coordination

Pre-Requisites

- Proficient in EMResource
- Proficient in EMTRack
- Proficient in COTS Liaison Role
- Knowledgeable of HICS and Regional Response Plans
- Knowledgeable of communication expectations with the COTS HIL
- NIMS
  - 100, 200, 700, 800 (300, 400 are a bonus)
- ICS
  - Proficient in HICS
  - Understands HICS reporting structure

EM Strike Team   8/27/2025

Purpose: An event has occurred that is impacting a hospital or healthcare facility that has stressed the emergency management staff at the facility. The Coalition has planned for and implemented an EM Strike Team that may be requested by the impacted facility to force multiply the emergency management resources on site or virtually.

1. An event has occurred, and additional EM resources are needed at the facility.
2. Requesting Facility will page the HIL to activate the EM Strike Team.

Page the HIL by calling:
855.266.7243 and enter ID 2687441 then enter your contact number:
OR
Email 26874451@onpage.com

Requesting Facility:
Questions to ask the Requesting Facility when the HIL is paged
What is the scenario?

HIL verify with caller: "Do you have the authority to request strike team or have you received permission to request Strike Team activation?"
# of Strike Team members requested.   And for what purpose?

What is the best number for the strike team member to reach you at?

Is there a secondary #? i.e. security
What is the address of the facility?
What is the location at the hospital the EM Strike Team member should report to upon arrival? Is there a specific door to enter?

Any known travel barriers/security/safety issues?

Where should team members park?

Page 2

Are there any urgently needed supplies the Team Member could bring with them?

How soon do you need the Strike Team?
How long do you anticipate to need the team?

HIL Activation of Team

HIL will send a TENS alert to the E M Strike Team TENS group activating the EM Strike Team.
TENS Script: "This is a real-world message from cots. The E.M. Strike Team for the central region is being activated for the event occurring in XXXX County. XXXX Hospital is requesting additional E.M. resources. Check your TENS alert text or email for the link to provide your availability. Do NOT Self-deploy!"
TEXT Script: The E M Strike Team for the central region is being activated. XXX hospital is requesting additional E M resources. Please click on the link to provide your availability.
https://veoci.com/v/n/form/bcc8iryxlqyh?c=310496
Email Script: "This is a real-world message from cots. The E.M. Strike Team for the central region is being activated for the event occurring in XXXX County. XXXX Hospital is requesting additional E.M. resources. Please click on the link to provide your availability.
https://veoci.com/v/n/form/bcc8iryxlqyh?c=310496 Do NOT Self-deploy!"

Information HIL Shares with Strike Team Members

HIL will create a list of volunteer strike team members and determine who is closest to the requesting facility. See appendix A for Strike Team

Requesting Facility:		Address:	
Any Specific Requested capabilities/assistance:			
Time to report to facility			
Contact numbers at facility:	Name: Cell: Phone:		Name: Cell: Phone:
Park at this location when you reach the hospital			
Report to this door and this location when you reach the hospital			
Travel barriers/safety/security concerns			

Page 3

Supplies to bring with you as requested by the hospital	
Bring To Go BAG and laptop	
Remind Staff to change status in Veoci when they arrive at the hospital.	

HIL Actions

Strike Team Member Status: In Veoci: HIL will update Team Member Status to Deployed/Activated or Stand by

Once the Strike Team has been identified, the HIL will give members access to EMResource, EMTrack and Veoci for the requesting facility.

Demobilization

Strike Team Members will page the HIL when their shift is complete.
Team Member will update Veoci to Demobilized status when they leave the hospital.
Team Member will update Veoci when they arrive home.
If there is no update to this status within 2 hours of demobilized status change, the HIL will reach out to the team member.
If a second rotation of EM Strike Team members is needed, the requesting EM will page the HIL for additional resources by hour 9.
The HIL will either request additional team members respond to location or resend the activation TENS alert.

Appendix A: Strike Team Members

Strike Team Members Volunteering to Report to requested location. If possible deploy 2 strike team members is requesting hospital's EM staff is unavailable.	Date:
Name	Cell Phone #

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Appendix B: Strike Team Members Deployed

Strike Team Members Who are Actively Deployed		Date:	
Name	Cell Phone #	Time In:	Time Out:

HIL TENS alerts for Team

- Consider alerting the Strike Team for awareness purposes at the start of the event/exercise.
- If the strike team is activated, include the team TENS group in alerts sent to the hospitals for cross-reaction awareness. This allows the team members to receive the same alert the hospital POCs are receiving.
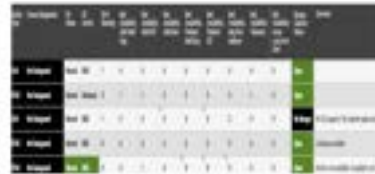
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Training

- Hosted two trainings
- Trained 19 hospital EM people

Agenda

- Review of Situational Awareness Platforms
- EMTrack Training
- Pre-Requisites- NIMS-ICS
- Review of Regional Response Plans
- Communication with the HIL
- Resource Request Process
- Review JAS
- Review EM Strike Team Annex
- Deployment Process- Veoci Site
- HICS forms
- Blood Transportation
- What goes in the "Go Bag?"

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Practice

Scenario- Tornado

- A large EF2 Tornado cuts a wide path of destruction through Knox County.
- Infrastructure is damaged, but the hospital maintains power and water. Essential services are not impacted at the hospital.
- There is however, widespread power outages in the county.
- There are fatalities reported, but it is not known how many at this time.
- Patients have started to report to the emergency department with a wide variety of injuries from lacerations to major trauma.

Practice Entering 5 patients into EMTrack

Name	Date of Birth	Gender	Triage Category	Chief Complaint
You choose the	12/9/1930	Female	Yellow - Delayed	Smoke Inhalation
Name	4/18/2001	Female	Yellow - Delayed	Abdominal Pain/Problem
Make	9/16/1998	Male	Yellow - Delayed	Traumatic Injury
Something	10/15/2002	Male	Green - Minor	No Apparent Illness/Injury
UP	4/19/1966	Male	Green - Minor	Ear Injury/Pain
	8/24/1994	Female	Green - Minor	Leg Injury
	10/9/1962	Male	Green - Minor	Lacerations
	4/18/2007	Female	Yellow - Delayed	Abdominal Pain/Problem
	9/24/1993	Female	Yellow - Delayed	SOB/Breathing
	3/13/2020	Male	Black - Decedent	Death
	8/3/1960	Female	Black - Decedent	Death

FSE: The 1st Test

- Veoci
  - There were initial access issues, but it was fixed during the exercise
- Request Process
- TENS Notification Process
- Activation Process
  - Received all the info he needed.
  - If in another region may need to give more background info when deploying.
- Scope/Work-
  - Completed EMTrack patient entries
  - Consider additional EMTrack drills with an objective to accept patients and transfer them to another hospital.
  - Include EMStrike Team TENS Group in additional TENS alerts that are sent out. (If from another region, they won't get the updated information in the Alert)
- Demob
  - Worked Well

VA Partners: A Team to Supplement the HIL

The team keeps growing

Adding team members from our VA partners that will supplement the HIL staff

Moving Forward

Improvement
- Continuous re-evaluation

Drill the Team
- FSE
- Bi-Annual Activation Drill with movement to another hospital
- Quarterly Activation Drills

What the Strike Team Offers

Rapid Specialized Support → Consistency and Expertise → Surge Capacity and Continuity

Each Piece Counts: Assembling Expertise to Deliver Operational Support in a Crisis

RHEP Coalition SEOHC Coalition

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Go Bags

- EMStrike Team Badge- to show security/LE
- Log in information for EMResource/EMTrack
- Important phone numbers: HIL
- Flashlight and batteries
- Pens/notebooks
- Drinks/snacks
- Dress appropriately- Change of clothes
- Clipboard
- Fill gas tank in care before leaving your jurisdiction
- Personal medications
- Cell phone/charger/batteries
- Laptop/charger
- Hotspot/MiFi
- At least 3 changes of PPE: masks/gowns/gloves

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Thank YOU!

Kelsey   *Jodi*

Kelsey Blackburn, CHEP

Emergency Management Manager

SE/SEC Ohio Regional Coordinator

kblackburn@cotshealth.org

Jodi Keller, RN

Director of Healthcare System Emergency Preparedness and Response

Central Ohio Regional Coordinator

jkeller@cotshealth.org

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Appendix K
EM Strike Team

A. **Define Strike Team Structure**

The Emergency Management (EM) Strike Team will be comprised for Hospital emergency management staff within the central Ohio region.

- EM Team members have received prior authorization from their senior leadership to participate on the EM Strike Team.
  - EM Team member will sign confidentiality agreements upon arrival if requested.
  - Hospital will continue to pay salary and travel expenses.
  - A Healthcare Incident Command System (HICS) Job Action Sheet (JAS) has been created for EM Strike Team Members.
  - EM Strike Team Members will wear a black HICS vest while deployed at a hospital denoting them as an EM Strike Team Member.

B. **Define Scope of Team**

- EM Strike Team members will have the following competencies:
  - Proficient in EMResource
  - Proficient in EMTrack
  - Proficient in COTS Liaison Role
  - Knowledgeable of HICS and Regional Response Plans
  - Knowledgeable of communication expectations with the COTS Healthcare Incident Liaison (HIL)
- The EM Strike Team is an optional resource available to impacted hospitals, Free Standing Emergency Departments (FSEDs), and other Healthcare Coalition (HCC) members.
  - Requesting the EM Strike Team is a voluntary decision made by the hospital incident commander in conjunction with the EM staff. There will be no self-deployment of the EM Strike Team.
- Assist facility Emergency Management (EM) with local, regional or state resource requests.
  - Completing 213RR form.
  - Submitting request via Veoci platform.
  - Paging the HIL.

- - *This may include Medical Counter Measures (MCM) from the Strategic National Stockpile (SNS).
- Assisting the EM by becoming a liaison between the facility and the HIL.
- Serving in a support role with EMTrack and EMResource updates.
- Supporting the EM in the county Emergency Operations Center (EOC).
- Assist Decon Team as a Decon Safety Officer.
- EM Strike Team operational period will rotate no longer than every 12 hours.
- Other Duties deemed appropriate by the facility EM, which may include assisting with documentation of action items.
- The HIL will consider sending a TENS alert to the Strike Team group for *awareness purposes* at the start of the event/exercises, even if the team has not yet been requested. Because the team includes members from both regions, not all team members will receive the initial alert for a specific region.

C. **Define the Request Process**
- Requesting hospital identifies the need for EM support for an event.
- Requesting hospital pages the HIL and requests activation of the EM Strike Team.
  - The HIL will obtain the following information from the requesting hospital EM:
    1. Details on the incident
    2. # of strike team members requested
    3. Is hospital EM available and on site? *If the answer is no, consider deploying 2 Strike Team members to the location.*
    4. Any specific requested capabilities/assistance? i.e. EMTrack, hazmat safety officer
    5. Time to report to facility?
    6. How long of a deployment do you anticipate?
    7. EM contact # for strike team members to use upon arrival. Is there a back up number? i.e. security
    8. Address of the facility?
    9. Location at hospital EM Strike Team Member should report to upon arrival. Is there a specific door to enter?
    10. Any known travel barriers/security/safety issues.
    11. Where team members should park.
    12. Are there any urgently needed supplies the Team Member could bring with them from their hospital?

D. **Define the Activation of the Team**
- The HIL will send a TENS alert to the EM Strike Team group activating the EM Strike Team.

TENS Script: *"This is a real-world message from cots. The E.M. Strike Team for the central region is being activated for the event occurring in XXXX County. XXXX Hospital is requesting additional E.M. resources.. Check your TENS alert text or email for the link to provide your availability. Do NOT Self-deploy!"*

TEXT Script: *The E M Strike Team for the central region is being activated. XXX hospital is requesting additional E M resources. Please click on the link to provide your availability.* https://veoci.com/v/p/form/bqc8kryxkqyh?c=310496

Email Script: *"This is a real-world message from cots. The E.M. Strike Team for the central region is being activated for the event occurring in XXX County. XXX Hospital is requesting additional E.M. resources. Please click on the link to provide your availability.* https://veoci.com/v/p/form/bqc8kryxkqyh?c=310496

Do NOT Self-deploy!"

- Hospital POCs who are willing and able to respond to the requesting hospital will click on the link provided in the alert to update their status in Veoci and provide availability for deployment. Additional deployment information will be available on the Veoci site.
- The HIL will determine who to deploy based on the requested specialty asset and proximity to the requesting hospital.
- Stand by members will be identified.
- If more than 2 Strike Team members are deployed, a Strike Team Leader will be identified by the COTS HIL for accountability and ease of communication with the HIL.
- COTS HIL will document activated TEAM members and stand-by members on the Veoci site.
- Veoci tracking: **Strike Team Member Status** chart will be used on the Veoci site to show status of each team member. The HIL or the team member will update their status as the deployment progresses.
  - Steady State: no activations at this time
  - Available: Team Member changes to status to "Available" if they are able to be deployed.
  - Deployed/Activated: The HIL will update this status for the team member when they have been deployed.
  - Arrived on Scene: Team member will update their status when they arrive on scene.
  - Demobilized: Team member will update their status once they leave the scene.
  - Arrived Home: Team member will update their status when they arrive home from deployment. If there is no update to this status within 2 hours of demobilized status change, the HIL will reach out to the team member.

- o Stand by Status: Team member is available, but not immediately deployed in the current operational period.
- Once a Team Member is deployed the COTS HIL will give account access to the requesting hospitals EMResource, EMTrack, and Veoci sites.
- MARCS

E. **Strike Team Go Bag**
- **Strike Team members are encouraged to establish their own "Go Bag" to take along with them when deployed to another location.**
- **Recommended items to include in the Go Bag:**
  - o EM Strike Team Badge to show security/Law Enforcement.
  - o Important log in information for EMResource/EMTrack
  - o Important phone numbers– HIL etc.
  - o Flashlight and batteries
  - o Pens/notebooks
  - o Drinks/snacks
  - o Dress appropriately
  - o Clipboard
  - o Fill gas tank in car before leaving your jurisdiction
  - o Personal medications
  - o Cell phone/charger/batteries
  - o Laptop
  - o Hotspot/MIFI
  - o At least 3 changes of personal protective equipment (PPE): masks/gowns/gloves

F. **Demobilization**
- Strike Team Members will page the HIL when their shift is complete.
- Team member will change status in Veoci to demobilized.
- If a second rotation of EM Strike Team members is needed, the requesting EM will page the HIL for additional resources by hour 9 of the current deployment.
- The HIL will either request additional team members respond to the location or resend the activation TENS alert requesting a new team.
- The HIL will remove account access to EMTrack, EMResource and Veoci for deployed Team Members.
- Each hospital to purchase at least 3 black HICS vests and mark them as EM Strike Team.
- Hospitals will add EM Strike Team information to their EOP.

EM Strike Team   8/27/2025

Purpose: An event has occurred that is impacting a hospital or healthcare facility that has stressed the emergency management staff at the facility. The Coalition has planned for and implemented an EM Strike Team that may be requested by the impacted facility to force multiply the emergency management resources on site or virtually.	
1. An event has occurred, and additional EM resources are needed at the facility.	
2. Requesting Facility will page the HIL to activate the EM Strike Team.	Page the HIL by calling: 855.266.7243 and enter ID 2687441 then enter your contact number: OR Email 26874451@onpage.com
Requesting Facility:	
Questions to ask the Requesting Facility when the HIL is paged	
What is the scenario?	
HIL verify with caller: "Do you have the authority to request strike team or have you received permission to request Strike Team activation?"	
# of Strike Team members requested. And for what purpose?	
What is the best number for the strike team member to reach you at?	
Is there a secondary #? i.e. security	
What is the address of the facility?	
What is the location at the hospital the EM Strike Team member should report to upon arrival? Is there a specific door to enter?	
Any known travel barriers/security/safety issues?	
Where should team members park?	

Created 6/13/2024 Updated 2-21-2025; 3/21/2025, 5/6/2025, 8/26/2025

Are there any urgently needed supplies the Team Member could bring with them?

How soon do you need the Strike Team?
How long do you anticipate to need the team?

HIL Activation of Team
HIL will send a TENS alert to the E M Strike Team TENS group activating the EM Strike Team. ***TENS Script:*** *"This is a real-world message from cots. The E.M. Strike Team for the central region is being activated for the event occurring in XXXX County. XXXX Hospital is requesting additional E.M. resources. Check your TENS alert text or email for the link to provide your availability. Do NOT Self-deploy!"* ***TEXT Script:*** *The E M Strike Team for the central region is being activated. XXX hospital is requesting additional E M resources. Please click on the link to provide your availability.* https://veoci.com/v/p/form/bqc8kryxkqyh?c=310496 ***Email Script****: "This is a real-world message from cots. The E.M. Strike Team for the central region is being activated for the event occurring in XXXX County. XXXX Hospital is requesting additional E.M. resources. Please click on the link to provide your availability.* https://veoci.com/v/p/form/bqc8kryxkqyh?c=310496 *Do NOT Self-deploy!"*

Information HIL Shares with Strike Team Members		
HIL will create a list of volunteer strike team members and determine who is closest to the requesting facility. See appendix A for Strike Team		
Requesting Facility:	Address:	
Any Specific Requested capabilities/assistance:		
Time to report to facility		
Contact numbers at facility:	Name: Cell: Phone:	Name: Cell: Phone:
Park at this location when you reach the hospital		
Report to this door and this location when you reach the hospital		
Travel barriers/safety/security concerns		

Supplies to bring with you as requested by the hospital	
Bring To Go BAG and laptop	
Remind Staff to change status in Veoci when they arrive at the hospital.	

HIL Actions
Strike Team Member Status: In Veoci: HIL will update Team Member Status to Deployed/Activated or Stand by.
Once the Strike Team has been identified, the HIL will give members access to EMResource, EMTrack and Veoci for the requesting facility.

Demobilization
Strike Team Members will page the HIL when their shift is complete.
Team Member will update Veoci to Demobilized status when they leave the hospital.
Team Member will update Veoci when they arrive home.
If there is no update to this status within 2 hours of demobilized status change, the HIL will reach out to the team member.
If a second rotation of EM Strike Team members is needed, the requesting EM will page the HIL for additional resources by hour 9.
The HIL will either request additional team members respond to location or resend the activation TENS alert.

Appendix A: Strike Team Members	
Strike Team Members Volunteering to Report to requested location. If possible deploy 2 strike team members is requesting hospital's EM staff is unavailable.	Date:
Name	Cell Phone #

Created 6/13/2024 Updated 2-21-2025; 3/21/2025, 5/6/2025, 8/26/2025

Appendix B: Strike Team Members Deployed			
Strike Team Members Who are Actively Deployed		Date:	
Name	Cell Phone #	Time In:	Time Out:

HIL TENS alerts for Team
• Consider alerting the Strike Team for awareness purposes at the start of the event/exercise.
• If the strike team is activated, include the team TENS group in alerts sent to the hospitals for cross-reaction awareness. This allows the team members to receive the same alert the hospital POCs are receiving.

Created 6/13/2024 Updated 2-21-2025; 3/21/2025, 5/6/2025, 8/26/2025

EM Strike Team

Mission: Assist the hospital emergency management staff as delegated.

Position Reports to: **Emergency Management (EM)**	Command Location: _____	
Position Contact Information: Phone: (____) - _____	Radio Channel: _____	
Hospital Command Center (HCC): Phone: (____) - _____	Fax: (____) - _____	

Position Assigned to:	Date: / /	Start: ___:___ hrs.
Signature:	Initials:	End: ___:___ hrs.
Position Assigned to:	Date: / /	Start: ___:___ hrs.
Signature:	Initials:	End: ___:___ hrs.
Position Assigned to:	Date: / /	Start: ___:___ hrs.
Signature:	Initials:	End: ___:___ hrs.

Immediate Response (0 – 2 hours)	Time	Initial

Receive appointment
• Obtain briefing from the EM Staff
  ○ Size and complexity of incident
  ○ Expectations of the Incident Commander
  ○ Incident objectives
  ○ Involvement of outside agencies, stakeholders, and organizations
  ○ The situation, incident activities, and any special concerns
• Assume the role of EM Strike Team
• Review this Job Action Sheet
• Put on position identification (e.g., position vest)		

Assess the operational situation Establish contact with the site hospital's EM upon arrival. • Establish contact with the COTS HIL		
Activities • Change status on the **Strike Team Member Status c**hart in Veoci to Arrived on Scene. • Verify access to the site hospital's EMResource and EMTrack platform . If you are unable to access EMResource and EMTrack for the facility, contact the COTS HIL • Assist EM staff by updating EMResource and EMTrack. • Assist EM staff and coroner's office by entering decedents from the scene into EMTrack. • Assist the EM with resource requests to COTS for regional, state and federal assets. • Assist EM staff by documenting incident details/timeline. • Assist EM staff by reporting to the county EOC if requested.		

	Time	Initial
Documentation • HICS 204: Appoint liaison team members, if assigned, and complete the Assignment List • HICS 213: Document all communications on a General Message Form • HICS 214: Document all key activities, actions, and decisions in an Activity Log on a continual basis • HICS 252- Document personal time in and out for employer records.		
Resources • If needed, deploy as a liaison representative to the local public health or emergency management Emergency Operations Center (EOC). • Request one or more recorders as needed from the Logistics Section Labor Pool and Credentialing Unit Leader, if activated, to perform all necessary documentation		
Communication *Hospital to complete: EMResource, EMTrack, RTAS and local situational awareness requests*		
Safety and security • Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques		

Intermediate Response (2 – 12 hours)	**Time**	**Initial**

Activities
• **If a second EM Strike Team is needed for the 2nd operational period, notify the HIL at hour 9 to activate second team.**
• Transfer the EM Strike Team, if appropriate
  ○ Conduct a transition meeting to brief your replacement on the current situation, response actions, available resources, and the role of external agencies in support of the hospital
  ○ Address any health, medical, and safety concerns
  ○ Address political sensitivities, when appropriate
  ○ Remind your replacement to complete the appropriate documentation and ensure that appropriate personnel are properly briefed on response issues and objectives (see HICS Forms 203, 204, 214, and 215A)
• Attend all briefings and Incident Action Planning meetings to gather and share incident and hospital information
• Provide information on local hospitals, community response activities, and Liaison goals to the Incident Action Plan (IAP)
• Report to appropriate authorities the following minimum data on HICS 259: Hospital Casualty/Fatality Report:
  ○ Number of casualties received and types of injuries treated
  ○ Current patient capacity and census
  ○ Number of patients admitted, discharged home, or transferred to other hospitals
  ○ Number deceased
  ○ Individual casualty data: name or physical description, sex, age, address, seriousness of injury or condition		

Documentation • HICS 204: Document assignments and operational period objectives on Assignment List • HICS 213: Document all communications on a General Message Form • HICS 214: Document actions, decisions, and information received on Activity Log • HICS 259: Report data from the Hospital Casualty/Fatality Report		

	Time	Initial
Resources • If needed, deploy as a liaison representative to the local public health or emergency management Emergency Operations Center (EOC). • Request one or more recorders as needed from the Logistics Section Labor Pool and Credentialing Unit Leader, if activated, to perform all necessary documentation		
Communication *Hospital to complete: EMResource, EMTrack, RTAS and local situational awareness requests*		

Demobilization/System Recovery	Time	Initial
Safety and Security • Ensure your physical Readiness through proper nutrition, water intake, rest, and stress management techniques. • Observe all staff and volunteers for signs of stress and inappropriate behavior, report issues to the Safety officer and logistics Section Employee Health and Well-Being Unit.		
Safety and security • Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques • Observe all staff and volunteers for signs of stress and inappropriate behavior; report issues to the Safety Officer and Logistics Section Employee Health and Well-Being Unit		
Activities • Transfer the EM Strike Team role, if appropriate. • Conduct a transition meeting to brief on your replacement of the current situation, response actions, available resources, and the role of external agencies in support of the hospital. • Address any health, medical and safety concerns. • Address political sensitivities, when appropriate • Instruct your replacement to complete the appropriate documentation and ensure that appropriate personnel are properly briefed on response issues and objectives (see HICS Forms 203, 204, 214 and 215A) • As objectives are met and needs decrease, return EM Strike Team to their usual roles. • Upon deactivate of your position, brief the hospital EM Staff on outstanding issues, and follow up requirements. • Page the COTS HIL to inform of demobilization status and give final report.		
Documentation		

• HICS 221- Demobilization Check-out		
• Ensure all documentation is submitted to Planning Section Documentation Unit.		

Documents and Tools

- ❑ HICS 205A - Communications List
- ❑ HICS 213 - General Message Form
- ❑ HICS 214 - Activity Log
- ❑ HICS 221 - Demobilization Check-Out
- ❑ HICS 252 - Section Personnel Timesheet
- ❑ HICS 259 - Hospital Casualty/Fatality Report
- ❑ Hospital Emergency Operations Plan
- ❑ Incident Specific Plans or Annexes
- ❑ Hospital policies and procedures
- ❑ Hospital organization chart
- ❑ Hospital telephone directory

Telephone/cell phone/satellite phone/internet/amateur radio/2-way radio for communication

Learning Objectives

- Recognize the Challenges of Executive Engagement in Emergency Management

- Explore Innovative Training Strategies for Executive Success

- Apply Practical Tools to Strengthen Executive Crisis Leadership

Bottom Line Up Front

- **Shift the Dynamic from "Technician" to "Navigator"** – Emergency Managers must overcome the "credibility deficit" by positioning themselves not as subordinates teaching basics, but as strategic partners ("Navigators") who help the Executive ("The Pilot") steer through the unique physics of a crisis.

- **Align Value Propositions (Safety vs. Reputation)** – Executives often disengage from training because they view disasters as operational "safety problems"; to gain buy-in, training must reframe crisis leadership as a defense of the organization's reputation, financial margins, and legal liability.

Bottom Line Up Front (cont.)

- **Provide "Direction," Not Just "Guidance"** – In high-pressure situations, executives reject broad, principle-based "Guidance" (All-Hazards plans) and instead demand granular "Direction" – specific, role-based checklists and "No-Regret Decisions."

- **Replace Static Training with Novel Immersion** – Traditional tabletop exercises fail to trigger the necessary physiological response; effective preparation requires Immersive Learning (creating presence/stress), Scenario-Based Decision Making (testing ethical/financial dilemmas), and Leadership Simulations (exposing blind spots in delegation and authority).

Structural and Psychological Challenges of Briefing Executives

- **Time Scarcity & Opportunity Cost**: Executives operate on highly compressed schedules where every hour has a tangible financial value. They resent "training" that feels academic, theoretical, or process-heavy. If the session does not offer an immediate, high-yield Return on Investment (ROI) that applies to their current strategic reality, they will mentally disengage.

- **The "Technician vs. Peer" Bias (Trust)**: Executives often view Emergency Managers as tactical implementers (who handle logistics and forms) rather than strategic thought partners. Emergency Managers frequently start with a "credibility deficit," meaning they do not yet trust that you understand the high-stakes political and financial pressures they face, which makes them resistant to your coaching on leadership behaviors.

Structural and Psychological Challenges of Briefing Executives

- **Divergent Value Propositions (Priorities):** There is a fundamental misalignment of goals: our priority is <u>life safety and protocol compliance (NIMS/ICS)</u>, while their priority is <u>reputation, margin, and legal liability</u>. Training often fails because it presents the crisis as a "safety problem" rather than a "business continuity threat," causing them to view the material as "someone else's job."

- **Cognitive Saturation (Noise):** Executives are constantly bombarded with information and are often suffering from decision fatigue before they even enter the room. They have zero bandwidth for new acronyms or complex workflows. They require simplified mental models (heuristics) that help them cut through the noise, rather than more data to memorize.

Structural and Psychological Challenges of Briefing Executives

- **Fear of Visible Incompetence**: High-performing leaders are often accustomed to being the expert in the room. They may subconsciously resist simulations or role-playing because they fear looking foolish or uncertain in front of their peers. This vulnerability can cause them to dominate the room or dismiss the scenario to protect their status.

The Engagement Paradox and Solution Architecture

- **The Observation**

  - **Disasters are Delegated:** Executives tend to view "disasters" (e.g., weather events, facility failures) as operational headaches. These are typically delegated to facilities management or safety officers

  - **Crises are Led:** Executives only actively engage when an event escalates to a "Crisis" – a situation threatening reputation, financial viability, or legal standing.

- **Moving from "Guidance" to "Direction."**

  - Traditional All-Hazards EOPs provide Guidance. They are broad, principle-based, and require interpretation during high stress.

  - Executives require Direction. They demand specific, sequential, and role-based checklists. (e.g., No-Regret Decisions)

  - Guidance (i.e., *What to think.*) vs. Direction (*i.e., What to do.*)

Meeting of Equals:
EM Experts Briefing Executives

The Core Philosophy: Context vs. Content

You must explicitly define the two distinct domains of expertise at the start of the engagement.

- **Their Domain (Context)**: They are the experts in their organization. They know the hospital system's culture, risk appetite, financial levers, and political landscape.

- **Our Domain (Content)**: You are the expert in the crisis environment. You know how disaster breaks systems, how human cognition fails under stress, and the physics of chaos.

"I am not here to teach you how to lead this organization – you are already the experts in that. I am here to translate your leadership skills into a foreign language: Crisis."

Meeting of Equals:
EM Experts Briefing Executives

The "Pilot vs Navigator" Analogy

Use this to set the stage. It removes the hierarchy and replaces it with functional roles.

- **They are the Pilot.** They have the controls (authority) and the destination (strategic intent).

- **You are the Navigator.** You have the storm charts. You know where the shoals are.

"In a blue-sky scenario, you don't need me. But when the storm hits, the organization's physics change. I am here to show you the map of that storm so you can fly the plane through it."

Meeting of Equals:
EM Experts Briefing Executives

Use "Incongruence" to Your Advantage

Executives often have an incongruent view of their crisis performance.

- **Ideal Self.** "I will be calm, decisive, and commanding."

- **Actual Reality.** Without training, they will likely micromanage, freeze, or bypass the chain of command.

You are not "correcting" them; you are "aligning" them. You are the mirror that shows them where their instincts will betray them.

> "In a blue-sky scenario, you don't need me. But when the storm hits, the organization's physics change. I am here to show you the map of that storm so you can fly the plane through it."

Meeting of Equals:
EM Experts Briefing Executives

Trading Superiorities

Applying the Dale Carnegie principle that "Every man is my superior in some way":

- Acknowledge their superiority in **Operations**: "You know how to move patients through this system better than anyone."

- Assert your superiority in **Disruption:** "But I know exactly how a cyber-attack stops that movement."

By granting them their expertise first, they are psychologically obligated to grant you yours.

Meeting of Equals:
EM Experts Briefing Executives

The "Executive Briefing" vs. "Training"

- Never call it "training." "Training" is for staff to learn how to use a fire extinguisher. Executives get "Briefings," "Simulations," or "Strategic Alignment."

- Use Executive Language:
  - *Bad:* "Understanding the Incident Command System."
  - *Good:* "Command & Control Architecture: How to maintain authority when the org chart dissolves."
  - *Bad:* "NIMS Compliance."
  - *Good:* "Regulatory Liability & Federal Resource Adjudication"

Preparing for a Crisis – as an Individual

- **Be calm and unemotional**
  - Learn real-time stress management techniques (e.g., box breathing, cognitive reframing, self-talk and confidence building, focus and distraction control).
  - Engage the team by looking professional and confident.
  - Be supportive and curious.
  - Exemplify good self-care.
- **Learn mental models to improve your crisis thinking.**
  - Pause, Prioritize, Proceed
  - OODA Loop: Observe, Orient, Decide, Act

Preparing for a Crisis – as an Individual

- **Think systematically:**
  - Identify: What needs to be solved now?
    - What can or should be delayed?
  - What problems should we anticipate in the next 12, 24, 36, 72 hours?
    - How can those be mitigated now?
  - What information do I have, and what information do I need?
    - What do I actually know, and what do I only think I know?
- **Use emergency plans:**
  - When plans do not exist or are not working, focus on values and core principles.

Preparing for a Crisis – as an Individual

- **Learn crisis-decision-making tools and models:**
  - Optimal versus First Available
  - Recognition-Primed Decision Model
    - Relies on experience and pattern recognition to make rapid decisions (mental slide-deck).
- **Treat crisis leadership as a high-risk and low-volume competency:**
  - Regular training and high-fidelity simulations
    - Training with realistic scenarios: rapid choices, tight time constraints, and information gaps.
    - Wargaming under adversarial conditions.

Preparing for a Crisis – as an Individual

- **Communicate frequently and genuinely:**
  - It is almost impossible to overcommunicate in a crisis.

Preparing for a Crisis – as an Organization

- **Think systematically:**
  - Identify: What needs to be solved now?
    - What can or should be delayed?
  - What problems should we anticipate in the next 12, 24, 36, 72 hours?
    - How can those be mitigated now?
  - What information do we have, and what information do we need?
    - What do we actually know, and what do we only think we know?
- **Use emergency plans:**
  - When plans do not exist or are not working, focus on values and core principles.

Preparing for a Crisis – as an Organization

- **Use structured and timely briefings**

- **Develop and execute several tactics** – do not devise and use just one plan.

- **Reverse engineer solutions** – determine the ideal outcome and plan backwards.

- **Conduct pre-postmortems** – identify what could create a negative outcome and work backwards to mitigate those causes.
  - Force leaders to confront uncomfortable risks.
  - Encourage diverse thinking.

Preparing for a Crisis – as an Organization

- **Treat crisis leadership as a high-risk and low-volume competency:**
  - Regular training and high-fidelity simulations.
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    - Wargaming under adversarial conditions.

Empowering Leaders in Crisis – Novel Training Strategies for Executive Success

Strategies for empowering senior leaders in crisis response have evolved significantly from static "tabletop exercises." The most novel approaches now leverage **AI**, **neuroscience**, and **hyper-realistic simulation** to train not just the *protocol*, but the *leader's brain and decision-making capacity* under pressure.

Empowering Leaders in Crisis – Novel Training Strategies for Executive Success

Immersive Learning: An umbrella term for any learning experience that surrounds the learner, creating a sense of "presence." The goal is to make the learner feel as if they are in the situation, triggering the same psychological and emotional responses as in real life.

- "The Pressure Cooker."
  - Create a "High-Fidelity Boardroom."
  - Instead of a paper handout, simulate a Cyber/Ransomware Attack. Turn off all "devices" in the conference room. Have the participants' actual phones ring with simulated calls from the organization and media. Project a "countdown clock" for the ransom payment on the screen.
  - You are creating the physiological spike that causes "executive freeze," allowing you to train them how to function through the panic.

Empowering Leaders in Crisis – Novel Training Strategies for Executive Success

Scenario-Based Decision-Making: Learning through specific, realistic stories or situations. Instead of learning a list of rules, the learner is placed in a narrative with a problem to solve.

- "The Ethical Cliff." For executives, the hardest decisions aren't logistical (where to put the beds); they are ethical and financial (who gets the beds).
  - Present a scenario where they must choose between two "wrong" options.
    - *Example:* "You have contaminated water. Do you evacuate the NICU (high risk of death during transport) or shelter in place without dialysis capabilities (high risk of clinical deterioration)?"
  - It forces them to pre-adjudicate their risk tolerance and liability concerns before the actual event.

Empowering Leaders in Crisis – Novel Training Strategies for Executive Success

Leadership Simulations: A specific type of training event designed to test and build leadership skills (e.g., delegation, crisis communication, strategic thinking) in a risk-free environment.

- "The Role Reset" For executives, the biggest challenge is stopping themselves from 'doing everything' and learning to stay in their lane.

  - Create a simulation where the leader must coordinate a response with competitors but has zero authority to order hospitals to comply. They must use soft power and influence.

  - It identifies "Diplomatic Blind Spots." It trains leaders how to build consensus rapidly when they cannot issue orders.

Bottom Line Up Front

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Empowering Leaders in Crisis: Novel Training Strategies for Executive Success

Roger Glick, MS, MBA, CEM, FACHE

Market Director: Healthcare + Emergency Management

Jensen Hughes

Roger.Glick@jensenhughes.com

540.521.7996

Jay Johnson, Ed.D, HcEM-M, CEM, MEP

Discussion Points

- An introduction to SETRAC and Regional Healthcare Preparedness Coalition

- Hurricane Beryl overview and response activities

- Lessons learned from responding to a hurricane

What is SETRAC
and
Regional Healthcare Preparedness Coalition

- A non-profit 501(c3), grant funded organization heading a regional network of healthcare agencies, EMS and response partners, public health officials and jurisdictional authorities within the twenty-five counties of Texas that make up TSA (Trauma Service Areas) Q, R, and H.

- Trauma Service Area (TSA): Designated geographic area with purpose of developing a trauma system consistent with patient care and transportation needs of local hospitals.

- Texas Department of State Health Services sub recipient of the Healthcare Preparedness Program - HPP.

What is SETRAC
and
Regional Healthcare Preparedness Coalition
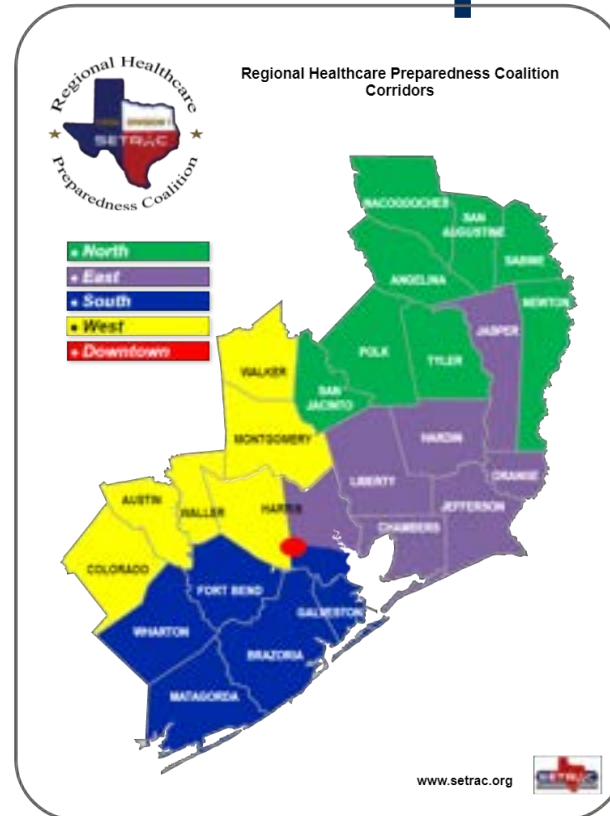
Our Coalition Region:

- 25 Counties
- 277 cities
- 9.8 Million* (36%)
- 897,000/disabilities* (24%)
- 180+ Hospitals
- 1100+ Nursing Homes, Assisted Living and ICF
- 2000+ Home Health and Hospice
- 2200+ Outpatient Services and Clinics

What is SETRAC
and
Regional Healthcare Preparedness Coalition

The Emergency Medical Task Force (EMTF)

- State and Federally (TXDSHS, ASPR) funded program with the mission of creating State-deployable medical teams, regionalized for rapid mobilization and readiness.

- The goal of the EMTF program is to provide a well coordinated response, offering assistance to emergency operation systems during large scale incidents. Immediately available resources include AMBUSes (Four in SETRAC Region), Mobile Medical Units, Ambulance Strike Teams (hundreds of units across Texas), RN Strike Teams, Medical Incident Support Teams and Staging Managers.

- Eight (8) full-time Regional Coordinators and one (1) State Program Manager assure emergency resources are immediately available across Texas.

- The EMTF-6 Region is managed by SETRAC.

Regional Healthcare Preparedness Coalition:
Responding to Hurricane Beryl

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What is SETRAC and Regional Healthcare Preparedness Coalition

Catastrophic Medical Operations Center "CMOC"

- Last Resort Medical Operation Center as the **Operations arm of the Coalition**, housed in City of Houston EOC. Secondary location Harris County Office of Homeland Security.

- Collaboration of local, statewide and Federal level Emergency Management (Including Waivers)

- Can be activated 24/7 by an authorized governmental entity. If facility needs to activate CMOC, we will work with local OEM to ensure proper activation and support.

- The mission of the CMOC is to **protect and maintain the medical infrastructure of all regional healthcare agencies, coordinate regional healthcare systems response,** provide situational awareness, identify and allocate resources, and develop a well-trained resilient medical community

CMOC Functions

- Information Collection
- Communication & Dissemination of Information
- Resource Management
- Coordination Among Healthcare Agencies

**Regional Healthcare Preparedness Coalition:
Responding to Hurricane Beryl**

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CMOC Organizational Chart

CMOC Chief

CMOC Deputy Chief

EMTF Task Force Leader(s)

CMOC Liasons

Planning Branch Director

Finance / Admin Branch Director

EMTF Coordinator

Logistics / Communications Branch Director

EMS / Transportation Branch Director

Medical Populations Branch Director

Public Health Branch Director

Clinical Care Branch Director

Ambulance Staging Houston

Ambulance Staging Beaumont

Staging Air Assets

Deputy Clinical Branch Director

Corridor Coordinator (North)

Corridor Coordinator (South)

Corridor Coordinator (East)

Corridor Coordinator (West)

Corridor Coordinator (Downtown)

Corridor Coordinator (TMC)

MIST Group Leader

MMU Group Leader

TMORT Group Leader

RNST Group Leader

Position Legend:

- CMOC Position
- Field Position
- EMTF Position
- Expanded Position

Regional Healthcare Preparedness Coalition

SETRAC

Regional Healthcare Preparedness Coalition: Responding to Hurricane Beryl

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Hurricane Beryl 2024

Catastrophic Medical Operations Center (CMOC) Activated

- ❖ Landfall July 8, 2024
- ❖ Cat 1 Hurricane
- ❖ Local and State Emergency Operation Centers Activated July 7th
- ❖ Minor Flooding
- ❖ Major Infrastructure damage to power lines
- ❖ 2.2 million residents without power 10 plus days

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Proactive Approach for Hurricane Beryl

FC Fidel Calvillo
To: Fidel Calvillo
Cc: Lisa Spivey

Reply | Reply All | Forward

Fri 7/5/2024 1:56 PM

General\All Employees (unrestricted)

This message was sent with High importance.

📎 Beryl_24July5_11am.pdf
968 KB

📄 ATT00001.txt
421 bytes

Good afternoon Special Population Stakeholders,

As everyone has been receiving the latest weather information from our partners, SETRAC will continue to provide you the latest weather information once we have received it. The latest forecast has bumped the possible landfall to the north from the initial weather updates we have received earlier this week.

As a reminder to everyone as we are all watching the forecast and preparing for the potential hurricane we urge everyone to be proactive and stay ahead of this threat.

All Facilities and home bound agencies

- Start contacting your transportation vendors, fuel vendors, generator contractor, water supply vendors, your evacuation receiving facilities, food vendor, etc..
- 96-hour cache should be reviewed and checked
- Planning for staffing support
- Contacting your clients for any changes to treatment schedule and providing information how to contact your agency
- Ask your home bound patients to make sure they are registered on STEAR (211)
- Home bound clients have sufficient medication, supplies, O2, other DME safeguards
- If you are a receiving facility begin contacting your sending facility to ensure all resource needs are discussed

Home Heath, Hospice, Dialysis, Clinics

Make sure your clients have the resources they need and your agency's contact information.

Nursing home, assisted living, ICFs

Make sure you have all resources to keep you operational to maintain your continuity of care if you will be sheltering in place or evacuating.

Again, thank you everyone for being a proactive stakeholder in preparing your agency for this type of event. We had a preview of this situation during our May 9th exercise and each agency took away some great lessons learned. Our Emergency Preparedness Bootcamps held these past three months also prepared those that attended for this type of scenario.

As always, please feel free to contact me if you have any questions or need additional guidance. Have a great afternoon.

**Regional Healthcare Preparedness Coalition:
Responding to Hurricane Beryl**

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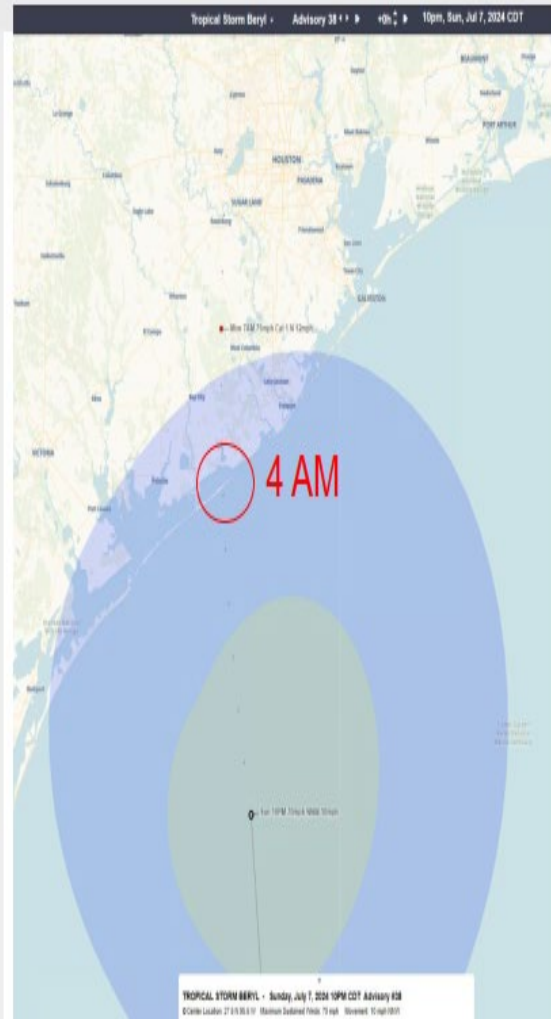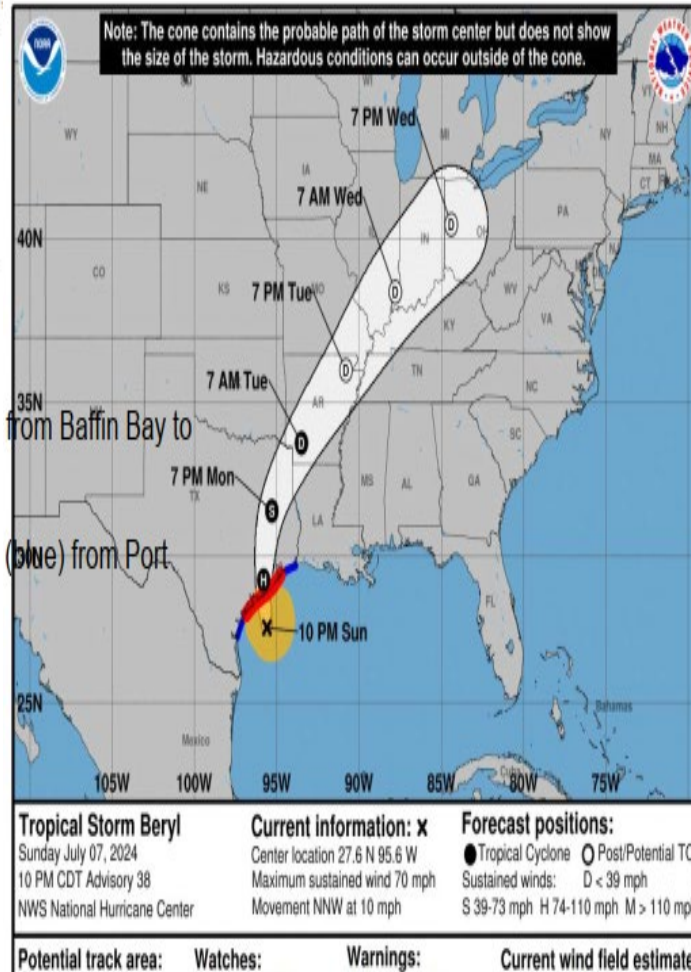Tropical Storm Beryl
Beryl

5:00 AM
Saturday, July 6th, 2024

- NHC forecast brings Beryl into the Mid Texas Coast on Monday as a hurricane then tracks more north to northeast as a weakening tropical storm.
- Additional slight shifts in the forecast are possible.
- Impacts, intensity will be highly dependent on track.
- Hurricane Watch area shown (in pink).
- Stay tuned for updates as watches could be expanded, could become warnings.

Tropical Storm Beryl
Hurricane Beryl

11:00 AM
Saturday, July 6th, 2024

- NHC forecast brings center of Beryl into Texas coast, mostly likely near or S of Matagorda Bay, with center line near Port O Connor. Forecast to be a category one at landfall.
- After landfall, Beryl takes a more northerly track.
- Forecast track has been fairly consistent past 18 hours, confidence increasing but some shifts could still occur.
- Hurricane Watch area shown.
- Stay tuned for updates as warnings likely to be introduced for portions of the area with 4 pm advisory.

National Weather Service - Houston/Galveston, TX

Tropical Storm Beryl
1030 PM Sunday, July 7th, 2024

from Baffin Bay to
(blue) from Port

4 AM

5:20 AM

BERYL
CATEGORY 1
WIND: 80 mph G 100
MOVEMENT: N at 12mph
PRESSURE: 979 mb

Georgetown   College Station   Opelousas

The Woodlands   Lake Charles   Beaumont

Sealy   Houston   New

Friendswood

n Antonio   Galveston

Floresville   Cuero   El Campo   Angleton

Edna

Port Lavaca

Beeville

Sinton   Rockport

Corpus Christi

SETRAC

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Responding to Hurricane Beryl

Regional Healthcare Preparedness Coalition

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Tropical Storm Beryl Leaves 2Mln Texans Without Power, Outage Expected for Days -Officials

HCC Response

The SETRAC/CMOC Activation Objectives

- Maintain situational awareness of real time medical surge capability and medical infrastructure

- Maintain readily deployable assets to support medical operations as requested

- Monitor Conditions (weather, traffic, events) for adverse effects to long term care facilities and healthcare facilities and agencies

- Assist local jurisdictions as requested

- Assist Healthcare facilities and agencies with guidance and resource requests when needed

- Monitor healthcare needs and maintain constant communications with hospitals, long term care facilities, home based and outpatient services, dialysis , EMS, and other health clinics, also serving as a link between the various types of providers

- Patient tracking and assistance with placement as requested

- Assistance in placement, evacuation, and repatriation of medical population in the SETRAC area

- Screen requests for placement in Medical Shelters and coordinate with hospitals/NEMR to transfer

Medical Infrastructure Operational Status

- ❖ 26 Hospitals Internal Disaster Operations
- ❖ 434 est. LTCs/ALFs; 1 assisted evacuation
- ❖ 40 Dialysis Clinics Closed

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- Lakewood shelter closes at 8p, notified CMOC to help with finding a location for a person left there.
- HFD only staffing Houston EOC from 6a to 10p. They are transferring the call/requests for oxygen to the CMOC line from 10p to 6a.
- As of 07/12/2024 at 0600 the census of NRG shelter is 66, we mission tasked 16 Pts, but only 5 have been transported.
- Novellus Living Memory Care at 5611 Cypresswood Dr, 40 Pts with 23 non-ambulatory and 3 Pts on oxygen. The have had no power for 4 days with no ETA. List as unmet needs. CMOC called CenterPoint to get ETA and list as a priority. Listed under unmet needs.
- 3 oxygens run were made 1900 07/11/2024 to 0700 07/12/2024
- We have asked the MIST in both areas to begin assessing the residents that have received this service to see if their electricity is restored and their providers are back in service. If so, we will begin collecting any outstanding cylinders and returning them to NRG. 18 total oxygen exchanges as of 1750
- Repatriation of Bay Bridge Nursing Home back to their home facility completed. Following up on all NH on power status and dialysis centers to update their operational status.
- The psychiatric surge plan in Harris County was implemented yesterday. Yesterday they received 18 referrals, 8 were accepted, 12 rejected due to not being Harris County residents. 20 additional referrals have been received this morning and are currently being vetted.
- Supporting 3-1-1 with bed bound citizens calling in for help. Mission assignments are being sent to NRG staging to assess citizen at their home and determination will be made shelter or hospital.
- 10 hospitals still participating in EMS Surge Plan at hospitals. Interim demobilization process developed.
- Novellus Memory Care corporate refused to evacuate. Regulator did site visit. Residents had food, water, some spot coolers. STAR request for additional spot coolers.
- 2 Cardinal manufacturing site are without power. This will disrupt medical supply chain. Information shared with CenterPoint and DSHS to push for further action.
- Updated STAR 16-335467, spot coolers for SNF – spoke to DDECO-16
- Worked request from SMOC IC about oxygen facility in Alvin, TX that has no power and major supplier to greater Houston healthcare. Provided requested information, passed along as priority for power restoration.
- Reconciled with HCA Northwest, they had numerous Pts that had never made the NRG Shelter
- 3 oxygen runs made 1900hrs 07/12–07/13 0700hrs
- As of 07/13/2024 at 0600 the census at NRG shelter is 75. We mission tasked 5 and 1 have been transported.
- Welfare check Reunion Court in Kingwood. 2 AMBUS', 1 MIST and 1 supervisor sent. Facility cool, residents in good spirits, 10 cases water left at facility.
- HCA Kingwood (off internal disaster) stated their generator is getting overheated. Facility called TDEM.

-0024 Hurricane Beryl

9

Deployed Assets

1. 100 Oxygen cylinders from SETRAC
2. MMU for staging staff cooling (2 – 860 Zumro's, 8 HVAC units and 2 45 k generators)
3. EMTF ambulances assigned by SCO
4. SETRAC Assets staged at warehouse.
5. RCVQ to NRG for staging support
6. 20 cots and 5 wheelchairs from SETRAC warehouse to HFD EMS Surge teams.
7. 25 oxygen cylinders from SETRAC cache
8. 10 boxes of 500 each box EMTF wrist
9. StarLink activated on RCVQ
10. 6 Stryker stretchers from SETRAC to Ben Taub for ED Surge
11. 6 Spot coolers to Novellus Memory Care from SETRAC general have been returned 07/14/2024
12. A 25kw generator with spider box deployed to Novellus Memory Care from SETRAC warehouse. Picked up on 07/14/2024.
13. Picked up cots from MH Greater Heights and returned to NRG staging 07/15/2024

CMOC/ EMTF

- 9-1-1 Support
- Hospital surge support missions to assist in times
- 92 agencies from across Texas

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Lessons Learned

- DME providers are not required to provide assistance outside normal operations

- Facilities not signed on power company's critical care load

- Using the correct terminology for healthcare facilities

- Long term use of generators

- Shelter vs Cooling Centers

- Medical Sheltering coordination

- Dialysis readiness not all the same

- Educate elected and senior officials on preparedness and disaster response activities

Preparedness Strategies

- Emergency Preparedness Workshops

- Conduct exercises – relevant to them

- Meet with your State Agency Regulatory

- Educate on local and Regional Response Plans

- End Stage Renal Disease Network (ESRD Network)

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Want to recognize a dedicated First Responder? Nominate someone today to be recognized at a Houston Texans game.

Jeremy Way, Preparedness Manager TSA R

832-849-7310

Jeremy.Way@SETRAC.ORG

Fidel J. Calvillo, Preparedness Manager Special Populations

832-849-7315

Fidel.Calvillo@SETRAC.ORG

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Questions?

Regional Healthcare Preparedness Coalition:
Responding to Hurricane Beryl

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Steven Hoeger
Director, Corporate Emergency Management & Compliance;
University Health
Chair, MARC Health Care Coalition

Jennifer Sutherlin, MPH, BSN
Emergency Services Health & Medical Program Manager,
Missouri Region A Readiness & Response Coordinator;
Mid-America Regional Council

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- Counties: 13 (16 with KS)
- Population: 1.45M
  - *2.3M with Kansas Metro*
- Member Organizations: 267
- Active & engaged membership
- Work closely across state lines- (Kansas City Metro)
- Urban and rural
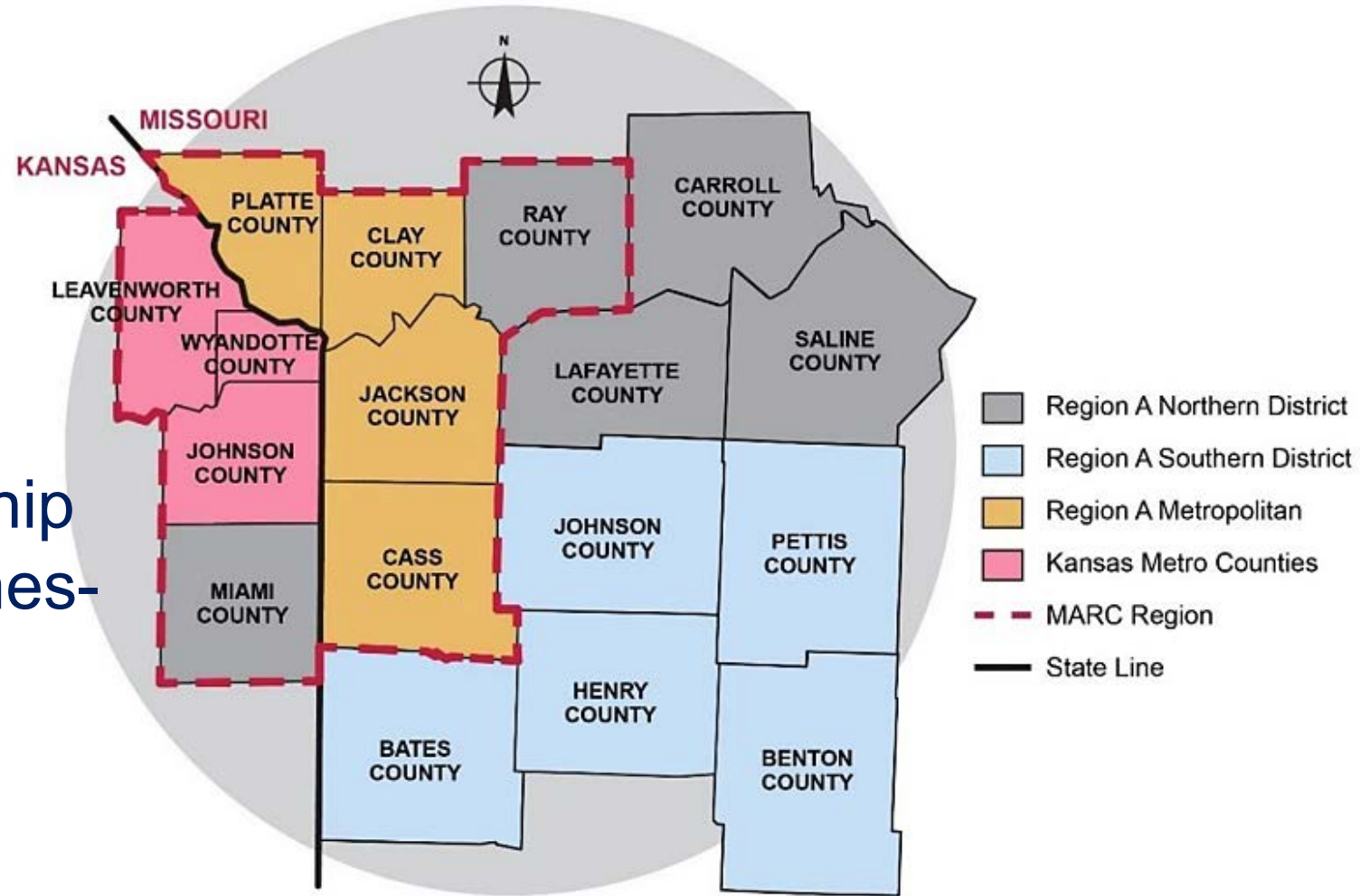
#NHCPC25

Great!
So...now
what?
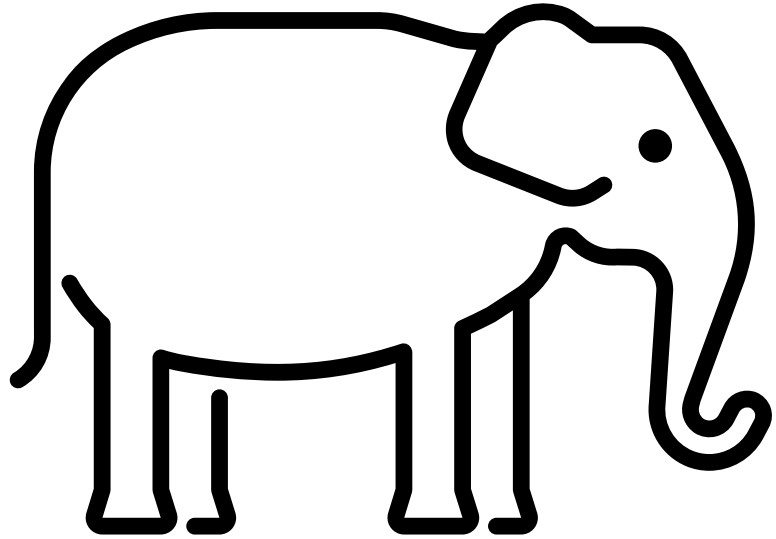
How do you eat an elephant?

FIFA 18 PLANNING CONSIDERATIONS
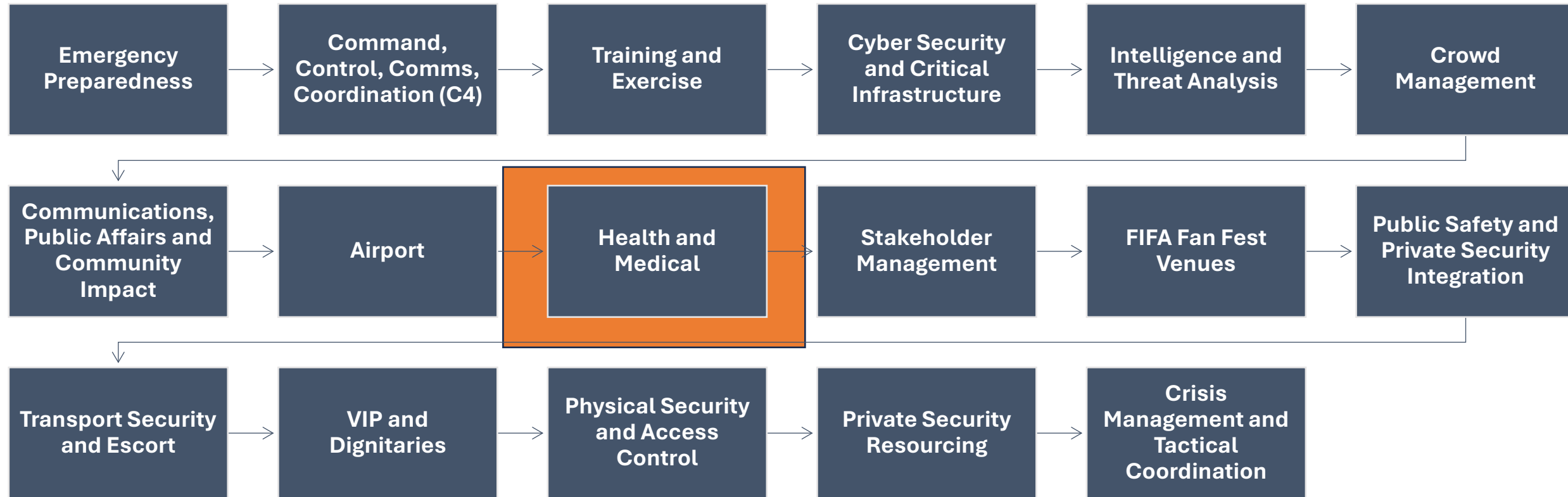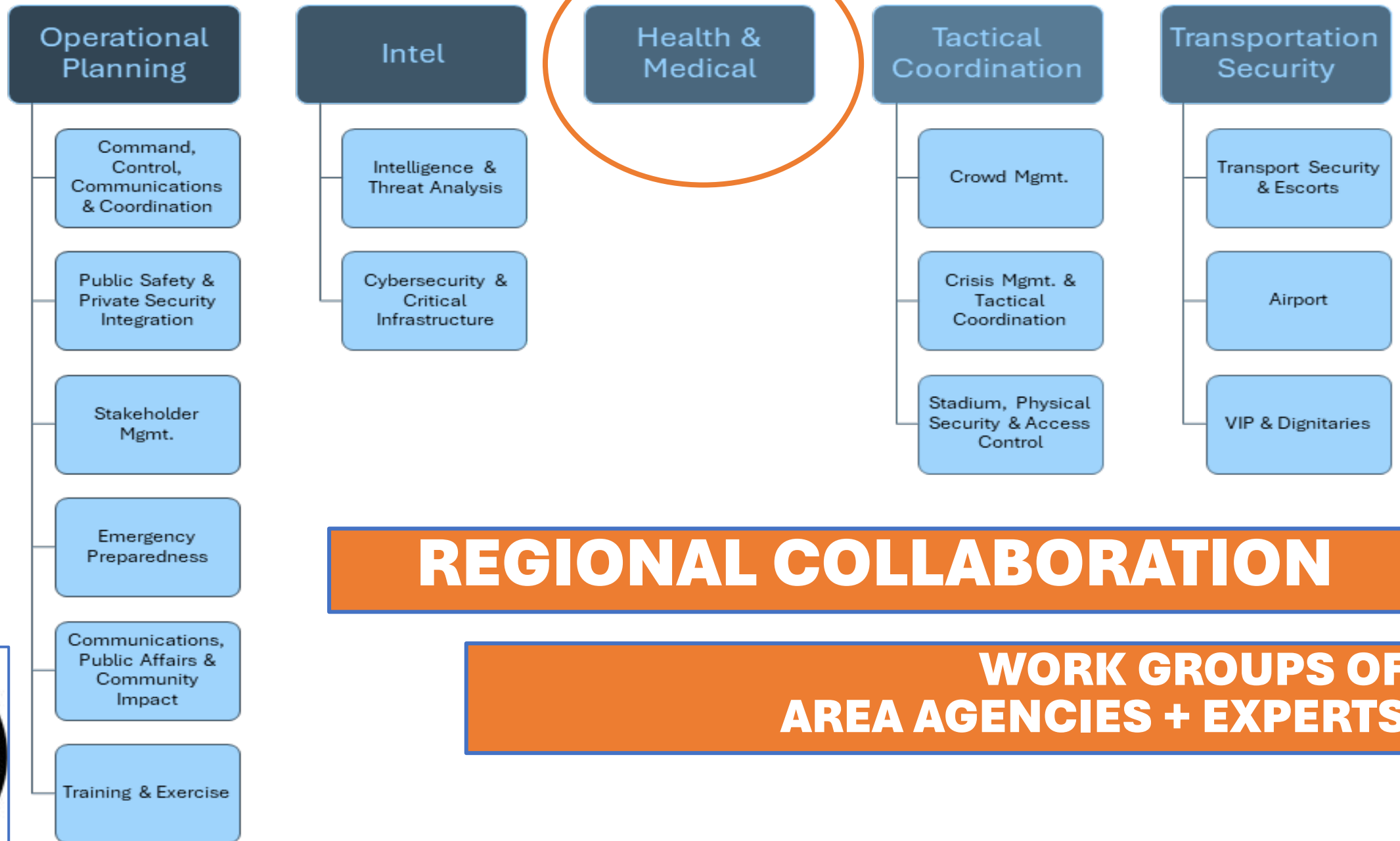
What does this have to do with the Health Care Coalition?

HCC Core Functions

Assessment & risk mitigation	→	Information sharing	→	Specialty care & coordination
Respond	→	Health care workforce support	→	Resource management
Training, Exercise & Evaluation	→	Continuity & Recovery	→	Organizational Development

Health and Medical

FIFA Minimum standards

MS 2.4.4 — Establish or identify processes to define medical threats and risks to capture mitigation strategies for each threat or risk. Ensure mitigation strategies are implemented as appropriate, documenting the results of each.

MS 2.4.5 — Establish or identify information sharing processes, to include data collection, between the Host Cities and FIFA.

MS 2.4.6 — Identify potential roles and responsibilities during emergencies or mass casualty incidents.

MS 2.4.7 — Establish or identify processes that recognize personnel, equipment, training and response gaps specific to health and medical and identify strategies to address them. Prioritize resource needs and identify the criticality and impact of potential gaps and unmet needs.

Don't reinvent the wheel.

Medical Standard 2.4.1

Establish or identify organizational structures to coordinate health and medical resources and need across all local sites within the Host City and/or Host City region if appropriate.
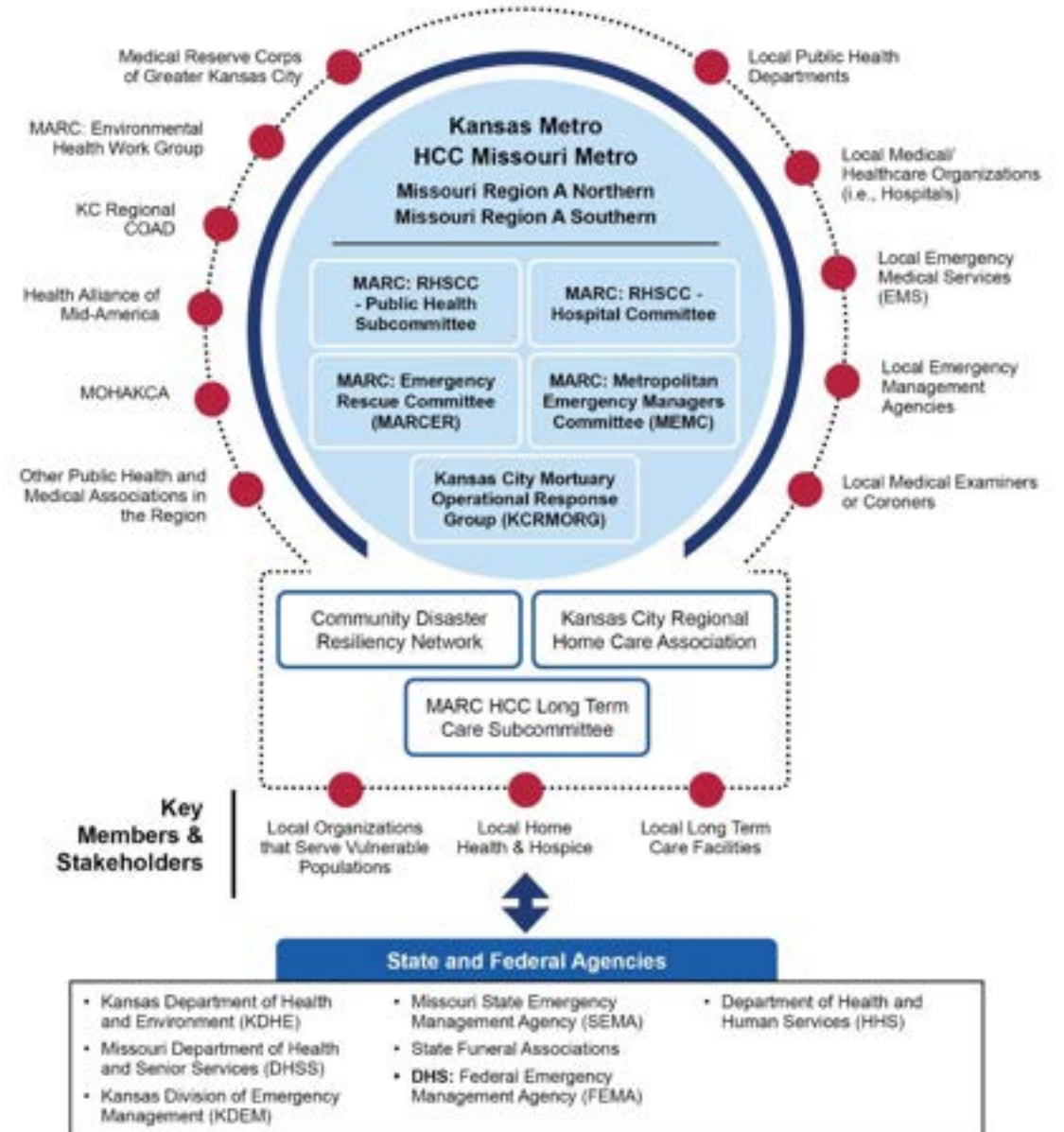
MARC RHSCC Circle of Friends

The MARC Health Care Coalition exists as the health and medical arm of the Regional Homeland Security Coordinating Committee. This structure allows collaboration and coordination across disciplines and agencies to ensure inclusive planning and response.
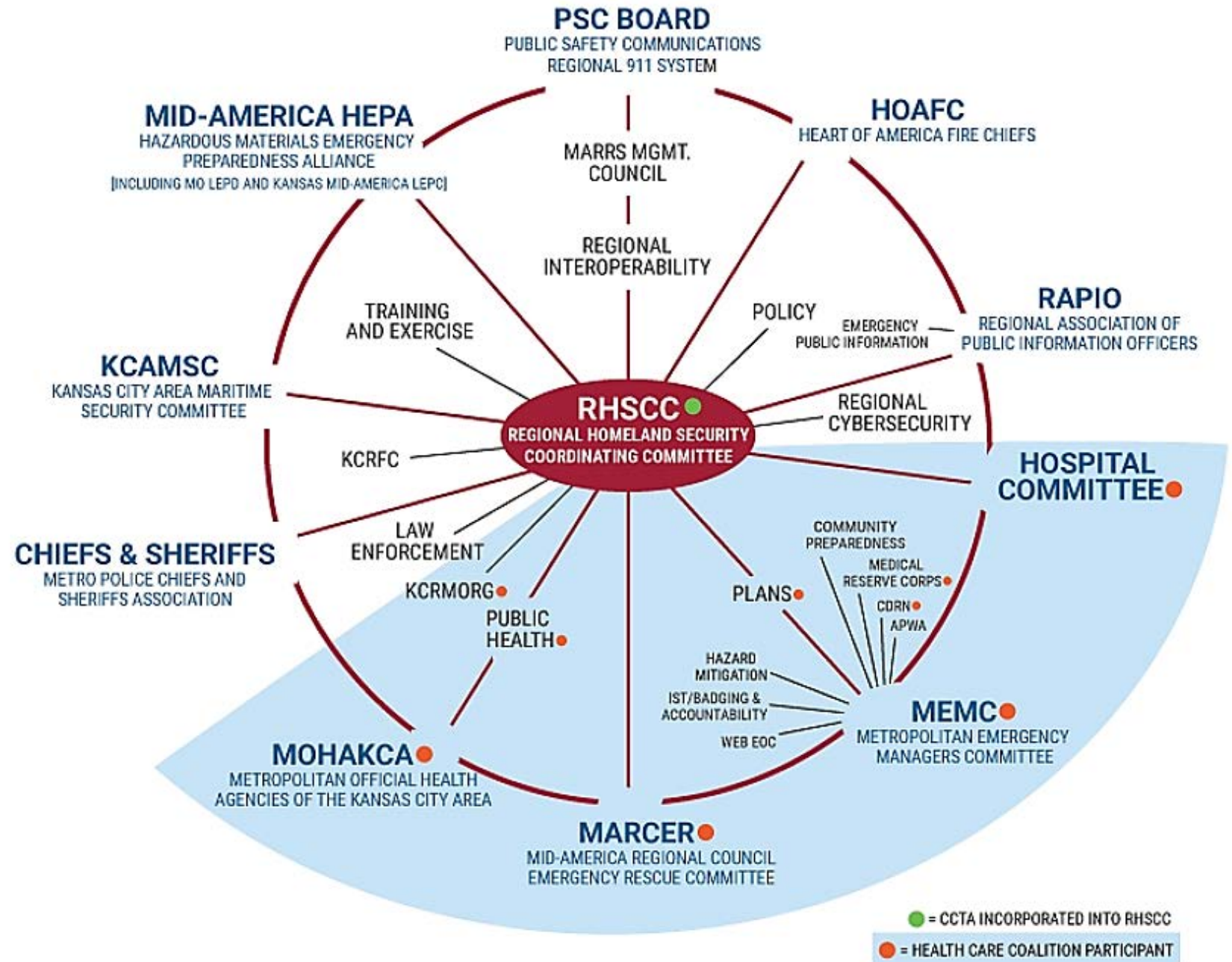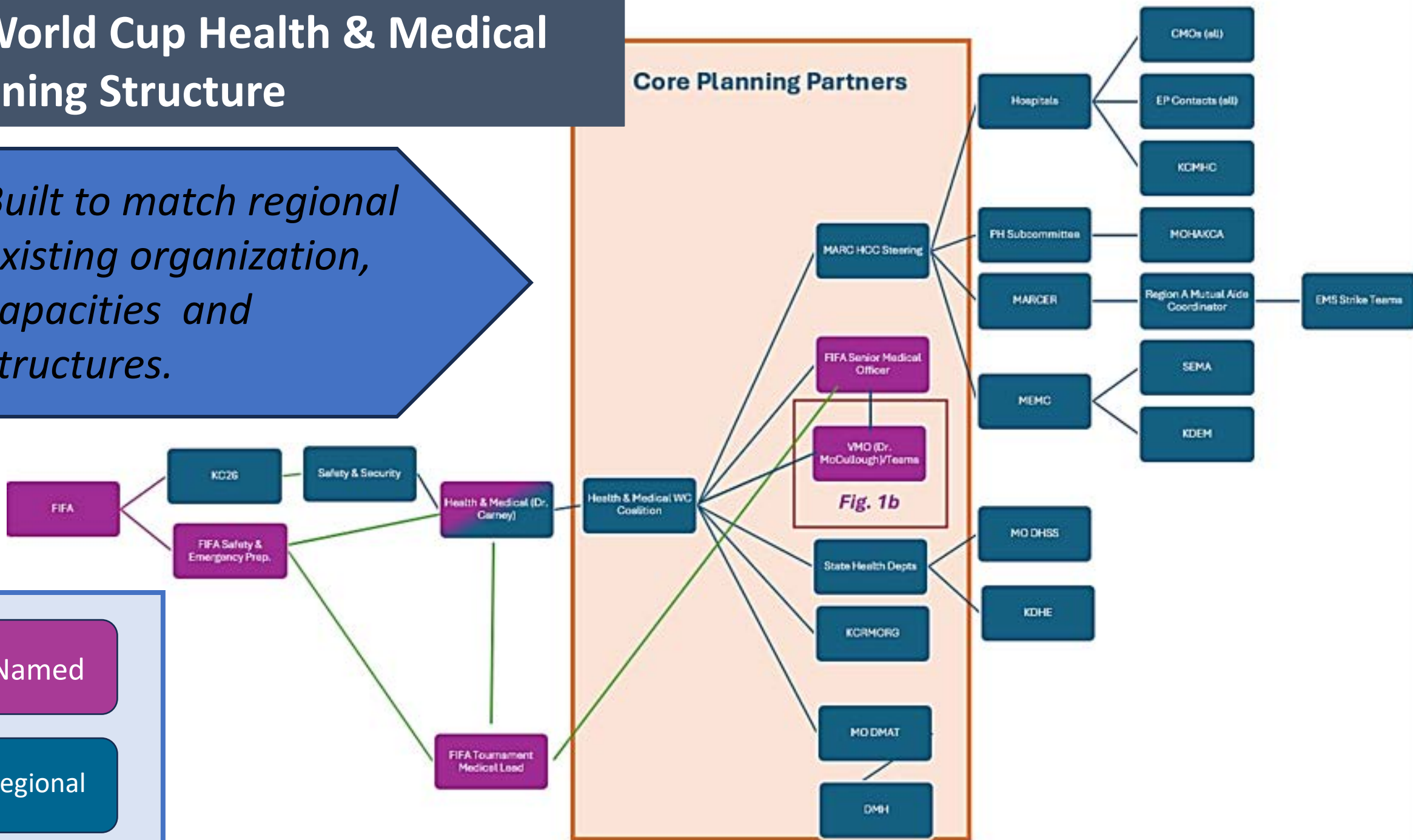
MARC Health Care Coalition Structure

KC World Cup Health & Medical Planning Structure

Built to match regional existing organization, capacities and structures.

FIFA Named

Local/Regional

Workgroups

National

⚽Event associated heat illness mitigation

⚽Natural and man-made disasters

⚽Medical Surge

Regional

⚽Capacity utilization and infrastructure

⚽Hospital/EMS coordination

⚽Visitor communication/education about healthcare

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MS 2.4.2

Establish or identify local **communications processes**, protocols, tools, and networks to ensure coordination of health and medical providers and integrate them with tournament-wide processes, protocols, tools and networks.

JUVARE

MS 2.4.5

Establish or identify **information sharing processes**, to include data collection, between the Host Cities and FIFA.

EMResource

- **Hospital Status Dashboard**

- **Regional Situational Awareness for hospitals and EMS**

- **Bed Availability**

eICS

- **Regional Health & Medical Information Sharing**

- **Just-in-time and pre-planned events coordination with Health Care partners**

WebEOC

- **Information sharing**

- **Situational awareness**

- **Resource Requests**

Establish or identify local **communications processes**, protocols, tools, and networks to ensure coordination of health and medical providers and integrate them with tournament-wide processes, protocols, tools and networks.

Statewide system (Missouri)
Missouri and Kansas City Metro
Kansas statewide in process

HIPAA Compliant EMS to Hospital Communications

PATIENT TRACKING

INFRASTRUCTURE

Pulsara **ONE**

Pulsara **MED OPS**

OR

✓ ALL   ✓ ALL
✓ ALL   ✓ ALL
                ✓ ALL
                ✓ ALL

Always Free to Everyone   Free to Hospitals in MED OPS Regions

pulsara®

MARC HCC Threat Assessment Team (TAT)

Triggers that initiate the MARC HCC Response Plan

Significant Public Health and/or Medical Incident Occurs or is Anticipated

MARC HCC Duty Officer receives a telephone call (913-608-9425) from a HCC member requesting monitoring or activation of the HCC Response Plan

MARC HCC Duty Officer notifies the MARC HCC Threat Assessment Team via eICS

MARC HCC Threat Assessment conducts a threat assessment via Conference Call or In-Person Meeting Call

Note: Additional attendees may include the impacted HCC member(s) and/or Local ESF8

MARC HCC Threat Assessment determines the appropriate response level and appropriate next steps.

Potential Next Steps:

- No Further Action Necessary
- Continue Monitoring
- Activation of Regional Healthcare Coordination

MARC HCC Threat Assessment notifies the MARC HCC members via eICS and/or WebEOC and/or email of the:

- 1. Situation
- 2. Response Level
- 3. Next Steps

(as appropriate)

Activation of RHCS Needed

MS 2.4.3

Establish or identify **contingency plans and/or resources** which may be leveraged to increase health and medical capacity, if necessary (regional resources, Disaster Medical Assistance Teams, mutual aid, or Emergency Management Assistance Compacts).

- MO 1-DMAT
- HCC Response Plan & Regional Resource Annex
- Missouri Region A EMS Mutual Aid Coordinator
- Kansas Emergency Management & EMS (MARCER)
- Medical Reserve Corps (MRC)
- Hospital Mutual Aid Agreements & Regional Resource Sharing Agreement

MS 2.4.4

Establish or identify processes to **define medical threats and risks** to capture mitigation strategies for each threat or risk. Ensure **mitigation strategies** are implemented as appropriate, documenting the results of each.

- Regional Hazard Vulnerability Analysis (HVA)
- Threat & Hazard Identification & Risk Assessment (THIRA)
- Regional Fusion Center
- Information Sharing re: emerging threats

MS 2.4.6

Identify potential **roles and responsibilities during emergencies** or mass casualty incidents.

o Individual hospital, public health and EMS surge plans
o Existing Regional MCI and surge plans
o Well established protocols and information sharing platforms
o Regional Safety & Security Planning Framework

MS 2.4.7

Establish or identify processes that recognize **personnel, equipment, training and response gaps** specific to health and medical and identify strategies to address them. Prioritize resource needs and identify the criticality and impact of potential gaps and unmet needs.

o Continuous process for identifying gaps
o Lead up training and exercises ongoing
o Assessing current capacity and surge demand for language translation services

Learning from experience

Getty, 2015.

NFL/Tyler Kaufman, 2023.

David Eulitt, Getty, 2024.

KC Star, 2024.

Planning Assumptions

MEDICAL SURGE

MASS GATHERINGS

FOREIGN VISITORS

EVENT SPECIFIC THREATS

Planning Assumptions: Medical Surge

- Hospitals should plan for increased ED (20-30%), inpatient (10-20%) and outpatient clinic (15-25%) volumes.

- Hospitals should plan for difficulty/delays with interfacility transfers.

- Hospitals/EMS should plan for influx of heat related illness.

- Be aware of/prepared for increased risk of infectious disease outbreaks (endemic and non-endemic).

- Public health should be prepared for increased surveillance, monitoring, testing, quarantine and isolation.

- Overall increased risk of drug overdose.

Planning Assumptions: Mass Gatherings

- Pre-deployed/dedicated assets

- Ingress/egress

- Multiple simultaneous events/soft targets

- Awareness of threat environment

- Increased risk of food-borne illness outbreaks

- Pre-planning for communication, understanding regional hospital capacity and patient tracking

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Planning Assumptions: Foreign Visitors

- Visitors may be unfamiliar with American health care system including appropriate levels of care and payment systems.

- Increase of Non-English speaking patients will require pre-planned and just-in-time translation services.

- Awareness of and ability to provide culturally sensitive care.

- Increased strain on public transportation.

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Planning Assumptions: Event Specific Threats

- Human trafficking

- Geo-political considerations; VIPS/VVIPS; protests/counter protests

- Cyber

- Terrorism

- Event duration/resource constraints

Hospital Assumptions

Number	Assumption	Time Frame	location
1	Expectations include approximately ten (10) total patient transports from official matches during match play under typical conditions.	Match Play	Arrowhead
	note-this number is expected transports from official match location only and does not include watch parties, community events, etc.		
2	Hospitals should plan for increased ED Volume, 20-30% above baseline, for the duration of the tournament.	Duration of tournament	region wide
	Driven by crowd-related injuries, dehydration, alcohol-related incidents, and heat exposure		
	https://ferw.eu/the-hidden-health-risks-in-fifas-world-cup-host-choices/		
	https://bjsm.bmj.com/content/58/1/42		
3	Hospitals should plan for increased inpatient volume, 10-20% above baseline, for the duration of the tournament.	Duration of tournament	region wide
	Mostly short-stay admissions for trauma, cardiovascular events, and acute illnesses.		
4	Hospitals should plan for increased outpatient clinic volume, 15-25% above baseline, for the duration of the tournament.	Duration of tournament	region wide
	Includes minor injuries, infections, and medication refills for travelers.		
5	Hospitals should plan for delays and/or difficulty with non-emergent/interfacility transfers.	Duration of tournament	region wide
6	Hospitals should be aware that international visitors may be unfamiliar with the American healthcare system including, but not limited to, payment procedures and appropriate levels of care (i.e. what is appropriate for urgent care versus emergency department).	Duration of tournament	region wide
	https://www.orlandohealth.com/campaigns/visit-orlando/tips		
7	Hospital staff should be aware of the increased risk of human trafficking associated with large scale sporting events, including the World Cup.	Duration of tournament	region wide
	https://ncbrt.lsu.edu/programs/worldcup/pastthreats.php		
	Missouri Hospital Association (MHA) Human Trafficking Toolkit		
8	Hospital discharge planners should be familiar with logistics of repatriation for international visitors.	Duration of tournament	
	Discharge planners should consult with facility legal teams to address repatriation issues of patients needing ongoing care.		
9	Hospitals should be prepared an influx of heat-related illness.	Duration of tournament	region wide
	https://ferw.eu/the-hidden-health-risks-in-fifas-world-cup-host-choices/		

Resources and Training

Challenges

⚽ **Being inclusive while remaining functional.**

⚽ **Avoiding duplication of effort.**

⚽ **Flow of information from national efforts.**

⚽ **Hurry up and wait.**

Thank you!

Jennifer Sutherlin jsutherlin@marc.org
Steve Hoeger steven.hoeger@uhkc.org

The Box on the Top

Mark Becmer
Sean Sullivan

#NHCPC25

The Box on The Top

Healthcare Preparedness Edition

Healthcare Preparedness

Readiness focus
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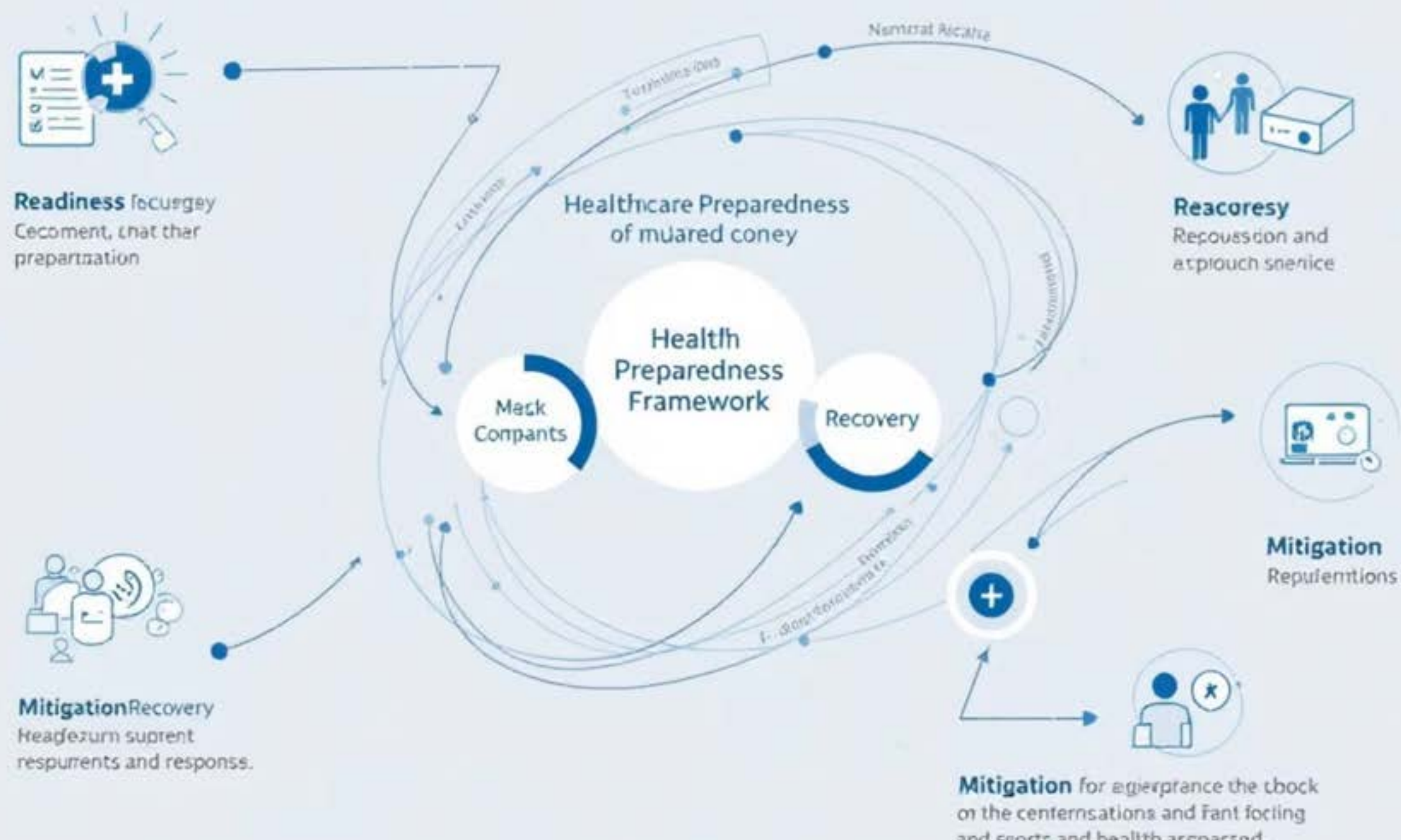
The Box on The Top: Enhancing Enhancing Preparedness in Healthcare and Public Health Health

Mark Becmer & Sean Sullivan

TRG

Goal: Provide practical leadership insights to improve improve preparedness.

Objectives:

Strengthen Leadership Capacity in Healthcare Healthcare Emergencies

Implement and Integrate HICS/ICS Principles Across Healthcare Systems

Enhance Surge Capacity and Resource Management

Foster Coalition Collaboration and Community Lifeline Integration

Why This Matters

Complex Threats & Coordinated Leadership

Healthcare facilities face complex threats requiring coordinated leadership.

Resilience & Continuity of Care

ICS/HICS builds resilience and continuity of care.

Lessons from Emergency Management

Lessons learned from years of emergency management experience. experience.

Actionable Leadership Improvements

Attendees leave with actionable leadership improvements.

The All-Hazards Environment: Healthcare Focus

Natural Disasters

Natural disasters disrupt patient care and supply chains.

Man-Made Incidents

Man-made incidents trigger surge or evacuation.

Infectious Disease Outbreaks

Infectious disease outbreaks strain public health systems.

Planned Events

Planned events require proactive coalition coordination.

Leadership in Healthcare Emergencies

- Leadership influences and guides under pressure.

- Effective leaders stay calm, delegate, and communicate.

- Balance strategic decisions with compassion.

- Leadership directly affects patient and staff outcomes.

PASS Priorities in Healthcare Context Context

Life Safety

Protect patients, staff, and visitors.

Incident Stabilization

Keep essential services running.

Property Preservation

Secure infrastructure and systems.

Society Restoration

Resume full operations and community care.

NIMS Management Elements for Healthcare

Applying NIMS (National Incident Management System) elements is crucial for effective healthcare surge management and continuity during emergencies, ensuring a coordinated and efficient response.

Comprehensive Resource Management

Coordinate essential medical supplies like ventilators and PPE to manage healthcare surges effectively.

Integrated Communications

Utilize redundant communication systems to ensure reliable information flow during crises, connecting all stakeholders.

Unified Command

Align leadership from hospital operations and public health agencies to establish a clear, single command structure.

Common Terminology: HICS Alignment

- Shared language avoids confusion during incidents.

- Use standardized terms across coalition partners.

- Translate facility-specific lingo to ICS structure.

- Supports effective interagency coordination.
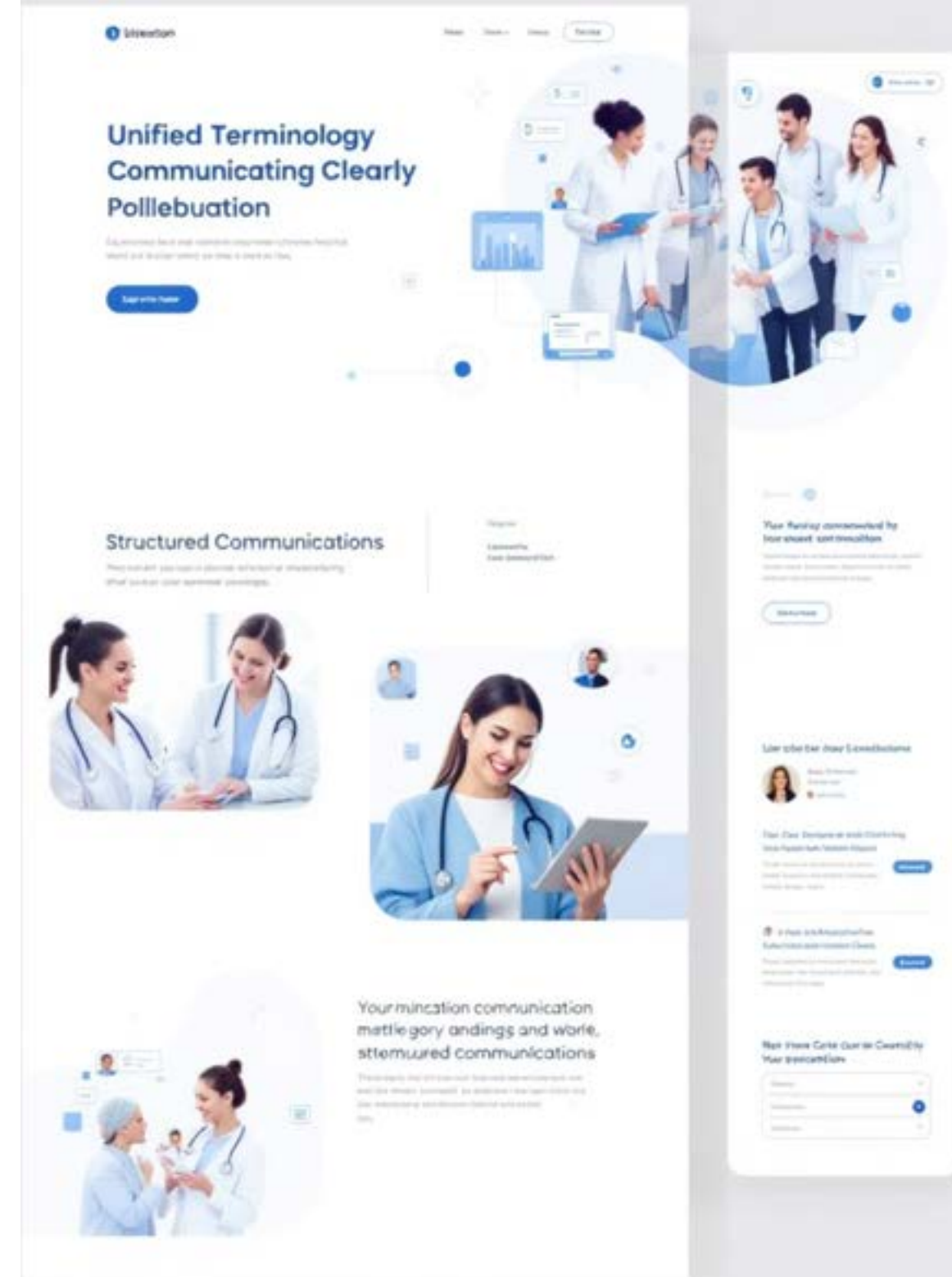
Establishing Command in Healthcare

- Activate HICS early to gain control.

- Assign clear roles and responsibilities.

- Coordinate with coalition and EOC partners.

- Maintain situational awareness.
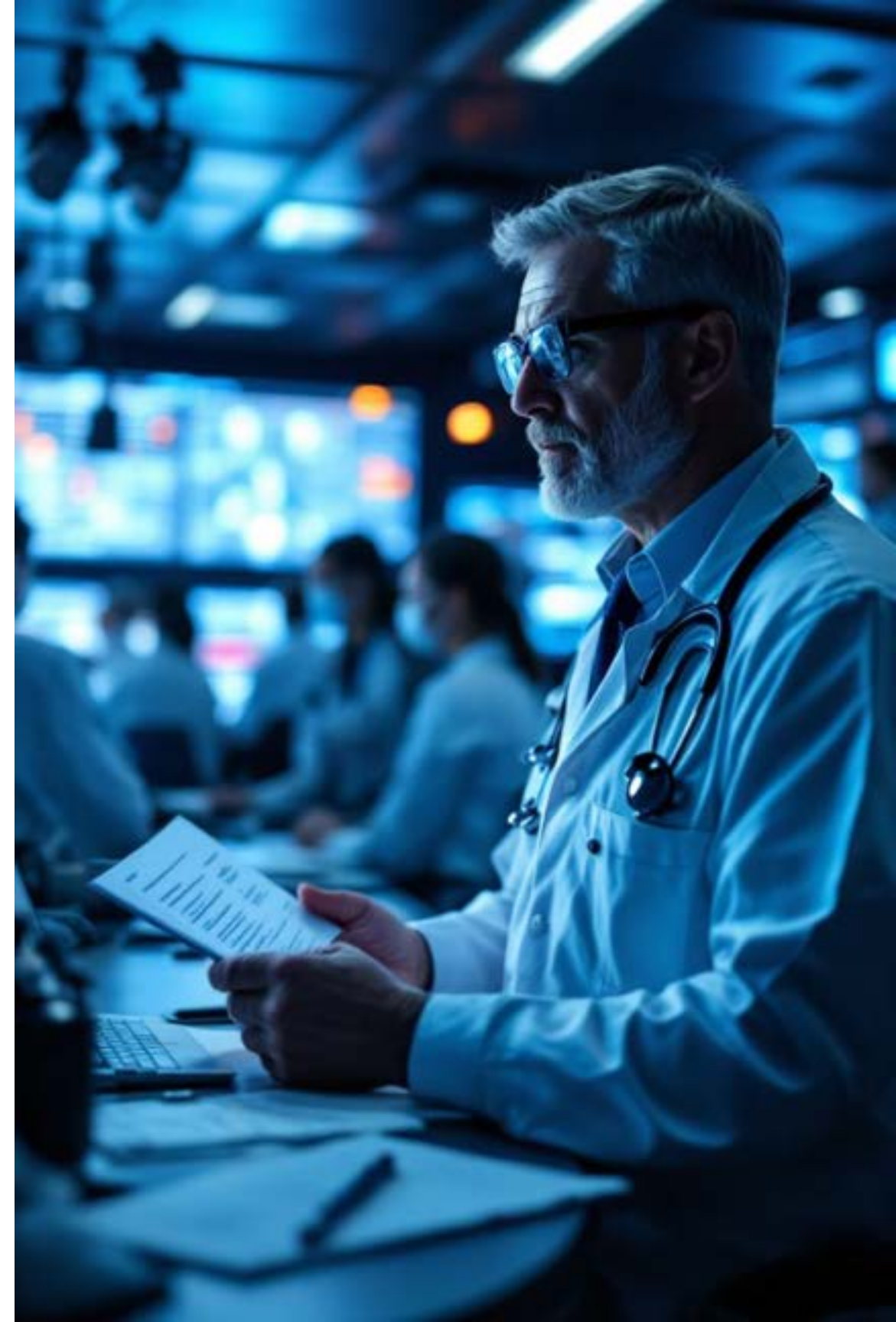
Incident Types Requiring HICS

Infectious disease clusters

Rapid spread of illnesses requiring coordinated containment and treatment strategies.

Facility evacuations

Situations necessitating the safe and organized movement of patients and staff due to immediate threats.

Cyberattacks affecting patient care

Malicious digital intrusions disrupting healthcare systems, patient data, and critical medical devices.

Regional surge events needing coalition support support

Large-scale incidents overwhelming local resources, requiring requiring external aid and multi-agency collaboration.

Unified Command & Healthcare Coalitions

Integrated Systems

Coalitions integrate hospitals, public health, and EMS for a coordinated response.

Streamlined Data Flow

Shared information prevents duplication of efforts and ensures accurate understanding.

Enhanced Decision-Making

Unified command structures improve clarity and efficiency in critical situations.
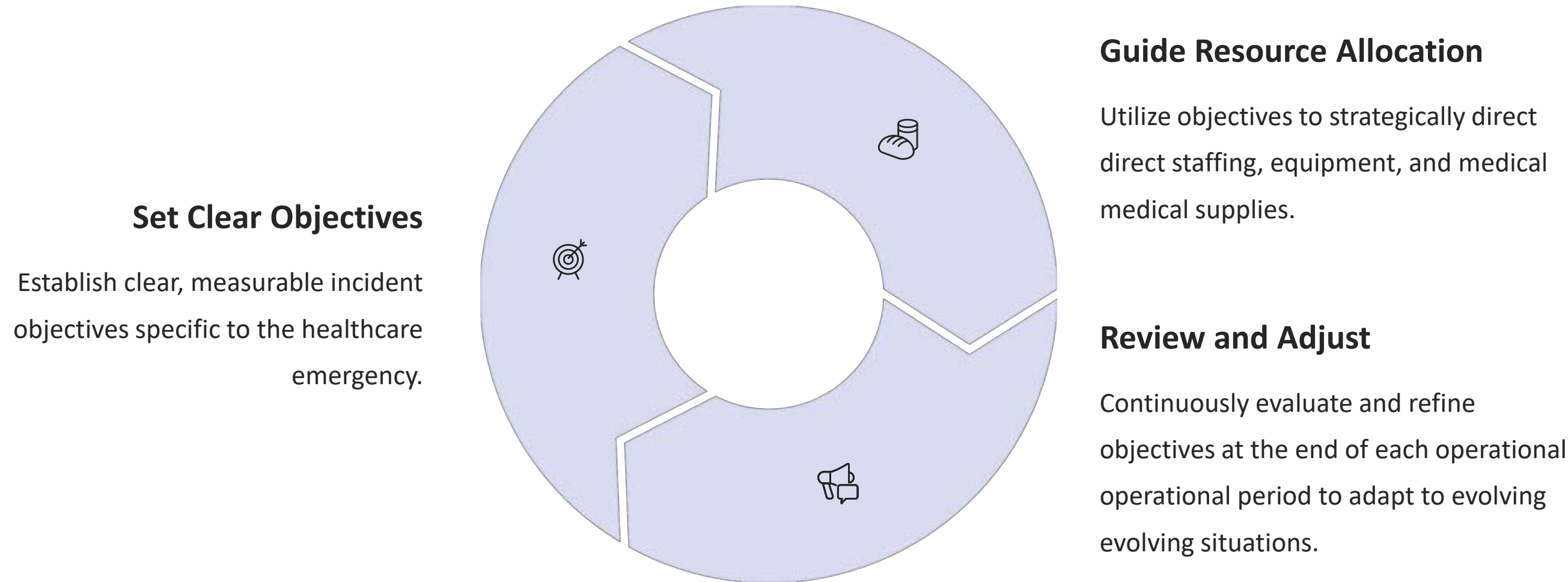
Optimized Resource Sharing

Effective resource allocation is key to managing and optimizing surge response capabilities.

Management by Objectives in Healthcare

Guide Resource Allocation

Utilize objectives to strategically direct direct staffing, equipment, and medical medical supplies.

Set Clear Objectives

Establish clear, measurable incident objectives specific to the healthcare emergency.

Review and Adjust

Continuously evaluate and refine objectives at the end of each operational operational period to adapt to evolving evolving situations.

Example: Maintain Emergency Room operations at 80% capacity throughout a mass casualty incident.

Modular Organization & Surge Capacity

Expand Structure

Expand organizational structure to meet surge needs.

Add Specialized Units

Add branches for alternate care or isolation units.

Delegate Effectively

Delegate effectively to maintain control.

Flex Resources

Flex resources as patient load changes.

Using the Community Lifelines

Lifelines describe essential services to stabilize.

Healthcare leaders use lifelines to set priorities and report report status.

Align hospital reporting with EOC and coalition partners.

Support decision-making during complex incidents.

Interacting with Field ICS and EOCs

Link with Command

Hospitals must link with fire, EMS, and law enforcement command.

Utilize Liaisons

Use liaisons to connect HICS with field ICS/EOCs.

Share Situational Reports

Share situational reports using ICS forms and common language.

Coordinate Resources

Coordinate resource requests through coalition and EOC channels.

Incident Action Planning in Hospitals

Utilize HICS Forms

Use HICS forms to plan each operational period, ensuring a standardized approach to incident management.

Define Objectives & Track Progress

Set clear daily objectives and consistently track progress to ensure ensure efficient incident response.

Coordinate with Partners

Coordinate planning efforts closely with public health agencies and agencies and coalition partners for a unified response.

Adapt Plans Dynamically

Continuously adjust plans based on real-time situational updates and updates and evolving incident conditions.

Span of Control in Healthcare

- Maintain manageable supervision ratios.

- Avoid overburdening supervisors during surge.

- Use additional branches to balance workload.

- Train staff on span of control principles.

Incident Facilities and Locations

Identify triage, decontamination, and alternate care sites.

Secure support areas for staff and supplies.
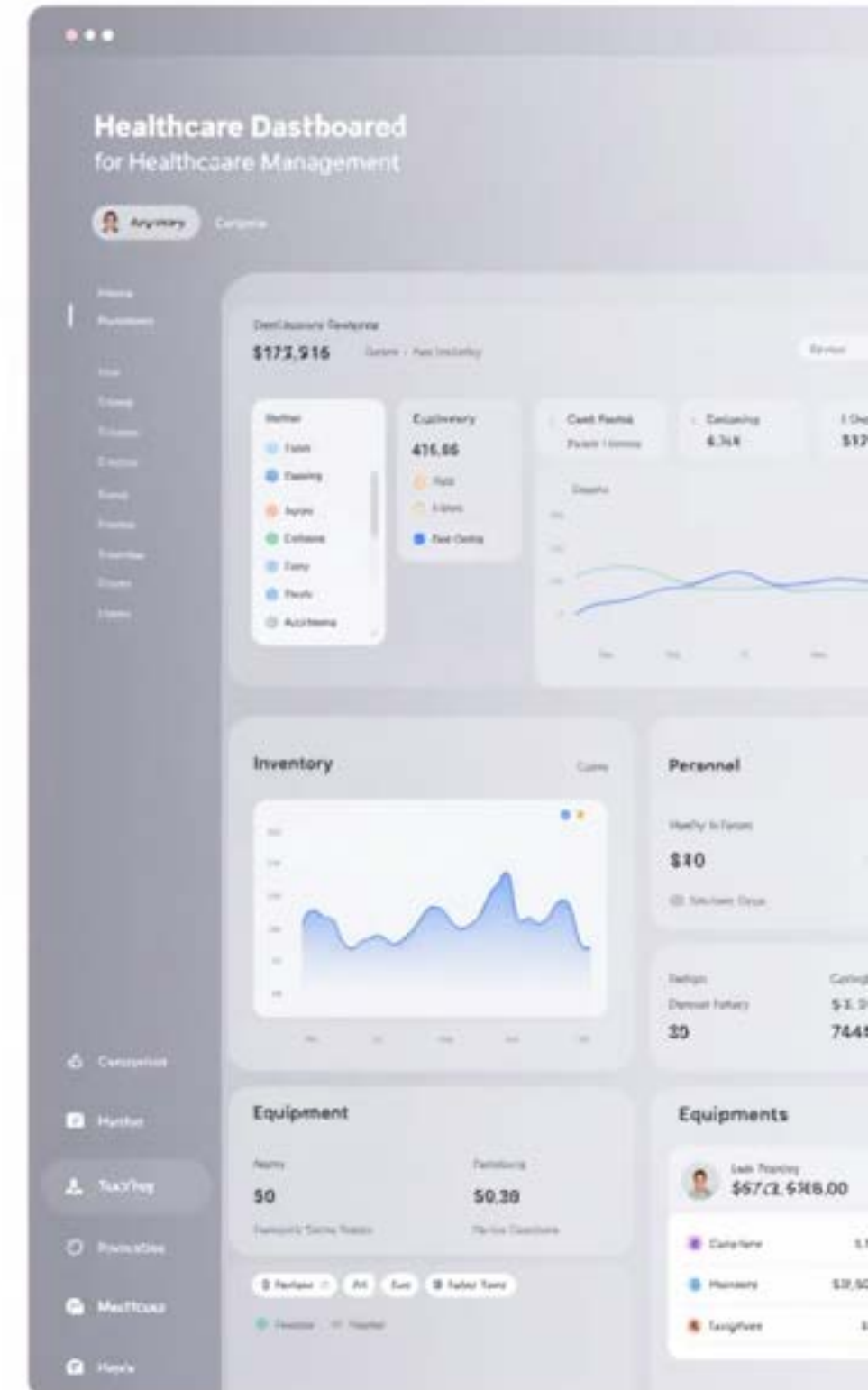
Coordinate with community shelters and transport.

Document facility locations in IAPs.

Comprehensive Resource Management

- Track all supplies, personnel, and equipment.

- Prioritize scarce resources based on patient needs.

- Coordinate requests through healthcare coalitions and EOCs.

- Use digital systems for accuracy.

Integrated Communications Communications

- Maintain redundant communication channels.

- Share updates with staff, coalitions, and EOCs.

- Use radios, secure messaging, and web platforms.

- Train staff on communication tools.

Intelligence and Information Management

Data Collection

Collect comprehensive data on patients, available resources, and potential threats for informed decision-making.

Situational Analysis

Analyze gathered information to build and share real-time situational awareness with all relevant stakeholders.

Information Coordination

Coordinate seamlessly with public health authorities and Emergency Operations Centers (EOCs) for unified response efforts.
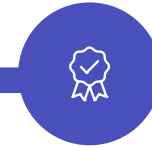
Data Protection

Implement robust measures to protect sensitive information, maintaining patient confidentiality and operational security.

Accountability in Healthcare Emergencies

Track staff assignments and patient movements.

Use check-in systems for responders.

Document actions for legal and reimbursement purposes.

Enforce safety protocols.

Dispatch and Deployment

- Rapidly deploy surge staff and resources.

- Pre-identify staging areas for incoming support.

- Use coalition agreements for resource sharing.

- Monitor deployments for efficiency.

Mission Support for Healthcare Facilities

Ensure logistics for food, fuel, water, IT support.

Provide staff shelter and security during incidents.

Maintain backup power and supplies.

Coordinate with external vendors.

Policy and Authority in Healthcare Response

Delegation of Authority

Establish clear delegation of authority.

Emergency Policies

Ensure policies support emergency actions.

Decision Documentation

Document decisions for accountability.

Regulatory Alignment

Align with local and state regulations.

Strategic Direction in Public Health Response

- Set broad strategies for warning, evacuation, sheltering.

- Align with public health and EOC priorities.

- Provide clear guidance to all stakeholders.

- Reassess strategies as conditions change.

Case Study: Pandemic Surge Surge

- Surge of patients requires rapid scaling.

- Coordinate with coalitions for resources.

- Adjust care models for high demand.

- Debrief and integrate lessons post-event.

Case Study: Chemical Exposure Exposure

- Activate decontamination protocols.

- Protect staff with appropriate PPE.

- Communicate with public health and EOCs.

- Provide clear public messaging.

Thank You

- Sean Sullivan - Director of the Public Safety Program

- Ssullivan@responsegroupinc.com

- Mark Becmer – Deputy Director of Public Safety / Training Lead

- mbecmer@responsegroupinc.com

- "You may choose to look the other way, but you can never say again that you did not know."

Why Talk about ROI in Preparedness?

Preparedness isn't a compliance box — it's an operational performance lever.

- Disruptions are rising, and recovery costs are ballooning.
- Yet, preparedness is still perceived as an *expense*, not an *investment.*
- This session reframes readiness as measurable value: stability, trust, and time.

"Unplanned downtime in healthcare costs an average of **$9,000 per minute.**" — *Ponemon Institute*

The Real Cost of Disruption

- When systems fail, cost accrues across every dimension of care:
  - Cancelled appointments and delayed imaging
  - Staff overtime and burnout
  - Lost billing and regulatory penalties

- Every untracked minute compounds into hours of financial and clinical risk.

"70% of healthcare outages last longer than 8 hours. — *Becker's Hospital Review*

ROI Belongs in Every Preparedness Plan

- Every hour reduced in downtime is measurable savings.
- Resilience planning protects revenue, reputation, and regulatory standing.
- The return is tangible: fewer incidents, faster recovery, stronger teams.

"Hospitals that invest in resilience report 30–50% shorter recovery times after major disruptions."
— *KPMG Healthcare Resilience Report, 2024*

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Quantifying Preparedness Starts with Measurement

- Reliable data doesn't just appear, it's collected.

  Key inputs for ROI analysis:

- **Incident logs:** duration, cause, response time

- **Staff impact:** overtime, reassignment, fatigue

- **Financials:** billing delays, lost revenue, cost of overtime

- **Patient metrics:** throughput, canceled sessions, LOS variance

"96% of hospitals experienced unplanned EHR downtime in the last three years."
— *Journal of Hospital Medicine*

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Turning Data into Insight

Data is only powerful when it tells a story.

- Patterns reveal where resilience gains compound:
- Heatmaps show vulnerable sites.
- Trendlines reveal improvement or decay.
- Correlations justify budget asks.
- Every dashboard should answer: *"What's changing, and why?"*

"Network disruptions alone cost healthcare organizations an average of $7,500 per minute."
— *Ponemon Institute*

Case Study: From Disruption to Justification

A mid-sized U.S. hospital (approx. 200 beds) experienced recurring outages in its imaging system (PACS/RIS).

- Downtime disrupted throughput and delayed diagnostics across departments.

- Annualized revenue loss: approximately **$300,000**

- By tracking downtime patterns and quantifying impact, leadership justified investing in upgraded infrastructure, which paid for itself in under six months.

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Case Study: Practice Pays Off

A multi-facility health system conducted tabletop drills to test continuity plans for laboratory operations.

- The exercise revealed a critical single-vendor dependency in reagent supply.
- Corrective actions (dual sourcing and stock buffer adjustments) prevented an estimated **$50,000 in annualized losses per lab**.
- Staff also reported higher confidence in manual and alternate workflows after the exercise

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Making Preparedness a Board-Level Conversation

- Executives don't buy "peace of mind." They buy:
  - **Reduced risk exposure**
  - **Protected revenue streams**
  - **Brand resilience**

- To prove ROI, link preparedness metrics to business outcomes:
  - **Missed revenue avoided**
  - **Fines prevented**
  - **Operational uptime gained**

"EHR outage for a medium hospital: $1.7M/hour; large systems up to $3.2M/hour." — *Giva*

Start Measuring What Matters Today

- Use what you already have:
- Microsoft Forms for incident capture
- Excel or Power BI for cost trends
- SharePoint or Teams dashboards for visibility
- The power lies in *consistency*, not complexity.

What do you track today?

Your 30-Day Readiness ROI Sprint

You don't need a task force. You need a starting point.

Within the next 30 days:

1. Track one recurring disruption this month.
2. Note duration, impact, and affected roles.
3. Visualize it, even with a simple chart.
4. Share one data story with leadership.

Preparedness Isn't a Cost, It's a Catalyst.

You can't manage what you don't measure.

ROI isn't just financial, it's operation and human.

When teams see their data, they see their impact.

"Hospital system downtime in critical environments can exceed $5 million per hour."
— Forbes, "The True Cost of Downtime"