Hospitals: 9 of 15 Hospitals (60%) attended.
- Assumption Community; Elizabeth Templet
- Franklin Foundation Hospital; Charles Ibert
- Lady of the Sea General
- Leonard J. Chabert; Vera Folse
- Ochsner-St. Anne General; Kathy Hebert
- Physicians’ Alliance Hospital of Houma
- Physicians Medical Center
- River Parishes Hospital
- Specialty Rehabilitation Hospital of Luling
- St. Charles Parish Hospital; Ken Rousseau
- St. Charles Specialty Rehab Hospital
- St. James Parish Hospital; Mary Lanassa
- Teche Regional Medical Center; Jena Aucoin, Owen Williams
- Terrebonne General; Percy Mosely, Charles Schefferstein,
- Thibodaux Regional; Eric Degravelle

EMS: 4 of 4 EMS Providers (100%) attended.
- Acadian Ambulance; Chad Davis
- Acadian Air Med Services; Chad Davis
- Lafourche Ambulance; Brady Daigle
- St. Charles Parish Hospital EMS, Ken Rousseau

Guests: Alicia Prevost, DHH-OPH; Glennis Gray, DHH/OPH; Yvette Legendre, LERN; Kayla Guerrero, R3 OPH; Erin Beittie, R3 OPH

Facilitators: Kim Beetz, Region 3 ADRC; Percy Mosely, Region 3 Hospital DRC, Asha Smith, HHS/LHA; Marcia Fries, HHS/BEMS; Karla Houston, HHS/LA Ambulance Alliance

WELCOME AND INTRODUCTIONS
Marcia Fries welcomed everyone to the meeting. She asked that everyone introduce themselves. She mentioned that the agenda would include: Grant Requirements and ESF 8 Changes, ESF 8 Software Training/Overview, Strategic National Stockpile and Cities Readiness Initiative (CRI), Site Visits, Frequently Asked Questions and Grant Directives and the 2011-2012 Spending Timeline. She also mentioned that the group will break out into subgroups and that EMS and Hospital will meet separately to discuss specific planning objectives for their subgroup.

GRANT REQUIREMENTS AND GRANT CHANGES
Ms. Fries indicated that the grant requirements have not change and that Level One, Level Two and the Overarching Requirements must be met by all States. To be eligible to receive HHS grant funds all hospitals and EMS providers must meet the 14 National Incident Management System (NIMS) requirements, which is included in the Overarching Requirements. Another important point is that facilities need to make sure they are developing their After Action Reports after each drill, exercise or event.

Ms. Fries indicated that the first part of the meeting would focus on the ESF 8 Portal, Louisiana’s Bed-Tracking System, and Partnerships which are centered on the Strategic National Stockpile and Cities Readiness Initiative (CRI).

Bed Tracking - ESF 8 Portal Software
Ms. Fries indicated that Louisiana’s Bed Tracking System, EMSystem, is being replaced with the EMSTAT and the new ESF 8 portal. EMSystem will no longer be available beginning November 15, 2011. Hospitals should begin updating their LERN screen in the ESF 8 portal. Hospitals should also complete a Point of Contact Form for their facility and return it to Henry Yennie (henry.yennie@la.gov) if they have not already done so.

Henry Yennie, from the Department of Health and Hospital, provided a presentation on the new ESF 8 portal software suite. The content of the presentation included: (1) Overview of the ESF 8 Application Suite and how to access it, including the mobile version, (2) Review of the single sign-on capabilities and plans, (3) Timelines for implementation and role of the Facility Point of Contact, and (4) Known issues with the application suite and their status and the process for getting support.

Mr. Yennie also provided a demonstration of the core applications:

a. **Security Portal**
   i. Changing passwords and security questions
   ii. Entering contact information
   iii. Creating Persons and Users for a facility

b. **Resource Management**
   i. How to update facility status items for both regular dashboard and LERN views.
   ii. Protocols for frequency of updates (some regional discussions were held)
   iii. How to update the Bed Poll section
   iv. How to send a message using the Alert feature
   v. How to run basic reports

c. **Messaging**
   i. How to create an event and an associated notification
   ii. How to use templates to link events and notifications
   iii. Discussion of regional template needs
   iv. Discussion of the role of groups in messaging and the role of Position Titles in Person creation
   v. Using groups in crafting a notification
   vi. Tracking the outcome of a notification and sending updates to an ongoing event

Mr. Yennie ended his presentation taking general questions and wrap-up.

**Strategic National Stockpile Update (SNS) and Cities Readiness Initiative (CRI)**

Ms. Fries indicated that the second Hot Topic was the development of Partnerships. The grant requires that Partnerships be developed in the Cities Readiness Initiative (CRI) areas in the state and an equal number of partnerships in non-CRI areas. The CRI in Louisiana includes Region 1, 2, 3 and 9. Thus, partnerships were to be developed in not only these regions, but 4 other regions of the state per the grant guidelines. To fulfill this requirement, Louisiana, has been using the partnerships that were developed around the Strategic National Stockpile (SNS) and the CRI in each region of the state.

Ms. Glennis Gray, from the Office of Public Health – Center for Community Preparedness, provided an overview of the SNS and CRI programs in Louisiana. The Centers for Disease Control and Prevention’s (CDC) Strategic National Stockpile (SNS) is a repository of potentially life-saving pharmaceuticals and other medical supplies that can be used in a public health emergency when locally available supplies have been depleted. The Cities Readiness Initiative (CRI) is a federal effort designed to increase bioterrorism preparedness in the nation’s larger cities. The goal is to save lives in these selected cities by rapidly dispensing medication to their entire population within 48 hours of the decision to do so. Since 2004, CDC has provided special funding for CRI through the Public Health
Emergency Preparedness Cooperative Agreement (PHEP). The funding is provided to enhance the mass dispensing capabilities of the CRI MSA’s and their metropolitan statistical areas (MSA’s). 72 MSA’s will use this special funding to develop plans that support mass dispensing of drugs to 100% of the identified population within 48 hours of a decision to do so. A total of 72 cities are included in this initiative. Louisiana has 2 MSA’s. They are New Orleans/ Kenner and Baton Rouge. In an effort to bridge the gap between CRI regions and non-CRI regions the state will maintain a focus on making all regions CRI compliant regardless of funding.

The SNS grant update focused on relaying information to the regions on CRI activities to maintain grant status. There was an overview of the Public Health Emergency Preparedness Cooperative Agreement (PHEP) Budget Period 11 (2011-2012) standards inclusive of the Medical Countermeasure Distribution and Dispensing Composite Measure Guide (MCMDD). The state also provided updates on the resource and resupply request for hospitals which remains in draft form. The general outline is that the hospital DRC will note the need for resupply. The Hospital DRC will notify the regional office (PHERC) of the need that will in turn send the request to the state EOC via phone request and/or web EOC for fulfillment. The state EOC will fill the request and report back to the PHERC and Hospital DRC of anticipated delivery.

With the announcement of the new PHEP cooperative agreement funding opportunity, the CDC defined a capability –based approach to building public health preparedness standards. As part of the process of capability demonstration, PHEP awardees must meet a number of annual requirements and achieve Pandemic and All-Hazards Preparedness Act (PAHPA) benchmarks. Therefore, the state SNS program during the 2011-2012 grant years will focus on a full-scale exercise scheduled for February 28 2012-March 1, 2012, focusing on CRI regions 1, 2, 3 and 9. Region 6 will also be included as a requirement for Project Public Health Ready. Non-CRI regions 4, 5, 7 and 8 will serve as controllers and evaluators. June 12, 2012 the non-CRI regions will have a tabletop exercise and the CRI regions will serve as controllers and evaluators. The table-top exercise will also serve as a PHEP capability requirement.

The group asked Ms. Gray to provide to training on the Strategic National Stockpile and an After Action Review from the recent drill that was held by the Office of Public Health.

SITE VISITS
Ms. Fries indicated that the site visits increased from 5% to 20%. 55 hospitals and 11 EMS providers will receive visits sometime between November 2011 and February 2012. Every hospital and EMS provider will be visited over the next 5 years regardless of whether they participated in the last grant cycle. Site visits are more comprehensive than in the past. In addition to grant purchases, HHS grant staff will be reviewing and confirming: NIMS compliance, Survey responses, Compliance with Participation Agreement (Attachment A for hospitals) and to ensure hospitals have surge plans. If a “red flag” is found in site visit, corrective action measures will be taken. Facilities may no longer be eligible to receive grant funds until measures have been met, facilities may be asked to return a portion grant funds received or facilities may be asked to provide justification as to why measure cannot been met. A more detailed discussion was held during the individual break-out sessions.

GRANT DIRECTIVES AND FREQUENTLY ASKED QUESTIONS
Ms. Smith indicated that the handouts included a Frequently Asked Questions listed about the grant purchases. The following questions were discussed:

1. Who “owns” the items purchased with grant funds (ownership of the items especially as it relates to inventory taxes, insurance and storage costs)?
Individual purchases - Any item purchased with HHP grant funds is deemed to be a federal asset. However, the purchaser of the equipment shall retain the title to the equipment and is responsible for the purchase and payment of all inventory taxes, insurance, and/or storage costs associated with items purchased with HHP Grant funds.

Regional Assets - Purchases that have been made on behalf of the region (i.e. western shelters, mass fatality trailers, etc.) are “owned” by the purchaser but are deemed to be a regional asset and are available for use by other members of the region upon request. As a best practice, it is prudent for regional assets to have a written agreement or Regional MOU that addresses at a minimum: storage of the asset, activation of the asset, and notification protocols. If applicable, a written process for leasing and insurance should also be included in the document.

2. What responsibility does the provider have to make purchases available to the State and under what circumstances?

The equipment shall be used to meet local, regional and state medical surge needs and can be used for training, drills and response activities related to mass casualty incidents and other local, regional and/or state disasters. The State along with the Grant PI may request and direct the use of grant purchased equipment in a state or parish declared emergency. As a working policy, equipment purchased with grant funds should be used to provide “for the greatest good” for the citizens of Louisiana.

3. What is the process for the disposal of purchases – unusable, expired, broken or lost?

Facilities may:
- Sell and use proceeds for another allowable HHS grant project (ex: larger storage trailer)
- Dispose of equipment/supplies and make a record on inventory tracking form including the date and reason for doing so (ex: batteries, pharmaceuticals)
- Donate it to another eligible recipient

4. What are the provider replacement obligations for expired, broken, or lost items?

Provider should develop internal procedures to maximize the ongoing availability of assets funded with grant funds through rotation, maintenance procedures, etc. However, in incidents in which an asset may be used (events or trainings), become broken, lost or expire, the provider should identify and maintain an inventory of these items to be replaced with future grant funds. The provider is responsible for maintaining records regarding the status of items purchased with HHP grant funds including those expired, broken or lost. Records for property and equipment acquired with federal funds shall be retained for 3 years. However, purchasers are encouraged to keep records for at least 7 years.

5. What assurances are there of replacement grant funds?

There are no guaranteed assurances that the HPP grant funds will continue. However, the Health and Human Services (HHS) Assistant Secretary’s Office of Preparedness and Response (ASPR) has indicated that grant funds will be available with a match requirement of at least 10% for the following 3 to 5 years.

6. Who determines the appropriate use of funds? Is there an approval process?

The Participation Agreement provides organized material from the grant guidance and cost directives manual. A budget proposal is submitted to HHS Grant Staff PRIOR to purchases being made so that any “problems” can be flagged and grant dollars redirected if the proposal identifies a project that may be at-risk for being unallowable by
grant guidance. If requested item is not listed on Participation Agreement, purchaser must obtain approval from the HHS Grant Staff prior to purchase.

7. Who determines the appropriate use of equipment? Can purchases be used on a daily basis?

**Non-Disposable Equipment over $1,000** - Equipment such as radios, trailers, ventilators, spine boards and/or generators are some examples of non-disposable equipment that may be used on a daily or frequent basis to maintain operability. Pharmaceuticals should not be used on a daily basis but set aside for readiness upon being formally activated by the State. Please note that for pharmaceuticals (surge cache) should not be used on a daily basis, but the cache should be rotated to ensure an updated cache is available for surge.

**Disposable Material under $1,000** - Disposables such as gloves, gowns, masks should be handled similarly to pharmaceuticals. The purpose of the grant is to ensure medical caches are available for a surge event. If these materials are used on a daily event, it defeats the purpose of the grant and having a surge cache.

8. Can the purchases be used to respond to an in-state event? Is there an approval process?

Yes, equipment can be used to respond to an in-state event. For regionally-owned purchases like trailers or tentage, the purchaser should notify their regional partners that the trailer/tentage is being used in their region for a specific regional purpose; or alternatively, that the region’s trailer/tentage is being moved to another region.

9. Can purchases be used to respond to an out-of-state event? Is there an approval process?

Yes, HPP purchased equipment can be used to respond to an out-of-state event. However, approval must be sought from the State as movement of an HPP asset to an out-of-state event will require an Emergency Management Assistance Compact (EMAC).

10. What spending restrictions exist?

HHS grant funds should not be used for new construction, antivirals, vaccines, subscription charges, and personnel cost (Except for Match Requirement). For certain items, written permission is required prior to purchase. Written permission should be sought for any retrofitting that will take longer than 60 days, the purchase of security equipment, vehicles, trailers/storage shed purchases, and leased warehouse space.

11. How long must the provider keep grant documentation? What on-going documentation is required for the provider to keep?

Records should be retained for a minimum of three (3) years from the date of submission of the final expenditure report or date of the submission quarterly or annual financial report. Facilities are, however, encouraged to keep records for at least seven (7) years.

12. What must facilities submit to obtain reimbursement?

Facilities must submit Acceptable Documentation of Proof of Payment along with other state requirements as listed in their participation agreement. Acceptable Documentation of Proof of Payment includes:

- Receipts stamped “Paid” along with the “check number” and “date paid”.
- Copies of the corresponding check(s) used to pay invoice/receipt.
- Invoice(s) indicating items have been paid with a credit card. Credit card payments must be accompanied by the credit card statement and proof of payment of the credit card statement.
• If claiming sales taxes that are not listed on the invoice/receipt, documentation supporting your tax percentage should be submitted.
• If purchases were paid using an electronic transfer of funds (ETF), a tracking or reference number along with the date of the transfer and signature authorizing this payment method should be written on the invoice.

13. What should be included on the awardee’s property records and inventory list?

• A description of the equipment;
• Manufacturer’s serial number, model number, federal stock number, national stock number, or other ID;
• Source of the equipment, including the award number;
• Whether title vests in the recipient or the Federal Government (proportionate share);
• Acquisition date and cost;
• Percentage of HHS’s share in the cost of the equipment;
• Location and condition of the equipment and the date the information was reported;
• Unit acquisition cost; and
• Ultimate disposition data, including date of disposal and sales price or the method used to determine current fair market value where a recipient compensates the HHS awarding agency for its share.

GRANT AMOUNTS AND SPENDING TIMELINE
Ms. Fries indicated that Louisiana received $5,055,790 for the FY 2011-2012 grant year. Approximately 70% ($3,468,790) of the funds are distributed to hospitals and EMS providers. The remaining 30% ($1,587,000) is for administrative cost including the grant staff’s salaries and benefits, the ESAR-VHP program, continuing education units for educational programs and the Bed Tracking System. Of the $3,468,790, 75% is distributed to hospitals and 25% is distributed to EMS providers. For individual facilities amounts, Ms. Smith directed them to the electronic Grant Management System.

Ms. Smith indicated that there are three dates in which hospitals and EMS Providers can submit acceptable documentation of proof of payment for reimbursement:

<table>
<thead>
<tr>
<th>DOCUMENTATION DEADLINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 30, 2012</td>
</tr>
<tr>
<td>April 30, 2012</td>
</tr>
<tr>
<td>May 31, 2012</td>
</tr>
</tbody>
</table>

Facilities may submit acceptable documentation of proof of payment on any of the three deadlines. However, all documentation must be submitted at one time. Facilities should wait until all documentation has been gathered and all funds have been spend before submitted their acceptable documentation of proof of payment on one of the three documentation. Approved Acceptable Documentation of Proof of Payment must be dated from **July 1, 2011** to **May 16, 2012**. Any documentation dated before or after this time period is not acceptable. Final documentation must be submitted by the last deadline of **May 31, 2012** or grant funds are forfeited. Facilities should expect to receive documentation within 60 days for documentation deadline.

To meet the match requirement, Mrs. Smith indicated that there are 5 ways in which hospitals and EMS providers account for their match. First, the grant summary worksheet should be used to account for all in-kind contribution and cash expenditures. The match can be accounted for in the following ways.
a. **Direct in-kind cash** – Examples of direct in-kind cash include costs incurred by the facility that are more than the reimbursable amount.

b. **In-kind staff time for attending Emergency Preparedness meetings** – If the facility chooses to demonstrate the match in staff time, required documentation such as sign-in sheets, meeting agenda and a meeting summary showing a reasonable dollar value must be submitted so as to support the dollar amount of the in-kind staff time. Facilities should complete the second tab on the in-kind contribution worksheet including the employee’s name, name and number of hours of meeting as well as the hourly pay rate of that employee. If the facility chooses not to provide the exact hourly pay rate for that employee, they are asked to provide the lowest amount possible an employee in that department or pay grade can make. In the event of an audit, the facility must be able to prove that that employee made at least the amount they provided on the worksheet.

c. **Mileage for attending Emergency Preparedness meetings** – Travel to and from emergency preparedness meeting may also be used toward your match requirement. If the facility chooses to use the match in mileage, then required documentation such as travel authorization or travel reimbursement requests and a copy of the participants reimbursement check should be submitted. If claiming mileage using the in-kind contribution worksheet, the mileage rate must be consistent with the state rate of 0.51/mile.

d. **On Campus Storage Space** – If your hospital is currently storing HHS grant equipment or emergency preparedness equipment in a storage room on your hospital campus, you can use the value of the storage space toward your match. If your facility chooses to demonstrate the match using storage space, you will be required to provide the size of storage space as well as the amount it would have cost you to rent a space of that size. The amount or estimated rental cost must be reasonable in that if your facility was to rent this space from an outside source, the dollar amount would fairly be the same. Facilities are encouraged to obtain an outside quote for a space of the same size for comparable purposes. Quotes should be attached to the in-kind contribution worksheet.

e. **On Campus Meeting Space** – If your facility holds meetings or classes related to Emergency Preparedness, you can use the value of the meeting space towards the match. The calculation should be based on the amount you would normally charge for use of the space or what the charge would be if you were to go somewhere within your region and rent a meeting space of that size. Facilities are encouraged to obtain an outside quote for a space of the same size for comparable purposes. Quotes should be attached to the in-kind contribution worksheet.

**HOSPITAL BREAKOUT SESSION**
Asha G. Smith indicated that during the break-out session, the group will discuss the site visit template and the expectations of the visits as well as the Hospital Emergency Response code recommendations.

**Site Visit Template**
The group reviewed the site visit template thoroughly. The following topics were discussed.

- **NIMS** – Hospitals must have met all 14 NIMS requirements. During site visit, HHS staff will be looking for proof that requirements have been met. Staff will review Emergency Operations Plan, copies of NIMS certificates, and tracking methods to ensure facilities have records of personnel that need and have taken the NIMS courses.

- **Surge** – The surge bed, critical care beds and ventilator goals are based on the amount hospitals have available over their daily average census. Anything over and above the daily average census can be counted
toward the facility’s surge goal. HHS Staff will be reviewing the hospital’s survey responses to ensure they are accurate and the surge goals listed on Attachment A of the hospital’s participation agreement to ensure the facility has met their individual surge goals as listed in the Attachment A.

- **PPE** – HHS staff will ensure hospitals have the number of weeks of PPE as indicated on Attachment A.

- **Decontamination** – HHS Staff must ensure all Tier 1 hospitals have a decontamination team and the appropriate equipment for each team member.

- **Mass Fatality** – The grant requires that mass fatality planning must be done. Louisiana has been fulfilling this requirement with regional mass fatality planning. However, Louisiana was dinged because not all hospitals had a mass fatality plan. This year we must ensure the hospitals have a written mass fatality plan in place. Facility Mass Fatality plans should include how remains will be handled during a disaster. The mass fatality plan may be apart of the facility’s surge or emergency operations plan. HHS Grant Staff will be reviewing the facility’s mass casualty plans and will ensure the facility have a stockpile of body bags as indicated in their participation agreements and Attachment A.

- **Pharmaceutical** - HHS Staff will ensure each facility has developed a biological drug cache. Hospitals should be rotating and maintaining this cache. Expired drugs may be replaced with upcoming grant funds. HHS Grant Staff will also review the hospitals’ survey responses to ensure they have the drugs they indicated they have on hand on the survey.

**Hospital Emergency Response Codes**

Ms. Smith indicated that Louisiana adopted a standardized emergency response code back in 2005. The current codes are:

- **CODE BLUE** - Medical Emergency-Cardiac/Respiratory Arrest
- **CODE RED** - Fire
- **CODE GREY** - Severe Weather
- **CODE BLACK** - Bomb
- **CODE PINK** - Infant/Child Abduction
- **CODE YELLOW** - Disaster-Mass Casualty
- **CODE WHITE** - Security Alert-Violence/Hostage
- **CODE ORANGE** - Hazardous Materials

A survey was conducted in March 2011 and the survey revealed that out of the 250 hospitals, 86% of the hospitals currently use the recommended codes. The survey also revealed that 39% of the hospital felt that the codes should be reviewed and that other emergency response codes that are not currently included in the recommended list should be considered. They are as followed:

CODE YELLOW - Disaster – Mass Casualty
CODE ORANGE - Hazardous Materials
CODE WHITE - Security Alert – Violence/Hostage

Of the original eight (8) codes, additional clarification points were asked to be added for CODE YELLOW and CODE ORANGE. For a CODE YELLOW, hospital personnel should clarify whether it is an internal or external mass casualty disaster when using the code. Similarly, personnel should also clarify whether it is an internal or external hazmat spill when using a CODE ORANGE.
To distinguish between a combative person with a weapon and one without a weapon, CODE WHITE has been split into two split codes. CODE WHITE should be used only for a combative person and CODE SILVER should be used for a combative person with a weapon.

The hospitals were asked if there were any objections to these recommendations. As there were no objections, the recommendations will be taken to the Louisiana Policy and Regulatory Committee for adoptions.