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Partnering for a Healthy Response

By Joseph Straw

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Debbie Drake, a nurse and emergency management coordinator at St. Alphonsus Regional Medical Center in Boise, Idaho, was chatting casually with her counterparts from neighboring institutions about procurement of supplies like emergency respirators. They were shocked to learn that their supplier had told each of them the same thing: he had 30 on hand if they were needed. That meant just 30 for all three facilities and for the region in the event of a disaster.

Drake realized that the region's healthcare providers, which are market competitors day-to-day, had to align and be ready to unite instantly in the event of a disaster, or even a smaller mass-casualty event. That realization, some years ago, led to the Healthcare Coalition in Southwest Idaho, under which 12 institutions—covering 150 square miles—plan, exercise, and respond together.

Recently, the University of Pittsburgh Medical Center's (UPMC) Center for Biosecurity, which monitors the federal government's National Healthcare Preparedness Program (NHPP), issued a report on the country's level of preparedness for catastrophic health events. UPMC recommended that every hospital in the country be a member of a healthcare coalition. While the U. S. Department of Health and Human Services has included coalition participation in its NHPP grant guidance, the agency has not yet assessed participation nationwide, according to agency spokeswoman Gretchen Michael.

UPMC recommends that federal grant programs require hospital participation in healthcare coalitions and that the government promulgate national guidance, goals, and metrics for their establishment. Once set up, coalitions should establish formal relationships to share situational-awareness data regionally and across state lines, the researchers said.

Members and administrators of existing healthcare coalitions have said they would prefer that members be able to determine the exact nature and administration of their allied groups.

Such coalition groups currently operate under one of two arrangements: either they sign a memorandum of understanding (MOU) or they form a governing body, such as a nonprofit corporation. The Southwest Idaho Coalition, for example, like the Twin Cities' Metropolitan Hospital Compact, is linked by MOUs. The Northern Virginia Hospital Alliance (NVHA), formed in the Washington, D.C. region soon after the 9-11 attacks and the anthrax letters, is a board-led corporation, funded through a combination of member contributions and federal government grants.

In each case, the day-to-day benefits of the coalitions include relationship development, planning, exercises, and savings on bulk procurement of stockpiled emergency supplies. In smaller coalitions, such as Southern Idaho's, resources are not stockpiled; instead, members simply make each other aware of their separate inventories and agree that they will be shared as needed. Any institution using them in an emergency either replaces the material or reimburses the donating institution, Drake says.

When major emergencies occur, however, the critical element of a medical surge effort is situational awareness—in particular: the number of victims, their locations, and the nature and severity of their injuries; available beds and locations; staffing needs and

available medical personnel; and equipment needs and locations. To achieve that situational awareness, groups know that they need to develop near-real-time information-sharing tools. Getting that done is already a prerequisite for receiving NHPP funding, and states are trying various ways of meeting that requirement.

Minnesota has instituted the Minnesota system for Tracking Resources, Alerts, and Communication (MnTRAC), a Web-based database. At its core, the system is maintained to show bed availability accurate to within 30 minutes, but it also offers data on victims, staff, equipment, and events themselves, says Aggie Leitheiser, director of emergency preparedness for the state Department of Health. Each hospital inputs the relevant information in case of an incident. Like the state's overall public health system, this system is administered based on seven regions, with individual hospital data accessible only to designated regional administrators.

For Minnesota's Metropolitan Hospital Compact, the first operational benefits of MnTRAC came during 2007's I-35W bridge collapse, when the area's hospitals successfully used the system to fill staffing needs and share command information. More recently, the state has expanded the system to include mental health and assisted-living facilities.

The Commonwealth of Virginia maintains a statewide bed-tracking system, the Virginia Hospital Alerting and Status System (VHASS), which is updated by facilities whenever the state's Department of Health issues a data call. In addition to the statewide system, the 13-hospital NVHA operates its own data tracking system through its Regional Hospital Coordinating Center (RHCC), which operates around the clock. It is handled during business hours directly by NVHA. Nights and weekends are handled by the firm that manages regional helicopter medevac services, says NVHA Executive Director Zachary Corrigan.

The RHCC's emergency function activates when an incident meets any of several "trigger" criteria, such as 10 or more victims, victims transported to three or more hospitals, or certain hazmat events. As with VHASS, during a mass casualty event, RHCC contacts hospitals over the region's public safety radio networks. Member hospitals have 10 minutes to provide the RHCC with bed availability data, and as an incident develops, information on the needs and status of individual victims.

Southwest Idaho's coalition relies on the Idaho Hospital Bed Tracking Program, maintained by the state's Department of Health and Welfare, which is updated at least daily by individual hospitals.

While hospitals throughout Idaho can view regional data on the Bed Tracking Program, data is not always as current as that on systems like Virginia's. During rapidly unfolding emergencies in Idaho, Drake says that she and her counterparts at other hospitals rely on more traditional forms of communication, such as conference calls, which she says illustrates the need for establishing trusted relationships well before incidents occur.

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