Department of Health and Human Services

Nevada State Health Division

Emergency Preparedness Summit

Final Report

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I. Introduction

"On August 23, 2010 at about 2:30 p.m. a truck, transferring hydrochloric acid into the tanks of the Fallon, Nevada water treatment center, spilled approximately 10,000 gallons of the highly corrosive substance onto the treatment facility floor. Personnel immediately evacuated the building and locked it down.

"The City declared a state of emergency. Churchill Volunteer Fire Department and Naval Air Station Fallon Federal Fire Department crews arrived as first responders. A hazardous materials crew arrived on site and soon joined by the Churchill Community Hospital and Emergency Management Services. Surrounding cities and counties delivered fire department crews and other emergency assistance.

"With a population of approximately 8,500, the City had reason to be concerned. Since Fallon uses well water, contamination was a serious issue.

"Emergency crews cleaned up the spill, saving the City's water supply. There were no serious injuries. Various agencies within and outside Churchill County handled the emergency quickly and efficiently. Many involved in the emergency attributed the success of the operation to efforts over the last decade to bring a common language of emergency preparedness, procedures and communication to all emergency responders."

- From the Gap Analysis of Emergency Preparedness in Nevada's Rural Counties, NV State Office of Rural Health, University of NV School of Medicine, Reno NV, June 2011

Public Health Emergency Preparedness is a growing concern across Nevada and the entire United States. When emergency situations occur like the one described above, collaboration is required across federal, state, county and tribal agencies in order to mitigate disaster. Volunteers are called upon for aid and unless advance preparations are made, disasters can quickly become catastrophic events. Recognizing the need for more emergency preparation and training, especially for Nevada's rural counties, the Nevada Department of Health and Human Services, Nevada State Health Division organized the state's first Public Health Emergency Preparedness Summit for rural counties.

The Summit was held on May 30-31, 2012 at the Fallon Convention Center, Fallon, NV. The goals of the Summit were to create awareness of the role that the Nevada Division of Health plays in an emergency and the resources that the state can provide to counties when faced with an emergency. A further objective was for counties to work together to start to identify gaps in their emergency preparedness plans and discuss how to rectify those deficiencies.

The highlight of the Summit was the breakout session where attendees were divided into groups and were able to work through real life emergency scenarios. The composition of

the breakout groups allowed the participants to interact with and learn from colleagues from other counties.

The Planning Committee wanted to ensure that the attendees had ample opportunity to interact not only with speakers and Division of Health staff but also with each other, tribal attendees and public officials. Therefore, special breakout sessions were included on both days when attendees could network with each other as well as invited elected officials and state and federal emergency personnel. Attendees were able to hold meaningful conversations with State Senator Don Gustavson, Corinne Corson, Emergency Management Specialist from the U.S. Department of Health and Human Services, and Eugene Ripper, Public Health Analyst, Hospital Preparedness Program from the U.S. Department of Health and Human Services as well as several local elected officials.

The response to the Summit was overwhelmingly positive. A total of one hundred people attended the Summit representing 13 of the 14 rural counties invited. Attendees noted on Summit Evaluations appreciation for receiving emergency preparedness information but also for the opportunities provided to collaborate with other emergency responders across the state. Presentations and breakout session scenarios facilitated discussions among participants regarding lessons learned, resources available and gaps in local plans.

Attendees left the Summit enthusiastic about delivering information to their local communities and reviewing local plans to further identify gaps and work on solutions. Participants also indicated a desire for the state to provide on-going activities to help maintain momentum and offer support for continued improvement in emergency preparedness.

II. Objectives of Summit

When the Summit Planning Committee began meeting in January 2012 there was much enthusiasm for the topic of emergency preparedness as well as varying opinions about the focus of Summit topics. The Committee was comprised of sixteen state, county and tribal representatives. Meetings were held at the Nevada Public Health Foundation Offices in Carson City with call-in capability for those who could not attend the meetings in person.

The Committee began with a working document to organize their thoughts on goals, objectives and outcomes for the Summit. Over the next few months the Committee worked to refine the goals and objectives for the Summit. The overarching goal of the Summit was to create awareness among the rural counties regarding the role of the Division of Health in preparing for and responding to an emergency.

Additional objectives for the Summit were to:

- Clarify what constitutes a Public Health Emergency
- Review types of Public Health Emergencies and what Public Health staff provides at local levels
- Strengthen awareness of Public Health roles in emergencies and medical disasters
- Raise awareness of gaps in current emergency plans
- Build consensus among tribes, rural and state for working together in emergencies
- Raise awareness of the need for volunteers to register
- Provide information to help counties recognize the need to review emergency plans

III. Summit Planning Committee

Please see Attachment Seven for a list of the members of the Summit Planning Committee.

IV. Logic Model

In order to effectively outline the strategies and projected outcomes/impacts of the Summit, and to clearly communicate those to stakeholders upon completion of the Summit, the Planning Committee developed a Logic Model. This is a graphical representation of the relationship between resources, goals, activities and projected benefits. A Logic Model provides an outline for the sequence of events as well as a way to gauge end results.

Beginning with the finalized Objectives agreed upon by the Committee, Activities, Outputs, Actual Outcomes and Impacts were identified. Items listed in the subsequent columns flow from and link to specific Objectives.

In the chart below the numbered objectives in column one serve as the foundational goals for the Summit. The activities in column two are numbered to indicate which objective(s) each activity is directed toward. The same is true for the remaining columns.

OBJECTIVES	ACTIVITIES	OUTPUTS	OUTCOMES	IMPACT
1. Clarify what constitutes a Public Health Emergency. 2. Review types of Public Health (PH) emergencies and what PH staff provides at local levels. 3. Strengthen awareness of PH role in emergencies and medical disasters. 4. Raise awareness of gaps in current emergency plans. 5. Build consensus among tribes, rural and state for working together in emergencies. 6. Raise awareness of need for volunteers to register. 7. Provide information to help counties recognize the need to review emergency plans.	1,2,3 Emergency defined and further detailed regarding PH emergencies. Overview and handouts of NIMS Field Guides provided. 4,5,6,7 Presentation and handouts provide general conclusions regarding common gaps across NV. Hands-on activity working together through scenarios brought to light NV gaps and need for communication and unified response. 6 Volunteerism and need to register discussed. 1,2,3,4,5,6,7 Scenario discussions, summit summary/materials provide momentum for counties to review plans and work with others.	1,2,3,4,5,6,7, Handouts and presentation materials distributed for individuals to take back for local level dissemination. 3,5,6 Scenario templates create lists that identify gaps. Working with others across tribes, rural and state provides opportunities to learn from others. 3,5,6 Discussion within breakout sessions facilitates recognition of gaps. 3,6,7 Info provided on volunteer organizations and forms available to register and take for further dissemination.	1,2,3,4 Attendees are able to describe PH emergencies. 1,2,3,4,5,6 Attendees are aware of resources available to assist in PH emergencies. 5,6,7 Presentation and breakout materials identify any gaps in local plans. 4,5 Breakout sessions spur discussion regarding ways to bridge gaps in emergency plans. 1,2,3,4,5,6 Tribal, rural and state communications and cooperation established. 6,7 Awareness generated for Volunteers to registered. 1,2,3,4,5,6,7 Participants leave with materials to provide at local level for review of local plans. 1,2,3,4,5,6,7 Next steps identified to build and strengthen local response in emergencies.	**CURRENT IMPACT:** 1,2,3.4 PH recognized as a resource in emergencies. 3,4,5,6,7 Collaboration established among tribes, rural and state for working together in emergencies. **FUTURE IMPACT:** 1,2,3,5,6,7 Gaps in local emergency plans identified and improvements made at local level. 2,7 Emergency workforce capacity increased. 1,2,3,4,5,6,7 Sustainable and collaborative Emergency plans in place with engaged stakeholder involvement. 1,2,3,4,5,6,7 Statewide emergency preparedness enhanced. 1,2,3,4,5,6,7 Fewer lives lost due to poor emergency preparedness.

V. Summit Presentation Summaries

The following is a summary of the sessions presented during the Summit.

Day One

From the beginning, the overarching aim of the Committee was to provide a high-level view of Public Health Emergency Preparedness in rural and frontier Nevada counties. Since this was the first Summit of its kind it was understood that some of the topics offered would need to be very basic in order to remove some of the pre-conceived notions that surround emergency preparedness in general. Defining emergency preparedness as it relates to Public Health was paramount since not even all the Committee members clearly understood the role Public Health plays in this arena.

Summit attendees were warmly welcomed by Mary Liveratti, Agency Administrator for the Division of Aging and Disability Services. Ms. Liveratti thanked the audience for their participation in this important event and set the stage for the Summit's agenda.

The logical place to kick off Summit presentations was with a panel discussion by Public Health representatives, JoAnne Malay, Health Program Manager II, Nevada State Health Division, Erin Seward, Nevada State Immunization Program Manager, Nevada State Health Division and Tami Chartraw, Administrative and Programs Manager for the Public Health Preparedness Program for the State of Nevada's Health Division. The panel spoke to what constitutes a Public Health Emergency and how Public Health is at work to help prevent medical crises. As pointed out in the panel presentation, "the role of Public Health is to promote physical and mental health and prevent disease, injury and disability." Highlighting Public Health's role in disasters helped build awareness of the often behind-the-scenes work performed by Public Health agencies such as administering immunizations, hospital and healthcare facility capacities and duties performed by community health nurses.

Second on the agenda was a presentation by Chris Smith, Chief, Nevada Department of Public Safety, Division of Emergency Management/Homeland Security (DEM), Homeland Security Advisor to Governor Sandoval. Mr. Smith cited the duties and responsibilities of the DEM as they relate to public safety and federally mandated emergency preparedness. This presentation helped to differentiate Public Health Emergencies and the DEM's Emergency and Disaster Operations.

After a short break, Tami Chartraw, Administrative and Programs Manager for the Public Health Preparedness Program for the State of Nevada's Health Division addressed the topic

"Hospital Preparedness as part of Community/Local Response." Ms. Chartraw's presentation highlighted Public Health and Healthcare preparedness capabilities and noted the importance of strengthening Healthcare Coalitions.

The Summit Steering Committee felt it crucial to include speakers in the program who could address specific real-life emergency responses from recent Nevada disasters. Day One's lunch-time presentation was hosted by Ron Juliff, Churchill County Emergency Manager and Steve Endacott, City of Fallon Emergency Manger. The disaster covered in this topic was the June 24, 2011 Amtrak-Truck Collision near Trinity Crossing. Playing an important part in the successful management of this incident was the full scale operational exercise conducted seven weeks prior to the train wreck. Being prepared for such a disaster made it possible for emergency responders to work together effectively and mitigate the situation quickly and efficiently.

Gerald Ackerman from the Nevada State Office of Rural Health, University of Nevada School of Medicine was the first afternoon speaker. He addressed the topic "Raising Awareness of Rural Preparedness." Mr. Ackerman pointed out the Health Care Service Providers for rural Nevada and noted that much of Nevada is considered "frontier" since many rural Nevadans live far from population centers with large healthcare facilities. This topic spoke to the struggles faced by remote areas to be adequately equipped for large scale emergencies. Mr. Ackerman noted that for Nevada, particularly in remote areas, some gaps exist in local emergency plans. He reviewed gaps typical to Nevada and highlighted areas for improvement.

The focus of "Tribal Emergency Preparedness" was addressed by Daniel Thayer from the Inter-Tribal Emergency Response Commission. Mr. Thayer spoke to the need for counties, tribes and state to work together in preparing for and executing emergencies. He pointed out that for Nevada Tribes, funding is being made available to assist with training exercises and equipment caches. In addition, partnerships are being formed among the tribes, counties and local organizations to plan for and aid one other during times of crisis.

An extended break time was provided in Day One's afternoon segment to allow attendees to meet and connect with each other as well as the elected officials and federal representatives also in attendance. Among those present were State Senator Don Gustavson, Corinne Corson, Emergency Management Specialist from the U.S. Department of Health and Human Services, and Eugene Ripper, Public Health Analyst, Hospital Preparedness Program from the U.S. Department of Health and Human Services.

Another real-life emergency presentation was made by Washoe Tribe Representatives, Larry Manning, Ruby Manning and Rozilyn Jones. The focus of this discussion was the Murphy Complex Fire of 2007 on the Duck Valley Indian Reservation and surrounding areas. The

lightning-caused fire became a complex event when three large fires converged; the Elk Mountain Fire, the Rowland Fire and the Scott Creek Fire. The total area burned was 680,000 acres. Adding to the seriousness of this disaster was the fact that some areas became completely closed off by the fire. Many were without electricity, water and waste water systems for extended periods. Since the fire occurred in July, extreme heat also became an issue for humans and animals. The local tribal staff was utilized for incident command and this group managed disaster relief as well as maintaining communication with individuals in fire damaged areas. Lessons learned from the event included the need for crisis intervention by clinical staff. Because of the remoteness of the area, local response was the only source of aid for up to 72 hours. An important outcome of this event was the recognition of the need to reach out to farther locations for help during emergencies.

Closing out Day One was David Fein, Project Manager, Interoperable Communications with the Department of Public Safety, Division of Emergency Management. Mr. Fine defined Interoperable Communications and outlined the organizational structure of statewide emergency communications. The National Emergency Communications Plan (NECP) was presented and Nevada's progress in meeting federal standards was summarized. One particular point of interest to attendees was learning about the state's "SatComm Vehicles." These are vehicles that can be mobilized to disaster areas to provide a communication translation source for the various emergency response teams. Often each group responding to an emergency has its own communication frequency and may not communicate with other teams onsite. The SatComm Vehicle serves as an invaluable tool to aid responders in working together effectively.

Day Two

Day Two began with a presentation on "Building Volunteer Capacity" by Wendy Luck, State ESAR-VHP and MRC Coordinator, Nevada State Health Division. Ms. Luck outlined the need to build community resiliency by enhancing Nevada's Emergency System for the Advanced Registration of Health Care Professionals Registry. A well-maintained registry allows volunteers to be properly identified, screened, credentialed and trained. Registered volunteers are crucial to providing timely and qualified aid in disaster situations. Ms. Luck provided information about the registry and volunteer opportunities as well as hard copy registration forms for participants to distribute in their local areas.

High on the priority list for Summit topics was breakout time for small group interaction to work through emergency scenario case studies. Significant time was devoted to this activity on Day Two. Two hours and forty-five minutes were spent in breakout sessions. Four groups were formed consisting of twelve to twenty people. Laura Valentine, Health Resource Analyst II, Nevada State Health Division provided each small group with a scenario and established the ground rules for participation. Ms. Valentine also made note of how the

groups would come back together in the afternoon to discuss how each scenario was executed. Groups were given specific questions to address and asked to comment in the afternoon large group meeting what went well and what lessons were learned as a result of their execution of the scenario. The end result was as the Steering Committee had hoped – the groups worked through scenarios using an incident command structure, they identified positive outcomes and noted certain gaps in the implementation of their plans. Please refer to Attachment Four for the Scenarios and discussion questions.

Day Two's lunchtime presentation was led by Nico Simponis, EMS Clinical Coordinator, Humboldt General Hospital. Mr. Simponis' discussion was focused on Humboldt General Hospital's (HGH) solution to rural healthcare, "Community Paramedicine." This concept was described as "the use of Community Paramedics in a "non-traditional" expanded role, within the community in an effort to connect an underserved population with underutilized resources." Since approximately 25% of the US population is in rural areas and nearly 90% of physicians are located in urban regions, Community Paramedicine can make a difference in providing care for a largely unreached segment of individuals.

Dr. Ellen Clark, Forensic Pathology, Washoe County Chief Medical Examiner and Coroner was the last large group presenter. Dr. Clark and her colleague, Karen Brown, spoke to Summit attendees about the Washoe County Medical Examiner's Mass Fatality Plan, the Mission and Vision of the Coroner's Office and the various capabilities and tools available in the event of a mass fatality incident. Dr. Clark noted that the work of the ME/Coroner's Office is often overlooked as part of emergency response since much of their work is done when all the other responders have left the scene.

Please see Attachment One for the Summit Program which includes Speaker Bios, Attachment Two for Speaker Presentations and Attachment Three for Scenario Breakout Materials.

VI. Summit Outcomes

The Nevada Public Health Emergency Preparedness Summit resulted in several positive outcomes. They are:

Information and Education

- Attendees gained an understanding of Public Health's role in emergencies.
- Attendees were provided documentation outlining federal standards for emergency preparedness plans.

- The role of Public Health Preparedness in an emergency was defined.
- Various roles and responsibilities during emergencies were identified and described.
- Current events regarding Tribal Emergency Preparedness were discussed.
- Rural Preparedness was defined.
    - Circumstances unique to Nevada were identified:
        - Large percentage of rural areas
        - High number of remote/frontier counties
        - Low statewide population means low funding
        - Lack of medical facilities and personnel in remote areas
- Real Life Nevada Disaster presentations were given.
- Lessons learned from Nevada emergencies were discussed. These include:
    - The value of Memorandums of Understanding (MOU's) between counties, tribes, state and other provider organizations
    - The importance of emergency training exercises
    - The necessity of clear communication among responder groups
    - That a well organized Incident Command System makes the event run more efficiently
    - Schools provide excellent evacuation shelters
    - A designated central command post with phone and internet capability assists with the flow of information and validation
    - Emergency Operations Center phone systems may be inadequate and should be evaluated for updates
    - Direct contact by cell phones during an emergency can result in redundant requests for resources
    - Nearby resources may not be available during a large and prolonged emergency such as the Murphy Complex Fire so establishing MOU's with areas beyond close proximity is important
    - The extent of an emergency situation may not be realized early on and that can limit the availability of state and federal resources
    - The importance of caring for emergency personnel especially during extended emergencies
- Interoperable communication resources were identified:
    - Four Core Radio Systems tied together by Session Initiation Protocol
    - Four County Ethernet Microwave Links
    - Cross Band Repeater System
    - 16 Interoperable Communications Talk Groups
    - Clark County Microwave Interconnection
    - NV Dispatch Interconnect
    - SatComm Vehicles

    - Radio Caches around the state
- Awareness of the role of the state medical examiner/coroner was expanded.
- State and local program resources were identified:
    - SERV-NV (State Emergency Reserve Volunteers)
    - ESAR-VHP (Emergency System for the Advanced Registration of Health Care Professionals Registry)
    - MRC (Medical Reserve Corps)
    - HAN (Health Alert Network)
    - Community Paramedicine
    - Statewide Immunization Program
    - Community Nursing
    - ASPR HPP (Office of the Assistant Secretary for Preparedness and Response Hospital Preparedness Program)

Bridging Gaps

- A presentation was given by Gerald Ackerman about Nevada Rural Preparedness and typical gaps identified in the state.
- Gaps in local plans were identified in the breakout sessions as participants worked through scenario situations during Day Two.
- Discussion within the group sessions and during break times provided additional time for conversations with others about local gaps and ways to bridge those gaps. Some of the ways gaps identified to bridge gaps include:
    - Regular training exercises
    - Registered volunteers in place
    - Local pharmaceutical supply caches audited and updated
    - Properly maintained response equipment
    - Funding to augment medical supplies and equipment
    - Establishing MOU's for aid during an event
    - Updating communication equipment and training
    - Connecting with other responders and exchanging lessons learned
    - On-going education regarding state and federal resources available
- Collaboration was established between tribal representatives, state, federal and county level attendees.
- Individuals expressed the need and desire to broaden their connections in order to be better prepared themselves for emergencies.
- Attendees conversed about ways to serve as a resource to each other.
- The value of MOU's between counties, tribes, state and others was discussed.
- Murphy Complex Incident brought to light specific gaps in local plans such as:

- State of Emergency was requested but delayed because the seriousness of the incident was not understood
- Incident Command System didn't work efficiently at first due to lack of communication
- Lack of available equipment – Command center was dependent on electricity but no backup generator was provided in emergency preparedness plan
- Local MOU's were useless since all local areas were affected. Need for MOU's in extended areas was noted

Volunteerism

- Volunteerism was outlined and promoted.
- The benefits of registered volunteers were emphasized.
- Attendees were given volunteer registration materials.
- Attendees were provided with contact information for volunteer registry personnel who could assist local areas with the registration process.

Networking and Collaboration

- The Day One "Meet and Greet" extended break allowed time for attendees to interact with state and federal representatives, elected officials, leaders in public health emergency preparedness and other Summit participants.
- Opportunities to connect with others were provided during breaks and lunchtimes.
- Collaboration within breakout sessions gave opportunities for working with individuals from other regions and from various healthcare disciplines.
- Interaction with county commissioners helped attendees see them as a resource instead of a political hindrance during emergencies.

Summit participants left encouraged, taking back what they learned with the intention of reviewing and improving their local emergency plans. Additionally, Summit participants expressed interest in the following:

- Additional Summits of this type
- Training for hands-on emergency preparedness
- A statewide newsletter to keep local areas abreast of news, resources and training opportunities
- Table-top exercises
- On-going provision of Emergency Preparedness Materials
- Assistance with creating MOU's between counties, tribes and organizations for aid during emergencies

- Assistance for funding and medical supplies
- Enhancing Interoperable Communications to the 2013 standard
- Other areas of focus were recognized as needs for future emergency preparedness events
    - Mental Health
    - Psychological First Aid
    - Special needs populations
        - Children
        - Elderly
        - Persons dependent on medical technology
        - Persons with disabilities
        - Chronic medical conditions
        - Pets
        - Farm/Ranch animals
- Additional groups and organizations were named for inclusion in future events
    - Churches and other religious organizations
    - NDOT
    - NHP
    - Coalitions
    - Latino Groups

Summit participants were provided many physical resources during the two day conference. The items provided included:

Summit gift bags

- Federal standard NIMS Incident Command System Field Guides
- Emergency Preparedness for People with Functional Needs flyers
- Pandemic Flu and Hygiene Checklist
- Incident Command System Booklet
- EMS Conference Post Card
- "Wash Your Hands" Note Pad
- Grab & Go Safety Tube Kit containing
    - Drinking Water
    - Light Stick
    - Emergency Whistle
    - Medical Gloves (1 pair)
    - Adhesive Bandages (4)
    - Antimicrobial Hand Wipe
    - Cleansing Hand Wipe

Summit Packet Information Provided

- Summit packet items included:
  - Summit Programs describing
    - Day One and Day Two Summit Schedules
    - Day One and Day Two Notes Sections
    - Speaker Bios
  - Copies of the PowerPoint presentations
  - Emergency Preparedness Checklist (English and Spanish Versions)
  - An Overview of the Office of the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program (HPP)
  - "What to Do After a Fire" Brochures
  - Pandemic Flu and Hygiene Brochures
  - Summit Evaluations

Items Available in Conference Center Lobby

- Items available for individuals to take as desired included:
  - Information on the Nevada State Immunization Program
  - Interoperable Communications Information
  - "Rural Health Care, an Overview" Brochures
  - Public Health and Clinical Services – SERV-NV Registry Applications
  - Autistic Rescue: Firefighters teach how to help autistic people in emergencies.
  - CDC Emergency Response Guides
  - HAN Brochures
  - Quick Series reference guides for various groups including
    - Nurses
    - Fire chiefs
  - Hand Washing Procedure Posters
  - Emergency Purified Drinking Water Flyers
  - Emergency Purified Drinking Water Can Banks

VII. Next Steps

Since this Summit was the first of its kind for the state, it serves as a foundation for future work in the area of Public Health Emergency Preparedness. While information was collected and connections were made at the Summit, follow up activities with Nevada's rural and frontier counties should be implemented without delay to maintain momentum

for improved emergency preparedness. While it is easy to provide a laundry list of "action items" that the state could do to maintain momentum, a more effective next step would be for the Division of Health to hold a planning session where they outline their role with regard to the rural counties, how they would like to interact and communicate with the counties on an on-going basis, and prioritize the types of interaction that will provide the greatest "bang for the buck."

Development of a Communication Plan is essential. As part of this process, the state can review the types of next steps that were expressed by counties at the Summit, determine which of these activities fall within the purview of the Division and create a cohesive implementation schedule for each.

Action items that capitalize on the momentum gained from the Summit and address suggestions of participants include:

- Communication and Collaboration:
  - Develop and distribute a quarterly statewide rural Public Health Emergency Preparedness Newsletter containing:
    - Upcoming events
    - Tips for improving local plans
    - Resource contact information
  - Send out bi-weekly emergency preparedness email summaries.
  - Utilize Social Media.
    - Facebook
    - LinkedIn
    - Twitter
    - Emergency Preparedness weekly blog post
    - Dynamic statewide preparedness website
  - Coordinate networking events for federal, state, local and elected officials to connect with local responders, firefighters, nurses, EMS, hospital representatives, volunteers, etc. for collaboration and exchange of best practices.
  - Engage special populations experts to keep local areas abreast of needs and developments within these groups.

- Direct Assistance:
  - Coordinate monthly calls with state, county and tribal representatives to address a set of objectives aimed at leading the counties and tribes through the emergency planning process.

- Conduct informational calls in which the state provides updates on Public Health Preparedness information, trends, changes, new resources, etc.
- Schedule roundtable calls for participants to call in to discuss specific topics.
- Perform low level local preparedness assessments.
- Promote volunteerism and provide onsite registration assistance.
- Provide assistance for building community healthcare coalitions.
- Collect and distribute information regarding resources available in various areas of the state for use during emergencies.
- Engage other groups and organizations (religious, state, private, tribal, military, etc.) to collaborate with local groups for training and sharing of resources.
- Coordinate Coroner presentations at county level.

- Training:
  - Establish priorities for developing training courses and exercises.
  - Investigate existence of courses already available.
  - Obtain / develop course content.
  - Identify training resources.
  - Determine best format for training (web-based, onsite, regional workshops, etc.).
  - Locate training facilities and equipment.
  - Set training schedule.
  - Publicize training.
  - Coordinate training activities.
  - Evaluate training success.

- Statewide and regional summits:
  - Establish planning committee.
  - Determine objectives.
  - Enlist speakers.
  - Secure conference site.
  - Provide materials.
  - Organize logistical requirements.
  - Publicize event.
  - Coordinate summit activities.
  - Evaluate.

VIII. Evaluation Summary

Evaluations for any conference are important for gleaning a broader perspective on what participants really think about various aspects of the meeting. This Summit's evaluations provided a wealth of insight and highlight several items of note.

First of all, a total of 50 evaluation forms were returned indicating that 50% of attendees took time to fill out the forms. Response rates for evaluations vary drastically. In the United States, typical surveys/evaluations ask ten or fewer questions[1] (the Summit Evaluation asked 18) and the response rate can be as low as 10-15% depending on the motivation for respondents to reply. Based on prior experience, receiving input from 50 individuals out of 100 attendees represents a high percentage of responses for this type of evaluation feedback.

Second, the evaluations were overwhelmingly positive about the Summit. Most respondents indicated they appreciated the information, the speakers and the facilities as well as the agenda and overall flow of the Summit activities. Comments included appreciation for the handouts, gift bag materials and extra information provided in the lobby.

The third item of note is that there were a lot of extra comments along with the agree/disagree checkbox answers. It is unusual to have so many handwritten comments on an evaluation form. This indicates that Summit attendees are keenly interested in Public Health Emergency Preparedness and have a desire to help improve future endeavors in this area.

Please see Attachment Six for an overall summary of the evaluation results along with attendee comments. Original copies of the submitted evaluations will be included with the hard copy Summit Report on file with the Nevada State Health Division.

[1]Jackie Antig, *SurveyMonkey: Average number of questions asked in a survey*, (January 2012)

IX. Facilitation and Conference Support

For the planning and execution of the Summit Activities two organizations were hired by the State: QuantumMark, LLC for Summit Planning and Facilitation and the Nevada Public Health Foundation for Conference Logistical Support. The tables below outline the scope assigned to each organization and the accomplishments achieved.

QuantumMark, LLC

Scope	Accomplishments
I. Planning for the Summit: a. Participate in pre-summit planning meetings with Public Health and Clinical Services and community partners that are chaired by Laura Valentine from the Health Division	QuantumMark developed the agenda for six pre-summit planning committee meetings and served as facilitator for the meetings.
b. Facilitate development of summit agenda, training exercises, breakout sessions, and overall flow of summit activities to meet summit objectives.	QuantumMark worked with Laura Valentine and committee members to define and later refine the over-arching objectives for the summit. These objectives served as the foundation for the more comprehensive Logic Model developed to provide the flow and organization of the summit activities. Breakout session details, speaker topics and talking points were facilitated by QuantumMark in these meetings along with finalization of the summit agenda, presenters, informational materials to be distributed, provision of networking opportunities and the scenario exercises.
II. Summit Facilitation: a. Facilitate discussions on known gaps in emergency preparedness at the county and state levels and possible ways to bridge the gaps.	Much discussion was given to this goal during planning sessions. It was determined that subject matter expert, Gerald Ackerman would deliver a presentation about the known gaps common to Nevada (as noted in the 2011 "Gap Analysis of Emergency Preparedness in Nevada's Rural Counties" prepared by the Nevada State Office of Rural Health, University of Nevada School of Medicine, Reno, NV). This presentation would give the foundation for discussions during breaks and in the small group scenario sessions. Discussions and presentation regarding gaps and ways to bridge them were facilitated by QuantumMark.
b. Build consensus for the roles of	QuantumMark conducted research to gain

Scope	Accomplishments
participant organizations during a health emergency that meet federal guidelines.	understanding regarding federal emergency preparedness guidelines and assisted the planning committee in ensuring that federal guidelines were defined and appropriate handouts and materials were provided for attendees. The roles of various participant organizations were presented in the agenda topics and ways to work together during emergencies were outlined. QuantumMark facilitated the presentations and oversaw group discussions.
c. Build consensus for a set of action items that participants will take following the summit.	Working with the planning committee to prepare objectives and projected outcomes for the summit, QuantumMark gave direction for the summit presentations that would address action items to be taken by participants after the summit. QuantumMark also assisted in providing discussions with attendees and presenters regarding what action steps are needed for follow up in local areas.
III. Wrap up and debrief: a. Conduct one post-summit meeting with planning committee to review the strengths and weaknesses of the summit and discuss content of summit report.	QuantumMark met with the summit planning committee on June 14, 2012 to discuss and evaluate summit activities and how the committee's objectives were met. QuantumMark provided the committee with a summit report template and gained agreement on the format and relevant points to be included.
b. Conduct one meeting with planning committee to review draft of summit report.	QuantumMark met with the summit planning committee on July 11, 2012 and presented a walk-through of the draft summit report. QuantumMark facilitated discussion and gathered feedback for finalizing the report.
c. Conduct one meeting to present final summit report to the planning committee for approval before the State posts it to the website and distributes to summit participants.	QuantumMark met with the summit planning committee on July 20, 2012 and delivered a hard copy final report along with summit evaluations, scenario activities and other documentation from the summit. Electronic copies of the final report and all attachments were also provided.
IV. From discussion to paper documenting the plan: a. Prepare a draft summit summary document capturing the key discussion points, agreements and action items.	QuantumMark prepared a draft document summarizing the summit key discussion points, agreements and action items.
b. Finalize the summit summary	QuantumMark utilized the feedback from the

Scope	Accomplishments
document based on the feedback from the planning committee.	summit planning committee to finalize and submit the comprehensive summit summary document.

Nevada Public Health Foundation (NVPHF)

Scope	Accomplishments
I. Plan for the Summit: Planning Session Pre-Work: a. Participate in pre-summit planning meetings with Public Health and Clinical Services staff and community partners to develop summit agenda, training exercises, breakout session, and overall flow of summit.	NVPHF participated in all pre-summit planning committee meetings and gave input in the development of the summit agenda, training, breakout session and flow of the summit.
b. Conduct all logistical activities which include: copying of all needed materials, purchasing of summit supplies, obtain space for summit, coordinate services of national speakers.	NVPHF performed all background support for the execution of the summit. These activities included but were not limited to: 1) locating and securing summit facilities, 2) researching and hiring caterers to provide breakfasts and lunches for the 2-day summit, 3) finding and purchasing healthy snacks for breaks, 4) collecting speaker bios and resumes for documenting and offering CEU's for attendees, 5) organizing and creating the summit brochure, 6) copying all speaker presentation materials and inserting them into individual packets for distribution, 7) researching and purchasing summit gift bags and items of value to include in bags, 8) coordinating summit online and registrations and updating website information to assist with registration, 9) arranging for registration tables and name tags for attendees at the summit, and 10) organizing and fulfilling summit speaker and attendee reimbursements as applicable.
c. Participate in post-meetings with Public Health and Clinical Services staff and community partners to prioritize next steps.	NVPHF actively participated in all post-summit committee meetings and provided input and evaluation regarding the summit activities, goals, objectives and next steps.
II. Wrap up and debrief: a. Conduct post facilitation meeting to ensure satisfaction with planning process, obtain feedback, and determine next steps.	NVPHF, along with QuantumMark, met with the Health Division to provide final debrief of summit activities, obtain feedback and determine next steps.

X. Author Qualifications

QuantumMark is a certified Women Owned Business by the National Women Business Owner's Corporation (NWBOC). The Company's Principals have over two decades of experience providing consulting service to the public sector assisting agencies to make break-through improvements in their ability to serve their customers. QuantumMark excels in turning strategies into reality through well constructed projects that achieve the desired results; on time and on budget.

Areas of expertise include:

- Capacity planning
- Organizational design
- Change management
- Facilitation
- Implementation planning
- Implementation oversight
- RFP development
- Reengineering and process improvement
- Assessments
- Project audit
- Strategy execution
- Project planning
- Project management and mentoring

Customers include the National Cancer Institute; Departments of Health in Alaska, Arkansas, Georgia, Nevada, Oregon, Pennsylvania, and Tennessee; Nevada Departments of Motor Vehicles, Wildlife, Health and Human Services and Personnel.

QuantumMark was engaged by the Department of Health and Human Services, Nevada State Health Division to provide facilitation for the Public Health Emergency Preparedness Summit that took place in Fallon, NV on May 30-31, 2012. The Scope of Work (SOW) for the project included facilitating six Summit Committee planning sessions, working behind the scenes with state and community partners to complete activities leading up the Summit and facilitation of the two-day Summit. QuantumMark was responsible for introducing presenters, facilitating the Summit activities, summarizing agenda topics and helping to provide an environment to build consensus for action items that participants would take following the Summit.

The final deliverable items for the project include wrap up and debrief with the Summit committee, submitting a final report draft and gathering feedback, modifying the final report based on the committee's input and submission of the completed final Summit Report.

XI. Attachments

Attachment One: Summit Program

Attachment Two: PowerPoint Presentations

Attachment Three: Breakout Session Scenarios and Questions

Attachment Four: Attendee List

Attachment Five: Press Release and Media Coverage Samples

Attachment Six: Evaluation Summary and Comments

Attachment Seven: Summit Planning Committee

Attachment One: Summit Program

Public Health Rural Emergency Preparedness Summit

May 30 and 31st, 2012

Presented by:
Nevada State Health Division

Hosted by:
Nevada Public Health Foundation

Public Health and Clinical Services section of the State Health Division's mission is to make rural or "frontier" Nevada a safe and healthy place to live, work or visit. Frontier areas face many challenges in providing access to health and human services. The PHCS Program is here to help bridge the gap and over come barriers that frontier areas face in assessing quality care for rural Nevadans.

Schedule

Day One
Wednesday, May 30, 2012

9:00 a.m. - 9:30a.m.	**Registration/Check-in, Breakfast**
9:30 a.m. - 9:45a.m.	**Welcome**
9:45 a.m. - 10:30 a.m.	**"The Role of Public Health in Emergencies"** - Nevada State Health Division
10:30 a.m. - 11:00 a.m	**"Clarification and Definition of an Emergency"** - Christopher Smith, Division of Emergency Management and Homeland Security
11:00 a.m. -11:15 a.m.	**Break**
11:15 a.m. - 12:00 p.m	"**Hospital Preparedness as part of Community/Local Response"** - Tami Chartraw, Public Health Preparedness, State Health Division
12:00 p.m. - 1:15 p.m.	**Lunch** (Provided) Presentation by Fallon Emergency Management - Ron Juliff, Steve Endacott
1:15 p.m. - 1:45 p.m.	**"Raising Awareness of Rural Preparedness"** - Gerald Ackerman, University of Nevada, Reno School of Medicine
1:45 p.m. - 2:15 p.m.	"**Tribal Emergency Preparedness"** - Dan Thayer, Inter-Tribal Emergency Response Commission
2:15 p.m. - 2:45 p.m.	**Meet and Greet.** Time is provided for participant interaction with elected officials and other leaders in public health emergency preparedness.
2:45 p.m. - 3:45 p.m.	**"Murphy Complex Incident" -** Larry Manning, Ruby Manning, Rozilyn Jones, Washoe Tribe Representatives
3:45 p.m. - 4:45 p.m.	**Interoperable Communications"** - David Fein, Division of Emergency Management, Project Manager
4:45 p.m. - 5:00 p.m.	**Wrap-up and preview of next day schedule**

Schedule

Day Two
Thursday, May 31, 2012

8:00 a.m. - 8:30am	**Check-in/Registration, Breakfast**
8:30 a.m. - 9:00 a.m.	**"Building Volunteer Capacity"** - Wendy Luck, State Health Division
9:00 a.m. - 11:45 a.m.	**Scenario Activity Breakout Session -** Laura Valentine, State Health Division
11:45 a.m. - 1:00 p.m.	**Lunch** (Provided) **Presentation by EMS Humboldt General Hospital -** Pat Songer
1:00 p.m. - 1:30 p.m.	**"Washoe County Medical Examiner Mass Fatality Plan"** - Ellen Clark, MD
1:30 p.m. - 3:00 p.m.	**Panel discussion by county representatives. Topics may include:** Roles and responsibilities in community response Bridging the gap between response entities (tribal, rural and state) Communications Building capacity
3:00 p.m. - 3:15 p.m.	**Closing comments**
3:15 p.m. - 3:30 p.m.	**Complete and submit Summit evaluations**

Summit ends

Thank you for attending the 2012 Public Health Preparedness Summit

Day One - Notes

Meet and Greet: Please take this time to meet with fellow participants and any elected officials who might be present. Tables of information are set up for you to gather additional information on emergency preparedness or other services offered by the State Health Division and other partners.

Day Two - Notes

Breakout Discussion (guidelines)
This IS NOT a test of current capabilities or a critique of existing response, but rather:
- Make the exercise real for you/your group
- Use the knowledge and information available in your group
- Use active thinking, listening and participation
- Respect others in group - challenge ideas, not people
- Understand that people may come from other areas of the state but may have encountered the same situation, barrier, etc.
- All ideas/dialogue are welcome
- No hypothetical assumptions of resources or expectation of resolution

Purpose:
- Promote an understanding of the capacity to provide public health emergency preparedness in rural areas, including the role of public health
- Examine current policies, resources, capacity, etc.
- Promote a greater understanding to bridge the gaps between partners (rural, tribes, state)
- Raise awareness of the full capacity needed for a community-wide response
- Look at possible next steps in terms of training and exercises
- Understand the need to include at-risk/vulnerable populations

Biographical Sketches of Presenters
In Alpha Order

Gerald Ackerman, M.S.
Program Director Nevada AHEC System/Nevada State Office of Rural Health University of Nevada School of Medicine
Mr. Ackerman has served as the Program Director for Nevada AHEC in Elko, Nevada since 2011. Prior to that, he was the Deputy Director for the Center of Education and Health Services Outreach University of Nevada School of Medicine and the Associate Director Rural Programs, Nevada State Office of Rural Health. He serves, or has served, on numerous committees and advisory boards in Nevada since 1989.

Tami Kyburz Chartraw, MPA
Administrative and Programs Manager for the Public Health Preparedness Program for the State of Nevada's Health Division
Ms. Chartraw has a Master's of Public Administration in Health Administration and Policy and a background in the development, implementation and administration of healthcare information systems. She is certified in healthcare compliance and served as chief compliance officer for a large healthcare system.

Ellen G.I. Clark, MD
Forensic Pathology, Washoe County Chief Medical Examiner and Coroner
Dr. Clark s a physician specializing in Forensic Pathology, and was appointed Chief Medical Examiner and Coroner for Washoe County, Nevada in July of 2007. Her medical specialty and subspecialty trainings were completed at the Universities of Texas and New Mexico. She has resided in Reno, Nevada as a practicing forensic and hospital pathologist since July of 1989. As a forensic pathologist and medical examiner, Dr. Clark is responsible for consulting in and overseeing medical legal death investigations and postmortem examinations for Washoe County and many other counties throughout Nevada and northeastern California. Cases falling under the Medical Examiner's jurisdiction include unexpected, unusual, unexplained, unattended and traumatic deaths.

Biographical Sketches of Presenters Continued

Steven M. Endacott
Emergency Manager, City of Fallon
Mr. Endacott became the Emergency Manager for the City of Fallon in 1994, shortly after 20 years of service with the U.S. Navy. Mr. Endacott oversees the city's plans, preparedness and response capabilities. He works closely with Churchill County Emergency Management in efforts to provide a highly coordinated and well rounded suite of capabilities for the respective communities. He has facilitated several emergency drills and exercises, as well as responding to real world natural and man made disasters. As a side profession, Mr. Endacott has been a consultant for a variety of civilian and military projects. He was a Naval Aviator in A-7 Corsair, F-5 Tiger and F/A-18 Hornet aircraft. He holds a Bachelor of Science degree in Aero-space Engineering from the U.S. Naval Academy.

David Fein
Project Manger, Interoperable Communications
Department of Public Safety, Division of Emergency Management
Mr. Fein is an accomplished Microwave/Radio Frequency professional with over 25 years experience in all facets of the radio wave propagation field from design and development of components and subsystems to senior management of market leading companies. Most of his work has been with Aerospace/Defense and wireless communications, including infrastructure for cellular networks in the USA and around the world. In recent years, Mr. Fein has been involved in various facets of the wireless telecom industry. In his current assignment, he is responsible for overseeing approximately $32M worth of communications projects throughout the state. He holds an ASEE and BSEE in Electronics Engineering. He also has a wealth of experience with manufacturers and solutions providers in the communications arena. He is a native of Massachusetts and has lived in New Hampshire, Maryland, Virginia, Ohio and Nevada, with an overseas assignment for 2.5 years in Bordeaux, France. He considers Nevada home, and has lived here since 1998.

Biographical Sketches of Presenters
Continued

Rozilyn Jones
Property and Supply Specialist
Shoshone-Paiute Tribes
Ms. Jones has been employed by the Shoshone Paiute Tribes as Property & Supply Specialist for 19 years. She oversees the inventory of Fixed Assets, infrastructure, equipment and the procurement and equipment disposal system. She has been a member of the Tribal Emergency Response Commission since it began. Having worked under a tribal government system and a public health system, Ms. Jones is able to incorporate this knowledge and provide both with optimal services.

Ron Juliff
Emergency Manager
Churchill County
Mr. Juliff has served as the Emergency Manager for Churchill County, Nevada since April 2009. In this capacity, his responsibilities include ensuring compliance with Federal and State mandates, as well as, securing grants from various sources to fund the program. Mr. Juliff prepares and coordinates training and exercises with first responder agencies throughout the county. During actual emergency incidents he functions as the director of the Emergency Operations Center. He is also the Chairperson of the Local Emergency Response Committee (LEPC). Prior to assuming his Emergency Manager role, he retired as the County Manager for Inyo County, California. Mr. Juliff is an attorney admitted to practice before the Federal and California Bar. He holds a B.S. in Law and a Juris Doctor of Law degrees. He has held executive positions in both the electric utility and entertainment industries.

Wendy Luck
Stat ESAR-VHP and MRC Coordinator
Nevada State Health Division
Ms. Luck has been responding to disasters and emergencies for 12 years. She started her career in response while working on a movie about a small town and was introduced to others working in the fire department. In addition to firefighting, Ms. Luck obtained her EMT-Basic License and advanced to the level of EMT-I,99. Ms Luck was the technician in the Wyoming Medical Center, ER department. She was recruited to be the Natrona County MRC Unit Coordinator.

Biographical Sketches of Presenters Continued

Wendy Luck Continued
Upon completion of her Master's degree in Crisis and Emergency Management. Ms. Luck moved to Nevada where she serves as the State ESAR-VHP and MRC Coordinator. Ms. Luck believes volunteer service is key to survival and success in disaster response and is committed to the constant improvement of these systems in Nevada.

JoAnne Malay
RN, MPH
Manager Community Health Nursing Program and Rural/Frontier Public Health Preparedness
State Health Division
Ms. Malay plans, develops, implements and evaluates public health programs assigned to her unit.

Larry Manning
Retired, Former Facility Manager
Owyhee Community Health Clinic
Mr. Manning, was a member of the Tribal Emergency Response Commission on the Duck Valley Indian Reservation. He was the facility manager during the Murphy Fire Complex. He still serves on the Tribal Emergency Response Commission in the capacity of a Community Representative.

Ruby Manning
Firefighter/TERC Secretary
Shoshone-Paiute Tribes
Ms. Manning is one of the firefighters and serves as the TERC Secretary. She is the Citizen's Emergency Response Team (CERT) Trainer/Coordinator for the Tribe. This is a vital new team for future incidents on the Duck Valley Indian Reservation.

Biographical Sketches of Presenters Continued

Erin Seward
Nevada State Immunization Program Manager
Nevada State Health Division
Ms. Seward attended the University of Nevada, Reno and majored in Health Ecology while running on a full-ride scholarship in cross country and track. In 2007 Ms. Seward earned her Master of Public Health degree with an emphasis in Community Health from Oregon State University. She has been with the State Immunization Program since February 2009 as the WebIZ Manger and now the Immunization Program Manager. Additionally, Ms. Seward has worked in several areas of public health including HIV/AIDS, anti-tobacco, substance abuse and statutory rape prevention.

Christopher Smith
Chief, Nevada Department of Public Safety, Division of Emergency Management/Homeland Security, Homeland Security Advisor (HSA) to Governor Brian Sandoval
Mr. Smith leads the Nevada Division of Emergency Management/ Homeland Security (NDEM). He serves as the NDEM for the State Administrative Agency (SAA) and Governor's Authorized Representative (GAR). He is responsible for coordinating statewide emergency management efforts including planning, mitigation, preparedness, response and recovery, establishing and maintaining agency policies and communication procedures for all state employees. Additionally, Chief Smith coordinates, develops and implements the Emergency Operations Plan for the State. He reports to the Governor as the Homeland Security Advisor and coordinates security planning and preparedness activities and operations with federal, state, local and international agencies. He oversees the monitoring and evaluation of security threats and the dissemination of information regarding the risk of terrorist acts to federal, state, tribal, local authorities and the public. Chief Smith is also responsible to provide oversight on the planning and evaluation of security response exercises and the administration of security planning and preparedness grants.

Biographical Sketches of Presenters
Continued

Pat Songer
NREMT-P, ASM, CMTE
Director of Emergency Medical Services and Rescue for Humboldt General Hospital
Winnemucca, NV
Mr. Songer oversees a critical care ground transport program that responds to approximately 275 calls yearly to take patients to trauma centers in Reno, NV. HGH EMS Rescue was recently nationally accredited through the Commission on Accreditation of Ambulance (CAAS) Services and is among the smallest and most rural services to ever receive the CAAS certification. Mr. Songer is a licensed flight paramedic and over the past 21 years served with Tri State Care Flight, Big Sky Paramedics and the Lewistown Fire Department before coming to Humboldt General Hospital in September 2005.

Laura Valentine
Health Resource Analyst
State Health Division
Ms. Valentine has helped expand homeless prevention programs across Nevada. She has developed and implemented orientation and training programs for state and contract employees. She conducted audits of state and grant-funded providers as well as provided training on various topics. As the Director of Support Programs for Rural Services, she was responsible for program development and ongoing oversight of Service Coordination, Residential Programs, Mental Health Court, Rehabilitation and Consumer-run programs. Currently, with the State Health Division, she coordinates the public health preparedness in the rural/frontier parts of Nevada. Ms. Valentine is finishing her Master's in Human Behavior.

Nevada State Health Division
Public Health & Clinical Services
4150 Technology Way
Carson City, NV 89706-2009
Laura Valentine, Health Resource Analyst II
Phone: 775.684.5981

NEVADA PUBLIC HEALTH FOUNDATION
www.nphf.org
3579 Hwy 50 East, Suite C
Carson City, NV 89701
Phone: 775.884.0392
Fax: 775.884.0274

Attachment Two: PowerPoint Presentations

Attachment Two A – Public Health Preparedness – Joanne Malay

7/17/2012

Rural and Frontier Public Health Preparedness Program

Nevada State Health Division
Public Health & Clinical Services
Jo Malay, RN MPH
Health Program Manager

Public Health-Community Health Nursing

- 10 Essential Services of Public Health
- Capabilities based approach
- Infrastructure capability

Capability Based Approach

- Public Health Emergency Preparedness and Community Health Nursing: Defining our Role
  - Grant requirements
  - Our ability to deliver

Infrastructure

- Located in 10 Rural and Frontier Counties
- 14 clinic sites
- Funded through federal, state, and county
- Staff are part of their communities

Rural and Frontier

- Priorities for 2013
  - Low level assessment
  - Mass dispensing efforts
  - Special Needs Population

1

From Identified Needs to Action

- *The overall goal of action planning is to increase your community's ability to work together to affect conditions and outcomes that matter to its residents—and to do so both over time and across issues of interest.*

Questions

- What are your needs?
- How does CHN fit into filling those needs?
- What are the next steps in collaboration?

Attachment Two B – State Immunization Program – Erin Seward

7/17/2012

Nevada State Immunization Program

Erin Seward, MPH
Program Manager
775-684-3269
eseward@health.nv.gov

Nevada State Immunization Program

NSIP

- Vaccines for Children (VFC)
- Nevada WebIZ
- Perinatal Hepatitis B Prevention
- Special Projects

VFC
- Federal entitlement program for all ACIP recommended vaccines
- To be eligible must be 0-18 years of age &:
  - Uninsured
  - Underinsured
  - Medicaid eligible/enrolled
  - American Indian/Alaska Native
  - Nevada Check-Up

Nevada WebIZ
- Immunization Registry
- NRS 439.265 and corresponding regulations mandate that all administered vaccinations be recorded into Nevada WebIZ.
- People do have the option to opt-out.

Perinatal Hep B Prevention
- Case manage all babies born to Hep B positive women

Special Projects
- 317 funds
- Hep A/Hep B for high risk uninsured or underinsured adults
- Hep B for household/sexual contacts of the Hep B positive pregnant women.
- Dtap for adults and school located clinics
- Tdap for nursing in birthing hospitals and OB/GYN offices

Funding $$$$$$

- 100% federally funded
  - Operational Funds – staff, travel, supplies, subgrants
  - Vaccine Funds (Spend Plan)
- Federal Vaccine Funds: are managed through Spend Plans and monthly reconciliations
  - VFC vaccine funds ≈ $32 million
  - 317 vaccine funds ≈ $1.5 million (most recent amount but has been continually shrinking)
    - Special Projects
    - Disease Outbreaks

Disease Outbreaks

- How Are We Notified?
  - Per state law NRS 441A.450 – 441A.725, any positive cases of reportable diseases must be reported to the local health authority. Local health authority then mandated to report to state Office of Epidemiology.
  - NSIP is notified immediately when vaccine preventable diseases are identified and reported.
  - The Office of Epidemiology has read only access to WebIZ.
- Vaccine Preventable Disease outbreak
  - VFC vaccine is utilized for those who have been infected or exposed if they meet the requirements for the VFC program.
  - Section 317 discretionary vaccine is utilized for adults or children not eligible for VFC who are infected or exposed.
  - If exposed child or adult are fully insured = send to medical home and bill their insurance
  - CDC allows flexibility in our spend plans to provide vaccine for unanticipated public health events.
- H1N1 or other major disease outbreak
  - H1N1: Flu vaccine doses were allocated to Nevada based on a population model
  - Large Disease Outbreak (example = Measles)
    - CDC allows flexibility in our spend plans to provide vaccine for unanticipated public health events

Getting Vaccines to People

Account at CDC (Spend Plan)
- VFC ≈ $32 million
- 317 = 2012 $1.5 million

Provider administers vaccines

Vaccines stored at distributor McKesson in Sacramento

Provider stores the vaccines

Provider places vaccine request with NSIP

NSIP places order with McKesson

McKesson ships vaccine to provider

Who are our Providers?

As of April 2012, we have 277 providers

VFC
- Pediatricians
- Family Medicine
- Internal Medicine
- Hospitals (Hep B birth dose)
- Health Districts
- CHN's
- NV Health Centers
- Elementary & High Schools
- Tribal

317
- Hospitals (Hep B birth dose & Tdap)
- Behavior Health
- Prisons
- Health Districts
- CHN's
- OB/GYN's

Benefits of NEVADA webIZ

- As of April 2012, Nevada WebIZ has:
  - 1,073 providers,
  - 1,923 clinics,
  - 9,252 active users,
  - 2,438,800 patient records,
  - 23,796,543 vaccinations.
- Official Immunization Record
- Manage provider inventory
- Identify pockets of need
  - Measles outbreak – find who hasn't had 2 doses of MMR
- Reminder/recalls
- CRA Module

Other Preparations

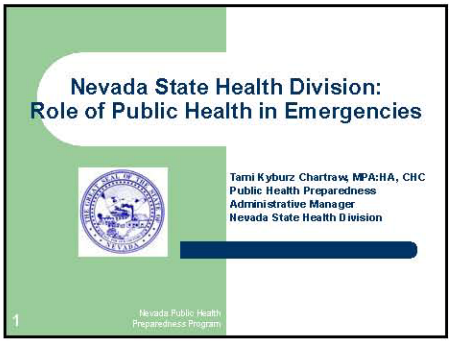
- IZ Public Health Emergency Operation and Response Manual
  - Prior to H1N1- State Public Health Preparedness Program (PHP) planned on taking the lead with Countermeasures and Response to a public health emergency (including vaccines).
  - However due to vaccine ordering and distribution mechanisms currently in place with State Immunization Program- H1N1 vaccine distribution became Immunization Program's responsibility for Nevada.
  - After H1N1, Immunization Program created an operations manual to address a public health emergency requiring vaccines as a counter measure.
  - The manual was developed in conjunction with state PHP program.

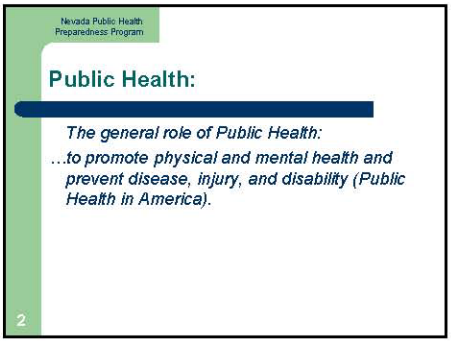
Immunization Program is Ready

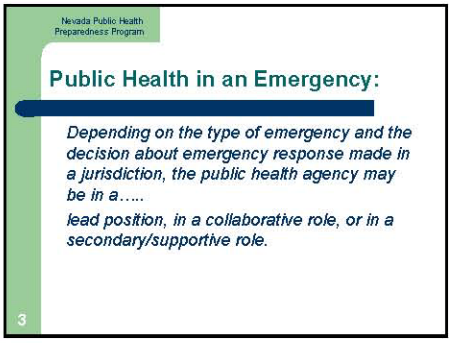
- H1N1 provided the State Immunization Program the opportunity to plan, implement, test, and make improvements based on lessons learned and gaps identified during the pandemic.

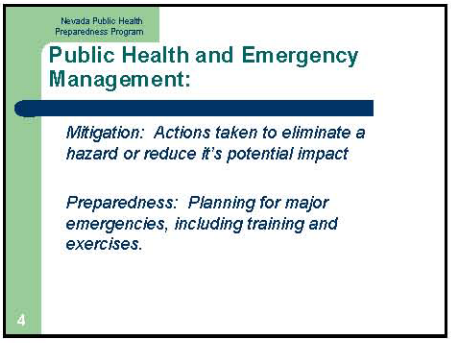
Attachment Two C – Role of Public Health – Tami Chartraw

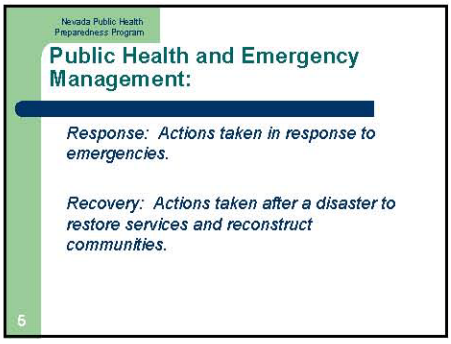
7/17/2012

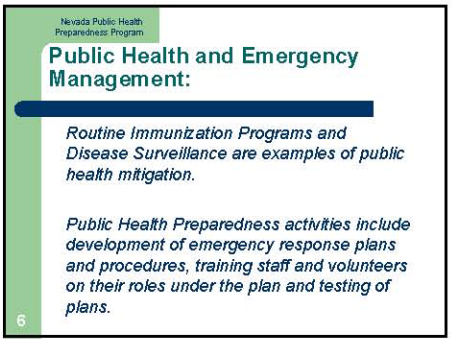












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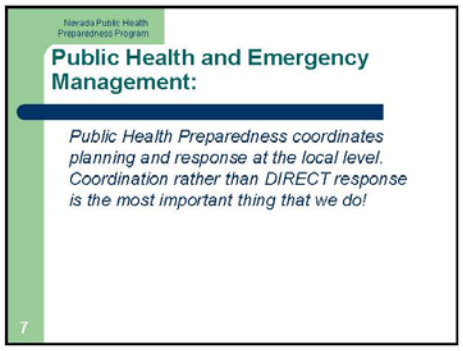
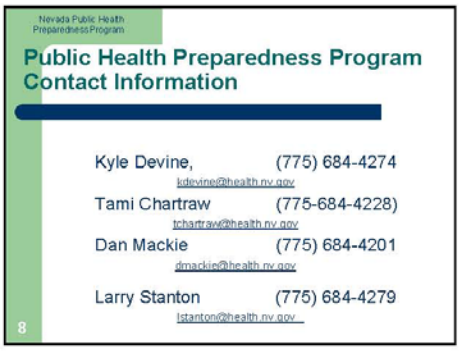

Nevada Public Health Preparedness Program
Public Health and Emergency Management:
Public Health Preparedness coordinates planning and response at the local level. Coordination rather than DIRECT response is the most important thing that we do!
7


Nevada Public Health Preparedness Program
Public Health Preparedness Program Contact Information
Kyle Devine, (775) 684-4274
kdevine@health.nv.gov
Tami Chartraw (775-684-4228)
tchartraw@health.nv.gov
Dan Mackie (775) 684-4201
dmackie@health.nv.gov
Larry Stanton (775) 684-4279
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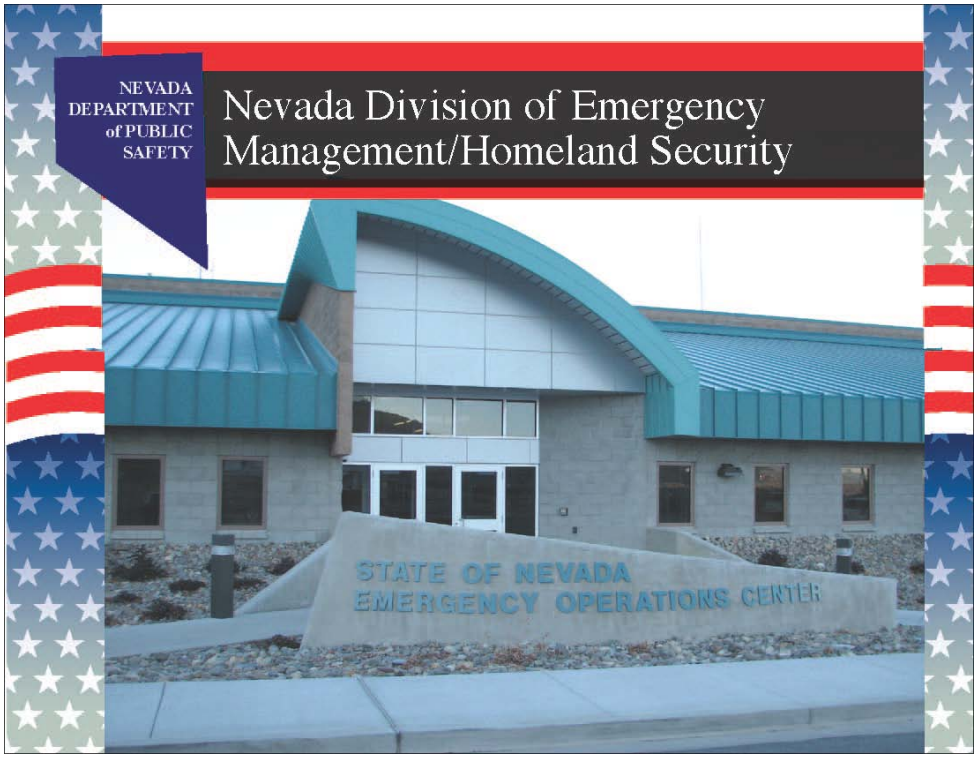
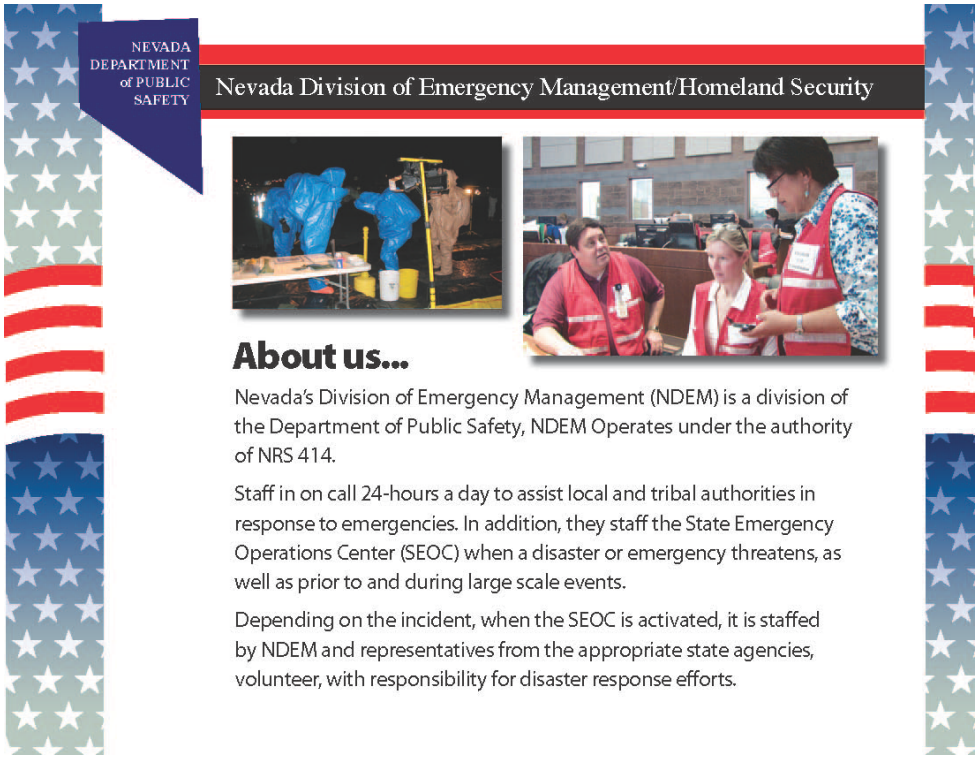
Attachment Two D – Division of Emergency Management/Homeland Security – Chris Smith





RESPONSIBILITIES
BY AGENCY DIVISION...

Day-to-day responsibilities of emergency management are carried out by the following agency divisions...

ADMINISTRATIVE

Budgets, Fiscal accounting, personnel, payroll and other support functions.

NEVADA DEPARTMENT of PUBLIC SAFETY

Nevada Division of Emergency Management/Homeland Security

NEVADA DEPARTMENT of PUBLIC SAFETY

Nevada Division of Emergency Management/Homeland Security

GRANTS MANAGEMENT

Office of Domestic Preparedness (ODP) funding, Emergency Management Planning Grant (EMPG) funding, Department of Energy (DOE) funding and Waste Isolation/Project Plant (WIPP) funding.

OPERATIONS & PLANNING

Statewide planning, operations support and communications.

NEVADA DEPARTMENT of PUBLIC SAFETY

Nevada Division of Emergency Management/Homeland Security

NEVADA DEPARTMENT of PUBLIC SAFETY

Nevada Division of Emergency Management/Homeland Security

PLANNING, TRAINING & EXERCISE

Training, anti-terrorism planning, critical infrastructure analysis.

RESPONSE & RECOVERY

Hazard mitigation, hazard analysis and risk assessment, and grants.
Public assistance - Mutual aid, coordination of financial assistance for state of emergencies and Presidential declarations.

NEVADA DEPARTMENT of PUBLIC SAFETY

Nevada Division of Emergency Management/Homeland Security

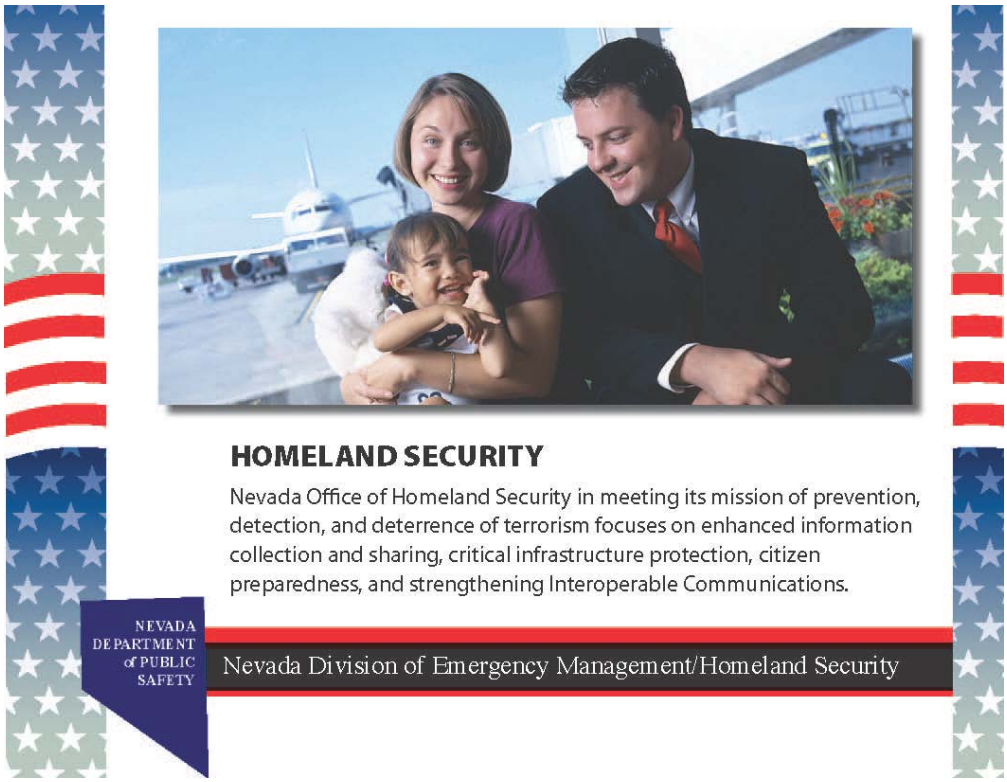
NEVADA DEPARTMENT of PUBLIC SAFETY

Nevada Division of Emergency Management/Homeland Security

NEVADA DIVISION of EMERGENCY MANAGEMENT/HOMELAND SECURITY
Mitigation
Preparedness
Response
Recovery

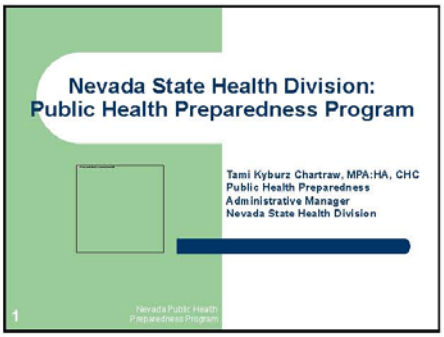
STATE EMERGENCY OPERATIONS CENTER

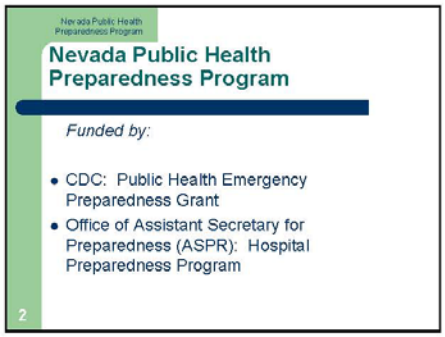
Only activated when local capabilities are overwhelmed.

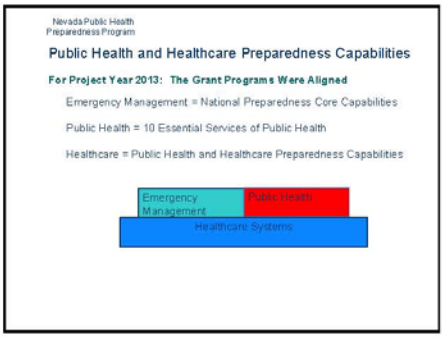

HOMELAND SECURITY
Nevada Office of Homeland Security in meeting its mission of prevention, detection, and deterrence of terrorism focuses on enhanced information collection and sharing, critical infrastructure protection, citizen preparedness, and strengthening Interoperable Communications.
NEVADA DEPARTMENT of PUBLIC SAFETY
Nevada Division of Emergency Management/Homeland Security

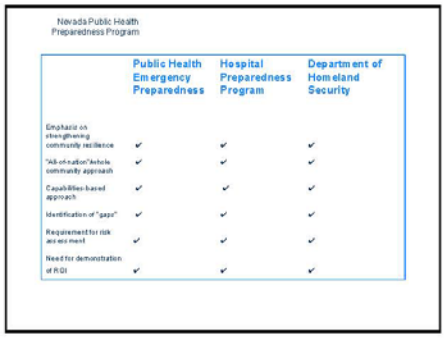
Attachment Two E – Hospital Preparedness – Tami Chartraw

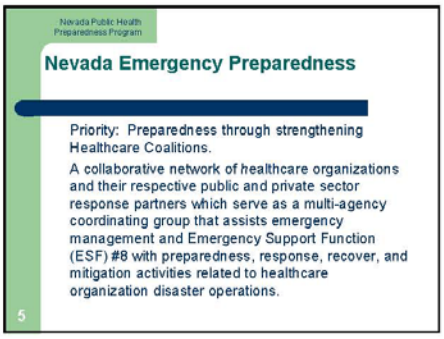
7/17/2012











1

Nevada Public Health Preparedness Program

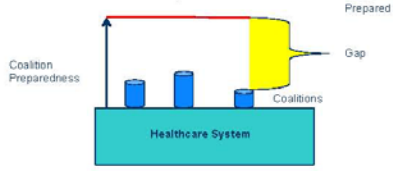
Healthcare Coalitions Functions

- Coordinate healthcare system emergency preparedness activities involving the member organizations.
- Coordinate with emergency management to develop local and state emergency operations plans.
- Identify and prioritize healthcare assets and essential services within a healthcare delivery area or region
- Perform resource assessments
- Coordinate training for healthcare responders
- Coordinate an exercise
- Participate with planning to address at-risk individuals

7

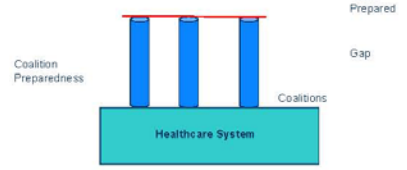
Nevada Public Health Preparedness Program

Importance of Coalitions in Community Resilience and Preparedness



Nevada Public Health Preparedness Program

Achieving Success through Partnership and Collaboration



Nevada Public Health Preparedness Program

From the Coalition to Hospital/Community Level

- Regulations: Local, State and Federal
  - Specific to Hospitals: 109 pages of requirements, regulations and EXPECTATIONS/ASSUMPTIONS for hospitals related to preparedness and response
  - For our Local Partners: …
  - SHARED requirements and responsibilities
    - ICS or HICS
    - Preparedness Planning, Training and Exercises

10

Nevada Public Health Preparedness Program

Planning for Actual Events at the Local Level

- Amtrak
- IHOP Shooting
- Air Races
- Lockdowns and other violent events
- Planned community events
  - using actual events to help meet requirements rather than expending resources for additional exercises

11

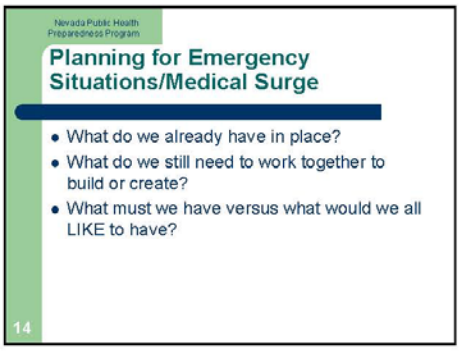
Nevada Public Health Preparedness Program

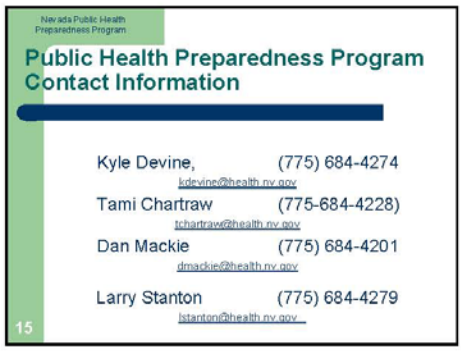
Statewide and Regional Efforts to Identify HPP Priorities

- Discover and Quantify Gaps In Hospital Capability
  - "See the Need …. Fill The Need," Nevada Hospital Association
  - Provide Data to Hospital Preparedness Partners
  - Create Workable Strategies to Address Capability Gaps
- Technical Assistance from the NSHD PHP Program
  - Provide guidance through regional coalitions
  - Coalition planning
  - Statewide planning to address gaps
  - Tracking of NIMs compliance

12


Nevada Public Health Preparedness Program
All Emergencies are Local
– More than anything local partners can speak to critical role of cooperation, communication and education.
13


Nevada Public Health Preparedness Program
Planning for Emergency Situations/Medical Surge
• What do we already have in place?
• What do we still need to work together to build or create?
• What must we have versus what would we all LIKE to have?
14


Nevada Public Health Preparedness Program
Public Health Preparedness Program Contact Information
Kyle Devine, (775) 684-4274
kdevine@health.nv.gov
Tami Chartraw (775-684-4228)
tchartraw@health.nv.gov
Dan Mackie (775) 684-4201
dmackie@health.nv.gov
Larry Stanton (775) 684-4279
lstanton@health.nv.gov
15

Attachment Two F – Fallon Emergency Management – Ron Juliff and Steve Ednacott

7/17/2012

Churchill County and City of Fallon Emergency Management Mishap Lessons Learned

23 August 2010: HCl Release at City of Fallon Water Treatment Plant

24 June 2011: Amtrak/Truck Collision, Trinity Crossing

Hydrochloric Acid Release

- Water Treatment Plant
  - Serves both the City of Fallon and NAS Fallon.
  - Designed to lower the natural arsenic level from 75 ppm to under 10 ppm.
  - HCl is used in the treatment process
- HCl storage tank ruptured while being replenished.
- CC Fire was the first to respond and assumed on-scene commander responsibilities
  - Determined that Level "A" entry would be required, which is beyond local capability.

Water Treatment Plant

Unique Challenges

- This is the largest HAZMAT release in Nevada history (10,000 gallons)
- It took two days for the HAZMAT response contractor to fly in personnel from east coast.
- The contractor had significant equipment issues.
- Summertime high temperatures effected responders
- Seasonal water usage and the immediate implementation of water conservation measures.
- Operating the water system to fully maintain all applicable water quality standards.
- HCl's effects on pumps, hoses, fittings, tanks, building and people.

Courses of Action

- Assistance requested under Nevada Fire Mutual Aid Agreement.
- NV DEM assistance in standing up a Type 1 team, similar to a wildfire scenario.
  - A Task Organized team of regional fire agencies, NAS Fed Fire, HAZMAT contractor and local support agencies (Fallon PD, public works, etc)
  - IC, John Gillenwater Central Lion County Fire
- State of Emergency declared by City and County

R

Incident Command Center

1

Responders

The "Goods"

- Fallon/Churchill Fire and Naval Air Station Fallon Fire teams reacted appropriately and quickly.
- Existing mutual aid agreements facilitated response actions.
- The water treatment plant was designed to contain a spill of this magnitude.
- The building's containment structure significantly reduced the escape of vapor in the surrounding area.
- Safety was exceptional. There were no injuries as a direct result of the mishap.
- Use of a professional public relations firm.

The "Goods"

- Fallon Police Department forensic technicians did an excellent job with photography, evidence collection and preservation.
- The Incident Management Team and Mutual Aid collaborated well due to the experience and professionalism of the Department Chiefs.
- Twice daily teleconferences with all the parties were sponsored by the DEM.
- Communications were efficiently managed.
- Support from Nv DEM Damage Assessment Team
- The total cost of the mishap was recovered from the City's insurance company

The "Others"

- The response contractor's capabilities, training and equipment.
- Small vine thorns along the path to the entry point punctured protective suits.
- The protracted length of this incident, use of personnel and equipment concerned elected officials in the supporting jurisdictions.
- The Mutual Aid agreement's lack specificity when addressing complex incidents with protracted duration and specialized HAZMAT responses.
- The recovery grant process is cumbersome. The grant does not cover all costs and has several restrictions.

Insert Scary Pictures Here

Air vent dissolved by HCl

Bottom of HCl Storage Tank

Damage from HCl fumes throughout building

Recommendations

- Due to contractor limitations, we recommend that government response capabilities and certifications be enhanced to include chemical HAZMAT neutralization and removal.
- Review and modernize Mutual Aid agreements. Clarify the responsibilities and the liabilities.
  - Insurance company issue.
- Enhance the Wildland Fire management model to support other large scale HAZMAT incidents.
- Address the differentiation between mitigation and clean up in a complex, hazardous material spill in future Mutual Aid agreements.
- During hot wash, members expressed their anticipation of a high retirement and turnover rate. They recommend a training initiative focused on leading complicated HAZMAT incidents and sharing command and control functions.

Questions?

Background

- Mishap site is 32 miles North of Fallon
- A mining truck slams into the side of an Amtrak passenger train.
- An explosion and fire erupt in first passenger car. Two cars are completely destroyed and 1 partially
- Train continued several yards past the crossing, onto the desert flats. 4WD or 2 legs required for access.

Background

- First to Respond: Churchill County EMS and Sheriff Office. CC Fire shortly behind.
- NAS Fallon leadership deploys Crash Trucks

But…before I tell you the rest of this story, I have to tell you another.

Operation Arco

7 weeks to the day before the Amtrak mishap, local entities conducted a full scale operational exercise. The scenario was a USAF tanker aircraft crash near two schools. Players included:

CC Fire and NAS Fire working combined operations

Helicopter units (NAS and Care Flight) sharing the same LZs

Arco Players (continued)

- Churchill County School system
  - Actions included shelter in place, accountability and the use of school busses
- The same law enforcement agencies

Arco Players

- The same hospital and EMS in the mass casualty scenario
- The same volunteers – CC school, Red Cross, Scouts

Arco Players

- The same media scrutiny by the same media outlets

- The same Emergency Management personnel and EOC Coordination – City/County and NAS Fallon

Now back to the first story…

Unique Challenges

- Mass casualty situation
  - 6 deceased
  - 9 Serious injuries requiring air transport
  - 50 minor injuries requiring local emergency room
- Summer temperatures – high 90's
- Protection for passengers (evacuation)
- Firefighting & rescue in desert terrain
- Meeting investigative needs of Amtrak/NTSB

Courses of Action

- Mutual aid from 26 agencies
- NDEM assistance provided
- County declared a State of Emergency
- Evacuation of passengers
  - School buses
  - Elementary school becomes a shelter
- Human remains recovery effort
  - Washoe medical examiner/forensic experts
- Protect & secure the scene for investigation

Evacuation Operations

- Incident Commander required transportation and shelter for approximately 120 displaced train passengers.
- Churchill County School District bus maintenance workers departed within minutes of notification.
  - The busses were equipped with radios and cell phones.
  - The displaced passengers were taken to the designated shelter or Banner Churchill Community Hospital in Fallon.

Emergency Shelter Operations

- E. C. Best Elementary School selected
  - Close proximity to Banner Hospital (located across the street)
  - Kitchen facilities and relative restrictive access for security.
  - Trained Volunteers
- School district personnel began preparing the school
- Fallon City and Churchill County Emergency Managers made arrangements to support the emergency shelter.
  - Red Cross and local grievance counselors
  - Fallon Police for security and accountability
  - Notifying appropriate local elected officials
  - Two emergency shelter supply trailers
  - Additional volunteer organizations.

Emergency Shelter Operations

- The speed of activation and set-up was extremely impressive.
- The shelter had a significant calming effect on the passengers.
- Almost all passengers were without their luggage and some without their purses, wallets or cell phones. Many were without their prescription medications. Red Cross and local pharmacies to the rescue
- Sub sandwiches were ordered by the Red Cross and delivered by local vendors.
- Additional rooms were opened within the school for specific purposes such as the cafeteria for food service, the computer room for internet/email access, a play room for young children and a sleeping room with cots.

The "Goods"

- Years of planning, drills and training – particularly the Arco exercise and CC School District training plan.
- The proactive deployment of NAS Fallon Fed Fire.
- Smooth transition from IC – unified command – IC
- Shifting from rescue to recovery / coroner duties
- The rapid response of the Red Cross and other volunteer organizations.
- Fallon Police Department deployment of shelter management personnel, portable phones and other resources.
- The modular expansion and creative uses of the elementary school.
- The willingness of local pharmacies to work with the Red Cross on prescription issues.
- Support of elected officials.
- The availability of shelter supply trailers that were resourced during the State Emergency Shelter Plan initiative.

The "Others"

- Communications with the County Emergency Operations Center (EOC) were curtailed by phone system limitations.
- Direct contact via cell phone sometimes contributed to redundant requests for resources or contradicting information that added to "the fog" of the situation.

R

Recommendations

- Integrate backup electrical power into E.C. Best Elementary school for mass power out scenarios (blizzard, earthquake, etc).
- The EOC phone system is inadequate. A new system was requested and is requested and is being installed.
- Shelter management should use one of the rooms in the school as a command post. This would assist information flow and validation.

This response and recovery was made possible by the following organizations

Churchill County Sheriff's Office	Winnemucca Police Department
Churchill County Road Department	Washoe County Coroner
Churchill County EOC	Reno Fire Department
Fallon/Churchill Volunteer Fire Department	Mason Valley Fire Department
Federal Fire Department (NAS Fallon)	BLM Fire Crews
Banner Churchill Community Hospital & EMS	Care Flight
Naval Air Station Fallon/Federal Fire	Red Cross
Churchill County School District	Boy Scout Troop 1776
City of Fallon	Wal-Mart/Walgreen/CVS Pharmacies
Lyon County/City of Fernley	Governor Sandoval and staff
Pershing County/City of Lovelock	Humboldt County
State Division of Emergency Management	Nevada Highway Patrol
Winnemucca Police Department	Nevada Department of Transportation

Steve Endacott
Emergency Manager
City of Fallon
sendacott@sci-nevada.com
775 427-4346

Ron Juliff
Emergency Manager
Churchill County
ccem@phonewave.net
775 423-4188

Attachment Two G – Rural Preparedness – Gerald Ackerman

7/17/2012

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School of Medicine

Rural Health Care an Overview

Gerald J. Ackerman, M.S.
Director
April 24, 2011

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School of Medicine

Who Provides Health Care Services in Rural Nevada?

- Overview of Rural Frontier Nevada
- Underserved Health
- Native American
- Veterans
- Minority
- Hospital
- Long-Term Care
- Health Professions Workforce
- Emergency Response

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The Great State of Nevada Beyond the Boarders of Reno, Carson, Las Vegas, North Las Vegas and Henderson

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Nevada (Hours Vs. Miles)

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Frontier Counties of the United States, 2000

Frontier Definition (RAC)

Outline Level

Ninth Outline Level Clickto edit Master text styles

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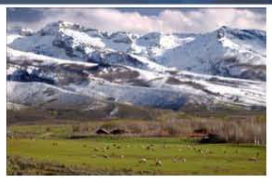

I live here for a reason!

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Lets look at Nevada

- Providing Care in Nevada

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PUBLIC HEALTH

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Public Health- Health Districts

- Southern Nevada Health District
  625 Shadow Lane
  P.O. Box 3902
  Las Vegas, Nevada 89127
  Phone: (702) 759- 1000 The mission of the Southern Nevada Health District is to protect and promote the health, the environment and the well-being of Southern Nevada residents and visitors.
- Washoe County District Health Department
  1001 East Ninth Street
  P.O. Box 11130
  Reno, Nevada 89520
  Phone: (775) 328-2400
  Fax: (775) 328-2275 The Washoe County District Health Department, through its programs and services, pursues the public health mission of health promotion, disease prevention, and protection of the public and the environment, to improve the quality of life for all citizens of Reno, Sparks, and Washoe County.
- Carson City Health & Human Services
  900 E. Long St.
  Carson City, NV 89706
  Phone: (775) 887-2190
  Fax: (775) 887-2248
- The Carson City Health & Human Services is charged by State law and City Code with protection of the health of the Carson City's citizens and visitors

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Who Provides Public Health to the Rest of the State

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Nevada State Health Division

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Community Health Nursing

- Mission Public Health /Clinical Services, as the sole provider of public health nursing in Nevada's 14 frontier and rural counties, endeavors to promote optimal wellness through the delivery of public health nursing, preventive health care, and health education. Services Each Community Health Nursing Service health center offers a variety of services including nursing services for residents of all ages and incomes. Twenty one (21) Community Health Nurses provide services in 14 primary health center locations.
- Each Community Health Nursing Services health center provides these services at a low cost or using a sliding scale dependent upon income for residents of all ages and incomes, including:
- Family Planning, Education, Counseling and Treatment;
- Health Education;
- Cancer Screening;
- Immunizations;
- Well-Child Examinations and Healthy Kid Screenings;
- Sexually Transmitted Disease Education and Counseling;
- HIV/AIDS Counseling, Education and Testing;
- Communicable Disease Investigation;
- Tuberculosis Screening and Education;
- School Health Promotion and Education; and
- Children's Special Health Care Needs referrals.

In addition to providing essential public health services such as immunizations, we also serve as school nurses in school districts without a school nurse. With an area of responsibility of over 96,000 square miles, our nurses average 1,000 miles per month of traveling throughout the rural counties in the State Of Nevada. Community Health Nursing has earned a reputation of reliability and is a trusted source for healthcare for the working poor, uninsured, indigent, and rural populations within Nevada. We operate on a sliding fee scale depending on your income. We do not deny services due to inability to pay.

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Care for the Underserved

- A look at the Community Health Center Program

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Role of Federal Qualified Health Centers

- A federally qualified health center (FQHC) is a type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. Requirements for Indian Health Service funded FQHCs may differ from the requirements for FQHCs receiving Section 330 grants and for FQHC Look-Alikes.
- There are many benefits of being an FQHC. For FQHCs that are PHS 330 grant recipients, the biggest benefit is the grant funding. For new starts, funding up to $650,000 can be requested. Other benefits include:
- Enhanced Medicare and Medicaid reimbursement
- Medical malpractice coverage through the Federal Tort Claims Act
- Eligibility to purchase prescription and non-prescription medications for outpatients at reduced cost through the 340B Drug Pricing Program
- Access to National Health Service Corps
- Access to the Vaccine for Children program
- Eligibility for various other federal grants and programs
- Not all of these benefits are extended to FQHC Look-Alikes. The funding for new starts - up to $650,000 - is not available to FQHC Look-Alikes.

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Federal FQHC Community Health Center Program

Nevada Health Centers, Inc.

Nevada Health Centers, Inc. is a private non-profit community health center that provides health services throughout the state of Nevada. We presently have over thirty medical and dental centers and other health related programs. Everyone is welcome at our health facilities and we offer a sliding fee scale for uninsured patients' that is based on family income.

Health Access Washoe County

- HAWC provides quality, affordable, comprehensive primary health care services for those in need.
- HAWC is the role model for quality, cost-effective primary health care delivery amongst community health centers.
- Our state-of-the-art facilities and systems are patient-focused and efficient. We rely on partners, both local and national, to help us meet our increasing patient needs and provide financial stability.
- Our highly qualified and compassionate team is committed to continuous improvement throughout the organization.

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Nevada Health Centers (Map)

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Providing Services to Native American's

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Indian Health Service Clinics

- Ribbon Tribal Health Center Gardnerville, NV 775 265-4215
- Yerington Tribal Health Clinic Fallon, NV 775 423-3634
- Nevada Urban Indians, Inc Reno, NV 775 788-6600
- Southern Nevada
- Name of Clinic Location Phone
- Las Vegas Paiute Tribe Health & Human Services Las Vegas, NV 702 382-0784
- Rural Nevada
- Duckwater Health Department Duckwater, NV 775 863-0222
- Duck Valley Health Center Owyhee, NV 775 757-2415
- Battle Mountain Health Center Battle Mountain, NV 775 635-8200
- Ely Shoshone Tribe, Nemo Medical Clinic Ely, NV 775 289-4133
- Moapa Tribal Clinic Moapa, NV 702 865-2700
- Pyramid Lake Health Clinic Nixon, NV 775 574-1018
- Southern Bands Health Center Elko, NV 775 738-2252
- Walker River Tribal Health Center Schurz, NV 775 773-2005
- Ft. McDermitt Health Station McDermitt, NV 775 532-8622
- Yerington Paiute Tribal Health Clinic Yerington, NV 775 463-3305
- Bi-State (Border Nevada)
- Name of Clinic Location Phone
- Barrio Nuevo Health Center Sonoyta, Mx (CA 520-285-2042)

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Care for Veterans

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Elko Outreach Clinic

Ely CBOC

VISN 19

- Elko Outreach Clinic
  762 14th Street
  Elko, Nevada 89801
  (775) 753-2014 (direct to clinic)

  Ely CBOC
  William Bee Rinie Rural Health Clinic

  #6 Steptoe Circle
  Ely, Nevada 89301
  (775) 289-3612 ext. 131

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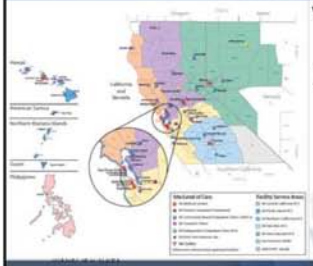

VISN 21

- Fallon
- Winnemucca

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Nevada Rural Hospitals

6-75 Beds
Sole Community Hospitals
CAH/FLEX Hospitals
Private Hospitals
Hospital District Hospitals

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CRITICAL ACCESS HOSPITALS (CAH)

* A Critical Access Hospital (CAH) is a hospital that is certified to receive cost-based reimbursement from Medicare. The reimbursement that CAHs receive is intended to improve their financial performance and thereby reduce hospital closures. Each hospital must review its own situation to determine if CAH status would be advantageous. CAHs are certified under a different set of Medicare Conditions of Participation (CoP) that are more flexible than the acute care hospital As of September, 2010, there are 1,320 certified Critical Access Hospitals located throughout the United States. The Flex Monitoring Team maintains a [illegible] which includes the hospital name, city, state, zip code and effective date of CAH status.

* What is the Medicare Rural Hospital Flexibility Program and how is it related to the CAH program?
Answer: The Medicare Rural Hospital Flexibility Program (Flex Program) was created by the Balanced Budget Act of 1997 and is intended to strengthen rural health care by encouraging states to take a holistic approach. A major requirement for participation in the Flex Program is the creation of a state rural health plan. The Flex Program provides grants to each state which are used to implement a Critical Access Hospital program, to encourage the development of rural health networks, to assist with quality improvement efforts, and improve rural emergency medical services. The Flex Program promotes a process for improving rural health care, using the Critical Access Hospital (CAH) program as one method of promoting strength and longevity through CAH conversion for appropriate facilities.

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Fallon, NV 89406

Battle Mountain, NV 89820

Boulder City, NV 89005

Gardnerville, NV 89410

Fernley, NV 89408

Caliente, NV 89008

Winnemucca, NV 89445

Incline Village, NV 89451

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Mesquite, NV 89027

Hawthorne, NV 89415

Northeastern Nevada Regional Hospital
Elko, NV 89801

Tonopah, NV 89049

Lovelock, NV 89419

Yerington, NV 89447

Ely, NV 89301

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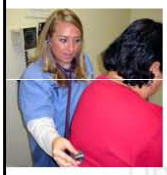
Long Term Care Centers

Free Standing
Hospital Based

University of Nevada
School of Medicine

Rural Health Clinic (attached to Rural Hospitals)



- A Rural Health Clinic (RHC) is a clinic certified to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is improving access to primary care in underserved rural areas. RHCs are required to use a team approach of physicians and midlevel practitioners such as nurse practitioners, physician assistants, and certified nurse midwives to provide services. The clinic must be staffed at least 50 % of the time with a midlevel practitioner. RHCs are required to provide out-patient primary care services and basic laboratory services.
- RHCs receive special Medicare and Medicaid reimbursement. Medicare visits are reimbursed based on allowable costs and Medicaid visits are reimbursed under the cost-based method or an alternative Prospective Payment System (PPS). Ordinarily, this will result in an increase in reimbursement. RHCs may see improved patient flow through the utilization of NPs, PAs and CNMs, as well as more efficient clinic operations.

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Rural Health Care Resources

14 hospitals with 2,219 employees and a payroll of $117.8 million, including 11 Critical Access Hospitals (CAHs)

18 federally designated Rural Health Clinics (RHCs) & Community Health Centers (CHCs)

13 tribal clinics and medical centers

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28

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Rural Health Care Resources

Resource	Rural	Urban	Nevada
Hospital Beds	281	4,777	5,058
Beds per 1000 Population	1.0	2.0	1.9
Long-Term Care Beds	671	4,888	5,559
Beds per 1000 Population	2.4	2.0	2.1

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29

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Population and Health Status

University of Nevada School of Medicine

Forces Affecting Rural Population Health

- Same forces affecting urban population health
- Macro economy, boom-and-bust cycles
- Demographic trends and transitions
- National policies – esp., DHHS, CMS & Medicare reimbursement, USDA, national health reform
- Geographic isolation and the culture of rural life
- Slower spread of technology – esp., diffusion of and access to medical care and technology

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Forces Affecting Rural Population Health

- State policies – esp., Medicaid reimbursement & licensing
- Health insurance coverage – esp., under 65 population
- Health workforce shortages and access to health professionals and specialists
- Health system barriers = substantial financial, geographical, and resource barriers

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Populations and Place in Rural Nevada

Defining "urban" and "rural" and "frontier"

Census Bureau and Office of Management & Budget = "rural" and "non-metro" areas are basically areas that aren't "urban" or "metropolitan" i.e., residual categories

Nevada = highly urbanized state with unique rural and frontier population characteristics

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Distribution of Population by Place

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General Trends

- Widespread shortages of health care professionals across most health care occupations and specialty areas versus other states
- Geographic maldistribution – Shortages are particularly acute in rural and frontier regions
- Shortages are compounded by boomer-fueled demand and the looming retirement of boomer-born health care professionals in Nevada and the US
- Good news for students-Health care occupations are recession-resistant, if not recession proof

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Geographic Maldistribution

- With few exceptions, the number of licensed health professionals per 100,000 residents is much lower in rural versus urban counties
- Rural clinics and hospitals are at a competitive disadvantage versus urban facilities in their ability to recruit and retain health professionals

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Geographic Maldistribution

- Single-county health professional areas (HPSAs) in rural Nevada:
  - 11 primary medical care HPSAs
  - 13 mental health care HPSAs
  - 13 dental care HPSAs
- Substantial population-based and geographic areas within urban counties are HPSAs

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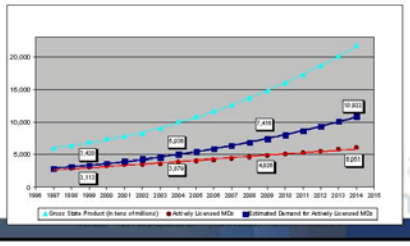
Supply and Demand of Physicians (MD) in Nevada – 1997 to Projected 2014



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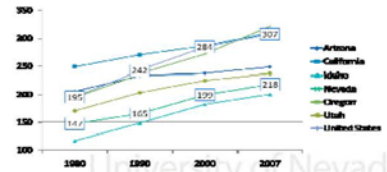
Number of Physicians per 100,000 Population – 1980 to 2007



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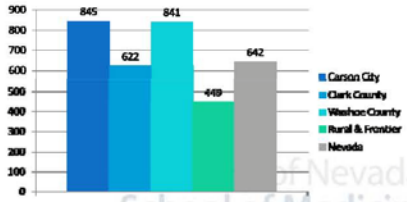
Registered Nurse (RN) Workforce in Nevada – 2008



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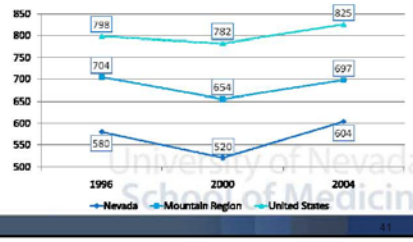
Employed RNs per 100,000 Population in Nevada, Mountain Region, and US – 1996 to 2004



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Estimated Dentists and Dental FTEs per 100,000 residents in Nevada – 2006

Region	Dentists Employed (Estimated)	FTEs	2006 Population	Dentists per 100,000	FTEs per 100,000
Urban South	819	638.6	1,805,109	45.4	35.4
Urban North	268	210.9	489,102	54.8	43.1
Rural / Frontier	69	55	328,839	21	16.7
Nevada Total	1,156	904.5	2,623,050	44.1	34.5

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Need versus Demand for Mental Health Care Services in Nevada

- Statewide shortage of psychiatrists and other mental health care providers
- Threats to state-supported rural mental health clinics
- Poor population health and mental health indicators – second highest suicide and 4th highest rates in US
- High levels of alcohol and other substance abuse
- Severe economic downturn – highest unemployment in a decade, one of the highest rates of home mortgage foreclosures

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Unique Geography of Rural and Frontier Nevada

Average Distance from a Rural Hospital to:

Nearest incorporated town: 46 miles

Nearest hospital: 59 miles

Nearest tertiary hospital: 115 miles

Office of Rural Health & NRHP: 231 miles

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Population Growth – 1990 to 2010

Rural and Frontier: +116,461 (70.5%)

Range: -30.1% in Mineral County to +162.3% in Lyon County

Urban: +1,323,132 (127.6%)

Clark County: +1,161,043 (156.6%)

Washoe County: +147,334 (57.9%)

Nevada: +1,439,593 (119.8%)

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Nevada's Population Health Profile

Perennial rank among the bottom tier of US states on many population health measures

High levels of mental illness and behavioral health problems

Compounded by high levels of "at risk" behaviors including cigarette smoking and immoderate alcohol consumption

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Health Insurance Coverage – Under 65
Percent Uninsured in 2007

Rural and Frontier: 20.1%

Range: 15.2% in Mineral County to 29.4% in Lincoln County

Urban: 20.8%

Range: 20.5% in Washoe County to 24.6% in Carson City

Nevada: 20.7%

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Health Insurance Coverage – Under 20
Percent Uninsured in 2007

Rural and Frontier: 13.5%

Range: 7.3% in Mineral County to 22.5% in Pershing County

Urban: 16.0%

Range: 13.9% in Washoe County to 16.9% in Carson City

Nevada: 15.8%

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Health Insurance Coverage – 18 to 64
Percent Uninsured in 2007

Rural and Frontier: 22.2%

Range: 14.5% in Mineral County to 32.0% in Lincoln County

Urban: 23.0%

Range: 22.9% in Clark County to 26.7% in Carson City

Nevada: 23.0%

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Medicare Enrollment – 2010

Rural and Frontier: 17.1%

Range: 9.2% in Elko County to 25.5% in Nye County

Urban: 12.1%

Range: 11.7% in Clark County to 17.9% in Carson City

Nevada: 12.7%

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Medicaid Enrollment – 2010

Rural and Frontier: 10.8%

Range: 1.7% in Storey County to 17.2% in Nye County

Urban: 12.5%

Range: 11.3% in Washoe County to 14.5% in Carson City

Nevada: 12.3%

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Nevada Checkup Enrollment – 2010

Rural and Frontier: 4.3%

Range: 0.8% in Storey County to 10.7% in Esmeralda County

Urban: 4.8%

Range: 4.6% in Clark County to 9.1% in Carson City

Nevada: 4.8%

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Suicide
Age-Adjusted Deaths per 100,000 Population

Rural and Frontier: 25.9

Clark County: 17.5

Washoe County: 18.6

Nevada: 18.8

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So Where Do The Health Professionals Come From?

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Nevada Health Rankings – Mental Health

Licensed Psychiatrists – 43rd among US states
Licensed Psychologists – 44th
Licensed Clinical Social Workers – 48th

National Center for Health Workforce Studies

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Nevada Health Rankings – Physicians

- Physicians, MDs – 46th among US states
- Primary care physicians – 45th
- General/Family physicians-45th
- Psychiatrists – 43th
- Obstetricians and Gynecologists – 32st
- General surgeons – 49th
- Specialty surgeons – 50th
- Physicians, DOs – 19th

Source: Health Care Rankings 2009. Washington DC: CQ Press.

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Nevada Health Rankings – Other

- Dentists – 38th (was 42nd in 08)
- EMTs and Paramedics – 41st (was 40th in 08)
- Optometrists – 33rd (was 30th in 08)
- Pharmacists – 34th (was 26th in 08)
- Physical Therapists – 50th
- Physician Assistants – 35th

Source: Health Care Rankings 2009. Washington DC: CQ Press.

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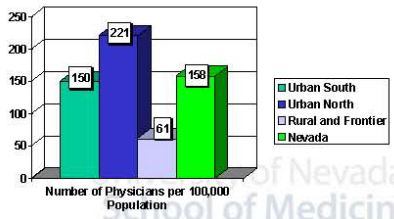
Physician Workforce in Nevada – 2006



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Rural Health Care Workforce

Statewide shortages of health professionals, including acute shortages of primary care providers, nurses, and mental health professionals

Lower number of most health professionals per capita in rural versus urban areas of Nevada – particularly, primary care providers, general surgeons and many allied health occupations

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Nevada's Ranking Among US States and the Geographic Maldistribution of Health Professionals Within Nevada

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Primary Medical Care HPSAs – 2011

- Most regions of rural and frontier Nevada are federally-designated HPSAs
- 9 rural counties are single-county HPSAs
- Most rural and frontier census tracts of Clark and Washoe Counties are Primary Care HPSAs

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Mental Health HPSAs – 2011

All 14 rural and frontier counties are mental health HPSAs

With the closure of numerous rural mental health clinics, access to mental health services in rural areas is major public health issue in Nevada

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Dental HPSAs – 2011

- 9 of 14 rural and frontier counties are dental HPSAs
- Majority of census tracts in rural Clark County are also HPSAs
- Counties such as Churchill, Humboldt, and Lyon have historically been dental HPSAs

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Number of Licensed Health Professionals per 100,000 Population – 2010

Professional	Rural and Frontier	Urban	Nevada
Dentists	34.1	53.0	51.0
EMTs	612.7	204.6	248.2
Lab Techs	267.6	338.9	331.3
Pharmacists	41.5	86.4	81.6
Primary Care Physicians	44.0	80.0	76.2
Psychiatrists	0.7	5.8	5.2
Psychologists	7.1	13.3	12.6
Registered Nurses	479.2	749.0	720.3
Social Workers	48.6	65.9	64.1

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Nevada EMS and Responders

70+ - Total Licensed EMS services

County, Private, Industrial, Military etc.

Fire, Law Enforcement, etc.

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Emergency Preparedness in Nevada's Rural Counties

Based on Gap Analysis of Emergency Preparedness in Nevada's Rural Counties-Prepared by the Nevada State Office of Rural Health for the Nevada State Health Division

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Findings

Nevada's 12 Rural Counties varied in readiness over the entire range of capacities surveyed. However, the analysis revealed consistent strengths in areas of emergency preparedness.

Major Strengths

Nevada's 12 rural counties varied in readiness over the entire range of capacities surveyed. However, the analysis revealed consistent strengths in areas of emergency preparedness. The major strengths identified in this gap analysis are as follows:

- All counties have emergency operation plans consistent with NIMS standards. Many counties reported that recent audits by the Division of Emergency Management revealed various issues, usually in language, and they are updating these plans to address the problems the audit revealed.
- All but one of the counties participates in exercises, evaluations, and corrective actions following the guidelines of HSEEP. Some counties do not have the resources to facilitate these exercises on their own, so they participate in the exercises performed in Nevada's larger counties.
- All counties reported they have interoperable communication systems.
- All but one of the counties has identified alternate care sites.
- All but one of the counties has some form of mobile medical assets.

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Primary Areas for Improvement

The survey revealed several opportunities to improve Nevada's rural counties' abilities to respond to emergencies that include public health incidents. While there were a variety of strengths and weaknesses particular to each individual county, the survey showed need for improvement in the following areas for most if not all counties.

- While most counties had a reliable communications system and a backup system, some are struggling to reach the 2013 standard of 100% P25 CAI interoperability. Emergency managers consistently cited funding as the prime hindrance in reaching this goal.
- The majority of emergency managers had little, if any, knowledge of hospital bed tracking through the HAVBED program, medical volunteering through ESAR-VHP or the Medical Reserve Corps. Most commented that these were the responsibility of the hospital. Most emergency managers were aware of emergency medical technicians and veterinarians in the area.
- Only two of the twelve counties had a pharmaceutical cache or an AAA with the local pharmacy. Some counties had a limited supply of medicines available in the mass casualty trailer.
- While the 12 rural counties have emergency plans consistent with NIMS standards and have annual exercises following HSEEP guidelines, many do not have regular education and preparedness training. Many emergency managers commented that they could not conduct adequate training programs due to lack of funding or difficulty in providing training in close proximity. Many counties use volunteers to assist in their emergency operations. This means bringing the training to the volunteers is often necessary to achieve full participation.

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Summary Matrix

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Building the Infrastructure

Training
Staff
Volunteers
Equipment
Coordination
Challenges

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So how long does it take to grow one?

Physician- 4 years undergraduate, 4 years medical school, 3-6 years residency

Nurses- 3-6 years

Public Health- 6 years

EMS 1-3 years

Physician Assistants and Nurse Practitioners- 2-7 years

Other Health Professions- 4-8 years

If you have the training experience

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Resources

Federal Budget

State Budget

County Budget

Local City Budget

Whose responsibility is it?

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Closing Thoughts

Attachment Two H – Murphy Complex Incident – Larry Manning, Ruby Manning, Rozilyn Jones

Attachment Two I – Interoperable Communications – David Fein

7/18/2012

Interoperable Communications

What It Means
How It Works
Funding

Why Interoperable Communications?

- September 11, 2001, disaster strikes the USA
- After Attack analysis determines a major gap in First Response effectiveness
- Voice Communications between First Responders (Law, Fire, Medical) could not be established
- By 2006 goals, objectives, and funding were established to fill the gap

Definitions

- **Interoperable Communications**
  - The ability for first responders to communicate by voice directly with each other at an incident
- **Nevada Communications Steering Committee (NCSC)**
  - Established by Governor's Executive Order
  - Advisory to the Governor and the Nevada Commission on Homeland Security
- **Statewide Interoperable Communications Coordinator (SWIC)**
  - Appointed by the NCSC to facilitate Interoperable Communications Statewide.

Organizational Structure

- **Department of Homeland Security (DHS)**
- **Nevada Commission on Homeland Security (NCHS)**
  - Appointed by the Governor
- **NCSC**
  - Appointed by the Governor
- **SWIC**
  - Appointed through the NCSC
- **Individual Projects**
  - Vision through the NCSC, supported by the SWIC, managed by the Certified Project Manager

National Emergency Communications Plan (NECP)

- **Three Goals for the NECP:**
  - **Goal 1:** Urban Area Strategic Initiative (UASI). Achieved Goal 1 on December 31, 2009-January 1, 2010 (New Years Eve).
  - **Goal 2:** 75% of counties in the state must self assess and determine if they can interoperate with their neighbors and Statewide first responders within one hour of an incident or event. Goal achieved September 1, 2011, with all 17 counties in Nevada
  - **Goal 3:** By 2013, 75 percent of all jurisdictions are able to demonstrate response-level emergency communications within three hours.

Progress to Date

- **DHS has provided over $30M for Nevada Interoperable Communications since 2006.**
  - ✓Currently 54 funded projects, of which 35 are complete.
- **Major Projects**
  - Four Core Radio Systems tied together by Session Initiation Protocol (SIP)
  - Four County Ethernet Microwave Link
  - Cross Band Repeater System
  - 16 Interoperable Communications Talk Groups
  - Clark County Microwave Interconnection
  - Nevada Dispatch Interconnect
  - SatComm Vehicles
  - Radio Caches around the state

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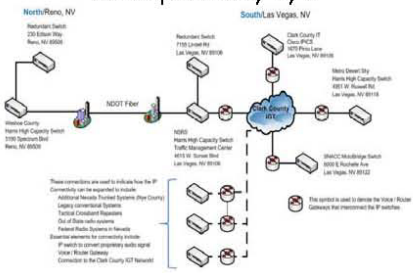
Interoperability by IP



Cross Band Repeaters

16 Talk Groups

Talkgroup Plan			
Talkgroup Use	Location	Number	Talkgroup Names
Local Use (Events)	North	4	NVTAC71X NVTAC72X NVTAC73X NVTAC74X
Regional Coordination	North	2	NVCRD61X NVCRD62X
Local Use (Events)	South	4	NVTAC81X NVTAC82X NVTAC83X NVTAC84X
Regional Coordination	South	2	NVCRD66X NVCRD67X
Statewide Coordination	Statewide	4	NVCRD51X NVCRD52X NVCRD53X NVCRD54X

SatComm Vehicles

- Mobile Internet Connection by Satellite or Commercial Cellular Network
- Wireless Hot Spot
- Mobile Interoperable Communications Device
- Mobile Satellite Phones
- Fax/Scanner
- National TV News Delivery

Progress to Date II

- **Public Safety Interoperable Communications (PSIC) grant program.**
  - Training is still available for the asking, through June 30, 2012.
    - Statewide Interoperable Communications plan (SCIP)
    - Regional Tactical Interoperable Communications Plans (TICP's)
    - Nevada Interoperable Communications Field Operations Guide (NVIFOG)
    - COM/L and COM/T training and certification
    - Training on the SATCOMM Vehicles

Future Funding/Application Process

- The NCSC issues a call for projects, usually in the autumn. Interested parties prepare and present an Investment Justification (IJ).
- The NCSC appoints a subcommittee to vet the projects.
- The Subcommittee sends its recommendations to the NCSC for ratification.
- NCSC sends the ratified list to the NCHS Finance Committee for review and funding recommendation to the NCHS.
- NCHS makes the final recommendation to the Governor for approved projects and funding levels.

2

Questions

Thank You

Attachment Two J – Volunteers in Disaster – Wendy Luck

7/17/2012

Volunteers in Disaster

Emergency and Disaster Volunteer Response

SERV NV

Wendy Luck
Nevada State ESAR-VHP/MRC Coordinator

What should/would we do if…

- Our Public Health System is understaffed and underfunded…
- Our Healthcare System is understaffed and doesn't have medical personnel surge capacity…
- We aren't prepared and our communities are not resilient…
- We know that there are people out there who would volunteer to help…

Answer: Build Community Resiliency

4 R's of Resiliency

1. Robustness
2. Redundancy
3. Resourcefulness
4. Rapidity

-Bruneau et al

SERV NV "At A Glance" -Who are you?

- Nevada's ESAR-VHP (Emergency System for the Advanced Registration of Health Care Professionals) Registry
- Registry of medical & non-medical volunteers willing to respond in to an emergency/disaster anywhere in Nevada
- Current programs utilizing the registry include:
  - Nevada SERV (State Emergency Reserve Volunteers
  - Mental Health Crisis Councilor Volunteers
  - Medical Reserve Corps of Nevada
    - Washoe County MRC
    - Western Nevada MRC
    - Southern Nevada MRC

SERV NV "At A Glance" -What do you do?

- Volunteer Management
  - Identify
  - Screen
  - Credential
  - Train
- Affiliate/integrate with existing programs and resources-utilization of the registry
- Foster resiliency in communities around the state

1

A Brief History
-The Start of it all…

- Following the 9-11 attacks
  - Thousands of unaffiliated volunteers
    - Issues identified:
      - ID/Credentials
      - Liability
      - ICS
      - Management

A Brief History
-How We Came About

In 2002 Congress passed the Public Health Security and Bioterrorism Preparedness and Response Act to facilitate the effective use of volunteer health professionals during public health emergencies. Each state now has and maintains their own ESAR-VHP registry.

SERV NV

Homeland Security Presidential Directive (HSPD) 21

The Federal Government must formulate a comprehensive plan for promoting community public health and medical preparedness to assist State and local authorities in building resilient communities in the face of potential catastrophic health events.

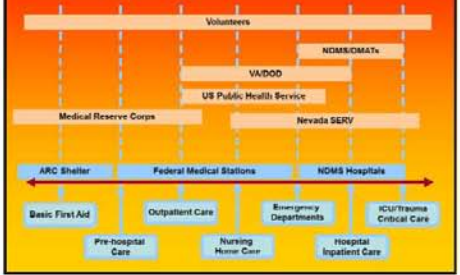
Volunteer Composition

- Medical and Public Health Professionals
  - In training/school
  - Active practice
  - Inactive
  - Retired
- Support Service Volunteers
  - Logistics
  - Operations
  - Planning
  - Finance

Types of Volunteer Opportunities

- Emergency preparedness exercises used as training maneuvers to educate volunteers on response activities
- Public health events- example- Mass immunization centers, POD operations
- Emergency or disaster situations- catastrophic state of affairs that demand immediate response and actions. Example – field treatment centers, hospital surge

Spectrum of Care and Medical Resources



Preparedness

Hazards

Hazards can be natural or man made:

- Weather related – highest likelihood
- Public Health Disaster
- Domestic and International Terrorism
- Technology
- Accidental release of toxic material

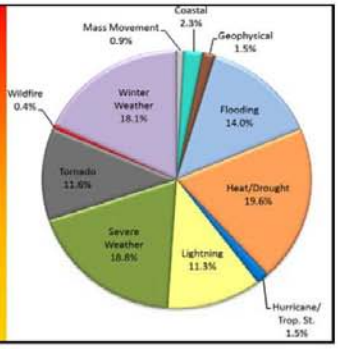



Considerations

Vulnerable Populations

- Children
- Elderly
- Pets
- Dependent on Medical Technology
- Persons with Disabilities
  - Physical and Developmental
- Chronic Medical Conditions
- Mental Health Disorders

Spatial patterns of natural hazards mortality in the United States, Kevin A Borden and Susan L Cutter, International Journal of Health Geographics

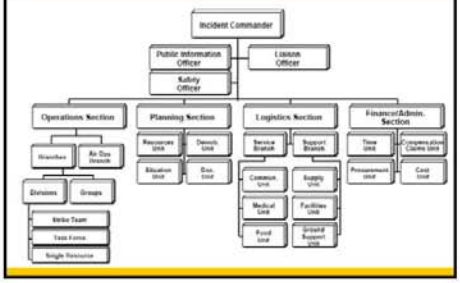


How a Disaster is Managed

National Incident Management System

- Federal Emergency Management Agency
  - Coordinates with Federal and State Agencies
- Nevada Department of Homeland Security and Emergency Management
  - Coordinates with State Agencies and County Emergency Management
- County/City Emergency Management
  - Coordinates with Communities/Neighborhoods

Incident Command System




Volunteering for Disaster Response & Recovery
Scope of Volunteering
• Local, State, Federal, International
Volunteer Organizations
• Meeting the needs, finding the right fit.
• Government, Non-Profit, Faith Based
Roles in a Disaster
• Leadership, support
• Communications, Logistics, Planning, Public Safety, Public Health, Business Continuity, Debris Removal, Recovery Assistance


Contact Information
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Attachment Two K – Humboldt Community Paramedicine – Nico Simponis

7/17/2012

Community Paramedicine

To fill the gaps in healthcare services
by identifying the particular needs of our community residents and
develop ways to meet those needs.

What is Community Paramedicine?

The use of Community Paramedics
in a "non-traditional" expanded role,
within the community
in an effort to connect
an underserved population
with underutilized resources

Why Do We Need Community Paramedicine?

- 50 million Americans live in rural areas
  - 25% of the population
  - Only 10% of US physicians practice in rural communities
- An ageing population
  - With increasing needs
  - Higher chronic disease rates

A National Rural Health Snapshot

	Rural	Urban
Percentage of US Population	~25%	75%
Percentage of US Physicians	**10%**	90%
Num. of Specialists per 100,000 populations	40.1	134.1
Pop. Aged 65 and older	**18%**	15%
Population below the poverty line	14%	11%
Average per capita income	$19K	$26K
Adolescents (12-17) who smoke	19%	11%
Made death rate per 100,000 (ages 1-24)	80	60
Female death rate per 100,000 (ages 1-24)	40	30
Population covered by private insurance	64%	69%

Rural Issues For Rural Residents

- Access to health care
- People in rural areas face different health issues than people who live in urban areas
- Inability to travel long distances for routine checkups and screenings
- Increased seriousness of health problems due to lack of care and monitoring

1

7/17/2012

Rural Issues Regarding Physicians And Hospitals

- Fewer physicians and dentists
- Certain medical specialists might not be available
- Access to quality health care is challenging (Referral Appointments)
- Access to quality health care is costly.

Community Paramedicine Opportunities

- To address the primary care shortages by
  - Providing access to healthcare
  - Taking a proactive role in home healthcare
- Decrease the cost of healthcare

Why Community Paramedicine?

- Community Paramedics:
  - Can fill the gaps in home and clinic healthcare with education and expanded skills
  - Know how to assess resources and make critical decisions
  - Will have the time and ability to deliver quality healthcare to residents in there homes and or clinics

What Community Paramedicine Can Offer

- Encourage responsibility of the patient to manage his/her care and treatment proactively
- Work with the patient's healthcare team to follow a care plan for their individual needs

What Community Paramedicine Can Offer

- Treat healthcare issues and advise on follow up care
- Provide assistance in locating appropriate social service needs

What Community Paramedicine Can Offer

- Health and wellness programs
- Health screening and education
- Medication screening and education
- Wound care
- Immunizations
- Risk assessments
- Assist with mobility issues

2

What Community Paramedicine Can Offer

- Monitor and document blood glucose levels, and properly regulate medication(s) administration
- Monitor and document blood pressure
- Monitoring of diabetic patients
- Monitoring of cardiac patients
- Monitoring of stroke patients

Positive Benefits of a Community Paramedicine Program

- Reducing the volume of 911 calls
  - Patients benefit from receiving medical care without having to call 911
- Reducing Emergency Department visits
  - Decreased non-critical patient transports
  - Improve field screening capabilities
  - Referring patients to the appropriate facility
  - Reducing healthcare costs

Positive Benefits of a Community Paramedicine Program

- Reducing hospitalizations
  - Reduction hospitalizations costs
  - Decrease hospital readmissions
  - Promoting health and wellness
- Reducing long-term care beds
  - Providing patients the opportunity to stay at home longer

Positive Benefits of a Community Paramedicine Program

- Care is provided in the home and offers alternatives to costly ED visits
- Treat and refer/release will result in cost savings to the patient and the industry

Positive Benefits of a Community Paramedicine Program

- Economic efficiencies in the overall healthcare system
- EMS will be more cost effective
- Decrease cost
- Staff opportunity:
  - Career advancement
  - Decrees burnout
  - Retention

How it Works

1. Identification of patients that would benefit from the Community Paramedicine Program
2. Referral from a physician
3. Community Paramedicine Coordinator contacts the patient to schedule a visit
4. Community Paramedic provides services in the home that are within current scope of practice
5. Community Paramedic will communicate with physician to ensure quality of care and oversight

Challenges

- Funding and reimbursement
- Regulation
- Medical direction and program oversight
- Development of expanded scope of care
- Education
- Data collection and program evaluation
- Integration and collaboration with other healthcare professionals

Current Community Paramedicine Programs

- **Nova Scotia**
  - Issues
    - Small population
    - 2+ hours to nearest hospital
    - No local healthcare provider

Trends in Community Paramedicine Programs

- Nova Scotia's Community Paramedicine Program
  - Over a five year period
    - 40% reduction in Emergency Room visits
    - 28% reduction in clinic visits

Trends in Community Paramedicine Programs

- State of Alaska's Community Paramedicine Program
  - Large remote communities
    - 180 villages
    - > 300,000 patient encounters
  - Provides
    - 24-hr emergency care
    - Urgent care
    - Prenatal care
    - Preventative care
    - Chronic care

Questions?

COMMUNITY PARAMEDIC

Attachment Two L – Washoe Mass Fatality Plan – Dr. Ellen Clark

Washoe County Medical Examiner Mass Fatality Plan

Chief Medical Examiner: Ellen Clark, M.D.

Chief Medical Examiner/Coroner Vision and Mission

Vision:

Comprehensive, scientifically sound, compassionate death investigations are a community standard.

Mission:

Investigate unexpected and unexplained deaths in order to identify and report on the cause and manner of death. We use sound scientific techniques, integrity and compassion to serve persons impacted by these deaths.

Legal Authority

Under the authority of Nevada Revised Statutes 244.163 and 414.00 and Washoe County Codes 35.170 and 65.300, the WCMECO is the principle agency and incident in which there is loss of life. Once the search and rescue operations are completed, the incident becomes a search and recovery operation under the authority of the WCMECO.

This Mass Fatality Plan becomes a guide for an occasion when the WCMECO is activated and procedures and protocols within this plan utilized.

Washoe County Medical Examiner/Coroner Mass Fatality Plan

Chief Medical Examiner: Ellen Clark, M.D.

- 2007: Supplies/Capacity
  - 10 Disaster Barrels
  - 80 Pouches
  - Paper Tags
  - String/Stakes
  - 20 gurneys, 6 stackable trays
  - 40-50 refrigeration capacity
  - 20 garage Capacity
  - 5 Autopsy Stations
  - Transport via funeral homes
  - 1 Office Vehicle

Purpose

- Assign responsibility for activities in a catastrophic disaster, which may exceed the local resources for handling fatalities.
- Builds on MCI plan, for fatality management.
- Provides a structure for coordination and communication among multiple emergency medical, law enforcement and emergency management agencies.

Scope and Applicability of Plan

- Provides concept of operations and roles and responsibilities for mass fatality incidents in Washoe County.
  - Applies to (WCMECO) and partner agencies and organizations having a role in implementing this plan
  - Describes the legal authority for mass fatality operations in the county.
  - Is countywide in scope
  - Defines roles and responsibilities for WCMECO staff
  - Describes the process for providing assistance for mass fatality management outside of Washoe County

1

Mass Fatality Planning Initiative

- Leverage multiple funding sources- ASPR Health Grants, UASI, etc.
- Analyze most likely Mass Fatality Incidents (MFI) for each region of NV (include neighboring State/Counties)
- Include all Coroners, ME/Pathologists, and Sheriffs with Coroner duties Statewide

Unified Victim Identification System (UVIS)

- Call Center Operations
- Family Assistance Center Operations
- Ante-Mortem Interview questionnaire
- DNA / Personal Effect accessioning
- Electronic collection of post mortem data
- Disaster Victim Identification (AM-PM Comparisons)
- Dental Comparison Module

ICRA sapphire inc.

Rural Response Trailers

Components:

Tent
Backboards
Wheeled Carriers
PPE
Body Bags
Exam Table
Cameras
Printer/FAX

Equipment staged in 14 counties
(All minus Clark, Carson City, and Washoe)

2011 Capabilities

- Rural counties have enough supplies to function until ME Office arrives for mutual aid
- WCMEO can set up DPMU, perform examinations & begin identification process until Federal assistance is available
- DPMU allows us to perform essential daily operations if Kirman were inaccessible
- WCMEO now has storage for an additional 35 cases

WCMEO functions for OA

- At the request of the Sheriff/Coroner's Office:
- Medical Examiner consults (case review)
- External Examination
- Autopsy
- Identification

WCMEO Role in rural MFI

- Confer with local sheriff/coroner
- Assist (as needed) with scene investigation, recovery, transport storage
- Perform postmortem examinations
- Assist in identification

Disaster Portable Mortuary Unit: Deployment

Module 1: Decedent Transport Device

- 2 Office Vehicles Capacity: 4
- Refrigerated Trailer Capacity :18

Module 2: Storage Containers

Polar King Refrigeration Unit Capacity -16
Can be wired to WCMEO for supplemental storage or be towed to DPMU & powered by generator

Module 3: Tents

- DRASH Tents
- Powered by generator, climate controlled HVAC
- Receiving, processing, examinations
- 17 examinations performed during Longley deployment

Module 4: Anthropology Trailer

Module 5: Automation Equipment

- Server
- Laptops
- Fax Machines
- Presently with Command Trailer (in progress)

Module 6: Dental Equipment

Used in both daily operations & mass fatality event

- Integral in identifications for Amtrak and Air Races
- AM/PM comparison

Module 7: Generators (Electrical)

Capability to power

- Morgue equipment
- X-ray equipment
- Refrigeration units
- Exterior lighting
- Office equipment

Module 8: Hand Tools Maintenance, Office Equipment

Module 9: Morgue

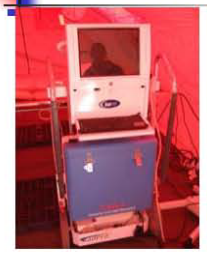
Module 9: Morgue Specific

- Admitting Station
- WCMECO Log In/Out Report
- Morgue Tracker Team
- Forensic Pathology Station
- Forensic Photography Station
- Personal Effects Station
- Identification Station
  - Fingerprint
  - Dental
  - Radiology
  - Anthropology
  - DNA

Module 10: Pathology

- Tools for examinations
- Pathologist tools
- Technician tools
- Med. Exam & Autopsy Kits

Module 11: X-ray Equipment



- Allows shooting and processing of x-rays in DPMU
- Same processing system as our office unit
- Document injury
- Assist with identification
- Identify safety issues (firearms, explosives)

Module 12: Safety Equipment

- Hardhats
- Work Gloves
- Reflective Vests
- Head Lamps
- Hand warmers, Beanies
- Cooling wrap, electrolyte drink mix

Module 13: Command Post

Hospital Role in MFI

- Notification to ME/Coroner
- Providing patient names to aid in identification process
- Update on patient status (brain death)
- Obtain NOK info

2012 Goals: Hospitals

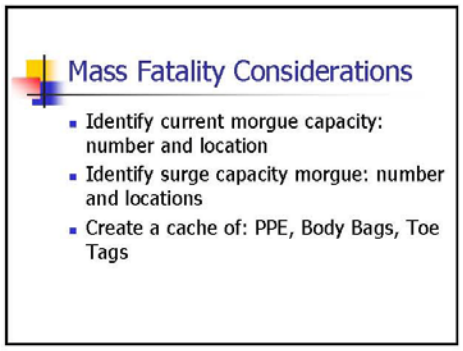
Utilize lessons learned from MFI to:

- Train with Hospitals (Plan, procedures & UVIS)
- Table top

Hospital Planning

- Identify points of contact for information on Mass Fatality Incident planning resources
- Coroner/Medical Examiner
- Local Health Authority and/or Local Emergency Manager
- Funeral Directors
- Cultural and Faith-based community contacts

5


Mass Fatality Considerations
Identify current morgue capacity: number and location
Identify surge capacity morgue: number and locations
Create a cache of: PPE, Body Bags, Toe Tags


Thank You

6

Attachment Three: Breakout Session Scenarios and Questions

Attachment Three A – Scenario One Meningitis – Laura Valentine

7/17/2012

BREAKOUT DISCUSSION (guidelines)

- This IS NOT a test of current capabilities or critique of existing responses, but rather:
  - Make the exercise real for you/your group
  - Use the knowledge and information available in your group
  - Use active thinking, listening and participation
  - Respect others in group – challenge ideas, not people
  - Understand that people may come from other areas of the state but may have encountered the same situation, barrier, etc.
  - All ideas/dialogue are welcome
  - No hypothetical assumptions of resources or expectation of resolution

1/00/2012 2

PURPOSE

- Promote an understanding of the capacity to provide public health emergency preparedness in rural areas, including the role of public health
- Examine current policies, resources, capacity, etc.
- Promote a greater understanding to bridge the gaps between partners (rural, tribes, state)
- Raise awareness of the full capacity needed for a community-wide response
- Look at possible next steps in terms of training & exercises
- Understand the need to include at-risk/vulnerable populations

1/00/2012 3

OBJECTIVES

- Evaluate policies and resources
- Evaluate command and control, including communication
- Identify training needs
- Create action plans/next steps

1/00/2012 4

SCENARIO

- A student from a local tribe reports to the school nurse with symptoms of:
  - Fever
  - Nausea
  - Headache
  - Stiff neck

- Background –
  - 7 other students have called into school sick today with those same symptoms – 4 of these people have special needs
  - 4 people at the local nursing facility/senior center also mention to staff having these symptoms

1/00/2012 5

SCENARIO – PAGE 2

- The school nurse sends the student to their local healthcare provider
- Shortly thereafter, the student develops a pinpoint rash
- Lab work is conducted to determine if this is a case of meningitis or common flu (it is meningitis)
- What are next steps?

1/00/2012 6

QUESTIONS

- What does each person in each step of the scenario need to know
- How is information obtained
- What do policies indicate
- What are you going to do
- If suddenly health care provider (other entity) has determined that 20 people (3 more people with special needs, 7 other students, 5 elderly, and other 5 in various remote areas) now have these same symptoms – what is the protocol
- What actions are next taken – activate incident command? (if so, describe structure)

1/00/2012 7

ICS STRUCTURE QUESTIONS

- Does your community have an ICS incident commander (who might that be and is it more than one person)
- Who is the public information officer
- Who is the liaison officer
- Who is the operations chief
- How will you incorporate medical services
- What other ICS positions will you need to activate for this scenario and who will fill them

1/00/2012 8

SCENARIO UPDATE

- You find out that 2 corresponding communities are facing the same situation and have been for the last 8 days
- Hospitalized people have been treated and are getting better
- 1 other county does not have any reported incidents but provides services to many of the same people who have been infected
- Over the next 2 weeks people are starting to get care and recovering

1/00/2012 9

QUESTIONS

- What else do you need to know
- What was the flow of information
- Who are the players that would have been involved in this incident
- Who was forgotten
- What did the ICS command structure do (or didn't do)
- What other improvements need to be made and how can Health Division assist

1/00/2012 10

HOT WASH

- How well did incident command structure work
- How well did others brought into the incident work together
- How well did communications plan operate and assist, including community education
- Who was required to work together in this scenario
- What external agencies did Liaison officer bring in
- Are agreements (MOA) in place to facilitate
- What improvements needs/next steps

1/00/2012 11

ACTION PLAN/NEXT STEPS

- The scenario team brought away from this:
  - Keep doing _____
  - Stop doing _____
  - Start doing _____
  - What else _____
  - How can Health Division assist _____
  - What do counties need to be successful

_____

and who else needs to be involved:

_____

1/00/2012 12


CAN YOU NAME
• Who were the community partners that were identified in this scenario
• Did it include everyone:
• Rural
• Tribal
• State
• Private entities (volunteers)
• Private organizations
• Who else
1/30/2012
13


CONCLUSION
• The Division of Public Health and Clinical Services (formerly known as FaR) is available to assist with:
• Training
• Technical assistance
• Information
• resources
Thank you for participating in this scenario
1/30/2012
14

Attachment Three B – Scenario One Meningitis QUESTIONS – Laura Valentine

Scenarios #1 – Questions to be answered by group

1. What does each person in each step of the scenario need to know (in general)?

2. How is information obtained?

3. What do policies indicate?

4. What are you going to do?

5. If suddenly a health care provider has determined that 20 people (3 with special needs, 7 students, 5 elderly, and 5 in a remote area) have symptoms, what is the protocol?

6. What actions are taken next (activate incident command, etc.) – describe?

7. Does your community have an ICS incident command?

8. Who is the public information officer?

1

9. Who is the liaison officer?

10. Who is the operations section chief?

11. How will you incorporate medical services?

12. What other ICS positions will you need to active for this scenario and who will fill them?

13. What else do you need to know?

14. What was the flow of information?

15. Who are the players that would have been involved in this incident?

16. Who was forgotten?

17. What did the ICS command structure do (or not do)?

18. What other improvements need to be made and how can the Health Division assist?

19. From scenario, what is the team's suggestion about what should continue doing?

20. From scenario, what is team's suggestion about what should be stopped?

21. From scenario, what is team's suggestion about what should be started?

22. From scenario, what is team's suggestion about what else should be done?

23. How can the Health Division assist?

24. What do counties need to be successful?

25. Who else needs to be involved?

Attachment Three C – Scenario Two Weather – Laura Valentine

7/17/2012

BREAKOUT DISCUSSION (guidelines)

- This IS NOT a test of current capabilities or critique of existing responses, but rather:
  - Make the exercise real for you/your group
  - Use the knowledge and information available in your group
  - Use active thinking, listening and participation
  - Respect others in group – challenge ideas, not people
  - Understand that people may come from other areas of the state but may have encountered the same situation, barrier, etc.
  - All ideas/dialogue are welcome
  - No hypothetical assumptions of resources or expectation of resolution

1/30/2012 2

PURPOSE

- Promote an understanding of the capacity to provide public health emergency preparedness in rural areas, including the role of public health
- Examine current policies, resources, capacity, etc.
- Promote a greater understanding to bridge the gaps between partners (rural, tribes, state)
- Raise awareness of the full capacity needed for a community-wide response
- Look at possible next steps in terms of training & exercises
- Understand the need to include at-risk/vulnerable populations

1/30/2012 3

OBJECTIVES

- Evaluate policies and resources
- Discuss the activation of the command structure
- Evaluate command and control, including communication
- Provide input for continued operations
- Identify training needs
- Create action plans/next steps

1/30/2012 4

SCENARIO

- A community is planning a softball tournament/community fair consisting of:
  - Children and families of 3 counties
  - 3 balloons to provide rides
  - A dozen or more craft vendors
  - Locals with horses to provide rides
- Background –
  - Although rain is expected in the forecast, it is not to arrive for late in the day and minimal precipitation and winds were forecast
  - Midway through this event, the winds pick up rapidly and quickly lead to high gale force winds with percipitation

1/30/2012 5

SCENARIO – PAGE 2

- The winds and rain prevent easy disbanding of people from event
- Shortly thereafter the roads in lower areas start to flood so that some people from surrounding counties can no longer head home
- One of the balloons was affected by the winds and all 5 people in the balloon have been severely injured
- What are next steps?

1/30/2012 6

QUESTIONS

- What does each person in each step of the scenario need to know
- How is information obtained
- What do policies indicate
- What are you going to do
- If, suddenly during the remaining hours, 7 more people are injured – what is the protocol
- What actions are next taken – activate incident command? (if so, describe structure)

ICS STRUCTURE QUESTIONS

- Does your community have an ICS incident commander (who might that be and is it more than one person)
- Who is the public information officer
- Who is the liaison officer
- Who is the operations chief
- How will you incorporate medical services
- What other ICS positions will you need to activate for this scenario and who will fill them
- What protective measures are taken

SCENARIO UPDATE

- You find out that this weather pattern is affecting surrounding counties and the storm is expected to last for the next 24+ hours
- People may or may not have access to medical care
- The weather system is impacting radio and television reception
- Three structures have been damaged: a nursing facility, the local health/mental health clinic and an animal hospital

QUESTIONS

- What else do you need to know
- What was the flow of information
- Who are the players that would have been involved in this incident
- Who was forgotten
- What did the ICS command structure do (or didn't do)
- What other improvements need to be made and how can Health Division assist

HOT WASH

- How well did incident command structure work
- How well did others brought into the incident work together
- How well did communications plan operate and assist, including community education
- Who was required to work together in this scenario
- What external agencies did Liaison officer bring in
- Are agreements (MOA) in place to facilitate
- What improvements needs/next steps

ACTION PLAN/NEXT STEPS

- The scenario team brought away from this:
  - Keep doing _____
  - Stop doing _____
  - Start doing _____
  - What else _____
  - How can Health Division assist _____
  - What do counties need to be successful

_____

and who else needs to be involved:

_____


CAN YOU NAME
• Who were the community partners that were identified in this scenario
• Did it include everyone:
• Rural
• Tribal
• State
• Private entities (volunteers)
• Private organizations
• Who else
1/20/2012
13


CONCLUSION
• The Division of Public Health and Clinical Services (formerly known as FaR) is available to assist with:
• Training
• Technical assistance
• Information
• resources
Thank you for participating in this scenario
1/20/2012
14

Attachment Three D – Scenario Two Weather QUESTIONS – Laura Valentine

Scenarios #2 – Questions to be answered by group

1. What does each person in each step of the scenario need to know (in general)?

2. How is information obtained?

3. What do policies indicate?

4. What are you going to do?

5. If suddenly, during the remaining hours, 7 more people are injured, what is the protocol?

6. What actions are taken next (activate incident command, etc.) – describe?

7. Does your community have an ICS incident command?

8. Who is the public information officer?

1

9. Who is the liaison officer?

10. Who is the operations section chief?

11. How will you incorporate medical services?

12. What other ICS positions will you need to active for this scenario and who will fill them?

13. What protective measures are taken?

14. What else do you need to know?

15. What was the flow of information?

16. Who are the players that would have been involved in this incident?

17. Who was forgotten?

18. What did the ICS command structure do (or not do)?

19. What other improvements need to be made and how can the Health Division assist?

20. From scenario, what is the team's suggestion about what should continue doing?

21. From scenario, what is team's suggestion about what should be stopped?

22. From scenario, what is team's suggestion about what should be started?

23. From scenario, what is team's suggestion about what else should be done?

24. How can the Health Division assist?

25. What do counties need to be successful?

26. Who else needs to be involved?

Attachment Four: Press Release and Media Coverage Samples

Attachment Four A – Press Release – Richard Whitley

Richard Whitley, M.S.
Administrator

Tracey D. Green, M.D.
State Health Officer

Contact Name: Laura Valentine
Phone Number: 775-684-5981
Release Date: May 24, 2012
Page 1 of 1

NEVADA STATE HEALTH DIVISION

NEWS RELEASE

Rural Counties Brace for Emergencies at 2-day Meeting

Public Health Rural Emergency Preparedness Summit coming to Fallon

Carson City, NV - Emergency response leaders from rural and frontier counties of Nevada will gather at the Fallon Convention Center on May 30 and 31 for a *Public Health Rural Emergency Preparedness Summit*. This is the first gathering of its kind in Nevada.

The *Summit* is funded by the Assistant Secretary for Preparedness and Response (ASPR) and the Centers for Disease Control and Prevention (CDC). Rural Assemblyman Pete Goicoechea has been a major champion of the *Summit*.

Expert presenters at the *Summit* will provide guidance on preparedness and encourage collaboration among counties for preventing and handling public health emergencies and disasters. In addition to the presentations, the *Summit* will feature tabletop exercises so that participants can practice responding to incidents such as a public health or weather emergency in a rural county.

"Of Nevada's total population, about 11% reside in the frontier and rural communities, but that area represents 87% of our land mass," said Tracey D. Green, MD, State Health Officer. "Most of these communities are long distances from a major health center, which presents extra challenges during medical emergencies."

Many Nevadans are aware how emergencies in rural areas can quickly overwhelm local responders. County resources and are aggravated by remote geographic locations, extreme conditions and limited resources characteristic of remote areas. Hence, partners are vital when counties plan, train, and exercise emergency preparedness. In light of federal budget consolidation and decreased funding, the *Public Health Rural Emergency Preparedness Summit* is a rare and valuable opportunity for rural partners to learn more about the issues related to emergency response.

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For information about the Nevada State Health Division, go to: www.health.nv.gov. For details regarding the *Public Health Rural Emergency Preparedness Summit*, contact Laura Valentine, NSHD Health Resource Analyst, at 775-684-5981

HEALTHY NEVADANS 2020

Richard Whitley, Administrator

4150 Technology Way, Suite 300 Carson City, Nevada 89706
Phone (775) 684-4200, Fax (775) 684-4211
NEVADA STATE IS AN EQUAL OPPORTUNITY EMPLOYER

Rural counties to discuss emergencies at 2-day meeting

MAY, 22 2012
SPECIAL TO THE LVN

Emergency response leaders from rural and frontier counties of Nevada will gather at the Fallon Convention Center on May 30-31 for a Public Health Rural Emergency Preparedness Summit.

This is the first gathering of its kind in Nevada.

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http://www.lahontanvalleynews.com/apps/pbcs.dll/article?AID=/20120522/NEWS/120529988&parentprofile=search&template=printart

Making rural Nevada safe and healthy

'Frontier' areas face challenges to provide health services

MAY, 31 2012

BY STEVE RANSON

LAHONTAN VALLEY NEWS

Health responders from Northern Nevada converged in Fallon for the past two days to learn more about their various roles in emergency preparedness including the prevention and handling of public health emergencies and disasters.

More than 100 professionals from health, fire and law enforcement met at the Fallon Convention Center to hear speakers talk about current trends on Wednesday and to participate in a "scenario activity" on Thursday. The Public Health Rural Emergency Preparedness Summit ended with a panel discussion focusing on the roles and responsibilities for a community response, the coordination among different agencies and organizations and communications.

Attendees didn't need any reminders of how busy the past year has been with man-made and natural disasters in Northern Nevada. Since late June 2011, the area has witnessed a truck collision with an Amtrak passenger train in Churchill County that killed six people; an airplane accident at the Reno Air Races that killed 11 and injured scores more; a gunman going on a rampage in a Carson City restaurant killing five people including himself; and two devastating wildfires near Reno that destroyed dozens of homes.

Each speaker provided guidance on preparedness and encouraged cooperation among the counties for handling emergencies and disasters.

In her opening comments, Mary Liveratti, administrator with Aging and Disability Services Division, said agencies cannot "do it alone" when a major disaster strikes. She said the initial response starts at the local level, and from there, agencies will determine what additional levels are needed.

Chris Smith, chief of the Nevada Department of Public Safety, Division of Emergency Management/Homeland Security, discussed how his agency assists communities during emergencies.

He said the State Emergency Operations Center (SEOC) would become operational when a situation triggers the need for assistance.

"We reach out with whatever you need," he said. "We activate the EOC when a community declares an emergency."

Such was the case locally when Churchill County first-responders and other agencies mobilized during the Amtrak collision north of Fallon. Likewise, since last June, Smith said the EOC stood up for other disasters, and most recently, the EOC was operational during the TRE fire near Topaz Lake.

"We take our job seriously and we're here to support," he said.

Smith said the Division of Emergency Management has a good, working relationship with the Nevada National Guard, Naval Air Station Fallon and Nellis Air Force Base in southern Nevada.

Ron Juliff, emergency manager for Churchill County, and Steve Endacott, emergency manager for the city of Fallon, gave a presentation examining the local response to a chemical spill at the city's water treatment plant and during the Amtrak emergency.

Juliff said a mass casualty exercise six weeks before the Amtrak crash helped the response teams because the same people involved in the drill also participated in the actual emergency.

"It worked the way we really wanted it to work," Juliff said.

Endacott took the attendees through a timetable and discussed how the DEM assisted the city with a Type 1 team, which he said was similar to a wildfire scenario.

The role of public health professionals also has a big role in responding to emergencies.

Jo Malay, Health Program manager for the state's Public Health and Clinical Services, discussed the challenges of meeting the needs of the state's communities, especially with dwindling budgets.

"It's a challenge to meet grant responsibilities and remain true to the mission," she added.

She said community health nurses are located in 10 rural counties at 14 clinic sites, which are funded through federal, state and county agencies.

Goals for 2013, she said, are to conduct low-level assessments and look at mass dispensing efforts for immunizations. Malay said communities must identify their special needs citizens.

"We need to empower the counties to identify the needs and then increase the communities' abilities to work together to affect conditions and outcomes that matter to its residents," she said.

Erin Seward, program manager for the Nevada State Immunization Program, also discussed how the federal government funds her program 100 percent. She discussed the recent outbreak of four Whooping Cough or Pertussis cases in Churchill County and how those cases are reported.

The Public Health Preparedness administrative manager for the Nevada State Health Division examined the healthcare partnerships in Nevada to include hospitals, emergency management, public safety, etc. Tami Kyburz Chartraw said the functions focus on coordinating emergency preparedness situation with the various organizations and identifying and prioritizing healthcare assets and essential services.

Gerald Ackerman, program director for Rural Health, University of Nevada School of Medicine, talked about rural Nevada preparedness and the people served by healthcare professionals.

"Public health is important in rural Nevada," said Ackerman, who lives in Elko County.

He pointed out the many services provided to individuals include Native Americans, military veterans and minorities; however, because of the distances separating communities, he said individuals might travel many miles to seek the services they need.

As for the rural communities, he said there's not a better person who will assist residents than the local community health nurse, but he said the nurses are restricted in what they can provide because of tightened budgets.

Ackerman also said the number of counties operating hospitals has also dwindled as big corporations have bought the facilities; instead of decisions being made at the local level, they are made at a regional or corporate site.

The Assistant Secretary for Preparedness and Response and the Centers for Disease Control and Prevention funded the Summit.

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http://www.lahontanvalleynews.com/apps/pbcs.dll/article?AID=/20120531/NEWS/120539986/1055&parentprofile=1045607&template=printart

Attachment Five: Evaluation Summary and Comments

Attachment Five A – Summit Questionnaire – Blank

Public Health Emergency Preparedness
May 30-31, 2012
SUMMIT EVALUATION

1. Health Division Presentation

NOTE: make one choice for each question	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree
Session objectives were clear					
Session length was appropriate for time allowed					
Content was well-developed					
Presentation provided an overall understanding of agency					
Comments:					

2. Division of Emergency Management and Homeland Security Presentation

NOTE: make one choice for each question	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree
Session objectives were clear					
Session length was appropriate for time allowed					
Content was well-developed					
Presentation provided an overall understanding of agency					
Comments:					

3. Hospital Preparedness Presentation

NOTE: make one choice for each question	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree
Session objectives were clear					
Session length was appropriate for time allowed					
Content was well-developed					
Presentation provided an overall understanding of agency					
Comments:					

4. Fallon Emergency Management Presentation

NOTE: make one choice for each question	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree
Session objectives were clear					
Session length was appropriate for time allowed					
Content was well-developed					
Presentation provided an overall understanding of agency					
Comments:					

5. Raising Awareness of Rural Preparedness Presentation

NOTE: make one choice for each question	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree
Session objectives were clear					
Session length was appropriate for time allowed					
Content was well-developed					
Presentation provided an overall understanding of agency					
Comments:					

6. Tribal Emergency Preparedness Presentation

NOTE: make one choice for each question	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree
Session objectives were clear					
Session length was appropriate for time allowed					
Content was well-developed					
Presentation provided an overall understanding of agency					
Comments:					

Thank you for taking the time to complete this evaluation 1

7. Murphy Complex Incident Presentation

NOTE: make one choice for each question	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree
Session objectives were clear					
Session length was appropriate for time allowed					
Content was well-developed					
Presentation provided an overall understanding of agency					
Comments:					

8. Interoperable Communications Presentation

NOTE: make one choice for each question	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree
Session objectives were clear					
Session length was appropriate for time allowed					
Content was well-developed					
Presentation provided an overall understanding of agency					
Comments:					

9. Building Volunteer Capacity Presentation

NOTE: make one choice for each question	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree
Session objectives were clear					
Session length was appropriate for time allowed					
Content was well-developed					
Presentation provided an overall understanding of agency					
Comments:					

10. Humboldt General Hospital Presentation

NOTE: make one choice for each question	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree
Session objectives were clear					
Session length was appropriate for time allowed					
Content was well-developed					
Presentation provided an overall understanding of agency					
Comments:					

11. Washoe County Coroner Presentation

NOTE: make one choice for each question	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree
Session objectives were clear					
Session length was appropriate for time allowed					
Content was well-developed					
Presentation provided an overall understanding of agency					
Comments:					

12. What part of this Summit did you find the most beneficial?

13. What part of this Summit did you find the least beneficial?

14. Do you have suggestions for this Summit or future Summits or other future collaborations?

Thank you for taking the time to complete this evaluation 2

15. What other activities would be helpful for me and/or my community?

☐ ICS training in my community	☐ Tabletop & other exercises in my community
☐ Emergency Prep Materials (specify below)	☐ Newsletter or list-serv communication
☐ Other types of training (specify below)	☐ Other (specify below)

Specify from above:

16. My primary job duties would fall within the following category:

☐ Hospital Administrator/Manager	☐ Other hospital staff person
☐ Emergency Medical Staff	☐ Emergency Manager
☐ Tribal participant	☐ Fire, police, or other first responder
☐ County Employee	☐ State Employee

17. What other additional information/materials could help your community?

18. Any other comments:

Use the space below to provide any additional information you did not include anywhere above:

Thank you for taking the time to complete this evaluation 3

Public Health Emergency Preparedness
May 30-31, 2012
SUMMIT EVALUATION

1. Health Division Presentation

NOTE: make one choice for each question	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	N/A
Session objectives were clear	27	8	11	0	2	2
Session length was appropriate for time allowed	31	8	7	2	0	2
Content was well-developed	25	9	8	5	0	3
Presentation provided an overall understanding of agency	29	7	10	0	1	3
Comments:						

2. Division of Emergency Management and Homeland Security Presentation

NOTE: make one choice for each question	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	N/A
Session objectives were clear	35	8	4	0	0	3
Session length was appropriate for time allowed	39	8	3	0	0	2
Content was well-developed	37	11	2	0	0	2
Presentation provided an overall understanding of agency	36	9	2	0	0	3
Comments:						

3. Hospital Preparedness Presentation

NOTE: make one choice for each question	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	N/A
Session objectives were clear	27	11	4	3	0	5
Session length was appropriate for time allowed	29	9	8	1	0	3
Content was well-developed	24	12	8	2	0	4
Presentation provided an overall understanding of agency	24	12	9	1	0	4
Comments:						

4. Fallon Emergency Management Presentation

NOTE: make one choice for each question	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	N/A
Session objectives were clear	40	6	2	0	0	2
Session length was appropriate for time allowed	39	6	2	0	0	3
Content was well-developed	38	9	1	0	0	2
Presentation provided an overall understanding of agency	37	8	1	0	0	4
Comments:						

5. Raising Awareness of Rural Preparedness Presentation

NOTE: make one choice for each question	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	N/A
Session objectives were clear	36	9	1	1	0	3
Session length was appropriate for time allowed	31	10	5	0	0	3
Content was well-developed	34	9	3	1	0	3
Presentation provided an overall understanding of agency	33	8	5	0	0	4
Comments:						

6. Tribal Emergency Preparedness Presentation

NOTE: make one choice for each question	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	N/A
Session objectives were clear	25	12	8	1	1	3
Session length was appropriate for time allowed	27	13	4	0	1	5
Content was well-developed	25	13	7	1	1	3
Presentation provided an overall understanding of agency	25	13	6	1	1	4
Comments:						

Thank you for taking the time to complete this evaluation 1

7. Murphy Complex Incident Presentation

NOTE: make one choice for each question	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	N/A
Session objectives were clear	36	7	6	0	0	1
Session length was appropriate for time allowed	37	6	5	0	1	1
Content was well-developed	35	9	4	1	0	1
Presentation provided an overall understanding of agency	37	6	5	0	0	2
Comments:						

8. Interoperable Communications Presentation

NOTE: make one choice for each question	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	N/A
Session objectives were clear	31	13	5	0	0	1
Session length was appropriate for time allowed	27	10	6	4	0	3
Content was well-developed	32	12	5	0	0	1
Presentation provided an overall understanding of agency	27	16	6	0	0	1
Comments:						

9. Building Volunteer Capacity Presentation

NOTE: make one choice for each question	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	N/A
Session objectives were clear	42	4	0	0	0	4
Session length was appropriate for time allowed	38	6	1	0	0	5
Content was well-developed	40	5	0	0	0	5
Presentation provided an overall understanding of agency	38	5	0	0	0	7
Comments:						

10. Humboldt General Hospital Presentation

NOTE: make one choice for each question	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	N/A
Session objectives were clear	35	4	3	1	0	7
Session length was appropriate for time allowed	33	8	2	0	0	7
Content was well-developed	34	6	2	0	1	7
Presentation provided an overall understanding of agency	33	6	2	1	0	8
Comments:						

11. Washoe County Coroner Presentation

NOTE: make one choice for each question	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	N/A
Session objectives were clear	33	4	2	0	0	11
Session length was appropriate for time allowed	33	4	2	0	0	11
Content was well-developed	32	3	4	0	0	11
Presentation provided an overall understanding of agency	32	4	2	0	0	12
Comments:						

12. What part of this Summit did you find the most beneficial?

13. What part of this Summit did you find the least beneficial?

14. Do you have suggestions for this Summit or future Summits or other future collaborations?

Thank you for taking the time to complete this evaluation 2

15. What other activities would be helpful for me and/or my community?

☐ ICS training in my community	☐ Tabletop & other exercises in my community
☐ Emergency Prep Materials (specify below)	☐ Newsletter or list-serv communication
☐ Other types of training (specify below)	☐ Other (specify below)

Specify from above:

16. My primary job duties would fall within the following category:

☐ Hospital Administrator/Manager	☐ Other hospital staff person
☐ Emergency Medical Staff	☐ Emergency Manager
☐ Tribal participant	☐ Fire, police, or other first responder
☐ County Employee	☐ State Employee

17. What other additional information/materials could help your community?

18. Any other comments:

Use the space below to provide any additional information you did not include anywhere above:

Thank you for taking the time to complete this evaluation 3

Summit Evaluation Comments

1. Health Division Panel – JoAnne Malay, Tami Chartraw, Erin Seward

Comments:

- No material handed out to follow presenters.
- Inaccurate info given esp re: immunization funding.
- Iz (?) good but long.
- Unorganized. Slides did not match presentation, only snapshot of program. *Slides in handout not user friendly, flip flopped, font too small in handout.
- Multiple presenters.
- A little slow start – being first might have mattered. A little difficult to follow.
- Some of the info was not true in 'real life'.
- IZ (Erin S.) provide a good presentation.
- EMS was not identified during presentation. EMS is important to Public Health.
- Content for presentation was not very organized and they rushed (? Handwriting on last word.)

2. Division of Emergency Management and Homeland Security Presentation – Chris Smith

Comments:

- Good overall – should focus on rural/frontier areas/issues.
- Handouts pretty – not much substance. Looks expensive.
- Great speaker.
- Entertaining and informative – thanks!
- Good presentation – very dynamic speaker.
- Very informative.
- Great prop.

3. Hospital Preparedness Presentation

Comments:

- Need more focus on rural areas involvement.
- Very brief. Did not articulate beyond what was on slides.
- Slide handout very hard to follow along/immunization printout fonts too small.
- Enjoy the speaker!

- Clarified a lot of the confusion surrounding PHP as a whole.

4. Fallon Emergency Management – Steve Endacott and Ron Juliff

Comments:

- Good presentation.
- Good, targeted presentation.
- Very good, interesting.
- Slides in handout did not match presentation.
- Kudos to City of Fallon and Churchill County EM as well as all of the additional responders.
- Good account of how disasters handled at local level.
- Good to know what is happening at our communities.
- Presenters worked well together.
- Excellent! Great slide presentation.
- Pictures were great. I am glad to know how our communities are helping each other in times of need.
- No real mention of EMS response/activities.
- Good presentation.
- No material handed out to follow presentations for 1st presentation. *(Note: this person seems to be referring to the fact that the presenters added a section at the beginning and talked about an acid spill at the water treatment plant.)*

5. Raising Awareness of Rural Preparedness – Gerald Ackerman

Comments:

- Speaker – very good.
- Best presentation so far. Great data available.
- Great speaker!
- Very valuable information.
- Too long during too long after lunch.
- Wish there was more time – great presenter.
- Should have covered EMS in depth.
- Found this very interesting and informative.
- Very interesting – scary info.
- Did not fit PHP Summit Subject. The last 3 minutes were good.
- Too much school of Medicine, not enough preparedness focus.
- Short.

6. Tribal Emergency Preparedness – Daniel Thayer

Comments:

- What was this?
- Definitely a passionate/gifted speaker. Informative but not really useful.
- Not well developed presentation – little flow.
- Good job on presenting, nice presentation.
- Glad to hear that someone else realizes the need to bring all response into this together.
- Impromptu approach worked in this case.
- Good to know and be aware of our neighbors in tribal communities.
- Very good presentation.
- Well presented.

7. Murphy Complex Incident - Larry Manning, Rozilyn Jones, Ruby Manning

Comments:

- Excellent presentation.
- Couldn't hear many questions being asked.
- Nice job.
- Nice flow well.
- Great presentation and great job in keeping your community 'going' during a serious time of need.
- Very good, personable presentation. Present unique challenges of tribes.
- Is the State aware of tribal issues? Excellent info.
- Awesome.
- It is upsetting to know that no one went the extra mile to help. It is a good thing that the tribe members are being positive about this incident. Something should be done next time.
- Great debrief of event – rambled a lot toward end.
- Mutual admiration societies. (? Handwriting hard to read.)
- What is the state going to do next time? I am just disappointed that the tribe had to do all this work by themselves. Nevada should have helped. Thanks to those people that helped and didn't leave those members to suffer.

8. Interoperable Communications – David Fein

Comments:

- Needed more rural connection examples.
- Well the presenter was friendly. This level of detail was a little too much for most people. A general overview may have sufficed.

- Great presentation.
- Very good!
- Thought this was very technical but VERY interesting and good info.
- Good trying to make a very difficult subject to non-techies understandable and interesting.
- Great speaker!!!
- Really good information.
- Handout too small to read slides.
- This was presented 2 years ago to EM locally. NOT NEW! Could have been done in less time. "Beat a dead horse."
- Pretty technical – did not understand much.
- Rambled on and got too technical.
- Very technical – presenter was enthusiastic, but content was very technical.

9. Building volunteer Capacity – Wendy Luck

Comments:

- Provide more detail on types of volunteers listed in registry.
- Examples of volunteer categories and vetting process needed.
- Great speaker!
- Excellent presentation, information.
- Excellent program – great opportunities for volunteers.
- Wow! What a find for NV!
- Great presentation.
- Useful information, of interest, good resource to know about. Very good, fun speaker, liked her personal approach.
- Good speaker.
- Very good speaker and very informative.
- Great speaker.
- Wendy did a nice job.
- Very interesting. I liked the information.
- Well done.
- Excellent speaker. Organized. Dynamic. Best.
- I really liked this presentation – fun interaction with audience.

10. Humboldt General Hospital – Nico Simponis

Comments:

- Great idea to review facing our ER dept and ambulance services.
- Very interesting.

- Very good presentation.
- What a concept!
- Good and very applicable presentation.
- Fascinating. I was not aware of this initiative.
- Great ideas for the rural and urban areas.
- Enjoyed this one.
- Who pays for program?? $
- Interesting presentation. Lots of food for thought.
- Misleading? Probably.
- Too many opinions – too few facts.

11. Washoe County Coroner – Dr. Ellen Clark and Karen Brown

Comments:

- Followed script – nice presentation.
- Never really thought about the death side of a disaster and what goes on with that process.
- Great presentation – interesting.
- Difficult but important topic. Glad it was covered.
- Good info to know.
- This was one of the best presentations.

12. What part of the Summit did you find the most beneficial?

- The work group sessions.
- Tribal news of preparedness activities; Good food.
- Networking.
- Coroner presentation.
- The tribes' presentations were the best. Learning about the SatCom vehicles.
- Raising awareness in rural preparedness. Building volunteer capacity. (These gave) information that can be uses! Great speakers.
- Meeting of other agencies and personnel.
- Stories about Murphy Complex and Fallon incident/snacks.
- Everything.
- That great effort went into including the NV tribes in the presentations and scenarios.
- Murphy Complex Incident.
- The group break out sessions.
- Networking.
- Bringing together groups of professional preparedness workers who work on the same problems but who might not cross paths and who can benefit from working together.

- All of it was good.
- All parts – exercise was very helpful to participants but it was good for me to learn about programs and resources.
- Duck Valley Indian Reservation learning experience. Items in place MOU, etc. ESAR-VHP as volunteer program coordinator for Pershing Co.
- Volunteers. The 2 event presentations (Duck Valley and Amtrak). Communication vehicle.
- I appreciated knowing the issues or being aware of what our communities really need. Plan to be prepared in so many ways whether medical/health or natural or manmade disasters.
- Murphy Complex. Coroner.
- The advantages/disadvantages of being rural communities.
- Barriers that small communities and tribes are faced with, especially Duck Valley whose state of emergency was denied
- Presenters and their real life experiences.
- Where we broke off into groups for the disasters.
- Many of the presentations were interesting/informative. The handouts and folder and bag were nice. Food was good!
- Networking with partners.
- Day Two was much better than Day One. I liked the group work and all presentations on day two.
- Para Medicine.
- Scenarios.
- Networking.

13. What part of the Summit did you find the least beneficial?

- AM of first morning seemed unorganized and sporadic.
- Materials not always available or always match.
- The break out session; meet and greet.
- None.
- Coroner – but good to know.
- None.
- Scenario activity.
- That many had to be brief with presentations.
- All components were beneficial.
- I found all parts to be of benefit.
- Break out session was too lengthy and not very helpful due to lack of scenario details.
- Lack of knowledge of attendees that are in the fields. Need to step outside the box. Break out session lacking guidance.
- The Health Departments (first 2 day one presentations).
- All of it was beneficial.

- Interoperable communications.
- Knowledge crap of personnel during the exercise.
- Scenario – not enough info. Didn't flow well.
- The scenario was not very prepared and was too long.
- Some was out of my scope – I am not the one to say.
- Very little of the conference had anything to do with emergency preparedness.
- All was beneficial.

14. Do you have suggestions for this Summit or future Summits or other future collaborations?

- More breaks – allow time for lunch, not rushing through sections when summit is already ahead of schedule. Lack of sufficient breaks causes attendees to lose interest and fail to interpret information being presented.
- Emphasize healthcare coalition building/interaction.
- The was good.
- Don't make it too long. Please prepare more next time. Other than that the presenters were great.
- Participants should introduce themselves. It was difficult to know who to network with if you don't know who is in the room.
- Provide all invites with the FEMA training site and recommend IS-100 be review to provide everyone with common knowledge.
- Should have quarterly.
- Please make our tribes are notified of trainings, summits, etc. Include them in a mailing list. Tribes were informed by Daniel Thayer but it would be great to be notified directly.
- Include mental health/psychological first aid aspect.
- Forgot to include emergency mental health during a disaster.
- Group like groups together for sessions.
- Here, Public Health invited many preparedness workers from different groups. Perhaps we could foster invitations to public health workers at other groups meetings. A future collaboration that incorporated a training/exercise run by an expert would be useful as a learning tool.
- Great summit! How about tabletop exercises that include all the local and state players, i.e. counties, city, tribes, NASF, state, NGO, etc. Learn from each other, open dialogue, relationships, and understandings.
- Focus on planning for specific populations. What is being done in NV?
- Include more public/private collaboration.
- More summits! More education!
- More frequent breaks. I felt bad for taking my own breaks during presentations. Like I was interrupting.
- Keep breakfast and lunch service.

- Inclusion of the tribal gov't organization in relation to emergency response.
- None.
- More involvement from State EMS.
- Private partners, live stream or archive video of summit for those who cannot attend.
- Ensure presenters are aware of their time frames and don't have them go for 15 minutes when 30-60 were allotted.
- Keep this going.
- Rotate to other counties throughout the state/conduct annually.
- Please do not exclude the EMS office.
- More group sessions and table top exercises.

15. What other activities would be helpful for me and/or my community?

☐ ICS training in my community = 17
☐ Tabletop & other exercises in my community = 19
☐ Emergency Prep Materials (specify below) = 13
☐ Newsletter or list-serv communication = 13
☐ Other types of training (specify below) =
☐ Other (specify below)

- Emergency Prep materials – Samples of written plans or how to develop a plan.
- Online newsletter.
- Web content and updates
- Making communities more aware of what their town/city has as far as materials, volunteers, etc.
- Div of Health (create if non-existent)
- ICS 300-400
- Mass Care Transport
- Training on identifying vulnerable populations, especially children
- Blood borne Pathogens Training (2)
- Coroner presentation to EMS – county sites
- "My question is what could I do to help? Where can I get training to be an asset in case of an emergency?" (State Employee)
- POD exercises in ALL rural counties, at least annually
- List of State Resources / List of Radio Contact numbers and systems, etc.
- Psychological First Aid

16. My primary job duties would fall within the following category:

☐ Hospital Administrator/Manager = 1
☐ Other hospital staff person = 0
☐ Emergency Medical Staff = 5
☐ Emergency Manager = 8

☐ Tribal participant = 9
☐ Fire, police, or other first responder = 4
☐ County Employee = 6**
☐ State Employee = 15
☐ Community Health = 1
☐ No Answer = 7

*Please note that some respondents listed two primary job duties.
** County Employees included Elected Officials

17. What other additional information/materials could help your community?

- Efforts for MOA's between military and tribal agencies and exercises for both. Include Indian Health Services (HIS, ITCN, IHBN)
- Rural EMS should have received more attention. State EMS was present but prevented from participating. Why?
- Invite the Medical Directors (doctors) of the 50 or more EMS services.
- Stronger emergency response team.
- List of resources available to access such as ESAR-VHP, NV Division of Homeland Security, SatComm, etc. area specific.
- More information/presentation on ESAR-VHP. ICS classes for those that need to know all components of emergency preparedness.
- Public relations protocol – to inform the public as to services and protocol.
- Once a month meetings for the people in the community, works, nurses, etc.
- How to prepare for disaster in your home.
- Have my community be more involved.
- The county commissioners in attendance opened the eyes of the attendees – they are a resource and want to be part of the team. They were aware that in several presentations "the politicians" were mentioned as a potential obstacle and not a partner and resource. This is an area that needs to be addressed. The elected officials need to be a part of the team.

18. Any other comments:

- The NV Division of Emergency management did not have this Summit on their calendar. Tim Carey – MEP, Exercise officer, NDEM (775) 687-0389 is the contact and he did find the information for me after some research.
- Please keep this going. We need to get groups like this together to keep communication open.
- EMS is the provider of last resort in all rural/frontier areas with 24/7/365 responsibility regardless. When the clinics, hospital and other providers are unavailable for any reason EMS must pick up the call. This includes performing duties usually covered by Public

Healthcare, Home Health and Primary Care Providers. Not addressing them and the challenges rural, mostly volunteer EMS have during emergencies is a troubling omission during this Summit. Although EMS providers and state regulators were present this Summit was obviously oriented towards the Public Health RN's. You should utilize the subject matter experts.

- Do this more often.
- Great conference. Liked the presentations and time allotted. Loved the breakfast and lunches. Great items in the bag. GOOD JOB! Also, glad to meet and network with other agencies. Good to hear from elected officials also.
- To be able to allow other individuals to collect the CEU's for like safety manager/emergency response personnel, etc.
- Excellent Summit!
- The workshop was great and very informative. We should have more with tribal and community.
- NV needs to mirror California Office of Emergency Services (O.E.S.) for EMS and fire statewide mutual aid. "Form" "Nevada O.E.S."
- EMS needed to give a presentation at a state level.
- LEO's are not the enemy of CMS (from county commissioner)
- Thank you
- The debrief of the group discussion was not dynamic. Could have moved better if the group spokespersons presented the group plans and then proceed with questions.
- Thank you so much for having this training/conference in Fallon. It is a great place to visit. It is great for you to come to Fallon. Wendy Luck is wonderful. She probably could do a whole days training with examples and experiences she has had. Enjoyed her and learned a lot in the short time she spoke.
- Overall we have had great info. Just not enough time to cover more material.
- Good overall conference. I made some great contacts for future collaborations. Thank you.
- Set up statewide quarterly response call, webinar, etc. so people can touch base and know what resources are available.
- 1. Would like to have more what's working panel discussion. "What training have you done and what were the outcomes." 2. Regional meetings with the people in them to get them working as a team. Assign an EOC planning person to assist and help them set up, hold exercise and report back with IEP in next year's Summit. This will help to get counties working together. 3. Send an email to all attendees of each other's email contacts to help with partnering. 4. Social media! How to use it in PHP event. 5. We need to do this again.

- Why was the state EMS office not allowed to speak or present? Their office has much to offer in regards to education, staff, resources, and EMS owned equipment available for disasters. Big loss for the conference a lot of info lost/not available to participants.
- Good food and snacks. Nice conference facility.
- Fallon was a nice area for the Summit. Having meals provided was nice as it eliminated the extra time to find a place to eat and it allowed networking (unstructured).
- The presenters were very informative. There was a lot of good information. Please add more to the scenarios. Some things were not prepared. Kim West did a great job keeping people informed about the meeting. Invite people like NHP, NDOT, Churches, Coalitions, County Commissioners, Latino groups.
- Thank you for an overall informative and insightful program. Great job Rota and team!
- Thank you for having all the speakers' PowerPoints as part of the conference packet/handouts. Overall this was a good conference with good speakers and information. Thank you!

Attachment Six – Summit Planning Committee

Name		Title or Department	Phone	Email
Gerald	Ackerman	University of Nevada, Reno		gackerman@medicine.nevada.edu
Stacey	Belt	Carson City Health and Human Services	775-283-7218	sbelt@carson.org
Michelle	Candee	Division of Emergency Management	775-687-0300	mcandee@dps.state.nv.us
Kathi	Haynie	Carson City Health and Human Services		
Linda	Lang	Nevada Statewide Coalition Partnership	775-882-6674	dlhlang@pyramid.net
Darlene	Loff	Division of Emergency Management	775-687-0300	dloff@dps.state.nv.us
Joanne	Malay	Health Program Manager II	775-684-4006	jmalay@health.nv.gov
Christy	McGill	Healthy Communities Coalition (part of the statewide partnership)	775-246-7550	cmcgill@healthycomm.org
John	Packham	University of Nevada, Reno		jpackham@medicine.nevada.edu
Rota	Rosaschi	Nevada Public Health Foundation	775-884-0392	rota@nphf.org
Josh	Taff	Med Surge Planner for Nevada Hospital Assn	775-250-8749	josh@nvha.net
Daniel	Thayer	Inter-Tribal Emergency Response Commission	775-355-0600	Daniel@itcn.org
Cassidy D. (Chad)	Williams	Tribal Liaison	775-684-4000	cdwilliams@dhhs.nv.gov
Tami	Chartraw	ASPER Grant Manager	775-684-4228	tchartraw@health.nv.gov