

Promising Practices in Disaster Behavioral Health Planning: Financials and Administration Operations

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Moderator: Now, let's begin with Promising Practices in Disaster Behavioral Health: Financials and Administration Operations. The webinar will feature Ms. Terri Spear, Emergency Coordinator of the SAMHSA Office of Policy, Planning & Innovation; Ms. Lori McGee, Training and Curriculum Manager of SAMHSA DTAC; and Dr. Anthony Speier, Deputy Assistant Secretary for Development in the Louisiana Office of Behavioral Health. We start today with Ms. Terri Spear. Ms. Spear serves as Emergency Coordinator in the Substance Abuse and Mental Health Administration's Division of Policy Coordination, where she coordinates the SAMHSA's response in emergency situations, including ensuring cross-SAMHSA coordination regarding terrorism and mass trauma events. She serves as the primary SAMHSA liaison with counterparts in other Federal, State, local, and voluntary agencies, organizations, and governments participating in crisis response operation. Ms. Spear earned a master of education in counseling psychology from the State University of New York at Buffalo. Please join me in welcoming Ms. Terri Spear.

Ms. Spear: Thank you very much. The first message I wish to deliver is that SAMHSA wishes to welcome all those accessing this webinar. As you may be aware, this is an element in a series of webinars focused on promising practices within disaster planning. This initiative is directly linked to efforts SAMHSA has included in its March 2011 document, *Leading Change: A Plan for SAMHSA Roles and Actions, 2011–2014*. SAMHSA introduces eight new strategic initiatives that will guide SAMHSA's work to help build strong communities, prevent behavioral health problems, and promote better health. This initiative falls under trauma and justice within those eight. Research has shown that 18.9 percent of men and 15.2 percent of women in the U.S. reported a lifetime experience of a natural disaster. We know that over the past 10 years the number of disasters occurring across the country ranges between 65 and 100 federally declared disasters and many more that occur that are not even declared. So as States look at limited resources and begin to make changes to their plans and their action based on restricted funding and the like, planning is of utmost importance. This series is focused on disseminating the best of what is known in order to equip the best response possible with the resources at hand. Again, I thank you for accessing this information and I hope you find it useful.

Moderator: Thank you very much, Ms. Spear. I'd like now to introduce Ms. Lori McGee. Ms. McGee serves as the Training and Curriculum Manager for SAMHSA DTAC. She has more than 11 years' experience working with program and curriculum developers to improve services using evaluation findings. At SAMHSA DTAC she supervises the development of trainings, both in person and web based. She is also the lead on the Crisis Counseling Assistance and Training Program activities. Ms. McGee has worked with at-risk and delinquent youth populations, populations receiving mental health services, women and families in crisis, and minority students. She has prior experience in providing counseling and legal services to survivors of domestic violence and in developing programs to reduce and prevent violence in schools. Ms. McGee holds a bachelor in psychology from Barnard College and a master in

criminology and criminal justice from the University of Maryland, College Park. Please join me in welcoming Ms. Lori McGee.

Ms. McGee: Thank you, Marcela. Welcome everyone. I'm glad that you've taken the time out to be with us, today. We know that you're all very busy, especially following this spring's activities. I just wanted to say a little bit about SAMHSA DTAC. Many of you are familiar with our services. Some are not. We are established by SAMHSA and we are established to support SAMHSA's efforts to prepare States and Territories and Tribes to deliver effective behavioral health response. When we say behavioral health, we are including both mental health and substance abuse response. Our services are free to States and Territories and Tribes and even to the general public who call in for questions and assistance with any behavioral health needs in response to a disaster. Now let's talk a little bit about what we do. We provide many services, primarily consultation and trainings on disaster behavioral health topics, in preparedness and DBH response, interventions, and promising practices, particularly with special populations. We send out consultants, sometimes. We send out DTAC staff and assist those who are in need and have questions. I know some of you have benefited from these services, and if you haven't, we encourage you to call us if you have any needs that are pressing. We also provide more dedicated training and technical assistance to some of the DBH response grants, such as FEMA's Crisis Counseling Assistance and Training Program, commonly referred to as the CCP. Then, as part of today's webinar, identification and promotion of promising practices in disaster preparedness and planning, this webinar is part of that particular bullet there, that you see on your screen. In addition to those general services, we also have a Disaster Behavioral Health Information Series. We call that our DBHIS. This contains an abundance of resources and toolkits about topics like DBH preparedness and response. Some toolkits are disaster-specific, like floods or tornadoes, even down to a very specific disaster like an oil spill or the Haitian earthquake, something of that magnitude. Then we have a series on specific populations, such as youth and children, older adults, and public safety workers. There's a screenshot of our website right there that you can go to and find many of these resources. We also have many e-communications that come out like our SAMHSA Bulletin, which is a monthly newsletter of resources and upcoming events. There are instructions here on how to subscribe to that. You can do that just by emailing us. The Dialogue is a quarterly journal of articles written by professionals in the field. You can subscribe to that by going to SAMHSA.gov and entering your email address in the mailing list box. Then you'll be prompted to select what you're subscribing to and select SAMHSA's disaster technical assistance newsletter. Finally, the DTAC Discussion Board. It's a place to post resources and ask questions of the field. Sometimes, we might poll you for a particular activity or events and when trying to plan some of our upcoming activities. You can subscribe to that by registering at the site listed here. Finally, I want to encourage you if you have any training or technical assistance inquiries to call either our toll-free number, 1-800-308-3515, or email us at DTAC@SAMHSA.hhs.gov, or visit our website if you just want to browse around and see some of the features that we have going on. Dr. Amy Mack, your Project Director, has her contact information there. That's her direct line and email, if you have any specific questions for her.

Moderator: Thank you so much, Ms. McGee. I'd now like to introduce Dr. Anthony Speier. Dr. Speier serves as the Deputy Assistant Secretary for Development in the Louisiana Office of Behavioral Health. He served as Deputy Assistant Secretary for the Office of Mental Health and Chair of the Adult Services Division of the National Association of State Mental Health Program Directors. He's also currently overseeing the Deepwater Horizon Oil Spill recovery operation. Please join me in welcoming Dr. Anthony Speier.

Dr. Speier: Good afternoon, everyone. I'd like to also extend the welcome of the tri-State consortium of Mississippi, Alabama, and Louisiana. We are meeting on the oil spill and have incorporated this webinar into our meeting. This meeting, and the goals of the webinar, are pretty straightforward: to identify

promising practices, including policies and procedures, in disaster and behavioral health both before and after a disaster. We're really focusing here on the financial and administrative aspects, which are oftentimes a forgotten feature until it's too late. Then, you don't have enough money and enough administration to carry out your project. It's a very important goal and process to keep in mind. The second goal is to demonstrate the importance of clear communication. This is communication across all strata of behavioral health, organization, and the collaborating agencies that are necessary to work within a disaster. There are some basic facts about working in a disaster that DTAC and SAMHSA have put together from interviewing many of you in different States as well as some additional ones that I've had here collected from our colleagues of our experience with disasters and some things that are pretty true that we come across time and time again with disasters. This is the most important one: The majority of States do not have an annual budget appropriation line item for the task of behavioral health. There is no pot of money to work from. Local and State-level public sector administrative procedures are not designed in a way that facilitates rapid communication, mobilization, and deployment of assets and resources. State government is really designed with a lot of redundancy in it and processes that have checkers and double-checkers in it. That's not the way disasters move. My third point is that disasters are rare and typically the response relies on ad hoc processes, from expenditures being covered out of existing resources. Additional basic facts: local resources from both the county and regional health programs are also limited, much like the State, and most of their funding is highly dependent on post-reimbursement through the Crisis Counseling Program. Another big shocker, it's a basic fact that one should always take into account, is administrative non-compliance with decisionmaking. You think you're doing the right thing and then all of a sudden you're not doing the right thing with administrative compliance. The other thing which is always a surprise is complicated funding and reimbursement rules. If you don't understand these rules well at the beginning, it's hard to figure them out in the middle of a disaster. From the consequences you'll see on the screen are expenditures being denied, after you get reimbursement for them, refusal by local behavioral health programs to deploy staff without any kind of guarantee of funding, delay in implementation because of contract and temporary hiring processes can't be implemented. You can't process volunteers as quickly as you need to. In the absence of the structure to get a Crisis Counseling Program grant written adequately and finding out you had inadequate administrative resources once you do get the grant to manage it properly, some of the tools that are readily available for you are the many financial and administrative assistants and guidance from SAMHSA. This is in the documentation as well as from Project Officers. Another major tool and one I swear by is the Command System. This is a model that matches resources with the situational demands of the incident and creates the ability to provide an active response and deal with the recovery phase in a very systematic manner. Then, identifying pre-event your levels of capability and the role assessments are necessary to identify the proper staff to perform these various functions within the ICS structure, the finance, and administration components, which are referenced on this particular slide. With the assistance of DTAC, SAMHSA has put together a series of standards about disaster behavioral health planning. This particular standard is the standard which expresses that your plan should exhibit clarity in financial and administrative operations. You'll see on the screen some of the particular points to pay attention to. The financial support for behavioral healthcare needs to be in place and so do your hazard communications policies and procedures. That takes a lot of work at a lot of different levels of government. You need to balance both your current disaster behavioral health response and the grand implication development process. There's a resource allocation feature you have to pay attention to and policies and procedures for notification of response personnel prior to and during the event. Also, attention needs to be paid to potential sources for supplemental funding. Your State and county governments may have additional resources available. If you work early with them before the disaster itself, you can identify these and not be solely dependent upon the Federal mechanisms. You also need mechanisms set in place for tracking funding and services. These can be things as simple as various forms that you agree upon and before the disaster occurs, training of staff of how to complete the forms. Also, contracting mechanisms for hiring staff need to be established more rapidly than usual.

Ascription of the funding structure ahead of time lets the administration people who have to approve things understand how it's related. The organizational design of the disaster response model that you're using, very specifically pointing out the administrative functions. I'd like to spend a moment on the Incident Command System. A number of you have used this. The Incident Command System, as you can see from the definition, is a way of combining facilities, equipment, personnel, and procedures, often from different sources, in communications so that they can operate as a common organizational structure designed to aid in the incident management activity. You can't be dependent on just a few people with all of the knowledge. You have to be able to expand this information across the range of personnel that you will be relying on. Some of the pre-ICS determinations that one should take into account in your planning process are recognizing and anticipating the requirement that the organizational element be activated, what must be activated, and the necessary steps to delegate authority as appropriate. That has a lot to do with what the scope of the disaster is the number of agencies involved, and locations. You need to establish incident facilities as needed to support field operations. This may be a reassignment or a redeployment of locations and resources that are used for different things during a non-disaster times into a disaster-focused activity during the event. Establish the use of common terminology. That has always been a problem when you work across agencies. People have different terms for different things. It slows down your response capability. The key to successful implementation is rapidly evolving from oral direction to a written Incident Action Plan. If you look at this next chart, this gives you the basic organization features that are included in an Incident Command structure. The thing about Incident Command is that this could all be included in one person in a very small incident, or it could get as complex as each of these boxes having multiple layers underneath of them in a very complex disaster. As you look you will see there are five boxes. The incident commander, then you're planning, logistics, finance, and the actual operations. The emphasis of this webinar is on the finance and administration piece. I want to show you some examples from our experience in Louisiana as we go through how this actually works. You will see on the screen a screenshot of an emergency operation center in Louisiana. While I don't expect you to recognize everybody's face in there, what you ought to see is that there are a lot of people, each with a lot of tabs, which means a lot of confusion if you don't have a way to organize properly. Each of those little clusters of desks and chairs are a well-organized cell within the Incident Command structure. Another thing is assessing your capability and various role assessments that need to be carried out. Specifying the DBH response and recovery roles in a general sense but then being able to think through them when the size of the actual event occurs is an important drill that every State should go through. Set expectations about the capabilities and resources that will be provided before, during, and after an instance that are necessary to support the DBH roles. A lot of this emphasis is on the administrative pieces in this particular feature, when you are talking about capabilities and resources. Being able to inventory and categorize your resources available for an incident. Those of you who operate State facilities, 24-hour facilities, how many fans do you have that you can plug in if the air conditioning system goes out? How many small generators do you have if your whole system is on a generator? What's your backup for diesel fuel and how do you get more? Those are all administrative functions that one should take into account. Then, establishing and verifying the level of capability needed. I underlined verifying. Continuing with functions and responsibilities of finance, documenting resource management during an incident. This could mean simple cost data documentation is essential. Time and place and the kinds of resources that are identified and then allocated through your Incident Command System, you have a very easy and much more successful rate of getting full reimbursement for things that are qualified. The second point is something I'm repeating, identifying the requirements of the reimbursement that are necessary, the ordering and requiring and procurement of goods during the disaster, and the authorizations or authority to do that, being able to mobilize these items quickly, and even after you get them, track and report the time of staff that are involved in this process. The important thing here is in an event, you often need things right when you need them, and not a week later. You can have a real problem with having a lot of inventory that comes in after the need has passed. You have to recover, demobilize what comes in,

be able to reimburse appropriately to the persons that bought it, and then inventory your items. In our case, we have a whole stockpile of computers that have been acquired over multiple events that are all available for us to remobilize and re-task in another disaster event. SAMHSA is not going to want to give us more computers. We know that so we're holding onto those and will use those in the near future if necessary. There are some basic administrative mechanisms that are needed on any mission assignment, and a way to think about it is policy and coordination and support. Policy is really the development, the revision, the signing, and mobilization of policies and procedures, mutual aid agreements, assistance agreements, and/or plans. Personnel change, those agreements become gold in making the administrative decisions that are necessary to mobilize resources. Coordination is really another way of saying practicing at the administrative level so that your resource management is linked into other resource management activities in other agencies. Support. The administrative support necessary for emergency management and instant response and activities cannot be underestimated. Again, if you think of the finance administration box in the ICS framework, these would be three functions underneath of that which are necessary in your planning process to fully understand. Additional functions that I don't think rise to that level but are understood corollaries are your communication capacity, continuity of operations, which we have not spoken to directly in this webinar but will in others, and the credentialing of others and volunteers. If that administrative function is not clear, it will be a huge detriment to the bringing in of and deployment of resources. In some examples from Louisiana, you'll see how our capacity to manage has evolved. Going back to Hurricane Katrina, this is the LSU basketball arena where, with just a few hours notice, was turned into the largest medical shelter in our history of disaster response. I was involved with setting up this shelter. We had 3–5 hours of pre-use notification, there was initial staff and resource mobilization that was all done orally and not done under an Incident Command structure, and there were maybe 30 people trying to set this up. Federal support doesn't show up in that disaster or usually other disasters usually until 24 hours after the event has occurred. Multiple agency resource assignment was very necessary and done on the fly, as was most of the planning. When all was said and done, we had 800 beds, 1,700 medical personnel, and 6,000 patients being seen at the medical special needs shelter. Most of the people were being flown in on Black Hawk helicopters or bussed in. There was a constant flow of people through the center. Giving you a sense of what it looked like on the inside, imagine that as any major college or professional basketball arena and those are all beds and various medical work stations. You'll see from the next slide some of the complexity. I realize that you cannot read that slide, but that's the center of the basketball arena and each of those little lines is a different task. If you don't have your administrative and financial processes in place and if you're not using an ICS model, you can see you're going to have pure chaos. That's where we learned our lesson, right there. The second example is Hurricane Gustav. With Hurricane Gustav we learned to use an H-hour construct. H-hour is the time when a hurricane's tropical force winds are reaching the coast of the State. We have a very organized, common terminology of discussing and planning pre-incident activation of activities and then evacuating various entities. At a certain H-hour, we evacuate nursing facilities, State psychiatric hospitals, we activate what are called strike teams in the ICS lingo to set up a medical special needs shelter. Again, that's all administrative. The activation is all administrative. Those are a reassignment of resources. That whole process depends on that particular cell. Activation of the behavioral help desk is another major feature that occurs. At the emergency operation center we mobilize staff, we assign staff so they know mobilization is imminent, we manage the surge based on the event, and then there's a whole concept of what we call bus triage. In lower southeast Louisiana and the greater New Orleans area, there are many people who don't have the means to manage their own evacuation. We have to manage their care and their transportation. Again, we will have a discussion on that at another time. The next example is the Deepwater Horizon Oil Spill, which is what we are here in Biloxi discussing today. The activation in April, once the explosion occurred, in Louisiana we had emergency response activation almost immediately. First, for the family members of the 11 persons who were killed, and we were there to do crisis response interventions with the families as they waited for the people who were workers on the oil site to be brought back to shore. We

were able to activate our Louisiana crisis team, which is still on the field, and first responder interventions were set up. It's a huge responsibility to get that set up in a way where we used nontraditional providers. Without having the financial and administrative structure in place, we could not have reimbursed those people quickly. Setting up stress management teams through nontraditional providers, having the financial and administrative services in place to allow us to access and use these nontraditional resources. Again, communications. Having full communication tracks in place allowed us to provide a lot of prophylactic levels of information to the community. As one would expect, this was a very intensive, ongoing event that involved multiple agencies and agencies that were not trained in disaster management. By having structures in place at the administrative level, one could manage the size and scope of response and the orientation and introduction to the various roles of agencies as new agencies came on board that in prior disasters would never have been involved. I think I have given three examples of how our whole emergency management approach has evolved from on-the-fly planning and the goodwill of many people to use of the ICS model, refinement of the ICS model, and practicing it in all of its phases—in this instance, the finance and administration. If you get those right and put your emphasis there, now, when you are exposed to an event and the year after the event when you're trying to make sure all of the bills were paid and you'll have partners for the next disaster. If you do that and take care of that now, then you'll have partners in the future. That concludes my presentation.

Moderator: Thank you so much, Dr. Speier. We're now going to open the floor up for questions. If you have a question, please remember to use the chat feature on the bottom left-hand side of the screen. Dr. Speier, we have three questions for you right now. First, do you have an example of a creative way to fund the development of a DBH plan?

Dr. Speier: I can give you some examples. Sometimes they're more creative than others. The Office of Public Health has several grants that come through CDC and other sources that they use as planning in their hospital systems. For years we've been able to access some small amounts of funds in a collaborative fashion with our Office of Public Health to do disaster planning. You may know it as HRSA funds. Another way to do it is if you have a strong county structure, you can have the county programs look at their home security monies and try to mobilize monies across counties for planning activities. One of the things we try to plan out is you'll spend more money denying that you're going to have a disaster than you would spend planning for one.

Moderator: Thank you so much, Dr. Speier. We have another question that came in via chat. Other than the CCP grants, are there any Federal financial resources available to States?

Dr. Speier: I'm not aware of any SAMHSA funds directly that are planning funds that are available at this time. Some of the disaster technical assistance people may have more knowledge about that. What we are looking for constantly are from the major foundations, looking at niches that are consistent with our need and what they fund. Another kind of creative way is a number of large cities have geographically specific area-wide foundations that have monies from private sources for a variety of reasons. They're also a good source of funding for planning.

Moderator: Thanks, Dr. Speier. Terri, do you have anything to add to that?

Ms. Spear: At one time, SAMHSA was able to secure behavioral health planning dollars through a supplemental appropriation through Congress. At that time, we allotted funding to States in order to focus on behavioral health planning. Thankfully, almost all States took us up on those offers, even though the funding was minimal at best, given some of the other kinds of planning dollars that were available. In 1997, the PAHPA Act removed behavioral health planning from the HRSA program and from the CDC program. We've been working ever since to get that reinserted on an advocacy sort of level. At this time,

several States have included behavioral health issues in their public health preparedness plan and that has been based primarily on the personal relationships between the Behavioral Health Coordinators, of which I hope many are on this call, and with the public health department. We've worked to ask Congress to reinsert mandated language into the reauthorization of the PAHPA Act to our Federal means, and that has not been successful to date. We do know that we continue to work with CDC and with ASPR to ensure that, in fact, behavioral health is given a strong focus in both of those funding programs.

Dr. Speier: I'd like to add that we've found 256 references to building behavioral health capability but no mandate to work with behavioral health. I agree with Terri that it's through personal relationships in your State that you can access those funds.

Moderator: Thanks, Dr. Speier. We have another question for you. What are some common challenges in activating a DBH plan?

Dr. Speier: I think one of the common challenges is that you have not practiced your plan. The people who wrote the plan are different from the people you expect to activate the plan. If there is a political change in your State for one reason or another, either at the Governor's level or in local metropolitan areas, and the new administrators have not been oriented or briefed on what their goal is and what the expectations for performance are, that's a communication feature that keeps the decision makers briefed. What you do with your practice is build relationships with those people and network with those people who will have to activate it. Another thing that is really important is making the disaster behavioral health initiative in your State a core aspect of your functions or your mandates as a behavioral health agency as well as the primary agencies you'd be working with. If everybody has emergency responses as a core function, it radically changes how people respond.

Moderator: Dr. Speier, we have another question on chat. You've spoken about documentation to get reimbursed for activities that take place prior to CCP application and funds. Do you know of anyone who has had success with this reimbursement, and is there any plan to develop some sort of template to make this reimbursement more likely?

Dr. Speier: I think there are elements that could be included in a template. I don't think any one template works because each State's administrative data systems are different. For example, a big expense for us is personnel who are employed into different environments, so where they normally sign in and sign out and where their shift hours are located are different or aren't available to them. Because of our particular computer model of personnel management and time management, we have to develop our own form. I think your colleagues at FEMA can work with you on this, what are their reimbursement items? What are their audit checks in the documentation? There will be issues with the proper authorizing signature and if the individual has initialed their timesheet. Are the locations and the hours and dates in place? There are some basic audit checks that are necessary and if you know what those are, they can guide you in the construction of your form.

Moderator: We have one more question coming in from chat. Have you identified a way that community mental health centers can hire new staff to perform the disaster outreach in an ISP grant without those short-term event-specific employees being able to file for unemployment once the grant has ended?

Dr. Speier: I think every State has its own set of rules that one has to be aware of. We have had some experience in our State of some of our nongovernmental organizations hiring people as contractors and not as employees. I am not an attorney so I have no way of knowing the accuracy of what I'm told, but what I'm told is that there is a different personnel status if you are a contract person and have a contract

with an agency, versus being brought on as an actual employee of the agency. That's something that I would ask you to look into in your particular State and see if that model would work for you.

Ms. McGee: Thank you, Dr. Speier. This is Lori McGee with SAMHSA DTAC. I'm seeing several questions come in through chat related specifically to the CCP grant, so if your question is not answered today, I want to encourage you to reach out to DTAC, give us a call, or drop us an email with specific questions. We're always happy to answer questions and our technical assistance staff can provide more guidance and answers to those questions.

Moderator: It seems that we don't have any additional questions for you, Dr. Speier. Thank you again for your presentation.

Dr. Speier: You're welcome.

Moderator: Ms. Terri Spear now has some closing remarks for us. Ms. Spear?

Ms. Spear: As you have heard today, the planning for administrative and financial capability is not oftentimes the most glamorous and exciting activity to take hold of, but as you've heard from Tony and the examples he's shown, you've become clearly aware that it is one of the most critical functions that a group can do to secure the success of the project. Again, I encourage you to review this webinar when it becomes available and if you have any additional questions for you to seek those out through the resources. This concludes the Financial and Administration Operations webinar, which is a part of the Promising Practices in Disaster Behavioral Health Planning series. There will be several other webinars available and hopefully you will participate in those as you begin to look at your State disaster behavioral health plan and begin looking at ways of revising or perhaps improving or updating that plan, and enhancing the disaster behavioral health response.

Ms. McGee: Thank you, Terri. We have a couple of upcoming webinars in this series: Building Effective Partnerships will take place on July 27th at 2 p.m., the next after that is Implementing Your DBH Plan, that's the following day, July 28th, at 2 p.m. eastern time. This is the remaining calendar for the others on the series. Assessing Services and Information will take place on August 4th at 2 p.m. That will feature Dr. Anthony Speier again. Logistical Support on August 10th at 2 p.m. eastern time, Legal and Regulatory Authority on August 18th at 2 p.m. Integrating Your DBH Plan is on August 25th at 2 p.m. Plan Scalability is the final to conclude the series on August 30th at 2 p.m. and we're glad to have Dr. Anthony Speier back with us on that day.

Moderator: Thank you so much Ms. McGee, Ms. Spear, and Dr. Speier, and thank you all for participating in the Promising Practices in Disaster Behavioral Health: Financials and Administration Operations webinar.

[End of session.]