

Utah's Regional Medical Surge Coalitions

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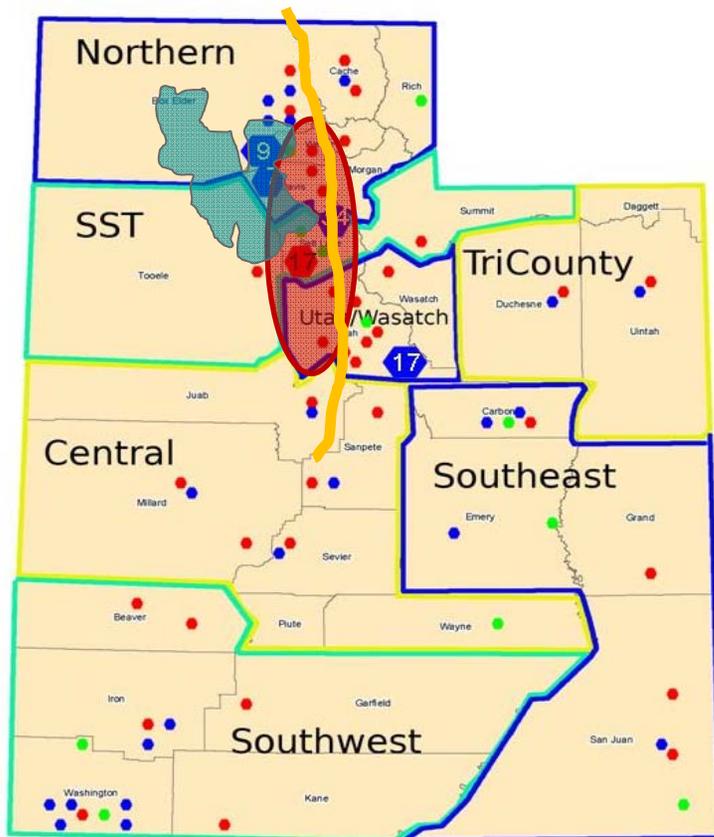


UTAH DEPARTMENT OF
HEALTH

NACCHO
National Association of County & City Health Officials

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Utah Coalitions Structure and Characteristics



- ⬡ Hospitals -50
- FQHC Community Health Centers-11
- ⬡ Long Term Care Facilities-96

07/2011

Population Density (29 Counties)

- 4 Urban (Wasatch Front) 75%
- 12 Rural
- 13 Frontier (<7 persons/ mi.²)

Hospital Density

- 87% of beds in state in 3 Regions
 - SST, Northern, Utah/Wasatch (86% of population)

Coalition Composition

- SST – 107 members (3 LHD)
 - 17 hospitals, 37 LTC, many others
- Southeast – 12 members
 - 4 hospitals, clinics, EMS, S.T.P.



Key Elements of Coalition

	SST – Urban/Rural	SE – Rural/Frontier
Structure	LHD Hosted (1 of 3)	LHD Hosted (1 of 1)
Funding	HPP – Staffing, Training, Equipment, Exercises	HPP – Staffing, Training, Equipment, Exercises
Funding (Staff)	Full FTE + Admin Asst.	1/2-2/3 FTE
Funding (Eq./Tr./Ex.)	~\$45,000	~\$12,000
Meetings	Full coalition bi-monthly, Executive Committee bi-monthly	Full Coalition quarterly, monthly coordinator attends LEPC, EMS, hospital EM meetings
Key Documents	By-Laws & Signed MOU Base Response Plan Resource Management Plan Commo Plan	Charter Base Response Plan Commo Tree or protocol
Priority Threats	Pandemic/Novel Event Earthquake Hospital Evacuation Large MCI – Plane Utilities Interruption	MCI-Bus Crash Receiving Earthquake Evacuees Pandemic/Novel Event HazMat – Gas/Oil Event Severe Weather/ Fire



Factors to Pursue the Model

- Historic – SLC Area hospitals participation in CSEPP, 2002 Winter Games, Cities Readiness Initiative; included SL, Summit and Tooele -> SST
- Assessment of Existing Regions – Homeland Security, Bioterrorism, LHD
- Assessment of hospital catchment areas, normal patient access and transfer patterns with EMS and hospitals, geographic barriers
- Local Health Districts as host
 - LHD approx. match patient movement patterns
 - LHD was developing increased role in ESF8 in jurisdictions
 - Additional support to LHD Emergency Response Coordinator in assisting with medical facility coverage in command centers
 - History of success with PHEP in LHD and ongoing excellent relations
 - Relative ease of grants processing, budgeting, and workplans
 - Use local people to serve local agencies, take advantage of existing relationships



Barriers or Challenges

- Communication gap between entities – limited LHD-hospital-LTC planning
 - Rotate meetings between sites, include a tour and presentation by host
- Rural challenges – up to 150 miles between some facilities, response is county-based
 - Coordinator to travel to sites and do 1-1 meetings
 - Coordinator to attend ESF8, LEPC or other meetings
- Impression that Coalition was walking over existing groups – LEPC, ESF8
 - Clarity to all response partners how Coalition is an asset – caches, comms systems, plans to support impacted facilities
- Recruitment is much easier than retention
 - Ensure that meeting content and goals are system-based, and that all participants can benefit from shared Coalition funds, also CMS CoP
- Difficulty in completion planning targets, deferral to Coalition for progress
 - Empower Coordinators to develop content, then seek edits



Short and Long-Term Sustainability

- Short Term Sustainability
- Invest in the process and people – 40% of Utah’s grant to Coalitions
- Sustain a Regional cache, training, and exercise fund
- Work across all levels of Responder agencies to define value of Coalition
- Leverage the champions in each community
- Longer Term Sustainability
- Yearly exercise in each Region in which any members can play
- Region as primary on technical assistance for CMS EM Rules
- Increased inter-Regional and interstate coordination
- Development of Regional Resource hospitals
 - Burn and pediatric receiving hospitals
- Continued coordination with State and local EMS agencies for MCI planning



Materials or Resources

- Regional Coalition Workbook
 - Resource Element Assessment
 - Membership Tracker
 - Program Measures Tracker
- Priority Resource Element Checklist
- Yearly Top-level goals
- Shared Regional equipment, training, exercise budget
- Less reporting narrative, more reporting checklists
- Sustainability, strategic, and satisfaction assessments
- Fit project to community, not community to project – e.g. a Rural and Frontier Coalition may never become a MACC, but can find great success with the preparedness work
- Kevin McCulley ---- kmcculley@utah.gov ----- 801-273-6669



Healthcare Coalitions: Governance and Sustainability

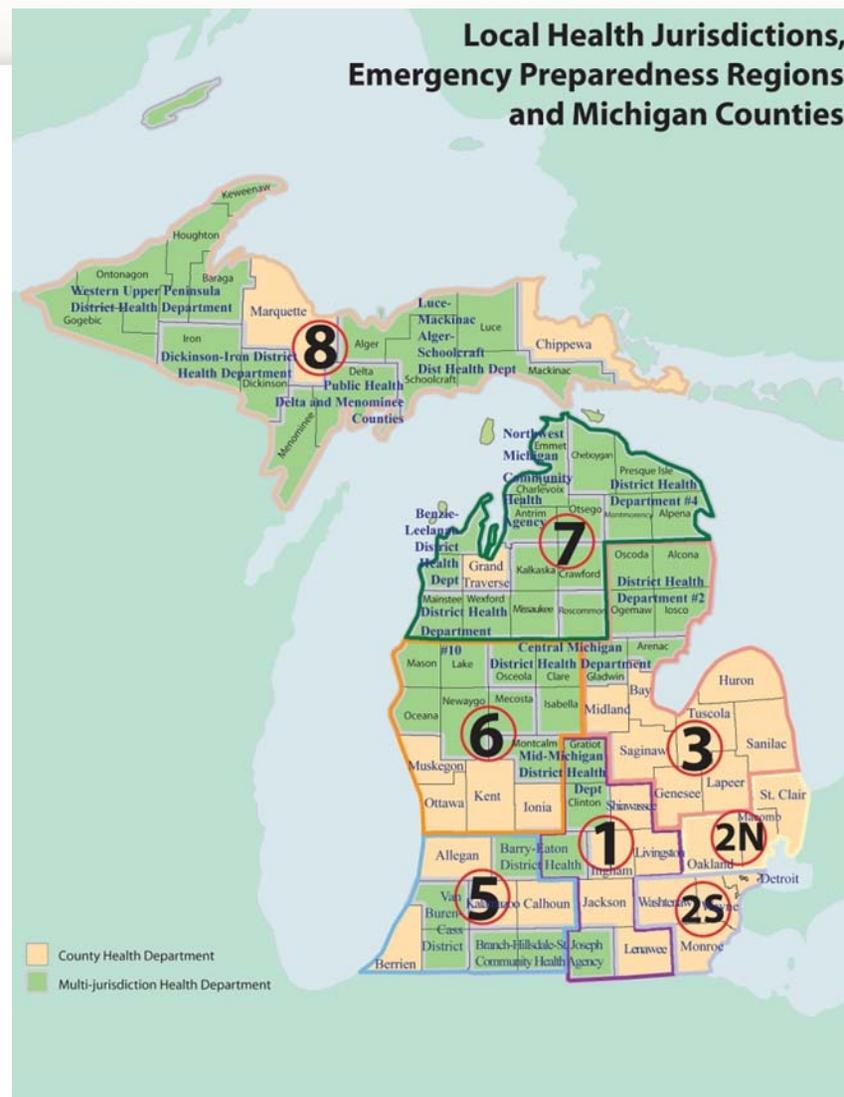
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Michigan Emergency Preparedness 8 Healthcare Coalitions

- 83 Counties
- 45 Local Health Dept.
- 12 Federally Recognized Tribes
- 110 Emergency Mgmt. Programs
- 191 Hospitals
- 440 LTC facilities
- 800 Life Support Agencies
- >300 FQHC, MHC, RHC



Governance Model – Healthcare Coalitions

Medical Control Authority (MCA) Fiduciary

Medical Director - .25FTE

Regional Coordinator

Assistant Regional Coordinator

Consistent Bylaws

- Planning Board
 - Consensus on project and funding allocations
- Advisory Committee Meetings
 - Workgroups

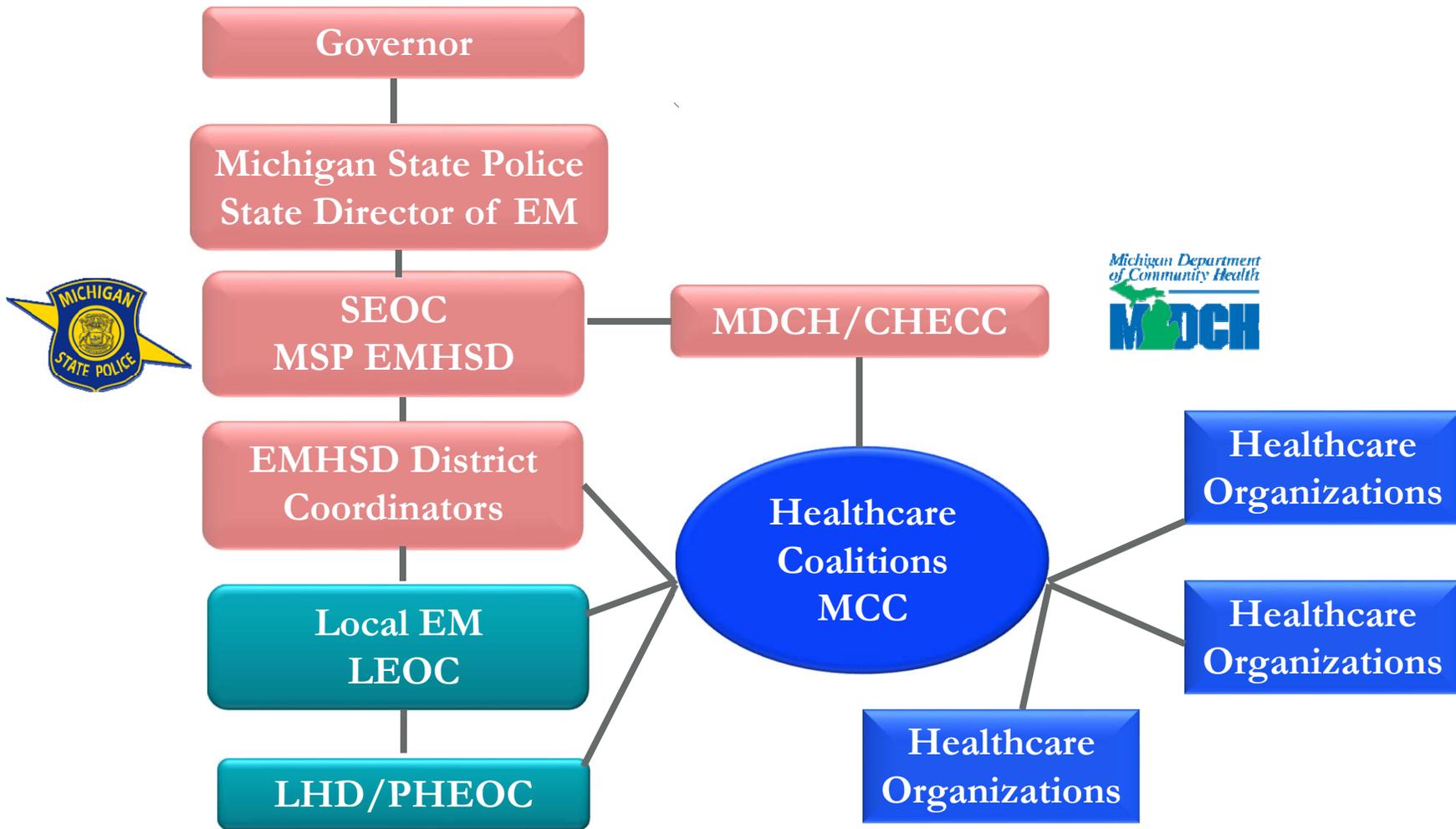


Medical Control Authority (MCA)

- MCA - an organization designated by Michigan Department of Community Health, EMS Office under Part 209 of PA 368 of 1978
- Responsible for supervision, coordination of emergency services within a specific geographic area through State approved protocols
- Each hospital w/ED must participate in a MCA
- Medical Director of MCA – board certified in Emergency Medicine/ACLS & ATLS certified



Healthcare Coalitions Medical Coordination Center



Michigan Mass Casualty Incident Protocol

6. REGIONAL MEDICAL COORDINATION CENTER

The MCC serves as a regional multi-agency coordination center entity as defined by the National Incident Management System (NIMS). The MCC serves as a single regional point of contact for the coordination of healthcare resources. The MCC is intended to optimize resource coordination among hospitals, EMS agencies, medical control authorities and other resources. The MCC serves as a link to the Community Health Emergency Coordination Center (CHECC).

The MCC acts as an extension and agent of the Medical Control Authority.

I. MCC Responsibilities include, but are not limited to:

- A. Maintain communications with all involved entities
 - 1. EMS Branch Directors
 - 2. EMS Division/Group Supervisors
 - 3. EMS Unit Leaders
 - 4. Hospitals
 - 5. Local EOCs (when activated)
 - 6. CHECC (when activated)
 - 7. MEMS sites (when activated)
 - 8. Other Regional MCCs (as appropriate)
- B. Provide initial and update alerts via available communications resources.
- C. Provide frequent updates to on-scene EMS Branch Directors/Group Supervisors (or designee) regarding hospital casualty care capacity.
- D. May relay casualty transport information to receiving facilities.
- E. May relay urgent and routine communications to appropriate entities.
- F. May assist in coordination and distribution of resources.
- G. Other appropriate tasks as necessary for an effective regional medical response.

7. REGIONAL MEDICAL COORDINATION CENTER IMMUNITY FROM LIABILITY

It is the intent of this protocol that the Medical Coordination Center and the personnel staffing the MCC and performing the functions are afforded immunity from liability whether or not a Mass Casualty Incident has occurred, as provided through MCL 333.20965 of Part 209 of PA 368 of 1978, as amended. This section specifically provides

immunity from liability protection to Medical Control Authorities in the development and implementation of department-approved protocols (see language below):

333.20965 Immunity from liability.

Sec. 20965 (3) Unless an act or omission is the result of gross negligence or willful misconduct, the acts or omissions of any of the persons named below, while participating in the development of protocols under this part, implementation of protocols under this part, or holding a participant in the emergency medical services system accountable for department-approved protocols under this part, does not impose liability in the performance of those functions:

- (a) The medical director and individuals serving on the governing board, advisory body, or committees of the medical control authority or employees of the medical control authority.
- (b) A participating hospital or freestanding surgical outpatient facility in the medical control authority or an officer, member of the medical staff, or other employee of the hospital or freestanding surgical outpatient facility.
- (c) A participating agency in the medical control authority or an officer, member of the medical staff, or other employee of the participating agency.
- (d) A nonprofit corporation that performs the functions of a medical control authority.

STATE COMMUNITY HEALTH EMERGENCY COORDINATION CENTER

- I. Operated by MDCH Office of Public Health Preparedness
- II. EMS Personnel should be aware of the existence of CHECC but are not expected to directly interface with CHECC.



Regional Medical Coordination Center (MCC)

- A Multi-Agency Coordination System (MACS) compliant with the National Incident Management System (NIMS)
- Coordinates activities above the field level through the prioritization of the incident demands for critical or competing resources, serves as a resource to local and state emergency operation center(s)
- Facilitate standardization and interoperability of health care operations and ensure optimum and efficient use of resources.
- 24/7/365 PSAP like answering with 3 deep staffing for HCC roles
- Fixed sites in each HCC but can be virtual and mobile to meet needs
- Streamlines communications and information requests



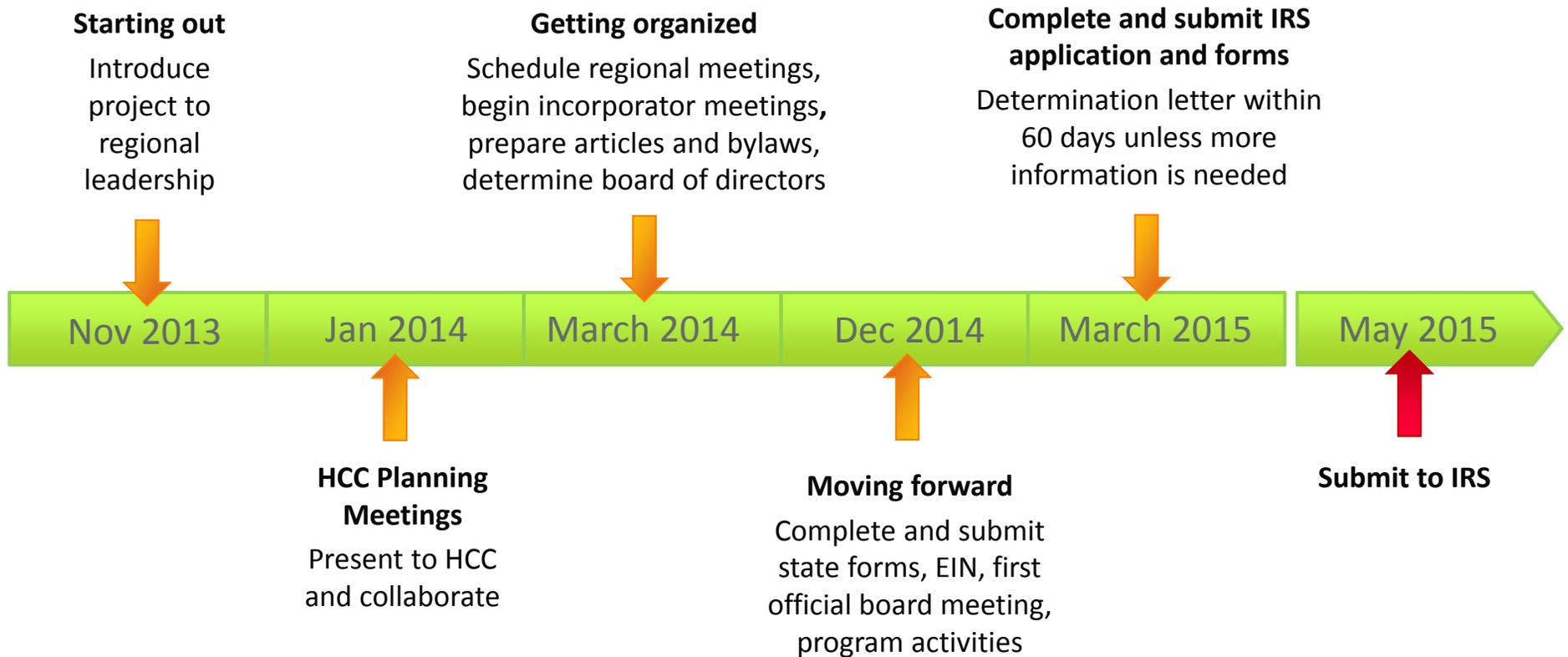
Factors to Pursue the 501(c) 3 Model

Sustainment

- Will allow Regional HCCs to be exempt from federal income tax, while being eligible to receive tax-deductible charitable donations.
- Individual and corporate donors are more likely to support organizations with 501(c)(3) status
- Assures foundations and other grant-making institutions that they are issuing grants or sponsorships to permitted beneficiaries
- Path to financial stability and sustainment



When Will all this Happen?



HCC 501 (c) 3 Status Update

- Region 8 (Upper Peninsula) submitted all paperwork to IRS and State of MI
- Regions 2N & 2S (urban) working to incorporate into current fiduciary non-profit status as subsidiary
- Regions 5 & 6 forming a consortium in collaboration with all Medical Control Authorities in jurisdictional boundaries
- Region 6 & 7 forming a combined 501(c)3 representing both HCCs
- Regions 1 & 3 working with HCC partners to determine format that meets jurisdictional needs



Continued Value in Planning & Response

Participation in a HCC has been shown to ...

- Improve communications horizontally & vertically
- Improve situation awareness, expanding access
- Improve relationships between HCO, Public Health and Emergency Management includes: recognition of roles and responsibilities before, during and after response
- Improve access to resources and supplies used not only during significant incidents but planned events
- Improve organizational response to local incidents, including weather related



Available Tools

- HCC Bylaws Template
- Regional Operations Guidelines
- Statewide Patient Tracking Algorithm
- EEI Template
- Ethical Guidelines for Scarce Medical Resources
www.mimedicaethics.org
- Mass Casualty Incident Burn Surge Plan
- Long-term care preparedness resources
www.michigan.gov/lcprepares



Advancing our Coalition – the Northwest Healthcare Response Network

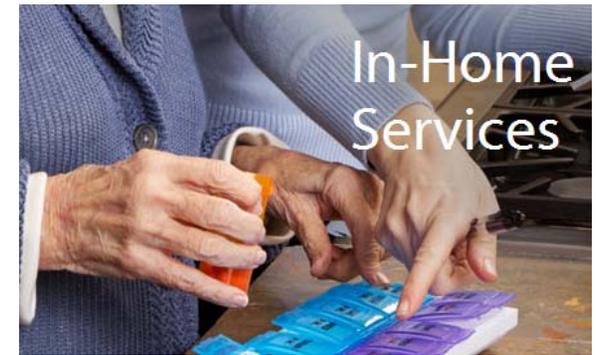
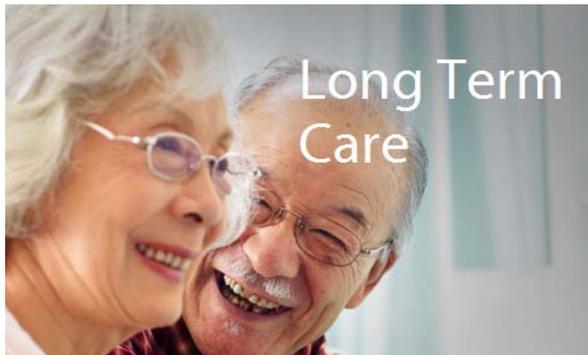
Onora Lien
Executive Director



Our Vision



**A resilient healthcare system saving lives
and serving the community during emergencies.**



Our Footprint



NORTHWEST HEALTHCARE
Response Network

- 2.7 million residents
- 2 local health jurisdictions
- 2 counties; 57 cities
- 3 sovereign tribal nations
- 33 hospitals
- 38 community health clinics
- 1,600 + long-term care facilities
- 8000 + in home services clients



Organizational Change



**Program of local public health
with 501c3 foundation partner**



Independent nonprofit – 501c3

Executive Council



Board of Directors

No fees



Membership dues

**Federal funding and healthcare
sponsorships**



**Federal funding, memberships,
charitable giving, fee for
service and event revenue**

Staff at three organizations



Staff employed by NWHRN



Pursuing a Better Model



NORTHWEST HEALTHCARE
Response Network

Strengths	Weaknesses
<ul style="list-style-type: none"> ▪ Strong healthcare executive leadership ▪ Integrated services for all healthcare sectors ▪ Strong relationships with local health departments ▪ Innovative and responsive to participant needs ▪ National leader in healthcare preparedness programming ▪ Experienced staff with broad expertise 	<ul style="list-style-type: none"> ▪ Small organization with limited resources ▪ Staff turnover ▪ Lacking in-house expertise on nonprofit administration and business operations
Opportunities	Threats
<ul style="list-style-type: none"> ▪ Potential to expand geographic service area ▪ Ability to accept funding from different sources ▪ Diversification of revenue streams ▪ Clarification of distinct NWHRN roles and responsibilities ▪ More distinct and independent organizational voice ▪ Increased sense of community ownership 	<ul style="list-style-type: none"> ▪ Consistent decline in federal funds ▪ New revenue model relies heavily on membership dues, philanthropy and sponsorships ▪ Perception challenges with paid membership model ▪ Balancing start- up of new business with sustainment of ongoing coalition activities ▪ Administrative and program requirements for use of federal vs other non-restricted funding



24 month planning process



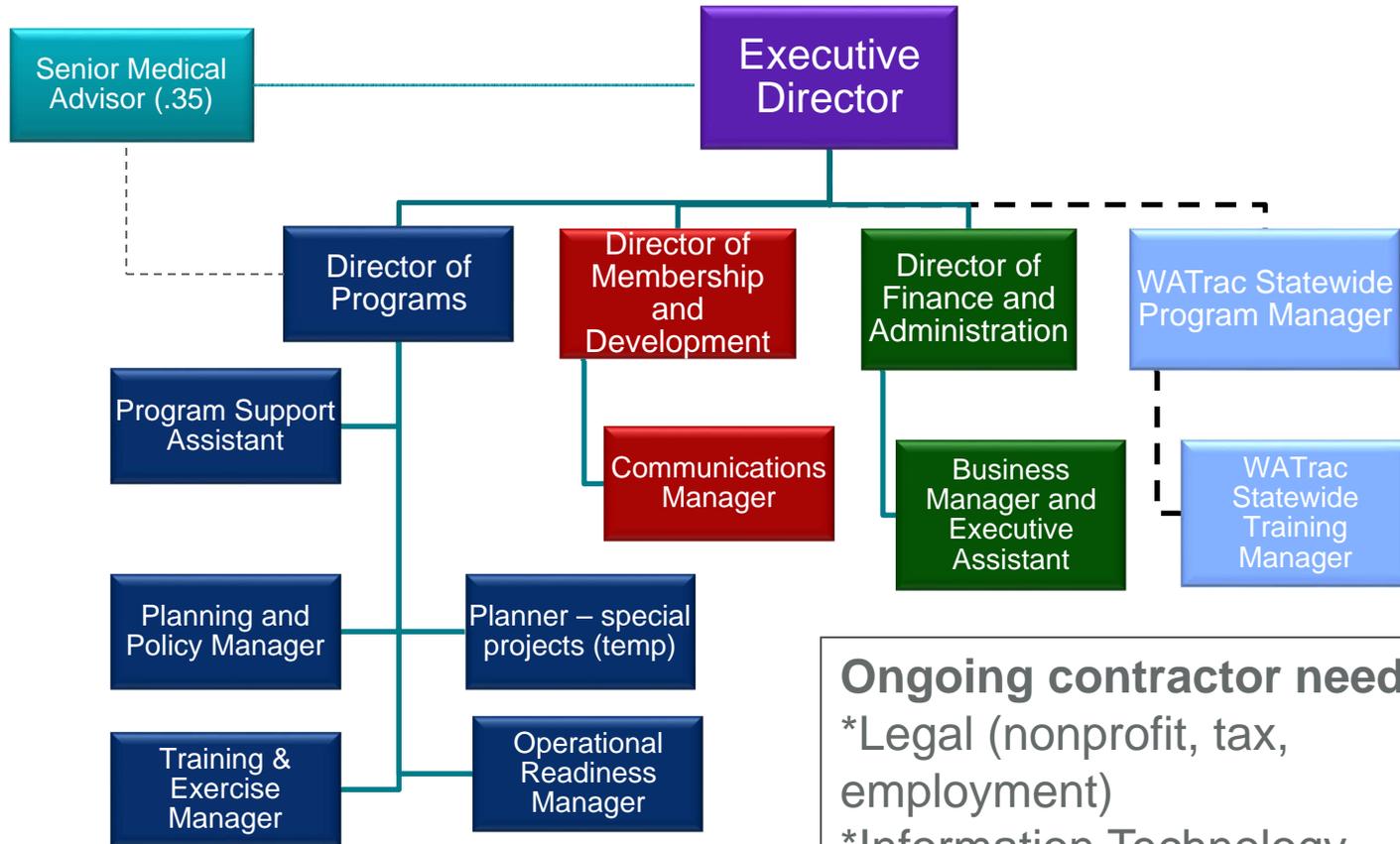
NORTHWEST HEALTHCARE
Response Network

- Leadership decision to develop business plan after comparing potential business models
- Revision of mission, vision and values; identification of strategic priorities and supporting objectives
- Development of membership structure
- Determination of governance structure, establishing new board and developing legal organizing documents (articles of incorporation, bylaws)
- Development of staffing and operational model
- Completion of financial projections and revenue modeling
- Approval of business plan and implement founding member campaign

■ Transition to new business opening on Jan 1, 2014 (licensing, HR, space, operations)



Staffing Model



Ongoing contractor needs:

- *Legal (nonprofit, tax, employment)
- *Information Technology
- *Bookkeeper and accountant

Our Founding Members



NORTHWEST HEALTHCARE
Response Network

UW Medicine



Franciscan Health System



GroupHealth®

MultiCare 
BetterConnected



Seattle Children's
HOSPITAL • RESEARCH • FOUNDATION



Virginia Mason

EvergreenHealth

PC THE POLYCLINIC



Puget Sound Blood Center
research | medicine | blood & tissue services

NORTHWEST
Kidney Centers

sound
mental health



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Always learning...



NORTHWEST HEALTHCARE
Response Network

- Running a coalition as a business is different !
- Essential to assess different business and governance models and understand pros and cons before making a decision
- Have a solid finance and revenue development plan, before finalizing governance model
- Unrestricted cash flow beyond federal grants is essential just to manage business operations



NACCHO
National Association of County & City Health Officials

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Always learning...



NORTHWEST HEALTHCARE
Response Network

- Legal and financial subject matter expertise for non-profits is essential at every step
- When members or other financial contributors pay money it adds new expectations and they may differ from grant obligations
- Financial contributions are earned and not easily given – must continue to demonstrate value and return on investment



***For more information about the
Network:***

www.NWHRN.org

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**NATIONAL
HEALTHCARE
COALITION**

Resource Center



HEALTHCARE EMERGENCY RESPONSE COALITION PALM BEACH COUNTY, FLORIDA

Mary Russell EdD MSN

Emergency Services, Boca Raton Regional Hospital,
Boca Raton Florida

Healthcare Emergency Response Organization
(HERC), Palm Beach County, Florida



HEALTHCARE EMERGENCY
RESPONSE COALITION
of Palm Beach County



Characteristics of HERC



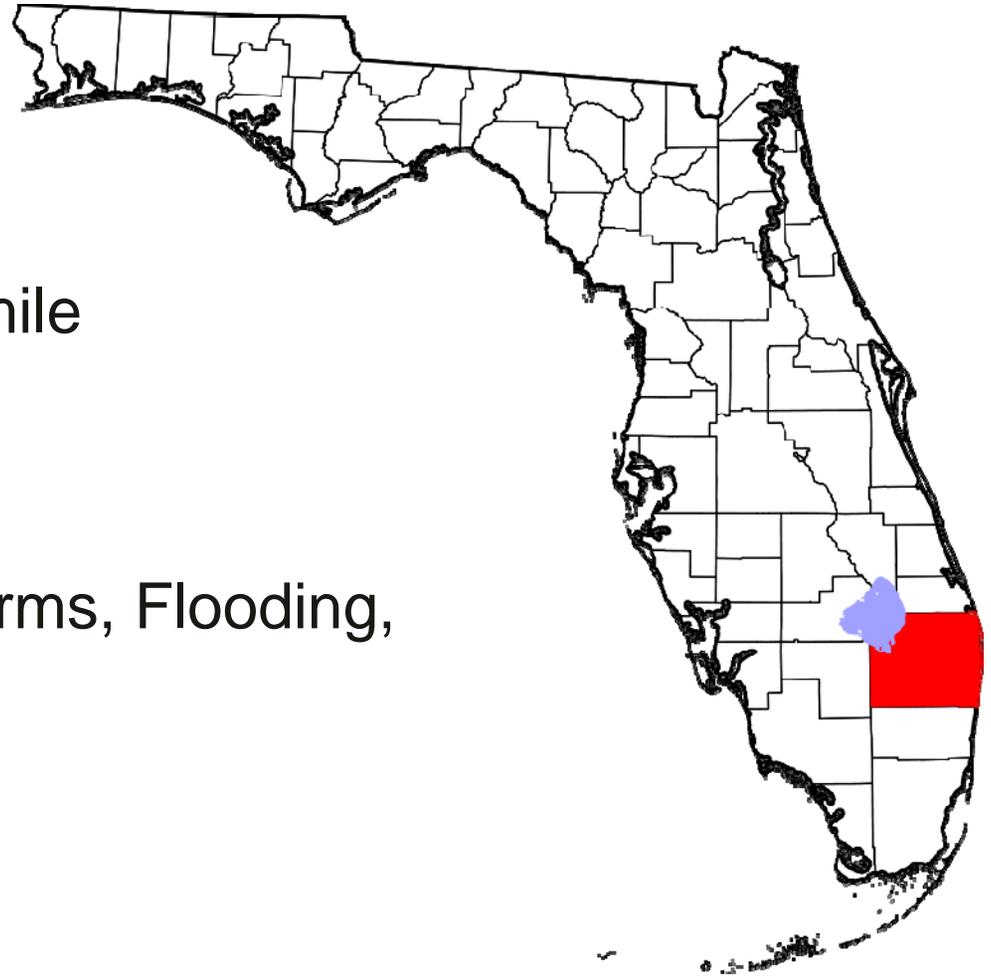
HEALTHCARE EMERGENCY
RESPONSE COALITION
of Palm Beach County

Palm Beach County

- 1.3 million residents
- 2 million tourists/year
- 2000 square miles
- 670 people per square mile
- 22.5% of population 65+

Notable Hazards:

- Weather (Hurricanes/Storms, Flooding, Tornadoes, Heat Waves)
- Wildfires
- Infectious Diseases
- Man-Made Disasters



Governance Model



HEALTHCARE EMERGENCY
RESPONSE COALITION
of Palm Beach County



- HERC is a program of PBCMSS, a 501c3 non-profit organization promoting quality health care for PBC residents
- PBCMSS established in 2001
- HERC formalized in 2003
- HERC has a representative on the Board of PBCMSS
- PBCMSS is a member of HERC



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Governance Model



HEALTHCARE EMERGENCY
RESPONSE COALITION
of Palm Beach County



- Aligned with our mission
- Offer centralized meeting location
- Supportive structure
- Sponsored consultant to get us started
- Provides Administrative Coordinator
- Provides accounting & audit support
- Provides link to physicians

10% of HCC's nationally are linked
with Medical Societies



Factors to Pursue the Model

- Existing & evolving partnerships
- Hurricane Andrew 1992
- Anthrax Attack 2001
- Collaborative working relationships with Health Department & Emergency Management
- Dedicated & committed emergency preparedness leaders
- Recognition that healthcare needed a special focus as part of critical infrastructure





HEALTHCARE EMERGENCY
RESPONSE COALITION
of Palm Beach County



HERC Member Organizations

- Acute Care Hospitals
- Specialty Hospitals
- LTC Facilities
- Florida Health in PBC
- PBC Emergency Management
- PBC Fire Rescue
- PBC Sheriff's Office
- PBC Medical Society Services
- Florida Hospital Assn
- Health Care District of PBC

**27 VOTING
MEMBERS**

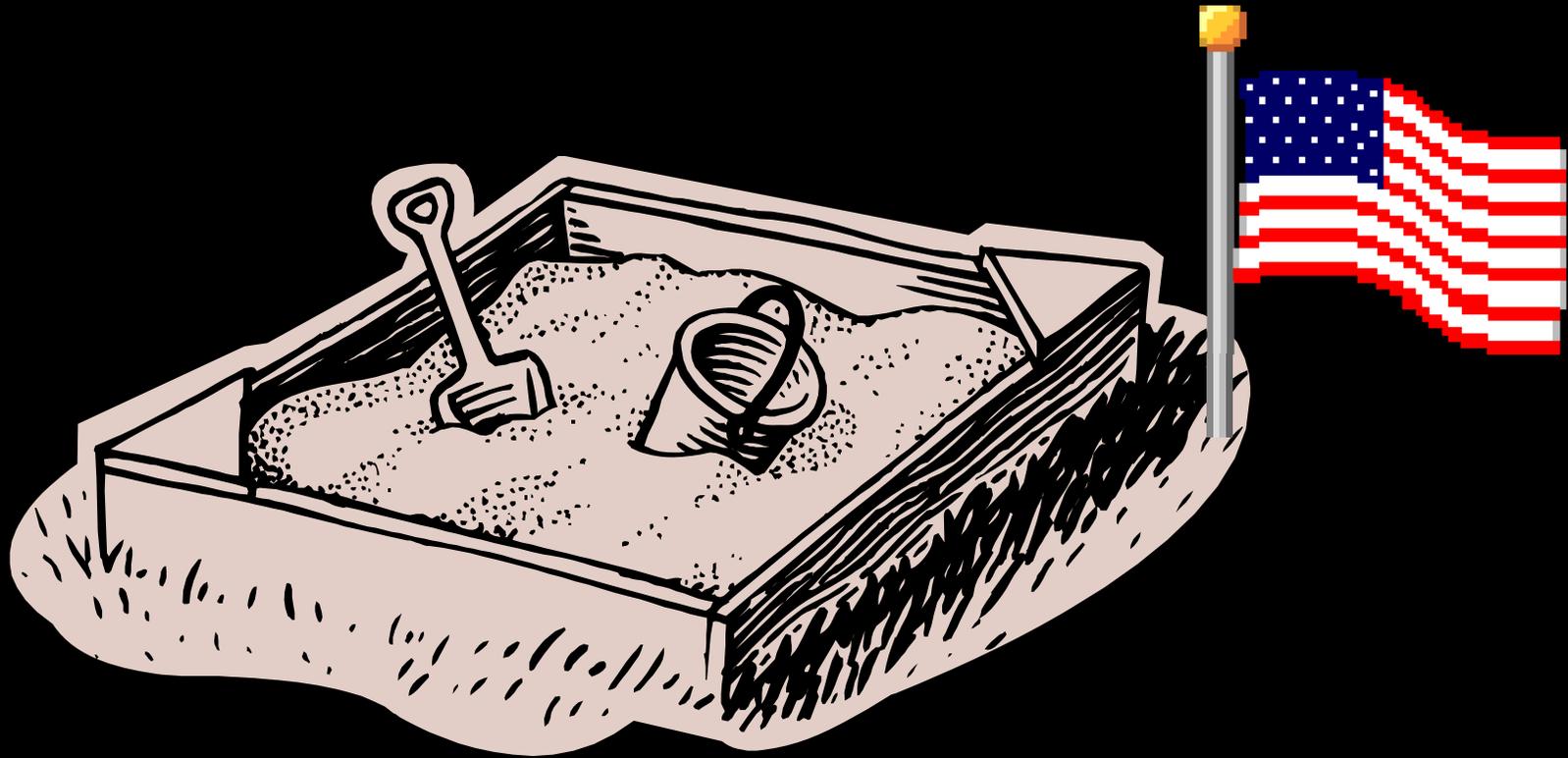


HERC Trusted Partner Organizations

- **PBC Medical Reserve Corps (MRC)**
- **PBC School District**
- **Palm Healthcare Foundation**
- **Florida's Blood Centers**
- **Region 7 Representative**
- **Regional Special Needs Shelters**
- **Fresenius Medical Care**
- **South Florida Hospital & Healthcare Assn.**
- **Public & Private Universities**
- **Behavioral Health Centers**
- **Pharmacy Association**
- **Others (Disaster Recovery Coalition, ME, Veterinary Assn, Utilities, Hospitals from bordering county)**



Healthcare System Partners can work together



Haiti 1/14/10/ AP



Barriers or Challenges

- CEO Support:
 - MOA hand carried to each organization (initially just acute care hospitals) for signatures on one common document
 - HCC membership eased accreditation visits
 - Turnover can be an issue for strong HICS
- Membership Turnover:
 - 3-deep ICS concept used to support attendance
 - Attendance is tracked; calls made to non-attendees
- Communication:
 - Weekly radio roll-calls
 - Email distribution lists; Mass notification drills
 - Conference calls during incidents; Technology support



Short and Long-Term Sustainability



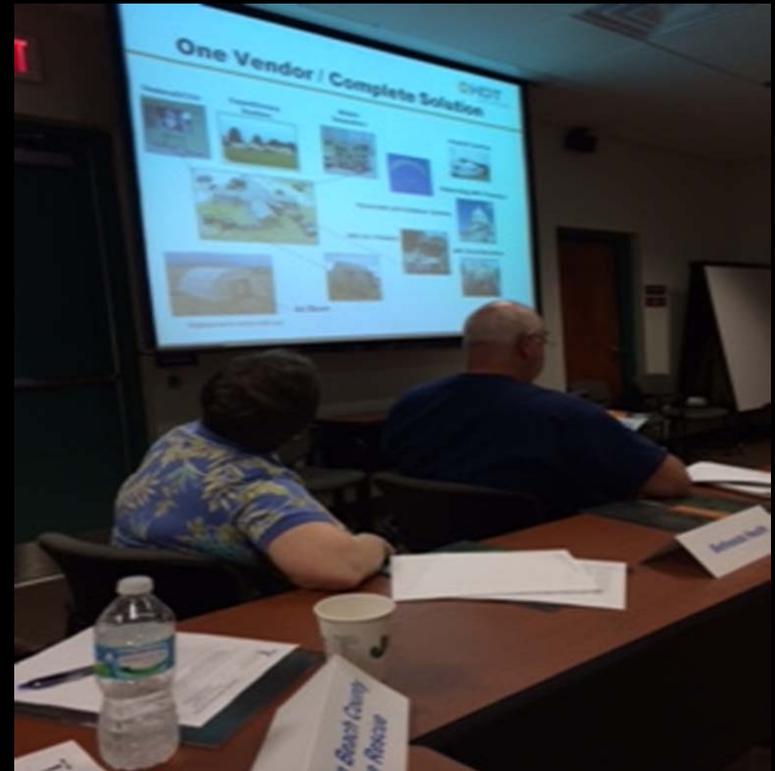
- **Members want situational awareness**
- Membership dues: \$500 for voting members
- Vendor presentations/exhibits at monthly meetings
- Publications: Community Report & Books
- Foundation support
- County Commissioner support
- Recognition Events
- In-kind support



Sponsors

Examples:

- Communications
- PPE
- Evacuation Equipment
- Shelters
- Water Filtration Systems
- Emergency Lighting
- MRE's
- Event Management Software
- Disaster Recovery
- Security Products
- Others





Texas Healthcare Coalitions Governance & Sustainability

Ray Apodaca

HPP Team Lead

Texas Department of State Health Services



Texas Healthcare Coalitions (HCCs)



22 Statewide Healthcare Coalitions

- TX DSHS contracts with a lead HCC agency to facilitate & administer day-to-day HCC activities required in order to meet the NHPP Healthcare Preparedness Capabilities, grant requirements & state preparedness expectations
- HCCs vary in size (population & geographic) including small rural, mid-size urban & very large metropolitan
 - TX DSHS adopted the existing EMS/Trauma geographic structure for the TX HPP statewide regional boundaries
- Smallest HCC includes two hospitals & the two largest HCCs include 100+ hospitals plus many ESF-8 partners
- Each regional HCC includes multiple counties and ESF-8 Health & Medical partners (acute care/long-term care/specialty hospitals, EMS, LHDs, state PH, emergency management, other first responders, etc.)



TX HCC Governance



- 20 of the 22 HCCs are governed as 501c(3), non-profit, coalitions that have established a membership charter, by-laws, etc.
 - The governance structure from the lead/host agency was in-place prior to the NHPP as part of the Texas EMS/Trauma System
 - Most non-profit agencies amended their existing governance structure to incorporate the HPP HCC membership requirements & expectations
- 2 of the 22 HCCs include a local health department lead/host & they have established a governance charter and by-laws for their HCC membership.
- All 22 HCCs are funded annually by TX DSHS
 - Approximately 70-80% of TX HPP federal funding award is awarded to the TX HCCs via contract sub-awards
 - TX HCCs provide TX DSHS recommendations for statewide HCC funding allocation formulas
 - TX HCC lead/host agencies are selected through a competitive RFP



Why Did TX DSHS Select the Existing HCC Model?



- TX Legislature limits state agency staffing. TX DSHS does not have sufficient staff in-place to administer & implement preparedness for 625+ hospitals.
- TX DSHS attempted to partner with the Texas Hospital Association to implement HPP, but THA declined. THA remains a TX HPP partner.
- TX DSHS elected to implement a statewide regional structure for HPP in order to manage 22 regional contracts as opposed to contracting with each hospital and participating healthcare entity. HPP funds cannot be allocated without a written and executed sub-award/sub-contract agreement.
- Year 1 of TX HPP, 22 non-profit, 501c(3) trauma regional advisory councils (RACs) were selected to lead the TX HPP regional programs & future HCCs
 - RACS already had a structure in-place with a membership that included pre-hospital, hospital, and other health/medical partners
- Year 6 & 12 TX DSHS conducted a competitive RFP to select HCC lead agencies. HCC funding awards are based on individual budget period contracts with options to renew each year until the next RFP is conducted.



Barriers or Challenges



- Difficult to develop all 22 TX HCCs at the same pace & level of preparedness required by the NHPP capabilities.
 - Small/medium/large HCCs have different levels of ESF-8 resources & receive different funding allocations.
 - During Year 10-12, TX HPP established a 3-year strategic plan with HCC annual minimal levels of preparedness milestones for each of the HPP capabilities
- Nationally, awardees & HCCs struggle with HCCs having a response role
 - TX HCCs serve a very important response role for real-life events.
 - TX DSHS includes response expectations in the annual state/HPP HCC contracts
 - TX DSHS and/or State Medical Operations Center (SMOC) issues written mission tasking to HCC lead agencies during real-life events in order to provide them response authority & funding



Short & Long-Term Sustainability



- In 2010, the TX HPP & HCCs realized that we needed to develop a hospital preparedness component that can exist & function beyond NHPP funding.
 - Since 2010, HCCs have been building & refining 8-Emergency Medical Task Force (EMTF) teams that include ambulance strike teams, mobile medical units, nurse strike teams & ambulance buses (AmBuses).
 - This effort has been a huge success & best practice. The TX EMTF teams/resources are used for real-life events on a regular basis.
 - They serve as a local/regional resource but can also be deployed as a state resource.
- The future of the 22 mature, well established TX HCCs is currently at risk due to federal NHPP funding cuts.
 - Since TX DSHS allocates 70-80% of federal funding award to HCCs, future funding cuts may require Texas to reduce the number of HCCs.
 - TX HCCs are successful because of the full-time HCC staff that continue to develop and enhance the current HCCs.



Materials or Resources Available



- TX DSHS/HCC contract templates, statement of work, etc.
- Sample HCC charters, by-laws, etc.
- HCC membership sub-agreements, MOAs/MOUs, etc.
- TX HPP Emergency Medical Task Force (EMTF) overview





Pennsylvania Healthcare Coalition Model

Characteristics

- Pennsylvania has nine Regional Healthcare Coalitions
- The coalitions were born out of the nine Regional Task Forces that were created in 1998
- Comprised of healthcare facilities, EMS, public health agencies, long term care, community groups, behavioral health agencies, EMAs and other response partners
- The coalitions vary in size, population type served, and preparedness activities

Governance

- Coalitions' governance models vary
- All have regional and cross regional MOUs
- Some have adopted bylaws
- Coalitions had grassroots/volunteer beginnings that have continued to grow
- Members continue to be volunteers within the coalition
- Joining and participating in the coalition does not require paying fees or membership dues

Challenges

- In the past, Pennsylvania used an individual healthcare facility funding model
- Currently transitioning to a regional coalition funding model
- Reviewing options for regional coalition funding and sustainability

Resources

- Pennsylvania has various resources that are available and provided to our coalitions at no charge
- These resources can be utilized for planning, exercises, and response needs
- Available at the coalition and the individual healthcare facility or agency level
- Formal unmet needs request process in place and exercised regularly

Resources, continued

- Examples of available resources include:
 - Regional field staff for planning and response needs
 - Knowledge Center
 - Three State Medical Assistance Teams (SMATs)
 - Mobile medical assets
 - EMS strike teams
 - Communication equipment
 - Rx and PPE caches

Questions?

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