

Capitol Region Emergency Planning Committee  
RESF-8 Health and Medical  
*December 1, 2010*  
East Hartford Public Safety Complex  
East Hartford, Connecticut

Members Present: (See attached corrected attendance list)

The meeting opened at 9:07 a.m.

**DEMHS Report:** Mr. Gavaghan reported:

1. Local emergency managers are being asked to review and update their local plans by checking off items on a prepared list.
2. A letter has been received by the Governor concerning the *Save the Children* project. Connecticut has several missing elements of local planning. Identified as missing are a plan for evacuating kids in child care, reunifying families after a disaster, written child care facilities plans for children with special needs and an evacuation plan for schools. It is suspected that many local plans have been created for many of these elements, but the information has not been centrally located. Work is underway to bring local plans into compliance.

**DPH Report:** Ms. Duly reported:

1. WebEOC training in the hospital updates is being offered December 2 and 3 (4 sessions) at CHA. This will include the bed reporting and Hospital Incident Command System boards.
2. The next phase of WebEOC development will allow for expanded use by hospitals in managing day-to-day activities.
3. DPH has submitted a proposal to HHS for funding to “front load” the Everbridge system for a hospital based alerting and notification. It is proposed to initiate the service for those hospitals that want it and to support the costs for four years of operations. Back up funding possibilities are also being explored.
4. The DPH/hospitals statewide meeting will be held on December 20 from 1-3 p.m. at CHA.

**CREPC Training:** Mr. Scace reported:

1. There have been four responses to the RFP for a CREPC Citizen Preparedness Project.
2. A contract is being drafted for the vendor selected to maintain the state and regional emergency management trailers located within Region 3.
3. ICS 300 and 400 classes are being scheduled for the Hartford Police Department and the Ambulance Service of Manchester.
4. A series of activities are being planned around WMD for the 2011 exercise program. On January 20, 2011, a seminar is being planned for multi-agency integrated responses to a weapon of mass destruction.
5. The regional Everbridge project is being developed with the creation and maintenance of the database.

**Section Reports:** the following year-end reports were provided by the different sections. During the reports, a summary outline was maintained on the white board. (See attachment 1 on page 6 below for a copy of this summary):

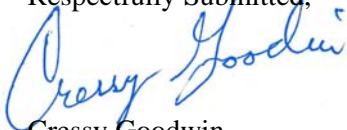
1. *EMS:* A written report was presented by Mr. Bova on behalf of Mr. Kosciuk, Chairman. This is attached (See pages 7-8, below).

2. *Hospitals*: Mr. Falaguerra reported:
  - a. Formulated and solidified our Region 3 hospital plans and the cyclical need for exercises.
  - b. Coordinated planning with regional planning considering unique regulatory (Joint Commission) requirements.
  - c. For 2011:
    - i. Increase the number of hospitals actively participating,
    - ii. Develop regional surge capacity planning,
    - iii. Define alternate care facility authorities and implementation strategies,
    - iv. Mutual aid planning following long term care facilities model,
    - v. Continue coordination with Region 3 exercise and training activities.
3. *Local Health Departments*: A written report was orally highlighted by Ms. Marquis. (Attachment 3, pages 9-14, below).
4. *Behavioral Health*: Ms. Davis presented an oral report:
  - a. Behavioral health personnel available at the regional level are state assets. These are state sponsored, but regionally coordinated.
  - b. All objectives established for 2010 in Region 3 have been met.
  - c. The Region 3 behavioral health team has been integrated into ESF-8 operations.
  - d. Among the strengths is new leadership for the regional operation, defined roles. Training of new members. Also cited was the ability to bring in resources from all over the state if an emergency is in just one region.
  - e. Among the weaknesses are the assignment of people for regional emergency responses who do not work at their state-level positions in emergency settings, isolated provision of behavioral health resources by other groups (e.g., Manchester Red Cross) resulting in need for coordination.
  - f. Also cited as a threat is the uncertain level of state funding. Cited is a planned Red Cross exercise in June with 5 districts standing up; behavioral health resources cannot commit to participate because of uncertain funding.
5. *Long Term Care Facilities*: No report was given
6. *Medical Reserve Corps*: Ms. McCormack gave the following oral report:
  - a. A more robust statewide strategy for MRC development is needed, and one or more meetings in 2011 are recommended to address this.
  - b. Ongoing callouts have engaged new people to remain motivated; this should be continued.
  - c. Recruitment and retention need to continue to expand membership
  - d. Planning is needed to define expectations of what MRC can support in different types of emergencies.
  - e. More specialized training is indicated to meet different unique operational needs.
  - f. One barrier was identified: many people cannot respond 24/7. Some can only respond nights, others only on weekends, etc.
7. *CMED*:
  - a. In 2010, CMED responded with coordination and communication with EMS responders at a fatal bus crash in Hartford, the Kleen Energy explosion in Middletown, and the shooting incident in Manchester.
  - b. Last year, in October, the CMED facility was forced to evacuate for the first time. This disrupted service and led to intensive planning and exploration of alternatives.

- c. A weakness was identified: CMED has too many constituents not organized into levels or echelons of priority. Dispatchers call looking for scene status. Hospitals are increasingly calling CMED asking for patient information and expected transports which CMED may not have. There is a need for planning to better identify the coordination and control functions that CMED can and should provide. Alternative mechanisms for local officials and hospitals to get the required information need to be developed.
- d. In 2011, there is a need to further develop mechanisms for CMED to receive information, especially through electronic mechanisms (e-mail, cell phone transfer of photographs and video, texting, *etc.*)

The meeting adjourned at 11:20 a.m.

Respectfully Submitted,



Cressy Goodwin  
Recorder

ATTENDANCE:  
**CREPC ESF-8 Meeting**

December 1, 2010

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ATTENDANCE:  
**CREPC ESF-8 Meeting**

December 1, 2010

Name	Affiliation	e-mail Address
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Attachment 1 – Summary from Whiteboard

ESF-8 Meeting – December 1, 2010 – Whiteboard Notes

EMS	HOSPITALS	LOCAL HEALTH	BEHAVIORAL HEALTH
<p>EPT (Electronic Pt. Tracking)            Issues of Authority            Define Responsibilities</p> <p>EMS Strike Teams            ↑ Volunteers Participation            ↑ Plan Awareness</p>	<p>Coordinated Planning with Exercises            Hospitals Coordinate with R3</p> <p>↑ Hospital Participation            Regional Surge Plan            Regional ACS Plan            Regional Mutual Aid Plan</p>	<p>Strong Unified Planning            Plans Vetted, Tested, Exercised            Strong Regional Presence ESTs</p> <p>↑ Training Exercises            Regional POD Ops / CONOPS            Include Closed PODs            PHW Training            Integrated Exercises</p>	<p>DMHAS Asset            Can Draw Well-Trained Assets From Across State</p> <p>↑ Integrate with ESF-8            ↑ Leadership at Regional Level            ↑ Integrated Exercises            Develop Regional Leadership</p>
<p>MRC</p> <p>↑ Support for PH Operations            Re-do Statewide MRS Plan            ↑ Membership            ↑ Training for Specific Responses            ↑ Planned Deployments</p>	<p>LTC            (No Report)</p>	<p>CMED</p> <p>Critical Communications Platform            SMED Disaster Plan            Regional MCI Protocol            Primary Role – FMOP</p> <p>Build Intra Integrated Cooperation            ↑ Training in Regional Plans            ↑ EMS/Hospital Communications</p>	

Attachment 2: EMS Section Report

**A. Goals and Objectives from 2010**

1. Continue Design, train, equip and implement EMS Strike Teams within the region
  - a. Much energy has gone into this goal. We have developed a strong concept of operations and implementation plan. We collaborated with DEMHS and brought Strike Team Leader training to the state and held 3 programs training almost 20 people in the region and 60 statewide. We have identified salient issues that must be addressed and managed by the state partners prior to implementation can occur. These issues have been forwarded onto both DPH and DEMHS along with requests for meetings to proactively address the issues. To date, while receptive to the issues, no meetings have occurred and no solutions have been identified.
2. Design, Acquire, implement a patient tracking solution
  - a. Goal is on the fast track to completion. Invitations for steering committee will be going out within 7 days.

**B. The current planning and response capabilities of the EMS Section**

1. Planning capabilities – strong. Group meets monthly with good representation from commercial/fulltime providers. We are missing solid representation from the volunteer sector. Team is small enough that we have the ability to come together on the fly to proactively plan and manage issues that affect the system. We have recognized that a failure to do that, only negatively impacts the entire system. This capability has been continually strengthened by the increased amount of pre-planned Special Operations that occur throughout the region. Each year it seems these are growing in numbers and generating more and more patients requiring treatment and transport.
2. Operational capabilities – strong. We are operational day to day. EMS is a very fluid business that comes with a very high cost of readiness that is not often in line with what is reimbursed. In this region alone there are multiple delivery models and many stakeholders within the EMS system. Because EMS is so heavily relied upon to fill so many roles, in time of operational need, the lack of centralized coordination could impair our operational efficiency. It is essential that we continue to work on this important piece of the FMOP to identify what this threshold is and drive a culture change region wide to respect that threshold and work within the established framework. When thinking about operational capability, keep in mind we only have just so many resources. It is through prudent triage that the resources be appropriately distributed and that the rest of the healthcare system standup to support EMS. The quicker calls can be turned around, the more operational capability the system can have.

**C. What would you like your planning and response capabilities to be in three years?**

1. Planning

- a. We would like to see a better, more educated understanding of existing plans from our workforce.
- b. We would like to see an increased representation from our volunteer EMS groups
- c. We would like to ensure that we (EMS) have formally identified what all the capabilities that the region requires of us are, and that we have begun the process of building out those capabilities.

2. Operational

- a. Have EMS Strike Teams in Place
- b. Be able to monitor in real time our system strength
- c. Be moving toward utilizing electronic patient tracking on a day to day basis

### Attachment 3 – Local Health Departments

DEMHS Region 3 ESF- 8 Public Health Section Year-end Report December 1, 2010

#### **Initial Goals and Objectives for 2010**

The past year's goals and objectives were limited to the priority response to the H1N1 Flu Pandemic and improvement in the Technical Assistance (TAR) scores for the Cities Readiness Initiative. During the year the PH Section held monthly meeting on the first Friday of every month to provide information and to receive feedback. Workgroups were formed to address topics such as closed POD guidance, Communication Plan and the formation of an Epi Strike Team. Minutes of each monthly meeting were posted on the CRCOG/CREPC webpage.

#### **Achievements and successes**

During the year the following workgroups were tasked and each completed their assigned work in a timely and professional manner.

##### **Communications Workgroup-**

The communications workgroup was tasked with developing/restructuring the communications plan for ESF-8, and more specifically for public health. We had multi-disciplinary meetings consisting of members from EMS/CMED, PH, EM, MRC, and had inquired information from hospitals about their communications pathways with ESF-8. A formalized communications plan was developed and disseminated in the Spring '10. We are currently in the process of uploading all ESF-8 and local health specific contacts into the regional Everbridge System. Once completed, we will use that system to perform quarterly communications drills within local health.

##### **Closed POD Workgroup-**

The Closed POD workgroup was convened in the Spring 2010 to develop regional guidance for identifying and creating Closed PODs within the region to take the burden off of the Mass Distribution Area (MDA) PODs. The group quickly identified best practices and models nationally to work off of, and developed the regional Closed POD guidance for region 3.

##### **Epi Support Strike Team Workgroup-**

After Region 3 submitted their Project Public Health Ready (PPHR) application in 2006, the ESF-8 PH group investigated areas that were identified as gaps by the national NACCHO reviewers. One of those gaps was having a solid Epidemiological investigation plan for the region. It was decided to work on this for the next application review. Thus, an Epi Support Strike Team group was formed after much work had been done on resource inventory and typing. The next logical progression was to develop a strike team concept. After 3 years of working on this project, we are pleased to announce that Region 3 now has an Epi Support Team plan in place. ESF-8 PH is now tasked with creating a selection committee and then identifying personnel from the region to be part of this team. It's anticipated that this team would be activated similarly to other resources in the region (ie. phone call to RICS requesting this resource).

**TAR Score Improvement**

This is an analysis and comparison of the TAR scores from the '08-'09 and the '09-'10 CRI contract years. We have again ranked each section within the TAR from highest to lowest. In addition, a comparison table is provided to reflect the changes between the two years. As with last year, we have identified gaps as well as potential training opportunities.

This year was marked with great improvements taken from the recommendations we provided last year, as well as a real world event known as H1N1. H1N1 provided many local health departments and mass dispensing areas the opportunity to use their vaccination clinics to count towards trainings, drills and exercises.

The goals of the TAR summary comparison are to:

1. Identify gaps or areas for improvement at the local and regional levels
2. Outline training opportunities at the local and regional levels
3. Identify model or best practices from colleagues within the region for implementation where appropriate
4. Advance, through regional collaboration, planning components that need to be further developed

Outcomes:

1. Evaluate the steps above by completing another TAR this spring and summer
2. Repeat the cycle

**Comparison of ranked sections  
'08-'09**

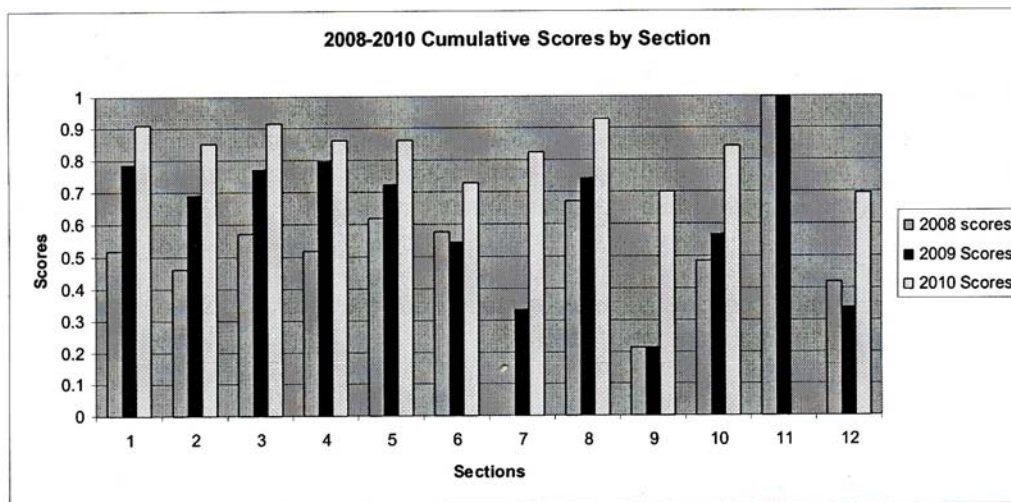
<b>Section</b>	<b>Score</b>
Hospital/Alternate Care Facility (sec. 11)	100%
Communications plan (sec.4)	79.7%
Developing plan with SNS elements (sec. 1)	78.6%
Requesting SNS (sec. 3)	77.1%
Controlling Inventory (sec. 8)	74.2%
Public Information/Communication (sec. 5)	72.4%
Management of SNS (sec. 2)	69.1%
Dispensing prophylaxis (sec. 10)	56.6%
Security (sec. 6)	54.3%
Training, exercise and evaluation (sec.12)	53.6%
Regional/local Distribution Site (sec. 7)	39.3%
Distribution (sec. 9)	21.4%

**Cumulative average for region was 0.670125 (67%)**

'09-'10

Section	Score
Hospital/Alternate Care Facility (sec. 11)	NA
Controlling Inventory <sup>1</sup> (sec. 8)	92.9%
Requesting SNS <sup>2,3</sup> (sec. 3)	91.4%
Developing plan with SNS elements <sup>3</sup> (sec. 1)	91.1%
Communications plan <sup>3</sup> (sec.4)	86.3%
Public Information/Communication (sec. 5)	86.2%
Management of SNS <sup>3</sup> (sec. 2)	85.1%
Dispensing prophylaxis <sup>3,1</sup> (sec. 10)	84.3%
Security <sup>3</sup> (sec. 6)	72.9%
Distribution* (sec. 9)	69.9%
Training, exercise and evaluation <sup>3</sup> (sec.12)	69.6%
Regional/local Distribution Site (sec. 7)	57.1%

Cumulative average for region was .805729 (80.6%)



**H1N1 Response**

DEMHS Region 3 submitted a 32 page After Action Report to the Connecticut Department of Public Health in July, 2010. Copies of the report are available upon request to Melissa Marquis at CADH.

**Objectives not accomplished and obstacles incurred.**

During the year the focus on the H1N1 Pandemic Response and the improvement of TAR scores did not address the need to improve our all-hazards competency or capabilities.

This is vital as local public health's capacity is being forced by the economic challenges to do more with fewer resources.

**Recommendations to increase scores by section for next year:**

Some overall recommendations from the SNS coordinator and regional coordinators include: conduct trainings, drills, and other exercises at the local level as well as participating in the regional exercises; spend time developing a volunteer and staff management plan that encompasses both the distribution staff as well as the dispensing staff; encouragement to have appropriate documents from After Action Reports available the day of your review; send an electronic copy of your plan sent to Corinne 2 weeks prior to your review; review the recommendations that Corinne has identified and work off that in preparation for the next year TAR; set up an appointment with Corinne ahead of time to discuss mid year issues if you feel you need additional assistance in increasing your TAR score; and remember to document, document, and document. If you think it's important to your MDAs readiness and score, then make sure you have record of it.

**Gaps and recommended actions**

**Section 1:**

1.4- Documentation from local agencies/organizations with roles/responsibilities in SNS planning elements.

Recommendation: develop a standard template and have participating agencies sign it. Create a single document (signatory page) with multiple lines for signatures of participating agencies, rather than individual letters to agencies.

**Section 2:**

2.4- Local jurisdiction conducts and documents call down exercises of 2.2 quarterly.

Recommendation: Increase no-notice drills

**Section 3:**

3.4- Local plan has procedures to request re-supply of SNS material from the State.

Recommendation: Use the appropriate documents to request re-supply to the state. Follow defined communications pathways for requests.

**Section 4:**

4.5- Communication networks (equipment/hardware) tested/exercised quarterly.

Recommendation: Test equipment with no-notice quarterly drills

**Section 5:**

5.2- Written PIC plan

Recommendation: Develop PIC plan which includes information on media policies and getting at-risk public to and through the clinic.

**Section 6:**

6.2- Security plan for transportation of medical material have been developed.

Recommendation: individualized assistance to address this gap.

6.3- Security plans for Mass distribution sites and/or dispensing sites (PODs) have been developed.

Recommendation: Use security checklist from TAR to guide plan development.

6.5- Site-specific security plans developed for POD and/or RDS.

Recommendation: Use security checklist from TAR to guide plan development at all other PODs or distribution sites.

**Section 7:**

7.4-7.11- JAS and JITT for MDA Distribution Sites

Recommendation: continue to train staff and volunteers and document that training done. Can use CT Train as a method to track training and document that training occurred.

7.12- Call-down rosters for 24/7 operations are accurate and tested quarterly.

Recommendation: Tie this into the call down exercises from section 2. Need documentation (AAR).

7.17- The local plan addresses staff/volunteer management (e.g., work breaks, shift schedules, meals/snacks, lodging, family care, etc.).

Recommendation: Develop standard template which MDAs can then modify to fit local needs.

**Section 8:**

8.2- All inventory staff are trained in IMS functions.

Recommendation: Ensure all IMS staff identified and trained based on JAS and JITT. Document training.

**Section 9:**

9.1- Distribution manager & back-ups have a job action sheet are trained.

Recommendation: Encourage training on existing JAS and JITT

9.4- Written plan & agreement for back-up agency/organization to distribute medical material.

Recommendation: identify resources that exist locally that can assist in distribution of medical materiel (Dept. of public works, or other resources with trucks). Speak with member towns DPW, or if single municipality- speak with area warehouses perhaps that can provide trucks and personnel to drive.

**Section 10:**

10.4- Local mass prophylaxis/dispensing plan has criteria to alter for increasing throughput.

Recommendation: Use Corinne's email for guidance.

10.6- Procedures for providing prophylaxis to homebound and other at-risk populations.

Recommendation: Look at best practices from Capitol Region or other MDAs on ways to distribute meds to home bound populations.

10.7- There are site specific plans for each of the dispensing/POD sites.

Recommendation: Use the site survey tool.

10.13- Local plan addresses staff/volunteer management.

Recommendation: Develop a template (refer to 7.17).

**Section 12:**

12.4- Has an exercise plan developed in accordance with the Department of Homeland Security Exercise and Evaluation (HSEEP) that allows medical/mass prophylaxis plans to be tested/evaluated.

Recommendation: Use regional training and exercise plan as a template and bring it down to the local/MDA level with respect to drills and exercises.

12.6- Drills and exercises that have been conducted over the last year, documentation available to support this evidence.

Recommendation: Encourage drills and exercises. Conduct quarterly communications exercises that touch on 2.2, 4.5, and 7.12.

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We will conduct an information sharing session to identify best practices to address some of the gaps listed above. Please come prepared to discuss specific details about some of your innovative methods to dispense and distribute prophylaxis to the public.

After this workshop, CADH, CRCOG, and Steve Huleatt will compile the best practices into a single document and share with the entire region. Additionally, we will look to develop templates or regional “fixes” as a result of the information from this workshop.

**What do you believe are the current planning and response capabilities of your section?**

Currently DEMHS Region 3 PH can support a local incident’s public health response and sustain the response for three days. However, DEMHS Region 3 does not have the capability to sustain a region wide public health response for three days.

**What would you like your planning and response capabilities to be in three years?**

DEMHS Region 3 needs to engage community support through awareness, training and resources to support a region-wide public health response for three days. ESF-8 PH needs to retain or increase the skilled public health workforce without further reductions due to the challenging economic times.