Preface
The National Association of County and City Health Officials (NACCHO) conducted its annual Public Health Preparedness Summit in Atlanta, Georgia. The Summit contained a variety of interactive sessions and half to full day workshops which participants could register for. The various tracks provided insight into best or promising practices, project reports, and federal partner guidance. Additionally CT-Region 3 was being recognized for being Project Public Health Ready (PPHR) for a second time. PPHR is a NACCHO sponsored certification that local and regional public health departments/districts have met specific criteria for Public Health Emergency Preparedness.

Tuesday 3-12-13
Plenary Session
A Community United: An Integrated Response to the Aurora Mass Shootings
Healthcare system review of the Aurora theater shootings last year via panel discussion with representatives from Hospital, Mental Health services, Tri-County Health Department/RESF-8 Public Health and Medical Services.

Presentation covered the challenges of a Mass Shooting with the specific circumstances as found in this incident, namely the number of walking wounded or those carried out by others as police arrived. Unique challenges of an active shooter situation whereby EMS was staged and how the PD started loading those wounded into cruisers and transporting directly to the closest hospital 3 miles away. In this instance it turned out to be the correct response given that all patients except 1 DOA transported via the PD survived the incident. Emphasis on the right decision at the right time with the right set of circumstances.

Other discussion points highlighted:
1. Receiving 23 patients with gunshot wounds into the Emergency Room at the University of Colorado Hospital within 12-15 minutes
2. The need to augment 211 info-line and special hotlines for patient information and reunification efforts
3. Surge needs for behavioral health and the ongoing need for behavioral health services beyond the incident
4. Use of EMTrack not only for patient tracking but as the basic information tool used by 211 while maintaining HIPPA awareness

Special Note: EMTrack was identified as the foundation for required hospital bed and status reporting systems in a couple of sessions during the Summit

Keys for CREPC
Incidents such as Aurora, and now Sandy Hook provide direct insight into response theory versus response reality and providing flexibility where needed in response guidance. The value to the Region lay within the review of presentations and AARs and aligning strengths and areas for improvement against local / regional guidance and practices. (Note Official AARs for active shooter situations are usually delayed due to legal matters especially in the Aurora incident with the shooter going to trial). Specifically for these types of incidents the use of EMTrack by the hospital proved to be extremely valuable and eventually provided a more efficient “system” response to which patient went to which hospital. As we are seeing in Sandy Hook Behavioral Health services still play a key role to recovery and should not be overlooked. Finally the value of a “Regional” public health department which serves as the RESF-8 lead and assisted by coordinating the EMTrack and info-line, and resource coordination across the ESF.

Recommendations:
1. Full use of patient tracking system -having data processed as soon as possible to incident inception is key
2. Develop process/committee to be the CREPC eyes to review AARs from real world incidents that may provide lessons for CREPC to learn from.
3. Continue to encourage participation in active shooter trainings and exercises at local level.

Session 1
Building and Sustaining Successful Healthcare Coalitions
As we are well aware Healthcare Coalitions are emerging as an effective community based “resiliency network”. This writer has heard the 3 presenters a number of times but they all presented new material at this summit. Two presenters were from hospital based systems, and one was from a multi-county public health system. All three spoke to the need for pay to play and the need to add value to everyday operations and to stop talking about disasters, but instead using business models and continuity of operations as the basis for discussions and planning.

Keys for CREPC
Region 3 (CREPC) has built a strong coalition within RESF-8, but we are still lacking in private sector/business engagement and demonstrating the value of the Region beyond disaster planning. Additionally compared to local public health activities the Region 3 ESF-8 Hospital Section may need to be re-think how it drives planning and collaboration in building out its piece of the coalition. Sustainment discussion is important and how it relates to the cost of doing business vs. just planning for disasters hence speaking to the bottom line and making it attractive to be part of a coalition that provide services across multiple organizations at a lower
cost than each institution paying for “their own”. Options include tying coalition services directly to Joint Commission Environment of Care standards, funding of a single Full Time Equivalent to manage certain functions across all hospitals for preparedness efforts, cache management, exercise planning and conduct, disaster reporting systems, interoperable “maintenance” etc. The key is to be open minded and flexible in thought and practice. Currently these types of activities are traditionally “add on” duties to current staff which takes away from their direct “value” or full time hospital essential activities. The fee/dues can be structured accordingly but the hospitals alone could fund services through the coalition with grant funds now. Once the value is realized it becomes the price of doing business which would be readily absorbed when funds run out. In the two hospitals based systems highlighted in this session fees might be considered substantial by some as one presenter stated “we figured out the base price that would make the hospitals choke and subtracted a dollar”. Now there is no question or hesitation due to the rate of return to the hospitals through the coalition. The presenter on from the public health system based coalition states they will be moving to fees for service at the direction of the executives that head the organizations that will have to pay the fees.

Recommendations:
1. If possible bring presenters into CT either face to face or virtually
2. Review the work of the RESF-8 Hospital group and provide structure guidance moving to models of best practice as seen across the US
3. Bring key partners together for 2-4 hour workshop(s) to review initial steps to a real coalition
4. Do away with MOUs and produce business contracts

Session 2
Real Tools for Emergency Preparedness
Review of work done by focus group for legal analysis of all preparedness statutes from 11 states and the Federal government broken down into functional areas of response. The tool is a database searchable by keywords, state/fed, response function etc. and links directly to specific statutes in the survey group. Started with the assumption around 26 different “agents” whose mission touches on the health and well-being/safety of the public, and how those statutes mandate some type of responsibility for preparedness, response, or recovery. The work was done by researchers/attorneys who searched the statutes of the 11 states and the feds “by hand”. (System name -PHASYS)

Keys for CREPC
Nice tool to see what the different 11 states have in the form of statutes tied to emergency preparedness, response, and recovery. The tool would be good for research for those organizations such as CREPC that have been given some “authority” in statute to provide certain services and responses. The tool is limited in its look at the Universe but if funding continues it could include more states, or software development to do the same work the attorneys did by computer.
Recommendations:
1. Investigate use of tool to see if there are CREPC like organizations “protected” or provided certain authorities in state statute

Session 3
Improving Preparedness Practice: What’s Research Got to do with it?
Session looked at how CDC conducts research and provides guidance for practices, and the development of toolkits.

Keys for CREPC
High level look at where research impacts local practice for public health driven initiatives. Nice to know and informative.

Recommendations:
1. Ensure RESF-8 stays connected to CDC toolkit and preparedness guides

Wednesday 3-13-2013

Plenary Session
To Stay or Go? What Storm Sandy Taught Us about Hospital Evacuation and Healthcare Preparedness
Panel discussion from all levels of preparedness and response. Greater detail to lessons learned can be found through AARs and white papers so these notes will only capture what I perceived as key to discussion.
NY State ESF-8
Challenges –
- Extended operations for weeks, 18-20 work days w/4 hours of sleep after 4-5 days staff significantly impaired
- Activated National Ambulance Contract
  - TS Irene about 180 ambulances activated for 2 weeks
  - Storm Sandy about 350 ambulances activated for over 4 weeks, met the 49M dollar contract max

Session 1
Strategic Implementation: Using Assessment Information to Align State, Regional and Local Priorities within the Capabilities Framework – North Carolina’s Department of Public Health Strategic Planning Process.

Systemwide / Systematic approach – currently public health can only dedicate 30% of its time to preparedness efforts. NC contracted from 7 to 4 public health preparedness regions, very big very diverse. Took 2 full day sessions to develop Strategic Plan (– get slide presentation –) aligned against PHEP capabilities released in 3/2011. State conducted aggregated assessment – modular approach within each preparedness region; they using spreadsheet and open dialogue boxes with 114 tabs for each capability function – no right or wrong answers.
Sheet contains:

- Function descriptor
- 3 open boxes current
  - Current status
  - Gaps
  - Plans to address the gaps

Information was synthesized into 88 page report of gaps only.

*North Carolina PH – Nov. 2012 -Preparedness Systems Capabilities Assessment Gap and Strategies*

Functional use of report:

- Policy determinate
- Communications with partners
- Documentation of basis for measuring progress
- Can show folks what you are expecting of them
- You develop your outputs as you check off the gaps for grant reports

NC-DPH developed 3 Top Priorities with their partners – not just the largest or hardest gap but included one that can also be completed in reasonable time frame gives you a win. As you attack one you are also addressing components of others when developing plans, communications, etc.

Addressing Gaps through Corrective Action Plans:

<table>
<thead>
<tr>
<th>What is to be done</th>
<th>Who is going to do it</th>
<th>When is it going to be done</th>
</tr>
</thead>
</table>

Evaluation Tool

MS Access – funded with CDC $$, captures significant milestones, basic reports on identifying gaps and how they are being addressed; identify and build on strengths; accountability and transparency at all levels. All partners have access to tool where they report as frequently as necessary but at least quarterly on their milestone activities addressing the priorities set. Covers everything from attending meetings to completed projects, full scale exercise; with direct and in kind services etc.

Keys for CREPC

Currently CT-DPH is reviewing capabilities they reported on last year to US HHS. I have been asked to work on a small workgroup looking at Hospital Preparedness Program and Public Health Emergency Preparedness Capabilities for Healthcare Coalition Preparedness/Recovery, and Community Preparedness/Recovery functions. I am not sure what the process is for the other 11 Capabilities and if I will be involved. CT-DPH approach as any assessment is subjective but overall I think it is fairly accurate as to capability and associated function but there is no discussion at this time as to how the gaps will be addressed. As to addressing gaps the Region has always had a sense of what it the right thing to do and short of direct guidance from higher levels of government this process has not in and of itself failed. Staying connected to this type of assessment process may be critical to accessing grant dollars in the future. The system in North Carolina worked well based on both the formal and informal networks such as those in
existence for CREPC and CT, but they have learned how to take advantage of those networks better than we do in CT.

Recommendations:
1. Continue full engagement of local public health in RESF-8 activities
2. Presentation would be of value for CREPC and CT
3. Conduct like capabilities assessment for RESF-8
   a. We can do this on our own using the North Carolina approach
4. Measure assessment against prior assessments and After Action Reports

Session 2
Meeting the National Challenge: Measuring Progress in Building Resilient Communities

Large Panel discussion - Looking at abstract high level definitions of what community resiliency (CR) is and how to measure it at the local level. Resiliency crosses many domains, not just economic, being able to get / buy stuff but the physical, political, and psychological perceptions and how they affect how well we bounce back. Each sector of what we believe makes a community is impacted (research book – Building Resilience). Strong social networks not only between people but people and business and governments are the best predictor of how well a community will bounce back. First presenter spoke to the same/main tenets of the Neighborhood Emergency Team program which engages at the neighborhood level. Neighbors are the first responders when folks need help; denoted as “Strengthening Social Capital”. We can’t have resilient communities without a healthy community, we have to do a better job of educating CEOs of the value of a healthy community and its true cost benefits with a better prepared community.

Challenges not uncommon across the globe, e.g. Japan, Europe. Resiliency is conceptually messy, what do you measure, how do you measure it, when do you measure it (Research is available through Rand). In final examination the measure of how well you were prepared is how long it takes you to recover. With that said you cannot then measure resiliency until after disaster strikes but there are proxy indicators for resiliency. Identify those proxy indicators those may be easier to measure than CR itself; lights on, stores open, kids in school, other social and environmental indicators etc., etc. Rand developed 8 levers of CR from prior disaster analysis. (other research - Coastal Resilience Index). Levers can be deconstructed to direct activities building resilience.

LA County (research LACCDR) – 10 M - population, 88 diverse communities but approach is neighborhood based – how do neighbor to neighbor connections affect/determine public health. Looking at plans and translating into day to day “well-being” and wellness practices using the Rand 8 Levers. Moving from Individual based activities to Interdependent based activities. LACCDR survey/project communities; 8 service plan areas along with an additional 8 preparedness communities which will be tested/measured. Each community must have population of 30-40K with a downtown commercial area. Neighborhoods will look at the same 11 US HHS PHEP capabilities, functions and tasks which currently apply to public health departments and decide which apply to their neighborhood – social structure- and what tools are needed to build and measure resiliency (Research tool -PARTNER). This is a 3 year project.
CoPEWELL Project – 3 year project – Johns Hopkins University - You can only see resilience after a shock to the system – a latent capability. Discovered models with incomplete concepts in past work when looking at community resilience, as an example some have taken into account people but did not take into account social dynamics, or population density. Discovered models that did not take into account specific weighting, meaning all factors and indicators were given equal weight. Current thinking - “parameter of interest” is post-event functioning and well-being vs. “resilience”. Post event functioning varies among different events. Pre-event functioning predicts short and long term post event functioning. The impact of the event is mitigated or impacted by system actions such as emergency management and response, and in place supports, as well as external influences, meaning assistance from outside the community. Ultimately want project to aid impact predictions which will inform mitigation strategies and design day to day resilience practices and recovery actions.

Looking at a Resilient Nation in 2030 - Individuals and communities are the first line of defense offering mutual aid and developing governance structures to manage crisis together. Educated populace – federal government that invests in networked and local resilience. We have done a poor job of determining the costs of disasters outside of financial loss or cost. National Resilience Scorecard to prompt needed change absent an event which would look at entire post event functioning reports and apply them pre-event. Applies across the whole community not just emergency management activities. Community resiliency begins with strong local capacity which has to be institutionalized within each community.

Keys for CREPC
This session gives light to the various work and projects that are currently underway which will provide guidance in resilience efforts going forward. Given the size of CT we could be a great project/ Beta site for some of these other projects currently are taking place via multi-year grants to develop a delivery based product. This session highlights the need to be fully engaged in activities of ESF-14 Long Term Recovery especially focusing on the integration of pre-event/mitigation actions. Long Term Recovery should not start after the event but partner with those activities which shorten the window of recovery.

Recommendations:
1. Seek out and review resilience research projects and project data
   a. This may require a sub-group or committee within RESF-14
2. Ensure the continuation of Citizen Preparedness efforts

Session 3
Building Bridges: Crossing the Gap between Public Health Preparedness and Emergency Management
Presentation aimed at engaging and sustaining Emergency Management (EM) with public health preparedness efforts. Challenges discussed – predictors of collaborative engagement; EM representing diverse geographies/populations (urban, rural, farm/wildland), no standard professional criteria, full time, part time, and volunteer positions with disparate qualifications and experience. Discussion focused on effective practices to build relationships with local EM. EMs don’t necessarily think that responding to a public health emergencies/illness involves
them. Need to emphasize whole of community and resilience within a public health and well being perspective.

Keys for CREPC
Presentation didn’t highlight anything new to consider for CREPC challenges are the same regardless of State. Discussion should focus on common problems and cause with common solutions, asking EM what keeps them up at night regarding public health, then engage. In this instance recommendations are focus on engaging local EM across all regional activities and not just local public health.

Recommendations:
1. Continue and strengthen efforts to engage all local EM partners
2. Continue to provide training opportunities; e.g. NIMS, ICS, etc.
   a. All jurisdiction and discipline participation in “White Powder” response trainings
3. Offer value added assistance for:
   a. Exercises
   b. Planning
   c. Systems review
   Assists CRCOG/CREPC sustainment
4. Strengthen LEPC connections with EM and Public Health
5. Develop Regional newsletter
   a. Quarterly highlighting local and regional activities

Session 4
Ignite Session – presenters have 5 minutes to present 20 slides that auto advance – purpose is to ignite interest whereby the audience seeks out more information

Collaboration A Road to Ironman - Utah presentation to prepare for Ironman 2012 competition - Medical Surge training/exercises using Blue Med Tent – Decision made to go with tent system for med surge distributed throughout state, tent operators realized they couldn’t do it on their own. Used Ironman as tool to engage all public and private partners to “set up a hospital”. Conducted trainings, created a video then exercised leading to “hospital erection” for the 2012 Ironman competition. Sought volunteers by advertising tie to being part of Ironman event. Tent system set up was managed by Blue Med Tent quarter masters who managed tent components coming off and going back on tent trailers. Each component had a mission assignment or specialists, e.g. tent erection, HVAC, Generator, tent outfitting, etc. Used ICS modules, JITT. They had 4500 volunteers 80% local, covering 97 different functional areas for Ironman competition.

Second portion of session reviewed the collaborative efforts in Rhode Island integrating State’s public health Immunization Program with statewide SNS mass dispensing plan. Purpose was a real world test of public health emergency preparedness program with a real world need of system wide immunization shots/vaccinations. The State and local partners got to test in real time emergency plans and give back a value added benefit by immunizing state residents. RI used 69 PODs throughout the State but never had more than 4 running at any one time. The PODs were staffed with local first responders coordinated by EM. A staff of 120 could manage
a vaccination throughput of appr. 500 people per hour. As a result of this collaboration the state of Rhode Island had the highest rate of immunizations in the US. (Research Operation Big Green on LLIS).

Keys for CREPC
MRC tent system presents the same challenges as seen in Utah all though MRC tents are smaller than the larger Blue Med Tent system. As a region we do a poor job of integrating MRC activities and the MACU with planned real world events. This not only increases team proficiencies, but builds a sense of worth among MRC Unit by doing “something real” to add to training. The second portion of the presentation followed nicely again with identifying a “public need” and using an emergency response component and plan. The value was the teams were exercised and per RI representatives the volunteers came away with a sense of value while doing something good for the community. Municipalities saw the value of participating in a real world event that had real world results meeting program needs vs. just another exercise.

Recommendations:
1. Seek out opportunities to use real world planned events to exercise regional and local emergency response components and plans
2. Develop JITT for specific response components such as the MACU

Thursday 3-14-2013

Session 1
Coalition Building and ESF-8 Integration Workshop
Presentation of high level project conducted by Univ. of Colorado providing framework and strategies for building coalitions and ESF-8 capabilities through a participatory format.
Developed the framework of the project with 2 interns gathering baseline information through surveys and 40 interviews with Subject Matter Experts (SME). Project developed and provided all documents, templates, and back ground information then conducted 12 - 2 day workshops over 8 weeks throughout 10 counties in CO using the Target Capabilities (US DHS) (for EM/first responder buy in) and the Healthcare Coalition Capabilities through US HHS as the metric. The various Healthcare Coalition (HC) members then had the tools to go back and complete capabilities assessment going forward. Project end result was an AAR formatted SWOT and Strategic Plan for the next 3 years for each HC. Format serves as Train the Trainer going forward the coalitions should be able to do this on their own.

Project had 4 Stages
Understanding the Capabilities –Developing that Common Operating Picture – What does your HC system look like. Had to stress Healthcare Coalition “operations” is not boots on the ground but coordination centers using MACC model. Coordinating information and resources from/partner members and updating other key stakeholders.
   Stage 1 - Determine HCC Structure PHEP Capability 1 Function 1
   Stage 2 - Coordinating planning PHEP Capability 1 Functions 2-7
   Stage 3 - Develop strategies for PHEP Capabilities 2, 3, 5,7,10, 14 & 15
   Stage 4 – Strategic Plan development
Broke down the Stage 3 Capabilities into quarterly outputs for the next 3 years. 
(Presenter used quote from Tim Cook – You can focus on things that are barriers or you can focus on scaling the wall or redefining the problem).

Project Materials – Strategy Roadmap addressing Capability function, task, and element, and assessed each by priority for completion in year 1, 2, or 3. As they went through each meeting agendas were developed for follow up coalition meetings. Cost mainly for material development and facilitator, venue and support was provided by the host communities.

Keys for CREPC
When CREPC conducted Regional capabilities assessment the basic format in concept was the same as this project. The presentation highlighted a system of using ESF-8 section heads as workgroup leads responsible for the elements within their group. Currently Region 3 has a strong sub structure for ESF-8 with 7 sections where others may have 4-5. However there is room to add sections such as Community Health Centers, and Primary Care Associations as just an example. A review of Region 3 past SWOTs and Capabilities Assessments, while funds for contractor are still available, can be useful for providing some structure for future planning as well as facilitate the development of value added services from CRCOG/CREPC to coalition members and the communities making sustainment efforts an easier sell. For us the first external conversation we should have would be high level dialogue with DEMHS and DPH. This cannot be just a check the box process but a document that can be used for any competitive grant process and progress going forward becomes the metric. This last item is key for the review work. A majority of recommendations within this brief can possibly be addressed through the stated review process.

Recommendations:
1. Assess previous SWOT and Capabilities assessment to where the Region is now
   a. This can be done through CRCOG staff / contractors and select SMEs in the Region **WITH** State partners
2. Develop strategy for next steps after review process is complete
3. Seek out and engage points of contacts for critical partners not yet part of our RESF-8 Public Health and Medical Services.

Session 2
New PHEP Performance Measures
Public Health Emergency Preparedness (PHEP – US HHS/CDC grant program)
Performance measures at the national level focus on identifying gaps and providing technical assistance in the PHEP guidance. Walk through of revised performance measures within PHEP capabilities which are detailed in these notes. (Research new PHEP measures when published). PHEP measures apply to grant awardees whereby grant awardees should identify gaps within the capability and use grant funds to assist in capability and capacity build out. Majority of presentation was the scientific reasoning behind the methodology of how PHEP measures are developed and revised based on data (AARs, required reporting, direct feedback/input) from local and state preparedness reports which become the tool to measure how well awardees are doing and if they are meeting the deliverables of the CDC PHEP Cooperative Agreement.
Keys for CREPC
Currently CRCOG is in the 3rd year of a 3 year PHEP grant period (20,000.00 per yr.) through the Regional Public Health Advisory grant deliverables as a sub-contractor providing the CRCOG brand for local public health emergency preparedness. CRCOG is not responsible for the associated PHEP performance measures, but is part of the “system” for our Regional Public Health Advisor to meet his deliverables (R-3 RPHA is Steve Huleatt – West Htfd/Bloomfield HD). CRCOG provides planning support for CRI activities and exercises and integration with the Capitol Region – MMRS program.

Deliverables included:
- Development of Region 3 Public Health Emergency Response Plan (PHERP)
  - R-3 PHERP was used as the baseline for the Region’s re-recognition as Project Public Health Ready through NACCHO (National Association of County and City Health Officials)
- Exercise support where requested at the local level
  - City of Hartford 1/2013
- Integration with Regional Training and Exercise Planning Workgroup

US HHS has issued capabilities for PHEP (CDC-public health) and HPP (ASPR- hospital preparedness); these capabilities are the lynchpin for assessing where the Region is and where the Region should be going in the future. As with the National Target Capabilities List no one community can meet all measures on their own hence the new focus on formalized healthcare coalitions. Through CRCOG and CREPC a strong foundation and Regional infrastructure has been built but to think all the questions have been answered as to meeting capabilities and capacity would be foolish. Compared to best practices presented at this summit Region 3 is a toddler; upright and able to walk but a little wobble and are far from running without falling. It is key for the Region and all stakeholders to know what the roles and responsibilities are pertaining to any capability, i.e. who is the lead, who supports the capability, what is the foundation of the capability local, regional, state, etc. Much work still needs to be done to socialize (educate) Regional plans and processes with municipal partners.

Recommendations:
1. Continue partnership with public health preparedness efforts
   a. Provide support
   b. Serve as facilitator, or co-lead with local public health for PHEP capability building
2. Leverage remaining MMRS funds to support building out capabilities
   a. Better prepares Region to compete regionally for Healthcare Coalition grant funds IF and WHEN US HHS issues grant guidance for Healthcare Coalitions

Session 3
Integration of Automated Capability Assessments and Strategic Planning
Web site https://dchd.isc.cemp.com
User: PHPS13
Password: CEMP2013
Illinois planning initiative—Public Health based Comprehensive Emergency Management Program. Standardized reporting forms for integration into regional planning, training, and exercise initiatives and enhancement of strategic planning. Moving from static word documents and spreadsheets to internet based system, critical especially if you want to actively track progress, see real time data, etc.

Large systems in Illinois, 7 regions/preparedness systems, 185 hospital systems, 92 local health systems, 11 EMS /Regional Healthcare Coalition Hospital systems. Can measure progress on a day to day basis for PHEP measures and capability building as well as having access to updated plan products such as job aides, task sheets, templates, etc. CEMP is a preparedness program that resides in the “cloud” open to members and provides dynamic reporting to CDC in Atlanta. Secure system ties locals to regions to state to feds, instantaneous updating of contact data, plan and product revisions, and reporting tools up and down through the program (local, regional, state, federal). One plan (interactive) in one location shared throughout multiple systems. System price based on population not number of users (Integrated Solutions Consulting). Users = Admin, editors, updaters, ready only, etc. Secure access is managed through the Point of Contact for the systems listed above. When granted access you only see the specific parts of the CEMP that pertain to your permission level.

Capability Planning Guide (CPG) – (PHEP/HPP Capabilities)
ISC built automated assessment tool, providing functionality beyond just a word or excel document. Templated forms offer the ability to add a note which does not come with CDC template. You can then link to the corresponding CEMP link (referenced in the preceding section above) which ties the assessment to the actual plan document. You can track significant comments from the previous year’s assessment, and upload relevant documents.

Reporting – Report function locates all reports tied to the various capabilities and strategies from local up through state reporting requirements in one location. With one click you can see the CPG progress within each system, and drill down to each locality. Tracks/incorporates document review process from locals through region, up to the state then to CDC. The interactive view across the system allows you to see at a click other partners that may have a capability built out to a higher level. You can then compare your gaps against a “promising practice” or product to assist your initiatives from that jurisdiction. For planning purposes if you rank a capability/function as highly important or critical, but you have only developed a limited capability then you can “see” where you need to address your planning efforts over a determined period of time. If you have gaps in a capability that you rank as “of limited importance” you can then address your planning needs to accept, transfer, or mitigate that gap and either not waste time, or give yourself a win if the capability is “low hanging fruit” meaning little or no funding, and little level of effort is needed to close the gap.

Jurisdictional Risk Assessments
Jurisdictions within each system previously identified used the CEMP tool to develop their healthcare system hazard vulnerabilities. All tools and foundational documents or information for hazard vulnerability assessments is in the CEMP by jurisdiction – healthcare focused. As they progressed through the process they identified the partners that were being pulled into all the various evaluation processes meaning the same partners going to multiple meetings addressing
the same planning elements. Process became much more streamlined once they aligned task to product, meaning surveying partners once or meeting once to cover the various components addressing all 3 program elements:

- Plan development and maintenance
  - Includes implementation checklists or tasks
- Capabilities Assessment
- Jurisdictional Risk Assessments

Used evidence based risk analysis looking at community condition, system impacts, recovery needs.

Keys for CREPC

These notes cannot adequately capture the power of this tool and the over 400 systems built into it. Once up and running the tool becomes the watchdog of the preparedness system and strategic planning. First year is the most intensive from then on the system updates from year to year through traditional user inputs across various grant reporting requirements. The combined CEMP and Capability Assessment Tool would strengthen the value of CREPC if CRCOG became the lead for tying the locals into the region and up through the state for developing a well-rounded accurate State Preparedness Report. The value added to the locals is the visual tracking of capabilities important to them and those for which they are directly responsible for with the tie into the Region where the regional plans and resource coordination completes the full capability through the RESP or regional teams, e.g. Hazardous Materials, Dive Teams, SWAT, etc. The third component for Jurisdictional Risk Assessment ties into the same CEMP tool again tying the PLAN to CAPABILITIES to RISK ASSESSMENT. If there is any funding for the CREPC in the future it will not come without more stringent metric reporting requirements so this type of tool keeps the Region on track with building capabilities and then provides reporting and competitive grant documentation. A combined project integrating locals up through federal planning, measuring and reporting requirements would probably be one of the best cost to benefit tools for preparedness brought into the State.

Recommendations

1. Investigate ISC type products while funds are still available
   a. If future IECGP funds are available this should meet the definition for interoperability planning and integration with use of a cloud based information and plan sharing tool
2. Engage HH CoE, DPH, DEMHS for active partnership in developing this capability or refining current processes at the very least

Friday 3-15-2013

Session 1
Volunteers as a Resource and Not a Burden: Workshop in using Volunteers to Create an Effective Response – Fort Bend County TX Medical Reserve Corps – appr. 630,000 in population contiguous to Houston TX.

Built their volunteer system around the Strategic National Stockpile (SNS) and receiving Cities Readiness Initiative designation in 9/2006 – created MRC Unit in 6/2007.
Target for volunteers – 5000, currently has 2400 active team members (response and participation averages slightly over 25% per event; higher response rate for annual exercise event). They use the term Team Members vs. “Volunteers” – “that is just a pay grade whereas Team Member better describes who they really are; part of the team”.

3 Keys

1. Identify needs of your community in order to design a volunteer program
   a. What is your mission (staffing PODs is not a sustainable model add planned real world events to training and exercises)
2. Creating the infrastructure
   a. Need this before you recruit
3. How do you communicate with your volunteers
   a. Develop database which tracks everything the individuals in your unit does (Camber First model)
      i. When using polling mechanism insert option for identifying folks that want to opt out of notifications / change in cell numbers, etc.
   b. If you conducting training and want to know who is coming add link to survey tool that takes registration information and tracks who is coming
   c. Text messaging used by younger population vs. email

Applying the Effective Response Model to your program

1. Engagement
   a. What are the community needs and available resources, creating community partnerships
   b. Train and empower
      i. Fort Bend trains and then depends on Team Members to “run the show”
      ii. Trained to operate and manage the County PODs
      iii. Developed Task Books – position specific training
         1. Monitored by leadership and signed off as training is completed
            a. Enhances retention through good spirited competition to get the training – more “stickers”
   c. Engage full range of partners
      i. Include private businesses
      ii. Civic / Faith Based Organizations
      iii. Professional group alliances
      iv. School partnerships – access to kids
         1. Aided in evaluating POD throughput
2. Exercise
   a. Keeping Unit busy
   b. Engaged in planned real world events which build Team excitement
3. Evaluation
   a. Include Team Members in evaluation process
   b. Implement changes where appropriate after evaluations
   c. Task Book program tied to evaluation process
4. Excitement
   a. Recognition and rewards
b. Include enthusiasm in all aspects of building a response model

c. Incentives
   i. As members process through identified position training small sticker goes on ID Badge. Each member receives 2 badges (fire ground accountability model); Badge with completed training/competency stickers is left at sign in location as accountability but also offers visual cues to assign proper duties to Member. When Member signs out they get the badge back

d. Creating Community Recognition Program
   i. Newsletter, and/or newspaper especially small independent “Press” community papers
   ii. With partners develop community “night out”
   iii. Ask for things that are free
      1. Minor League Baseball – Restaurants-Picnics, etc.
      2. Brings people to businesses, further engages private sector

Keys for CREPC
The MRC Unit highlighted in this session presented practices that should be easy to replicate regardless of MRC Unit size and can add to recruitment and retention efforts for the CR-MRC. The Fort Bend MRC Unit has more community partners then all of CREPC has been able to achieve. Their reach out and engagement practices could serve as a best practice for the Region and not just the CR-MRC. Have we ever tried to integrate other CREPC ESF activities into MRC capabilities such as ESF-20 Faith Based Organizations, ESF-20 Collegiate Services, etc.? Those ESFs may have team members looking for opportunities to participate.

Consider providing a value added service to the communities by managing volunteers regionally beyond MRC. The Region should track IRS Form 990 filings which allow for 501 (c) 3 non-profit medical services, hospitals, community services, etc., the ability to apply their participation as a line item against income to maintain certain tax exempt status on the 990 form. (Research 990 filings on irs.gov)

Recommendations
1. Work with CR-MRC to identify where “regionally” we can enhance recruitment and retention and integrate activities across RESF structure where appropriate
2. Investigate organizations required to file IRS Form 990’s (501 (c) 3) to engage partnerships that positively affect their bottom lines
3. Examine how CREPC is currently reaching out to as many partners as possible; both traditional and non-traditional
   a. Identifying new partners can be achieved through “brain pooling” workshop of CREPC leadership, staff/contract support and select SMEs.

Summary
This conference was rich with opportunities for CREPC to mine for potential practice applications. The primary motivation for this “AAR” was to capture notes into a conference brief to share with all interested parties. Sharing information with CREPC core leadership at the very least is where you see return on the investment of sending staff and CREPC members to
conferences and the Region might want to consider a policy of having AARs generated after conferences and trainings when Regional grant funds are used. Those briefs do not have to be as voluminous as this document and to make it easier the Region can offer an AAR form of one to two pages to be completed during or upon return and submitted with associated reimbursement requests. The forms would be crafted into a number of questions making it easier for the conference/training attendee to complete highlighting key or critical points developed from the conference along with recommendations where appropriate. This type of format may assist the Region in its Corrective / Improvement Action Planning by identifying easily replicable practices and a point of contact to gather more information. Again, this could be constructed as a value added service back to the entire region and member municipalities with the development of an indexed library truly making the information gathered by an individual at a conference available to anyone.

This document was developed rather easily by typing notes as the sessions progressed thus avoiding the time of going back and translating handwritten notes. This process may not work for all and all conferences and trainings may have a format making it difficult if not impossible. However, publishing/distributing a form beforehand would act as a guide for individuals to easily answer questions as it pertains to application back in the Region and municipal levels.

Respectfully Submitted,

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