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CT Region 3 RESF 8

Storm Alfred After-Action Report

A Review of RESF 8 Actions and Responses
to Storm Alfred

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For RESF 8

1 December 2011



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***Activities of the CT Region 3 RESF 8 (Public Health and Medical Services) for the Period 28 October – 7 November 2011
Response to Storm Alfred***

After Action Review

Introduction

The State of Connecticut is divided into five emergency preparedness and planning regions designated by the Division of Emergency Management and Homeland Security (DEMHS), a division of the CT Department of Emergency Services and Public Protection. DEMHS provides each region with a Regional Coordinator who acts as the State's liaison to local municipalities situated within the DEMHS region. There are 41 municipalities in CT Region 3, also known as the Capitol Region, with a combined population of approximately 1,082,000 individuals (US Census 2010). The region is a 1,074 square mile mix of urban centers and rural farm areas.

Each region has identified a Regional Emergency Planning Team (REPT) responsible for developing and implementing a Regional Emergency Support Plan (RESP). In CT Region 3, the Capitol Region Emergency Planning (CREPC) Committee, a sub-committee of the Capitol Region Council of Governments (CRCOG), acts as the Region 3 REPT. CREPC is organized by Regional Emergency Support Functions (RESF) in accordance with the National Incident Management System (NIMS). Each RESF has both planning and operational responsibilities as identified in the Region 3 RESP.

The operational purpose of RESF 8 (Public Health and Medical Services) is to facilitate communication, cooperation, and coordination among local municipalities and supporting agencies concerning regional health and medical services activities during a regional emergency. RESF 8 focuses on sharing information with its stakeholders regarding disruptions of health and medical services, and provides a mechanism for inter-municipal coordination of resource deployment to meet the needs of the emergency.

Purpose of this Report

CT Region 3 has adopted a policy of providing formal reviews of both its exercise program and its response to real-world incidents. These reviews provide insight into the decision making process occurring at the sub-state regional level, and allow stakeholders an opportunity to provide perspective and to voice concerns. The intended end result of this current report is an honest, fact-based analysis of the effectiveness of the actions of Region 3 RESF 8 in response to Storm Alfred, leading to recommendations for a regional program of directed improvement.

This report is intended to assist the stakeholders of the CT Region 3 RESF 8), including those local and state agencies who provide regulatory and support services, to learn from their reactions to the Storm Alfred event in order to facilitate excellence. This report will:

- Identify strengths of the response that can be sustained and enhanced
- Identify a variety of challenges and potential areas for improvement
- Aid in the development of a plan for corrective action

Executive Summary

Storm Alfred arrived in Connecticut on 29 October 2011, and left some residents without power for as long as 11 days. The storm brought up to 20 inches of heavy wet snow to Region 3 that clung to autumn leaves on tree limbs, a “perfect storm” that would damage hundreds of thousands of trees and down tens of thousands of power lines. The storm was unprecedented in the damage to utility infrastructure, virtually leaving the entire Region without commercial power for days.

At the peak of the power outage, 3 of the Region’s hospitals, and 55 of the 78 long-term care facilities that participate in the Region 3 Long-term Care Mutual Aid Plan (LTC-MAP), reported being on generator power. Most of these were located in the central part of Region 3 that sustained the greatest amount of damage to the power distribution system. Managing the consequences of such a widespread power outage became the central focus of Region 3 activities in the coming weeks.

The LTC-MAP was activated on 29 October to support the potential demands of its member facilities. The LTC-MAP Regional Coordination Center (LTC-RCC), located at Duncaster Retirement Community in Bloomfield, CT., was activated and staffed beginning on 30 October. It should be noted and appreciated that the volunteer LTC-MAP members who were staffing the LTC-RCC were administrators and facility personnel from regional LTC facilities that were facing problems of their own as a result of the storm.

Generally the LTC-MAP operated as intended, serving as the gathering hub and clearing house for information, and coordinating the actions of all LTC stakeholders and collaborating agencies. Some methods of communication were damaged or compromised, but the LTC community showed exceptional resiliency and creativity in meeting its mission to support not only their individual facilities but the LTC-MAP, as well as assisting the Acute Care Hospitals in managing the evolving hospital surge issues.

Similarly, the Region 3 Regional Coordination Center (RCC), located in Manchester, CT, was opened by 4:00 pm on 30 October. From this location, representatives from the various Regional Emergency Support Functions (RESF) that comprise the Capitol Region Emergency Planning Committee (CREPC), especially RESF 5 (Emergency Management) and RESF 8 (Public Health and Medical Services), gathered, verified and and shared information among the Region’s stakeholders and with state agencies, coordinated the deployment of personnel and equipment in response to local requests for assistance, and engaged in often hastily arranged conferences with a variety of policymakers statewide to facilitate the *ad hoc* response to the storm.

Key strengths identified during the RESF 8 After-Action Review conducted on 17 November 2011 included:

- Successful implementation of the LTC-MAP, and the extraordinary support from volunteer LTC facilities personnel in supporting the LTC-RCC

- Effective and timely communications between RESF 8 and the Region’s healthcare stakeholders
- Collaboration and Coordination with the CT DPH Facility License and Investigation Section (FLIS)

Key areas for RESF 8 improvement included:

- Clarification of the roles and responsibilities of ESF 6 Mass Care and the ESF 8 acute care hospitals regarding the management in shelters of functionally disabled or medically fragile people who do not require hospitalization but are unable to be at home
- Clarification of statutes and regulations that define or limit regional roles and responsibilities regarding the establishment of regional medical shelters
- Coordination between local shelters, hospitals and long-term care facilities to implement medical surge plans
- Improved coordination among local, regional and state agencies in processing local requests for assistance

Discussion of Region 3 RESF 8 Activities

Region 3 RESF 8 activities throughout the response were directed toward preserving the regional healthcare system, and mitigating those consequences of the storm that threatened the system. This mission was accomplished, with varying degrees of success, by timely and accurate information sharing, by developing a regional common operating picture focusing on the Region’s hospitals, long-term care facilities, community shelters and local health departments and districts, and by coordinating the deployment of healthcare equipment and personnel in response to local requests for assistance.

Immediately following Storm Alfred, the biggest challenge facing Region 3 from a public health/medical perspective was the appropriate management of so-called “boarders” at the 11 acute care hospitals (ACH) and at the 37 community shelters operating in Region 3. Generally these individuals were searching for a place to plug in their electronically dependent medical devices or to obtain medications, but had no presenting conditions requiring hospital admission. ACH emergency departments were inundated with boarders seeking shelter who had minimal medical needs and who normally were self-sufficient at home.

Similarly, after Storm Alfred, many of the community shelters received large numbers of these same types of medically dependent individuals who required varied levels of assistance from trained healthcare personnel, some of them arriving with caregivers who also had to be accommodated in the somewhat austere environments of community shelters. Shelter personnel in many communities were immediately overwhelmed by this development, and many lacked the trained staff and the administrative experience to manage the growing demand. One exception occurred in the Town of Manchester that proved to be a best practice. There the shelter operators from the local health department and the local hospital created an effective system for managing these vulnerable individuals.

Volunteer staffers at most community shelters were not prepared to assume the duties of providing medical care and were reluctant to accept that responsibility due to concerns about providing appropriate care and subsequent issues of liability. Early on in the incident, several communities refused to accept these medically needy individuals at their shelters and simply

sent them to their local hospital for care. At the same time, some of these individuals were sent to community shelters by the hospitals, only to have those shelters call 911 or other transportation services to take these same individuals back to a hospital.

The medical support at the shelters consisted largely of certified nursing assistant (CNA)-level care, including providing personal hygiene services, overseeing feeding, and monitoring of vital signs. Later, as it became clear that these individuals would be in for a prolonged stay in the shelters, larger shelters sought the assistance of RN's to oversee medical aspects of their operation. Throughout the incident, there were difficulties in locating and soliciting a sufficient number of shelter volunteers who could fill either of these roles. The lack of a comprehensive volunteer management system statewide proved to be a major cause of inefficiencies in the response to Storm Alfred.

Clearly there was an issue of appropriate and timely communications between the hospitals and the communities they served that was creating confusion and threatening to compromise the care of citizens. RESF 8 set about to improve the flow of information within the Region in the hope of minimizing the impact of failed communications systems among the healthcare stakeholders. This was accomplished by means of regularly scheduled stakeholder teleconferences and by the publication of timely situation status reports. RESF 8 also engaged local and state officials in fruitful discussions to identify and resolve some of the regulatory obstacles inhibiting creative approaches to response.

Late on 30 October, CT DPH advised Region 3 RESF 8 to consider establishing a "regional medical shelter", a location where equipment and healthcare personnel could be concentrated for maximum effectiveness, and to where both the hospitals and the community shelters could relocate their boarder populations to relieve the pressure on those facilities. CT DPH recommended that a hospital alternate care facility (ACF), as defined in hospital emergency operations plans, might be activated by a regional hospital and supported administratively by community and regional personnel. CT DPH indicated also that CT-1 DMAT would be available to assist at the ACF if needed to manage the medical issues there.

It should be noted that the concept of a regional medical shelter has been discussed at the state level on many occasions and, through the leadership of CT DPH, an inter-agency workgroup did develop guidance for "Supportive Care Shelters" (SCS). The SCS document was written specifically to address the sheltering of those individuals with medical needs but who presented with no illness or pre-existing conditions that would necessitate admittance to an Acute Care Hospital. The SCS guidance was submitted as a draft document in June of 2009. Neither CT DPH nor CT DEMHS have since done any work to adopt this useful guidance for action or implementation. As a result, providing shelter to medically needy people at community shelters following Storm Alfred was new territory for most local governments.

It should also be noted that sub-state regional entities like CREPC have never been given the authority to implement operations at regionally supported shelters, and no policies or protocols exist at the state agencies to support the concept. Nor does the draft SCS guidance document from CT DPH address the role of the sub-state regions in activating regionally supported shelters. In truth, under current state statutes, the operation of a regionally based medical shelter appears to be illegal. Following this event however, it seems clear that regional medical shelters fill a gap in the spectrum of the CT healthcare system, and would be best accomplished as part of a statewide plan that is supported locally and operated at the regional level, and is supported in state statute. Conversely, leaving the responsibility for developing a shelter management system to each local community is inefficient and wastes resources.

Over the next 24 hours, Region 3 RESF 8 personnel located at the Region 3 RCC in Manchester, CT conducted conversations with local and state agencies to determine how a community-based, regionally administered medical shelter could be implemented in Region 3. Questions of altered standards of care, liability, credentialing of volunteers, and waivers to normal policy (i.e., use of certified EMS for transport to an ACS, modifications to admission procedures, etc.) were discussed at length. Region 3 RESF 8 personnel were fully committed to opening a regional medical shelter that would accept medical boarders and thus relieve the pressure on the hospitals and the shelters.

It is noted that in CT Region 5, a regional medical shelter utilizing an alternate care facility opened by Danbury Hospital was successfully implemented, and somewhat reduced the boarders' burden on the Region 5 hospitals, though the more distant a Region 5 community was from Danbury, the heavier the boarder burden at the community shelters. Region 3 RESF 8 solicited support from the region's hospitals to implement a similar facility in Region 3, but the severity of the storm's impact on the hospitals (shortage of staff and full emergency departments) precluded that possibility.

Nevertheless, clearly there has been established a need for an entity such as a regional medical shelter, able to operate in a time of disaster, within the spectrum of the CT healthcare system. Citing the Region 5 success as a best practice then, there is a valuable opportunity to engage local, regional and state stakeholders in a process to implement a statewide plan and protocols for the operation of regional medical shelters. That process must include a discussion regarding ways to modify or waive those regulations and policies that inhibit local flexibility in meeting the exigencies of a disaster.

One Region 3 hospital approached the officials of the community in which it is located and asked for assistance in identifying a location to serve as an alternate care facility at which a regional shelter operation could be established. Due to perceived concerns about liability, the municipality refused to allow the establishment of a regionally operated shelter that included medical operations. Similarly, a Region 3 RESF 5 solicitation to several Region 3 communities asking any of them to open a regional medical shelter was met with considerable reluctance and concerns about local liability.

RESF 8 turned then to the CT Region 3 LTC-MAP for assistance in managing the regional influx of medically ambulatory but electronically dependent storm victims. On the morning of 1 November, RESF 8 presented a proposal to the participating members of the LTC-MAP, asking them to accept as many boarders as they could from the hospitals. The LTC facilities readily agreed to help. RESF 8 then held a series of teleconferences with the hospitals, with CT DPH and with several EMS agencies to present the Region's hospital decompression plan with a target activation time of noon that day. It should be noted that DPH personnel, especially those who represented the DPH Facility License and Investigation Section (FLIS), were extremely helpful in facilitating the procedures required to make this heretofore untried process work. Many of the region's LTC facilities, despite operating with reduced staff and on generator power, prepared for the influx of patients from the hospitals.

At noon, the transfers began as planned, but very soon a number of major obstacles appeared that threatened to cause the process to fail. These included issues of payment, insurance, transportation, and admission procedures. In a hastily arranged teleconference at 1:00 pm between Region 3 RESF 8, DPH and the CT Department of Social Services (DSS), the identified obstacles were presented one-by-one and discussed in detail to find ways to work

around the issues. While some problems were amenable to solution, others could not be altered or suspended, and these remained as obstacles for the remainder of the event.

The State Emergency Operations Center (SEOC) Sheltering and Functional Needs Task Force issued a memorandum to municipal Emergency Managers, Hospital CEOs, regional RESF 8 Chairs, and CT DEMHS stating that local shelters were to admit all residents, including those with functional needs, and only those residents with acute medical needs were to be sent directly to acute care hospitals. The DPH Facility License and Investigation Section (FLIS) was able to offer a waiver to the LTC facilities that allowed an accepting facility to increase its capacity to 110% of its licensed bed capacity, and 15 Region 3 LTC facilities applied for that waiver. DPH also released a guidance document that detailed the process and standards for accepting boarders at the LTC facilities, and described pre-admission screening and admission resident review (PASRR) procedures, regulatory exemptions, and admission requirements, including the CT W10 form requirement.

In the LTC-MAP after action review held on 10 November, the participating LTC facilities stated that the DPH guidance document was helpful and appreciated, but did not solve the need for waivers relating to the payment process, and payer uncertainty remained the primary source of confusion., LTC-MAP members stated that further discussion with DPH is necessary to clarify procedures for accepting medically dependent victims into a sheltering environment vs. having to admit them as patients.

Confusion about policies and regulations, and a perceived reluctance on the part of state authorities to find ways to circumvent certain regulations for the benefit of the region's residents, led to limited success in Region 3 in managing this group of at-risk and vulnerable citizens. Discussions with DPH regarding state and federal waiver processes, especially for Medicare and Medicaid (federal 1135 waivers), were especially informative and helpful, but DPH appeared hesitant to make any requests for relief. Once requested by the Governor, the Federal declaration of a "major disaster" under the Stafford Act proved to be time consuming, with the final declaration not coming until the week after Storm Alfred.

During the several after-action reviews conducted in Region 3, considerable discussion occurred regarding the decision by DPH not to declare a state public health emergency (PHE), as both hospitals and LTC facility operators believed that such a declaration may have facilitated relief from the burdens of regulation that inhibited an effective regional response. As noted later, under Section 319 of the federal Public Health Service Act, the US Health and Human Services (HHS) Secretary or a designee can waive or modify certain Medicare, Medicaid, and Health Insurance Portability and Accountability ACT (HIPAA) requirements by declaring a federal Public Health Emergency. The PHE declaration may be made whether or not a Presidential declaration of emergency under the terms of the Stafford Act has been made.

However the issue is complicated by the fact that, under the terms of the Social Security Act (SSA), 1135 waivers require both a Presidential Stafford Act declaration and a public health declaration by the Secretary of HHS to be invoked. At that point, HHS regional coordinators can assist local as well as state officials in obtaining 1135 waivers. Requesting a PHE under Section 319, as noted above, along with a state and local request for 1135 waivers, may have given the State the federal major disaster declaration sooner, resulting in an earlier acquisition of response and recovery resources.

At the time of this incident, none of this was clearly understood by or adequately explained to local and regional response agencies and institutions. The resulting confusion limited an

effective regional response to the medical boarders issue. In any case, CT received the Presidential declaration of emergency, but did not receive a declaration of Public Health Emergency from HHS as it was not requested. LTC facilities were willing to provide some relief to the hospitals by accepting boarders at their locations, but without the identification of a payer source, and with admission vs. sheltering concerns, the LTC-MAP was not able to achieve its full potential as an effective regional medical surge resource.

RESF 8, faced with increasing demands for both healthcare and non-medical personnel from the community shelters, initiated several actions designed to acquire the needed volunteer personnel, including:

- Activation of the Capitol Region Medical Reserve Corps and solicitation of volunteers from its membership
- Recommendation to local communities to activate their Community Emergency Response Teams (CERT), and to reach out to local VNA and school nurses
- Requested DPH to facilitate the activation of the ESAR-VHP system in support of shelter operations (denied by DPH)
- In conjunction with the United Way of Central and Northeastern Connecticut (UW), RESF 8 issued a blast email requesting shelter volunteers that was sent via UW and 211 Infoline to 400 non-profit agencies and dozens of companies statewide; that information was re-issued by several major corporations via blast fax to their employees
- RESF 8 activated a phone bank at the RCC to manage calls from potential volunteers; eventually approximately 120 volunteers were placed in shelters through this effort
- RESF 8 solicited healthcare and public health personnel from the other CT regions; Regions 1, 2 and 4 responded with nursing personnel and sanitarians

RESF 8 then facilitated the solicitation of healthcare personnel for hire to meet the continuing demands for medically trained personnel at the shelters. RESF 8 contacted several temporary personnel agencies and enlisted their help in locating additional healthcare workers who were available for hire. RESF 8 then facilitated the placement of healthcare personnel for hire in Region 3 from the other CT regions; Region 1 RESF 8 was particularly helpful in making this work.

Despite these efforts, the scope of the emergency eventually drained Region 3 of available healthcare workers for shelter operations. Finally, on 4 November RESF 8 issued an advisory to all stakeholders that all Region 3 personnel resources were tapped out, and that all requests for personnel to staff shelters would be referred directly to the state for fulfillment. The scope of the incident had finally exceeded the Region's ability to meet the demands for resources. This situation may have been minimized had the state requested the appropriate federal waivers earlier in the course of the response.

Region 3 RESF 8 After-Action Review 17 November 2011

On 17 November, approximately 35 Region 3 RESF 8 stakeholders and representatives from state agencies met to evaluate the effectiveness of the RESF 8 regional response to Storm Alfred. In a spirited discussion, there emerged a consensus that, while RESF 8 provided the Region's agencies and institutions with meaningful support following the storm, there remain issues of authority for sub-state regional operations that significantly impeded the regional response and its overall effectiveness. Also the group noted several deficiencies in planning and

preparedness by RESF 8 that require immediate attention. Here are some of the findings from the after-action review:

From the RESF 8 Hospitals Section:

Strengths –

- Successful application of individual hospitals' emergency operations plans
- Cooperation and flexibility of hospital staff in meeting unanticipated needs
- RESF 8 establishment of regularly scheduled briefings and situation status reports helped hospitals to understand the big picture
- RESF 8 - supported effort to provide staff and equipment was helpful but incomplete
- Support of RESF 8 at the state level was helpful in advocating for regulatory changes
- Cooperation of DPH in finding solutions to policy issues was appreciated

Areas for Improvement –

- Lack of clear policy and protocols for managing boarders that address questions of payment, liability, and credentialing; these policies must include hospitals, skilled nursing facilities and local shelter operations
- Failure of DPH to declare a public health emergency to alleviate concerns about payment, liability, etc.
- Lack of understanding of the role of Region vs. role of State in support of hospitals
- Failure of the state ESAR-VHP system to provide meaningful assistance to hospitals needing staff; the system needs to include a mechanism to assist those hospitals who request assistance in identifying likely volunteers and contacting those individuals on behalf of the hospitals
- Refusal of DPH to activate the ESAR-VHP system for shelter staffing support; the system needs to be much more flexible in its design, and should include all types of medical caregivers including CNA-level providers, the category of worker most in demand during the response
- Failure of WebEOC as a means to access up-to-date information and to transmit requests for assistance: "WebEOC was useless" was a phrase heard often during the Region 3 after-action reviews
- Hospitals would benefit from a mutual aid plan
- Regional exercises do not test the surge capacity of the hospitals effectively

Recommendations –

- Develop standards for regional operation of alternate care facilities/sites short of an 1135 waiver that can be implemented easily at the regional level
- Define and build the concept of operations of a regional medical shelter including protocols and activation triggers
- RESF 8 should advocate in conjunction with the CT Hospital Association to bring about needed changes in state regulations and policies
- Region 3 and hospital partners should engage DEMHS and DPH in discussion to clarify regional roles and authorities
- Build a Region 3 Hospital Mutual Aid Plan based on the LTC-MAP model
- Build regional exercises to strengthen regional surge capability
- Re-visit the state ESAR-VHP program to improve its functionality and its scope

From the RESF 8 Long-term Care Facilities Section:

Note: The RESF 8 LTC Facilities Section conducted its own after-action review on 3 November and has issued its own report that is available for review

Strengths –

- Willingness of LTC facilities to help the Region manage medical boarders and decompress the hospitals
- Flexibility of facilities staff in accommodating boarders: “we made things work”
- Successful volunteer operation of the LTC-RCC and implementation of the LTC-MAP
- Support of Russell Phillips Associates in managing the LTC-RCC
- Support of RESF 8 in advocating at the state level for the LTC’s to obtain regulatory permissions and waivers
- Willingness of DPH/FLIS to work with the Region 3 agencies to find solutions
- Partially successful regional collaboration with CT-DPH/FLIS and DSS in resolving payment issues inhibiting patient flow from the hospitals to the LTC facilities

Areas for Improvement –

- Confusion regarding pertinent regulations impeded the transfer of boarders to the LTC’s
- State and federal payment regulations effectively stopped the effort to accept boarders into the LTC’s
- Lack of priority of LTC facilities for power restoration created unnecessary problems including generator failure

Recommendations –

- Improve effective communications between hospitals and LTC facilities
- Amend LTC-MAP to include process for sharing resources among the LTC facilities
- Pre-event development of protocols and procedures for completing LTC admission waivers
- Clarification of emergency sheltering protocols for the LTC facilities
- Develop the process for implementing transfer of individuals among the facilities participating in the LTC-MAP
- Develop the concept of regional medical shelters
- Advocate for prioritization of power restoration at LTC facilities with power utilities and state regulators
- Train on inter-facility transfer process

From the RESF 8 Local Health Directors Section:

Strengths –

- High level of cooperation among individual health departments and districts in Region 3 developed before the event proved valuable
- Cooperation between health departments and community emergency management officials in operating shelters
- Adaptability of health department staffs and willingness to take on additional responsibilities
- LHD Section managed requests for resources from shelters and filtered them to RESF 8
- Effective communications from RESF 8 to locals; RESF 8 effectively used conference calls and email to gather information and provide status updates
- RESF 8 advocated with other regions for additional staff
- Willingness of other regions to provide staff support

Areas for Improvement –

- Many health department staffers could not get to work, resulting in departmental shortages when time came to re-open businesses
- DPH, the State EOC and RESF 8 were all fielding requests received sometimes from the same agencies, leading to redundant effort and confusion
- Behavioral health support at the shelters was a major issue but was not being addressed at the regional level

Recommendations –

- Examine promising practices such as those used in Danbury and Manchester in developing solutions to sheltering residents with medical needs
- Clarify role of RESF 8 vs. CT DPH in managing resource requests from local health departments
- Clarify procedures and policies for inter-regional sharing of resources, especially personnel
- Consider using GPS to monitor location of staff assigned to field work
- Train on policies for managing requests for assistance to eliminate duplicative work
- Establish regional policies for obtaining behavioral health support

From the RESF 8 EMS/CMED Section

CMED:

Strengths –

- North Central CT CMED Center staff reported for duty throughout the storm and were very creative in managing communications equipment breakdown and power loss.
- The redundancy (multiple positions) within the CMED Center, and the ability to communicate from multiple tower sites using a combination of microwave and telephone lines, allowed CMED to remain operational throughout the storm.
- As equipment failures progressed, the CMED Center made a decision to limit radio communications. We processed Priority One and Medical Control patches. Ambulance Priority 3 Notifications were suspended. We continued to monitor the disabled sites, assure adequate staffing and assess the call volume.
- We created an alternate email address for North Central CT CMED that was distributed to the RESF 8 sections.
- We maintained contact with the RESF8 Duty Officer by phone/email and with the LTCC throughout the power outage.

Areas for Improvement –

- CMED was not always kept in the loop regarding conference calls, directives issued by the Region or the state, or other important developments
- CMED policies for power outage events are not defined

Recommendations –

- Prepare a CMED Communications Plan for power outages
 - CMEDs throughout CT and Springfield, MA should conduct a pre-storm and post-storm roll call on MEDNET; the post-storm roll call will determine the extent of damage and operational capabilities of each CMED Center.

- Develop an internal CMED technical support checklist.
- During an event, CMED will contact DPH, LTC-RCC and RESF 8 to give primary and alternate telephone and email addresses so that the CMED Centers will receive email and blast faxes.
- RESF 8 and the LTC-RCC should alert CMED to regional and/or state conference calls and/or DPH directives that potentially involve facility evacuation and EMS transportation. (FMOP/MCI Level1)
- The RESF8 Duty Officer should notify all RESF8 section leaders when a conference call is being held with any of the RESF8 subgroups.
- Develop a concept of operations for regional medical shelters and define support roles of CMED/EMS.

EMS:

Strengths –

- EMS system expanded as needed to support increased volume, increased time on task
- EMS services managed to navigate difficult roadways without major issues
- EMS supported Acute Care Hospital discharge plan to LTC facilities when requested

Areas for Improvement –

- At least one major EMS provider relied solely on commercial fuel stations, resulting in prolonged delays in acquiring fuel for its vehicles
- Region 3 has no way to effectively communicate with all of the individual EMS services
- There are no regulations supporting mandatory sign-on to CMED by EMS services when a Forward Movement of Patients Plan activation has occurred

Recommendations –

- Providers who rely solely on commercial fuel stations need to identify a backup vendor and a plan to acquire fuel from alternate sources
- Region 3 should gather the necessary contact information from all regional EMS providers and place the information into the regional Everbridge notification system
- Everbridge alerts to EMS should be drilled frequently to assure familiarity with system
- RESF 8, DPH, CMED and EMS providers should develop mandatory sign-on procedures during a regional event to ensure successful coordination

From the RESF 8 Medical Reserve Corps Section

Strengths –

- The Capitol Region Medical Reserve Corps (CR-MRC) notification and recall system via Everbridge is well established
- The CR-MRC communications structure is well established and capable of notifying specific groups (e.g. nurses) with tasking
- The CR-MRC was able to gain some level of member support for local shelter operations in both medical and non-medical roles
- CR-MRC leader was well versed in the activation process and managed the process in support of MRC requests
- Networking with statewide MRC units yielded some support for additional personnel

Areas for Improvement –

- Communications systems were not functioning due to power outages and systemwide communications outages; some MRC members did not receive MRC notifications sent on Sunday until Thursday
- MRC recruiting process is insufficient to build adequate regional MRC capability
- The role of the MRC in supporting shelter operations is not clearly defined
- Mechanism for statewide collaboration and support among MRC's is not defined
- Local and regional requests for MRC support often did not reflect actual needs

Recommendations -

- Establish enhanced mechanisms for notification beyond systems that rely on power and other standard infrastructure; recall notifications that rely on direct contact and local TV/radio broadcast should be explored
- Expand current recruiting locally and statewide for both medical and non-medical members to the MRC
- Establish protocols for MRC shelter support missions: determine if sheltering is an MRC role and if so, define both the medical and non-medical responsibilities in a shelter environment
- Develop a regional support/coordination request process, and the accompanying forms that include specifics of requests/mission, supports tracking and filling of requests, and supports prioritization of requests
 - End goal would be the same process is used at all times for any regional requests (current regional messaging system could be adapted but it is not universally used)
- Build out the statewide process for MRC collaboration to overcome the barriers/lessons learned from this incident

Conclusions Based on Region 3 RESF 8 Activities

Overall, the mission of the Region 3 RESF 8, to manage the flow of information to and from regional healthcare stakeholders and to coordinate the deployment of regional healthcare resources, should be considered as partially successful after Storm Alfred, but there is considerable room for improvement before the next event occurs.

RESF 8 communications with its stakeholders was identified as a major strength of the regional response. Considerable creativity was shown in meeting the staffing demands emanating from the hospitals and the community shelters, and RESF 8 initiated fruitful discussions with its state partner agencies that improved the Region's response. Yet the effectiveness of RESF 8, and the Capitol Region Emergency Planning Committee as a whole, continues to be limited by longstanding issues of limited operational authority that have been identified in previous after-action reviews and debated with state agencies, but remain unresolved. There is also the perception of a mutual distrust between sub-state regional officials and state agents that, in the course of the response to this event, played out many times in many ways.

Fortunately, in the aftermath of Storm Alfred, we have a golden opportunity to work together to find a common ground. A "common ground" would include the following elements at minimum:

- Recognition that the authority and responsibility to protect citizens and preserve property rests at the local and the state levels, but that a sub-state regional entity such as the Regional Emergency Planning Team (CREPC in Region 3) is likely the most appropriate

mechanism to achieve effective preparedness in anticipation of incidents or events that surpass the response and recovery capacities of an individual community.

- Acknowledgment that the state role in response in the early hours and days of an incident is largely one of oversight and regulation, while the early boots-on-the-ground response relies on local leadership and assets supported by a mechanism to share resources among communities within a region, as promulgated through the five CT Regional Emergency Support Plans.
- Identification of clearly defined areas of responsibility is critical, and a willingness by local, regional and state agents to respect the boundaries is essential.
- Defined rules of engagement that allow all stakeholders the flexibility to do their jobs well under the most adverse circumstances are an absolute requisite for success.

As our stakeholders learned during the response to Storm Alfred, when some of these elements are at least partially in place, the resulting cooperation leads to better and more effective action. Despite the unprecedented impact of this early season snowstorm, the willingness of personnel at CT DPH to participate in efforts to find creative solutions to unanticipated obstacles was remarkably helpful.

There are a number of additional recommendations emanating from the various after-action reviews conducted in Region 3. There are several that, if accepted and steps are taken to implement them, can yield remarkable improvements in sub-state regional and state healthcare preparedness. They include:

- Build a more effective process to share critical information in a timely and accurate way, then train and exercise the process.
 - This process should include a critical assessment by the state, in collaboration with the regional REPT's, of the statewide WebEOC system. As currently employed by the state, WebEOC simply lacks any effective protocols for use in developing an accurate and timely common operating picture, a significant but thus far unrealized benefit to all municipalities and agencies involved in a response. As a result, only a fraction of response and support operations following Storm Alfred could be verified on WebEOC, leaving emergency managers and other response agents without a mechanism to see the big picture. Incident management software such as WebEOC is a powerful tool when optimized beyond its current utilization in Connecticut. Other states use this type of software as the principal method for collecting and disseminating information in a timely manner, but CT uses it as a "documentation" tool only. Unfortunately, even this minimally effective use falls short due to a lack of confidence in the system, and the lack of knowledge of the system's potential, at the local level.
- State agencies need to accept and support the concept of sub-state regionalization.
 - Storm Alfred immediately overwhelmed the Region 3 communities, to the point where normal mutual aid among municipalities was rendered ineffective. Yet the state agencies, having done very little planning in conjunction with the sub-state regions, were ill prepared to effectively utilize the plans and procedures in place at the regional level. The simple lack of understanding of and appreciation for the years of effort at regional preparedness led to unnecessary duplication and inefficiency when responses to requests for assistance were being received simultaneously at the regional and state levels.

- Following the storm, both Regions 3 and 5 received excellent support and cooperation from the remaining regions. Questions of inter-regional protocols for the transfer of assets were negotiated and resolved at the regional level, and new levels of coordination were achieved. State agencies would do well to encourage and support this type of planning within the regions.
- DEMHS, in close coordination with both CT DPH and the five REPT's, needs to implement an effective plan of training to increase the awareness and socialization of sub-state regional plans and protocols for municipal Chief Executive Officers and Emergency Management Directors, with special emphasis on the value of local participation in regional preparedness efforts. Such a training effort would only improve and enhance the collaboration between local, regional and state agencies when managing requests for assistance.
- Develop a workable, pragmatic statewide plan for the management of volunteers.
 - It was evident during the response to Storm Alfred that solicitation of volunteers to work at shelters was severely impaired by the lack of any useful pre-planned system for this purpose, resulting in unnecessarily complex, inefficient and time-consuming efforts at the local, regional and state levels. Promising practices being developed by Norwalk, CT and by the New York City Regional Catastrophic Planning Team warrant closer examination as possible models for a coordinated volunteer management system in Connecticut.
 - In Region 3, the “normal complement” of volunteers upon whom we call to assist in response were simply not available, as they themselves had become the victims. The value to Region 3 of inter-regional coordination to identify volunteers from other areas of the state cannot be overemphasized. Any statewide volunteer management system thus must include strong support for a process to share personnel among the five identified regions, and must address such issues as liability, compensation and credentialing.
 - From a healthcare workforce perspective, the state’s Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) proved to be of little use in meeting the staffing needs of Region 3 hospitals, and simply was not authorized for use in finding healthcare staff to shore up medical activities at our community shelters. ESAR-VHP needs to be thoroughly re-evaluated.
 - Given the number of federal dollars received by the state to support ESAR-VHP, our state healthcare system deserves a truly useful, workable ESAR-VHP program. When a hospital asks for assistance in locating supplemental staff, it is no help at all to simply provide that facility with a potentially outdated list of volunteers and then leave it up to the distressed hospital to make the telephone calls to individuals on the list. At its worst, this could mean that some individuals on the list would receive separate calls from numerous hospitals soliciting their services. The ESAR-VHP “system” should include a mechanism, staffed at the state level, to perform the solicitation on behalf of the struggling facility.
 - Similarly, the ESAR-VHP concept should be expanded to include its use in soliciting healthcare personnel to work at sites other than hospitals, specifically when staff are in critical demand to support healthcare services being provided at community shelters. If federal ESAR-VHP

rules currently preclude its use outside of the hospital environment, then those rules need to change, or another system needs to be developed.

- Through the reinstatement of a statewide sheltering workgroup, address the totality of the sheltering question.
 - Is there a role for the sub-state regions in providing shelter services? During the response to Storm Alfred, the activation of regionally supported medical shelters seemed like a good idea to the state, but there are no policies or protocols for this process, and there are no authorities in local or state statutes to allow a sub-state region to perform this function. Local, regional and state agents need clarity regarding their specific responsibilities, and a thorough understanding of when and why a regionally supported medical shelter may be a better choice than a general population shelter that happens to provide medical services.
 - What is the potential role of long-term care facilities (LTC) in community sheltering and hospital decompression? What policies and protocols need to be developed before we go down this road again? Can we reasonably expect private entities such as the majority of long-term care organizations to support these community and institutional efforts at decompression, if state agencies are hesitant to pursue all avenues to ease the burdens of regulation and compensation (i.e., a declaration of a state public health emergency)?
 - A newly reconstituted statewide sheltering workgroup needs to find solutions to these questions. The workgroup should review the CT DPH-developed “Regional Emergency Supportive Care Shelter Operations and Planning Guidance” document and use it as a basis for discussion. As part of their work, there needs to be an honest discussion of the merits of declaring a state public health emergency, especially as a declaration might provide relief from burdens imposed by those statutes that may inhibit an effective *ad hoc* response to the exigencies of the moment.

There are additional recommendations that apply specifically to Region 3 and, if followed, can significantly strengthen the Region’s response capabilities. These include:

- As the Region 3 Long-term Care- Mutual Aid Plan is considered a best practice, expand the LTC-MAP to include the 11 acute care hospitals located in Region 3.
 - Much of the confusion and uncertainty among the hospitals while attempting to manage the influx of “medical boarders” likely would have been lessened had a fully supported hospital mutual aid plan (HMAP) existed at the time of Storm Alfred. A functioning HMAP also would have helped RESF 8 greatly in managing the transfer of boarders. Region 3 should proceed at all due speed to implement the HMAP.
 - As the combined LTC-MAP and the HMAP evolve, the Region should consider a joint medical operations and coordination center that maximizes the sharing of information and coordination of resources among the hospitals, the LTC’s and RESF 8. The Boston Medical Intelligence Center (MIC), operated by the Boston EMS, is a best practice that might be emulated in Region 3.
 - It is noted that the excellent support provided by Russell Phillips Associates in the operation of the LTC Coordination Center, though much appreciated and very effective, may be a crutch upon which the Region has come to rely. The Region 3 LTC-MAP needs to stand on its own and be prepared to manage any emergent situation without professional assistance.

- Engage the CT Hospital Association and other state healthcare advocacy organizations to maximize support for sub-state regional planning that effectively improves statewide healthcare preparedness.
- Improve information sharing among RESF 8 and Region 3 stakeholders.
 - During the various Region 3 after-action reviews, the sharing of information between RESF 8 and the Region 3 healthcare stakeholders was considered very helpful and effective. Yet attempts to communicate using the day-to-day methods with which we are familiar (phone, email, Everbridge, etc.) often were ineffective during the response to Storm Alfred due to systems failures. Region 3 needs to explore the use of alternate communications systems (TV, radio, conference calls, etc.) that will serve our needs when traditional systems fail.
 - Region 3 needs to invest in some type of conference call capability. Currently the Region relies on others to provide this capability and access to this means of communication thus is unreliable. The capacity of Region 3 to host teleconferences and conduct web-based information sharing must be a top priority moving forward.
 - During the Storm Alfred response, Region 3 experienced a high failure rate in communicating to regional stakeholders who use proprietary email systems. Some of our volunteer groups did not receive any messages from the Region until power was restored. It is recommended that Region 3 RESF 8 acquire a single email account through which all RESF 8 email communications would be conducted, and which can be accessed by all RESF 8 stakeholders wherever they may be located. The RESF 8 email account also would provide continuity of communications among RESF 8 Duty Officers who likely will not be co-located during a disaster response.
- CREPC needs to build out its RESF structure so that the Region can fulfill its responsibilities regarding resource management.
 - RESF 7 (Logistics Management and Resource Support) is an essential asset to a complicated response, yet during the response to Storm Alfred the responsibilities of resource management fell principally to RESF 5 and RESF 8 in a relatively haphazard approach. Establishing a strong RESF 7 workforce should be a Region 3 priority.
 - RESF 16 (Volunteer Management) must be expanded to include the management of spontaneous volunteers, not just pre-identified CERT teams. Both RESF 15 (External Affairs) and RESF 16 also need to identify additional personnel to ensure their representation when called upon to report to the RCC; this was not the case during the storm response.
 - RESF 5 (Emergency Management) should find a way to document the historical response to an event. Currently this responsibility is left to the individuals at the RCC, a spotty process at best, but this essential procedure can be managed much more efficiently by assigning scribes and other recorders.

As the statewide response to Storm Alfred developed, many of the obstacles encountered when local, regional and state agencies interacted had been encountered before, and had been identified as problems to be solved in prior local and regional after-action reviews. As we have learned the hard way, a sluggish response to problem solving by state agencies has left the sub-state regions with many good plans but with little authority to make those plans work for the benefit of our citizens.

As of the initial drafting of this AAR CREPC was unaware of any after-action reports or reviews conducted by DEMHS, with the exception of the independent investigations of the Kleen Energy explosion in Middletown, CT and the current investigation being conducted by the Governor's Two Storm Review Panel. For investigations such as these to be truly effective, efforts must be made to closely examine state and local response as well as the root cause(s) of the event itself. Of paramount importance is what happens next: what corrective actions have been identified leading to an improvement plan whereby specific corrective actions are assigned to the proper authorities and personnel responsible for those actions. If in fact the State has "published" After Action Reports it would be extremely valuable to all regional stakeholders and to the state agencies to be 1.) made aware of such reports and 2.) included in corrective action planning as appropriate.

Ultimately, it now appears that any enhancement of coordinated local-regional-state response requires a full-bore effort, led perhaps by the Office of the Governor, to address issues of governance and responsibility that once and for all are resolved so that municipalities, sub-state regional entities like Region 3's CREPC, and state agencies may function to the best of their abilities through planned coordination and cooperation. Efforts to resolve these longstanding issues should result in mutual trust that leads to improved care for our citizens, marked by timely and effective support when they most need it. This is an opportunity we cannot afford to miss.

ATTACHMENT A: RESF 8 Response Timeline 28 October – 7 November 2011

Friday 28 October

RESF 8 Duty Officer J. Shaw

1530:

- 1st RESF 8 Duty Officer notification via email to RESF 8 Section Leads: advised we are monitoring storm and to report any alterations in contact information to Duty Officer

Saturday 29 October

RESF 8 Duty Officer J. Shaw

1900 Hours –

- Call received from RESF 5 Duty Officer (D. Janell) advising that Hartford Health Department (HHD) was asking for nurses for their shelters. RESF 8 advised that since this was the height of the storm we would not be able to deploy regional assets anywhere until the storm ended; call to Tung Nguyen at HHD to clarify request: how many nurses and where? HHD was only advising the Region they were opening shelters in Hartford and may need personnel at some point, so request cancelled.
- Spoke with Capitol Region Medical Reserve Corps (CRMRC) Commander (K. McCormack) to alert that MRC personnel would be needed when storm ended.

2000 Hours –

- Call received from Scott Aronson. The Region 3 Long-term Care Facilities Mutual Aid Plan (LTC-MAP) had been activated and was monitoring LTC's, thus far no issues. Discussion about using LTC assets such as using LTC 4-wheel drive vehicles to support potential hospital requests for staff movement into the hospitals, and we agreed that was not part of the LTC mission.

2145 Hours –

- Email from K. McCormack stating she had received an Everbridge message that Johnson Memorial Hospital (JMH) had lost power and its generator had failed.

Sunday 30 October

RESF 8 Duty Officer J. Shaw

0315 Hours –

- Based on McCormack email, RESF 8 spoke with CMED (Mark) who was unaware of any issues at JMH or any other hospital, except that JMH was on diversion. Mark then called JMH, discovered that JMH had generator power and was not contemplating any patient issues at that time.

1130 Hours –

- Received status update from RESF 8 Hospitals Section/Falaguerra: Region 3 hospitals are updating their WebEoc bed counts; most hospitals receiving medically dependent but otherwise healthy patients and expressing concerns about what to do with them
- RESF 8 advises by email, cc J. Best at DPH, that shelters also were accepting same type of patients, and may be time to consider a regional medical shelter.

1600 Hours –

- RESF 8 established at Manchester Regional Coordination Center (RCC), J. Shaw and D. Kosciuk for RESF 8

1700 Hours –

- RESF 8 participates in DPH-Hospitals telecall and responds to DPH request for shelter information re: medical patients; LTC-MAP activated and deployed at Duncaster; Region 3 Forward Movement of Patients Plan (FMOP) at Level 1 activation status
- EMS Section/A. Groux reports that EMS units throughout region are struggling with blocked roads and downed power lines, and call times are escalating

1800 Hours –

- RESF 8 consult with DPH (L.Guercia private call): DPH recommends that Region 3 consider setting up a regional medical shelter using a hospital alternate care site; staff support could be provided by CT-1 DMAT

2030 Hours –

- CRMRC activated; request faxed to DPH/Duley per K. McCormack

2050 Hours –

- RESF 8 email sent to Hospital Section and RESF 8 Leads requesting help in selecting a location for a regional medical shelter

2220 Hours –

- LTC-MAP reports 75/78 LTC's have reported their bed status, prepared to assist as directed
- 55 of 79 LTC's on generator power

Monday 31 October

RESF 8 Duty Officer J. Shaw; J. Shaw and D. Kosciuk for RESF 8 at RCC

0615 Hours:

- Email to RESF 8 Leads: still searching for a medical shelter location; RESF 5/8 in contact with RESF 20 to determine availability of a faith-based location

0830 Hours –

- RESF 8 conducts 1st Region 3 (R3) telecall with Hospitals; hospitals expressed concerns about power outages (three R3 hospitals currently on generator power), staffing shortages, and increasing numbers of medical "boarders"

0900 Hours –

- CRMRC (Scace) sends Everbridge request to CRMRC for volunteers to work at shelters

1250 Hours –

- CRMRC (Scace) reports on available MRC volunteers; very few available due to impact of storm

1300 Hours –

- RESF 8 conducts teleconference with Local Health Directors (LHD) Section; review status of departments and develop protocol for requests for additional staff ; M. Lexius (Manchester HD) is designated LDH Section Lead for duration

1320 Hours –

- DPH distributes via email Guidelines to Hospitals and Shelter Operators for accommodation of medical boarders

- R3 hospitals and shelter managers begin to call RCC for assistance in acquiring personnel to manage boarders

1410 Hours –

- RESF 8 emails Duty Officer schedule for Strom Alfred response to all stakeholders

1430 Hours –

- RESF 8 distributes via email Guidelines to Hospitals and Shelter Operators for accommodation of medical boarders to all Region 3 stakeholders
- RESF 8 LHD Section (Lexius) assumes coordination of regional requests for healthcare staff at regional shelters as submitted by local health directors
- RESF 8 issues advisory on management of requests to be directed through LHD Section and forwarded to RCC for completion

1730 Hours –

- RESF 8 issues email request to regional RESF 8 chiefs for telecall 1 November at 1100 Hours

1800 Hours –

- RCC closes for day; RESF 8 Duty Officer J. Shaw

Tuesday 1 November

0700 Hours –

RCC re-opens, J. Shaw and D. Kosciuk for RESF 8

0820 Hours –

- RESF 8 emails community shelter status to RESF 8 stakeholders

0830 Hours –

- RESF 8 conducts 2nd R3 Hospitals telecall; increasing concerns about number of boarders at hospitals and a request to RESF 8 to find a solution; advised hospitals same requests coming from shelters; some hospitals planning to cancel surgical schedules for next day
- RESF 8 unable to determine an accurate count of medical boarders seeking assistance in the Region, but numbers are climbing
- RESF 8 contacts four large hospitals to determine if any was willing/able to open an alternate care site (ACS); none could comply due to staff shortages and patient overload

0900 Hours-

- Teleconference with LTC-MAP and RESF 5 to consider medical shelter options; LTC's step up and offer to accept medical boarders to help hospitals decompress

0915 Hours –

- RESF 8 and RESF 5 conference with DPH to develop plan and protocols for patient transfer from hospitals to LTC's

1015 Hours –

- 2nd conference call with hospitals and DPH advising of R3 plan to decompress hospitals using LTC's as accepting facilities; plan to kick off at 1200 Hours

1020 Hours –

- RESF 8 emails contact information and guidance to hospitals and LTC's for coordinating boarder transfers
- Area EMS agencies and CMED advised of potential surge at 1200 Hours

1130 Hours –

- RESF 8 conducts telecall with regional RESF 8 chiefs, advised we may be seeking resources from other regions; concerns expressed about protocols and need for MOU's

- RESF 8 offers J-I-T training via webinar to hospitals on regional electronic patient tracking system to track boarders
- Region 4 RESF 8 (S. Mansfield) sends preliminary inventory of public health assets available for deployment to R3, and a template for other regions to use in determining asset availability

1200 Hours –

- Hospital-LTC transfer plan activated; FMOP remains at Level 1; hospitals advised to use normal day-to-day transfer protocols

1300 Hours –

- RESF 5/8 issue Sitstat to all stakeholders; 1st mention of chokepoints in hospital-LTC transfers, some LTC's balking at accepting transfers without further clarification of procedure from DPH
- CADH issues draft protocol for inter-regional deployment of public health assets, distributed by RESF 8 via email to all R3 stakeholders and regional RESF 8 chiefs
- RESF 8 conference call with DPH/FLIS and LTC-MAP to iron out transfer issues; 1st issue is payment, some LTC's refusing to accept hospital transfers w/o clarification; secondary issues are W10, PASSR requirements prior to transfer

1400 Hours –

- 3rd RESF 8/Hospitals telecall of the day; hospitals and LTC's are working through issues but payment is still the main issue; some hospitals considering cancellation of OR schedules; 120-150 patients eventually transferred to LTC-MAP facilities, enabling hospitals to maintain their OR schedules
- RESF 8 Sitstat emailed to all stakeholders

1800 Hours –

- RCC closes for the day; J. Shaw RESF 8 Duty Officer

Wednesday 2 November

0700 Hours –

RCC re-opens; J. Shaw and D. Kosciuk for RESF 8

0830 Hours –

- LTC-MAP sends advisory to LTC's for status update by 1000 Hours
- RESF 8 conducts daily R3 Hospitals teleconference; hospitals still receiving boarders but numbers down due to transfers – estimated total transfers now @ 120-150
- RCC receiving multiple requests for healthcare and non-medical personnel at shelters

1000 Hours –

- R4 RESF 8 (Mansfield) issues draft protocol for deploying R4 resources into R3
- DPH conducts 1st telecall with hospitals and RESF 8 Leads;
 - RESF 8 requests use of ESAR-VHP to support shelter operations – denied (M. Duley)
 - DPH/M. Duley states all requests for shelter aid should come through DPH for forwarding to DEMHS; RESF 8 clarifies that in R3 all requests to go through RESF 8, those that cannot be filled will be forwarded to DEMHS as per the R3 RESP

1100 Hours –

- RESF 8 issues guidance to LDH on payment to hired healthcare staff coming into R3 from other regions (agreements to be individually negotiated between the provider and the health departments)
- RESF 8 determines all R3 dialysis centers are up and running; notice sent to all stakeholders

- RESF 8 (Koscuk) identifies 3 temporary personnel agencies willing to work with shelters for healthcare personnel needs; information emailed to LHD's
 - RESF 8 continues to field many requests from community shelters for assistance in acquiring medical staff needed to manage medical device-dependent citizens
- 1130 Hours –
- CADH issues clarification from DPH on use of retired healthcare personnel at shelters and protocol for R3 requests for LDH personnel through RESF 8; information forwarded to all stakeholders
 - LTC-MAP issues Sitstat: 39 LTC's currently on generator
- 1200 Hours –
- On noon teleconference, RESF 5 (Perkins) requests Governor to intervene in restoring power to Hospital for Special Care in New Britain
- 1215 Hours –
- Phone call from DEMHS/T. Gavaghan that Hospital for Special Care fixup has been given a high priority
- 1350 Hours –
- DPH/Duley calls RESF 8 to advise that Middletown/J. Leonardi is asking for healthcare resources through DPH; Duley requests we coordinate requests from Middletown and report back to DPH
- 1400 Hours –
- DPH/LHD/RESF 8 Chiefs teleconference; LHD's express concerns about shelter ops and about anticipated need for additional inspectors
- 1450 Hours –
- DPH issues updated shelter guidance to EMD's; forwarded by RESF 8 to all RESF 8 stakeholders
- 1500 Hours –
- RESF 8 asks United Way of Central CT (P. Gilberto) for assistance in advertising for shelter volunteers to Region 3; RESF 8 drafts message that was sent in an email newsletter by UW to 400 NPO's and corporations statewide and to 211 Infoline
 - RESF 8 conducts telecall with R3 LDH's to review status and to clarify policies for requesting resources
- 1600 Hours –
- RESF 8 asks LTC-MAP for additional staffing for 3 November to man a phone bank
 - M. Lexius advises West Haven MRC may have staff to assist R3; assigned to CRMRC/D. Scace for followup
 - Shelter staffing requests coming into the RCC are now referred to CRMRC/D. Scace for fulfillment/referral
- 1700 Hours –
- RESF 8 Sitstat to regional RESF 8 chiefs requesting updates on available public health and nursing personnel for 3 November
 - Hospital for Special Care reports power restored
 - RESF 8 Sitstat to all R3 stakeholders
- 1725 Hours –
- RESF 8 notification to R3 RESF chiefs of potential closure of Middlewoods assisted living facility in Newington due to generator failure
 - MRC/Scace reports on acquisition of West Haven MRC RN's for deployment in R3
- 1800 Hours –
RCC closes for the day; RESF 8 Duty Officer J.Shaw

Thursday 3 November

RCC re-opens at 0730; J. Shaw for RESF 8

0815 Hours –

- DPH/Duley issues request for MRC Sitstat and RESF 8 replies with approximate status of CRMRC

0830 Hours –

- RESF 8 conducts Hospitals Section telecall – hospitals stabilizing though still boarding large numbers; transfers to LTC's has all but ended due to obstacles of policy

0900 Hours –

- RESF 8 at RCC reorganized to provide maximum support for shelter personnel requests
 - 2 volunteers from LTC-MAP report to RCC to manage phone requests and volunteer staff calls
 - phone bank established by RCC manager with rollover phone lines
- CRMRC/D. Scace managing volunteer personnel requests for RESF 8

0930 Hours –

- LTC-MAP issues Sitstat: 28 LTC's still on generator power, all hospitals currently on full power

1000 Hours –

- DPH/Hospitals/RESF 8 chiefs telecall

1055 Hours –

- RESF 8 issues advisory to all stakeholders that Middlewoods/ Newington issue has been resolved

1400 Hours –

- DPH/LHD/RESF 8 Chiefs teleconference
- RESF 8 (Koscuk) notified by DPH (Fillipone) that Johnson and Bristol Hospitals' request for staffing have been referred to Yale to fill through ESAR-VHP
- RESF 8 negotiates with DPH for expanded usage protocols for paramedics working at shelters and hospital EDs
- RESF 8 (Scace) sends healthcare staffing update via email to state agencies (Gavaghan, Duley, SEOC) on inability to fulfill requests for medical staffing at 4 locations

1435 Hours –

- Reply to Scace message from DPH/Duley with recommendation to keep working on the problem
- ESAR-VHP blast email from DPH sent statewide requesting medical staff for Johnson Memorial and Bristol Hospitals

1440 Hours –

- Mass Mutual notifies RESF 8 (Koscuk) that the company is blast faxing their employees the UW blurb to encourage volunteering at shelters

1630 Hours –

- Hospital for Special Care notifies RESF 8 that power has been restored

1730 Hours –

- RESF 8 Sitstat emailed to all stakeholders

1830 Hours –

RCC closes for the day, RESF 8 Duty Officer J. Shaw

Friday 4 November

0730 Hours –

RCC re-opens; J. Shaw, C. Centrella for RESF 8

0830 Hours –

- RESF 8 conducts Hospitals Section telecall; staffing issues continue at JMH and Bristol, ESAR-VHP notification re-sent statewide by DPH this morning at 0815 Hours
- 0900 Hours –
- RESF 8 continues to coordinate R1 and R4 healthcare personnel coming into R3
 - D. Scace notifies Bloomfield of nurses from R2 and R4 available to staff its shelter
- 0915 Hours –
- RESF 8 issues email advisory to all stakeholders on use of paramedics to staff shelters and hospitals as relayed from phone conversation with DPH/Guercia
- 1000 Hours –
- DPH/Hospitals/RESF 8 chiefs teleconference
- 1020 Hours –
- SEOC forwards request to assist a Simsbury couple; D. Scace contacts Simsbury Chief Kowalski who agrees to assist the couple;
 - SEOC (Lillipop) informed of resolution at 1132 Hours, acknowledged by email at 1134 Hours
- 1130 Hours –
- RESF 8 (Centrella) sets up an RCC account on Gmail for information exchange
 - LTC-MAP issues Sitstat: 17 LTC's still on generator
- 1140 Hours –
- DPH/Duley issues request for update on R3 shelters and staffing; reply sent 1315
 - Duley reply at 1317 that report was lacking detail
 - RESF 8 sends 2nd email notification to SEOC and DPH that R3 has no more healthcare personnel resources to staff shelters and will refer all future inquiries to DPH
- 1220 Hours –
- RESF 8 sends advisory to R3 EMD's requesting status update at shelters and asking whether towns are willing to pay for healthcare personnel at their shelters (no replies were ever received)
- 1400 Hours –
- RESF 8 participates in DPH-LHD-RESF 8 Chiefs telecall
- 1500 Hours –
- Multiple requests continue to be received from shelters and DPH for healthcare staff; Johnson Memorial and Bristol Hospitals still looking for staff
 - Phone consult T. Gavaghan/K. Flaherty on shelter needs in Farmington Valley; advised that FVHD has to consider hiring RN's as no more volunteers are available in the region; email sent to DPH/M. Duley advising of conversation and advising that K. Flaherty may be calling her directly
- 1525 Hours –
- DPH/Duley emails written guidance on use of paramedics at shelters; forwarded via email to all RESF 8 stakeholders
- 1725 Hours –
- Middletown (Leonardi) announces shelter has closed
- 1800 Hours –
- RESF 8 Sitstat sent to all stakeholders
 - RCC closes; RESF 8 Duty Officer J. Shaw
- 1925 Hours –
- RESF 8 sends email advisory to state and regional stakeholders that R3 no longer has any personnel assets for shelters, and all future requests will be directed to SEOC and DPH for fulfillment

- 2nd RN for Bloomfield acquired through R1 RESF 8 (Cleary); SEOC notified
- LHD Section issues updated sitstat on requests for resources from R3 LHD's

Saturday 5 November

RCC opens at 0730; J. Shaw for RESF 8

- RESF 8 requests for personnel essentially at zero; RCC staff focuses on options for consolidating shelters and how to manage residual medical boarders when shelters close
- RESF 8 notifies United Way to discontinue requests for shelter volunteers

0930 Hours –

- RESF 8 telecall with HHS Boston (Pettis) asking for sitstat on regional shelters and hospitals

1400 Hours –

- RESF 8 Sitstat emailed to all stakeholders

1800 Hours –

- RCC closes; RESF 8 Duty Officer J. Shaw

Sunday 6 November

RCC remains closed; RESF 8 Duty Officer J. Shaw

0900 –

- LTC-MAP issues Sitstat; 7 LTC's and 2 AL's still on generator power

0945 Hours –

- RESF 8 sitstat to stakeholders

1700-1845 Hours –

- RESF 8 in conference with LTC-MAP, Hebrew Home, West Hartford EMD (G. Allyn) and SEOC (J. Gustafson) on power status at Hebrew Home and generator failure at Summerwood; RESF 8 issues 3 email alerts to RESF 8 stakeholders

2110 Hours –

- SEOC emails resolution to the Hebrew Home-Summerwood power issues
- SEOC (Gustafson) calls to advise that further requests for assistance from R3 must be directed to the SEOC ESF 8 Desk and not to DPH due to delays in conveying messages and inaccurate assessments

Monday 7 November

0730 Hours –

RCC re-opens at 0730 Hours; J. Shaw and C. Centrella for RESF 8

0830 Hours –

- RESF 8 conducts Hospitals Section telecall; RESF 8 asks hospitals to gather data for individual AAR's and to prepare for an RESF 8 AAR in a week or so
- RESF 8 emails R3 Hospitals sitstat to all stakeholders

900 Hours –

- RESF 8 (Scace) emails AAR template to Hospitals Section

1000 Hours –

- DPH/Hospitals/RESF 8 Chiefs teleconference
- LDH Section Lead transfers from M. Lexius to S. Huleatt

1400 Hours –

- DPH/LHD/RESF 8 Chiefs teleconference
- RESF 8 requests AAR from RESF 5 (Austin) following stand-down of RCC and RESF 8

1545 Hours –

- Updated LDH staff inventory received from Region 2

1800 Hours –

- RESF 8 emails Sitstat to all stakeholders
- RCC closes for duration; RESF 8 Duty Officer J. Shaw
- RESF 5 Duty Officer to monitor further events and open RCC as indicated

ATTACHMENT B: UNITED WAY APPEAL

URGENT NEED FOR VOLUNTEERS TO ASSIST IN HARTFORD AREA SHELTERS

An Urgent Message from the Capitol Region Regional Coordination Center

Thousands of Hartford area residents have filled 30+ community shelters to overflowing. Restoration of power is progressing, but many citizens face several more days in cold homes. Volunteer shelter workers are nearing exhaustion. We need your help in locating additional volunteers willing to work shifts in the shelters.

Volunteers are needed for all shifts, especially for the evening and overnight hours (6:00 pm-6:00 am) when demand is greatest. Typical work includes assisting in food distribution, assisting frail and elderly people to move about the shelter, to assist people in taking showers, and just to listen to people's problems. We have a specific need for people with medical training or certification (CNA, LPN, RN, EMT). These unfortunate people need your help now.

We ask you to give us a call if you can help us staff the shelters this weekend. No special skills are needed, but if you can tell stories, sing or tap dance, we promise you will become an instant hero! We are especially in need of folks to help evenings and on the coming weekend.

Volunteers will be screened, so bring your personal identification with you.

To volunteer, call us at the RCC right now at 860-645-5500 Extension 71006

RCC will operate from 8:00 am-5:00 pm today and tomorrow

Our coordinators are waiting to hear from you

We thank you from the bottom of our hearts for your help!

ATTACHMENT C:

DRAFT STANDARD OPERATIONS GUIDE FOR INTER-REGIONAL COLLABORATION Developed by Region 4 RESF 8 1 November 2011

Mutual Aid for Local Public Health Departments

A Standard Operations Guide for Sharing Resources in the Aftermath Of a Widespread Incident

In the aftermath of a series of storms with widespread impacts on local public health infrastructure, the need has arisen for the use of more structured guidelines on resource sharing and recovery operations. When local resources are stressed or expected to be stressed, the use of regional resources is indicated and a review of requesting procedures follows.

Resource Sharing

Internal: Resource requests inside a region will utilize current procedures within the established regional ESF 8 plans. Coordination and sharing of information about resource requests with Emergency Management will be clear to ensure that duplication of requests is not being made through multiple channels.

External: If an internal request for resources can't be supplied within the region, the regional lead in coordination with the RESF-8 Chair for that region may contact the regional leads from the other 4 region to fill the request. Documentation of this request needs to be in writing and identify the specific resources needed, the duration of need, and the operational jurisdiction in which the resources will ultimately be deployed.

State Support request: If a resource request cannot be filled by any of the other regions in the state, that request should be forwarded to the State EOC via the DPH ECC. Resource requests will then follow established protocol for state or federal level resources to be applied to the incident.

Coordination of Inter-Regional Resources

Regional public health and medical resources will be coordinated through the Regional ESF 8 lead based upon the determination by the requesting region of the need for inter-regional support of a local incident.

- o Individual Resource Inventory: Each discipline (Public Health, Hospital, and EMS) within RESF-8 will determine what resources are immediately available to provide as regional support.
- o Regional Reporting of Resources to Regional Coordination Center: Each responding agency will share a summary report on the resources available to assist in a regional response.
- o Compilation of Data and Report of Available Resources: The ESF8 RCC Chair/Regional Coordination Center personnel will compile the data received from all of the public health and medical agencies in the DEMHS Region and prepare it in a format to share with other regions.
- o Deployment of Regional Resources:
 - In the event that inter-regional resources will be required at the local incident site, the local EOC's Liaison Officer or local Emergency Management Director will notify the RESF-8 Chair or Regional Coordination Center in their region which of the available regional resources will be needed for the next operational period*. The ESF8 RCC Chair will work with the regional public health advisor to determine the best use of inter-regional resources to support local incidents in the region.
 - In smaller scale incidents when the local EOC has not been activated, local health departments/districts can contact the regional public health lead agency to determine what resources are available to support them in the absence of establishing the emergency management structure.
 - In the event that deployed resources, human or material, need to be recalled from an incident site by the responding agency to support local needs, the Regional Coordination Center will serve as the conduit of the recall request. This will allow the Regional Coordination Center to arrange for other resources to be sent to the incident site to assure that continuous support is provided where it is needed. In the event the RCC has not been activated, this role will be assumed by the ESF8 RCC Chair.

*Operational period – A twelve hour operational period (generally 7am to 7pm) will be established. Always working to fill requests one operational period at a time, the RCC will keep all agencies apprised of the status of a request.

- On-going communication from the regional lead agency or RCC will be sent to inter-regional partners in one of the following formats:
 - Regional Public Health Stand-by Notice- This notice requires action on the part of Inter-regional partners, in that they need to increase awareness in the operational posture of their organization to be prepared to supply resources to support an inter-regional response to an incident. Upon receipt of this notice, LHDs should perform an inventory of their available resources, both material and human, using the Individual LHD Inventory Form, and submit it to their Regional Coordination Center.
 - Regional Public Health Preparation Notice- This notice requires action on the part of regional partners, in that they need to prepare specific resources, designated by the regional coordination center, for deployment to the incident site. If the RCC determines an LHD needs to be notified to prepare their resources for support of the incident, this notification will be accomplished using the Regional Public Health Preparation Notice.
 - If Human Resources are being requested, the RCC should request contact information as part of the Action Required section of the message from the LHD supplying the resources. This contact information will include:
 - o Full Name
 - o Drivers License Number
 - o LHD they work for

- o Office Phone #
 - o E-mail Address
 - o Cell-phone #
- Regional Public Health Activation Notice- This notice requires action on the part of regional partners, in that they will send the designated resources to the incident site for the period agreed to by sending agency. The RCC will notify the LHDs supplying resources two hours prior to the projected operational period to deploy the specific resources. This will be accomplished using the Regional Public Health Activation Notice. This notice will include:
 - o Verification of contact information for deploying personnel (if applicable)
 - o Point of Contact at Incident Site
 - o Incident Site Location (with directions)

Requesting that regional partners prepare resources to provide support to the requesting agency.

Once the inventory of available resources have been compiled and sent to the requesting agency, the RCC and requesting agency can begin to make decisions as how best to support the response to the request for resources. The requesting agency should review the available resources and identify which resources they need for the next operational period to assist in the local response. Once they have been identified, the RCC must determine which of the agencies would be best to task with preparing and providing support. This is a decision that can be based upon several factors, such as:

- Geographical proximity to the incident site
- Operational capacity (How large is the agency providing resources)
- Operational tempo (Will the incident require continuing support)
- Overall availability of resources

Once it is determined from which region the resources will be requested, a Preparation Notice should be sent to the Regional Public Health Advisor/ RESF-8 Chair identifying which resources are being requested and for what operational period. This notice serves as the official request for resources from the RCC and notifies the sending region that they should prepare for the activation of resources that they said were available from their region.

If human resources are being requested, the RCC should request contact information as part of the Action Required section of the message from the LHD supplying the resources This contact information will include:

- o Full Name
- o Drivers License Number
- o LHD they work for
- o Office Phone #
- o E-mail Address
- o Cell-phone #

The purpose of collecting this information is to be able to provide it to the requesting agency to ensure that personnel deploying to the incident site are expected and can be notified if there are any changes in their assignment prior to the operational period.

If material resources are being requested, the RCC should ask how transfer of the material will be handled in the Action Required section of the message. Information about material resources will include:

- Nomenclature/Type of material resource required
- Quantity Required
- Unit of measure (each, set, gross, box)
- Where resource should be sent/picked up from
- Determination of approximate value of resource
- o Location to Report On-site