The meeting was opened at 9:14 a.m. by David Koscuik.

Those present introduced themselves.

The minutes of February 1, 2012 were accepted for filing by unanimous vote.

**Ms. Dean gave a report on the Behavioral Health Section.**
- Last month, a section meeting was held to review and revise strategies, plans and protocols guiding operations during an emergency.
- A behavioral health presentation has been prepared to give information to the other four regional ESF-8 groups in the state.
- A training course was conducted for a broad representative group explaining the role of behavioral health. A follow up course is being planned for CERT volunteers.

**Mr. Falaguerra reported on the Hospitals Section.**
- Efforts are continuing with the creation of the Region 3 Hospital Mutual Aid Plan (HMAP).
- There remains interest in developing greater effectiveness using WebEOC, and this will be discussed at the next section meeting.
- Discussion is also underway to expand the use of Everbridge at hospitals to alert and notify staff of an emergency situation.

**North Central CMED activity was reported.** The back up CMED remote units are now being installed in hospital emergency departments. If the North Central CMED console fails to remain online, ambulances will use an assigned medical frequency to communicate to each hospital directly on these remote units. Each hospital remote unit is preset on just one med channel. Mr. Wentworth identified a problem with this project at Johnson Memorial Hospital. Tolland County CMED serves this Region 3 hospital. The hospital’s remote unit is not yet functional, and some effort will be required for it to become active.

**Mr. Groux identified a new issue the EMS section is addressing.** OEMS has recently requested that all ambulance vehicles need the ability to communicate on all 252 CMED medical channels instead of the traditional 10 med channels formerly required. This will allow every ambulance to be functional on every med channel for every EMS region in Connecticut along with additional channels used in Massachusetts.

**Ms. Cherniak-Lexius gave the Local Public Health Section report.**
- The DEMHS advisory committee meeting is scheduled for March 8.
- Planning is underway for an exercise in the next few months, and several legal issues are being addressed.
- The Public Health Advisory Committee is meeting on April 19.
Mr. Austin reported on behalf of CRCOG.

- The Connecticut Annual Citizen Corps Council Conference has just been held. The theme of this conference was “The Citizen Responder – A New Dimension.” Citizen Corps Councils include participation of community leaders from all sectors and the public. The goal is to strengthen community safety and preparedness to develop strategies tailored to specific needs. This statewide conference was very successful in achieving this goal.
- On March 15, CRCOG will present an Emergency Management Seminar and roll out the new Citizen Preparedness web site. The focus will be how CRCOG and CREPC serve local emergency management directors, elected officials and citizens. A realistic scenario will illustrate how the citizen preparedness program will be helpful. Registration is required – there are currently 110 people registered.

Mr. Scace reported on a planned statewide exercise to be held July 28, 29 and 30.

- Work currently underway is narrowing the scope of the objectives. For Region 3, this exercise will help to resolve several regional / state issues and conflicts.
- The role of hospitals in this exercise is somewhat limited. Each region is to establish one shelter during this exercise. Mr. Falaguerra suggested setting up medical capability in shelters as one possible role of hospitals. Mr. Scace identified that a separate committee is working on the issues of mass care sheltering. He also identified current planning to identify one shelter in each region that will be supplemented with medical resources – rather than spread these limited resources thinly over multiple local shelters.
- Another role for hospitals might be monitoring the exercise at each facility using WebEOC.
- Yet another objective could be the planning of responses by utilities to provide priority support to restoring power to hospitals and long-term care facilities.
- Mr. Austin pointed out the current work underway is only conceptual – planning has yet to involve any operational objectives. DPH is participating, but their roles and responsibilities, if any, have yet to be defined. One of the issues being addressed is that those assigned responsibility for planning the exercise do not have any authority to commit resources for implementing these plans. One way to resolve this would be to involve the commissioners and the governor’s office in the planning, but this has not yet happened.
- One major issue identified affecting future operations in a power outage was discussed: managing public expectations. Accurate, consistent information of projected delays in restoring power will be required. Also essential will be managing public expectations that shelters will be set up in identified locations and time frames that are announced early and continuously are accurate.

Mr. Gavaghan’s written state DEMHS report was distributed (page 7). He was not able to be present at this meeting.
There was no formal DPH report.

Mr. Centrella reported there is a rapid drawing down of available MMRS funds to meet deadlines (2008 funds must be expended by September 2012). Several expenditures were identified: purchase vests for behavioral health responders, implement the patient tracking system, complete the Everbridge system, and include assisted living and residential care facilities to the long term care mutual aid planning project.

Mr. Cyr presented a summary of the recent shooting at the Hospital for Special Care. One of the significant lessons learned was the value of hospital officials working very closely with public safety groups to better coordinate joint operations.

Major Cavanna from the 14th Civil Support Team, Connecticut National Guard made a formal presentation on the resources and capabilities of this unit to support community responses to weapons of mass destruction (WMD) attacks. Copies of the slides used by Major Cavanna are attached (pages 8-12)

Ms. Duly from the Department of Public Health led a discussion about the current status of the Connecticut Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) program. ESAR-VHP is a U.S. Department of Health and Human Services national program implemented at the State level to support efforts to recruit, organize, and manage healthcare volunteers. The program includes verifying the credentials of health professionals so volunteers can be deployed quickly at the time of an actual incident

More information about the national program can be found at:  
http://www.phe.gov/esarvhp/Pages/default.aspx

- In Connecticut, the program began in 2003 when Chris Canon from Yale New Haven Hospital and Lenworth Jacobs, MD from Hartford Hospital mutually agreed on differentiating roles for strategic planning. Since 2003, Yale has headed up this state’s ESAR-VHP effort.
- 31 acute care hospitals have signed agreements to participate in this program. Hospitals are under contract with the DPH and funding has been provided to support their efforts.
- Under these contracts, each hospital is to have monthly meetings with their professional services and departments to encourage licensed and certified professionals to participate.
- During the two major storms in 2011, many hospitals found themselves limited in responding to their staffing needs. It became apparent that many hospital leaders were not aware of this program’s capability to provide additional staff from the outside sources.
- Two hospitals requested additional assistance – Johnson Memorial Hospital and Bristol Hospital. The Medical Reserve Corps (MRC) was deployed, but some confusion existed in filing a qualified request for activation of the ESAR-VHP program and in having people respond once they were requested.
- DPH is currently re-evaluating the planning process and activation procedures to enhance future responses. Ms. Duly is currently sending out the existing list of hospital contacts she has for corrections and additions.
• Those emergency care personnel and volunteers currently registered are being entered into the Everbridge system over the next six months to facilitate notification and alerting of personnel when they are needed.
• There are 18 professional groups in the current system. Flexibility exists to add other categories if specific needs are identified.
• It was stressed the credentialing official identified at each hospital is an essential part of the facility’s emergency planning committee and should be in attendance at all meetings.
• Three justifications to activate the system were identified. An event happens. Emergency operations officials work with their human resource personnel to gain internal support from all available staff. Next, outside agencies and groups usually supporting hospital staffing will be consulted. Only then:
  1. The hospital declares an emergency and their manpower needs cannot be met
  2. The governor declares a statewide emergency, and manpower is needed, or
  3. A federal disaster is declared, and more staffing is needed.
• Everbridge call up listings are being set up with the following categories:
  Type 1: Hospital ready
  Type 2: Clinical specialists (e.g., pediatric nurse) – non hospital
  Type 3: General capability (e.g., RN) – non hospital
  Type 4: Lay support staff.
• The activation procedure was outlined:
  o A request is received and approved;
  o A roster is released and volunteers are notified, requesting they report;
  o Willing volunteers reply and are then asked to contact the requesting agency;
  o The requesting agency agrees to accept the volunteer;
  o Details of when and where to report are agreed upon;
• Details of setting up hospital Everbridge systems, and other general questions were answered.
  One question was answered that State Workers Compensation provides liability protection.

Problems using this system during the storms last fall were discussed. It was learned, for example, many volunteers were available, but were at home without power unable to learn of their activation.

The meeting adjourned at 12:04 a.m.

It was decided to not hold a separate subsequent meeting for the Hospital Section, but to reschedule a demonstration and evaluation of WebEOC by hospitals during an emergency at the April Hospital Section meeting.

Respectfully Submitted,

Cressy Goodwin
Recorder
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**ATTENDANCE:**

**CREPC ESF-8 Meeting**

March 7, 2012
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RESF 8 Meeting
Gavaghan, Thomas [Thomas.Gavaghan@ct.gov]

Sent: Wednesday, March 07, 2012 6:34 AM
To: David Koscuk; David Koscuk

David –
I will not be able to attend the meeting today since I have been asked to attend a “mandatory” meeting at our Headquarters this morning.

I did want to share some information that some of the RESF 8 folks may not have. I will try to summarize:

1. As a result of the 2 storm panel that issued a report, the Governor has asked that a statewide exercise be held by September 1. Normally, it takes a year to put that size of an event in place. Therefore, much work is being done to accomplish it.
2. The date(s) are July 28, 29 and 30. That’s Saturday, Sunday and Monday. These were chosen recognizing that many smaller communities emergency services, EOCs, etc were staff by volunteers. This timing allows them to participate in the exercise. Monday was selected to accommodate the full time staff in other communities.
3. The exercise will extensively involve the private sector. This means, electric utilities, telephone service, cable companies and other private sector entities that come into play during a disaster.
4. Most State agencies will be involved as well as the National Guard.
5. All of this raises several questions, e.g. what training do all of these units require for them to fully participate effectively in a widespread exercise? Do they need to understand NIMS, ICS?
6. Major factors in such an event needs to address the following:
   a. To what extent are our communications systems able to respond to such a disaster? What do we need to do to bring them up to speed where necessary?
   b. What training needs to be done of all participating units?
   c. Have all the commodities distribution problems been solved? Have we resolved any coordination problems with FEMA? Are the town distribution points still in place? Do we have their GPS coordinates?
   d. Are all utilities in a position to respond should a disaster take place?
   e. Is the National Guard in a position to respond? They are also running an exercise modeled after the 1938 hurricane. Should we “piggy back” our exercise on theirs?
   f. Have we solved or have a solution coming to address the Mass Care issues that emerged during storm “Alfred”? To what extent will hospitals and other health care facilities be involved in the exercise? Do we want to have Regional shelters? If so, where will the be located?
   g. Are CEOs ready to be involved in such an exercise? Will they need training mentioned in item “b”?
   h. Are all State agencies in a position to participate and, if so, what briefing/training will they require?

At least 5 different task forces have been assembled to address these issues headed by DESPP/DEMHS reps.

A meeting of CEOs and EMDs was held last Friday to provide some information generated by the two storms. It was a start toward trying to provide them with some information resulting from the storms and to hear from a panel of CEOs and EMDs on their experiences during the two storms.
Mission

Support civil authorities at a domestic Chemical, Biological, Radiological, and Nuclear (CBRN) incident site by:

IDENTIFYING CBRN agents or substances

ADVISING on response measures

ASSESSING current and projected consequences

ASSISTING with appropriate requests for follow-on state support
14th CST Incident Callout Procedure
State/Federal Level

- Current Process:
  - Incident Commander Contacts local DEMHS Area Coordinator
  - DEMHS Coordinator Contacts CT National Guard Joint Operations Center (CTNG JOC) which is manned 24x7
  - CTNG JOC Coordinates with Adjutant General and deploys the team if warranted
  OR
  - Call the CTNG JOC at 860-524-4951
    OR
  - Maj Daniel Janusz 860-883-2423
  - CPT Miguel Colon 860-883-4109
  - SMSgt Matthew Gagnon 860-883-3815

Civil Support Team Training

- All 22 Personnel regardless of position complete the following courses:
  - Civil Support Skills Course
  - IS 100, 200, 300, 400
  - Chemical/Biological CBRN Defense Lab Course
  - Homemade Explosives Course
  - CST Radiation Response Course
  - Dynamics of International Terrorism

- Specialized training within sections include:
  - Field Management of Chemical/Biological Casualties (FMCBC)
  - Analytical Laboratory Operator Course
  - Advanced Communications Course
  - Rope Rescue/Confined Space Rescue

- In addition to each Individuals Military Occupational Specialty Training, the CST has completed over 14,338 hours of specialized CBRN training

Real World Responses/Support

- Hurricane Katrina
- High Profile Sporting Events: NFL, MLB, NASCAR
- Presidential Support Mission: NYC
- UN Support Mission: NYC
- Kent, CT
- Danbury, CT
- Governors Office
- South Windsor, CT
- TSA VIPR Missions