Capitol Region Emergency Planning Committee
RESF-8 Health and Medical – Leadership Group
September 14, 2011
East Hartford Public Safety Complex
East Hartford, Connecticut

Members Present: **See attached attendance list**, *pages 6-7*

The meeting was opened at 9:02 a.m. by Steven Huleatt.

During the introductions, several representatives from Community Health Services were welcomed to the group. Mr. Huleatt agreed to meet with these representatives after the meeting to explore ways this important resource might become integrated into the regional program.

Mr. Huleatt opened the meeting announcing a change to the agenda – due to conflicts in schedules, reports from CREPC, DEMHS and DPH will be moved to the next meeting. In their place, a decision was made to review the DEMHS Region 3 responses to Tropical Storm Irene starting before August 28th and continuing after the storm had left the state. Mr. Huleatt recommended that each of the section heads prepare written reports and submit these to him or Dr. Shaw.

Hotwash by responders to Tropical Storm Irene: As the storm was approaching and the days following:

RCC: Art Groux was the assigned duty officer on Saturday, August 27, and he gave the following report. He had been on a statewide conference telephone call Wednesday, August 24 between state, regional and local officials. It was identified that each community would be tied up during and after the storm hit making it difficult for the Regional Coordinating Center (RCC) to function by sharing resources between communities. It was decided to use the RCC to consolidate information coming in and out of the region, and it was activated

Early in the operation, an apparent conflict surfaced concerning the safety of first responders. The Governor had declared a statewide emergency before the storm arrived. Apparently fire standards call for the cessation of fire service responders once winds reach 55 mph. Ambulances, however, are required by statute and regulation to respond to all 911 calls without reference to high wind situations. The request was made of OEMS to formally relax this EMS regulation. The reply came back Saturday night, before the storm hit, with the advice for all EMS units to "follow their local plans for responses." It was noted that few if any local plans addressed responses in bad weather conditions. Later it was understood that the commissioner of health needs to declare a separate public health emergency before any such health department waivers could be issued. This was discussed at this ESF-8 meeting and some question remains about the authority of the governor's declaration covering all agencies of the state. ***Clarification of authority is needed for local EMS responders to restrict their responses during hazardous weather conditions will be followed up later.***

David Koscuk took over as duty officer and reported the following. The Town of Manchester wanted to use the space occupied by the regional RCC as its own local EOC to conduct a situation review. There were only 4 RCC staff present. The RCC and Manchester's EOC were co-located in the same facility. Had the situation required a more extensive regional resource coordination effort, the problem could have become a problem. ***Adequate staffing of the RCC and mitigation of the problem of co-locating with Manchester in this facility surfaced as two issues needing to be addressed in the after action plan.***

Mr. Koscuk continued his report. The greatest amount of regional coordination activity took place among the regional long term care facilities. It was reported that this coordination took place between the facilities themselves following the Long Term Care Facilities Mutual Aid Plan that had been previously approved. This activity centered on their regional coordinating center at Duncaster in Bloomfield, and the only role played by the RCC was to receive information of actions being taken. Other actions reported to the RCC included a West Hartford shelter that had received a large number of individuals with emotional and medical issues. Mental Health leaders were notified as was the Medical Reserve Corps (MRC). The MRC was activated and a nurse was sent to the shelter to ensure patient assessments were being done adequately.

Later, when it appeared the storm had passed and the emergency was over, Mr. Koscuk left the RCC with Don Janelle being the only Region 3 representative remaining. Mr. Janelle was also in charge of the Manchester EOC. Paul Wentworth contacted the RCC to report a situation at Johnson Memorial Hospital. The facility had lost power, and their emergency generators kicked in. But soon, these generators failed and the facility was without any power. Consulting with Mr. Koscuk by telephone while he was on the road, several options were discussed. The decision was reached to evacuate the more than 40 patients at Johnson Memorial Hospital. As discussed more fully, below, the remainder of the RCC activities took place outside the center itself – a process that led to the comment the regional coordination for the hospital evacuation took place in a "virtual RCC."

- ***This situation suggests the need for the RCC to plan for decisions required to formally stand down operations, including greater emphasis on the recovery phase before closing the RCC.***
- ***Associated with this is the need to evaluate the benefits and disadvantages from coordination of resources outside the RCC facility – should this be encouraged or not?***

Mr. Koscuk contacted the DPH EOC and talked with Len Guercia. An agreement was reached that Region 3 would oversee the evacuation with DPH providing support as needed. Mr. Koscuk then activated the relevant parts of the Regional Forward Movement of Patients Plan. Mr. Koscuk then contacted the incident commander at the hospital and established the liaison links for CMED to coordinate the dispatching of ambulances.

Betty Morris reported that at CMED ambulance organizations were contacted and 20 EMS units were placed on standby. Units were then dispatched as appropriate to meet the local needs. Ms. Morris contacted the hospital emergency departments with a heads-up alert. She contacted Robert Falaguerra and it was decided to request the activation of the state hospital alerting network to give more complete situational information to hospital administrative and emergency operations staff. A problem emerged when it was learned that by the time of this request, most if not all of the other local hospitals had closed their emergency operations centers; phone calls and other communications to these centers were not possible.

Mr. Groux was contacted and he was sent to Johnson Memorial Hospital to act as liaison with CMED. Every 30 minutes, CMED posted an update on WebEOC. Hospital bed managers were individually called to establish communications and keep them up to date. ***It was noted that CMED usually deals directly with the ED staff of hospitals, but for this event CMED needed to coordinate with other areas of each hospital when most of their coordinating centers had been closed. Planning needs to address this issue for future events of this kind.***

The contrast was discussed between the complications that arose for hospitals to plan for the evacuation of patients from one facility and the ease and effectiveness of similar planning for the evacuation of patients from and between long term care facilities during this same incident. ***It was recommended that a similar mutual aid planning effort be undertaken by the region's hospitals as has now been completed by the region's long term care facilities.***

Kathy Dean picked up on the theme that when the emergency is over, the threat may continue. She coordinated the CT-Disaster Behavioral Health Response Network (CT-DBHRN) resources in the region and statewide. CT-DBHRN operations did not close down until September 13; over two weeks after the storm came through. CT-DBHRN pre-planning activities included making certain regional team leaders were informed of the impending storm and that all had reviewed their roles and activation procedures. Kathy Dean and Alice Sadowski attended the planning meeting held at the RCC on Saturday morning and monitored RCC email to stay informed about Region 3 activities prior to, during and after Irene making landfall in Connecticut. Kathy also met with American Red Cross staff in Farmington on Saturday afternoon to coordinate procedures for sending CT-DBHRN team members to shelters state-wide if they were needed; 70+ team members were pre-identified to deploy to shelters, four team members did deploy to shelters on Saturday afternoon prior to landfall although not to Region 3 shelters.

One challenge she identified was the key CT-DBHRN person from the Department of Mental Health and Addiction Services (DMHAS) as well as his back up were both out of state when Irene made landfall. Thus, Kathy assumed the coordination leadership role for CT-DBHRN during the storm. (Kathy works for the University of Connecticut Health Center – Center for Trauma Response, Recovery and Preparedness.) A state CT-DBHRN command center was not activated; Kathy and the CT-DBHRN regional leadership used a virtual command operation maintaining communications statewide using email, text, cell phones and landlines. Kathy noted regional leads were able to maintain communications during the storm even though some did lose power at home.

During the aftermath of the storm, CT-DBHRN worked alongside Red Cross operations that were based in Middletown, deployed to town comfort stations and provided behavioral health consultation to town staff. Approximately 300 homes in Connecticut were significantly damaged or destroyed by Irene and many towns' residents were confronted with coping without power and/or water for days following landfall. By September 13, CT-DBHRN team members had made 117 separate trips to 41 towns in Connecticut to provide services to residents. A total of 71 team members were deployed to these Connecticut communities and an additional 17 team members worked Command and Logistics.
In a separate report on EMS services, Mr. Groux noted that Everbridge contact information was effective. However, ***contact data for all EMS personnel needing information during the operation needs to be reviewed and updated.***

In a separate report on CMED, Ms. Morris noted that ***information was not readily available for families identifying where the patients from Johnson Memorial Hospital were taken; this requires additional planning and development.***
Ron Buckman reported on the activities of the Medical Reserve Corps. At the start of the storm, there were 42 MRC members identified as available. A request for activation of the MRC to support the State's mobile hospital was reviewed to assist Johnson Memorial Hospital, but this was discouraged because of the continuing storm and windy conditions.

Requests were received for medical staff to assist at local community shelters, but because these shelters are not medical facilities, the MRC is not charged with this function. However, a request was received from a shelter in West Hartford for assistance to triage people for referral to more appropriate locations – a nurse was sent to this facility for patient assessment only – not to provide care. It was reported that Everbridge alerting messages were very effective. Also it was reported that DPH authorized a formal activation of the MRC if this was needed (which did not turn out to be the case).

Steven Huleatt reported on the responses of local health departments. No requests were received from local officials for assistance. Information was received that perhaps Chatham officials needed help, and Mr. Huleatt called. The local official stated they were all right. But the next day, the State DPH sent staff and found the need for additional resources. The local issues included contaminated food and wells, and beaches that were not closed contaminated with sewerage. ***This highlighted the need to clarify communications between local, regional and state officials, and a better operational understanding of the roles of each to identify and provide needed and coordinated assistance and support.*** In a related discussion, it was noted that if a local health department orders a restaurant to close, it has to be re-inspected and re-authorized before it can reopen. However, if a restaurant voluntarily closes, it can later voluntarily open without involving the local health department. Finally, it was reported that one health department lost all their stored flu vaccines when its refrigerator was not connected to an emergency power source.

During the remaining debriefing, topics were suggested and reinforced that need to be cross-reviewed from the different perspective of the RESFs in CREPC.

- ***Hospitals triage incoming patients quickly and refer them to the appropriate level of care. This is in contrast to shelters that must be set up quickly and take in all who come in – providing medical and emotional care to these people, perhaps over a prolonged period of time. Planning is indicated toward the ability for shelter personnel to triage people ho have medical needs.***
- ***Consideration might be given for comfort shelters in place of shelters – places where people can come in for warm meals, hot showers, and charge their cell phones, but go home at night to sleep.***
- ***Steps need to be identified to communicate with the public the different issues that can make individual RESF activities more efficient for example, (where to report for sheltering if you have medical needs, where evacuated hospital patients have been taken, etc.).***

The discussion shifted to the need to review the strategies developed earlier in the RESF-8 plan. This review considers reduction of funding, elimination of the MMRS program, and a revision of the federal Target Capabilities List. There now may be the need for setting new priorities. To begin this effort, Mr. Huleatt presented a detailed report***. (See PowerPoint Slides attached – Page 8 below.)*** This discussion will be continued at the next meeting.

Bill Austin was introduced to the group in his new role as CREPC staff focusing on strategic planning issues. Mr. Austin mentioned that Carmine Centrella now represents Region 3 on the Logistics Section of the Regional Catastrophic Planning Team (CT, NY, NJ, PA) (***see*** http://regionalcatplanning.org/regionalcatplanning.shtml). Future updates on this group's activities will be provided.

He stated an interest in attending future RESF-8 meetings because of the diversity of issues the group is addressing and the support it offers to the regional effort. He stated he will be communicating with others some of the issues discussed at this meeting, especially communications and the improved use of WebEOC.

Mr. Austin informed the group that city/town managers and selectmen are now being involved in programs that addresses sharing of resources when this can help local operations. The sharing of public works resources was cited when the state set up a commodities distribution center at Rentschler Field in East Hartford. Originally, local communities were sending their separate vehicles to pick up water, MREs, and other disaster relief supplies. When four communities expressed a need for help, a total of 11 tractor trailer loads of these supplies was coordinated for direct deliveries to these towns over several days.

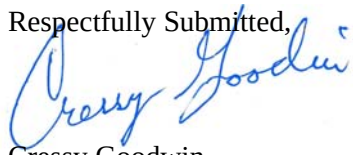
He provided advance notice of an impending intensive media campaign called "Get Ready Capitol Region." This will focus on the public's concern for diverse events such as shootings in Hartford, earthquake damage, flooding and hurricanes, and promote regional planning and coordination of resources. This campaign will begin the end of October and should greatly encourage local support of CREPC planning efforts.

Mr. Austin also announced the establishment of a Twitter® account that can receive and hold text messages during events. This will allow towns and cities to contact RESF-5 – and the RCC - by texting. This will be especially useful when other means of communication are not available.

Mr. Austin gave his cell phone number to the group with instructions for anyone to contact him about any question or issue that needs clarification or support. (860) 995-2281

The meeting adjourned at 12:02 p.m.

Respectfully Submitted,



Cressy Goodwin
Recorder

ATTENDANCE:
CREPC ESF-8 Meeting

September 14, 2011

Name	Affiliation	e-mail Address
Bev Wargа	Glastonbury Police Dept.	beverly.wargа@glastonbury-ct.gov
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ATTENDANCE:

CREPC ESF-8 Meeting

September 14, 2011

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Kathy Dean	CT-DBMRN	kdean@uchc.edu

Attachment 1 – PowerPoint[tm] Presentation

DEFINING THE RESF 8 STRATEGY

Target Capability: *Medical Surge*

Objective: Facilitate the rapid expansion of the capacity of the existing healthcare system in order to provide triage and subsequent medical care to victims of a public health emergency

DEFINING THE RESF 8 STRATEGY

T &PHT Action Steps

—Implement regional EMS Strike Teams to comply with the state EMS Mobilization Plan
—Build and sustain the regional Electronic Patient Tracking System
—Establish regional procedures to support Casualty Collection Points as described in the state Forward Movement of Patients Plan
—Conduct annual review of all pertinent regional plans and policies supporting pre-hospital response

DEFINING THE RESF 8 STRATEGY

Target Capability: *Community Recovery*

Objective: Support recovery of the regional healthcare system and its agencies

Action Steps:
— Develop a robust regional behavioral health response capacity
— Create awareness among the public of regional plans and procedures to assist our communities in recovering from the public health and medical aspects of disaster

DEFINING THE RESF 8 STRATEGY 2011-2012

- Last revisited our Strategy in January 2011
- What do we sustain in the face of budget cuts?
  - Funding through 2014 ?
- What matters enough to you to fight for when the dollars run out?
- What is our COOP plan?

DEFINING THE RESF 8 STRATEGY

- Much of the January 2011 RESF 8 Strategy depended on continued federal funding for regional projects
- Now we need to focus on those projects that are:
  - *Critical* to the Region's response and recovery
  - *Achievable* within the time period 2011-2012
  - *Sustainable* with minimal dollars beyond 2012
- Today we will discuss a modified action plan based on these criteria to develop a revised RESF 8 Strategy

DEFINING THE RESF 8 STRATEGY

Target Capability: *Triage and Pre-hospital Treatment*

Objective: Ensure the Region's capability to appropriately dispatch EMS resources, to provide feasible, suitable, and medically acceptable pre-hospital triage and treatment of patients, to provide transport as well as medical care en-route to an appropriate receiving facility, and to track patients to a treatment facility

DEFINING THE RESF 8 STRATEGY

Medical Countermeasures Dispensing Action Steps

—Maintain and sustain the regional Rx cache for first responders and their families
—Develop and implement regional Rx distribution plans and policies
—Develop and implement regional vaccination plans and procedures
—Provide logistical support to local Points of Distribution (PODs)
—Train local and regional stakeholders on Rx plans and procedures

DEFINING THE RESF 8 STRATEGY

Med Surge Action Steps

—Develop regional procedures for regional recovery and replenishment of resources
—Identify and establish a regional hospital bed surge capacity that conforms to national standards
—Support and sustain alternate care sites when established by regional hospitals
—Train the Medical Reserve Corps on nationally identified core competencies
—Train healthcare stakeholders on all medical plans, procedures, and equipment inventory

DEFINING THE RESF 8 STRATEGY

Target Capability: *Medical Countermeasures Dispensing*

Objective: Protect the health of the population through administration of critical interventions (e.g., antibiotics, vaccinations, antivirals) to prevent development of disease among those exposed or potentially exposed to public health threats