The meeting opened at the completion of the Initial Planning Conference for the region’s Exercise Program Tabletop Exercise.

It was noted that 9 of the region’s hospitals were represented.

Alternate Care Sites (Facilities): Mr. Falaguerra had staff review the registration form used by staff working at an ACS and it was noted a date of birth for each person registering should be included. It was also noted in the review the proposed staffing levels are quite high. The driver for staffing should not be the level of acuity as each ACS will be for non-acute care. It was also noted the model developed by the state has higher staffing levels than that for the region. A consensus is emerging that if a hospital is required to activate its Alternate Care Facility (as opposed to a community or other organization’s Alternate Care Site), hospitals will not take action to open such an ACF.

Another consensus was stated: a community Alternate Care Site won’t be activated until the Governor first declares a statewide public health emergency authorizing this. Staffing for a community ACS in the region will primarily focus on the Medical Reserve Corps supplemented by individuals listed on the state registry of medical staff who may be available. Finally, if staffing is not available to support the ACS, it cannot be opened.

The state program authorizing opening of an Acute Care Facility is based in that facility operating under a hospital’s license. Thus the state’s authority is enabling, not mandatory. In other words, the decision to activate an ACF must be made by the hospital medical director. If the medical director decides not to open the ACF, it will not open.

The state’s approach does not require or encourage regional coordination and logistics. This might require more work to develop a pre-agreed template defining the staffing of individual ACF to allow closer compatibility of operations by independent hospitals.

Hospital MOUs: Mr. Falaguerra identified the need to list the vendors who are expected to provide the following in an emergency: water, food, pharmaceuticals, expendable supplies, surgical supplies and fuel. This will be needed before the Tabletop Exercise.
Familiarity with Regional Plans: Mr. Falaguerra identified the need for leadership at each hospital to become familiar with and understand how the following plans are activated and how they function. This understanding is needed by the tabletop exercise:

- RED Plan (version 3.2)
- State and Regional Mass Casualty Incident Plans
- MMRS Forward Movement of Patients Plan

WebEOC: A question was raised if the hospitals will be using WebEOC as to communicate during the next three planned exercises. Right now, hospitals are waiting for the software templates to be installed for medical facilities. When, and to what extent this system will be available will be referred to OEMS for discussion. This can be explored more fully at one of the future Statewide Joint Hospital Planning Group meetings.

NIMS Compliance: It was identified that the California Hospital Association has made available a checklist to help hospital leaders understand NIMS compliance standards, and to measure the degree of success within any hospital.

Respectfully submitted

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Recorder
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Attendance

Kris Pagan HCC
Jennifer Martin Connecticut Childrens
Marge Kotitin
Robert Jakes
Laura Nagle Bristol Hospital
Bill Perkins UConn Health St.
Kristine Berul Bristol Hospital