Capitol Region Emergency Planning Committee
RESF-8 Health and Medical
January 9, 2008
East Hartford Public Safety Complex
East Hartford, Connecticut

Present

See attached attendance list

The meeting opened at 9:15 a.m.

Dr. Charles McKay (Hartford Hospital) discussed emergencies involving biological and chemical agents:

- Biological causes (diseases) result in a slow onset of people showing systems, a delay of any breakdown of medical systems, and result in a delay in public concern or hysteria, and a greater number of people can be affected over a wider area.
- Chemical causes create situations with a rapid onset, more rapid stress of local medical systems, and a more rapid public concern and hysteria but with fewer people involved in a more limited area.
- The number of patients from diseases tend to grow slowly over time and peak later in the cycle; patients from a chemical incident tend to increase in number rapidly at first, and then taper off over time.
- Today, 3,000 people die in the country every day. Based on the mortality rates during the 1918 Spanish Flu outbreak, a pandemic influenza outbreak today can be expected to produce 15,000 deaths daily.
- The epidemiology of the SARS epidemic in Hong Kong shows one peak in the number of patients. However, in Toronto, there were two peaks of increased incidence – caused by a relaxation of counter measures as the first peak started to subside, allowing infections to spread more rapidly.
- The mission of the health care system is to damp down these curves over time and thereby placing less stress on resources.
- The CDC recently examined each state's preparedness for dealing with pandemic influenza. Out of a score of 10, Connecticut scored 8. Cited as needing improvement is the ordering of anti-viral agents to be available when needed, and a lack of a Web-based disease tracking system. The Health Alert Network was started by the Department of Public Health in 1999, but planned modifications and enhancements that are required apparently have been stalled and more work is needed.
- As hospitals prepare to continue during any future pandemic influenza outbreak, it must be recognized that staff will be reduced resulting in the need for all those who can to come to work expecting long hours, shortage of supplies, and an increase in the number of ill patients.
- Workers must consider early who will be the care-givers for children and the elderly who are in the family at home after school and senior centers are closed; and who will care for pets if workers will have to stay several days at the workplace.

During the discussion that followed Dr. McKay's presentation, the idea emerged that EMS and other groups need to preserve the use of N-95 and other disposable PPE supplies early in an

outbreak. If masks are used for patients who *might* have influenza early on, there may not be any masks left for those patients later on who definitely do have influenza.

Ms. Cheryl Mayeran (CTDPH) reported on the CDC Cooperative development project:

- Federal funding for health preparedness programs are being reduced.
- CDC is placing an increasing emphasis on performance measures.
- A full-scale exercise is being developed to be held a year or so in the future.

Mr. Steve Huleatt (WHBHD) gave a report on public health preparedness:

- He attended an SNS training course held recently in Atlanta.
- CRI (City Readiness Initiative) program is currently addressing diseases like anthrax and other non- infectious diseases requiring antibiotics.
- The model developed for Points of Distribution (PODs) is too staff intensive – they require 10% of the population to staff these centers. The modeling now being developed is shifting to meet the needs for completed distribution in 48 hours from the decision being made.
- Funding for our CRI project includes the Hartford SMSA, not just the City of Hartford.
- The alternative distribution methods are "push" vs. "pull" - getting the pharmaceuticals out to the public or having the public come into PODs.
- PODs can be "open", such as community clinics; or "closed", such as large businesses developing a system for their employees.
- Prior systems that take medical histories and conduct medical evaluation are changing. In Texas, a system of non-medical PODs is being developed.
- The "Toolkit" is being revised – a manual and field operation guide for POD operations.
- A technical Assistance Review (TAR) is being done by the CRI programs. All local health departments will be included in this review. There are 124 criteria to be covered.
- The timetable was defined:
    - A committee convened to develop the toolkit and TAR process- April 2007
    - Toolkit to be finished – January 2008
    - Training in the toolkit – March 2008
    - TAR Reports to be finished – August 2008
- An SNS exercise is being planned for 2010.

John Shaw (RESF 8 Chair) gave a report on the MMRS program:

- The 2008 funding for the program was not supported by DHS or in the President's budget. Despite that, there has been a great deal of effort made by the individual jurisdictions in educating the congress to secure the $41M that is needed. Last year's funding was $32M.
- Even though the NDMS was transferred to DHHS last year, The Department of Homeland Security still has responsibility for overall coordination and control of emergency preparedness. How the relationship between DHS and DHHS plays out is anyone's guess.
- The National Response Framework has been released and touted as a much more workable document than the preceding National Response Plan – not certain how all these variables will sort out and how it will affect the program locally.

Katherine McCormack gave a brief update on the MRC program:

- December was spent evaluating the program and revising the recruitment brochure and introduction kit.
- Affiliation agreements were signed with West Hartford- Bloomfield Health Department to create a public health component of the Capitol Region MRC.
- The credentialing program is being examined with the goal that a member of one area MRC should be qualified for other groups. The state group is looking at this, and differences between the various groups are being discussed.
- Ms Janet Leonardi gave a brief update report about the MRC based in Middletown.

Mr. Klein gave a report on CMED:

- Revised CMED MCI guidelines are out for review.
- Hospital notification policies and procedures are also out for review.

Dr. Shaw reported that the region's Forward Movement of Patients plan was shared with other states at a recent meeting in Boston. Patient transportation is central to this plan's implementation. DPH has called a meeting with the CMEDs to plan for implementing a coordinated program statewide.

Mr. Stonoha reported on behalf of Mr. Falaguerra that Bristol Hospital is back on board as of November 2007. Also he reported that the Alternate Care Site program is moving forward. He stated that the After Action Report for the June Surprise exercise is 90% completed. A meeting will be called of the exercise planning committee to go over the Improvement Plan. A week or two will be required to finish this up.

New Business:

Dr. Shaw asked the group to review a document he distributed about the Capstone Project. The military support group to develop a regional logistics plan for supporting Alternate Care Sites if they are activated has defined that our group needs to answer several basic assumptions to allow CAPSTONE to proceed. Several working groups are being proposed, and Dr. Shaw asked for comments, suggestions and volunteers to begin this effort. He would appreciate feedback in the next week.

Dr. Shaw asked if the group would prefer to meet once every two months, allowing time at the alternate meetings for committees and task forces to meet. There were several good ideas offered, in favor and opposed to this idea, and Dr. Shaw stated he would consider the discussion and make a decision later.

The next meeting of ESF-8 will be on February 6, 2008 at the East Hartford Safety Complex.

The meeting adjourned at 11:50 a.m.

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ATTENDANCE:

CREPC ESF-8 Meeting

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