Capitol Region Emergency Planning Committee
RESF-8 Health and Medical
May 7, 2008
East Hartford Public Safety Complex
East Hartford, Connecticut

Present

See attached attendance list

Tom Gavaghan gave a report of DEMHS Region 3. He introduced Rita Reiss who recently joined the DEMHS Region 3 staff as a planner. She served for eleven years with the Northeast Council of Governments and provided CERT training, financial management and grant writing. Mr. Gavaghan announced training in the new WebEOC for staff to be held on May 13. The state Emergency management Symposium will be held on May 15, 2008 in Cromwell – 450 people are already registered. On June 10 there will be a Bloomfield point of distribution (POD) exercise focusing on communications. A conference is planned for emergency management directors in West Haven. This meeting on June 17 will focus on hurricane preparedness. Mr. Gavaghan displayed and passed around a copy of the new Disaster Field Manual that has been published by Yale. He is seeking copies for all emergency management directors and public health offices in the region.

Carmine Centrella reported on planning activities for Region 3. The Urban Area Security Initiative (UASI) grant application has been completed and submitted. The application had five focus areas, 13 different “investments” (project initiatives), and totals $16,242,000 in requested funds. A detailed outline of the application is listed on the CRCOG Web site:

http://www.crcog.org/homeland_sec/uasi.html

The funding decisions should be announced in 90 days after the submission, and money should become available this fall. Funding will not be a one time opportunity – there are provisions for continued funding for several years in the future as well.

John Shaw reported on old business. The Capstone project involves the US Military Academy at West Point to plan for logistics support for alternate care sites within the region. A group of cadets have been working on this since last September. Dr. Shaw and Dan Scace will be going to West Point on May 8 to receive the final briefing, and a report will be due very soon. Once this is received, further planning on Alternate Care Sites can proceed. There are negotiations for two more projects related to this Capstone initiative for next year. Dr. Shaw next gave an update on the MMRS program. For the first time ever, Congress has proposed a funding level for FY09 - $63M. Since the start of the program, funding levels have been around $50M. Over the last few years, this dropped to $30M or $35M. This increase will come with added responsibilities. Related to this has been a need for the past three years to hold a meeting with all the MMRS jurisdictions nationally. The last meeting was held in 2005 in Orlando and it was very controversial. Finally, another meeting will be held later in May, and Dr. Shaw and others will be attending.
Mary Duley gave an update on the Mass Fatalities Management project. The March 2008 two page strategy document had been previously distributed. This and the 21 page “Mass Fatality Management Guidance – Working Draft Edition #1” document define the statewide effort. Many areas have been planning for mass fatalities for several years, and it is important that all plans and operations become more uniform. These documents provide guidance toward that goal. This discussion is currently being shared with the ESF-8 sections in all five regions in the state. The state task force is in place to coordinate the program as it develops. FEMA has directed that mass fatalities planning during pandemic influenza (“regional catastrophic planning”) be expanded beyond state boundaries. Connecticut has been combined with New York City, New York State and New Jersey. DEMHS is working with DPH to coordinate this broader initiative. For example, following 9/11, New York City received large funding to purchase victim identification and mortuary equipment that is not used regularly. This equipment can now be shared with the three state partners in an expanded program. Following the model developed in Florida, a robust program is now being proposed as the Northeast Emergency Mortuary Operations Response System (NEMORS). In the discussion it was noted that nationally, hospitals are now mandated as part of their accreditation evaluations to demonstrate they have planned for mass fatalities. The energy and support from the hospitals for this effort could help in an early implementation regionally. If this operational planning is delayed, the hospitals will have to create their individual, community based plans in its place. It was noted that mass fatality planning is broader than just health and medical – police, fire, and other ESFs are integral to the local and regional planning.

Carmine Centrella facilitated a discussion applying the national strategy embodied in “target capabilities list.” This is the first of three meetings to be devoted to this strategy. Mr. Centrella used a series of slides to focus the discussion (attached). He stated we tend to compliment ourselves in Region 3 for the good work we have done over the past 7 years. To illustrate the need for a critical self evaluation, Mr. Centrella cited some examples he learned about at a recent national meeting in Charlotte, North Carolina. The Columbus Ohio UASI is made up of 24 counties, with 10,000 square miles located in three states. They have one plan addressing medical surge. The Virginia Beach area has over 6,000 square miles, and they have one regional radio system. The State of Connecticut has 5,400 square miles and a very large number of different radio systems being used.

There are 37 target capabilities identified nationally. These capabilities are intended to establish plans, procedures, systems, relationships, training and evaluation programs that enhance operational performance at the local level. He proposed to use the target capability list by focusing on just one activity – medical surge – and do a critical self evaluation.

For this activity, there are 17 critical tasks identified and 26 preparedness measures listed. Each preparedness measure was reviewed and discussed. (Slides, pages 5-6). The stated intent of the discussion was to identify (yes or no) if each performance has already been achieved. Direction was given by Mr. Centrella to judge any performance as a “NO” if a performance is 50%, 75% even 90% complete. The group should only identify as “yes” those not requiring further effort. This will allow future planning efforts to focus on the deficient areas. The group consensus was recorded (slides pages 7-8):
NO - Health care system to care for 500 cases per million (CPM) infectious disease... Y/N
(This calculates to 750 patients in Region 3 with a population of 1.5M)
YES - Health care system to care for 50 CPM ... Y/N (or 75 patients in Region 3)
YES - Health care system to care for 50 CPM ... burn/trauma Y/N
(75 Patients through initial stabilization only)
YES - Health care system to care for 50 CPM radiation-induced illnesses Y/N
(75 Patients through initial stabilization only)
NO - Process to project the demand for Medical Surge (e.g. how many people will need treatment,
how long it will take to secure facilities) Y/N
(YES - Regionally before an event; but NO at a hospital during an event).
NO - Scalable patient tracking system in place Y/N
(YES within a hospital; NO for tracking patients regionally between hospitals.)
NO - Community-based plan-surge hospital/bed surge capacity is in place Y/N
NO - 50-bed nursing sub-unit - per 50,000 pop.- can be staffed - Y/N
(1,500 beds for Region 3)
YES - 1 hospital per region = 10 total adult and pediatric patients at a time in negative pressure
isolation within 3 hours from the event Y/N
YES - Each ACH = negative pressure for 1 suspected case of highly infectious disease-febrile pt, or
concern for highly communicable disease Y/N
YES - Each ACH = 3 day supply of pharmaceutical countermeasures for staff and family Y/N
YES - Sufficient PPE for staff and for surge staff to work safely (SOP based) Y/N
NO- Secure and redundant communications ACH-to-responder jurisdictions Y/N
NO - Medical surge plans developed in conjunction with critical partners (public health, emergency
management, law enforcement, etc.) Y/N
YES - Use of existing facilities Y/N
NO - Plans to ID / set up ACFs, including staff, equip, meds - Y/N
NO - Plans for patient / resource transportation - Y/N
(The Forward Movement of Patients Plan has not been approved – no authority to act.)
NO - Plans for facility-based evacuation (e.g. ID of receiving facilities, coordination of
transportation assets) Y/N
(While hospitals have evacuation plan, there is no regional plan to support these.)
YES - Plans to operate 72 hours without utilities Y/N
NO - Plans for setup, staffing and operation of ACFs are in place Y/N
NO - Plans for Tx of Med Surge personnel and families (e.g. medical needs, stress management
strategies) Y/N
YES - Plans for timely, accurate, and publicly accessible information Y/N
NO - Data base to track the status of medical surge resources (e.g. meds, medical professionals) is
in place or accessible Y/N
NO - Management system in place for medical caches Y/N
NO - 3-day supply of pharmaceuticals for first responder-CI/KR personnel and families in place
Y/N (First public safety responders are covered but not critical infrastructure – utility
crews, public works, etc.)
NO - Inventory management and dispensing tracking system in place Y/N
On several of these topics, reference was made to external program requirements and regulations that suggest the performance identified must be in place. The group attempted to focus on what actually exists, not what should exist. One conclusion reached during this discussion is the advantage of regional planning to consolidate efforts rather than having 10 separate hospitals and a large number of pre-hospital agencies each working independently.

The next step will be for Mr. Centrella, Dr. Shaw and Mr. Scace to take the results of this self-assessment to develop a strategic plan to address the gaps and achieve the goals. In this process, it may be some of the strategies could become state-wide and not just regional, and partnerships will need to be leveraged.

The results will be brought back to the group at the next meeting for discussion. At that time, another activity will be similarly reviewed and assessed: mass prophylaxis.

At the July meeting, a year-long work program resulting from these discussions will be developed.

Dr. Shaw stated it is important we re-focus on regional planning – the past year has seen an increase in administrative requirements with additional tasks assigned to already busy people.

A brief discussion closed the meeting on the need to develop divergent locations and methods for transporting, setting up and maintaining the 9 portable equipment and trailers now housed in West Hartford.

The next meeting of ESF-8 will be on June 4, 2008 at the East Hartford Safety Complex.

Respectfully submitted,

Cressy Goodwin, Recorder
## ATTENDANCE:
### CREPC ESF-8 Meeting

**May 7, 2008**

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**CREPC ESF-8 Meeting**

**May 7, 2008**

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Target Capabilities List

THE ONE NATIONAL GUIDANCE STANDARD FOR EMERGENCY PREPAREDNESS PLANNING, RESPONSE AND RECOVERY

CUTS ACROSS ALL FEDERAL GRANTS ADDRESSING PREPAREDNESS MEASURES

Intent of Target Capabilities

- Intended to address capabilities based preparedness to prevent, protect against, respond to, and recover from terrorism, very large-scale disasters, pandemic health emergencies, or other major incidents

  o Use the TCL to establish plans, procedures, systems, interagency relationships, training and exercise programs, and mutual aid agreements required for major events enhances performance for all hazard response
Capabilities

- 37 Capabilities –
  - Common Capabilities
    - Planning
    - Communications
    - Community Preparedness and Participation
    - Risk Management
    - Intelligence and Information Sharing and Dissemination

Capability Breakout

- Capabilities are broken down into
  - Major Activities to perform capability
    - Each Activity is broken down into Critical Tasks and Preparedness / Performance Measures
ESF-8 Response Mission Capabilities

- Emergency Triage and Pre-Hospital Treatment
- Medical Supplies Management and Distribution
- Mass Prophylaxis
- Mass Care (Sheltering, Feeding and Related Services)
- Fatality Management
- Medical Surge

Target Capabilities – Medical Surge

MEDICAL SURGE IS THE CAPABILITY TO RAPIDLY EXPAND THE CAPACITY OF THE EXISTING HEALTHCARE SYSTEM (LONGTERM CARE FACILITIES, COMMUNITY HEALTH AGENCIES, ACUTE CARE FACILITIES, ALTERNATE CARE FACILITIES AND PUBLIC HEALTH DEPARTMENTS) IN ORDER TO PROVIDE TRIAGE AND SUBSEQUENT MEDICAL CARE
Outcome

- Injured or ill from the event are rapidly and appropriately cared for.

- Continuity of care is maintained for non-incident related illness or injury.

Preparedness Tasks

- Activity: Develop and Maintain Plans, Procedures, Programs, and Systems
- Activity: Develop and Maintain Training and Exercise Programs
- Activity: Direct Medical Surge Tactical Operations
  o Definition: In response to notification of mass casualty incident, provide overall management and coordination of medical surge operations
- Activity: Activate Medical Surge
  o Definition: In response to a mass casualty incident, activate medical surge through implementation of surge plan
- Activity: Implement Surge Patient Transfer Procedures
  o Definition: Transition from pre-event bed utilization to access surge capabilities
- Activity: Implement Surge Staffing Procedures
  o Definition: Maximize staffing levels in accordance with medical surge plans
- Activity: Receive and Treat Surge Casualties
  o Definition: Receive mass casualties and provide appropriate clinical care
- Activity: Demobilize Medical Surge
  o Definition: Prepare to return healthcare system to normal operations
**Activity: Develop and Maintain Plans, Procedures, Programs, and Systems**

- 17 Critical tasks
- 26 Preparedness Measures

**Planning & Program Critical Tasks**

- Establish a healthcare system to receive and appropriately treat incident specific casualties or illnesses
- Coordinate with WMD/hazmat to develop plans for managing/decontaminating self-presenting contaminated victims off-site
- Identify Local, State, sub-State, and Interstate behavioral health and substance abuse professionals or paraprofessionals by survey
- Integrate Local, State, and Regional behavioral health and substance abuse professionals or paraprofessionals in response planning, exercises, and drills
- Emergency system patient transport and tracking systems are interoperable with national and Department of Defense systems
- Comprehensive stress management strategies and programs are in place and are available to all emergency responders, support personnel, and healthcare professionals
Critical Tasks – cont’d

- Develop medical mutual aid agreements for medical facilities and equipment
- Develop surge capacity plans for Acute Care hospitals
- Coordinate with community healthcare systems when developing surge capacity plans for Acute Care hospitals
- Facility based evacuation plans to include identification of receiving facilities and transportation assets
- Develop healthcare system evacuation plans to include receiving facilities and transportation assets that are coordinated on a regional basis
- Identify adequate evacuation transportation assets and receiving facilities with adequate assets
- Develop plans to mitigate identified hazards to medical treatment facilities

Critical Tasks – cont’d

- Develop electronic medical records for recording treatment provided and patient self-reporting
- Develop plans to identify staff, equipment and resources to operate alternate care facilities
- Develop plan to restrict access and secure healthcare and surge facilities
- Develop a Local/State regional pharmaceuticals management system that captures current inventory of Metropolitan Medical Response System and CHEM-PACK caches; ensures a sufficient supply of pharmaceuticals to provide prophylaxis for 3 days to first responders and their families, other CI/KR personnel, and the general public as determined by local authorities; and tracks the dispensing of pharmaceuticals during the incident
## Preparedness Measures

- Health care system to care for 500 cases per million (CPM) infectious disease... Y/N
- Health care system to care for 50 CPM... Y/N
- Health care system to care for 50 CPM... burn/trauma Y/N
- Health care system to care for 50 CPM radiation-induced illnesses Y/N
- Process to project the demand for Medical Surge (e.g. how many people will need treatment, how long it will take to secure facilities) Y/N
- Scalable patient tracking system in place Y/N
- Community-based plan-surge hospital/bed surge capacity is in place Y/N
- 50-bed nursing sub-unit – per 50,000 pop. – can be staffed - Y/N
- 1 hospital per region = 10 total adult and pediatric patients at a time in negative pressure isolation within 3 hours from the event Y/N

## Preparedness Measures

- Each ACH = negative pressure for 1 suspected case of highly infectious disease-febrile pt, or concern for highly communicable disease Y/N
- Each ACH = 3 day supply of pharmaceutical countermeasures for staff and family Y/N
- Sufficient PPE for staff and for surge staff to work safely (SOP based) Y/N
- Secure and redundant communications ACH-to-responder jurisdictions Y/N
- Medical surge plans developed in conjunction with critical partners (public health, emergency management, law enforcement, etc.) Y/N
- Use of existing facilities Y/N
- Plans to ID / set up ACFs, including staff, equip, meds - Y/N
- Plans for patient / resource transportation - Y/N
- Plans for facility-based evacuation (e.g. ID of receiving facilities, coordination of transportation assets) Y/N
- Plans to operate 72 hours without utilities Y/N
Preparedness Measures

- Plans for setup, staffing and operation of ACFs are in place Y/N
- Plans for Tx of Med Surge personnel and families (e.g. medical needs, stress management strategies) Y/N
- Plans for timely, accurate, and publicly accessible information Y/N
- Data base to track the status of medical surge resources (e.g. meds, medical professionals) is in place or accessible Y/N
- Management system in place for medical caches Y/N
- 3-day supply of pharmaceuticals for 1st responder-Cl/CR personnel and families in place Y/N
- Inventory management and dispensing tracking system in place Y/N

Next

- Identify capability gaps
- Develop strategic plan to address gaps
- Leverage planning partnerships