12 Medical Surge

Medical Surge

Capability Definition

The capability to provide triage and then to provide medical care. This includes providing definitive care to individuals at the appropriate clinical level of care, within sufficient time to achieve recovery and minimize medical complications. The capability applies to an event resulting in a number or type of patients that overwhelm the day-today acute-care medical capacity. Medical Surge is defined as the increased need of personnel (clinical and non-clinical), support functions (laboratories and radiological), physical space (beds, alternate care facilities) and logistical support (clinical and non-clinical supplies) in a coordinated fashion.

Capability Outcome

After the first event, minimize new cases due to preventable exposure to disease, contamination or injury. This will include exposure from communicable diseases and/or injuries which are secondary to the primary event. The at-risk population receives the appropriate protection (countermeasures) and treatment in a timely manner.

Capability Discussion Points

When discussing and analyzing the NCR's homeland security preparedness capabilities, stakeholder participants should consider the following:

- The adequacy of current medical surge plans.
- Whether adequate personnel and resources are in place to include triage, treatment, transportation, communications, and security.
- Medical surge plans which include patient tracking from event site, through treatment and post treatment.
- The ways in which medical surge plans identify current and future NCR resource requirements appropriately.
- The organizational structure and personnel roles and responsibilities to ensure adequate Medical Surge capability.
- The types and frequencies of exercises used to gauge and improve Medical Surge capability.
- The way in which the NCR identifies the adequate amount of Personal Protective Equipment (PPE) to protect current and additional healthcare workers.
- The broader issue of responder safety and health of family members with respect to PPE, prophylaxis for caregivers and family members, decontamination of victims before they enter the facility, and security surrounding the treatment facility.
- The way in which medical surge plans address the interface between hospitals, Emergency Medical Service, public health, and private physicians.
- The legal and credentialing issues surrounding the use of out-of-state medical and allied health personnel.

NCR Discussion Results on Medical Surge

Resource	S/W	Comments
People	S	• Jurisdictional monitoring and surveillance for epidemiologists, *Essence*, are solid.
	W	• Having enough licensed providers is the limiting factor in surge response (4) • Need to connect surge plans and Medical Reserve Corp. volunteers who have medical training but are not integrated into planning (including credentialing, training, liability, IMS) (3) • Not enough qualified staff available to care for all special needs populations – particularly at their homes (3) • There is a severe and chronic shortage of healthcare professionals in the NCR (2) • Fire and EMS have a large role in dealing with medical surge (2) • Who is involved with a regional plan for responding to a jurisdictional event? • Virginia Medical Examiner's Office and hospital infection control/triage staff have limited ability to surge • Surge capacity depends on private sector response which may not be available • Need to provide for families of healthcare providers • Patient tracking and sustaining tracking systems like *Essence*
Equipment	S	• PPE has been obtained for employees through HRSA, but still need more (9) • Making headway in meaningful capability expansion (4) • CATI, *Essence,* patient tracking in effect, but requires additional funding (4) • Equipment needed mainly for communication can occur through EOC/NIMS (3) • UASI grant funding of equipment and supplies. Have begun to scratch the surface to put those supplies in place. • Equipment to be able to track people in non-traditional environments • Huge need to connect with people who are isolated/quarantined. Are systems in place, but need to be maintained and grown. • Disease surveillance capability. Utilizing essence. Been in place since around 2004. • Hospitals have approximately 72 hours worth of supplies to sustain normal operations. • Have more major medical educational facilities than other regions. • There has been some increase in the number of hospital beds and labs • The adult detention center in FX is identified as a potential site for alternative care
	W	• Need additional funds to procure equipment to supply critical care medical beds (24) • Need additional storage capacity; must be able to survive on our own for 72 hours. (9) • Need to track patients and equipment. (9) • Regionally lack the physical space to handle large number of patients (6) • Transportation (5) • Need increased capacity for safe storage of remains. (3) • Need to harden hospital facilities to withstand environmental assault, e.g., flood (3) • In worse case scenario have to plan for assistance that comes. Need to identify how would expand beyond your physical space. (2) • We need specific scenario oriented equipment such as burn, chemical, and Mark I kits (2) • Need to in crease maintenance and testing of special HVAC equipment (2) • Have received some funding but only around a million dollars which has provided some equipment, but not enough to meet the need of the area. Have major shortcomings that need to be addressed. • Sustainment and replacement issues. • Medical gases are a limiting factors. • Lab surge. • Physical space requirements for storage/triage/patient overflow for massive flow • Costs of preparedness are astronomical. • Need to keep in mind what constitutes a "bed." • In a CBRNE event would need detection equipment at a hospitals. • Need a system that will allow the tracking of patients no matter where they are until they are released.

Resource	S/W	Comments
		• Need funding for evaluation and validation of this system to determine its efficiency/effectiveness. Will be useful for e.g., pandemic flu, etc. • Supplies are budgeted for 72 hours and for normal operations; unrealistic level of supplies for a crisis. Need to budget for surge and for longer period of time. • Plans do not have contingencies for communications failures. • Have limited if any surge capacity. • Shortage of healthcare personnel in this region. • Will not have capability to build surge capacity • Not aware whether or not medical personnel would be willing/able to assist in medical surge. • Cannot rely national resources to be available. • In national event can't expect federal help. • NDMS etc., need facility for federal resources to work. Will bring resources place., etc • Don't have appropriate infrastructure to mobilize. • Communication capacities for PIO need to be increased. • Need additional PPE equipment. (depending on what the CDC standard is) • DC 211, referral system. People need to be able to find out what to/not to do. Needs to be improved. • Need enhanced communications interoperability, e.g., CBDA, satellite, amateur radio, etc. • Hospital pharmaceutical supplies will expire • Equipment needs to be provided to other "non-hospital" organizations • Lack of NCR Plan/Resources to support decontamination at hospitals • No or limited capability for CBRNE detection at hospitals • Need to increase credentialing capabilities • Lack of logisticians to stockpile medical treatment equipment • Need real time or near real time alerting system (current is 48 hours) • Need technology to support *Essence* • Need to support Special needs population • Need to equip labs (agricultural etc.) to provide medical lab surge • Unaware as to whether equipment can handle constant use
Training	S	• Staff is adequately trained because of their license (5) • WHC has internet based educational system that could be increasingly helpful to all disciplines • Competency based training • Online resources • A lot of training curriculum available
	W	• A standardized training for scenario based training which involves live and web based training with trackeable competency (18) • Staff may not handle mass casualty well because training size and nature is not on that scale (10) • Lack of PPE Training for community MDs and office (7) • Training for medical volunteers (6) • Disaster behavioral health (6) • Training on ESSENCE for public health/hospital personnel (5) • Support of Special Needs Citizens (5) • Training in management and systems for alternate care facilities (4) • Public education (4) • What is needed to support decontamination needs at hospitals (3) • Integration of roles between first responders and health (2) • Hospital/PH-HD/interface (2) • No training model for surge capacity (2) • Training for additional people (2) • Lack of rapid air monitoring for ID of CBRNE attacks and characterization of plans (2) • EMS role of assisting hospitals

Resource	S/W	Comments
		• What will fire department need to support quarantine plan • Training for non-medical volunteers • Need to practice NIMS-incident command • Epidemiological training/surveillance • Training on desired plan practices • No framework for JITT • Assigning local staff and training in roles • Lack of information exchange • Online resources have not been tapped effectively • Need blast fax/contact info • Backfilling staff while they are being trained • Need more creativity in training • Sustainability
Exercises/Evaluation	S	• Currently exercise regularly. (2) • Hospitals are required to train and exercise on an ongoing basis (JACHO). • Value of standardizations • IC is the same no matter the scenario. • Hospitals have twice yearly requirements need. • Northern Virginia military is beginning to consistently include behavioral healthcare. • Planning an exercise for 2006. • Have exercised decontaminations.
	W	• Need more regional, multi-ESF trainings that, among other things, exercises/tests mobilizations, procedures for handling hospital surge outside hospitals, handoff form hazmat to EMS, volunteers, behavioral healthcare abilities, capabilities regarding special needs populations, federal involvement in response, and surveillance systems. (51) • Need to centralize all evaluated weaknesses so that they can be prioritized and addressed. (4) • Hospitals and public health do not practice ICS and NIMS to the same extent as police and fire. (2) • Massive staffing required to conduct a real-time exercise since hospitals operate 24/7. • Need more creative or non-traditional exercise methodology. • Need to fill positions in order to train personnel. • Need a MRC exercise. • Never held a real surge exercise of a significant number of victims to stress the NCR, DOH, EMA, and hospital plans and systems. • Need to institutionalize new HSEEP exercise guidelines. • Exercises should reward identification of deficiencies instead of rewarding success. • Need public awareness campaign. • Need performance metrics related to requirements of electronic systems effectiveness.
Plans, Policies and Procedures	W	• Need to develop integrated plans to include: understanding of HIPAA as it applies to sharing information across agencies or jurisdictions, development of a coordinated public education campaign, coordinate mass transport, addressing legal and credentialing issues, development of mass fatality management plans, surge planning beyond hospitals, incorporation of insurance providers, develop detailed scenario specific plans, include medical examiners in planning. (18) • Family planning for health care providers so that they can come to work (2) • Standards of care decisions under different scenarios need to be developed (major shift for health professionals) • Need to develop plans to help with local implementation of federal orders as they apply to quarantine • Plan to communicate with public on what to expect • Need a gap analysis to identify issues like the need for alternative care facilities and staffing, special populations sheltering, medical care for people in quarantine

NCR Concept Papers and Initiative Plans

CONCEPT PAPER ***Preliminary Document – Presented for Review and Discussion***		January 27, 2006 Sheri Lewis Assistant Program Manager Johns Hopkins University Applied Physics Laboratory 11100 Johns Hopkins Road Laurel, MD 20723 240-228-7604 sheri.lewis@jhuapl.edu	
Project Title:	**National Capital Region Syndromic Surveillance Network (existing project)**	**Estimated Grant Amount**	$2 Million
NCR Strategic Goal Alignment:	3.1.3 Health Surveillance and Detection 3.2.2 Regional Interoperability	**Allowability**	Continuation of existing project
Estimated Timeline	06/01/06 – 12/31/07	**Dependencies and Cost Factors:**	N/A

Problem Statement/Project Description:

As we move forward towards our goal of transitioning the system to our NCR partners, we are requesting continuation funds to continue to operate and maintain the NCR and state-based surveillance sites, improve the sensitivity and specificity, ease of system use, and enhance compatibility with traditional surveillance tools. These capabilities will significantly strengthen the system along with fostering a higher degree of system independence and sustainability, thus aiding in the transition of the system to the jurisdictions.

Stand-alone ESSENCE systems exist in Washington DC, Maryland, and Virginia to receive, house, and make available fully identifiable data to respective local health departments for early event detection. A central integrated node was built and hosted at the JHU/APL so that regional surveillance nodes could transmit de-identified data for aggregation and viewing at the cross-jurisdictional level. As proposed, this system was built and a fully operational NCR Syndromic Surveillance Network was deployed and has been continuously available since the summer of 2004.

While much needed work has been performed under the FY '03 and FY '05 monies, many of the efforts have gone into needs assessments for the region and then appropriately addressing the complex requirements of the region – such as developing regional views, modifying existing algorithms for a regional perspective, coordinating regional response, determining how to share information with data providers (i.e. hospitals) etc. FY '05 monies are currently being used to continue the development of these tools to meet the region's unique needs – such as the development of communication tools, tailored training materials, etc.

Now that the NCR SSN has a solidified structure, the needs have shifted to strengthening the system. This will include evaluation and validation studies that direct the classification and utilization of data, tools to improve the ease of operations, and additional refinements to ensure that the NCR has the most up-to-date disease surveillance capability for CBRNE detection of not only of bioterrorism agents but also communicable diseases and emerging infectious diseases, such as pandemic influenza.

Preliminary Project Plan (Tasks, Resources, Deliverables, Collaborating Partners, etc.)

Task(s)	Owner(s) or Collaborating Partners	Deliverable(s)	Target Date(s) or Level of Effort
1. Continue system maintenance and upgrades	JHU/APL	N/A	Ongoing throughout the project
2. Evaluation/Validation Studies	JHU/APL and NCR Health Departments	Presentations and publishable manuscripts	Ongoing throughout the project

3. Traditional and Syndromic Data Integration	JHU/APL and NCR Health Departments	Presentations and added features/functionality to ESSENCE	Summer of '07
4. Simulation Framework	JHU/APL and NCR Health Departments	Stand-alone tool to generate simulated data with the ability for use on a simulated exercise web site	Spring '07 for the purposes of data generation for the spring exercise
5. Remote Data Capture	JHU/APL and NCR Health Departments	Added functionality to ESSENCE	Summer '07 for the purpose of exercising the tool in the Fall of '07
6. Event Communication System (Phase II)	JHU/APL and NCR Health Departments	Finalized communication tool	Spring '07 for the purpose of exercising the tool in late Spring '07
7. User Preferences System (Phase II)	JHU/APL and NCR Health Departments	Ability for users to customize the surveillance system for individual needs	Spring '07 for the purpose of exercising the tool in late Spring '07
8. IT Strengthening	JHU/APL and NCR Health Departments	Install tools and added system functionality	Ongoing throughout the project
9. Algorithm Strengthening	JHU/APL and NCR Health Departments	Added features/functionality to ESSENCE	Ongoing throughout the project

Project Performance Measures	**Baseline Value**	**Target Value**
1. Exercises	0	2 exercises
2. Simulation Framework Tool	Non-existent	Stand alone tool
3. Ability for remote data capture	Non-existent	New feature
4. Evaluation / Validation Studies	0	4 manuscripts
5. ESOG Meetings	Bi-monthly	TBD

INITIATIVE PLAN

National Capital Region
Syndromic Surveillance Network (ESSENCE)

1. Provide the Name of this Initiative. Describe how this Initiative will address the priority needs and strengths identified through the program and capability evaluation, and prioritization analysis.

National Capital Region Syndromic Surveillance Network (ESSENCE)

- The disease surveillance system is consistent with the National Preparedness Priorities to Strengthen Information Sharing and Collaboration Capabilities, Strengthen CBRNE Detection Response and Decontamination Capabilities, and Strengthen Medial Surge and Mass Prophylaxis Capabilities

2. Regional Construct: Briefly describe the geographical context of this Initiative.

This system is currently in use in Maryland, Virginia, and the District of Columbia. Each state has its own ESSENCE system behind their firewall which enables the capture of any data desired by the health department. Additional data that is captured regionally by JHU/APL is sent to each node. Then the health departments' systems aggregate and de-identify data for incorporation into a regional node which is a site that all three states can log into and view health data for the region.

3. Resources, Processes, and Tools: Identify the resources, processes and tools that already exist, and those that will need to be leveraged, created, or acquired for this Initiative. Briefly consider how these resources, processes and tools may be attained.

The equipment for the system is already in place at both JHU/APL and the health departments, there is connectivity between the health departments and hospitals, and response protocols are being developed. This project is a continuation of work funded since April 2004. The FY '06 work plan, outlined by our Enhanced Surveillance Operating Group (ESOG), a collaborative body comprised of the Johns Hopkins University Applied Physics Laboratory (JHU/APL) and the NCR Public Health community, includes funds to: 1.) continue the transition of ESSENCE to the local public health entities 2.) reduce the noise generated by the data and improve detection capabilities 3.) merge traditional surveillance data with syndromic surveillance data 4.) provide remote data visualization and entry 5.) create a simulation framework to enable scalable exercises 6.) provide training opportunities at the local level, 7.) strengthen IT capabilities.

4. Governance Structure: Describe the high-level governance structure (e.g., management plan, stakeholder involvement) required for successful implementation of this Initiative.

A collaborative body was created during the first year of this project. The Enhanced Surveillance Operating Group (ESOG) is comprised of representatives from both state and local health jurisdictions as well as technical representatives from JHU/APL. There is a chair appointed by the MWCOG Health Officials Committee who, in turn, is responsible to the Chief Administrative Officers Committee and the Senior Policy Group of the NCR. The hospital collaborative groups of each jurisdiction are routinely updated on the status of the system. A Data Sharing Agreement is in place between Maryland, Virginia, the District of Columbia, and JHU/APL to facilitate data sharing for the system. While JHU/APL maintains the central system node, each health department is responsible for the maintenance of their individual node, as well as day-to-day monitoring of both state and regional systems.

5. Program Management: Explain how this Initiative relates to the overall State homeland security program, and/or how it helps incorporate the three Overarching National Priorities.

This system directly relates to the three overarching National Priorities:

1. Implement the National Incident Management and National Response Plan

The ESSENCE system can be utilized by public health professionals during an incident, whether local or national, to help monitor the health's community as well as manage the public health response as need be.

2. Expanded Regional Collaboration

The NCR's disease surveillance capability is coordinated across the region. Maryland, Virginia, DC, and JHU/APL have all signed a data sharing agreement allowing aggregated data for all regions in the NCR to be shared across the regional node of the system. Similarly, regional response plans for disease surveillance are in the development stages.

3. Implement Interim National Infrastructure Protection Plan

The NCR Syndromic Surveillance Network supports the National Infrastructure Protection Plan in that it provides for the early detection of emerging infectious disease, either naturally occurring or manmade. Enabling early detection potentially limits the morbidity and mortality experienced by a community, thus in effect protecting the infrastructure.

The project is related to the following Priority Capabilities and further information can be provided upon request:

- Information Sharing and Dissemination
- Interoperable Communications
- CBRNE Detection
- Mass Prophylaxis and Medical Surge

CONCEPT PAPER ***Final*** ***CONTINUATION OF USAI FUNDED PROJECT***		January 22, 2006 Kathy J. Hurt-Mullen, MPH Senior Epidemiologist Montgomery County Department of Health and Human Services (240) 777-1643 Kathy.Hurt-Mullen@MontgomeryCountyMD.gov	
Project Title:	**Regional Implementation of Computer-Assisted Telephone Interview Capacity (CATI)**	**Estimated Grant Amount**	*$800,00 Total* *$600,000 hardware, software and telecommunications equipment* *$200,000 operating and program management*
NCR Strategic Goal Alignment:	*Strengthen medical surge* *Strengthen interoperable communications*	**Allowability**	**N/A**
Estimated Timeline	*Feb 2007 – March 2008*	**Dependencies and Cost Factors:**	Common platforms are needed to link NCR regions. Cost is dependent on adapting protocols to dissimilar telecommunications not knowing other network infrastructures.
Problem Statement/Project Description: Continuation of funding is required to expand the capacity being developed in the FY-2005 CATI Demonstration Projection. Isolation and quarantine management requires the automated support for placement and management of telephone calling,			

administration of individual-specific questionnaires and production of progress summaries to facilitate understanding of health status, compliance issues and administrative concerns. CATI usage will reduce hospital surge by enabling exposed persons to be managed at home and avoid seeking emergency department care. The cross-jurisdictional nature of commuting patterns in the National Capital Region require implementation of systems that will make information available to government officials and staff in multiple jurisdictions in a seamless manner. Continuation of the Demonstration project will allow for more complete elucidation of the individual technology and communication environments, as well as information sharing policies and agreements across these boundaries.

The funds requested will be utilized for planning the expansion of the Demonstration resources to additional jurisdictions and allow a complete understanding of the costs and staffing required to complete the implementation. Thorough planning is required in order to ensure the compatibility of resources and support of all involved governmental agencies.

Preliminary Project Plan (Tasks, Resources, Deliverables, Collaborating Partners, etc.)

Task(s)	Owner(s) or Collaborating Partners	Deliverable(s)	Target Date(s) or Level of Effort
1. Inventory current telecommunications and information technology resources in each NCR jurisdiction	All NCR jurisdictions, including partners in appropriate State (MD, VA, DC) agencies	Compiled inventory of all relevant resources and summary of compatibility assessment/challenges	First quarter completion
2. Complete jurisdiction-specific workplans for implementation of the CATI system, including project staffing needs	All NCR jurisdictions, including partners in appropriate State (MD, VA, DC) agencies	Written plans for implementation of NCR-CATI system which considers the information technology environment and administrative structure of each NCR jurisdiction	Two quarter completion
3. Evaluate connectivity resources available to support cross-jurisdictional access	Montgomery County, MW-COG NEIC	Selection of most efficient and appropriate connectivity resources (e.g., internet, microwave, etc)	Third quarter completion
4. Implement solutions based on above outcomes that will result in at least 70% of the NCR population served by a CATI system	NCR jurisdictions	Integrated turn key CATI solution	Fourth quarter completion

Project Performance Measures	Baseline Value	Target Value
6. Number of NCR jurisdictions for which completed surveys of telecommunication and information technology resources are obtained	1	3 States 7 counties
7. Number of jurisdiction specific work plans for NCR-CATI implementation	0	3 States 7 Counties
8. Staffing requirements for NCR-CATI implementation (plan)	0	1
9. Hardware and software requirements for NCR-CATI implementation (plan)	0	1

INITIATIVE PLAN

Regional Implementation of Computer-Assisted Telephone Interview Capacity (CATI)

1. **Provide the Name of this Initiative. Describe how this Initiative will address the priority needs and strengths identified through the program and capability evaluation, and prioritization analysis.**

   Computer Assisted Telephone Interviewing (CATI) systems will take a step by step approach to adapt to existing telecommunications infrastructure using in most cases commercial off the shelf software. Interconnectivity can be achieved by a common internet protocol platform that will allow NCR jurisdictions the ability to security share and access each others data.

   CATI expedites and augments staff time in the event of a mass quarantine or other shelter in place emergency. The ability for the health professional to focus on multiple tasks while being helped with phone dialing, record keeping, decision tree support and interacting with patient history at the point of contact allow staff to concentrate on collecting current valuable data. It also affords the telephone operator the needed information in the form of questions during high stress times.

2. **Regional Construct: Briefly describe the geographical context of this Initiative.**

   The geographical context of this initiative is the National Capital Region, i.e. The District of Columbia; the Virginia jurisdictions of: Alexandria, Arlington, Fairfax, Prince William, Loudon; the Maryland jurisdictions of Montgomery and Prince Georges

3. **Resources, Processes, and Tools: Identify the resources, processes and tools that already exist, and those that will need to be leveraged, created, or acquired for this Initiative. Briefly consider how these resources, processes and tools may be attained.**

   Network Technology experts and telecommunication consultants will augment existing county disciplines to implement these turn key solutions. Currently, the only process that exists for the proposed activity is to call quarantine individuals and track them in a database. Each jurisdiction would do this, on their own, with no sharing of information. We would leverage existing telecommunication platforms and network infrastructures at the jurisdiction level to connect call takers to computers and each other. To accomplish this project team would look to leverage existing bandwidth and if not sufficient look to ways to implement cost effective options.

4. **Governance Structure: Describe the high-level governance structure (e.g., management plan, stakeholder involvement) required for successful implementation of this Initiative.**

   Montgomery County manages the project. Local public health jurisdictions have indicated willingness to become CATI enabled. The Health Officials Committee and its subcommittee of Biological Emergency Planners (BEPS) will exercise oversight and provide guidance

5. Program Management: Explain how this Initiative relates to the overall State homeland security program, and/or how it helps incorporate the three Overarching National Priorities.

This initiative is directed toward making it possible to meet the requirements of the Overarching National Priorities by expanding regional collaboration and enabling a regional response to threats. This advances the Interim National Preparedness Goal.

CONCEPT PAPER ***Final***		January 24, 2006 Donald Shell, MD, MA Acting Deputy Health Officer Prince George's County Health Department 1701 McCormick Drive Suite 200 Largo, MD 20774 301.883.7834 dshell@co.pg.md.us	
Project Title:	**Gap Analysis for Health and Medical Readiness-Part 2, A Continuation Project**	**Estimated Grant Amount**	*$125,000*
NCR Strategic Goal Alignment:	*Goals 1&2 planning and decision making to enhance transparency, community engagement, and communication* *Goals 3&4 prevention & mitigation, NCR collaboration and plan modification based on gaps analysis*	**Allowability**	*[See instructions to confirm allowability; attach separate sheet if necessary]*
Estimated Timeline	*Coordination - Region-wide risk assessment framework, determination of public/private vulnerabilities (2 months)* *Communication – evaluate strategic communication plan, ESF/ SPG/CAO linked decision making, assessment of standardized alert notification, and long-term recovery issues (4 Months)* *Collaboration - Evaluate stakeholder involvement and agreement, NCR oversight and accountability (2 Months)* *Plan - Incorporation of lessons learned, real time emergent incidents, media partnership in NCR, methods of public emergency information dissemination, presence of public and individual preparedness plans (4 months)*	**Dependencies and Cost Factors:**	*Personnel*

Problem Statement/Project Description:

The National Capital Region's ability to regionally collaborate in the implementation of the National Incident Management System, National Response Plan, and the National Infrastructure Protection Plan must be evaluated. The Gap Analysis for Health and Medical Readiness continuation project will evaluate the NCR's capacity to provide medical care and or mass prophylaxis to a surge in the number of NCR residents requiring triage, treatment, health advice or direction in the event of a health threat confronting the NCR. The NCR's current capability to share information, collectively disseminate information, and collaborate in the utilization of resources must be analyzed. The NCR's competence in responding to the early detection of chemical, biological, radiological, nuclear, and or explosive (CBRNE) threats with timely interoperable law enforcement, public health, hospital, private healthcare providers, and Fire/EMS communications must be established. The Gap Analysis for Health and Medical Readiness continuation project will build on work done in preparing the Surge Capacity Concept of Operations, which describes the coordination structure for surge response. By reviewing and researching national and state standards and protocols, the Gap Analysis for Health and Medical Readiness continuation project will identify where either planning and or implementation breaches exist in the NCR's capacity and capability to meet the goals outlined in the National Priorities and Priority Target Capabilities. Recognition of NCR mass care shortcomings is ultimately required. Total project time 12 months.

Preliminary Project Plan (Tasks, Resources, Deliverables, Collaborating Partners, etc.)			
Task(s)	**Owner(s) or Collaborating Partners**	**Deliverable(s)**	**Target Date(s) or Level of Effort**
1. Region-wide risk assessment framework	Prince George's County Health Department, COG	Document	September 1, 2006
2. Determination of public and private vulnerabilities	Prince George's County Health Department, COG	Document	September 1, 2006
3. Identify ESF/ SPG/CAO decision making process	Prince George's County Health Department, COG	Document	January 1, 2007
4. Assessment of NCR alert notification	Prince George's County Health Department, COG	Document	January 1, 2007
5. Identify long-term recovery issues	Prince George's County Health Department, COG	Document	January 1, 2007
6. Evaluate NCR strategic communication plan	Prince George's County Health Department, COG	Document	January 1, 2007
7. Evaluate stakeholder involvement and agreement	Prince George's County Health Department, COG	Document	March 1, 2007
8. Review NCR oversight and accountability 9. Document lessons learned, real time emergent incidents, media partnership in NCR, methods of public emergency information dissemination, presence of public and individual preparedness plans	Prince George's County Health Department, COG	Document	March 1, 2007 July 1, 2007

Project Performance Measures	Baseline Value	Target Value
1. NCR regional gaps coordinated assessment		
2. NCR regional gaps communication development		
3. NCR regional gaps increased collaboration		
4. NCR regional gaps planning		

Dependencies and Cost Factors:

	Rates
• Principal Lynn L Frank	$125/hour
• Senior Advisors subject matter experts as needed	$75/hour
• Senior Editor	$55/hr

Estimate of Time and Cost		
Lynn Frank, Principal	**Hours**	**Cost**
6 meetings at COG at 4 hrs each	24 hours	
6 specialty meetings at 4 hour each	24 hours	
Assessing progress, reviewing team comments, phone calls, email response	60 hours	
Conference calls with team members ,chairperson and contract manager devoted to assuring project is meeting expectations of committee and contract manager	18 hours	
Research and report analysis of conflicting indicators and our benchmarks, review State and local plans	150 hours	
Direct specific tasks associated with subject matter experts, as directed by SPT	90 hours	
Total hours	366	
Total compensation for hours at $125/hour		**$45,750**
Senior Editor, Martha Rosacker		
Manage project	200 hours	
Research medical surge benchmarks, standards, indices	233 hours	
Compile gap analysis	400 hours	
Attend 7 SPT meetings at COG (may be different meetings from principal)	28 hours	
Edit all documents—Benchmarks, Gap Analysis, and various interim documents	230 hours	
Total hours	1,090	
Total compensation for hours at $55/hour		**$60,005**
Subject Matter Experts		
Specific Consultation to clarify specialty medical capabilities	70 hours	
Specialty analysis of conflicting standards or indicators	80 hours	
Clarification of credentialing of medical staff	20	
Clarification of technical legal issues as directed by the committee	20	
Total hours	190	
Total compensation for hours at $75/hour		**$14,250**
Travel		**$4,995**
Combination of car at Federal rate of 37.5 cents/mile, Metro, taxis, train, etc for attendance at relevant meetings and conference/ training sessions targeted to medical benchmarking and analysis		
Total		**125,000**

INITIATIVE PLAN

Gap Analysis for Health and Medical Readiness-Part 2, A Continuation Project

1. **Provide the Name of this Initiative. Describe how this Initiative will address the priority needs and strengths identified through the program and capability evaluation, and prioritization analysis.**

   "Benchmarks and Gap Analysis for Health and Medical Readiness (Part 2 of Surge Planning)" Donald Shell, MD, MA Prince George's County Health Department

   The National Preparedness Guide identifies eight Critical Capabilities that must be developed and maintained in the health arena. We propose to begin an analysis of the region's status regarding those critical capabilities. The Priority Capabilities included in the proposed gap analysis include:

   Coordination - Region-wide risk assessment framework, determination of public/private vulnerabilities

   Communication – evaluate strategic communication plan, ESF/ SPG/CAO linked decision- making, assessment of standardized alert notification, and long-term recovery issues

   Collaboration - Evaluate stakeholder involvement and agreement, NCR oversight and accountability

   Plan - Incorporation of lessons learned, real time emergent incidents, media partnership in NCR, methods of public emergency information dissemination, presence of public and individual preparedness plans

   The Surge Planning Team will build on work done in preparing the Surge Capacity Concept of Operations, which describes the coordination structure for surge response. During the writing of that document, the team saw a need to identify appropriate standards that can be applied to the unique multi-jurisdictional NCR. The region needs to research standards and protocols, find the ones that apply in this regional situation, and then check to see where the region falls short in both planning and implementation capacity and capability.

2. **Regional Construct: Briefly describe the geographical context of this Initiative.**

   The regional construct will include the entire NCR, including the capability of the regions jurisdictions as a part of their statewide capabilities.

3. **Resources, Processes, and Tools: Identify the resources, processes and tools that already exist, and those that will need to be leveraged, created, or acquired for this Initiative. Briefly consider how these resources, processes and tools may be attained.**

   This is part two of surge planning. Part 1 was the NCR Surge Capacity Concept of Operations. The Surge Planning Team was established by the SPG to develop a Surge Capacity Plan inclusive of Emergency Medical Services, medical care (especially hospitals) and Public Health. This team, consisting of representatives of states and district public health and EMS, hospitals, medical societies and local public health, has been working together since summer of 2004 supported by Lynn Frank (a former local health director) and COG staff. Federal guidelines, and state and local plans exist in various formats and varying detail, but need to be adapted to provide the regional plan requested by

the SPG and expected by the Federal government. The services of the consultant, Lynn Frank, need to be obtained to continue her support for the surge team. The participants will continue to obtain input, feedback, and buy-in from their discipline areas. This is essential to the success of the plan.

The consultant will work with the Surge Planning Committee to

- Research the most up-to-date standards, benchmarks and indices for regional health and medical surge planning
- Choose or adapt those most appropriate for this unique multi-jurisdictional region
- Determine the region's status in relation to these benchmarks, measuring the gaps between the benchmarks and the region's current readiness

Two documents will result from this yearlong collaborative project:

- A set of benchmarks for the region
- An analysis of the gaps between the benchmarks and the reality

Both of these documents will help to inform funding and allocation decisions throughout the region.

4. Governance Structure: Describe the high-level governance structure (e.g., management plan, stakeholder involvement) required for successful implementation of this Initiative.

The surge planning effort is under the governance of the SPG and is led by the appointed state representatives, who have asked the Health Officials Committee to provide a chairman. Additional members come from the 4 main discipline areas of EMS, Hospitals, Medical Societies and Local Public Health. Final approval of plan(s) involves the state health departments, SPG and local jurisdictions' health departments and CAOs. Logistics of the Surge Team work, including Ms. Frank's contract is managed by COG at the request of the SAA.

5. Program Management: Explain how this Initiative relates to the overall State homeland security program, and/or how it helps incorporate the three Overarching National Priorities.

Benchmarking and Gap Analysis are important to *Planning*, especially in the health and medical arena, since they are new to the emergency preparedness process. The Homeland Security Target Capability Areas addressed by this project include *Triage and Pre-Hospital Treatment, Isolation and Quarantine*, and *Medical Surge*. This initiative also addresses the target areas of *Critical Resource Logistics and Distribution*, *Mass Prophylaxis* and *Responder Safety*.

Planning, Medical Surge, and Mass Prophylaxis are three of the 15 priority capabilities for the NCR. Among the NCR "Priority Initiatives" listed for the NCR Strategic Plan is 1.3.2 *Prepare Comparative Gap Analysis.* This project addresses the health and medical piece of that initiative.

CONCEPT PAPER

Final

January 23, 2006

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Project Title:	**Raising Public Awareness for Public Health Emergencies: Going Beyond Mass Media for Message Dissemination**	**Estimated Grant Amount**	*$250,000*
NCR Strategic Goal Alignment:	*Goal 2, Community Engagement, Objectives 1,,3,4* *Emergency information targeting "special needs", Increase civic involvement in all levels of emergency preparedness, and targeted outreach to visitors to the NCR, through advertising.*	**Allowability**	*[See instructions to confirm allowability; attach separate sheet if necessary]*
Estimated Timeline	*Spring 2006-Spring 2007*	**Dependencies and Cost Factors:**	*[Attach via separate sheet if necessary]*

Problem Statement/Project Description:

Health Officials in the National Capital Region are concerned that specific health messages need to be communicated to the public in advance of any type of public health emergency. It is difficult to penetrate public consciousness on targeted health and hygiene messages using solely mass media. The public needs a greater level of understanding and awareness of these important health issues so that there will be a greater level of compliance with health authorities, hopefully limiting spread of illness, during times of public health emergencies such as outbreaks of communicable disease.

Many of the issues that surround protection of public health, including when to/not to use a mask for protection (what type of mask to use), when/how long to stay home from work/school/daycare, or how to take care of a patient confined at home (when hospitals are full) are not easily relayed to target audiences through mass media. They typically will use our messages only in times of crisis, not in advance. At these times, fears and emotions would be heightened and messages not be clearly understood or followed. Securing pre-event information channels, such as advertising in journals, newspapers, and magazines would help fulfill this important niche. Additionally, educational forums, designed to bring about greater citizen participation in health emergency response plans are another good way of educating, without relying on mass media to deliver important information.

While there have been some national dialogue sessions on pandemic flu, health information officers would like to plan additional dialogues here in the National Capital Region, with a focus on the many diverse communities here. Health PIOs work closely with County/City level PIOs and agencies to organize these events. Also, health officials need to know precisely how populations are receiving their health emergency information now. Our hotlines are not currently equipped to handle medical questions in various languages, for example. An assessment needs to be conducted on how health officials can best deliver their messages to targeted population across the region.

Preliminary Project Plan (Tasks, Resources, Deliverables, Collaborating Partners, etc.)

Task(s)	Owner(s) or Collaborating Partners	Deliverable(s)	Target Date(s) or Level of Effort
1. Health information officers will assess which contractors have capability/expertise to support this multi-layered effort of research,	NCR Health Information Officers	CONTRACTOR IDENTIFIED	May, 2006

template preparation, and multi-cultural audience forum generation.			
2. Health information officers will serve as guidance and oversight for compiling materials and information/expertise for local information forums.	NCR Health Information Officers, County/City PIOs, Contractor	Materials for local information forums completed	Oct. , 2006
3. Depending upon research, there could be as many as three forums held in the National Capital Region to seek public input, as well as share health information messages.	Contractor/Health PIOs	3 Forums Completed	December, 2006
4. Secure channels of communication for health message dissemination, beyond mass media. This may include, but may not be limited to, paid advertising in journals, magazines, and newspapers.	Contractor/Health PIOs	MOU/contract with mass media secured	August, 2006

Project Performance Measures	**Baseline Value**	**Target Value**
1. Health information officers will coordinate and oversee three public forums, as described above.		
2. Health information officers will identify and produce appropriate public information materials addressing public health topics surrounding emergency preparedness for several specific ethnic groups in the National Capital Region, in the appropriate languages.		
3. Health information officers will oversee purchase of advertising space in appropriate journals, newspapers, and magazines that cover the National Capital Region; to be identified.		
4. Health information officers will work closely with public information officers in RESF 14 in coordinating public health messages for citizen preparedness and secure health message channels through all appropriate agencies within county/local governments. Health messages will be inserted into any regional Citizen Preparedness campaign.		

INITIATIVE PLAN

Raising Public Health Awareness for Public Health Emergencies: Going Beyond Mass Media for Message Dissemination.

1. Provide the Name of this Initiative. Describe how this Initiative will address the priority needs and strengths identified through the program and capability evaluation, and prioritization analysis.

Raising Public Health Awareness for Public Health Emergencies: Going Beyond Mass Media for Message Dissemination. There is difficulty reaching the general public with common-sense health messaging and this has been identified as a weakness by ESF-08, the Health and Medical Subcommittee of Council of Governments.

2. Regional Construct: Briefly describe the geographical context of this Initiative.

This project will encompass all Cities, Counties, and municipalities across the National Capital Region, i.e. Alexandria, Arlington, Fairfax, Loudoun, Prince William, D.C., Montgomery, Prince Georges among the largest.

3. Resources, Processes, and Tools: Identify the resources, processes and tools that already exist, and those that will need to be leveraged, created, or acquired for this Initiative. Briefly consider how these resources, processes and tools may be attained.

Resources already existing include public information officers assigned to support public health messaging for their local and state health departments, in addition to support from federal agency information officials and those assigned to support local governments. We work closely on numerous issues and have formed a Health PIO committee where we convene to discuss issues of mutual concern, and plan to address regional challenges based on needs of the region. We have worked closely with county PIOs on the Citizen Education Campaign for emergency preparedness, and have numerous contacts with capable contractors in the region who are experts in emergency risk communications. These county PIOs will be invaluable to us as we proceed to address the many "special populations" in their communities with pre-event health messages, described in our proposal. Also, we work closely with PIO officials in the transportation industry, which will be valuable in targeting advertising to visitors to the region with emergency preparedness messages.

4. Governance Structure: Describe the high-level governance structure (e.g., management plan, stakeholder involvement) required for successful implementation of this Initiative.

The Health PIOs will serve as the lead action group for these initiatives. They will update the Health Officials Committee of the Council of Governments, as well as the local PIOs, on actions taken, progress made, and products delivered. Health PIOs will also work with a local contractor, to help guide efforts in special population identification and needs assessment.

5. Program Management: Explain how this Initiative relates to the overall State homeland security program, and/or how it helps incorporate the three Overarching National Priorities.

It is critical that health messages be delivered to the public in a timely manner in order that individuals may take appropriate protective actions. While mass media is one important avenue, health officials must not rely on media to deliver pre-event information and education regarding communicable disease, pandemic flu, and other public health emergencies. With current resources, officials are not sure how "special populations" are receiving their information now. Work needs to be done to find out, then develop and refine these communications channels so that they'll work for both routine health information matters that may affect a targeted population, as well as the urgent public health crisis, where every second counts.

Among the goals and national priorities are: Creating an informed and prepared community for those who live, work, or visit the NCR. These initiatives will help further this goal, as well as to engage the public in our plans so that they are better understood, and (hopefully) supported.

CONCEPT PAPER ***Final Document***		January 24, 2006 34 hospitals of the National Capitol Region (DCHA, NVHA, Maryland Hospital Collaborative) Jeffrey A. Elting, M.D., M.P.H. Patricia Hawes, RN, BSN, COHN Martin R. Breen 1250 Eye Street NW #700 Washington, DC 20005 jelting@dcha.org 202-289-4927	
Project Title:	**UASI FY 06 Medical Surge**	**Estimated Grant Amount**	**$4,700,000**
NCR Strategic Goal Alignment:	**Medical Surge - *Goal 4:* A sustained capacity to respond to and recover from "all-hazards" events across the NCR-**	**Allowability**	**Yes**
Estimated Timeline	**April 2006 to January 2008**	**Dependencies and Cost Factors:**	**See below**

Problem Statement/Project Description:

NCR hospitals have a baseline of approximately 8000 operational beds, which are operated at near full capacity without significant surge capability. In 2004 and 2005, UASI funds totaling $6 million were used to increase NCR medical surge capacity so that, during a major disaster, the region can provide healthcare for an additional 1000 acute medical patients above the baseline capacity. Nevertheless, there is still a critical shortfall (capability to care for 2000 patients) in hospital medical surge capacity in the NCR and current federal guidelines are not met. Therefore, the region's 34 hospitals will increase medical surge capacity so that definitive medical care can be provided for the residents of the National Capital with a focus on increasing the NCR hospital **capability to care for an additional 500 acute patients** who require hospitalization ($3 million). Additionally, improvements in medical surge capacity will require **concurrent upgrades in hospital detection, triage, decontamination, isolation, critical hospital infrastructure, medical stockpiles, citizen/staff education, security, transportation, and communications** ($1.7 million). This project will enable the NCR to achieve an acute care medical surge capacity that is greater than 50% (1500/3000) of the federal requirement.

Dependencies and Cost Factors: The NCR population is predicted to grow a minimum of 2% during 2006 and beyond such that the estimated NCR daytime population is 6 million residents. This application uses Department of Defense, regional sub-specialty medical expert (e.g. burn), and national healthcare association (e.g. American Hospital Association) tables of supplies and equipment, capacity, and cost estimates. This is a multi-year endeavor, and either additional funding of $9 million, this year or in subsequent years, will be required if the NCR is to meet their target capability requirement. Additionally, it is estimated that specialty (burn, trauma and other intensive specialty care) capacity improvements will require additional resources and funding, because specialty care (e.g. burn care, radiation injury treatment) is extremely resource intensive.

The federal requirements specify the following minimum capabilities: Triage treatment and initial stabilization, above the current daily capacity, for the following classes of adult and pediatric patients requiring hospitalization within three hours in the wake of a terrorism incident or other public health emergency: • 500 cases per million population for patients with symptoms of acute infectious disease – especially smallpox, anthrax, plague, tularemia and influenza • 50 cases per million population for patients with symptoms of acute botulinum intoxication or other acute chemical poisoning – especially that resulting from nerve agent exposure • 50 cases per million population for patients suffering burn or trauma • 50 cases per million population for patients manifesting the symptoms of radiation-induced injury – especially bone marrow suppression. Additionally, there is a need to have psychiatric care for 5000 per million of population.

Preliminary Project Plan (Tasks, Resources, Deliverables, Collaborating Partners, etc.)			
Task(s)	**Owner(s) or Collaborating Partners**	**Deliverable(s)**	**Target Date(s) or Level of Effort**
1. Hospitals will conduct floor space analyses of hospital areas and adjacent buildings with a focus on optimizing the use of already available staff, space, and equipment while identifying needs for infrastructure improvements and the extension of care to nearby alternative fixed facilities	Hospitals	Hospital plans for maximizing the utilization of current fixed facilities and expansion to adjacent facilities. Identification of equipment and medication needs. Memorandums of Understanding and other sharing agreements will be refined in order to maximize the use of the increases in medical surge capacity across the region	December 2006
2. Procure equipment, supplies, and medications	Hospitals	Attain the capacity to provide acute medical care for an additional 500 patients and achieve a total capacity of 1500 or 50% of the acute care capacity required by federal standards	January 2008
3. Make infrastructure improvements to support the increase in medical surge capacity	Hospitals	Upgrade hospital CBRNE detection, decontamination, prophylaxis, facility security, isolation, citizen/staff education, infrastructure, and communications capabilities so that acute medical care can be provided in an all hazards environment.	January 2008
Project Performance Measures		**Baseline Value**	**Target Value**
Medical Capacity to care for 500 more patients		1000	1500
Multi-year goal of 2000 more patients	An additional $9 million requirement not included in FY 2006 budget	1000	3000

INITIATIVE PLAN

UASI FY 06 Medical Surge

1. **Provide the Name of this Initiative. Describe how this Initiative will address the priority needs and strengths identified through the program and capability evaluation, and prioritization analysis.**

   Medical Surge
   This project will enhance the sustained capacity to respond to and recover from "all hazards" events across the NCR by improving medical surge capacity at the site of definitive healthcare (hospitals).

2. **Regional Construct: Briefly describe the geographical context of this Initiative.**

   This is a regional project, which strengthens the medical surge response in 34 hospitals, which are geographically located in 3 states and 23 jurisdictions defined as the National Capital Region. The Federal government and its employees located in the NCR will also be beneficiaries of this program. Medical surge is a broad based capability transcending specific jurisdictions and forms the composite basis of the regional response. DC, MD and Northern Virginia combine resources to respond and support each other in the NCR.

3. **Resources, Processes, and Tools: Identify the resources, processes and tools that already exist, and those that will need to be leveraged, created, or acquired for this Initiative. Briefly consider how these resources, processes and tools may be attained.**

   The National Capital Region's has 34 licensed and accredited hospitals and the District of Columbia Hospital Association, the Northern Virginia Hospital Alliance, and the coalition of suburban Maryland hospitals/Prince Georges County Department of Health already have a solid track record of working closely together to improve hospital medical surge capability. A Mutual Aid Memorandum and a communication system between hospitals have already been developed and there are tested linkages between the private hospitals and the public health officials throughout the NCR.

4. **Governance Structure: Describe the high-level governance structure (e.g., management plan, stakeholder involvement) required for successful implementation of this Initiative.**
   Hospital Chief Executive Officers with the assistance of their Emergency Preparedness staff are responsible for the successful implementation of this project at the hospital level. The respective state hospital organizations (District of Columbia Hospital Association, Northern Virginia Hospital Alliance, and Montgomery county/Prince Georges Hospital Collaborative) jointly serve as subgrantees and oversee the project. The Senior Policy Group of designated senior leaders from the three states with input from the jurisdictional Administrative Officers provides the strategic guidance for the project.

5. **Program Management: Explain how this Initiative relates to the overall State homeland security program, and/or how it helps incorporate the three Overarching National Priorities.**
   This project directly improves national **Response** capability by increasing medical surge capacity in the nation's capital. Specifically, it addresses:
   Res.C.1 3.3.2 Provision of emergency medical and dental care.

Res.C.1 3.3.8 Provide medical equipment and supplies in support of immediate medical response operations and for restocking health care as requested.
Res.C.1 4.2.2 Activate health care workers and volunteers call systems.
Res.C.1 4.2.4 Mobilize burn/trauma/pediatric health care specialists.
Rec. A.1 1.4.4 Execute medical mutual aid agreements.
Rec. A.1 3.1.1.2 Provide counseling support. (psychiatric hospitals)
Res. A.1 3.1.1.3 Provide family support services.
Rec. A.1 3.1.1.4 Provide for worker crisis counseling and mental health and behavioral health support. (psychiatric hospitals)
Res. C.1 3.3.3.3 Establish alternate emergency care sites/over-flow emergency medical care facilities to manage hospital surge capacity concerns.
Res. C.1.3.1.1.2.2 Ensure Comprehensive stress management strategies and programs are in place and operational for all emergency responders and workers. (psychiatric hospitals)

CONCEPT PAPER ***Final***		January 23, 2006 Yuri Millo, MD Director, Simulation and Training Environment Lab Washington Hospital Center 110 Irving Street NW, NA 1177 Washington, DC 20010 202-877-5200 yuri.millo@medstar.net	
Project Title:	**Hospital Disaster Life Support (HDLS)**	**Estimated Grant Amount**	*$250,000*
NCR Strategic Goal Alignment:	Surge Capacity, Mass Prophylaxis	**Allowability**	*Submitted courses to the ODP for non-SLGCP approval*
Estimated Timeline	*Start Date: July 2006, End Date: July 2007*	**Dependencies and Cost Factors:**	*See attachment*

Problem Statement/Project Description:

Currently there is no standardized course of instruction or continuing education exercise presentations for hospitals in the NCR. Individual efforts at training and exercises and time consuming, costly, and don't promote regional problem solving. The HDLS course will provide the opportunity for hospital and public health personnel to learn the principles of incident command and emergency response and work with one another to resolve three functional exercises. This is one of 4 continuing education programs included in the Methods and Materials for Increasing National Capital Region Hospital and Public Health Emergency Preparedness.

Preliminary Project Plan (Tasks, Resources, Deliverables, Collaborating Partners, etc.)

Task(s)	Owner(s) or Collaborating Partners	Deliverable(s)	Target Date(s) or Level of Effort
1. Present 16 hour seminar	Simulation and Training Environment Lab at the Washington Hospital Center, NVHA, DCHA,	10 – 16 hour seminars (same content each time) consisting of interactive presentations, hands-on	September – December 2006, February – June 2007

	Montgomery County/Prince Georges County Hospital Collaborative	tabletops and "live" exercises	

Project Performance Measures	**Baseline Value**	**Target Value**
1. Participant evaluations of the continuing education	250 participants	500 more participants
2. Completion of pre-test and post-test for the course	90% of above	100% of above
3. Regular faculty meetings, reviewing participant feedback and making needed changes based on feedback	4 x yearly	8 x yearly

INITIATIVE PLAN

Hospital Disaster Life Support (HDLS)

Not Available.

CONCEPT PAPER

Final

January 23, 2006

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Project Title:	**SiTEL On Demand**	**Estimated Grant Amount**	*$374,000* *Hospitals=$349,000* *Public Health=$25,000*
NCR Strategic Goal Alignment:	Surge Capacity and Mass Prophylaxis	**Allowability**	*Submitted courses to the ODP for non-SLGCP approval*
Estimated Timeline	*Start Date: July 2006, End Date: July 2007*	**Dependencies and Cost Factors:**	*See attachment*

Problem Statement/Project Description:

Not all hospitals in the NCR have access to a standardized serious of educational programs on emergency preparedness (13 NV hospitals and 5 DC hospitals do). Currently there is no regional internet-based educational platform for health department personnel. SiTEL On Demand will allow for around the clock, internet-based access to standardize regional educational programming for both hospitals and public health departments. This is one of 4 continuing education programs included in the Methods and Materials for Increasing National Capital Region Hospital and Public Health Emergency Preparedness.

Preliminary Project Plan (Tasks, Resources, Deliverables, Collaborating Partners, etc.)

Task(s)	Owner(s) or Collaborating Partners	Deliverable(s)	Target Date(s) or Level of Effort
1. Online access to 80 emergency preparedness interactive modules	Simulation and Training Environment Lab at the Washington Hospital Center, public health departments, DCHA, NVHA, and Montgomery County/Prince Georges County Hospital Collaborative	Around the clock access to online emergency preparedness continuing education modules	July 2006 through July 2007
2. Development of 5 15-minute public health modules	Simulation and Training Environment Lab at the Washington Hospital Center, public health departments, DCHA, NVHA, and Montgomery County/Prince Georges County Hospital Collaborative	Around the clock access to online emergency preparedness continuing education modules	July 2006 through July 2007

Project Performance Measures	Baseline Value	Target Value
1. Participant evaluations of the continuing education	50% of above	25% increase
2. Completion of pre-test and post-test for the course	50% of above	25% increase
3. Track module completion of participants	1500 completed	25% increase

INITIATIVE PLAN

SiTEL On Demand

Not Available.

CONCEPT PAPER ***Final***	January 23, 2006 Yuri Millo, MD Director, Simulation and Training Environment Lab Washington Hospital Center 110 Irving Street NW, NA 1177 Washington, DC 20010 202-877-5200 yuri.millo@medstar.net

Project Title:	**Code Orange**	**Estimated Grant Amount**	*$250,000*
NCR Strategic Goal Alignment:	Surge Capacity, Mass Prophylaxis	**Allowability**	*Submitted courses to the ODP for non-SLGCP approval*
Estimated Timeline	*Start Date: July 2006, End Date: July 2007*	**Dependencies and Cost Factors:**	*See attachment*

Problem Statement/Project Description:

Hospitals lack the ability to provide readily accessible incident command continuing education to their personnel. The biannual drills required of hospitals are insufficient at promoting incident command expertise and development of critical decision-making skills. Code Orange is a continuing education platform to exercise management of mass casualty incidents in hospital and pre-hospital settings. The platform is connected to a learning management system which tracks participant performance and competencies and verifies that the objectives of the education are met. This is one of 4 continuing education programs included in the Methods and Materials for Increasing National Capital Region Hospital and Public Health Emergency Preparedness

Preliminary Project Plan (Tasks, Resources, Deliverables, Collaborating Partners, etc.)			
Task(s)	**Owner(s) or Collaborating Partners**	**Deliverable(s)**	**Target Date(s) or Level of Effort**
1. Present an around the clock internet-based educational program on instruction of incident command	Simulation and Training Environment Lab at the Washington Hospital Center, NVHA, DCHA, Montgomery County/Prince Georges County Hospital Collaborative	Individual CD and internet-based incident command program that allow users 24/7 access to 3 levels of complexity covering 4 emergency scenarios	July 2006-July 2007

Project Performance Measures	**Baseline Value**	**Target Value**
1. Participant evaluation following education completion	0	200 users
2. Personal performance review through LMS analysis	0	200 users
3. Hospital performance and participation tracking	0	34 hospitals

INITIATIVE PLAN

Code Orange

Not Available.

CONCEPT PAPER

Final

1/22/06
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Project Title:	**HICS, and NIMS: A Forum on Hospital Incident Command**	**Estimated Grant Amount**	*$75,000*
NCR Strategic Goal Alignment:	*Surge Capacity*	**Allowability**	**NIMS compliance requires hospital education**
Estimated Timeline	*Start: July 2006 End: December 2006 [Insert tentative start and end dates]*	**Dependencies and Cost Factors:**	*See attachment*

Problem Statement/Project Description:

Hospitals in 2006 must become NIMS compliant. However, most hospitals and other healthcare facilities are neither aware of the expectation, know what must be done or how the new Hospital Incident Command System (HICS) can help meet some of the requirements. The proposed seminar will provide needed incite on NIMS requirements, how these expectations can be met and details about the new HICS and accompanying tools and educational materials. To optimize the availability of the training it will be presented 3 times; once in each jurisdiction. This is one of 4 continuing education programs included in the Methods and Materials for Increasing National Capital Region Hospital and Public Health Emergency Preparedness.

Preliminary Project Plan (Tasks, Resources, Deliverables, Collaborating Partners, etc.)

Task(s)	Owner(s) or Collaborating Partners	Deliverable(s)	Target Date(s) or Level of Effort
1. Present 8 hour seminar	Washington Hospital Center, California Emergency Services, Kaiser Permanente	3 - 8 hour seminars(same content each time) consisting of interactive presentations and scenario review	September, October, November 2006

Project Performance Measures	Baseline Value	Target Value
1. Participant evaluations of the training	0	300 participants
2. Follow on meetings among hospitals and public health to develop suggested common response procedures and critical response actions	0	4 meetings
3. Completion of expected NIMS coursework by identified hospital personnel	0	300 participants

INITIATIVE PLAN

HICS, and NIMS: A Forum on Hospital Incident Command

Not Available

INITIATIVE PLAN

(CONCEPT PLAN NOT AVAILABLE)

Methods and Materials for Increasing National Capital Region Hospital and Public Health Emergency Preparedness (NCR HoPHEP)

1. Provide the Name of this Initiative. Describe how this Initiative will address the priority needs and strengths identified through the program and capability evaluation, and prioritization analysis.

Methods and Materials for Increasing National Capital Region Hospital and Public Health Emergency Preparedness consists of the collaboration of four programs earmarked for educating hospital personnel and public health department staff on vital aspects of emergency preparedness: (1) **Hospital Disaster Life Support (HDLS)**, a 16-hour course that provides disaster response continuing education to National Capital Region first receivers who provide patient care and management direction in a hospital during the first stages of a Mass Casualty Incident (MCI), (2) **SiTEL On Demand**, a password secure, intranet-based multimedia rich, educational platform designed to provide instructional content on CBRNE, Avian Flu and other disaster-related topics, compliant with NIMS and NRP, for MD's, RN's, and other hospital staff. SiTEL On Demand will work with the NCR health officers and emergency preparedness planners to develop and implement five public health-specific online courses to promote the linkage of regional collaboration between public health departments and hospitals, (3) **Code Orange**, a computer-based continuing education platform playable over the internet that is used in hospital employee continuing education for Mass Casualty incident management, and (4) **HICS IV and NIMS Compliance**: **Their Impact on Hospital Incident Command** a series of three - 8 hour education seminars on NIMS compliance for hospitals and HICS, the new Hospital Incident Command System from California Emergency Services Authority.

Funding will be used to add public health supplements and provide these four programs at no cost to hospitals and public health departments in the NCR.

NCR HoPHEP programs will provide the following:

1. A standardization of emergency preparedness continuing education and education for the hospitals and health departments in the National Capital Region.
2. A forum for personnel from hospitals across the region to practice decision-making and improve communication and collaboration in an effort to reinforce NIMS, NRP, and NIPP according to HSPR-5.
3. Dedicated Simulation and Training Environment Lab (SiTEL) staff supporting these programs presents locally appropriate curriculum not otherwise available to hospitals and public health because of personnel and budget constraints.
4. The opportunity to push out "just-in-time continuing education" to NCR hospitals and health departments in cases of the occurrence of unpredicted events (SiTEL On Demand and Code Orange).
5. The HDLS course design presents core content, hands-on exercises and scenario-based drills which are more focused, mentored, and thus more beneficial and effective than those currently found in many NCR hospitals.
6. Present a forum that will discuss NIMS and hospital compliance expectations along with the new HICS IV incident command structure.

The need for NCR HoPHEP programs are supported based on the following strengths and weaknesses identified by the Metropolitan Washington Council of Governments:

CBRNE Detection: Strength – CBRNE continuing education developed and implemented by the Washington Hospital Center (HDLS) to address limited healthcare staff knowledge. Weakness – Lack of money to provide ongoing continuing education opportunities to staff in order for proficiency. USAI funding of HDLS, SiTEL On Demand and Code Orange will enable ongoing CBRNE Detection education and continuing education to the NCR to increase hospital and health department staff proficiency.

Medical Surge: Strength – The Washington Hospital Center has an internet-based educational system (SiTEL On Demand) that could be increasingly helpful to all disciplines, providing competency-based continuing education, online resources and many curriculum offerings. Weakness – A standardized, scenario-based, region–specific core curriculum which involves live and web-based continuing education with capabilities for tracking competency. USAI funding of HDLS, SiTEL On Demand and Code Orange will provide live and web-based continuing education to all NCR hospital and health department staff, allowing for competency tracking capabilities for a number of disciplines based on emergency preparedness.

Planning: Strength – Funding is available to provide for the already strong continuing education programs in the NCR. Weakness – ESF 8 does not have a continuing education curriculum or academy; and needs better defined goals to establish continuing education that will relate to federal, state, and regionally sponsored exercises. USAI funding of HDLS, Code Orange, and HICS IV and NIMS Compliance will provide a comprehensive template for regional continuing education curriculum goals to better facilitate emergency preparedness exercises and continuing education.

WMD/Hazardous Materials Response and Decontamination: Strength – Medical continuing education is available in-house and at conferences and institutes in the NCR; the mechanism to deliver programs. Weakness – Regional standardized continuing education; financial assistance for continuing education. Using funding of HDLS, SiTEL On Demand, and Code Orange will provide thorough, regional standardized continuing education to hospital and health department staff at no charge.

2. Regional Construct: Briefly describe the geographical context of this Initiative.

Educational programs will be made available to all of the health departments and hospitals in the Washington Metropolitan Area Council of Governments.

3. Resources, Processes, and Tools: Identify the resources, processes and tools that already exist, and those that will need to be leveraged, created, or acquired for this Initiative. Briefly consider how these resources, processes and tools may be attained.

HDLS and SiTEL On Demand both are fully developed and have been in use since 2004. Code Orange and HICS IV are in the final stages of development, and both are due for summer publication.

Resources and tools such as course faculty and educational content (developed by emergency preparedness experts from the National Capital Region), technological/communication equipment, SiTEL program directors and staff, and program support materials already exist; however, non-UASI funding of these materials is no longer available and new funding must be found to support the continuation of these programs.

4. Governance Structure: Describe the high-level governance structure (e.g., management plan, stakeholder involvement) required for successful implementation of this Initiative.

Hospital Chief Executive Officers with the assistance of their Emergency Preparedness staff are responsible for the successful implementation of this project at the hospital level. The respective state hospital organizations (District of Columbia Hospital Association, Northern Virginia Hospital Alliance, and Montgomery County/Prince Georges Hospital Collaborative) jointly serve as subgrantees and oversee the project. The Council of Government Health Officers will also provide strategic guidance for the project.

Hospitals in the NCR will be given funding through their respected hospital organizations to be spent on the four projects in NCR HPHEPTI. The Council of Governments Health Officers will receive funding to ensure the availability of the described intranet-based education for health department personnel in the NCR.

5. Program Management: Explain how this Initiative relates to the overall State homeland security program, and/or how it helps incorporate the three Overarching National Priorities.

HDLS course is an application of the NIMS and the NRP principles for hospital personnel, and adapts strategies from the 15 "all-hazards" disaster-planning scenarios approved by the DHS and the White House Homeland Security Council. HDLS, created by SiTEL of the ER One Institute in collaboration with experienced clinical, administrative and educational staff from four DC hospitals, is supported by NVHA and DCHA, and held at the vacant DC General Hospital Emergency Department. The course is presented 10 times a year and results in the annual continuing education of up to 500 hospital medical professionals and administrative staff from all 34 hospitals in the NCR, including military hospitals. Funding is requested to add public health supplements and complete implementation to all hospitals and health departments in the NCR.

SiTEL On Demand consists of 80 CBRNE and NIMS/NRP modules currently available online to various personnel at 18 of the 34 NCR hospitals. Funding is requested to add public health supplements and complete implementation to all hospitals and health departments in the NCR.

Code Orange expands Regional Collaboration by training hospital employees and public health staff in the NCR on a systematic approach to hospital incident command and basic principles in NIMS and the NRP. Code Orange provides an online gaming system so individuals at various NCR hospitals and public health departments can play simultaneously in an effort to learn together. Funding is requested to make Code Orange available at no cost to all hospitals and local health departments in the NCR.

The HICS IV and NIMS Compliance forum will provide attendees with the latest information on NIMS compliance for hospitals as well as provide an interactive discussion on the various materials included in HICS IV. In addition, practical application of the material and implementation principles

will be presented. HICS IV expands Regional Collaboration by promoting a systematic approach to the planning of emergency operations center management and response principles; therefore providing a regional standard for hospital incident command. Funding is requested to make the HICS IV and NIMS Compliance forum available at no cost to all hospitals and health departments in the NCR.

NCR HoPHEP recognizes the threat to various infrastructures, including healthcare facilities in the NCR. In this regard, aspects of the programs described above will reinforce select principles found in the Interim National Infrastructure Protection Plan.

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Scoring Sheet

Medical Surge

Scoring Criteria: All candidate Concept Papers are to scored on the basis of compliance with the following 5 criteria. Each criteria is to be scored from 1 to 10 points, with 1 being lowest compliance and 10 being the highest.

Criteria #1: How well does this Concept Paper/Initiative Plan address identified strengths and weaknesses of the 14 Priority Target Capabilities?

Criteria #2: How well does this Concept Paper/Initiative Plan address identified strengths and weaknesses of the 3 Overarching National Priorities?

Criteria #3: How appropriate is the funding requested with the deliverables proposed by the Concept Paper?

Criteria #4: How beneficial will this concept paper be in addressing regional needs?

Criteria #5: How important is it to implement this Concept Paper/Initiative Plan in FY 06?

Concept Paper		National Capital Region Syndromic Surveillance Network (existing project)									
Related Target Capabilities:		Intelligence/Information Sharing and Dissemination, Interoperable Communications									
Score:	Criteria #1 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #2 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #3 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #4 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #5 (1-10)	1	2	3	4	5	6	7	8	9	10
	Total: (5-50)										

Concept Paper		Regional Implementation of Computer-Assisted Telephone Interview Capacity (CATI)									
Related Target Capabilities:		Interoperable Communications									
Score:	Criteria #1 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #2 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #3 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #4 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #5 (1-10)	1	2	3	4	5	6	7	8	9	10
	Total: (5-50)										

Concept Paper		Gap Analysis for Health and Medical Readiness-Part 2, A Continuation Project									
Related Target Capabilities:		Planning									
Score:	Criteria #1 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #2 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #3 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #4 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #5 (1-10)	1	2	3	4	5	6	7	8	9	10
	Total: (5-50)										

Concept Paper	Raising Public Awareness for Public Health Emergencies: Going Beyond Mass Media for Message Dissemination										
Related Target Capabilities:	Mass Prophylaxis										
Score:	Criteria #1 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #2 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #3 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #4 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #5 (1-10)	1	2	3	4	5	6	7	8	9	10
	Total: (5-50)										

Concept Paper	UASI FY 06 Medical Surge										
Related Target Capabilities:											
Score:	Criteria #1 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #2 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #3 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #4 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #5 (1-10)	1	2	3	4	5	6	7	8	9	10
	Total: (5-50)										

Concept Paper	HICS, and NIMS: A Forum on Hospital Incident Command										
Related Target Capabilities:	Mass Prophylaxis										
Score:	Criteria #1 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #2 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #3 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #4 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #5 (1-10)	1	2	3	4	5	6	7	8	9	10
	Total: (5-50)										

Concept Paper	Code Orange										
Related Target Capabilities:	Mass Prophylaxis										
Score:	Criteria #1 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #2 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #3 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #4 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #5 (1-10)	1	2	3	4	5	6	7	8	9	10
	Total: (5-50)										

Concept Paper	SiTEL On Demand										
Related Target Capabilities:	Mass Prophylaxis										
Score:	Criteria #1 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #2 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #3 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #4 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #5 (1-10)	1	2	3	4	5	6	7	8	9	10
	Total: (5-50)										

Concept Paper		Hospital Disaster Life Support (HDLS)									
Related Target Capabilities:		Mass Prophylaxis									
Score:	Criteria #1 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #2 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #3 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #4 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #5 (1-10)	1	2	3	4	5	6	7	8	9	10
	Total: (5-50)										

Concept Paper		NCR HoPHEP									
Related Target Capabilities:											
Score:	Criteria #1 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #2 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #3 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #4 (1-10)	1	2	3	4	5	6	7	8	9	10
	Criteria #5 (1-10)	1	2	3	4	5	6	7	8	9	10
	Total: (5-50)										

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