Emergency Preparedness and Response

The Evolution of a Public Health Agency

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Deputy Commissioner
Office of Emergency Preparedness and Response (OEPR)
NYC Department of Health and Mental Hygiene (DOHMH)
I) Background: NYC – High Risk

II) Background: Department of Health and Mental Hygiene

III) DOHMH Role in Response

IV) Public Health Emergency Preparedness and Response
   – Capability: 2001 vs. 2014

V) Conclusion
NYC High Risk

- Residents: 8.3M
- Daytime: 9M
- Population Density: 27,000 per sq mile
- Tourists: 52.7M per year
- 21.6% of population <18 years
- 12.1% of population >65 years
- 36.9% of population foreign born
- 170+ language spoken
- 19.9% of population living below poverty level
NYC High Risk

Regional Transportation Hub
- 1.4M people commute into Manhattan
- 4.9M ride the subway each work day

International Transportation Hub
- 2 international airports
- 100 million travelers annually

International Icons/Landmarks
- Statue of Liberty, United Nations, Empire State Building, World Trade Center, etc.

Large Planned Events
- United National General Assembly, New Year’s Eve, Thanksgiving Day Parade, Superbowl 2014 and many other sporting events.
Mission
Protect and promote the health of all New Yorkers

- DOHMH has ~6,000 employees
- Annual agency budget: $1.3 billion
## Office of Emergency Preparedness and Response

**Mission:** To promote DOHMH’s and NYC’s ability to prevent, prepare for, respond to, and recover from health emergencies. (4 Bureaus / 67 staff)

| **Agency Preparedness and Response** | • Coordinate agency planning, training, exercise and evaluation  
• Maintain primary/alternate Emergency Operations Center and 2 Mobile Command Vehicles.  
• Maintain emergency communications  
• Manage ICS and ICS Coordinator Model |
| **Policy, Community Resilience and Response** | • MCM planning, training and manage RSS  
• Engage with community and faith partners to build resilience  
• Plan for needs of vulnerable populations  
• Coordinate NYC BioWatch program  
• Manage Medical Reserve Corps (7,500+)  
• Strategic planning and advocacy |
| **Healthcare System Readiness** | • Support 57 hospitals - plan, train, exercise  
• Increase readiness of long-term care facilities, primary care and dialysis centers  
• Build geographic network and function-based coalitions  
• ESF 8 planning |
| **Grants Management and Administration** | • Manage CDC, ASPR and DHS funds – includes grant application, progress reports and financial reports  
• Ensures compliance with all federal grant program requirements  
• Manage DOHMH COOP program  
• Admin support for OEPR |
<table>
<thead>
<tr>
<th>Funded Programs</th>
<th>#FTE Funded</th>
<th>% of Award (PS + OTPS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health &amp; Safety/Operations/Finance</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>Surveillance and Epidemiology</td>
<td>22</td>
<td>10%</td>
</tr>
<tr>
<td>Public Health Laboratory</td>
<td>20</td>
<td>10%</td>
</tr>
<tr>
<td>Informatics, Information Technology and Telecommunications</td>
<td>14</td>
<td>7%</td>
</tr>
<tr>
<td>Environmental Health</td>
<td>11</td>
<td>5%</td>
</tr>
<tr>
<td>Communications/External Affairs</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Emergency Preparedness and Response</td>
<td>58</td>
<td>56%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>4</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>133</strong></td>
<td></td>
</tr>
</tbody>
</table>
DOHMH’s Role in Emergencies

- Disease Surveillance and Epidemiology
- Public Health Orders, Clinical Guidance and Risk Communication
- Mass Prophylaxis/Vaccination
- Laboratory Testing (Biological and Radiological)
- Public Health Assessment
- Environmental Mitigation (Radiological and Biological)
- Animal-Related Surveillance and Vector Control
- Mental Health Needs Assessment and Service Coordination
Public Health Emergencies
1999-2014

1999: West Nile Virus
2001: World Trade Center
2001: Anthrax
2003: Northeast Blackout
2004: Republican National Convention - Radiological
2006: Inhalation Anthrax (Drummer)
2007: Steam Pipe Explosion
2007: Deutsche Bank Fire

2008: W. Village Hepatitis A (Restaurant)
2009: H1N1 (Spring and Fall)
2011: Hurricane Irene
2012: Superstorm Sandy
2013: Hep A, Bronx (Restaurant)
2013: Hep A, Manhattan (Market)
2013: Hep A, Manhattan (Restaurant)
2013: Ricin Letters
2014: Measles and Mumps

*** Includes only a sample of incidents ***
September 11, 2001

Impact

~ 2600 dead, 25,000 residents temporarily displaced, 17 acres of total destruction
DOHMH Response Activities

September 11th, 2001

- Activated agency leadership
- Triaged in lobby to treat the injured
- Assessed hospital resources
- Mental Health support
- Issued Public Health advisories
- Maintained essential public health services
- Conducted morbidity and mortality surveillance
- WTC worker injury surveillance/health (with support from CDC)
- Conducted environmental monitoring (with support from CDC)
- Implement Emergency Department syndromic surveillance (with support from CDC)
DOHMH Response

Anthrax 2001

• Rapidly developed clinical guidelines
• Prophylaxis for exposed
• Enhanced/Active Surveillance for anthrax cases
• Transitioned to electronic transmission of ED syndromic surveillance data
• Laboratory tested 3400 powder events
• Prioritized communication messages
• Environmental testing/clean-up at affected sites
GAPS  
9/11 and 2001 Anthrax

- Lacked a formal response structure
- No primary/back up EOC to manage response efforts
- Limited pool of leadership to run complex response
- Lacked pre-identified and trained staff to respond
- Limited IT Infrastructure
- No automated notification system to contact staff
- Limited capability to reach healthcare providers
- Limited response plans
- No automated Emergency Department syndromic surveillance
- Significant environmental issues and limited guidance
Capability Building

Public Health and Healthcare System Preparedness

- Emergency Operation Coordination
- Community Preparedness/Recovery
- Healthcare System Preparedness and Medical Surge
- MCM Dispensing/Medical Material Management & Distribution

- Lab Testing & Surv/Epi Investigation
- Emergency Public Information and Warning
- Volunteer Management
## Emergency Operations Coordination

<table>
<thead>
<tr>
<th>THEN</th>
<th>NOW</th>
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</thead>
<tbody>
<tr>
<td><strong>Operations Center and Communications</strong></td>
<td></td>
</tr>
<tr>
<td>❑ Response structure created in real-time</td>
<td>✓ ICS structure with assigned roles</td>
</tr>
<tr>
<td>❑ Limited IT capability</td>
<td>✓ Wireless and remote access</td>
</tr>
<tr>
<td>❑ No ability to notify and mobilize staff</td>
<td>✓ Emergency communications systems</td>
</tr>
<tr>
<td>❑ No primary or alternate Emergency Operations Center</td>
<td>✓ Employee Databank (EDB)</td>
</tr>
<tr>
<td>❑ ICS structure with assigned roles</td>
<td>✓ Redundant communications equipment</td>
</tr>
<tr>
<td>❑ Wireless and remote access</td>
<td>✓ Primary and alternate Emergency Operations Center (EOC)</td>
</tr>
<tr>
<td>❑ Emergency communications systems</td>
<td></td>
</tr>
<tr>
<td>❑ Employee Databank (EDB)</td>
<td></td>
</tr>
<tr>
<td>❑ Redundant communications equipment</td>
<td></td>
</tr>
<tr>
<td>❑ Primary and alternate Emergency Operations Center (EOC)</td>
<td></td>
</tr>
<tr>
<td><strong>Planning, training and exercises</strong></td>
<td></td>
</tr>
<tr>
<td>❑ Minimal response plans</td>
<td>✓ Operational plans (all hazard, pan flu, etc.)</td>
</tr>
<tr>
<td>❑ No pre-event training, limited exercises</td>
<td>✓ Threat Response Guides for 21 scenarios</td>
</tr>
<tr>
<td>❑ Informal relationships with first responder agencies</td>
<td>✓ Quarterly ICS trainings and notification drills; semi-annual functional ICS exercises</td>
</tr>
<tr>
<td>❑ Operational plans (all hazard, pan flu, etc.)</td>
<td>✓ Regular coordination with first responder agencies</td>
</tr>
<tr>
<td>❑ Threat Response Guides for 21 scenarios</td>
<td></td>
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<tr>
<td>❑ Quarterly ICS trainings and notification drills; semi-annual functional ICS exercises</td>
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<tr>
<td>❑ Regular coordination with first responder agencies</td>
<td></td>
</tr>
<tr>
<td><strong>Continuity of Operations</strong></td>
<td></td>
</tr>
<tr>
<td>❑ No continuity plan</td>
<td>✓ COOP plan updated annually</td>
</tr>
<tr>
<td>❑ No clear identification of essential services and staff at time-of-event</td>
<td>✓ Dedicated staff planning and response</td>
</tr>
<tr>
<td>❑ No dedicated staff or training for COOP</td>
<td>✓ Essential services/staff identified and defined</td>
</tr>
<tr>
<td>❑ COOP plan updated annually</td>
<td>✓ COOP protocols, trainings, and exercises</td>
</tr>
<tr>
<td>❑ Dedicated staff planning and response</td>
<td></td>
</tr>
<tr>
<td>❑ Essential services/staff identified and defined</td>
<td></td>
</tr>
<tr>
<td>❑ COOP protocols, trainings, and exercises</td>
<td></td>
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</tbody>
</table>
Trainings, Exercises and Evaluation

- City Hall BioWatch TTX, 2003
- NYC SNS Drill (10 PODs), 2004
- PODEX FSE (4 PODs), 2005
- Citywide Hospital Pan-Flu FSE, 2005
- Operation Relocation Drill (Bedford), 2005
- Emergency Communication WS, 2006
- Trifecta Internal Notification FE, 2006
- HurrEx Healthcare Facility FE, 2006
- CriCom Notification TTX, 2006
- NYC SNS TTX, 2006
- Pan Flu Planning WS, 2006
- EDEN Radiation Data Transfer Drill, 2006
- Five POD FSE, 2006
- REOP TTX, 2007
- Field Surveillance FSE, 2008
- POD Set-up Drill, 2008
- Coastal Storm TTX, 2008
- Anti-Viral Receipt WS, 2008
- Federal Anthrax TTX, 2008
- Pandemic Countermeasures Allocation WS, 2008
- Operation Transportation WS, 2008
- CriCom WS 2008
- Clear Communications WS, 2008
- POD C2 External WS, 2008
- FluEX Drill, 2008
- Continuity of Education WS, 2008
- SQUARE 1 WS, 2008
- Anti-Viral Receipt TTX, 2008
- POD C2 Internal WS, 2008
- Pandemic Antiviral Allocation TTX, 2008
- CRICOM FSE, 2008
- Clear Communication TTX, 2008
- CRICOM 2 FSE, 2009
- RSO Symposium, 2009
- Urban Remediation & Re-occupancy WS, 2008
- ICS Leadership White Powder TTX, 2009
- NYPD BioWatch, 2009
- POD FSE, 2009
- ICS Quarterly TTX - BioWatch, 2010
- BioWatch Mobilization, 2010
- ICS Quarterly TTX – Explosive, 2010
- OEM MCI-FAC FSE. 2010
- Distribution Center Coastal Storm WS, 2010
- ICS Quarterly TTX – Chemical, 2010
- SNS Asset Security WS, 2010
- PIO COT Call Down Drill, 2010
- MH Essential Services WS, 2011
- ICS Quarterly TTX – Botulism, 2011
- DIIT VPN Access Drill, 2011
- Unannounced DEOC Set Up Drill, 2011
- POD Screening & Dispensing FE, 2011
- PIO COT Deployment Exercise, 2011
- ICS Quarterly TTX – Coastal Storm, 2011
- BioWatch DAC & LICC WS, 2011
- POD Set Up Drills, 2011
- ICS Leadership Rad. Functional Exercise, 2011
- IT VPN Access Drill, 2012
- MH Resilience & Emotional Support Teams W/S
- PIB Staging Drill, 2012
- SNS Asset Security TTX, 2012
- Community Reception Center Workshops, 2012
- ICS Leadership Coastal Storm TTX, 2012
- COOP Workshop, 2012
- Multiagency Explosives Workshop, 2013
- Multiagency Environmental Sampling Drill, 2013
- ICS Leadership Bio Functional Exercise, 2013

- Online and in-person mandatory Emergency Roles training
- Required Quarterly ICS Leadership Trainings on specific scenarios
- Increasingly complex exercise progression.
- Corrective Action Retrospective Database (CARD) to track implementation of corrective actions
<table>
<thead>
<tr>
<th>THEN</th>
<th>NOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk-based planning</td>
<td></td>
</tr>
<tr>
<td>□ No risk assessment or hazard vulnerability analysis</td>
<td>✓ Public health-specific risk assessment for NYC and MSA</td>
</tr>
<tr>
<td></td>
<td>✓ Vulnerable Population Matrix</td>
</tr>
<tr>
<td></td>
<td>✓ Guides/materials specific for vulnerable populations</td>
</tr>
<tr>
<td>Community-level planning</td>
<td></td>
</tr>
<tr>
<td>□ No meaningful community input/engagement</td>
<td>✓ Established committees with community and faith leaders</td>
</tr>
<tr>
<td></td>
<td>✓ Input sessions to receive feedback on plans</td>
</tr>
<tr>
<td></td>
<td>✓ Developing tools to improve bi-directional communication</td>
</tr>
<tr>
<td>MH planning</td>
<td></td>
</tr>
<tr>
<td>□ No mental health preparedness or response planning</td>
<td>✓ Dedicated office for MH preparedness and response</td>
</tr>
<tr>
<td></td>
<td>✓ Mental Health Call Center</td>
</tr>
<tr>
<td></td>
<td>✓ Online training for providers to recognize signs</td>
</tr>
<tr>
<td></td>
<td>✓ Resilience and Emotional Support Teams (REST) within MRC</td>
</tr>
</tbody>
</table>
## Public Health Risk Assessment

<table>
<thead>
<tr>
<th></th>
<th>Severity</th>
<th>Probability</th>
<th>Planning</th>
<th>Manageable Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Score</td>
<td>Rank</td>
<td>Score</td>
<td>Rank</td>
</tr>
<tr>
<td>Coastal Storm</td>
<td>4.2</td>
<td>2</td>
<td>3.6</td>
<td>6</td>
</tr>
<tr>
<td>Pandemic Influenza</td>
<td>3.5</td>
<td>5</td>
<td>2.9</td>
<td>9</td>
</tr>
<tr>
<td>Heatwave</td>
<td>2.9</td>
<td>8</td>
<td>4.2</td>
<td>1</td>
</tr>
<tr>
<td>Flooding</td>
<td>3.4</td>
<td>6</td>
<td>4.0</td>
<td>4</td>
</tr>
<tr>
<td>Aerosolized Anthrax</td>
<td>3.9</td>
<td>4</td>
<td>2.8</td>
<td>10</td>
</tr>
<tr>
<td>Radiological Dispersal Device</td>
<td>4.0</td>
<td>3</td>
<td>2.7</td>
<td>11</td>
</tr>
<tr>
<td>Improvised Explosive Device</td>
<td>3.1</td>
<td>7</td>
<td>3.2</td>
<td>7</td>
</tr>
<tr>
<td>Improvised Nuclear Device</td>
<td>4.7</td>
<td>1</td>
<td>2.0</td>
<td>12</td>
</tr>
<tr>
<td>Winter Weather</td>
<td>2.8</td>
<td>9</td>
<td>4.1</td>
<td>3</td>
</tr>
<tr>
<td>Chlorine Release</td>
<td>2.7</td>
<td>10</td>
<td>3.6</td>
<td>5</td>
</tr>
<tr>
<td>Food Contamination</td>
<td>2.3</td>
<td>12</td>
<td>4.2</td>
<td>2</td>
</tr>
<tr>
<td>Tornado</td>
<td>2.7</td>
<td>11</td>
<td>3.1</td>
<td>8</td>
</tr>
</tbody>
</table>

*Top 3 values are in bold*
# Healthcare System Prep/Medical Surge

## Facilities vs System

<table>
<thead>
<tr>
<th>THEN</th>
<th>NOW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facilities vs System</strong></td>
<td></td>
</tr>
<tr>
<td>![Tick] Limited facility-level planning or system-wide planning</td>
<td>![Tick] Emergency Preparedness Coordinators at each hospital</td>
</tr>
<tr>
<td>![Tick] Healthcare system not planning with city agencies</td>
<td>![Tick] Include entire healthcare system (facilities and associations)</td>
</tr>
<tr>
<td></td>
<td>![Tick] Building coalitions (network, geographic and functional)</td>
</tr>
<tr>
<td></td>
<td>![Tick] Data-driven decision-making</td>
</tr>
</tbody>
</table>

## Scope of Planning

<table>
<thead>
<tr>
<th>THEN</th>
<th>NOW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scope of Planning</strong></td>
<td></td>
</tr>
<tr>
<td>![Tick] Limited plans</td>
<td>![Tick] Planning for at-risk populations (pediatrics, dialysis, burn)</td>
</tr>
<tr>
<td></td>
<td>![Tick] Share city plans with key healthcare partners</td>
</tr>
</tbody>
</table>

## Citywide Planning/Coordinated Health and Medical Function

<table>
<thead>
<tr>
<th>THEN</th>
<th>NOW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Citywide Planning/Coordinated Health and Medical Function</strong></td>
<td></td>
</tr>
<tr>
<td>![Tick] Weak/undefined ESF-8</td>
<td>![Tick] Defined ESF-8 roles</td>
</tr>
<tr>
<td></td>
<td>![Tick] ESF-8 workgroup meets regularly to address system gaps</td>
</tr>
<tr>
<td></td>
<td>![Tick] Strong Healthcare Evacuation Center (HEC)</td>
</tr>
</tbody>
</table>

## Patient Tracking

<table>
<thead>
<tr>
<th>THEN</th>
<th>NOW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Tracking</strong></td>
<td></td>
</tr>
<tr>
<td>![Tick] No patient tracking capability</td>
<td>![Tick] Systems in place to facilitate family reunification</td>
</tr>
</tbody>
</table>
### The “Readiness” Project

Ranks for Each Readiness Target, provided by hospital EPCs and planning partner representatives, Sept 2013, Queens, New York

<table>
<thead>
<tr>
<th>Target</th>
<th>Rank</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data/Information Sharing for Clear Situational Awareness</td>
<td>1</td>
<td>42</td>
</tr>
<tr>
<td>Multiagency Exercises Inclusive of Healthcare</td>
<td>2</td>
<td>34</td>
</tr>
<tr>
<td>Reliable Communications Systems &amp; Equipment</td>
<td>3</td>
<td>26</td>
</tr>
<tr>
<td>Health Care Staffing Issues are Addressed</td>
<td>4</td>
<td>21</td>
</tr>
<tr>
<td>Individual Facility Preparedness</td>
<td>5</td>
<td>19</td>
</tr>
<tr>
<td>Clear Resource Request Process</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>Clear Role of Healthcare Coalitions</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>Clear Response Roles</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Inclusive (Representative) Healthcare System for Planning &amp; Response</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Appropriate Emergency Preparedness Training (added in Oct, 2013 by nursing home and adult care facilities)</td>
<td>Not ranked</td>
<td>Not scored</td>
</tr>
</tbody>
</table>
Healthcare System Readiness Strategic Priorities 2014-2016

• Further Healthcare Sector Integration Into Jurisdictional Health/Medical Planning and Response
• Coalitions as Drivers of Facility Preparedness and System-Level Response
• Strengthening Facility Preparedness & Resilience

These priorities + Readiness Project Findings + HPP Capabilities Drive Our Work
# MCM Dispensing/Medical Materiel Management & Distribution

<table>
<thead>
<tr>
<th>THEN</th>
<th>NOW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Storage, Management and Distribution of MCM</strong></td>
<td>RSS capacity and robust inventory management system</td>
</tr>
<tr>
<td>- Limited storage/distribution capability</td>
<td>✓ Surveyed POD network to identify best sites (175)</td>
</tr>
<tr>
<td>- No inventory system</td>
<td>✓ Operational site manuals</td>
</tr>
<tr>
<td></td>
<td>✓ PIBs</td>
</tr>
<tr>
<td></td>
<td>✓ Modeling to optimize throughput</td>
</tr>
<tr>
<td></td>
<td>✓ Approval to develop Pre-Incident Action Plans for Phase 1 Operations</td>
</tr>
<tr>
<td><strong>POD Sites</strong></td>
<td></td>
</tr>
<tr>
<td>- No pre-identified POD sites</td>
<td>✓ 2,937 POD Core Team members identified and 70% trained</td>
</tr>
<tr>
<td></td>
<td>✓ 5,154 Staff assigned to POD roles and sites by home address</td>
</tr>
<tr>
<td><strong>POD Staffing</strong></td>
<td></td>
</tr>
<tr>
<td>- No pre-identified POD staff</td>
<td>✓ Auxiliary Distribution Program (ADP)-33 facilities, 7,229 patients, 7,809 staff</td>
</tr>
<tr>
<td><strong>Alternate Modes of Dispensing</strong></td>
<td></td>
</tr>
<tr>
<td>- Plan that focused only on PODs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓ Auxiliary Distribution Program (ADP)-33 facilities, 7,229 patients, 7,809 staff</td>
</tr>
</tbody>
</table>
Population Density & POD Locations
“Phase 1” PODs

Phase 1: 80 PODS
First Delivery: 2h 50m
Last Delivery: 6h 55m
POD Staff Site Assignment

POD Core Team and Distance to Assigned PODs

- # of Staff
- Cumulative %

Distance (Mi)

- 0.25
- 0.5
- 0.75
- 1
- 1.25
- 1.5
- 1.75
- 2
- 2.25
- 2.5
- 2.75
- 3
- 3.25
- 3.5
- 3.75
- 4
- 4.25
- 4.5
- 4.75
- 5
- More

- 8%
- 26%
- 45%
- 67%
- 73%
- 80%
- 83%
- 84%
- 86%
- 86%
- 87%
- 88%
- 88%
- 89%
- 89%
- 90%
- 90%
- 91%
- 100%
- 100%

n=2973
RAMPEx – SUMMER 2014

RAMPEx - Conducted August 1, 2014 to confirm the ability of the NYC, with the support of federal and state partners, to rapidly initiate citywide medical countermeasure dispensing operations in response to a bioterrorist attack, using current plans and without notice.

Preliminary Results:

- Over 850 staff responded on day of exercise
- Staff largely responded when and where they were directed to report – many arrived earlier than required
- Warehousing and delivery operations largely successful – all sites received deliveries, even with real-world problems (accidents, height restrictions)
  - Emergency delivery times would be significantly faster; trucks obeyed all traffic laws and police escorts did not use sirens
- Staff successfully set up PODs
- Confirmed overall speed of NYC’s ability to mobilize as well as some previously identified gaps:
  - Need more redundancy in leadership staff ("field promotions" were used effectively)
  - Need earlier access to medications.
## Lab Testing & Surv/Epi Investigation

<table>
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<th>THEN</th>
<th>NOW</th>
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</table>
| **Lab Testing Capacity** | ✓ BSL 3 Laboratory  
✓ Staff cross training for surge capacity  
✓ Clinical and environmental testing on over 400,000 specimens annually  
✓ BioWatch laboratory  
✓ PHL provides guidance and training to sentinel (hospital-based) lab staff re: proper handling/shipping/packing for specimen submission  
✓ Epi and Lab Data electronic linked |
| ✓ Processed 1-2 suspected bioterrorism environmental samples per month  
✓ Small Biosafety Level 2 (BSL-2) room with 2 staff  
✓ No electronic platform to easily share recent Epi data with our Lab |}

| **Surveillance and Epidemiology Capacity and Systems** | ✓ Surv/Epi staff increased surveillance and data analysis efforts  
✓ Automated ED surveillance  
✓ Automated prescription and over the counter (OTC) drug surveillance  
✓ 911 surveillance  
✓ School health nurse visit surveillance  
✓ Animal health surveillance  
✓ Electronic lab reporting  
✓ Staff depth and structure to support large investigations |
| ✓ 911 surveillance  
✓ Limited systems/integration between systems |
# Emergency Public Info & Warning

<table>
<thead>
<tr>
<th>THEN</th>
<th>NOW</th>
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<tbody>
<tr>
<td><strong>Message Development</strong></td>
<td></td>
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</table>
| - FAQ sheets created as needed | ✓ FAQs for 21 priority scenarios  
 ✓ Inventory of risk communications materials/templates that are available and ready to quickly modify  
 ✓ Rapid clearance protocol  
 ✓ Response Guides- in development |
| **Information Sources** |  |
| - Information to traditional media and press | ✓ NYC DOHMH Public Health Emergency Network website  
 ✓ NYC Partner Portal  
 ✓ Social Media Monitoring Team  
 ✓ Social Media Monitoring tools  
 ✓ Advanced Warning System |
## Volunteer Management

<table>
<thead>
<tr>
<th>THEN</th>
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<tbody>
<tr>
<td>Recruitment and engagement</td>
<td></td>
</tr>
</tbody>
</table>
| **No volunteer pool** | ✓ Largest Medical Reserve Corps program in nation, with 7650+ volunteers  
✓ Specialized volunteer cadres  
✓ 30+ trainings, exercises and drills  
✓ Recruitment events  
✓ Monthly newsletter  
✓ Facebook page |
| Management | |
| **No system to manage volunteers** | ✓ ServNY to register, credential volunteers  
✓ Automated system for notification  
✓ Online scheduling and deployment system- in development |
Critical Needs

1. Funding
   - Public Health Emergency Preparedness (PHEP)
   - Hospital Preparedness Program (HPP)

2. Medical Countermeasures
   - Immediate access to medications for Phase I PODs
   - Federal staff trained to fulfill POD Core team roles
   - SNS sustainability

3. BioWatch
   - Funds
   - Indoor guidance and bioremediation standards
   - Federal coordination
Critical Need: Decline in Federal Funds

NYC PHEP-HPP Awards

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<td></td>
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<tr>
<td>HPP Award</td>
<td>$5,92</td>
<td>$10,8</td>
<td>$12,8</td>
<td>$12,5</td>
<td>$12,4</td>
<td>$10,9</td>
<td>$10,4</td>
<td>$9,48</td>
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<td>PHEP Award</td>
<td>$22,8</td>
<td>$20,8</td>
<td>$26,1</td>
<td>$28,4</td>
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<td>$28,4</td>
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<td>$20,6</td>
<td>$19,2</td>
<td>$18,6</td>
<td>$17,8</td>
<td>$18,5</td>
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</table>
Critical Need: PHEP Funding

NYC PHEP award decreased 35% since peak in 2004

Funded Staff 2005  Funded Staff 2014

210  119

- Over 82% of PHEP funds core DOHMH preparedness and response staff
- Funds prioritized to meet key grant deliverables and maintain baseline

IMPACT:
- Limited funds for new initiatives/innovation or address gaps
- Endangers our ability to maintain syndromic surveillance systems
- Public Health Lab now has limited ability to respond after-hours
- Decreased regional coordination
- Elimination of redundant communications systems
Let's work together....

1. Quantify the value and impact of preparedness work
2. Identify strategic political champions
3. Tell the story
Critical Need: MCM Prepositioning

Estimated number of hours after notification that “Phase 1” NYC PODs could open (including mobilization of staff, supplies, set up and training)

4½-6

Estimated number of hours from authorization for delivery of SNS assets at NYC RSS

8-9*

Plus time from request to authorization and time to deliver from RSS to PODs

12-13

Actual estimated delivery time to PODs

- NYC can meet CRI mandate to prophylax population within 48 hrs
- Medication is rate limiting step
- Establishing and maintaining local MCM cache for public is cost-prohibitive
1. **Funding**
   - Limited funds from DHS Biowatch dedicated to support lab and field operations
   - No funds from CDC or DHS support public health planning
   - Implications are enormous and decisions need to be made almost immediately
   - In 2013 DOHMH estimated the cost of supporting the program to be approximately $650,000

2. **Indoor guidance and bioremediation standards**
   - 11 years after Biowatch program deployed in NYC, still no indoor guidance.
   - Nearly 13 years after Anthrax letter attacks no workable standards on how clean is clean:
   - If NYC were to apply the same standards used to remediate the Hart Senate Building (i.e., a zero spore count) to a wide-area release in Manhattan it would take 300+ years to complete

3. **Federal coordination**
   - Limited interagency BioWatch planning at the federal level
   - Critical gaps in preparedness, response, mitigation and recovery planning
   - Immediate response require close coordination at all levels
   - Role and responsibilities must be clear before an incident
Conclusion

- NYC continues to be at demonstrably high risk
- Capabilities have been built and tested
- Funding critical to sustain and build capabilities

- Let’s work together to.....
  - Ensure adequate level of funding
  - Ensure timely access of medical countermeasures to the public.
  - Ensure successful BioWatch program through adequate funding and coordination.
Development of Public Health and Medical Response Systems in Utah

Kevin McCulley
Public Health and Medical Preparedness Manager
Bureau of EMS and Preparedness
Utah Department of Health
Why Plan?
Resource Limited
Declared Disasters In Utah
1968 - Dugway
1999- Downtown Tornado
2008 – SE Ski Bus Crash

Colorado to Arizona
Ran off a curvy road and rolled down an embankment
Split open the vehicle’s roof and threw some passengers 100 yards.
Nine were killed and about 20 others injured.
2013 – Jensen Explosion
Ricin detected following suicide attempt at North Logan home

Tour bus crashes in Utah, 6 dead
Nephi, Utah (CNN) -- Six elderly women died and at least 19 others were injured Wednesday when their tour bus crashed on a mountain road during a fall foliage tour, authorities said.

San Juan County * The carbon

Carbon monoxide leak hospitalizes at least 40 at S. Utah school

Patient exhibiting Ebola symptoms admitted at Primary Children's Hospital

Dugway says lockdown caused by 'serious mishandling' of nerve agent
Development of Coordinated Medical Response

SALT LAKE 2002
Timeline

► HRSA 2002 National Bioterrorism Hospital Preparedness Program
  ▪ Hospital/stockpiling centric

► PAHPA 2006 creation of ASPR HPP
  ▪ All hazards/capability focused
  ▪ Inclusion of LTC/SNF and CHC

► 2010-present Regional Medical Surge Coalition development

► Now 40% Cut to HPP
Regional Medical Surge Coalition Development

- Assessment of Existing Regions, hospital catchment areas, normal patient access and transfer patterns with EMS and hospitals
- LHD approx. match patient movement patterns
  - LHD was developing increased role in ESF8 in jurisdictions
  - Additional support to LHD Emergency Response Coordinator in assisting with medical facility coverage in command centers
  - History of success with PHEP in LHD and ongoing excellent relations
  - Relative ease of grants processing, budgeting, and workplans
  - Use local people to serve local agencies, take advantage of existing relationships
Utah Coalitions Structure and Characteristics

- Population Density (29 Counties)
- Hospital Density
- Coalition Composition
  - SST – 107 members (3 LHD)
  - Southeast – 12 members (1 LHD)
- Coalition Targets
  - Planning – HVA, membership, comms and resource plans
  - Training – HCO and HCW needs
  - Exercising – Required yearly
  - Equipping – HVA -> Asset cache for the best for the most, tracking system
Grant Elements

- Priority
  - Recruit and Retain new and different members
  - Required Functional or Full-Scale Exercise
  - Finalize Regional equipment and supply cache inventory tracking system
  - Adopt new HPP Program Measures – Development, COOP, Medical Surge
  - Continue engaging VOAD, MRC, etc.
  - Sustain Interoperable/Redundant Comms and test
Barriers and Challenges

- Communication gap between entities – limited LHD-hospital-LTC planning
- Rural challenges – up to 150 miles between some facilities, response is county-based
- Impression that Coalition was walking over existing groups – LEPC, ESF8
- Recruitment is much easier than retention
Sustainability

- **Short Term Sustainability**
  - Invest in the process and people – 40% of Utah’s grant to Coalitions
  - Sustain a Regional cache, training, and exercise fund
  - Work across all levels of Responder agencies to define value of Coalition
  - Leverage the champions in each community

- **Longer Term Sustainability**
  - Yearly exercise in each Region in which any members can play
  - Region as primary on technical assistance for CMS EM Rules
  - Increased inter-Regional and interstate coordination
  - Development of Regional Resource hospitals
    - Burn and pediatric receiving hospitals
  - Continued coordination with State and local EMS agencies for MCI planning
Recent Progress and Successes

► CDC/ORISE Pediatric Medical Surge Workshop
  ▪ Tools for General Hospitals across the country
  ▪ Establish multi-state pediatric medical surge plan
  ▪ Advance partnerships within the state

► Western US Burn Surge Consortium
  ▪ Link 26 Burn Centers across Western US
  ▪ Bed Availability and Patient Movement

► Intermountain Center for Disaster Preparedness
  ▪ Training Center established in hospital
  ▪ All-hazards clinical training and disaster simulation
  ▪ Address training for students in health professions
10th Annual ASTHO’s DPHP

Oregon: Preparedness Program – A Ten Year Review

M.K. Harryman, MA
Director of Emergency Operations

Oregon Health Authority
Public Health Division

October 2014
Preparedness Program

1999 – 2 FTE
2002-2003 – PH Preparedness & Hospital programs established
2005 – Oregon’s Cities Readiness Initiative region established
2006 – Changed program focus to All-Hazards, moved to the Director’s Officer
2007 – Established the field Liaison Program and integrated PHEP & HPP
2007 – Moved SNS operations into the Immunization Program
2009-2010 – H1N1 Response
2010 – Major changes inside the state relating to HPP (Coalitions)
2011 – Changed name of program to Health Security, Preparedness & Response
2012 – Oregon Health Authority was established
2013 – HSPR moved to the Center of PH Practice
2014 – Current state staff funded on both PHEP & HPP – 35 FTE

Healthy Oregon
Figure 1  Oregon’s Public Health Hazard Vulnerability Assessment (PH-HVA)
HAN Presence by Group - 2007

- LHDs
- Tribes
- Hospitals
- Local Emer Mgmt
- State
- Federal Partners
- Cross Border Partners
HAN Presence by Group - 2014

- LHDs
- Tribes
- Hospitals
- Local Emer Mgmt
- State
- Federal Partners
- Cross Border Partners
<table>
<thead>
<tr>
<th>Region 1 Central/SW WA</th>
<th>ED Diversion</th>
<th>Trauma</th>
<th>Critical Care</th>
<th>CT Scan</th>
<th>EOP Activated?</th>
<th>Comment</th>
</tr>
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<tbody>
<tr>
<td>UIH - OHSU</td>
<td>Open</td>
<td>Open</td>
<td>Open</td>
<td>Open</td>
<td>Operational</td>
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<tr>
<td>DC - Doernbecher Childrens Hospital</td>
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<td></td>
</tr>
<tr>
<td>EM - Legacy Emanuel</td>
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<td>Open</td>
<td>Open</td>
<td>Operational</td>
<td>No</td>
<td></td>
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<tr>
<td>RCH - Randall Childrens Hospital at LTH</td>
<td>Open</td>
<td>Open</td>
<td>Open</td>
<td>Operational</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>GS - Legacy Good Samaritan Hospital</td>
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<td>Not Applicable</td>
<td>Open</td>
<td>Operational</td>
<td>No</td>
<td></td>
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<tr>
<td>PR - Providence Portland Medical Center</td>
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<td>Not Applicable</td>
<td>Open</td>
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<tr>
<td>SW - PeaceHealth Southwest Med Ctr</td>
<td>Open</td>
<td>Open</td>
<td>Closed</td>
<td>Operational</td>
<td>No</td>
<td>BEHAVIORAL HEALTH BEDS @ CAPACITY, NO LOCKED BEDS AVAILABLE</td>
</tr>
<tr>
<td>SCA - Legacy Salmon Creek</td>
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<td>Not Applicable</td>
<td>Open</td>
<td>Operational</td>
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<tr>
<td>VA - VA Medical Center - Portland</td>
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<td>ED at capacity</td>
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<td>no behavior health beds available</td>
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<tr>
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<th>ED Diversion</th>
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<th>CT Scan</th>
<th>EOP Activated?</th>
<th>Comment</th>
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</thead>
<tbody>
<tr>
<td>PA - Adventist Medical Center</td>
<td>Open</td>
<td>Not Applicable</td>
<td>Open</td>
<td>Operational</td>
<td>No</td>
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<tr>
<td>MH - Legacy Mt Hood Medical Center</td>
<td>Open</td>
<td>Not Applicable</td>
<td>Open</td>
<td>Operational</td>
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<tr>
<td>WF - Providence Willamette Falls Med Ctr</td>
<td>Open</td>
<td>Not Applicable</td>
<td>Open</td>
<td>Operational</td>
<td>No</td>
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<tr>
<td>SK - Kaiser Sunnyside Medical Center</td>
<td>Open</td>
<td>Not Applicable</td>
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<td>Operational</td>
<td>No</td>
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<tr>
<td>PM - Providence Milwaukee Hospital</td>
<td>Open</td>
<td>Not Applicable</td>
<td>Open</td>
<td>Operational</td>
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<th>Region 1 Western</th>
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<th>CT Scan</th>
<th>EOP Activated?</th>
<th>Comment</th>
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<tbody>
<tr>
<td>SV - Providence St Vincent Medical Ctr</td>
<td>Open</td>
<td>Not Applicable</td>
<td>Open</td>
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<td>No</td>
<td>L &amp; D and NICU on divert</td>
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<tr>
<td>MP - Legacy Meridian Park Hospital</td>
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<td>Not Applicable</td>
<td>Open</td>
<td>Operational</td>
<td>No</td>
<td>L and D on divert</td>
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<tr>
<td>TH - Tuality - Hillsboro</td>
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<td>Open</td>
<td>Operational</td>
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<td>WK - Kaiser Westside Medical Center</td>
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<td>Columbia Memorial Hospital</td>
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<td>Ocean Beach Hospital</td>
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<td>Operational</td>
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<tr>
<td>Providence Seaside Hospital</td>
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<td>Not Applicable</td>
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<tr>
<td>Tillamook Regional Medical Center</td>
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<td>PeaceHealth Sacred Heart MC - Riverbend</td>
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<tr>
<td>PeaceHealth Sacred Heart MC - University</td>
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<td>Operational</td>
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<td></td>
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<tr>
<td>Southern Cross Hospital and Health Center</td>
<td>Open</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Operational</td>
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</tbody>
</table>
Preparedness Surveillance and Epidemiology Team

Overview of PSET

• Responsibilities include maintaining situational awareness, supporting local hazard response planning, disaster epidemiology, supporting surge planning

Crisis Standards of Care Guidance

• State workgroups developed guidance for statewide guidance for how to respond if a major infectious disease or mass trauma occurs
• Workgroups included nurses, physicians, hospital administrators, health officers, EMS, EM, LHD, law, experts in ethics.
• Guidance presents an ethical framework and strategies for healthcare response in times of crisis

Hazard Toolkits

• Crisis and emergency risk communication toolkits complete for flooding, winter weather, extreme heat, wildfire, influenza
• Crisis and emergency risk communication toolkits under development for earthquake, drought, emerging disease, hazmat (including oil trains)
Integration of SNS/MCM Operations with Immunization Program

• Past to Present:
  – 2007 – SNS operations moved to OR’s Immunization Program
  – Partner with OR Board of Pharmacy – essential partner SNS, staff on SNS Strike Team
  – OR Immunization Program (OIP) enroll pharmacy users into ALERT IIS
  – Est. 97% of OR’s pharmacies are chain pharmacies
  – Work on state statues and administrative rules
    • 2012 – changed statute requiring pharmacist to report immunization into the ALERT IIS
    • 2013 – Bill authorized pharmacists to vaccinate down to age 3 during a public health emergency or outbreak when requested by the Public Health Director;
      – pharmacists can currently vaccinate down to age 11 without a prescription or down to age 2 with a prescription
    • 2014 – requires pharmacists to use ALERT IIS to determine patient’s vaccine history and to forecast needed vaccines before administering vaccines.
  – ALERT IIS is housed within the Immunization Program
State Lab Operations

• The only LRN-B Reference Lab for Oregon
  – 89 currently identified OR Sentinel Labs
• Level 3 LRN-C Lab
• Participate in LRN, PHEP and CDC Select Agent Program Requirements, drills and proficiencies
• “Pre & Post” Info: Large reduction from original PHEP/LRN staff and budget while still maintaining testing capabilities and surge capacities
• Coordinate and plan activities with HSPR and ACDP groups
Electronic Death Records

2005 – PHEP $1,050,000 to develop our Electronic Death Registration Systems


2013 – CDC DSLR special funding opportunity

Present – 31% of death records fully completed in the system
  61% of the death records are partially completed – hybrid
  Fully electronic deaths are now registered in 7 days after the date of death and hybrid records in 18 days
  We now send records to CDC 3 times a week

• Our goal is to have 80% of the death records fully electronic by Sept 2015.
Registered Nurse 39%

Physician 11%

Other occupations or occupations with less than 10 members, 16%

Other identified occupations with more than 10 members, 6%

Acupuncturist 2%

Veterinarian 2%

Physician, Naturopathic 2%

Physician Assistant 1%

Psychologist 1%

EMT, Intermediate 1%

Athletic Trainer 1%

Dental Assistant

Social Worker (LCSW)

Dental Hygienist

Pharmacist Intern

Student

Emergency Medical Responder

Respiratory Therapist

Counselor, Mental Health

Animal Health Technician

Public Health Administration

Total members: 2429

September 2014

SERV-OR Members

All units, all roles, by primary occupation

Nurse Practitioner (NP) 3%

Emergency Medical Technician (EMT) 4%

Pharmacist 3%

Paramedic 3%

Chiropractor 2%

CNA 2%

LPN 1%

Dentist 1%

Other identified occupations with less than 10 members, 16%

Physician, Naturopathic 2%

Physician Assistant 1%

Psychologist 1%

EMT, Intermediate 1%

Athletic Trainer 1%

Dental Assistant

Social Worker (LCSW)

Dental Hygienist

Pharmacist Intern

Student

Emergency Medical Responder

Respiratory Therapist

Counselor, Mental Health

Animal Health Technician

Public Health Administration

Other identified occupations with more than 10 members, 6%

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Physician 11%

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Psychologist 1%

EMT, Intermediate 1%

Athletic Trainer 1%

Dental Assistant

Social Worker (LCSW)

Dental Hygienist

Pharmacist Intern

Student

Emergency Medical Responder

Respiratory Therapist

Counselor, Mental Health

Animal Health Technician

Public Health Administration

Other identified occupations with less than 10 members, 16%
AmericaCorp/VISTA Program Success

- **128** VISTA members served with Oregon Public Health VISTA Program since 2009
- Total value of VISTA hours is over **$2,870,000**
- Average of **285 training hours** per VISTA member per year
- Shift in culture at local health departments toward **Continuous Quality Improvement**
- Standardized volunteer trainings at **Medical Reserve Corps** units
- **Wellness at Work** initiatives in nine local health departments
- VISTA Members “graduate” to become public health leaders (physicians, nurses, MPH, Volunteer Coordinators, CDC Fellows)
- Local and national recognition through awards and poster presentations
- Service year reflects graduate-level learning experience for VISTA members
Agency Operations Center

Healthy Oregon
Agency Operations Center

Healthy Oregon
Point of Contact Information

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Kansas Preparedness Program – 10 Year Review

Our Mission: To protect and improve the health and environment of all Kansans.
KDHE & Preparedness

• KDHE’s Mission: To protect and improve the health and environment of all Kansans

• KDHE Preparedness Mission: Provide leadership to protect the health of Kansans through efforts to mitigate, prepare for, respond to and recover from disasters, infectious disease, terrorism and mass casualty emergencies
Our Mission: To protect and improve the health and environment of Kansans.
2014 KDHE Preparedness Program

43 People

Our Mission: To protect and improve the health and environment of Kansans.
10 Years of Disasters

- 2006-2007 – ¾ Statewide ice storm
- 2007 – Large chemical fire
- 2007 – Greensburg tornado
- 2007 – SE KS flooding
- 2007 – Barton Solvents explosion
- 2007 – Chlorobenzyl chloride train leak
- 2007 – Statewide blizzard
- 2008 – Satellite re-entry: Hydrazine
- 2008 – Pittsburg mercury spill
- 2008 – Mumps outbreak
- 2008 – Laboratory mold
- 2009 – H1N1 pandemic
- 2010 – Galena “Virus”
- 2011 – NE KS flooding
- 2011 – KC water supply contamination threat
- 2012 – Wichita tornado
- 2012 – Hepatitis C exposures
- 2014 – Baxter Springs tornado
- 2014 – Measles outbreak
- *Every winter snow storms
- *Every spring tornados
- *Every summer heat
- *Countless suspicious powders
# Preparedness 5 Year Capabilities Strategy

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<td><strong>State Level Capabilities Work</strong></td>
<td>1, 2, 3,</td>
<td>4, 10, 15</td>
<td>6, 11, 12</td>
<td>5, 7, 14</td>
<td>1, 2, 3</td>
<td>8, 9, 10, 13</td>
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<td><strong>Local and Regional Level Capabilities Work</strong></td>
<td>8, 9, 13</td>
<td>1, 2, 3</td>
<td>4, 10, 15</td>
<td>6, 11, 12</td>
<td>5, 7, 14</td>
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<td><strong>Exercises</strong></td>
<td>8, 9, 13</td>
<td>Any capability</td>
<td>1, 2, 3</td>
<td>All Capabilities (Vigilant Guard 2014)</td>
<td>6, 11, 12</td>
<td>5, 7, 14</td>
<td>1, 2, 3</td>
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Joint Planning

• In Kansas, we look at the entire sector having roles in each capability. This helps engage hospitals and others into capability and function development.

• PHEP
  – Capability 4 – Emergency Public Information and Warning

• HPP
  – Capability 6 Function 1 – Healthcare information sharing with the public
  – Capability 3 Function 2 – Community notification of healthcare delivery status

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Our Mission: To protect and improve the health and environment of Kansans.

Capability 1, 2, 3

**Then**
- Fragmented agency response efforts
- Very limited health and medical planning coordination/requirement
- Public health emergency role?

**Now**
- Internal coordination
- Kansas Planning Standards
- LEPC and Coalition development
- Templates
  - Hospital COOP Plan
  - Community Alternate Care Site
  - Health Department COOP Plan
  - Hospital Emergency Operations Plan
  - Community Mental Health Center
  - Dialysis Center
  - Safety Net Clinic Emergency Management Plan
Capability 4

Before
• Message maps – SNS related

Today
• Public Information and Communication SOG
• Public Information included in the hospital emergency operations plan and other medical organization templates

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Capability 5

Past
- Kansas Funeral Directors Association mass fatality plan

Present
- Community-based standard operating guide template being developed
- Includes Family Assistance Center
Capability 6

Then
• Public Health Information Exchange

Now
• Multidisciplinary KS-HAN
• CRA
• Dispense Assist
• Preparedness and Trauma Program partnership to fund the state’s HAvBED application
Capability 15

**Formerly**
- Spontaneous volunteers

**Currently**
- Comprehensive Resource Management and Credentialing System
- Accountability and resource management
- Health and Medical Sector personnel qualifications integrated with ESAR-VHP
- 18 Medical Reserve Corps units, including one state-wide Kansas Veterinary MRC unit

Our Mission: To protect and improve the health and environment of Kansans.
Our Mission: To protect and improve the health and environment of Kansans.
Questions

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Our Mission: To protect and improve the health and environment of all Kansans.

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