

ANNUAL REPORT on public health preparedness



Public Health Preparedness Advisory Committee

January 1, 2008

**Annual Report on Public Health Preparedness
to Governor M. Jodi Rell
and the Connecticut General Assembly**

**Connecticut Department of Public Health
Public Health Preparedness Advisory Committee**

December 31, 2008

In accordance with Connecticut General Statutes, Section 19a-131g, the Connecticut Department of Public Health and the Public Health Preparedness Advisory Committee do hereby submit a status report on public health emergency preparedness planning in Connecticut.

LEADERSHIP AND PARTNERSHIPS

The Connecticut Department of Public Health (DPH) is the lead administrative and planning agency for public health initiatives, including public health emergency preparedness and response. Public health emergency planning is an integral part of overall emergency preparedness and response in Connecticut. Over the past nine years, DPH continues to collaborate with Federal, State, regional, and local partners to improve the state's ability to respond to a wide range of emergencies, including biological, chemical, radiological, and natural disasters that impact the public's health.

DPH Commissioner J. Robert Galvin continues to meet regularly with Governor Rell and the Connecticut Department of Emergency Management and Homeland Security (DEMHS) Commissioner Thomas to coordinate public health and overall emergency preparedness and response activities in Connecticut. DPH serves on the DEMHS Coordinating Council for emergency response and Homeland Security Workgroup for grant coordination.

DPH has assumed leadership of various state initiatives. For example, DPH chairs the Governor's Pandemic Influenza Strategic Planning Task Force and is actively working with the Judicial Branch and Probate Court representatives to develop consensus as to court operations in the event of a public health emergency requiring quarantine and isolation measures.

Commissioner Galvin established a workgroup on Standards of Care during a mass casualty event. The workgroup is comprised of ethicists, clinicians, local and state public health professionals, and attorneys. They are charged with identifying key ethical, legal and practical principles to guide decision-making during an influenza pandemic or any other mass casualty event. DPH and state partners will apply these principles to inform and educate the public regarding the options that will be considered during a widespread

public health emergency. The workgroup has met throughout 2008 and is preparing a Briefing Paper for publication in 2009.

DPH also convened an Interagency Workgroup to develop a standardized, regional approach for providing shelter to vulnerable, at-risk populations. While universal access shelters will provide services for people with special needs (physical, sensory, developmental, cognitive or psychiatric needs), there are people at-risk during an emergency because they do not have basic support of family or personal assistants. The Workgroup will define at-risk populations, identify needed locations, and list the levels of "supportive care" needed. Supportive Care Shelters (SCS) would operate by pooling the resources of state agencies, health care providers, and volunteers at a regional level.

PUBLIC HEALTH PREPAREDNESS ADVISORY COMMITTEE

The DPH Public Health Preparedness Advisory Committee met three times during 2008 and provided review and comment to the public health and health care system cooperative agreement applications. Starting in 2009, the Advisory Committee will become the Public Health Subcommittee to the Connecticut Emergency Management and Homeland Security Coordinating Council, established under Connecticut General Statute Section 28-1b. The DPH Public Health Preparedness Advisory Committee will retain its functions and membership as defined in Connecticut General Statute 19a-131g. Attachment A includes enabling legislation and federal funding requirements for a senior advisory committee.

Serving as the Subcommittee to the Coordinating Council will allow public health to have a stronger voice in overall emergency management in Connecticut and to share and review information on public health and health care systems emergency preparedness and response activities. The Subcommittee shall submit monthly reports to the Coordinating Council through the CT Department of Public Health. The Subcommittee will continue to submit an annual report to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to public health and public safety.

CRISIS AND EMERGENCY RISK COMMUNICATION

In 2007, the DPH conducted a statewide multi-media campaign to inform the public about pandemic influenza. The campaign continued in 2008 with distribution of more than 150,000 pamphlets throughout the state. To coincide with the flu season in October and November, DPH re-aired the 30-second television public service announcement on cable networks and placed print advertisements in ethnic newspapers.

To increase pandemic influenza awareness by healthcare providers, DPH mailed pandemic influenza posters to all hospitals and community health centers in the state. Posters were also distributed to local health departments for broader posting in their communities. Due to the large demand for the posters, DPH printed an additional 1,000 posters in English and 500 posters in Spanish for distribution to local health departments throughout the state.

In addition to the pandemic influenza educational campaign, DPH continued to improve its risk communication plan and prepared messaging materials. Media contact information

has been expanded, increasing the number of methods for message coordination and dissemination. DPH distributed public health preparedness guides to all Connecticut media outlets to ensure that the media has informational resources immediately available during an emergency.

DPH continued to focus on emergency information needs of special populations. Local health departments have included key contacts for special population groups in their community so that they will receive important health-related messages quickly and efficiently. The pandemic influenza education campaign helped identify non-English speaking populations and has developed relationships with the media that serves them. The pandemic influenza brochure was translated into Haitian Creole, Chinese, Vietnamese, Spanish, Polish, and Portuguese, and will be distributed to organizations that serve these groups. Other emergency preparedness documents will be translated in the coming year.

DPH sponsored a two-day training in July for local health departments, hospitals, school systems, and other state agencies on message development during an influenza pandemic. The trainer was Dr. Vincent Covello, an expert in the field of risk communication. A Crisis and Emergency Communication Plan template was provided to participants as well as an updated media list and other resources.

SURVEILLANCE

During 2008, there were two major types of surveillance efforts directed toward public health preparedness: 1) maintenance of special surveillance systems designed for rapid recognition of and response to outbreaks; and 2) maintenance of special surveillance systems used for monitoring influenza and pandemic influenza. In addition, there was further development on electronic reporting to enable timelier reporting public health emergencies.

DPH maintained four special surveillance systems designed to enhance detection of possible bioterrorism events and outbreaks: 1) the Hospital Admissions Syndromic Surveillance System (ongoing since October 2001); 2) the enhanced varicella surveillance system (ongoing since January 2003); 3) the Gram positive rod laboratory reporting system (ongoing since January 2003) for early detection of a single, initial case of anthrax; and, 4) the laboratory-based system using PFGE (ongoing since 1997), a genetic technique for fingerprinting bacteria, to detect outbreaks due to salmonella, *E. coli* and listeria. The first three systems are intended to minimize the potential for missing a first case of smallpox or anthrax or other unusual related disease. They identify suspect cases and clusters even if the physician seeing the patient did not consider smallpox or anthrax in the differential diagnosis of what was causing illness. The PFGE system is intended to detect geographically widely scattered related cases and outbreaks due to contamination of food at the food production/distribution level.

From October, 2007 through September, 2008, the following surveillance systems reported the following outbreaks and incidents:

▲ 45 hospital admissions of persons with fever and rash – confirmed not to be smallpox;

- ///74 persons with unusual cases of chickenpox (admitted to hospital or an adult with chickenpox) – confirmed not to be smallpox;
- ///382 reports of gram positive rods reported – confirmed not to be anthrax or the first indication of a cluster of cases of clostridium;
- ///2 Salmonella outbreaks detected by PFGE (that implicated consumption of ground turkey and jalapeno peppers), investigated in collaboration with CDC and other involved states; and
- ///19 other multistate clusters (16 Salmonella spp., 2 E. coli 0157, 1 Listeria monocytogenes) investigated in collaboration with CDC and other involved states; 18 of the investigations did not implicate a food item.

Surveillance for outbreaks continued using healthcare provider reporting. A total of 254 outbreaks were reported with DPH response:

- ///152 institutional outbreaks of respiratory illness (mostly influenza in nursing homes);
- ///75 institutional outbreaks of gastroenteritis (mostly in nursing homes);
- ///14 outbreaks of foodborne disease;
- ///2 outbreaks of waterborne illness;
- ///11 outbreaks due to other causes.

In addition, DPH responded to two reports of disease in people infected with organisms classified as Category A bioterrorism agents: one case of tularemia and two cases of anthrax. In all, infection was found to be due to natural causes, not due to attempted bioterrorism.

The following Influenza and Pandemic Influenza monitoring systems were maintained: 1) laboratory reporting of all laboratory confirmed influenza cases including the type of influenza (e.g., type A or B, sub-type H3N2, etc.); 2) daily Hospital Admissions Syndromic Surveillance System reporting of all unscheduled hospital admissions with pneumonia (excess admissions correlate very highly with influenza activity); and 3) daily Emergency Department Syndromic Surveillance (EDSS) system reporting of the total number and percentage of all visits that are for fever/flu, numbers that highly correlate with influenza activity. These systems are monitored at least weekly for levels of activity during the influenza season. Currently, there are 19 participating emergency departments covering the five major urban areas and all counties in Connecticut. The EDSS system can also be modified to look at the occurrence of any syndrome in the wake of any environmental or intentionally caused event that could increase the need for emergency care.

Connecticut has now joined 14 other state Public Health Departments to become part of the Hazardous Substances Emergency Events Surveillance (HSEES) system. The HSEES system was established by the Agency for Toxic Substances and Disease Registry's (ATSDR) to collect and analyze information about acute releases of hazardous substances and threatened releases that result in a public health action such as evacuation. The goal of HSEES is to reduce injuries and deaths of first responders, employees, and the general public that result from hazardous substances releases.

STATE LABORATORY

In 2008, the DPH Bioterrorism Response Laboratory (BT Lab) tested 83 unknown white powders submitted by law enforcement and subsequently reported them as negative for bioterrorism agents within 48 hours of their submission. The BT Lab also continued to participate in CDC's Laboratory Response Network's proficiency testing program. During the past year, the Laboratory successfully tested five clinical samples for *Coxiella burnetti*, five food samples for *Clostridium botulinum*, and five environmental samples for Ricin toxin. The laboratory received a score of 100% for all of the proficiency tests.

The BT Lab, in collaboration with the Hartford Hospital Center of Excellence, hosted a Laboratory Preparedness Conference. The topics presented included: *MRSA Testing at DPH, BT Refresher Training, The Emergency Credentialing Program and How It Will Work, Lymphocyte Isolation Procedure, How Some Labs in New Orleans Weathered the Storm, Customizable Protocols and the Role of the Poison Control Center in Surveillance and As A Hospital Resource*. Fifty-five representatives from sentinel laboratories attended.

Last year, the DPH Virology Lab processed 1,047 influenza screens compared to 606 for the previous year. It has undertaken a thorough review of testing methodologies that would be used in either a normal influenza season or a pandemic. Testing strategy has focused on implementation and validation of a molecular assay that would be fast and extremely accurate. Using a CDC approved method, DPH has now validated a molecular assay that is timely and offers specific results for Influenza A, including H1, H3 and H5 subtypes as well as Influenza B. With the new molecular assay in place, the DPH Laboratory is well positioned to handle future influenza testing demands.

During the past year, the Environmental Chemistry Division of the DPH Laboratory applied for and won a five-year cooperative agreement with the Environmental Protection Agency (EPA) to develop resources to respond to a radiological event. There is a nationwide lack in capacity for a radiological response, and Connecticut was one of three states that received an award to address this gap in preparedness. The Environmental Chemistry Division serves as the Primacy Laboratory for analyzing radionuclides in drinking water in Connecticut and is a reference laboratory for other New England states.

The cooperative agreement was awarded in September and provides approximately \$500,000 for equipment and a chemist. Grant activities will focus on the development of rapid analytical methods to analyze the large number of environmental samples that would be generated by a radiological event. Current analytical techniques for some isotopes can take up to 21 days per sample. The grant will also support analyzing sample types other than water (e.g. soil, concrete, asphalt, etc), add analytical techniques that are not currently performed by the laboratory, and enable the laboratory to receive samples with more than background levels of activity.

The Chemical Terrorism Response Laboratory (CTRL) provides a focus for the proper and secure collection, packaging and transport of clinical specimens (blood and urine) from persons potentially exposed to chemical terror events. CTRL serves as the primary connection between the acute care hospitals and the Centers for Disease Control and Prevention. In addition, CTRL has continued to develop and implement analytical capacity for Chemical Terrorism Preparedness and Response in support of a chemical terror event or emergency since federal funding for this component began in 2004.

To date, the CTRL at the Department of Public Health Laboratory (DPHL) has conducted validation of methods for cyanide in blood; organophosphate nerve agent metabolites (OPNA) in urine; 12 trace metals in urine; arsenic and selenium in urine; mercury, lead, and cadmium in blood; and 10 volatile organic chemicals (VOCs) in blood using the standard protocols and procedures mandated by CDC.

The DPH Laboratory also provides funding and support to our partners, including the Connecticut Agricultural Experiment Station (CAES) for chemical testing in food, the UCONN Pathobiology Lab for testing in animals, and the Yale Radiation Biodosimetry Laboratory for analysis on effects of radiation.

PLANNING, TRAINING, AND EXERCISES

DPH has worked collaboratively to address assessment, planning, training, and evaluation components consistent with federal guidance and state goals. DPH has designed a planning, training, and exercise model to maximize preparedness and emergency response efforts. Planning provides the protocol, training provides a competent workforce to implement the protocols, and exercises are intended to evaluate the completeness and appropriateness of both planning and training programs.

Planning

One of the major accomplishments in 2008 was the submission of the State's Pandemic Influenza Operational Plan to the CDC. DPH coordinated the submission that included input from a number of other state Departments, including: Administrative Services, Mental Health and Addiction Services, Education, Information Technology, Public Safety; and DEMHS. The Operational Plan included over 80 documents that define the state's preparedness, response, and recovery protocols for any pandemic. Connecticut received a passing score on its plan, assuring the state will continue to receive federal funding for public health preparedness.

Regional planning, initiated in 2004, has moved forward by DPH contracting with 5 local health departments to serve as regional public health liaisons. Contracts were awarded to Bridgeport and Milford Health Departments, and West Hartford/Bloomfield, Ledge Light and Naugatuck Valley Health Districts. The Liaisons collaborate with DPH and DEMHS to build a regional public health infrastructure and draft the public health emergency response plans. DPH meets monthly with the Liaisons to share best practices and corrective actions, as well as clarify overall regional planning goals.

Local health departments submitted their jurisdictional (municipal or district) public health emergency response plans to DPH for review and comment. Each plan was reviewed for consistency, appropriateness, and completeness. DPH issued guidelines for each local health department or district to update their plans. In addition, several programs within DPH collaborate to provide planning assistance to local public health and healthcare providers. A list of DPH staff that support public health preparedness planning is provided in Attachment B.

A risk assessment of hazardous materials shipped through Connecticut by rail was initiated this year. Rail HAZMAT data was obtained for analysis from the US Surface Transportation Board as well as the rail companies operating in Connecticut. The assessment seeks to determine the probability of a major rail accident occurring in Connecticut and identify towns along rail corridors that have residents who may be at risk should a chemical release occur.

Antiviral and Vaccine Distribution Plans

National and state stockpiles of publicly purchased antiviral agents have been created for use during a severe influenza pandemic. Currently the federal government is stockpiling two antiviral medications (Tamiflu and Relenza) that may be helpful in mitigating pandemic influenza mortality and morbidity. The federal plan is to purchase and hold enough antiviral medication in the federal SNS to supply Connecticut with 525,000 10-pill courses. In addition, Connecticut has already purchased 14,238 antiviral courses to begin distribution before the federally maintained stockpile arrives in the state.

DPH updated and submitted Connecticut's antiviral distribution and vaccination plans to CDC. The Antiviral Plan aims to expend the supply to achieve maximum benefit before antiviral drug resistance develops. The Connecticut plan also has built in flexibility to alter priority groups for antivirals on the basis of the severity of the pandemic, and for the evolution of the pandemic from the early to later stages of the outbreak.

For pandemic influenza vaccines, the State of Connecticut will follow the response approaches and guidelines developed by the federal government, which will be the source of the vaccine. The federal government requires that certain priority groups have access to pre-pandemic (vaccine developed against avian influenza strains circulating in Asia) and pandemic vaccine (developed against the strain that is creating the pandemic, which can only be done after the pandemic begins and the strain identified). In general, the priority populations are medical personnel, first responders, workers that maintain critical infrastructure (such as utilities), and those persons most likely to develop severe complications of influenza.

Connecticut will use the mass dispensing systems previously developed for smallpox and other diseases that could require mass distribution of countermeasures to implement the antiviral and vaccine distribution plans. Eighty local health departments comprise 41 mass dispensing areas and distribute countermeasure to "well" state residents who are at risk for developing disease. Consolidation efforts are being considered due to reductions in Federal public health preparedness funding balanced by categorical funding increases via the *Cities Readiness Initiative* (CRI), a program designed to help improve mass dispensing indicators in DEMHS Regions 2 and 3. One local health department in each region received continuing CRI funding to coordinate mass dispensing improvement activities for their region.

Training and Education

DPH looks to ensure the delivery of appropriate preparedness and response education and training to key public health and health care professionals. DPH continued to build 5 key activities with respect to supporting the workforce with public health preparedness and

response training: 1) maintaining a Learning Management System, TRAINConnecticut, to support users in identifying training opportunities, and planners and policy makers with training and evaluation data; 2) build an infrastructure to support distance learning; 3) deliver training through collaborative efforts with academic and practice partners that meet key content areas identified by federal guidance and local needs; 4) Provide data and ongoing evaluation of learning for planning purposes, and 5) build future workforce preparedness through student internships and rotations that assist with preparedness activities.

The TRAIN learning management system, purchased in 2005, now has 12,000 user accounts and 150 course providers posting courses. Implementation is ongoing and this year marketing and training to local health partners and MRC units has advanced the number of course providers utilizing and posting relevant trainings to the system. The system provides the only preparedness and response training data for the public health workforce, and a smaller portion of training data for health care and first responders. A comprehensive report on training data from 2005 to present will be finalized in January and will be shared with relevant committees to be used for training program evaluation and strategic planning.

DPH advanced the training infrastructure with the purchase of Mediasite technology which allows us to produce online learning through webcasting and web-based archiving for important presentations or seminars on preparedness topics. DPH utilized this technology to provide an online overview of the Mass Dispensing Toolkit for those who could not attend the training. This helps to make the training available over time as the workforce turns over and can be utilized as a refresher training or archived resource. This technology along with the learning management system, is utilized agency and statewide to support distance learning activities for all response workers at both the state and local levels.

During 2008, the following public health preparedness education and training was provided by DPH in collaboration with its partners (Yale Center for Public Health Preparedness, DMHAS, DEP, the CT Fire Academy, DEMHS, CEHA, and the CT Partnership for Public Health Workforce Development).

- /// Addressing Needs of Diverse Populations;
- /// Bioterrorism (BT)/ Chemical Response/Radiation Biodosimetry kits with training CDs ;
- /// Chemical Spill Preparedness and Response Workshop (part of the Connecticut Environmental Health Association's 2008 Yankee Conference);
- /// Crisis and Emergency Risk Communication;
- /// Crisis Decisionmaking Seminars;
- /// Disaster Field Manual for Connecticut for Environmental Health Professionals;
- /// Emergency Preparedness Training for Day Care Providers;
- /// Homeland Security Exercise and Evaluation Training;
- /// Incident Command System 300 and 400;
- /// ICS Planning Section Training for DPH staff;
- /// First Responder Training (Lab);
- /// Leadership Skills;

- /// Linking Behavioral Health and Public Health Systems;
- /// Local POD Trainers: Roles, Resources, and Strategies;
- /// Mass Dispensing Toolkit Training (Collection of plans, protocols, guidelines, forms, and educational materials that can be used to develop and operate mass dispensing sites at local health departments, acute care hospitals and eventually at sites where large employers will offer dispensing to employees and their families. The Toolkit was developed to help foster a systematic and efficient statewide mass dispensing capability, while encouraging creativity and maintaining the flexibility for local health department, hospitals and large employers and institutions to adapt to local conditions);
- /// Media Training;
- /// Mobile Field Hospital Training;
- /// Packaging and Shipping Infectious Substances Category A and B (34 laboratorians attended and received certification allowing them to legally ship infectious substances);
- /// Respiratory Fit Testing and Training;
- /// Surge Epidemiology Training;
- /// Smart Tag System;
- /// Technical Assessment Review Orientation for Mass Dispensing Operations;
- /// TRAIN Basic and Course Provider Training.

Exercises / Drills

DPH continues to support regional and statewide drills and exercises as part of the planning, training, and evaluation process. Each local health department / district, acute care hospital, and federally qualified community health center in Connecticut participated in at least one drill or exercise in 2008. In total, these health partners participated in over 120 drills, exercises, real events, and associated training sessions. This equates to a sixty-six percent increase since 2007. The total number of exercises includes thirty hospital exercises, forty-four local health exercises, fourteen community health center exercises, thirty-one exercises with hospitals and local health, and three exercises with hospital, local health, and community health partners. Twenty-five exercises were regional events. Two exercises were limited statewide events, one for all hospital laboratories and one for all thirteen lead community health centers. Eight events were real world occurrences.

Thirty-two local health departments / districts and eight hospitals conducted twenty-two points of dispensing / flu clinic exercises. The exercises tested jurisdictional pandemic influenza plans during seasonal vaccination of community residents for influenza and pneumonia. One clinic used the drive-through model to test the ability to triage and vaccinate citizens without a conventional brick and mortar clinic. The local health departments / districts in DEMHS Region I ran separate, simultaneous clinics at Metro North train stations in the Region.

The Centers for Disease Control (CDC) required CT to conduct eight special clinics over a four-week period. The purpose of these clinics was to test data acquisition for the recipients and rapid delivery of the data to DPH and CDC. The clinics had to report

recipient data to DPH within twenty-four hours of the close of the clinic. DPH had to aggregate the data and report it to CDC weekly. This was easy to do for eight clinics. The goal of the process is to report data to CDC during a pandemic in nearly live time.

Health departments / districts and hospitals conducted fourteen pandemic related tabletop exercises including two for school dismissal and four for Alternate Care Facilities. Ten community health centers conducted pandemic tabletop exercises. Several health partners participated in a risk communications seminar and tabletop at Fairfield University. Local health partners in Region II conducted Extreme Heat and Ice Storm / Extreme Cold tabletop exercises.

Continuing from 2007, hospitals conducted several evacuation exercises: four tabletops, one drill, two functional exercises, and one full-scale exercise.

The fifth annual Bioterrorism Response Functional Drill for clinical laboratories was held in October 2008, with 32 participating sentinel laboratories. Thirty hospital labs, one reference lab and one local health laboratory participated. The purpose of the drill was to assess competency, document turn-around time and validate contact information. The organism used this year was a stained slide of *Yersinia pestis*. Thirty out of the thirty-two facilities correctly identified the organism based on its appearance and accompanied patient history. This type of drill is now a grant requirement for sentinel laboratories to keep them well prepared in the event of a bioterrorism incident.

The Laboratory's Environmental Chemistry Division participated in a full-scale exercise, which was designed to test how governmental laboratories in EPA Region 1 would coordinate response to an event that overwhelmed the capacity of any one lab in the region.

MOBILE FIELD HOSPITAL

Vehicle and equipment maintenance is ongoing at the five locations housing field hospital components and has included servicing to every shelter trailer as well as the primary movers. A small portion of the field hospital was moved to Danbury airport in preparation for area response to that region or, if requested, beyond state borders based on an EMAC request. Assessments for preplanned deployment sites at acute care hospitals are being updated as a result of renovations or landscape changes to acute care facilities.

Previously established staffing mechanisms for the field hospital by means of the State sponsored Disaster Medical Assistance Team (DMAT), the Emergency Credentialing Program (ECP) and local level Medical Reserve Corp (MRC) remain in place. There is a continuous recruitment effort for credentialed medical and logistical personnel. The following training programs for the Mobile Field Hospital were conducted in 2008:

- ▣ Set-up and support of Special Olympic event in Madison with local fire and police personnel;
- ▣ Set-up and support to pandemic exercise in Bethel involving local health departments and three area hospitals;
- ▣ Set-up static display for legislative and Uruguayan diplomats at Camp Hartell, Windsor Locks;

- /// Set-up and support to Milford Health Department's "Vote and Vax" event (flu vaccination clinic) drill in Milford. Event included walk through educational tours for local middle school students and staff;
- /// Five separate trainings on the use and operation of medical equipment in Hartford, New Haven, and Torrington;
- /// Two-day training event at Camp Hartell for logistical set-up and facility operation, Windsor Locks.

Operational functions included:

- /// Incident Command Center support during Salute to Veteran's event at Brainard Airport;
- /// Aid station support at Department of Veterans Affairs Operation Stand Down in Rocky Hill;
- /// Aid station support for traveling Vietnam Wall Memorial, Renscheler Field;
- /// Incident Command Center and aid station support for Extreme Homemakeover Event, Voluntown.

STATUS OF PUBLIC HEALTH PREPAREDNESS FUNDING FOR CONNECTICUT

DPH oversees public health preparedness funding from the Department of Health and Human Services' Centers for Disease Control and Prevention (CDC) and the Office of the Assistant Secretary for Preparedness Response (ASPR). In 2008, CDC decreased funding by 20% but maintained the requirements to enhance and state and regional operational plans for responding to public health threats and emergencies. CDC also eliminated supplemental funding for pandemic influenza planning. At the same time, ASPR decreased funds by 10% to develop operational plans and protocols for medical and hospital surge capacity, mass fatality and alternate care sites. Similar decreases in funding are expected in future years.

Beginning with the new funding cycle in August, 2009, Connecticut will be required to contribute 5% in matching funds during the first year and 10% in subsequent years. Federal legislation also requires states to institute maintenance of effort to sustain preparedness activities. Failure to do so will impact the level of future federal funding.

Attachment A – PUBLIC HEALTH PREPAREDNESS ADVISORY COUNCIL mandates

Connecticut General Statutes

Sec. 19a-131g. Public Health Preparedness Advisory Committee. Report. The Commissioner of Public Health shall establish a Public Health Preparedness Advisory Committee. The advisory committee shall consist of the Commissioner of Public Health, the Commissioner of Emergency Management and Homeland Security, the president pro tempore of the Senate, the speaker of the House of Representatives, the majority and minority leaders of both houses of the General Assembly and the chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to public health, public safety and the judiciary, and representatives of town, city, borough and district directors of health, as appointed by the commissioner, and any other organization or persons that the commissioner deems relevant to the issues of public health preparedness. The Public Health Preparedness Advisory Committee shall develop the plan for emergency responses to a public health emergency. Such plan may include an emergency notification service. Not later than January 1, 2004, and annually thereafter, the committee shall submit a report, in accordance with section 11-4a, to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to public health and public safety, on the status of a public health emergency plan and the resources needed for implementation of such plan.

Sec. 28-1b. State-wide Emergency Management and Homeland Security Coordinating Council: Duties; members; chairpersons; meetings; vacancies; annual report. (a) There is established a state-wide Emergency Management and Homeland Security Coordinating Council to advise the Department of Public Safety, the Office of Emergency Management and, on and after January 1, 2005, the Department of Emergency Management and Homeland Security with respect to: (1) Application and distribution of federal or state funds for emergency management and homeland security; (2) planning, design, implementation and coordination of state-wide emergency response systems; (3) assessing the state's overall emergency management and homeland security preparedness, policies and communications; (4) the recommendation of strategies to improve emergency response and incident management including, but not limited to, training and exercises, volunteer management, communications and use of technology, intelligence gathering, compilation and dissemination, the development, coordination and implementation of state and federally required emergency response plans, and the assessment of the state's use of regional management structures; and (5) strengthening consultation, planning, cooperation and communication among federal, state and local governments, the Connecticut National Guard, police, fire, emergency medical and other first responders, emergency managers, public health officials, private industry and community organizations. The council shall advise the Governor and the General Assembly on its findings and efforts to secure the state from all disasters and emergencies and to enhance the protection of the citizens of the state.

(b) The council shall consist of: (1) The Commissioner of Emergency Management and Homeland Security; the Secretary of the Office of Policy and Management; the Commissioner of Public Safety; the Commissioner of Public Health; the Commissioner of Mental Health and Addiction Services; the Commissioner of Environmental Protection; the Commissioner of Public Works; the Commissioner of Transportation; the Adjutant General of the Military Department; the chairperson of the Department of Public Utility Control; the Chief Information Officer, as defined in section 4d-1; the State Fire Administrator; or their designees; and (2) the following members appointed as follows not later than July 1, 2004: Two municipal police chiefs, one appointed by the speaker of the House of Representatives and one appointed by the Governor; two municipal fire chiefs, one appointed by the president pro tempore of the Senate and one appointed by the Governor; one volunteer fire chief appointed by the minority leader of the Senate; one representative of the Connecticut Conference of Municipalities appointed by the majority leader of the Senate; one representative of the Council of Small Towns appointed by the minority leader of the House of Representatives; one local or regional civil preparedness director appointed by the speaker of the House of Representatives; one local or regional health director appointed by the president pro tempore of the Senate; one emergency medical services professional appointed by the Governor; one nonprofit hospital administrator appointed by the majority leader of the House of Representatives; and one manager or coordinator of 9-1-1 public safety answering points appointed by the Governor. Each member appointed under this subdivision shall serve for a term of three years from July 1, 2004, or until a qualified successor has been appointed to replace such member. No member appointed under this subdivision shall receive any compensation for such member's service on the council.

(c) The Secretary of the Office of Policy and Management, or the secretary's designee who shall be an employee of said office, shall serve as chairperson of the council until January 1, 2005. On and after January 1, 2005, the Commissioner of Emergency Management and Homeland Security shall serve as chairperson.

(d) The council shall hold its first meeting not later than August 1, 2004, and shall meet at least monthly thereafter.

(e) The chairperson of the council may request the participation of other representatives of federal, state, regional and local agencies as nonvoting members for purposes of consultation, planning and communication.

(f) Any vacancy on the council shall be filled for the unexpired portion of the term by the appointing authority having the power to make the original appointment. Any vacancy occurring on the council shall be filled within thirty days.

(g) The council shall submit a report to the General Assembly not later than January 1, 2005, and annually thereafter.

US DHHS, CENTERS FOR DISEASE CONTROL & PREVENTION
COOPERATIVE AGREEMENT FUNDING REQUIREMENTS

1. ...to establish a process for strategic leadership, direction, coordination, and assessment of activities to ensure state and local readiness, interagency collaboration, and preparedness for bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies.
2. Establish an advisory committee including representation from (but not limited to) the following groups: (a) state and local health departments and governments; (b) emergency management agencies; (c) emergency medical services; (d) the Office of Rural Health; (e) law enforcement and fire departments, emergency rescue workers, and occupational health workers; (f) other healthcare providers including university, academic, medical, and public health; (g) community health centers; (h) Red Cross and other voluntary organizations; and (i) the hospital community (including Veterans Affairs and military hospitals where applicable).
3. Ensure that high-level policy makers and elected officials at the state and local level are provided regular updates regarding preparedness activities.
4. Establish a coordinated and integrated process for monitoring progress, allocating resources, and developing work plans.
5. Sponsor jurisdiction-wide conferences and workshops bringing together partners and stakeholders.
6. Ensure that parts of the public health system not directly involved in bioterrorism preparedness are aware of and, when appropriate, participate in planning and implementation of cooperative agreement activities.
7. Ensure competency of project leadership through technical, managerial, and leadership training and career development activities.

2005 GUIDANCE/ADDITIONAL REQUIREMENTS:

1. The existence of or current efforts to establish or participate in a senior advisory committee during Fiscal Year 2005 (FY05) to coordinate funding with the U.S. Department of Health and Human Services' (HHS) Centers for Disease Control and Prevention; U.S. Department of Health and Human Services' (HHS) Health Resource and Services Administration (HRSA) hospital preparedness cooperative agreement; and FY05 Homeland Security Grant Program Department of Homeland Security, Office for Domestic Preparedness.

2007 GUIDANCE/CONTINUATION OF THE SENIOR ADVISORY COMMITTEE:

In FY 2005, Office of Grants and Training (OGT), CDC, and HRSA all required the establishment of a Senior Advisory Committee (SAC), comprised of senior officials overseeing assistance programs from these and other federal agencies providing homeland security assistance. The SAC is to enhance the integration of disciplines involved in homeland security, including public health and healthcare. This requirement remains in place in FY 2006 and underscores the importance that DHS and HHS put on grantees and subgrantees taking a holistic approach to implementing their strategic homeland security goals and objectives by considering all available support and assistance programs, regardless of the source.

The membership of the SAC must, at a minimum, include state officials directly responsible for the administration of OGT grants and CDC and HRSA cooperative agreements: the State Administrative Agency (SAA), HRSA Program Director/Primary Investigator, HRSA Bioterrorism Hospital Coordinator, and CDC Program Director/Primary Investigator. In addition, program representatives from the following entities should be considered for membership on the committee: State Homeland Security Advisor (if this role is not also the SAA); State Emergency Management Agency Director; State Public Health Officer; State Public Safety Officer (and SAA for Justice Assistance Grants, if different); State EMS Director; State Trauma System Manager; State Citizen Corps POC; United States Coast Guard Area Command or Captain of the Port; Senior Security Officials from Major Transportation Systems; and the Adjutant General.

States are encouraged to broaden membership of the Senior Advisory Committee to include membership from additional disciplines (e.g., medical examiners, legal counsel, agriculture, and finance), local jurisdictions, associations and regional working groups.

Attachment B – DPH Preparedness Support Team

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