NORTHEAST FLORIDA HEALTHCARE COALITION

Executive Board Meeting – Wednesday, November 18, 2015

12:30 pm

St. Johns County EOC

Call in: 1-888-670-3525
Code: 1130084513

AGENDA

I. Call to Order

- Validation of voting members present [accept designees, if required]
- Introductions
- *Approval of minutes from 10/21/15 meeting

II. Budget Update

- *Budget report
- Expenditure Requests
- Management and Administration update

III. Business

- *Overview of Draft Deliverables (due 11/30/15)
    - Risk Assessment
- Overview of Patient Tracking Work Group Meeting
- TEP Pre-Work

V. Other Topics

- Board Members Outreach Reports

Next Meeting Date: December 16, 2015

*** * * * * B o a r d M e e t i n g A d j o u r n s * * * * ***

1: 30 pm **Presentation – HCC Assessment by Cpt. Paul Link , ASPR**

General Membership &Executive Board Meeting
October 21, 2015
MINUTES

The general membership meeting and Executive Board meeting of the Northeast Florida Healthcare Coalition was held on Wednesday, October 21, 2015, at 9 am. It was hosted by UF Health North in partnership with the First Coast Disaster Council.

The meeting began with a welcome from Associate Vice President Mr. Marshall of UF Health. Tim Devin then provided a safety briefing.

CALL TO ORDER

The meeting was called to order by Chair Leigh Wilsey with a validation of a quorum, with the following Board members present:

Baker County – Dan Mann
Clay County – Leigh Wilsey, Chair
Duval County – Tim Devin
Flagler County – Dave Kovacs
Nassau County- Michael Godwin
St. Johns County – Tim Connor
Public Health – Dr. Wells
Hospitals – Rich Ward

Members Absent:
EMS – David Motes
Emergency Management – Jeff Alexander

For others in attendance, please see attached sign in sheet.

Introductions
Each attendee introduced themselves, as there was over 35 people in attendance, with many new faces.

Approval of Minutes
The minutes from the September 16, 2015 meeting were distributed at the start of the meeting and are up for approval. There were no comments or discussion on the minutes as presented.

The Chair called for a motion for approval of the September 16, 2015 meeting minutes. Tim Devin moved approval; seconded by Dan Mann. Motion carried.

PRESENTATION – THE NORTHEAST FLORIDA HEALTHCARE COALITION – PRESENT AND FUTURE

Leigh Wilsey presented an overview of the Northeast Florida HCC and included information on the previous year's accomplishments and detailed the deliverables for the current 2015-16 fiscal year. The PowerPoint Presentation is available on the website, www.neflhcc.org.

BUDGET UPDATE

Budget Report

Rich Ward presented the budget report. The budget report is in the newly requested format (combined fiscal years) and now shows an "Available Funds" column. There were no questions or discussion on the September 2015 budget report. *Tim Devin called for a motion to approve the September 2015 budget report, Tim Devin seconded. Motion carried.*

Expenditure Report

There are no expenditure requests at this time. Potential attendance at the National Healthcare Coalition Conference in San Diego was discussed, but at this time there are no planned attendees from Northeast Florida. A part of the discussion included a question on how a lack of attendance would affect our deliverables. There is no requirement to attend and like many conferences is learning and networking experience. Ms. Wilsey indicated that there are several local conferences (held in Florida) over the coming year that have a healthcare focus that may be more beneficial to attend.

Management and Administration Update

Ms. Payne provided a brief update:

- The website is currently being updated with additional Coalition documents. Please provide suggestions/feedback on the website.
- The first quarter deliverables were submitted and approved by FDOH. The invoice was submitted for $36,250 with payment pending.
- The NEFLHCC has a new contract manager at FDOH, Meghan Gregg. She is the same contract manager for the hospitals ASPR contracts. Ms. Payne indicated that she is copied on many of the hospital contract emails sent by Ms. Gregg, simply as an FYI. However, Ms. Payne is happy to help the hospitals if needed regarding contracts, etc.
- Currently staff is working on the upcoming quarterly deliverables – Vulnerability Assessment, Patient Tracking Monitoring Plan, COOP and Resource Coordination Process.

PRESENTATION – THE NORTHEAST FLORIDA HEALTHCARE COALITION PLANS

Nancy Freeman, consultant to the NEFLHCC, presented an overview of the Northeast Florida HCC plans as available to date. The focus centered on the recently drafted Communications Plan, but also provided information on the other plans that are required by the contract this fiscal year.

The approach to creating each plan was reviewed and for most plans, there are two phases for completion due to the deadlines. During the presentation, Ms. Freeman circulated a table for all agencies to fill out regarding more specific information for the Communications Plan. This will be used for Phase 2 of the Communications Plan. As developed, plans and procedures will be found on the Coalition's website. The PowerPoint Presentation is available on the website, www.neflhcc.org.

NEW BUSINESS

Upcoming Events

Ms. Wilsey asked everyone to take a look at the Coalition calendar, as provided. This is continuously updated calendar that includes meeting dates, conference dates, deliverable dates and potential dates for trainings, exercise and other relevant Coalition events.

Training Class Options

Ms. Wilsey asked the group if there were specific training classes that should be held by the Coalition. A few classes mentioned included COOP (potentially an online based template and training), the Role of ESF 8 and Cybersecurity.

Ms. Payne provided details on a recently sent out Training Needs Survey and indicated that the top choices for training included: ESF 8 related, COOP, Surveillance and Epidemiological and EM Resource Training.

All were encouraged to email Coalition members with suggestions.

OTHER BUSINESS

Summary of Statewide Taskforce Meeting

A Statewide Healthcare Coalition Taskforce meeting took place October 14 and 15 in Orlando. The meeting was attended by Leigh Wilsey and Beth Payne. The meeting included a series of presentations about a variety of other healthcare related activities taking place within FDOH across the State; include Pediatric Preparedness and the Florida Trauma System. The meeting providing information on the Ebola supplemental funds, including the dollars allocated and draft scope of work. The NEFLHCC will be receiving an additional $82,500. This comes with a set of deliverables including training, an exercise requirement and several workshops to be held. It was suggested that a workgroup be formed to address the implementation of this funding.

Additionally, the concept of regionalization of healthcare coalitions across the State at the RDSTF region level was discussed at length. FDOH is working through how to structure this moving forward and hopes to implement this in the 2016-17 fiscal year. More information will be presented as it is received on this concept.

Board Member Reports

Several board members provided a status on their outreach efforts to their assigned agency/group.

Ms. Faith McInnis from FDOH provided information on training opportunity available for a two hour Chemical Terrorism Awareness Class for collecting clinic specimens. She also indicated that they are always looking for additional partners for exercises.

PRESENTATION – NORTHEAST FLORIDA HEALTHCARE COALITION EXERCISE PLANNING: CONCEPTS AND OBJECTIVES MEETING

Eric Anderson, Senior Planner at the Northeast Florida Regional Council lead the concept and objectives meeting as the first step in planning for the NEFLHCC's exercise to be held in the spring of 2016. The objective of this meeting was to review the required objectives (in the contract) and begin to develop a scenario to test the objectives. All agreed to a previously discussed concept of exercising the special needs shelter and evacuation plan, including the use of hospitals during a Category 3 Hurricane or higher. There was much discussion by the participants on ideas for implementing the exercise. An exercise planning team will be designated in the near future and planning efforts will continue, with the Initial Planning Meeting tentatively scheduled for early December. The PowerPoint Presentation is available on the website, www.neflhcc.org.

The next meeting of the NEFLHCC Board will be held on Wednesday, November 18, 2015 at 1:30 p.m. The location will be at the St. Johns County EOC in St. Augustine.

With no additional business, the meeting adjourned at 11:15.

MEETING SIGN-IN SHEET – NORTHEAST FLORIDA HEALTHCARE COALITION

General Membership Meeting	Meeting Date: October 21, 2015
UF Health North	

Name	Title	Agency	E-Mail	Voting Member &Representation
Sandi Courson	RERA	FDOH	Sandi.courson@flhealth.gov	no
Bruce Scott	Regional Coordinator	FDEM	Bruce.Scott@EEA.myflorida.com	NO
Dave Chapman	Safety Manager	Brooks	Dave.Chapman@Brookshhs.org	NO
Tony McLaurin	Planner	WellFlorida	tmclaurin@wellflorida.org	NO
Kelli Wells	Health Officer	DOH-Duval	kelli.wells@flhealth.gov	yes
Ronnie Wessel	Environmental Spec.	DOH-Nassau	ronaldwessler@flhealth.gov	no
Michael Godwin	Env. Manager	DOH-Nassau	michael.godwin@flhealth.gov	yes
Duane Green	DPO	Kindred Hospital	Duane.Green@Kindred.com	no
Barbara Smith	SHJ Coordinator Specialist		barbara.smith@theuniquecare.com	
David Pelton	Planner	FDOH Clay	david.pelton@flhealth.gov	No
Faith McInnis	CT Coord. Clients	FDOH Baker Jax	Faith.McInnis@flhealth.gov	NO
Harvey Peterson	Director Plant Fire/Security	Baptist South	harvey.peterson@bmcjax.com	No
Linda Garcia	DON CMS	CMS	lindagarcia@flhealth.gov	no
Brian Teeple	CEO	NEFRC	bteeple@nefrc.org	NO
Tim Connor	Planner	DOH-St. Johns	timothy.connor@flhealth.gov	Yes
John Coffey	Emer. Prep Coordinator	St Vincent's Riverside	john.coffey@jaxlocal.com	no
Rob Linnens	RSTF3 Planner	FLDOT	Robert.Linnens@FLHEALTH.GOV	NO
Dan Mann	Planner	FDOT	john.mann@flhealth.gov	yes
Eric Anderson	Planner	NEFRC	eanderson@nefrc.org	NO

MEETING SIGN-IN SHEET – NORTHEAST FLORIDA HEALTHCARE COALITION

General Membership Meeting	Meeting Date: October 21, 2015
UF Health North	

Name	Title	Agency	E-Mail	Voting Member &Representation
Jacob Blanton	Batt Chief	Jax fire/rescue	jblanton-@coj.net	JFRS
Steph Grant	Captain	JFRS	grantc@coj.net	
DAVID KOVACS	Director of Facilities	Florida Hospital Flagler	DAVID.KOVACS@AHSS.ORG	Flagler
Joe Cipriani	Safety Mgr	Mayo Clinic	Cipriani.joseph@mayo.edu	
Greg Miller	EMS Coordinator	Memorial Hosp		
Sarah Winn	EPR Manager	FDOH-Duval	Sarah.winn@flhealth.gov	
Jennifer Stagg	Sr. Planner	Flagler EM	jstagg@flaglercountygov.com	Ker
Ernie Parker	Supervisor/EMS	UF Health	ernie.parker@jax.ufl.edu	
Kelly Herbert				
Tim Cash				
Kingsley	Director of Marketing	Lakeside	Gstin@lakeside management.com	
Dudley Lee	Shift Supervisor	Century Ambulance	Dudley.Lee@CAS Jax.com	
PATRICK FRANK	Region 3 SPNS Coordin	FDOH	PATRICK.FRANK@FLHEALTH.GOV	NO
RICH WARD	DIRECTOR SAFETY/SECURITY	OPMC	RICHARD.WARD@HCAHEALTHCARE.COM	YES
Timothy Devin	Emergency Manager	UF Health	timothy.devin@jax.UFL.edu	Yes
David Castleman	Chief of Rescue	JFRD	DavidS@coj.net	
NANCY FREEMAN	NEFLHCC Contractor		Nancymoss@yahoo.com	
Beth Payne	Director - EP	NEFHCC	epayne@nefhcc.org	

MEETING SIGN-IN SHEET – NORTHEAST FLORIDA HEALTHCARE COALITION	
General Membership Meeting	**Meeting Date:** October 21, 2015
UF Health North	

Name	Title	Agency	E-Mail	Voting Member &Representation
Betty Herendeen	Community Director	Allegro/ALF chapter head for St. Johns FALA	bherendeen@Allegroliving.com	
Terry Conlin	Executive Director	Community Home Health Care	teresaconlin@CommunityHHCare.com	
Wes Marshall	Emer-Prep	FDOH-Duval	wes.marshall@flhealth.gov	

FY 2015-2016

Community Hazard Vulnerability Assessment

Northeast Florida

Healthcare Coalition

Approved: _____

NEFLHCC Executive Board

NEFLHCC COMMUNITY HAZARD VULNERABILITY ASSESSMENT

FY 2015-2016

TABLE OF CONTENTS

Northeast Florida Healthcare Coalition

COMMUNITY HAZARD VULNERABILITY ASSESSMENT

FY 2015-2016

PURPOSE

This document is presented as an annual update of the *Northeast Florida Healthcare Coalition (NEFLHCC) Hazard Identification and Risk Assessment (HIRA*). The Coalition's first HIRA was developed as a contract deliverable for Fiscal Year 2013-2014 and expanded into a more comprehensive assessment for FY 2014-2015. The HIRA presented the six-county region's first unified assessment of hazard risk, vulnerability, capabilities, resources, and gaps as they impact and relate to the healthcare system in Northeast Florida. The HIRA also described the methodology used for the assessment, which serves as the basis for the *FY 2015-2016 Community Hazard Vulnerability Assessment* (CVA). Each succeeding annual update will consist of a review of the previous year's data (updating where appropriate), and integration of relevant new information as it becomes available. The annual HIRA/CVA update will also take into account lessons learned and corrective actions identified through plan updates and revisions, exercises, and real-world events.

METHODOLOGY

The hazard identification, probability, and prioritization tables from the *Northeast Florida Healthcare Coalition Strategic Plan/Risk Assessment* (June 2014) were the starting point for the FY 2015-2016 CVA update. Detailed data presented in the FY 2014-2015 HIRA will not be included in this update; however, summary charts that describe the priority hazards, capability proficiencies and gaps, and resource readiness gaps have been reviewed, updated and included in the FY 2015-2016 CVA.

The State of Florida Statewide Risk Assessment and Gap Analysis, Statewide Appraisal (July 15, 2015)

A new risk assessment report was reviewed for the FY 2015-2016 CVA. *The State of Florida Statewide Risk Assessment and Gap Analysis Statewide Appraisal ("Statewide Risk Assessment")*, July 15, 2015, documents the process that conducted risk assessments in each of seven regions in Florida to "identify gaps in prevention and response capabilities and provide the State of Florida a tool to make critical funding decisions to address gaps, vulnerabilities, and emerging threats." (Statewide Risk

Assessment, p. 3) Findings from this report were consistent with the proficiencies and gaps identified through the NEFLHCC risk assessment process and are included in the **Capabilities Proficiency Ranking and Gap Analysis** section of this document.

Operation Ender's Game Measles Virus Tabletop Exercise (conducted 4/29/2015) After-Action Report/Improvement Plan (undated)

The NEFLHCC hosted a region-wide tabletop exercise on April 29, 2015. The objectives of the exercise were to test the healthcare preparedness capabilities as they related to healthcare system recovery (continuity of operations), information sharing, and medical surge. In addition, the exercise was designed to assist with determining the Coalition's specific role in supporting the regional healthcare network and identifying potential gaps. Recommended corrective actions determined through exercise plan and documented in the *After-Action Report/Improvement Plan* and are incorporated into the FY 2015-2016 CVA update.

The Fiscal Year 2015-2016 contract between the NEFLHCC and the Florida Department of Health (FDOH) requires the submittal of the Community Hazard Vulnerability Assessment (CVA) as "**Exhibit 5"**, which is attached as **Appendix A** to this update. To update the CVA for FY 2015-2016, the FY 2014-2015 "Community Risk and Resource Capability Assessment" (submitted in FY 2014-2015 as Exhibit 6) was reviewed, specifically noting progress in achieving identified goals and gaps. In addition, some capability and resource gaps were redefined to support capability categories, align with healthcare system preparedness guidance, and provide more project-oriented descriptions.

The Executive Board of the Northeast Florida Healthcare Coalition, as the governing body of the Coalition, has the authority to approve this document.

SIGNATURE INDICATING APPROVAL OF THIS DOCUMENT

_____
Leigh Wilsey, Chair, NEFLHCC Executive Board

APPROVAL DATE:_____

HAZARD RISK AND VULNERABILITY – FY 2015-2016 REVIEW AND UPDATE

Review of hazard risk and vulnerability data from county-level Comprehensive Emergency Management Plans (CEMPS) and the Florida Public Health Risk Assessment Tool (FLPHRAT) indicated no change in identified and prioritized hazards. For the FY 2014-2015 NEFLHCC Risk Assessment, the hazard categories were aligned to be consistent with those described in the CEMPS and the hazards as defined in the FLPHRAT. The hazard categories and definitions (below) were adjusted and modified to integrate the prioritized hazards as characterized in the combined CEMP and FLHPHRAT ranking (*NEFLHCC 2014-2015 HIRA*, p. 17)

The hazards previously identified will be maintained as priorities for the FY 2015-2016 CVA and serve as the frame of reference for analysis of capabilities, resources, and gaps.

Table 1: Prioritized Hazards – FY 2015-2016

PRIORITIZED HAZARDS - NEFLHCC	
Priority*	***Hazard***
1	Technological (communications, transportation, cyber, hazardous materials accidents, major power failure, critical infrastructure disruption, etc.)
2	Tropical Cyclones (hurricanes, tropical storms, storm surge, wind, etc.)
3	Flood
4	Severe Weather (tornado, wind, coastal storms, winter storms)
5	Extreme Temperatures (heat and cold)
6	Terrorism (adversarial actions - chemical, biological, radiological, nuclear, explosives
7	Drought
8	Fire (including Large Scale and Wildfire)
9	Biological (unintentional)
10	Nuclear/Radiological Incident (unintentional)

Source: NEFLHCC 2014-2015 HIRA, p. 17

**Ranking methodology for this table is defined in the NEFLHCC 2014-2015 HIRA, (p.5-17)*

CAPABILITIES PROFICIENCY RANKING AND GAP ANALYSIS

The data summarized in **Tables 2** and **3** (below) is obtained from the FLPHRAT, the online risk assessment tool developed by the Florida Department of Health. Information entered into the FLPHRAT by county-level public health preparedness planners was submitted in December 2014 and updates have not yet been requested by FDOH (as of October 2015). Consequently, the capabilities proficiency rankings and gap analysis data for each county remains unchanged from the FY 2014-2015 HIRA.

Table 2: Summary of Prioritized Capabilities Proficiencies

FLPHRAT - CAPABILITIES PROFICIENCY RANKING	Baker	Clay	Duval	Flagler	Nassau	St. Johns	TOTAL SCORE
Community Preparedness	5	5	5	5	5	5	30
PH Surveillance/Epi Investigation	1	4	2	4	4	4	19
Information Sharing	4	1		2		3	10
Mass Care Coordination	3			1	2	1	7
Volunteer Management		2		3		2	7
Emergency Public Information and Warning	2		4				6
Community Recovery			1		3		4
Responder Safety and Health		3					3
Emergency Operations Coordination			3				3
Medical Surge Capacity					1		1

Source: NEFLHCC 2014-2015 HIRA, pp. 18-24, 31

Table 3: Summary of Prioritized Capabilities Gaps

FLPHRAT - CAPABILITIES GAP ANALYSIS SUMMARY	Baker	Clay	Duval	Flagler	Nassau	St. Johns	TOTAL SCORE
Community Preparedness	4	5		3		5	17
Volunteer Management	5	3		1	4		13
Community Recovery	2		3	5		3	13
Fatality Management		4		2		4	10
Information Sharing		2	1		5		8
PH Surveillance/Epi Investigation	3		4				7
Medical Countermeasure Dispensing			5		2		7
Medical Surge Capability	1			4			5
Emergency Operations Coordination					3		3
Mass Care Coordination/Med Surge		1	2				3
Medical Material Mgmt/Distribution					1	2	3

Source: NEFLHCC 2014-2015 HIRA, pp. 18-24, 31

RESOURCE READINESS GAP SUMMARY

The Resource Readiness Gap Analysis conducted for the FY 2014-2015 HIRA was based on the FLPHRAT Resource Assessment Scores determined by County public health agencies (NEFLHCC 2014-2015 HIRA, pp. 25-30, 32). The information provided in the FLPHRAT tool in December 2014, which was included in the FY 2014-2015 HIRA has not yet been updated and remains unchanged for the 2015-2016 CVA (**Table 4**).

Table 4: Summary of Prioritized Resource Readiness Gaps

FLPHRAT - RESOURCE READINESS GAP SUMMARY	Baker	Clay	Duval	Flagler	Nassau	St. Johns	TOTAL SCORE
Cyber/Technical Incident	5	5	5	5	5	5	30
Nuclear Attack			1	4	4	4	13
Communications Failure	3	2		2		3	10
Fires - Large Scale (not Wild Fire)	4	4					8
Pandemic Influenza	2	1	2				5
Biological Disease Outbreak		3			2		5
Severe Winter Storm			4				4
Radiological Incident (RDD)				3		1	4
Storm Surge			3				3
Biological Terrorism - Communicalbe (A-B-C Agents)					3		3
Radiological Incident - Transportation						2	2
Hurricane/Tropical Storms	1						1
Water Supply Contamination				1			1
Chemical Terrorism					1		1

Source: NEFLHCC 2014-2015 HIRA, pp. 25-30, 32

Vulnerable Population Assessments

Local Vulnerable Population Assessments (VPA) were conducted by County Health Departments in May-June 2013 as a comprehensive assessment of the status of county-level vulnerable populations. The six counties of the NEFLHCC contracted with the Northeast Florida Regional Council to develop the assessment methodology and compile the data related to ten pre-defined categories of vulnerable populations described in the FY 2014-2015 HIRA (p. 33). The VPAs have not been updated since June 2013.

Table 5: Summary of Vulnerable Population Priorities

Priorities - Vulnerable Populations	Total Points
1. Developmentally Disabled	15
2. Economically Disadvantaged	10
3. Elderly	6
4. Disabled	5

Source: NEFLHCC 2014-2015 HIRA, p. 34

State of Florida Statewide Risk Assessment and Gap Analysis

A Health and Medical workshop was conducted in Region 3 on June 15, 2015 to review natural, technological and human-caused hazards and assess the region's capabilities for preparedness and response. Representatives of several NEFLHCC member organizations participated in the workshop. *The State of Florida Statewide Risk Assessment and Gap Analysis, Statewide Appraisal*, July 15, 2015, documents the outcome of the State's risk assessment process. The threats and hazards identified through this process are consistent with the prioritized hazards identified by the NEFLHCC (Statewide Risk Assessment, Appendix 5, p. 4). Region 3 capability gaps relevant to health and medical (Statewide Risk Assessment, Appendix 5) were noted to include:

- Communications and On-Site Incident Management: Deficiency in the level of communications training provided to equipment operators, which has a detrimental impact on the ability of teams and agencies to communicate.
- Mass Care: Concerns about the abilities of partner organizations to adequately staff and/or support shelters; in addition, language barriers and a lack of trained translators present a potential issue in shelters.
- Public Health Surveillance/Epidemiology Investigation and Non-Pharmaceutical Interventions: Limited number of clinical staff available to appropriately monitor patients in the event of certain situations such as quarantine.
- Information Sharing: Multiple disciplines rely on informal communication channels and personal relationships to identify points of contact for notification and information sharing when an event occurs. For larger-scale events which may require coordination with private, other state or federal agencies, there may be a need for defined points of contact and more formal communications channels to ensure all parties are receiving the information they need.
- Cybersecurity: There are very few paper files maintained and any cyber breach may debilitate a hospital or Emergency Medical System.
- Responder Safety and Health: Availability of fewer medical assets may have an impact on the ability to respond in a timely manner to all counties.

The Statewide Risk Assessment summary for Region 3 notes that there are diminishing resources that could impact the ability of multiple disciplines to maintain capabilities. In addition, the lack of trained personnel with appropriate knowledge to fulfill responsibilities that are needed in any given response situation was highlighted as a gap.

The findings from the Statewide Risk Assessment are consistent with the capability and resource gaps previously documented in the *NEFLHCC 2014-2015 HIRA* and the Community Risk and Resource Capability Assessment FY 2014-2015 (Exhibit 6).

COMMUNITY RISK AND RESOURCE CAPABILITY ASSESSMENT (Exhibit 5)

The outcome findings for the FY 2015-2016 CVA are summarized in **Appendix A: *Exhibit 5* - Community Risk and Resource Capability Assessment Worksheet,** which describes hazards, functions, associated risks, probability, severity, contingencies, capability gaps, resource gaps and supporting evidence. Much of the information compiled and reported in spreadsheet format for the FY 2014-2015 Risk Assessment (as Exhibit 6[1]) was reviewed, updated, and retained in the FY 2015-2016 assessment, as applicable. Capability categories identified as gaps in **Table 3** provide the "functional hazard" categories described in the **Exhibit 5** worksheet, and are considered to be "overarching capabilities that the health care system must be able to perform before, during or after an incident. These functions may be performed [in] multiple incident types and have common risks."[2] For the purpose of this assessment, the "functional hazards" category is redefined as "capabilities – all-hazard". Each capability category establishes the framework for identifying specific gaps linked to the appropriate action, which is then assigned to one of the following corrective action categories:

- Planning
- Organization and leadership
- Equipment and supplies
- Training
- Exercise, evaluation and corrective actions.

The following substantive changes were made to ***Exhibit 5*** for the FY 2015-2016 CVA:

- Definitions and descriptions were revised where appropriate to clarify information, align with healthcare system guidance, and/or enhance consistency with project scopes.
- New information reported in the *State of Florida Statewide Risk Assessment and Gap Analysis, Statewide Appraisal*, July 15, 2015, and the April 2015 *Operation Enders Game Measles Virus Tabletop Exercise After Action Report/Improvement Plan*, undated, has been integrated into the outcome findings for this update.
- Capability and/or resource gaps identified in previous gap analyses that have already been addressed or will be addressed in FY 2015-2016 were moved to a separate sheet that will track completed projects. This will assist the NEFLHCC in monitoring progress in future years.

[1] Reference Part 3: Summary and Outcomes, *NEFLHCC 2014-2015 Risk Assessment*, March 18, 2015, pp. 35-41
[2] FDOH Worksheet Instructions

OPPORTUNITIES

Data presented in the NEFLHCC Coalition's CVA has been obtained primarily from county Emergency Management and Public Health agency reports, plans and assessments. Efforts will be made in future HIRAs/CVAs to incorporate hazard risk and vulnerability data from additional disciplines such as hospitals, emergency medical services, long-term care facilities, and others.

AUTHORITIES AND REFERENCES

- Florida Department of Health Contract with Northeast Florida Healthcare Coalition (through Northeast Florida Regional Council), Scope of Work, December 2014
- *Healthcare Preparedness Capabilities*, the Office of the Assistant Secretary for Preparedness and Response Hospital Preparedness Program (ASPR/HPP), January 2012
- *Baker County Comprehensive Emergency Management Plan* (2012)
- *Clay County Comprehensive Emergency Management Plan* (2014)
- *Duval County Comprehensive Emergency Management Plan* (2013)
- *Flagler County Comprehensive Emergency Management Plan* (2014)
- *Nassau County Comprehensive Emergency Management Plan* (2014)
- *St. Johns County Comprehensive Emergency Management Plan* (2012)
- Florida Department of Health Vulnerable Populations Assessments (May 2013) – Baker, Clay, Duval, Flagler, Nassau, and St. Johns Counties
- Florida Public Health Risk Assessment Tool (FLPHRAT) Charts (December 2014) – Baker, Clay, Duval, Flagler, Nassau and St. Johns Counties
- *"Surge and Succeed" Exercise After Action Report and Improvement Plan*, Northeast Florida Healthcare Coalition, June 13, 2014
- *2013-2014 Northeast Florida Healthcare Coalition Strategic Plan and Risk Assessment*, June 26, 2014

- *The State of Florida Statewide Risk Assessment and Gap Analysis, Statewide Appraisal*, July 15, 2015
- *Operation Ender's Game Measles Virus Tabletop Exercise* (conducted 4/29/2015) *After-Action Report/Improvement Plan*, undated

APPENDIX A: Community Risk and Resource Capability Assessment Worksheet

Coalition Risk Assessment Tool

Coalition Name:

EXHIBIT 5- Community Risk and Resource Capability Assessment (All-Hazard)

Name of Healthcare Coalition: Northeast Florida Healthcare Coalition

Capabilities (Functional Hazards)	Hazards	Associated Risks	Probability	Severity	Contingencies	Capability Gaps	Resources Gaps	Supporting Evidence
Community Preparedness								
Planning	All hazards	Multiple jurisdictions have conducted or participated in risk assessment and gap analysis at jurisdiction or discipline levels, and a regional risk assessment has been conducted, but additional input is needed from other health and medical agencies who are not yet HCC member organizations.	(See CVA FY 2015-2016 for hazard probabilities, impacts and vulnerability.)	(See CVA FY 2015-2016 for hazard probabilities, impacts and vulnerability)	1. Initial risk assessment and gap analysis developed as deliverable for first year HCC funding. 2. Continue to integrate regional, jurisdictional and discipline risk and gap information as it is developed. 3. Expand the current risk assessment to gain more detail related to health and medical risk and gaps based on Healthcare System Capabilities	Jurisdiction-specific data related to the risk and vulnerability of the healthcare system and at-risk populations from certain hazards.	Continue to identify capability proficiences and gaps for the regional healthcare system by incorporating information from hospital vulnerability assessments, JTHIRAs, and others into the annual NEFLHCC risk assessment.	HPC Capability 1, Function 2; 2014-2015 NEFLHCC Risk Assessment; 2015-2016 NEFLHCC CVA
Training	All hazards	Each county manages health and medical resources within individual agencies (day to day) and ESF 8 (during response and recovery)			Community-level partners are engaged in health and medical risk assessments with HCC member agencies and organizations	Regional awareness of other jurisidction and discipline capabilities and resources as they relate to specific threats and hazards.	Conduct awareness training on hazards and risks as they relate to impacts and consequences to the regional healthcare system.	HPC Capability 1, Function 2; HCC 2014 AAR/IP; 2014-2015 NEFLHCC Risk Assessment; 2015 Measles TTX AAR/IP
Volunteer Management								
Training	All hazards	Lack of knowledge about multiple jurisdictions' volunteer availability, credentials, training and engagement			CHDs maintain a Volunteer Management Plan that addresses local capabilities and resources. Multiple disciplines maintain volunteer programs that support discipline-specific needs (day to day and response), i.e. EMS, hospitals, EM (CERT).	Awareness of athe regional process for integrating and coordinating existing volunteer programs into incidents impacting the HCC healthcare system.	Conduct awareness training for the process of identifying, assigning, training, and integrating volunteers into health and medical response and recovery activities.	HPC Capability 1, Function 2; 2014-2015 NEFLHCC Risk Assessment; 2015 Measles TTX AAR/IP; 2015 Statewide Risk Assessment and Gap Analysis, Appendix 5 (July 2015)
Community Recovery								
Planning	All hazards	Disaster behavioral health agencies and services are not well identified. Specific at-risk populations may require additional services and resources.			CHDs maintain a Disaster Behavioral Health Plan that addresses local capabilities and resources.	Engaging behavioral health partners, conducting a behavioral health resource survey, and developing and maintaining a behavioral health coordination plan.	HCC disaster behavioral health coordination plan/procedure	HPC Capability 2, Function 1; 2014-2015 NEFLHCC Risk Assessment; 2015-2016 NEFLHCC CVA
Exercise	All hazards	Transition from normal to alternate operations and transition from crisis standards of care to conventional SOC's has not been fully tested. Identified at-risk populations may require additional services and resources.			Jurisdictional agencies and many healthcare facilities maintain continuity of operations/services plans. NEFLHCC sponsored COOP training for healthcare entities in February 2015.	Continuity plans have not been fully tested or exercised through a scenario involving multi-jurisdictional , multi-discipline,and multi-agency coordination.	HCC continuity of operations exercise to test continuity of services within the six-county healthcare system. [HCC COOP Plan addressed in HCC 2015-2016 Deliverable 16.]	HPC Capability 2, Function 2; 2014 HCC AAR/IP; 2014-2015 NEFLHCC Risk Assessment; 2015-2016 NEFLHCC CVA
Fatality Management								
Planning	All hazards	Private sector storage facilities, resources and capacities haven't been fully identified. Specific at-risk populations may require additional services and resources.			1. District Medical Examiner's Office maintains a response plan; 2. CHDs maintain Fatality Management Plans; 3. Emergency Operations Plans provide for functions to support fatality management	Identification of private sector resources and capacities for fatality management within HCC jurisdictions.	HCC mass fatality coordination plan/procedure	HPC Capability 5, Function 1; 2014-2015 NEFLHCC Risk Assessment
Information Sharing								
Training, Exercise	All hazards	2014 HCC AAR/IP noted gaps in the process to gather and disseminate information for situational awareness, common operating picture, hospital bed status, and other purposes. Multiple disciplines rely on informal communication channels and personal relationships to identify points of contact for notification and information sharing when an event occurs. For larger-scale events which may require coordination with private, other state or federal agencies, there may be a need for defined points of contact and more formal communications procedures and channels to ensure all parties are receiving the information they need.			Information sharing processes/procedures are developed at the agency and jurisdictional levels. Existing information sharing systems include, but are not limited to, PH surveillance networks, EOCs, RDSTF 3, FDOH Central Office, and regional Fusion Centers. NEFLHCC has autotmated callout system (Everbridge). All HCC County EOCs have WebEOC access. The NEFLHCC Communication Plan (Sept. 2015) provides a process to provide situation reports and share information with member organizations; however training is still needed to test and validate the plan.	Validation of the NEFLHCC role in gathering, validating, disseminating, and coordinating information among Coalition member jurisdictions, agencies, and organizations, as defined in the NEFLHCC 2015 Communication Plan.	Regional healthcare system communication and information coordination training and exercise.	HPC Capability 6, Functions 1 and 2; 2014 HCC AAR/IP; 2014-2015 NEFLHCC Risk Assessment; Statewide Risk Assessment and Gap Analysis, Appendix 5 (July 2015)
Public Health Surveillance/Epidemiology Invesitgation								
Planning	Biological Disease Outbreak, Pandemic Influenza, Biological Terrorism, Radiological Incident, Hurricane/Tropical Storms, Water Supply Contamination, Chemical Terrorism	Actions necessary to monitor and track widespread biological disease outbreaks and other hazards with potential public health and medical impact could exceed the resources of a single jurisdiction. Identified at-risk populations may require additional services and resources.			CHDs maintain Epi/infectious disease outbreak, laboratory, and medical surge plans and procedures. Mutual aid plans/agreements are in place to request and respond to other jurisdictions to assist in incidents that exceed local capabilities and resources. Regional DOH strike teams are developed and trained. Plans are periodically tested through exercises and real world events.	The Coalition's role and responsibilities in relation to an incident with regional impact have not been fully developed.	Identification of the NEFLHCC role in augmenting clinical staff in specific public health or medical incidents has not been clearly defined.	HPC Capability 10, Function 2; 2014 HCC AAR/IP; 2014-2015 NEFLHCC Risk Assessment
Medical Countermeasure Dispensing								

Training, Exercise	Biological Disease Outbreak, Pandemic Influenza, Biological Terrorism, Radiological Incident, Hurricane/Tropical Storms, Water Supply Contamination, Chemical Terrorism	Most counties require external resources to have sufficient manpower to dispense/vaccinate 100% of the population within the required amount of time. Identified at-risk populations may require additional services and resources.			CHDs maintain mass prophylaxis/Strategic National Stockpile plans and procedures to support mass dispensing. Plans are periodically tested through exercises and real world events.	Process to assess resource needs for regionwide medical countermeasure dispensing operation within the specific time frame	HCC medical countermeasure/SNS resource support and coordination may be addressed within the resource coordination guidelines [HCC 2015-2016 Deliverable 11]; however, a regional operation has not been tested through training, exercise or real world event.	FLPHRAT Hazard Index; 2014-2015 NEFLHCC Risk Assessment; Statewide Risk Assessment and Gap Analysis, Appendix 5 (July 2015)
Medical Surge Capacity/Mass Care Coordination								
Planning	All hazards	Individual county health and medical plans and procedures address medical surge, but currently there is not a process that would coordinate medical surge within the Coalition region.			1. County emergency operations plans address healthcare system and procedures. 2. CHDs maintain medical surge plans and procedures. Plans are periodically tested through exercises and real world events.	Regional coordination and integration of healthcare medical surge operations	HCC plan for catastrophic incidents that coordinates all agency operations. (Project currently in development for region-wide health and medical plan. (Reference: RDSTF 3 Health and Medical Co-chairs.]	HPC Capability 10; 2014 HCC AAR/IP; 2014-2015 NEFLHCC Risk Assessment; RDSTF 3 Health and Medical Co-chairs
Training	All hazards	Lack of understanding and knowledge of State Ambulance Deployment Plan could delay patient transport assistance in mass care situations. Identified at-risk populations may require additional services and resources.			Counties maintain mutual aid agreements and contracts for obtaining additional transportation resources. Plans are periodically tested through exercises and real world events.	Awareness of State's ambulance deployment plan and procedures and how to coordinate with Coalition partners	Guidelines for obtaining resources such as ambulances, and others, will be addressed in HCC 2015-2016 Deliverable 11., Resource Coordination Guidelines); however, training on the Guidelines has not yet been provided to HCC members.	HPC Capability 10, Function 2; 2014 HCC AAR/IP; 2014-2015 NEFLHCC Risk Assessment
Responder Safety and Health								
Planning	All hazards	The 2015 Statewide Risk Assessment and Gap Analysis, Appendix 5, noted potential limitation of medical/clinical staff in health or medical incidents, which may have an impact on the ability to respond in a timely manner to all counties in a regionwide event, and could increase risks to responders' health and safety. Identified at-risk populations may also require additional services and resources.			1. County Health Departments maintain Responder Safety and Health/Environmental Surety plans. 2. Plans are periodically tested at the local levels through exercises and real world events.	Process to integrate responder safety and health issues into HCC planning and resource coordination	Currently, the NEFLHCC planning process does not address responder safety and health as a cross-cutting issue in individual plans and procedures.	HPC Capability 1 and 6; 2014 HCC AR/IP; 2014-2015 NEFLHCC Risk Assessment; Statewide Risk Assessment and Gap Analysis, Appendix 5 (July 2015)
Emergency Operations								
Training, Exercise	All hazards	Each county manages health and medical resources within individual agencies and ESF 8, and some information is coordinated with other counties; however, a comprehensive Coalition resource coordination initiative has not been completed.			Some counties have developed resource inventories and management plans. The FDOH Regional Emergency Response Advisor collects and disseminates some resource data to CHDs. The NEFLHCC Resource Coordination Guidelines will address access to specific agency, organizaqtion and/or jurisdictional resources. Local plans are periodically tested through exercises and real world events.	Awareness of and access to specific agency, organization, and jurisdiction resources available through mutual aid, procurement or other arrangements.	Validate the NEFLHCC Resource Coordination Guidelines through training and exercise.	HPC Capability 3, Function 3; 2014 HCC AAR/IP; 2014-2015 Risk Assessment
Planning	All hazards	The 2015 Statewide Risk Assessment and Gap Analysis, Appendix 5, noted potential limitation of medical/clinical staff in health or medical incidents, which may have an impact on the ability to respond in a timely manner to all counties in a regionwide event, and could increase risks to responders' health and safety. Identified at-risk populations may also require additional services and resources.			1. County Health Departments maintain Responder Safety and Health/Environmental Surety plans. 2. Plans are periodically tested at the local levels through exercises and real world events.	Process to integrate responder safety and health issues into HCC planning and resource coordination	Currently, the NEFLHCC planning process does not address responder safety and health as a cross-cutting issue in individual plans and procedures.	HPC Capability 1 and 6; 2014 HCC AR/IP; 2014-2015 NEFLHCC Risk Assessment; Statewide Risk Assessment and Gap Analysis, Appendix 5 (July 2015)
Medical Material Management/Distribution								
Planning	All hazards	The 2015 Statewide Risk Assessment and Gap Analysis, Appendix 5, noted potential limitation of medical/clinical staff in health or medical incidents, which may have an impact on the ability to respond in a timely manner to all counties in a regionwide event, and could increase risks to responders' health and safety.			1. Most health and medical organizations maintain Employee/Responder Safety and Health/Environmental Surety plans. 2. Plans are periodically tested at the agency levels through exercises and real world events.	Process to integrate responder safety and health issues into HCC planning and resource coordination	Currently, the NEFLHCC planning process does not address responder safety and health as a cross-cutting issue in individual plans and procedures.	HPC Capability 1 and 6; 2014 HCC AR/IP; 2014-2015 NEFLHCC Risk Assessment; Statewide Risk Assessment and Gap Analysis, Appendix 5 (July 2015)

Appendix B: CAPABILITIES DEFINITIONS

1. Community Preparedness

Community preparedness is the ability of communities to prepare for, withstand, and recover — in both the short and long terms — from public health incidents. By engaging and coordinating with emergency management, healthcare organizations (private and community-based), mental/behavioral health providers, community and faith-based partners, state, local, and territorial, public health's role in community preparedness is to do the following: • Support the development of public health, medical, and mental/behavioral health systems that support recovery • Participate in awareness training with community and faith-based partners on how to prevent, respond to, and recover from public health incidents • Promote awareness of and access to medical and mental/behavioral health resources that help protect the community's health and address the functional needs (i.e., communication, medical care, independence, supervision, transportation) of at-risk individuals • Engage public and private organizations in preparedness activities that represent the functional needs of at-risk individuals as well as the cultural and socio-economic, demographic components of the community • Identify those populations that may be at higher risk for adverse health outcomes • Receive and/or integrate the health needs of populations who have been displaced due to incidents that have occurred in their own or distant communities (e.g., improvised nuclear device or hurricane).

2. Volunteer Management

Volunteer management is the ability to coordinate the identification, recruitment, registration, credential verification, training, and engagement of volunteers to support the jurisdictional public health agency's response to incidents of public health significance.

3. Community Recovery

Community recovery is the ability to collaborate with community partners, (e.g., healthcare organizations, business, education, and emergency management) to plan and advocate for the rebuilding of public health, medical, and mental/behavioral health systems to at least a level of functioning comparable to pre-incident levels, and improved levels where possible. This capability supports National Health Security Strategy Objective 8: Incorporate Post-Incident Health Recovery into Planning and Response. Post-incident recovery of the public health, medical and mental/behavioral health services and systems within a jurisdiction is critical for health security and requires collaboration and advocacy by the public health agency for the restoration of services, providers, facilities, and infrastructure within the public health, medical, and human services sectors. Monitoring the public health, medical and mental/behavioral health infrastructure is an essential public health service.

4. Fatality Management

Fatality management is the ability to coordinate with other organizations (e.g., law enforcement, healthcare, emergency management, and medical examiner/coroner) to ensure the proper recovery, handling, identification, transportation, tracking, storage, and disposal of human remains and personal

effects; certify cause of death; and facilitate access to mental/behavioral health services to the family members, responders, and survivors of an incident.

5. Information Sharing

Information sharing is the ability to conduct multijurisdictional, multidisciplinary exchange of health-related information and situational awareness data among federal, state, local, territorial, and tribal levels of government, and the private sector. This capability includes the routine sharing of information as well as issuing of public health alerts to federal, state, local, territorial, and tribal levels of government and the private sector in preparation for, and in response to, events or incidents of public health significance.

6. PH Surveillance/Epidemiology Investigation

Public health surveillance and epidemiological investigation is the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes, as well as to expand these systems and processes in response to incidents of public health significance.

7. Medical Countermeasure Dispensing

Medical countermeasure dispensing is the ability to provide medical countermeasures (including vaccines, antiviral drugs, antibiotics, antitoxin, etc.) in support of treatment or prophylaxis (oral or vaccination) to the identified population in accordance with public health guidelines and/or recommendations.

8. Medical Surge Capacity

Medical surge is the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of the healthcare system to survive a hazard impact and maintain or rapidly recover operations that were compromised.

9. Emergency Operations Coordination

Emergency operations coordination is the ability to direct and support an event or incident with public health or medical implications by establishing a standardized, scalable system of oversight, organization, and supervision consistent with jurisdictional standards and practices and with the National Incident Management System.

10. Mass Care Coordination

Mass care is the ability to coordinate with partner agencies to address the public health, medical, and mental/behavioral health needs of those impacted by an incident at a congregate location. This capability includes the coordination of ongoing surveillance and assessment to ensure that health needs continue to be met as the incident evolves.