

Florida Public Health & Medical 2010 County Response System Profile Analysis

Version 1.3

Last Update: September 20, 2010

OVERVIEW

The Florida Department of Health initiated a County Profile project in 2007. The county profiles are designed to gather information pre-event about county capabilities and capacities to affect a public health and medical response. The profiles are updated each year as part of the annual Hurricane Preparedness effort.

The County Profiles for the 2010 year were streamlined to focus on those response actions which would require assistance from the State ESF8. County Public Health and Medical Response System Profiles were received from 63 of Florida's 67 County Health Departments during June and July 2010.

At the state-level, ESF8 exists to support local public health and medical response objectives. State ESF8 needs information about local response capabilities in order to conduct advanced planning to provide necessary support.

The profiles contain information in three areas:

- County response contacts,
- Situation reporting, and
- Public health and medical response capabilities.

This analysis provides a summary of the key findings from the profiles and aggregates the reporting data. Individual profiles information is available by contacting Samantha Cooksey Strickland in the Bureau of Preparedness and Response at (850) 245-4444 ext. 3696 or by email Samantha_Cooksey@doh.state.fl.us.

NEXT STEPS

The profile results can be utilized to enhance Florida's public health and medical preparedness efforts in several ways. Results from the 2010 profiles and other preparedness initiatives have been reviewed to determine potential areas for improvement. An action plan is being developed to address specific gaps and vulnerabilities at the state-level. The Bureau of Preparedness and Response recommends the following over-arching next steps:

1. Validate information received through the Regional Emergency Response Advisors (RERA) and the Regional Health Co-Chairs.
2. Provide State-level planning, training and exercise assistance to prevent, reduce, or eliminate identified issue.
3. Utilize summary results to target specific counties indicating no progress or limited progress in certain capabilities for increased planning and support.
4. Share summary reports with federal ESF8 partners to assist them with resource planning for Florida.

DESCRIPTION OF 2010 PROFILE RESULTS

County Response Contacts

All 63 counties provided contact information for a primary and two alternates for the local public health and medical system. Also provided was direct contact information for the ESF8 or public health and medical desk in the county emergency operations center.

This information has been integrated in to the 2010 *State ESF8 Communication Procedures* and provided to key contacts in the State ESF8 structure.

Situation Reporting

All 63 counties provided information regarding how the state could receive their situation status information during a response. Information varied from county to county. In general, counties indicated that the state could obtain information from their county by:

- Contacting the ESF8 or public health and medical desk in the county emergency operations center, using the contact information provided.
- Reviewing standard reports such as county situation reports, incident action plans, special needs shelter reporting available through EM Constellation or sent directly to State ESF8.
- Consulting the Regional Emergency Response Advisor for the designated region.
- Participating in conference calls with counties for direct updates.

Public Health and Medical (PHM) Response Capabilities

In this portion of the profiles, counties were asked to complete a self assessment regarding 21 public health and medical response capabilities.¹ They assessed each capability utilizing a 0 – 10 rating scale. See figure 1 on the following page for a description of the rating scale. Additionally, counties were asked to describe each capability in their county, forecast any potential resource needs for three to five days post-impact and indicate what local agency has lead responsibility for the capability in their county.

The capabilities that were assessed:

- | | |
|--|---|
| 1. Public Health and Medical (ESF8) Activation and Operations | 12. Patient Tracking |
| 2. Responder Safety and Health | 13. Alternate Site Medical Treatment |
| 3. Public Health and Medical Workforce Surge | 14. Medical Care and Transport for Survivors |
| 4. Medical Supplies, Pharmaceuticals and Equipment Management | 15. Public Information Dissemination |
| 5. Healthcare System Damage Assessment | 16. Healthcare Provider Information Dissemination |
| 6. Vulnerable Population Community Assessment | 17. Restoration of Potable Water Delivery, Solid and Wastewater Disposal and/or Other Environmental Health-Related Services |
| 7. Health and Medical Services for Vulnerable Populations | 18. Disease Surveillance and Outbreak Investigation |
| 8. Special Needs Sheltering | 19. Behavioral Health Services |
| 9. Shelter Discharge Planning | 20. Mortuary Services and Body Recovery |
| 10. Healthcare Facility Evacuation | 21. Restoration of Public Health and Medical System |
| 11. Inter-facility Patient Transfers (intra-county and inter-county) | |

¹ These capabilities are sub-capabilities of the National Target Capabilities List, which are available online at <http://www.fema.gov/pdf/government/training/tcl.pdf>.

Figure1: Rating Scale for 2010 County PHM Response System Profiles²

Label	No Progress	Limited Progress			Moderate Progress			Substantial Progress			Objective Achieved
Explanation	<p>Score of 0: Indicates that no progress has been made toward achieving the identified capability. This may be because there has been no activity in this area or because insurmountable barriers exist.</p>	<p>Low to mid-range: Preliminary efforts have been identified. Needs related to this capability have been recognized and are beginning to be identified in this area. Few, if any, steps have been implemented successfully so far.</p> <p>Mid to upper-range: Needs have been analyzed, requirements are understood, and steps have been taken toward achieving the capability. Steps may include initial plans to develop this aspect of the capability, allocation of resources, and identification of personnel responsible for the achievement of the capability.</p>			<p>Low to mid-range: Significant efforts are underway, but the capability has not yet been fulfilled, important gaps remain, or challenges, which could potentially undermine achievement, exist and have not yet been resolved.</p> <p>Mid to upper-range: Significant efforts are underway and specific examples of progress in this area can be identified. Strategies for closing gaps and overcoming barriers to success are being developed and initiated.</p>			<p>Low to mid-range: Efforts to achieve this capability are established and stable. Some weaknesses or barriers that prevent success persist, but strategies to resolve them are documented and well underway.</p> <p>Mid to upper-range: Efforts in this area are mature. Few gaps or barriers to success remain. None are significant. Evidence documenting this level of progress is readily available. Evidence may include After Action Reports from exercises or events where this aspect of capability was demonstrated.</p>			<p>Score of 10: Indicates that the capability is fully achieved. All barriers to success have been overcome. Strengths are robust and likely to be sustained. Evidence is readily available attesting to this level of achievement.</p>
Scale Value	0	1	2	3	4	5	6	7	8	9	10

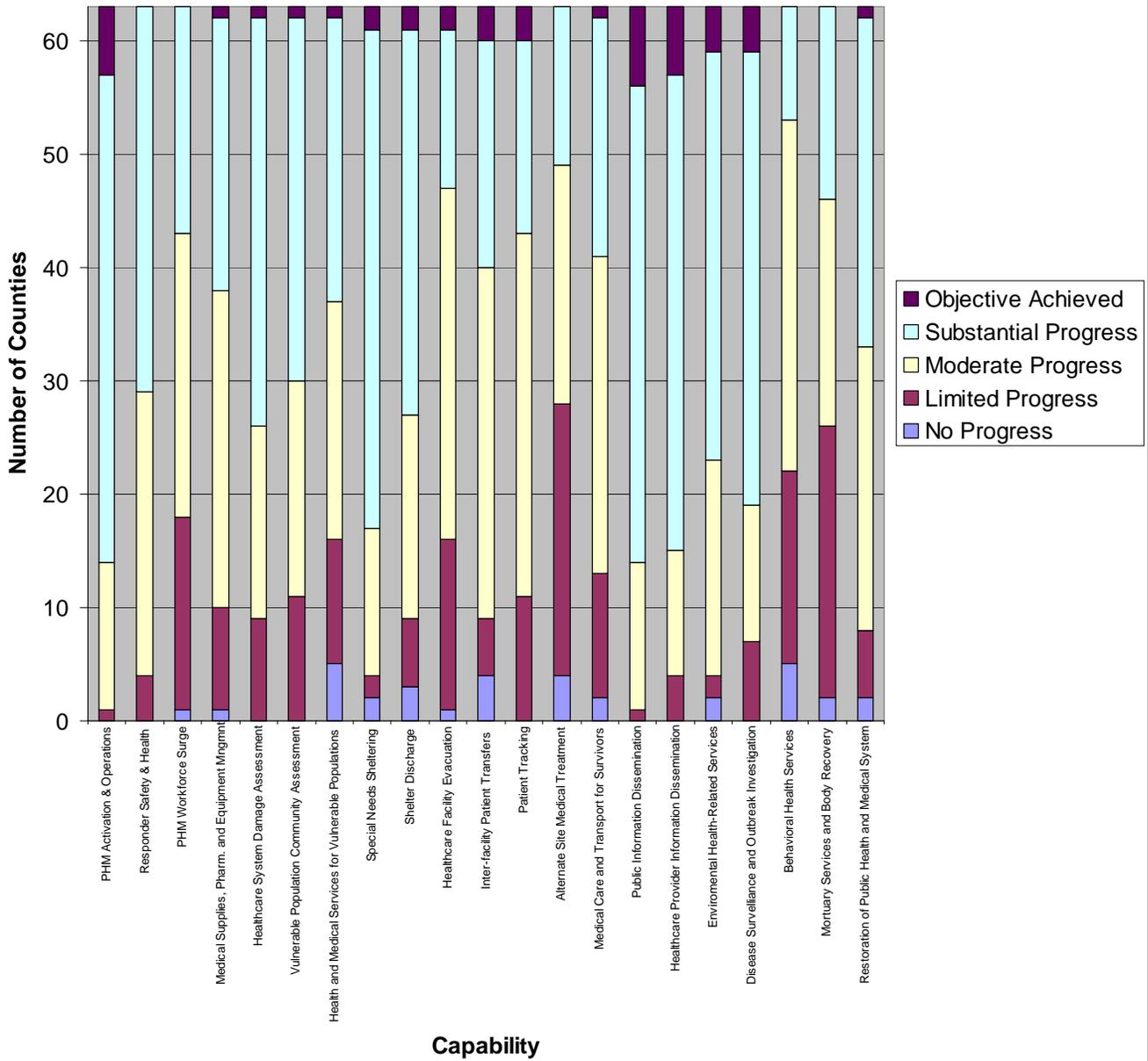
² Rating scale used for this assessment is the same scale used for the Domestic Security Capability Assessment.

**PHM Response Capabilities Summary
Number of Counties by Level of Progress**

PHMP Response Capability	No Progress	Limited Progress	Moderate Progress	Substantial Progress	Objective Achieved
Public Health and Medical (ESF8) Activation and Operations	0	1	13	43	6
Responder Safety and Health	0	4	25	34	0
Public Health and Medical Workforce Surge	1	17	25	20	0
Medical Supplies, Pharmaceuticals and Equipment Management	1	9	28	24	1
Healthcare System Damage Assessment	0	9	17	36	1
Vulnerable Population Community Assessment	0	11	19	32	1
Health and Medical Services for Vulnerable Populations	5	11	21	25	1
Special Needs Sheltering	2	2	13	44	2
Shelter Discharge Planning	3	6	18	34	2
Healthcare Facility Evacuation	1	15	31	14	2
Inter-facility Patient Transfers (intra-county and inter-county)	4	5	31	20	3
Patient Tracking	0	11	32	17	3
Alternate Site Medical Treatment	4	24	21	14	0
Medical Care and Transport for Survivors	2	11	28	21	1
Public Information Dissemination	0	1	13	42	7
Healthcare Provider Information Dissemination	0	4	11	42	6
Restoration of Potable Water Delivery, Solid and Wastewater Disposal and/or Other Environmental Health-Related Services	2	2	19	36	4
Disease Surveillance and Outbreak Investigation	0	7	12	40	4
Behavioral Health Services	5	17	31	10	0
Mortuary Services and Body Recovery	2	24	20	17	0
Restoration of Public Health and Medical System	2	6	25	29	1
Overall Average Response Capabilities ³	0	6	41	16	0

³ Based on average rating across all 21 capabilities assessed.

County Level of Progress by Capability



Analysis of Progress

- Of Florida's 67 counties, county response system profiles were received from 63. Average ratings for the 21 response capabilities assessed indicated 10% of counties with limited progress, 65% with moderate progress and 25% with substantial progress. No counties' average ratings indicated no progress or objective achieved.
- Counties indicated the most progress in Public Health and Medical (ESF8) Activation and Operation, Public Information Dissemination and Healthcare Provider Information Dissemination. 75% or greater of responding counties indicated substantial progress or objective achieved for these capabilities.

- Counties indicated the least progress in Alternate Site Medical Treatment and Mortuary Services and Body Recovery. Over 40% of responding counties indicated limited or no progress for these capabilities.
- No progress in a capability was indicated 5 times (the highest number reported) for both Behavioral Health Services and Health and Medical Services for Vulnerable Populations.
- Outliers existed for both high and low ends of the ratings.
 - Two counties indicated a significantly higher number of capabilities with a rating of 10, objective achieved. One county indicated this for 10 of the 21 capabilities assessed and the other for 8 of the capabilities.
 - Two counties indicated a significantly higher number of capabilities with a rating of 0, no progress. One county indicated this for 8 of the 21 capabilities assessed and the other for 6 of the capabilities.
- Of the six counties with average ratings indicating limited progress on the assessed capabilities, most attributed the low ratings to lack of resources locally, lack of written plans, no identified alternate medical treatment sites in county, and no medical facilities in county therefore no capability to support them with surge, evacuation and damage assessment.

Analysis of Progress by Size of County

For purposes of this analysis, counties were classified into rural (less than 50,000 population); urban (populations between 50,001 – 500,000; and metropolitan with populations over 500,000. Of the 63 counties responding, 23 (37%) are considered rural, 29 (46%) urban and 11 (17%) metropolitan.

**PHM Response Capabilities Summary
Percent of Rural, Urban and Metropolitan by Average Level of Progress**

County Size	Limited Progress	Moderate Progress	Substantial Progress
Rural	22%	61%	17%
Urban	3%	76%	21%
Metropolitan	0%	45%	55%

- The average rating across all 21 capabilities indicated “moderate progress” for rural, urban and metropolitan counties. Capability ratings increased slightly with the size of the county. The average rating for a rural county was 5.3, urban county was 6.3 and a metropolitan county was 6.7.
- 5 of the 6 counties that reported an overall assessment in the “limited progress” category are rural.
- For a majority of the capabilities assessed (19 of 21) metropolitan counties rated higher than urban and rural counties.
- Average ratings did not show a significant difference in ratings between rural, urban and metropolitan counties. The greatest difference between the high and low rating was 2.9 points for

Public Health and Medical Surge with rural counties average rating at 4.0 and metropolitan counties at 6.9.

- Of 34 total responses when counties indicated “no progress” in a capability, 79% of those were in rural counties.

Average Rating by Capability Based on County Size (Rural, Urban, Metropolitan)

Capability →	Public Health and Medical (ESF 8) Activation and Operations	Responder Safety and Health	Public Health and Medical Workforce Surge	Medical Supplies, Pharmaceuticals and Equipment Management	Healthcare System Damage Assessment	Vulnerable Population Community Assessment	Health and Medical Services for Vulnerable Populations	Special Needs Sheltering	Shelter Discharge	Healthcare Facility Evacuation	Inter-facility Patient Transfers (intra-county and inter-county)	Patient Tracking	Alternate Site Medical Treatment	Medical Care and Transport for Survivors	Public Information Dissemination	Healthcare Provider Information Dissemination	Restoration of Potable Water Delivery, Solid and Wastewater Disposal and/or Other Environmental Health-Related Services	Disease Surveillance and Outbreak Investigation	Behavioral Health Services	Mortuary Services and Body Recovery	Restoration of Public Health and Medical System	Average
Rural	7.1	5.9	4.0	5.2	5.5	5.4	4.1	6.6	6.0	4.3	4.7	4.7	3.3	4.2	7.1	7.2	6.3	6.4	3.5	3.6	6.1	5.3
Urban	7.6	6.9	5.5	5.9	6.3	6.4	5.6	7.4	6.7	5.7	6.0	5.6	4.4	5.6	7.9	7.0	7.0	7.2	5.1	4.8	5.8	6.2
Metropolitan	8.1	7.1	6.9	7.4	6.8	6.3	6.5	7.9	6.0	5.9	7.2	5.8	4.6	6.9	8.0	7.5	7.2	7.8	4.5	6.1	6.2	6.7
Statewide Average	7.5	6.6	5.2	5.9	6.1	6.0	5.2	7.2	6.3	5.2	5.7	5.3	4.0	5.3	7.6	7.2	6.8	7.0	4.4	4.6	6.0	6.0

Examples of Supporting Documentation

The following table provides select examples of the information counties provided about their local response capabilities. This information was used to describe the county's capacity to implement capability for 3 to 5 days post-impact. This information was critical to understanding the county's assessment rating for the capability.

An example is provided for both a county which rated as having limited progress and one indicating substantial progress or objective achieved for each assessed capability.

Capability	Examples of No Progress or Limited Progress Rating	Examples of Substantial Progress or Objective Achieved
Public Health and Medical (ESF8) Activation and Operations	Rating 3: At present County Has no EOC or a designated ESF 8 desk. Plans are to relocate to a non wind compliant facility that has no landline or computer capability.	Rating 9: ESF-8 is manned with Health Department staff. Each shift has a CHD nurse and environmental specialist stationed at the EOC/ESF-8 to complete any required questions or assignments that may arise. ESF-8 is staffed with 3 rotating shifts of 12 hours each. Training is conducted semi-annual or 48 hours prior to an event. The Human Need branch manager is a County Health Department staff member.
Responder Safety and Health	Rating 3: Each agency in County has an emergency plan that includes responder safety.	Rating 8: CHD has a safety policy, procedures and protocols in place with ongoing quarterly review. Agency consist of a safety officer and back up. Responder safety is enforced and practiced for all situations. County maintains necessary PPE for staff as well and provides necessary education updates.
Public Health and Medical Workforce Surge	Rating 2: Health department has a small staff of 26 personel; would not be able to sustain services if staff were affected by the disaster longer than three days.	Rating 8: CHD is unique in its Public Health Staff due to the collaboration with the school district to have nurses in each school. In addition to the clinical nurses, County has approximately 120 school health staff who are available during disasters. Two of the local hospitals systems and CHD have an MOU to support "green triage nurses," CHD nurses will support hospitals for single events based on availability. The hospitals have in place Mutual Aid agreements with other counties and states. In addition, coordination for the utilization of DCHAT teams has been utilized in the past for County.
Medical Supplies, Pharmaceuticals and Equipment Management	Rating 1: Limited work has been done in this arena due to the small number of pharmacies (4); limited capacity for storage of medical	Rating 9: CHD has the systems in place to manage any on-hand and received pharmaceuticals, medical supplies and equipment.

Capability	Examples of No Progress or Limited Progress Rating	Examples of Substantial Progress or Objective Achieved
	supplies	
Healthcare System Damage Assessment	Rating 3: The CHD COOP and COOP IT Plans address only the continued operations of SCHED, not the overall healthcare system (staff, facilities, and equipment) of the county. This area has not been previously addressed. Requests for resources would be requested through County Emergency Management to the State ESF8.	Rating 9: Our Environmental health team and Epi team start as soon as the winds die down and roads are safe and assessments are done first on the facilities that we regulate and then it is expanded to the whole county.
Vulnerable Population Community Assessment	Rating 2: CHD has some data online, such as the number of residents with disabilities, number on oxygen, etc. An MPH intern is beginning the week of May 24 with a project to locate vulnerable population pockets and determine the best way to reach each of them. CHD has the number of persons registering for the Special Needs Shelter and knows the location of nursing homes, assisted living facilities, and developmentally disabled group homes. Some information may be obtained from the No Person Left Behind group.	Rating 10: In County, annual assessment and recertification are conducted. County ADA Liaison is the lead for a subcommittee of the County-wide Special Needs Committee in which all relevant government and NGOs are represented. Vulnerable populations have been identified via the long term re-development plan. Agreements with home health, Centers for Independent Living, Red Cross, and other agencies to conduct assessments have been outlined. The subcommittee has developed quick identification stickers (decals) that would identify to responders if there were someone inside needing help. Damage assessment teams have been trained to look for and recognize the decals.
Health and Medical Services for Vulnerable Populations	Rating 1: Insufficient staffing, plans, and procedures to provide services to this specific population	Rating 8: An adequate capability is in-place to provide day-to-day services to this population. Long term or significant disasters - such as a hurricane - tends to interrupt this capability. Our regionally based CEMP review process helps to ensure private agencies involved have procedures in place to re-establish their operations after the event subsides.
Special Needs Sheltering	Rating 1: Each year approximately 1200 persons register for and are accepted to the Special Needs Shelter program. They are each told to bring a caretaker with them. However, there is room at the shelter to comfortably house 600 persons (another 100 could be squeezed in) and there are only 300 cots. Historically, ~300 is the highest number of persons coming	Rating 10: SPNS has capacity for 2100 beds with surge capacity for additional 1000 within the 3 existing shelters. Additional shelter space (as back up) has been identified within the county. Our goal is to shut down the shelters as quickly as possible post event and we do have (via EM) MOUs with LTFs to accommodate up to 100 SpNS clients should they not be able to return home.

Capability	Examples of No Progress or Limited Progress Rating	Examples of Substantial Progress or Objective Achieved
	<p>to the shelter despite the much higher number of registered shelterees. CHD can staff one shelter for six days, or two shelters for three days. Both locations have backup generators and pre-placed water.</p> <p>EMS stations a crew and ambulance at the SpNS.</p>	
Shelter Discharge Planning	<p>Rating 2: CHD discharge planning team was utilized in Hurricane Francis and encountered many challenges. The main challenges were lack of staff, no information on status of homes and limited long term facilities. CHD is working with EM and SO Patrol to get better data on status of homes</p>	<p>Rating 10: We have done this in actual storm response many times and are fully confident in our capability. EMS is a critical partner as they inspect the patient's home before we discharge. We also have local agreements with several facilities for a limited number of beds to use temporarily.</p>
Healthcare Facility Evacuation	<p>Rating 2: County's capacity is very low due to amount of ALS and BLS ambulances in county. Ability to med-evac could be substantial due to local County airport's long runway which could accommodate fixed wing aircraft.</p>	<p>Rating 7: A healthcare facility should have contingency plans to guide the facility if determined not safe for patients in their Emergency Operations Plans (EOP) that are sent yearly to Miami-Dade Department Emergency Management. Evacuation of patients will be made through agreements with private ambulances and EMS coordination</p>
Inter-facility Patient Transfers (intra-county and inter-county)	<p>Rating 1: Have one small hospital, 2 SNFs. Limited ability to transfer.</p>	<p>Rating 8: Our EOC Health and medical Branch has transportation and EMS transport units staffed by JFRD where all patient transport is handled. We use JTA buses, Pvt EMS transport and JTA connexion for special needs.</p>
Patient Tracking	<p>Rating 2: Currently working with FLDOH, Region 7 RDSTF, HERC, and EM to implement a Patient Tracking System</p>	<p>Rating 8: EMS currently uses a local system to perform patient tracking during medical transport. This system is used daily by EMS and hospitals</p>
Alternate Site Medical Treatment	<p>Rating 1: Low capacity related to high vulnerable populations, limited hospital staff, no identified facility, no stockpile of equipment and supplies</p>	<p>Rating 8: See Annex 9 Mass Care Plan for CHD which describes a Level 3 Community LEOC coordinated – ATS involvement for up to 50 patients</p>
Medical Care and Transport for Survivors	<p>Rating 1: CHD has not developed a plan for transporting survivors. CHD does not have the capability to establish an alternate medical treatment site. Transport of survivors should be addressed by ESF1</p>	<p>Rating 9: Depending on event and number of survivors - our county may be able to manage utilizing current Mass Casualty guidelines within EMS and Acute Care Facilities</p>

Capability	Examples of No Progress or Limited Progress Rating	Examples of Substantial Progress or Objective Achieved
Public Information Dissemination	Rating 3: County has one newspaper that is printed once a week. No local TV or radio stations, however, Blast Faxes or emails will be utilized.	Rating 9: County has a risk communication plan in place. Work with county 211 system to disseminate information to public. Website, electronic list serves (CHD and county) hotlines, strong relationship with media outlets. Ongoing relationship and communication with partner agency PIOs. Partner in county Joint Information Center.
Healthcare Provider Information Dissemination	Rating 3: Only routine blast fax and other business communications devices available for use	Rating 10: The H1N1 event allowed the development of mass communication through blast fax and blast email to all medical providers in the county. This comprehensive database is still maintained and successfully utilized by the CHD EPI Department for sharing health alerts with the LC medical community.
Restoration of Potable Water Delivery, Solid and Wastewater Disposal and/or Other Environmental Health-Related Services	Rating 3: County has 3 municipal water suppliers. There is not a single provider for solid waste disposal in the county. There are 3 liquid waste providers. Environmental Health works close with all of these entities and will work with them post disaster to restart their services.	Rating 8: County Health Department has an approved drinking water lab and has surge with an area private lab. The City also has an approved lab that upon request provides capacity to the County Health Department. Although operators are responsible for public water system, r County Health Department coordinates with DEP on BWN and conducts sampling support when needed. Limited Use System program staff contact permitted systems owners and verify status and provide necessary support. Media releases, brochures along with sampling information and collection containers are made available to private potable well system owners. BWN are issued as needed. County Health Department has a close working relationship with the three major utilities for County and city addition, Environmental Health has existing plans in place for post storm response, including health care facility damage assessment, mobile home park inspections, septic tank monitoring, and public information responsibilities on environmental hazards. EH filled the gaps of other agencies not locally positioned to assist in 2004 such as DEP, DBPR, and DOACS.
Disease	Rating 3: total of three	Rating 9: CHD has a team of 10-12

Capability	Examples of No Progress or Limited Progress Rating	Examples of Substantial Progress or Objective Achieved
Surveillance and Outbreak Investigation	environmental health workers between two CHD's	Epidemiologists that are available on a daily basis to assist in investigations if needed and to conduct passive surveillance on a day-to-day basis. We also have two other entities that may require activation during an outbreak, the Epi Strike Team and the Epi Response Team. The Strike team is made up of a smaller number of investigators that can respond on a moment's notice and can form independent teams that can investigate and interpret data as needed. The Epi Response team is made up of members from throughout the Health Department that have Epi or investigation experience and is organized into types of Teams, a Team Type 1, Type 2 or Type 3. The Type 1 teams can operate as an independent unit and can carry out investigations as needed. The type 2 teams are people with less experience but can with some minimal training and supervision, act as an investigation team, and Type 3 teams are basically support teams for the 1's and 2's and are comprised of clerks and assistants who can help the Type 1 and Type 2 teams with their functions.
Behavioral Health Services	Rating 2: Behavioral Health support services are scarce resources for many needy residents and especially for vulnerable populations. CHD Critical Incident Stress Management Team (CISM) is small/ not been tested. The Special Needs Shelter Staff provides "listening" support to clients/shelters. Referrals to agencies skilled in behavioral health such as School Administration, ARC, Social Services Counselors Hospice, the Harbors, Faith based counselors may be utilized	Rating 9 We have more than sufficient counselors on our response teams and all staff is trained in calming citizens that are frightened:
Mortuary Services and Body Recovery	Rating 2: Discussions have been conducted in this regard and consideration given for temporary morgue using refrigerated trucks located in the county	Rating 8: The identification and disposition of human remains in a mass fatality incident. The coordination, identification and disposition of the deceased may include requesting Disaster Mortuary Assistance Teams (DMORTs) in the event of mass casualties

Capability	Examples of No Progress or Limited Progress Rating	Examples of Substantial Progress or Objective Achieved
Restoration of Public Health and Medical System	Rating 2: This area is being discussed by community partners in quarterly meetings focusing on post disaster restoration of the community including medical infrastructure. If our community hospitals sustain significant damage our current options would include triage of patients to determine which would require transport to operational facilities, which patients could be cared for in an alternate treatment facility and which could be released.	Rating 9: This community is moderately dependent on CHD resources. The ability to function and provide care if infrastructure is damaged will be severely impacted. Possible to move treatment sites to other CHD building

Capability Lead Responsibility

Counties were asked to indicate the agencies with lead responsibility for each capability in their county. The intent of the question was to identify a single lead agency/department/organization but most counties included all agency/department/organization with a role in that capability. Therefore, it was impossible to quantify the lead responsibility for specific capabilities.

The agencies/departments/organizations most commonly listed for having a lead responsibility for capabilities included:

- County Health Departments
- Local ESF8 (unspecified agency)
- Emergency Management
- Emergency Medical Service or Fire Rescue
- Hospitals, or other licensed healthcare facility
- Agency for Healthcare Administration
- State Emergency Response Team
- State ESF8,
- State Department of Health
- Medical Examiner
- Law Enforcement (i.e. Sheriff, Police Department or local ESF16)
- School Board

Analysis

- Most (56 of 63 responding counties) listed the County Health Department as the lead (or a shared lead) for Public Health and Medical (ESF8) Activation and Operations.
- County Health Departments were indicated as a lead agency significantly fewer times for Healthcare Facility Evacuation, Inter-facility Patient Transfers (intra-county and inter-county), and Mortuary Services and Body Recovery capabilities. On average CHDs were listed less than half as many times as lead agency for these capabilities as they were for the other 18 capabilities. For these capabilities, responding counties indicated a significantly increased role for hospitals and other licensed healthcare facilities. The medical examiner was listed more often for fatality management.

- Several responses indicated a state-level responsibility for certain capabilities in some counties.
 - Four counties indicated a state-level responsibility for patient tracking in their county (i.e. State Health Department, Agency for Health Care Administration or Elder Affairs).
 - One county indicated a partial FDOH, CDC and SAMSA responsibility for responder safety and health.
 - Three counties indicated a state-level responsibility for Vulnerable Population Community Assessments.
 - Two counties indicated state-level responsibilities for special needs sheltering.
 - Two counties indicated a state-level responsibility for alternate site medical treatment.
 - Four counties indicated a state-level responsibility for behavioral health.
 - One county indicated a state-level responsibility for fatality management.
 - One county indicated a state-level responsibility for public information dissemination.
 - Three counties indicated state-level responsibility for Restoration of Public Health and Medical Systems.

Potential Resource Needs

Counties forecasted what resources may be needed within 3 to 5 days post-impact to support their local response. These resources may be obtained at the regional, state or federal level. In most cases, counties did not provide enough information to determine what the trigger would be to initiate these requests or at what point local capabilities would be overwhelmed. Many counties indicated a catastrophic impact would require additional resource needs.

Profiles were analyzed for potential resource requests and responses were grouped by the most common assets or the most appropriate existing asset for the capability. For example, if a county indicated “additional staffing” or “consolers” for the Behavioral Health Services capability it was counted as a Behavioral Health Team.

Some resources were grouped into a common category that includes several individual resources. For example:

- Fatality Management Equipment and Supplies includes portable refrigerator and body bags.
- Shelter Supplies and Equipment includes cots, oxygen, blankets and other shelter supplies.
- Clinic and Medical Supplies includes gauze and bandages, needles, medical equipment, and stretchers.
- Nurses and Physicians include licensed medical professionals acquired through contract services, volunteers, paid staff, or state or federal individual resources.
- Medical Teams include existing established teams of medical professionals such as a DMAT, SMRT, Medical Strike Team or other existing medical team.
- Fatality Management Team includes existing resources such as FEMORs or DMORT.

Listed on the following page is a table of the resources that may potentially be requested and the number of responding counties who indicated the particular resource may be requested within 3 to 5 days for each capability.

Potential Resource Needs Number of Counties and Anticipated Resource Requests by Capability

Capability →	Public Health and Medical (ESF 8) Activation and Operations	Responder Safety and Health	Public Health and Medical Workforce Surge	Medical Supplies, Pharmaceuticals and Equipment Management	Healthcare System Damage Assessment	Vulnerable Population Community Assessment	Health and Medical Services for Vulnerable Populations	Special Needs Sheltering	Shelter Discharge	Healthcare Facility Evacuation	Inter-facility Patient Transfers (intra-county and inter-county)	Patient Tracking	Alternate Site Medical Treatment	Medical Care and Transport for Survivors	Public Information Dissemination	Healthcare Provider Information Dissemination	Restoration of Potable Water Delivery, Solid and Wastewater Disposal and/or Other Environmental Health-Related Services	Disease Surveillance and Outbreak Investigation	Behavioral Health Services	Mortuary Services and Body Recovery	Restoration of Public Health and Medical System	Total Potential Requests by Counties
PERSONNEL RESOURCES																						
Ambulance Strike Teams / Other EMS	1	2	4	1	2		2			17	15	5	3	9								61
Behavioral Health Teams	3	3											1						55		2	64
Burn Specialists			1																			1
CHD Augmentation Teams	9		4				5							1						2	14	35
Disaster Community Health Assessment Team			1			3															1	5
Discharge Planners / Case Workers						1		1	19													21
EH Strike Teams	3		2		1	1		1					1				35	5			1	50
Engineers					1												4					5
Epi Strikes Teams / Other Epi Professionals	3		2								1		1			1		58			1	67
ESF8 Augmentation Teams	29									1			1	1							4	36
Facility Assessment Team			1		32																	33
Family Assistance Teams																				1		1
Fatality Mngmnt Teams	2		4		3							2	1	1						58		71
HAZMAT Team		5																				5
IT Staff Support	2	2													3	5					7	19
Medical Team (i.e. DMAT or SMRT)	6	2	41	2	7	3	14	1	1	4	3	4	38	1						2	18	147

Capability →	Public Health and Medical (ESF 8) Activation and Operations	Responder Safety and Health	Public Health and Medical Workforce Surge	Medical Supplies, Pharmaceuticals and Equipment Management	Healthcare System Damage Assessment	Vulnerable Population Community Assessment	Health and Medical Services for Vulnerable Populations	Special Needs Sheltering	Shelter Discharge	Healthcare Facility Evacuation	Inter-facility Patient Transfers (intra-county and inter-county)	Patient Tracking	Alternate Site Medical Treatment	Medical Care and Transport for Survivors	Public Information Dissemination	Healthcare Provider Information Dissemination	Restoration of Potable Water Delivery, Solid and Wastewater Disposal and/or Other Environmental Health-Related Services	Disease Surveillance and Outbreak Investigation	Behavioral Health Services	Mortuary Services and Body Recovery	Restoration of Public Health and Medical System	Total Potential Requests by Counties
Nurses or Physicians	1	1	31		3	5	6	4	2	1	2		18	4				3			5	86
Personnel for Well-Being Checks						1																1
PIO Support	3													1	24	8						36
Radiation Control Professionals		1																				1
Regional Emergency Response Advisors			1		5	1																7
Safety Officer		1																				1
Security Personnel													2	1						1		4
Special Needs Shelter Teams / Shelter Staff	7	1	1			3	7	39	5	1			3	1								68
Staff to Assist with Patient Tracking												2										2
Translators						2	1															3
Urban Search and Rescue Teams										1										3		4
Veterans Affairs Teams (Patient Reception)										1												1
Veterinary Assistance Teams	1																					1
Vulnerable Population Assessment Team/Staff ⁴					1	19	4	1														25
SUPPLIES, EQUIPMENT & SERVICES																						
Chempack				3																		3
Clinic or Medical Supplies		3	3	32	2		1				2		16	3							4	66

⁴ This is not an existing resource. Vulnerable Population Assessment Team/Staff includes any responses that indicated additional staff would be necessary to identify vulnerable populations that did not specify another existing resource. Response included “more staff”, “assessment teams”, “planning staff”, or “strike teams”.

Capability →	Public Health and Medical (ESF 8) Activation and Operations	Responder Safety and Health	Public Health and Medical Workforce Surge	Medical Supplies, Pharmaceuticals and Equipment Management	Healthcare System Damage Assessment	Vulnerable Population Community Assessment	Health and Medical Services for Vulnerable Populations	Special Needs Sheltering	Shelter Discharge	Healthcare Facility Evacuation	Inter-facility Patient Transfers (intra-county and inter-county)	Patient Tracking	Alternate Site Medical Treatment	Medical Care and Transport for Survivors	Public Information Dissemination	Healthcare Provider Information Dissemination	Restoration of Potable Water Delivery, Solid and Wastewater Disposal and/or Other Environmental Health-Related Services	Disease Surveillance and Outbreak Investigation	Behavioral Health Services	Mortuary Services and Body Recovery	Restoration of Public Health and Medical System	Total Potential Requests by Counties
Computers / Other IT Equipment	2				2																	4
DEP Support																	1					1
Fatality Management Equipment & Supplies																				13		13
Food Service	1						1	4														6
Fuel	1																2					3
Generators			1	3	1								2		1		8			1	2	19
Lab Support																	1	3				4
Mobile Command Post	1																					1
Mosquito Control																	2					2
Patient Tracking Technology												14										14
Personal Protective Equipment	3	16		3																1		23
Pharmaceuticals / Antivirals			1	27				1						1								30
Portable Hospital System	1	5			1						1		8								1	17
Portable Morgue																				3		3
Portable Sewage Systems																	4					4
Portable Toilets & Hand Washing Stations													1				9				1	11
Shelter Supplies and Equipment	1		4	23	2	3	4	17			1		14								1	70
SNS Push Package	1			10																		11
Temporary Housing									2													2
Transportation Resources	2		3	2	3	3	6	3	3	41	35	1	5	19							1	127

Capability →	Public Health and Medical (ESF 8) Activation and Operations	Responder Safety and Health	Public Health and Medical Workforce Surge	Medical Supplies, Pharmaceuticals and Equipment Management	Healthcare System Damage Assessment	Vulnerable Population Community Assessment	Health and Medical Services for Vulnerable Populations	Special Needs Sheltering	Shelter Discharge	Healthcare Facility Evacuation	Inter-facility Patient Transfers (intra-county and inter-county)	Patient Tracking	Alternate Site Medical Treatment	Medical Care and Transport for Survivors	Public Information Dissemination	Healthcare Provider Information Dissemination	Restoration of Potable Water Delivery, Solid and Wastewater Disposal and/or Other Environmental Health-Related Services	Disease Surveillance and Outbreak Investigation	Behavioral Health Services	Mortuary Services and Body Recovery	Restoration of Public Health and Medical System	Total Potential Requests by Counties
Vehicle Lifts										1												1
Ventilators				5	1																1	7
Water Storage Units													1				7				1	9
Water Testing Supplies																	7					7
Total Potential Requests	83	42	105	111	67	45	51	72	32	68	60	28	116	43	28	14	80	69	55	85	65	

Potential Resource Gaps & State-level Vulnerabilities

- The capability requiring the most resource support is Alternate Site Medical Treatment. This corresponds with the assessment rankings as it was the lowest rated capability statewide. In order to establish alternate medical treatment sites, a majority of counties indicated that significant resources would be required for all aspects including staff, equipment and supplies, pharmaceuticals, and facilities (i.e. tents or portable systems).
- Medical Supplies, Pharmaceuticals and Equipment Management is the capability requiring the second greatest amount of resources. Based on supporting information from counties it appears these request are to backfill supplies or to increase quantities in local caches.
- Public Health and Medical Workforce Surge was the capability requiring the third most resources. This capability received the second lowest rating of capabilities among counties.
- The single resource with the greatest number of potential requests (147 total across all capabilities) by counties was medical teams (e.g. SMRT, DMAT, or other contract, state, federal or volunteer based teams). Based on the limited number of pre-established in-state teams; State ESF8 may consider alternate staffing strategies.
- Transportation resources for patient movements including evacuation, and inter-facility transfers followed as the second most potentially requested resource (127 total, across all capabilities). These resource needs include EMS, buses, helicopters, water craft and bus drivers. If requests for specific numbers of EMS resources were included, transportation resources would raise to the most requested resource.
- 19 counties stated that they would request personnel resources to assist in the identification of, assessment of, or planning for vulnerable populations within 3 to 5 days post impact. Currently, no specific resource exists for this function that could be readily deployed during response. Additional pre-event planning may be necessary to assist counties in identifying and preparing for their vulnerable populations.
- 58 counties indicated that they would need immediate state or federal assistance in a mass fatality situation and that very few resources exist at the local level⁵. These request included personnel resources such as FEMORS, DMORT and USAR and equipment resources like portable morgues, refrigerator trucks, and body bags.
- 32 counties indicated that state or federal support would be necessary to conduct damage assessments. Most indicated this would be needed following a Category 3 or above hurricane. Minimal trained and experienced staff exists for this function in-state. State may consider alternate staffing strategies.
- 5 potential requests were indicated specifically for Disaster Community Health Assessment Teams (DCHATS), a resource which no longer exists in Florida.
- ESF8 augmentation teams were indicated as potential requests 36 times, for relief staffing that may be requested. State may consider developing standing ESF8 augmentation teams in each region similar to the SERT IMT strategy.
- Many counties indicated additional funding could increase local capabilities specifically for patient tracking and surge capacity.

⁵ Most counties did not define or quantify what would be considered a “mass fatality” situation. One example provided by Osceola County was anything over 10 fatalities would require support.

- Several counties indicated State EOC support would be necessary to track patients. There was concern that lack of a centralized system will make it difficult to accomplish at the county level. 14 counties indicated a patient tracking system or software is needed to carry out that capability.
- Numerous counties indicated they would need support during response in identifying alternate locations for evacuation of medical facilities or shelters, if necessary, as alternate locations are not available within their county.
- Some South Florida counties requested that deployed teams be Spanish speaking and others said translators would be needed for teams.
- Many counties indicated a reliance on other counties in their region. It appears that in a response that impacts the entire region, smaller counties' capabilities would be hindered by the inability of the larger county to provide support.
- The primary support needed from a public information standpoint was immediate distribution of statewide talking points and messaging that could be used at the local level.