Illinois Medical Emergency Response Team

Annual Report

FY 2011

This report will summarize program activities as related to the ASPR grant agreement between the Illinois Department of Public Health and the Illilnois Medical Emergency Response Team.

Grant No. 17282150

Contents

PROGRAM OVERVIEW

The Illinois Medical Emergency Response Team (IMERT) is a 501c3 not for profit organization of volunteers trained to respond to disasters and provide interim medical care for survivors or evacuees.

IMERT provides the State of Illinois with a medical response capability of a vetted, credentialed and uniquely trained response team in support of ESF-8 as directed by IDPH and IEMA. The team has responded to mass casualty incidents including EMAC requests and requests for medical assistance from communities in Illinois. IMERT also provides medical coverage for specialized state teams and at "high risk" events when a comprehensive medical response could be required.

IMERT partners with state, regional, and local agencies to participate in training exercises, table top drills, disaster response planning, and response team development. This includes: local health departments, medical reserve corps, municipal and regional coordinated exercises. These collaborations have improved IMERT's response capabilities as well as the overall response capabilities of the state.

The concept for a mobile, scalable medical response team emerged in 1999 when the need for organized medical capabilities during disaster operations in the state became apparent. From this shortfall, the IMERT concept emerged. This included developing organized response protocols, a formalized communications system, and identifying and training a core of specially prepared responders to assist in the event of a mass casualty event.

By 2002 IMERT was part of the Illinois Disaster Plan, and had started getting funding from the HRSA grants for program development and equipment purchases. Since then, IMERT's presence and initiatives have assisted the state in earning top ratings in disaster preparedness that is consistently above the national average. IMERT relies on ASPR grant funding from IDPH and a maintenance grant from the Department of Homeland Security through the Illinois Terrorism Task Force to continue operations and develop future initiatives.

Although the primary mission of IMERT is to assist with emergency medical treatment and response, IMERT also coordinates and develops education and training programs throughout Illinois for medical, nursing, pre-hospital and volunteer community responders.

In addition to its primary response team, IMERT has multiple divisions including; the Illinois Nurse Team (INVENT), State Weapons of Mass Destruction Team medical unit (SWMDT), and Urban Search and Rescue (US&R) responders. INVENT is composed of volunteer nurses from across the spectrum of patient care and is designed to foster sustainability of an IMERT response into the recovery phase. The SWMD team offers training to SWMD medics as well as provides medical coverage during drills and immersion events. Illinois US&R contains a group of specially trained IMERT volunteers who provide medical coverage at trainings and during search and rescue operations.

SIGNIFICANT ACTIVTIES

Beginning July 1, 2010 IMERT moved into offices at the Illinois Law Enforcement Alarm System (ILEAS) campus on a full time basis. IMERT is a 501c3 non-profit group, having attained that status in December of 2009. Before IMERT became a legal entity, ICEP (Illinois College of Emergency Physicians) had been the fiduciary agent for the IMERT grants and program. ICEP chose not to seek a working arrangement with IMERT as a separate entity. Moreover, ICEP took the position that all equipment purchased with the grants for which they acted as fiduciary agent belonged to them. This position and subsequent actions resulted in a dispute over the equipment between IDPH and ICEP. Significant efforts on the part of IDPH resulted in a resolution of the equipment dispute in late April 2011.

Despite the equipment ownership situation, the IMERT program continued without interruption. Transitional issues were supported with a short term grant from IDPH and program operations were supported by a grant from ITTF administered by ILEAS. Subsequent contingency plans for utilization of existing equipment caches were developed with the assistance of the Regional Hospital Coordinating Centers (RHCC). A suitable equipment response package was assembled and IMERT maintained the ability to have adequate medical supply resources to function in an austere environment for 48 hours.

Very early in this grant year IMERT was requested by the Illinois State Police to assist with a large community event in Old Shawnee Town. IMERT was requested to provide medical coverage for a special detail in Old Shawnee Town July 15 thru July 17, 2010. The request was made due to the large contingent of Illinois State Police on site in an area with sparse medical resources. Staffing and equipment resources were ample. A full Medical unit report is included as an addendum to this report.

The primary operational focus for this grant year has been on developing interagency partnerships and coalition development while providing “real-time” deployment experience for IMERT volunteers. IMERT, along with numerous state agencies, work together at monthly exercises as part of the State Weapons of Mass Destruction Team. The trainings are often in remote areas of the state which allows for the set-up of medical treatment areas in non-traditional settings. All ICS procedures are followed including development of an IAP (Incident Action Plan). IMERT participated in 9 exercises this grant year. Locations for these events rotate around the state. Scenarios generally involve a terrorist related event that includes the dispersal of a hazardous material. IMERT’s role is to provide stabilization and medical care for acute injury or illness as well as entry and exit vitals for designated participants. This provides a deployment like training opportunity for IMERT members in sometimes austere environments. The scenarios test readiness as well as integration of responders and various agencies’ missions.

In keeping with the partnership and coalition development focus IMERT conducted a skills building training session suitable for Illinois Medical Reserve Corps (MRC) volunteers. The inaugural session was in April 2011 for 62 attendees at central Illinois MRC conference. The session was well received. Feedback from attendees is being utilized to enhance the program and additional training opportunities will be provided. A course description is provided later in this report.

In collaboration with the IEMA Homeland Security training office six IMERT SWMD members were approved and attended an all-expense course on Response to Terrorist Bombings in New Mexico. This training was very well received and provided our medical responders with advanced technical training from national experts.

IMERT was notified by IDPH on April 30 of a deployment order to send an assessment team to southern Illinois in response to significant flooding that resulted in the evacuation of the town of Cairo, IL. IMERT started the deployment process with notification of the Medical Director, staff and appropriate team members. A forward assessment team arrived at the UAC on May 1 at 1300, then proceeded to the campus of Shawnee College where there was an American Red Cross Shelter populated by about 120 displaced flood victims. The deployment lasted 8 days. A copy of the medical unit report is included in the addendum section of this report.

BARRIERS:

1. The equipment dispute between IDPH and ICEP was not problematic operationally but it did have an impact in terms of time and energy spent on the matter. The resolution of the equipment dispute between ICEP and IDPH was a substantial achievement by IDPH from which IMERT benefitted greatly
2. The delay in the receipt of ASPR funds caused us to reconsider priorities for projects not directly related to response team operations. Particularly the hiring of contractors to assist with the deliverables that pertain to Alternate Care Sites (ACS), RMERT and MRC trainings.

IMERT FOUNDATION EXECUTIVE BOARD

IMERT has been established as a 501.c.3 nonprofit since 2009.

President
Moses Lee, MD, FACEP, FAAEM
moses567@gmail.com

Vice-President
Sharon Dotson, RN
tbear@fsi.uiuc.edu

Secretary/Treasurer
Shannon Comer, RN, MSN
comer.shannon@gmail.com

Members
Bernard Heilicser, DO, MS, FACEP, FACOP

Margaret Luczak, RN, MSN, EMT-B

George Beranek, MD, MBA, FACEP

Executive Director
Mary Connelly, RN, BSN

The IMERT Board of Directors holds meetings on a quarterly basis. Meetings were held on the following dates during the grant cycle:

August 12th, 2010

November 10th, 2010

February 9th, 2011

May 11th, 2011

PARTNERSHIPS AND COLLABORATIONS

Throughout the grant cycle, IMERT cultivated and fostered partnerships within the health care community and preparedness organizations. Additionally, the Team's leadership participated in all Regional Hospital Coordinating Centers (RHCC) meetings which were held on the following occasions:

9/17/2010	Tinley Park, IL
11/19/10	Carbondale, IL
3/18/2011	Highland Park, IL
6/9/2011	Hoffman Estates, IL

IMERT also participated in FEMAs Regional Catastrophic Planning Team Subcommittee Meetings:

7/30/2010	Schaumburg, IL
5/26/2011	OEMC, Chicago, IL
12/2/2010	Chicago, IL

INTERAGENCY PARTNERSHIPS

- Carle Hospital of Champaign Illinois
- Carle Clinic Foundation Pharmacy
- Chicago Fire Department
- Chicago Marathon, LaSalle Bank
- DuPage Public Safety Communication
- Emergency Medical Services for Children
- Environmental Protection Agency
- Faith-based Charities
- Illinois Emergency Management Agency
- Illinois Department of Public Health
- Illinois Law Enforcement Alarm System (ILEAS)
- Illinois Medical District Hospital Preparedness Coalition
- Illinois National Guard and other state response agencies
- Illinois Primary Healthcare Association
- Illinois Public Health Association
- Illinois State Police
- Illinois Terrorism Task Force
- Illinois Urban Search & Rescue Teams
- John H. Stroger Hospital of Cook County
- Medical Reserve Corps of Illinois
- Northwestern Hospital SimLab Education
- Regional Hospital Coordinating Centers
- Secretary of State Bomb Squad
- SWMDT (State Weapons of Mass Destruction Team)
- Urban Search and Rescue Teams, Illinois
- US Army Civilian Support Team

IMERT-INVENT staff and senior leadership participate on a number of additional committees both in Illinois, other states and at the federal level.

- **Interstate Medical Disaster Cooperative**
  Representative: Dr. Moses Lee, FACEP
  Medical response team leaders from multiple states whose primary purpose is to share lessons learned and further develop interoperability.
- **Illinois Medical District Hospital Preparedness Coalition**
  Representative: Dr. Moses Lee, FACEP
  Illinois Medical District Hospitals collaborate to discuss shared resources and interactions with regional, state, and federal assets during a disaster/medical surge.
- **Medical and Public Health Working Group, U.S. Dept. of Health & Human Services; FEMA**
  Representative: Mary Connelly, BSN
  Charged with developing resource typing for response teams to enhance the EMAC request process.
- **Illinois Terrorism Task Force**
  Representative: Dr. Moses Lee, Mary Connelly, BSN
- **Bioterrorism Committee, Illinois Department of Public Health**
  Representative: Mary Connelly, BSN
  A multi-agency co-operative that provides strategic policy and support for statewide bioterrorism preparedness, response, and recovery capabilities.
- **Regional Catastrophe Planning Team Joint Subcommittee, IDPH**
  Representative: Mary Connelly, BSN Moses Lee MD
- **Training Committee, Illinois Terrorism Task Force**
  Representative: Barbara Oliff, RN, BA
  Multi-agency group of representatives from across the Illinois Terrorism Task Force. The main objectives are to discuss training initiatives designed to promote compliance with DHS objectives and training budgets for the ITTF organization.
- **Pediatric Bioterrorism Committee, Illinois Emergency Medical Services for Children**
  Representative: Barbara Oliff, RN, BA
  Multi-agency specialists focused on pediatric considerations in mass casualty, outbreak and epidemic incidents. The main objective is pediatric disaster awareness. Includes pediatric physicians, school nurses, public health nurses, ER nurses, Pediatric ER nurses, IDPH, CDC, ARC, IMERT
- **Chicago Area Regional Recovery Initiative (CARRI)**
  Representative: Barbara Oliff, RN, BA
  Faith-based and voluntary associations and organizations working with government and business too seek out people with disaster-related needs from the July 2010 flooding, working to develop a metropolitan-wide and permanent recovery structure. This group relates to the Chicagoland Community Organizations Active in Disaster through the Long Term Recovery and Case Management Subcommittee.
- **Chicagoland Community Organizations Active in Disaster**
  Representative: Barbara Oliff, RN, BA
  A collaborative organization based within the Chicago area composed of public, private, and non-profit agencies focused on enhancing the community's ability to prepare for, respond to, and recover from the effects of disasters as well as developing a mental health disaster plan for the State of Illinois

MEETINGS

IMERT participates with state, federal, regional, and local agencies in training exercises, table top drills, disaster response planning, and response team development. This includes: local health departments, medical reserve corps, municipal and regional coordinated exercises. IMERT Staff meetings and joint meetings promote these and other collaborative practices and enhance awareness of the role IMERT can play in preparing for disaster.

7/1/2010	IMERT Staff Meeting	Urbana, IL
7/7/2010	Interstate Disaster Medical Cooperative	Teleconference
7/19/2010	IMERT Staff Meeting	Urbana, IL
7/29/2010	Ethics Forum on Altered Standards of Care	MCHC, Chicago, IL
7/30/2010	Regional Catastrophe Planning Team Subcommittee	Schaumburg, IL
8/4/2010	Interstate Disaster Medical Cooperative	Teleconference
8/5/2010	ITTF Training Committee Meeting	Champaign, IL
8/10/2010	IMERT Staff Meeting	Urbana, IL
8/13/2010	EMSC Pediatric Bioterrorism Committee	Teleconference
9/1/2010	Interstate Disaster Medical Cooperative	Teleconference
9/1/2010	IMERT Staff Meeting	Urbana, IL
9/8/2010	IDPH Leadership on upcoming grant deliverables	Springfield, IL
9/14/2010	ITTF Training Committee Meeting	Champaign, IL
9/17/2010	RHCC POD Hospital Meeting	Tinley Park, IL
9/28/10	IMERT Staff Meeting	Urbana, IL
10/6/10	Interstate Disaster Medical Cooperative Monthly	Teleconference
10/12/2010	IMERT Staff Meeting	Buffalo Grove, IL
10/26/2010	SEOC Collaboration Meeting	Springfield, IL
11/3/10	Interstate Disaster Medical Cooperative	Teleconference
11/4/2010	IMERT Staff Meeting	Urbana, IL
11/15/2010	EMSC Pediatric Bioterrorism Committee	Teleconference
11/18/10	DHHS Medical and Public Health Work group	Teleconference
11/19/10	RHCC POD Hospital Meeting	Carbondale, IL
11/30/2010	ITTF Training Committee Meeting	Champaign, IL
12/1/2010	IMERT Staff Meeting	Teleconference
12/1/2010	IPHA Training survey	Teleconference
12/2/2010	Regional Catastrophic Planning Team Subcommittee	Chicago, IL
12/2/2010	IMERT Operations Committee Meeting	Champaign, IL
12/3/2010	EMSC Pediatric Bioterrorism Committee	Teleconference
12/3/2010	SWMD Communications Meeting	Lincoln, IL
12/8/2010	ITTF Chair and Committee Meeting	Springfield, IL
12/13/2010	CCOAD, Mental Health disaster planning	Chicago, IL

12/14/2010	IMERT Staff Meeting	Teleconference
12/17/2010	Sim Lab Training Planning	Chicago, IL
12/23/2010	IMERT Staff Meeting	Teleconference
1/7/2011	Illinois Medical District Hospital Preparedness Coalition	Chicago, IL
1/17/2011	IMERT Staff Meeting	Urbana, IL
1/19/2011	EMSC Pediatric Bioterrorism Committee	Teleconference
1/24/2011	IMERT Leadership Meeting	Teleconference
1/26/2011	ITTF Chair and Committee Meeting	Springfield, IL
1/28/2011	IMERT Staff Meeting	Teleconference
1/28/2011	Chicago Fire Department Sim Lab Tour	Chicago, IL
1/31/2011	IMERT Leadership Meeting	Teleconference
2/1/2011	Sim Lab Training Planning	Chicago, IL
2/1-14/2011	SimLearning for Response Teams Coordination	Chicago, IL
2/2/2011	IMERT Leadership Deployment Planning	Teleconference
2/14/2010	IMERT Leadership Meeting	Teleconference
2/16/2011	IMERT Staff Meeting	Urbana, IL
2/18/2011	EMSC Pediatric Bioterrorism Committee	Teleconference
2/18/2011	MRC training development	Palatine, IL
2/21/2011	IMERT Leadership Meeting	Teleconference
2/23/2011	ITTF Chair and Committee Meeting	Springfield, IL
2/28/2011	ILEAS Regional Meeting	Salem, IL
2/28/2011	IDPH and ASPR Fiscal and Grant Management	Springfield, IL
3/3/2011	IMERT Staff Meeting	Urbana, IL
3/4/2011	Illinois Medical District Hospital Preparedness Coalition	Chicago, IL
3/10/2011	ITTF Training Committee Meeting	Champaign, IL
3/11/2011	IMERT Staff Meeting	Urbana, IL
3/16/2011	IDPH Bioterrorism Committee Restructuring	Teleconference
3/16/2011	Sim Learning for Response Teams	Chicago, IL
3/18/2011	RHCC POD hospital meeting	Highland Park, IL
3/22/2011	IMERT Staff Meeting	Urbana, IL
3/23/2011	ITTF Chair and Committee Meeting	Springfield, IL
3/24/2011	IMERT Staff Meeting	Teleconference
3/30/2011	Sim Learning for Response Teams	Chicago, IL
4/1/2011	Illinois Medical District Hospital Preparedness Coalition	Chicago, IL
4/4/2011	IMERT Staff Meeting	Teleconference
4/4/2011	Education Planning Meeting	Chicago, IL
4/4/2011	IMERT Lead Physician Meeting	Teleconference
4/6/2011	DMAT Status Meeting	Stroger, Chicago, IL
4/7/2011	IMERT Staff Meeting	Teleconference
4/7/2011	ESAR-VHP	Teleconference

4/8/2011	Education Leadership Meeting	Springfield, IL
4/11/2011	IMERT Equipment Meeting	Schaumberg, IL
4/11/2011	Volunteer management	IDPH Regional Office, Urbana, IL
4/11/2011	Inventory System Set up	Teleconference
4/13/2011	IDPH Bioterrorism Committee	Teleconference
4/25/2011	IMERT Staff Meeting	Teleconference
4/29/2011	CRIS Server maintenance	Teleconference
5/9/2011	Surge/All-Hazards Catastrophic Plan	MCHC, Chicago, IL
5/11/2011	IMERT Leadership Meeting	Stroger Hospital, Chicago, IL
5/17/2011	ITTF Training Meeting	ISP, Springfield, IL
5/17/2011	IMERT and IDPH leadership	Springfield, IL
5/18/2011	ESAR-VHP	Teleconference
5/24/2011	IMERT Staff Meeting	Hinsdale Oasis, IL
5/25/2011	IMERT Leadership Meeting	Springfield, IL
5/25/2011	ITTF Chair and Committee Meeting	Springfield, IL
5/26/2011	Regional Catastrophe Planning Subcommittee Meeting	OEMC, Chicago, IL
6/1/2011	ITTF Training Sub-Committee Meeting	IFSI, Champaign, IL
6/1/2011	Volunteer management	St Joseph's, Bloomington, IL
6/2/2011	IDPH Fiscal Management	IDPH, Springfield, IL
6/3/2011	Illinois Medical District Hospital Preparedness Coalition	Chicago, IL
6/7/2011	Interstate Disaster Medical Collaborative	Teleconference
6/7/2011	IDPH Fiscal Management	IDPH, Springfield, IL
6/7/2011	CRIS Server Status	IDPH, Springfield, IL
6/9/2011	RHCC POD Meeting	Hoffman Estates, IL
6/9/2011	Old Shawnee Town Planning	Carmine, IL
6/10/2011	EMSC Pediatric BT	Teleconference
6/20/2011	DMAT Creation Process	Milwaukee, WI
6/20/2011	CRIS Server Status	Teleconference
6/21/2011	Inventory System Set up	Teleconference
6/22/2011	IMERT Staff Meeting	Bourbonnais, IL

Over 395 planning and interagency coordination hours total for the grant year

CONTRACTORS AND STAFFING

IMERT hired the following contractors to address various tasks from April 1, 2011 through June 30, 2011. These individuals were from the University Of Illinois School Of Nursing.

Danea Atkins
Ariel Hugh
Jackie Gibson
Lauren Grabanski

Janie Huston, a volunteer programs assistant for ILEAS, was also hired for this same time period to perform administrative and office maintenance duties.

Some of the tasks completed were:

- IMERT identification cards – 493 deployable team member ID's were printed, 94 deployable team members were identified as not having a photograph on file.
- Updating team member files, verifying credentialing and NIMS compliance
- Website maintenance and updates
- Sorting of materials recovered from the ICEP agreement to determine if expired or still useful, including all storage units at Park 150, Box truck and ILEAS
- Repackaging usable medical and logistics supply items for response

STAFFING

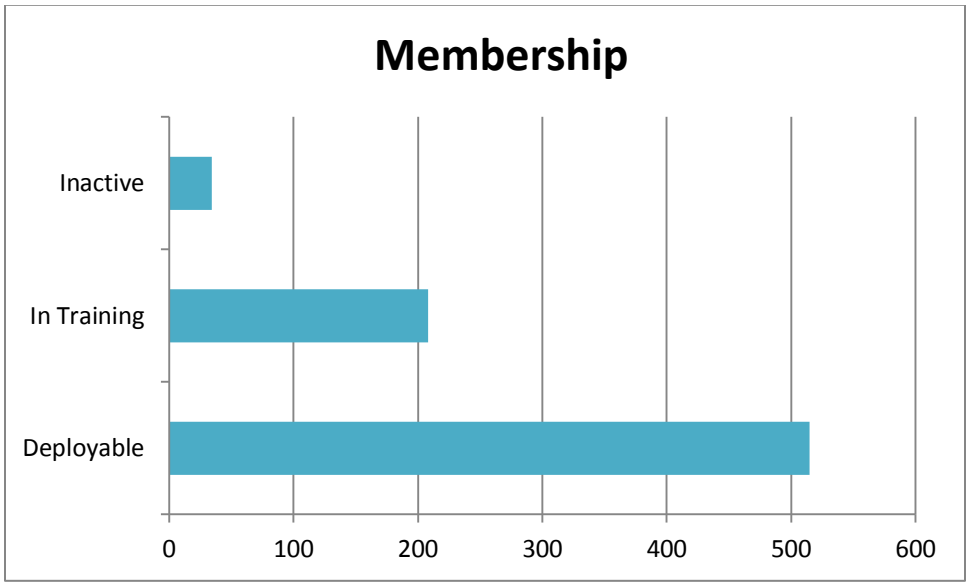
The IMERT staff includes the following individuals:

Executive Director: Mary Connelly, RN, BSN
Chief Nursing Officer: Barbara Oliff, RN, BA
Planning and Logistics Officer: Christopher Jansen
Training and Recruitment Coordinator: Susan Clemmons-Tysiak, EMT-B
Grant Administrator: Elizabeth Lee, MS

RESPONSE CAPABILITIES

VOLUNTEER STATUS

As of June 30th, 2011, IMERT has over 500 deployment ready members located throughout the State of Illinois. All deployable personnel have completed their NIMS and ICS training as well as a WMD awareness course and a training on deployment operations and procedures. Members who are still in training are in various stages of completing their WMD awareness courses and still need to attend the deployment operations and validation course.



RECRUITMENT, RETENTION, and OUTREACH

IMERT recruited and processed applications from 138 applicants this grant cycle. Of those, 54 passed the application process to become team members. Members who successfully complete the application process have had their credentialing information verified without restrictions and have undergone preliminary background screening. They have also completed the state and federally required ICS 100 and 200 and NIMS 700 courses.

IMERT utilizes a variety of forums to promote itself and recruit volunteers for the team. These include utilizing marketing and promotional materials, website, social media, and advertisement.

IMERT and INVENT utilizes its webpages at www.imert.org and www.invent.org to recruit and inform. The pages allow messages to be posted both to the public, and to team members only in the secure password protected Team Member's section. The Team Members Section features a front announcement page, information on policy and procedure, and activities, and allows members to download important forms. A section of the webpage on Disaster Preparedness helps improve awareness and empower responders and citizens with knowledge about what they can do to be ready.

To promote IMERT and celebrate Nurses' Week, IMERT ran an ad in the News-Gazette of Champaign-Urbana. This advertisement helped to celebrate the nurse volunteers who donate their skills and time during disaster as well as served promote IMERT's mission. The ad ran during May of 2011.

To keep volunteers connected to IMERT, news briefs are emailed on a bi-monthly basis. Topics include summaries of activities, information on upcoming events, policy notification, and information on outside education and volunteer opportunities, among others.

Another method of keeping in touch with the membership is IMERT's Facebook page. This media is utilized to notify members and fans of new developments and share links of interest. The page is also a medium for marketing IMERT-INVENT to outside agencies and potential members. Agencies connected to IMERT's page include IDPH's Office of Preparedness and Response, ILEAS, IEMA, and the Illinois National Guard. The link can be found at http://www.facebook.com/pages/IMERT-INVENT/183664916709, or by searching IMERT on Facebook.

Additional program promotion takes place at professional conferences around the state. IMERT attends a number of conferences and exhibits to recruit new members and raise awareness of the role health care workers can play in preparing their communities for disaster. During this grant period IMERT participated in multiple recruitment events.

9/8/10	IEMA Conference, Crowne Plaza, Springfield, IL
9/17/10	River City Trauma Symposium, Peoria, IL
9/17/10	Region 7 Conference, Brookfield Zoo, IL
9/21/10	Champaign County Preparedness, Champaign, IL
9/30/2010	Illinois Association of Occupational Nurses, Bloomington, IL
10/19/10	CDPH Coalition, Soldier Field, Chicago, IL
10/23/10	Illinois Association of School Nurses, Hoffman Estates, IL
10/27/10	School Nurse, Rockford, IL
10/29/10	Region 7 Conference, Tinley Park, IL
11/4/10	School Nurse, Springfield, IL

11/17/10	School Health Days, Arlington Heights, IL
11/18-19/2010	Advocate Injury Institute, Lisle, IL
12/3/10	ENA Symposium, Crowne Plaza, Springfield, IL
3/6-8/2011	ILEAS Conference, Crowne Plaza, Springfield, IL
4/15/11	ENA Conference, Lisle, IL
5/18/11	EMS Week, Chicago Fire Academy, IL
5/18-19/11	EMS Week, Stroger Hospital, Chicago, IL
6/14/2011	Bud's Ambulance, Dolton, IL

These events were attended by some 4,000 medical, emergency management, and support personnel.

Dr. Moses Lee, Medical Director and Team Commander, frequently gives presentations on behalf of IMERT and IDPH. Recent lecture venues include: American College of Emergency Physicians (ACEP) Scientific Assembly, UIC School of Public Health, and the New Hampshire EMS Assembly. Additional community presentations were given by team leadership at conferences throughout the year.

7/7/10	Emergency Preparedness and IMERT Team Erie Family Health, Chicago, IL	Moses Lee, MD
9/8/10	Reflections on the Medical Response to the Earthquake in Haiti IEMA Conference, Crowne Plaza, Springfield, IL	Bernard Heilicser, DO
5/4-5/2011	Chemical Weapons Presentation Stroger Hospital, Chicago, IL	Moses Lee, MD
6/14/2011	Mental Health in Disasters IPHA Conference, Lombard, IL	Kammie Juzwin, PhD
6/21/11	Chempack Lecture Chicago, IL	Moses Lee, MD

EQUIPMENT

IMERT continues its partnership with the Illinois Law Enforcement Alarm System (ILEAS). The campus contains over 120,000 square feet of safe and secure office, classroom, storage, and training space on a 13-acre campus. The facility and training rooms are utilized for office space, classroom space, and equipment storage, allowing a wider variety of educational opportunities to be offered. ILEAS houses IMERT's main office and provides secure storage with 24 hour access for volunteer records, program files and equipment. Vehicles and trailers for transport of medical responders, equipment and supplies are used and stored at the ILEAS training facility as well. IMERT has full access to the state-owned deployment vehicles and trailers.

In April of 2009, IMERT entered into an agreement with the pharmacy at Carle Foundation Hospital in Champaign-Urbana. The Carle pharmacy department agreed to maintain and store IMERT-INVENT's pharmaceutical cache. Maintenance includes rotation of pharmaceuticals by the Carle Pharmacy Department every 3-6 months. An inventory of the pharmaceutical cache is conducted every quarter. The hospital also provides secure, environmentally protected storage, and 24 hour a day access by approved IMERT personnel only.

IMERT also utilizes a storage facility called Park 150 in Urbana to store durable equipment. This facility provides secure fenced in storage and lighted grounds along with keypad gate for 24 hour access. Video surveillance provides added security. All temperature sensitive materials will be stored in a controlled environment and will be ready for roll out as needed.

The warehouse spaces have been organized into usage categories to utilize the total storage space effectively and make locating the necessary equipment or supplies easy and efficient.

EQUIPMENT MAINTENANCE

Preventative maintenance is performed on all equipment including: inspection and maintenance of battery-powered equipment, update of computers to be able to operate to current programs, replacement of bad power supplies and batteries, and added networked and encrypted hard drives. Digital and hard copy records are kept of all work done on the equipment and can be made available upon request. Warranties for extensive maintenance of medical equipment are retained when possible.

INVENTORY

IMERT is implementing a new inventory system that will streamline the inventory process of both IMERT equipment and that owned by IDPH in IMERT's possession. The system features a scanning system that will allow staff to track equipment from deployment to demobilization. It will also aid in performing the yearly inventory.

A copy of the current IDPH owned inventory of equipment maintained by IMERT is on file with the IDPH Office of Preparedness and Response.

Equipment to augment an IMERT response purchased with ASPR grant 17282150:

- PAPRs with filter, battery
- Light case, stake kit, doors
- Rehab chairs (6)
- Hyperthermia treatment
- 2 small transportable ZUMRO shelters
- Replacement insulation for Zumro Mobile Med tent
- Mobile Medical Unit Trailer
- Various vehicle parts and equipment, tow bar and jack
- Lighted traffic cones and safety signals
- Power Flare soft pack
- Air Shelter, insulation, stake kit
- Ice maker

DEPLOYMENT AND DEMOBILIZATION

IMERT DEPLOYMENT AND DEMOBILIZATION SOG

Request for IMERT Activation:

	TASK
○	Request for IMERT made through County Emergency Management Agency (EMA) or from the IDPH Duty Officer (for local health departments or hospitals) to the SEOC or the COM Center
○	IDPH Duty Officer has ascertained the following information • Time of call for request • Name of entity making request Name and title of caller and their return phone numbers(s) • Location of incident • General Nature of incident
○	SEOC Contacted designated IMERT's Management for pre-approval from the staff call list provided
○	IDPH *and* Director of IEMA approval deployment for incident
○	IMERT begins activation notification of IMERT Team members
○	IMERT obtains IEMA mission number from the IEMA Communications Center (COM Center) prior to deployment
○	IMERT staff will contact the requestor to obtain details to determine the applicability of IMERT to the incident
○	IMERT contacts Duty Officer with plan of action
○	IMERT will communicate details of deployment time, and number of personnel being deployed to the COM Center

IMERT Initial Deployment Checklist

	TASK
○	IMERT personnel informed of deployment mission and staging assignment
○	Incident Commander/Medical Director Assigned
○	At staging – IMERT personnel given deployment packages and instructions
○	Organizational Chart positions assigned
○	Planning Section Chief begins IAP process
○	ACS Facility selected (collaboration of IMERT Needs Assessment Team and locals)
○	Brief assigned Sections Chief Positions
○	Safety Officer identifies and corrects any initial safety hazards and prepares for briefing with IMERT personnel
○	Command Post established
○	Brief IMERT personnel
○	Establish location for IMERT personnel for rest and rehabilitation
○	Public Information Officer gathers initial information and designates media gathering location

○	Establish communication links with scene Incident Command, the local EOC, and designated personnel involved in the incident
○	Additional Staffing needs assessment conducted and notification of local resources requested
○	IMERT Logistics, Medical Operations, Safety, and Medical Director in collaboration with locals designate the layout of the ACS
○	Staff check-in location designated and staff assignments delegated
○	Job Action sheets distributed
○	Review of initial Incident Action Plan with IMERT personnel
○	Logistics Section Chief and Communications Unit Leader complete communication plan and distribute radios
○	Logistics establishes supply area to receive and process cache's
○	Medical Director and Medical Operations Section Chief/CNO obtain latest information on incident verification that ACS is established and ready to receive patients
○	Medical Director brief IMERT personnel on standards of care, required PPE, and type of patients that may be processed through the treatment area
○	Medical Operations Section Chief reviews patient processing from triage to discharge
○	Begin demobilization process

Notification Checklist

- ○ Scene Incident Command
- ○ Medical Director
- ○ Local County Health Department
- ○ Local Emergency Operations Center (LEOC)
- ○ Law Enforcement
- ○ Fire Departments
- ○ Area Communications Centers
- ○ Illinois Department of public Health
- ○ SEOC
- ○ Local Hospitals (RHCC and/or designated specialty facilities)
- ○ Private Ambulance transport services and air transport
- ○ Volunteer service agents
- ○ Local Chamber of Commerce

Contacts &/or Contact Numbers

SEOC _____

Local EOC _____

Illinois Department of Public Health OPR Director _____

Medical Director _____

Local County Health Department Director _____

Law Enforcement Contact _____

Fire Department Contact _____

RHCC Hospital Director _____

Communication Center _____

Private Ambulance Service _____

Air Transport _____

Local American Red Cross _____

Salvation Army _____

Mental Health Liaison _____

Logistics Checklist

- Utilize the ACS Tool Kit to establish the layout of the ACS
- Acquire an area near the treatment location to establish a resupply station
- Acquire an area for personnel to rest and acquire nutrition
- Arrange for appropriate PPE for personnel
- Acquire any needed garments or supplies to support the decontamination process
- Arrange for oxygen and water supply if needed
- Establish a lab/testing procedure
- Arrange for environmental services for cleaning the ACS and for waste removal
- Acquire additional external transportation (ambulances, helicopters, etc.)
- Establish a helicopter landing zone
- Establish strong security measure for the ACS
- Create signs within the ACS for easy recognition of established specialty areas
- Establish a strong communications plan and use the "Communications Checklist" to see that key areas are covered
- Ensure that the power supply is adequate and that backup generators are easily accessible and working
- In collaboration with the Medical Operations Section Chief, order any additional key supplies

anticipated to ensure that the ACS is adequately supplied
- Ensure proper food and beverages are in supply for personnel and patients if needed
- Establish an area for food and beverage supply away from the treatment area
- Track all cost and information associated with the establishment and operations for the ACS for the reimbursement process

Communications Checklist

- Establish a communications plan for the ACS
- Set up and distribute base and portable radios and provide "just-in-time" training for the personnel assigned radios
- Asses the functional use of a previously existing phone line system
- Publish and distribute the ACS internal communications plan (phone numbers and radio calls)
- Set up internet service
- Set up printers and fax machines
- Request additional communication needs from state or regional resources
- Ensure that backup communications systems are operational in case primary ones fail

Security Checklist

- Establish a secure perimeter another ACS
- Safeguard ACS personnel and patients from threats
- Establish a staff check-in point and ID system for the ACS
- Create a traffic flow pattern for the ACS
- Control disruptive patients and or family members
- Ensure that specialty supply caches are safe and secured (i.e., pharmacy)
- If deemed necessary, search victims and their belongings p to their entry into the ACS
- Establish a lock-up procedure for valuables for patients if needed
- Acquire additional resources for security staffing to accomplish security mission(Illinois State Police, ILEAS, etc.,)

Planning Checklist

- Establish an Incident Action Plan and distribute to designated personnel
- Establish a staffing plan for the ACS
- Acquire additional personnel for staffing the ACS from volunteer resources (MRC, CERT,

students, etc.)
- Utilize approved credentialing system for personnel staffing the ACS
- Set up patient tracking and records system
- In collaboration with Security, establish a personnel check-in station
- Establish an out-processing procedure
- Establish a reunification area

Medical Operations Checklist

- Appoint staff for designated treatment areas
- In collaboration with the Logistics Section Chief, establish appropriate flow for the ACS.
- Establish designated decontamination area
- Establish triage area, treatment area and discharge area
- In collaboration with Security, implement a security plan for all areas of the ACS
- Order any specialized teams needed (dialysis, Peds, etc.)
- Order any specialized resources needed
- Ensure Logistics established a designated landing zone for helicopters

Finance Checklist

- Track all costs associated with the establishment and operations of the ACS
- In collaboration with Logistics, keep track of all costs and information necessary for later reimbursement process
- Keep track of all time sheets for personnel hours
- Facilitate the purchase of goods and services and coordinate with Logistics Section on financial issues

IMERT Demobilization Checklist

○	IDPH Duty Officer and Director of IEMA are notified by IMERT management of demobilizations process and estimated day of departure from ACS
○	IMERT Medical Director briefs IMERT personnel on expected demobilization date
○	Sections Chiefs collect deployment documentation utilized in their designated areas. Forms collected are but not limited to; finance reimbursements, patient charts, tracking of goods and services, cost analysis, patient tracking, IAP HICS forms, staffing credentialing and volunteer services
○	Ensure that all Sections collaborate and assist each other as need to ensure a safe, swift, and organized demobilization
○	Ensure return/retrieval of equipment and supplies
○	Ensure IMERT personnel has access to stress management and after-action debriefings
○	Establish communications process for person departing ACS
○	Under the discretion of the Medical Director, all IMERT personnel may be requested to have exit vitals taken before departure
○	Ensure that IMERT personnel submits deployment packets designated staff member
○	Ensure IMERT personnel contact designated staff member upon arrival to final destination after deployment
○	Advise the IEMA Communications Center of end of deployment and close IEMA mission number

IMERT RESPONSE PACKAGES

Strike Team: IMERT State Weapons of Mass Destruction, Medical Unit
Purpose: provide medical coverage for SWMD training/incidents or other special event

Team: 7-15 with IMERT physician on site or immediately available via phone/text

Composition: (1) Team Lead, (2-5) RNs, 3-5, (3-4) EMT-P/B, (1-3) logistics/comms

Arrival Time Frame: Advanced notification for training exercises, 12-24 hours for no notice response with state supported transportation

Equipment: (1) transport vehicle for medical equipment, (1) trailer {optional}, SWMD medical supply package.

Limitations: Not capable of emergent travel, medical equipment package located in Champaign/Urbana, self-sufficient limited to 24 hours max, team members will likely respond via POV, PPE limited to cold zone ops only.

Capabilities: To provide on-site medical care, communicate with local EMS and hospitals, assist with resources to determine potential impact of hazardous material on surrounding community.

Strike Team: IMERT Medical Needs Assessment
Purpose: Ascertain scope of medical needs at a disaster scene, casualty collection site or alternate medical treatment site

Team: 4 with access to an IMERT physician by phone/text

Composition: 4: (1) IMERT staff. (1) Charge Nurse, (1) EMT P/B provider, (1) Logistics/Comms

Arrival Time Frame: 24 hours, dependent on travel conditions and location of incident

Equipment: (1) response truck, (1) trailer with gator {optional}, strike team medical supply response package

Limitations: Cannot travel emergently, carry minimal medical equipment, limited to 12 hour shifts

Capabilities: Can be self-sufficient for 72 hrs., can assist local medical officials with evaluation and planning, can provide site specific conditions to SEOC, and can evaluate existing structures for suitability for utilization as an alternate medical treatment site.

Strike Team: IMERT Primary Medical Response Team
Purpose: Assist local medical providers with initial medical stabilization; assist with set up of temporary medical treatment site

Team: 8-15 IMERT, physician on site or available by phone/text

Composition: (2-3) IMERT staff including Director or Chief Nurse. 4-5 RNs, 2-5 EMS providers, 2-4 logistics/comms.

Arrival Time Frame: 24-48 hours, dependent on travel conditions and location of incident

Equipment: (2-3) response trucks, (2-3) trailers, 50 patient response package, 15 team member support package.

Limitations: equipment and transport vehicles need to be retrieved from Urbana, personnel will need to stage at ILEAS or other secure location, fully loaded trailers travel slow, difficult to maneuver in high wind situation, may require security assistance, may need lodging or sleeping quarters assistance.

Capabilities: can be self-sufficient for 72 hours, can integrate with local medical responders to provide emergency medical care, supply package can support approximately 50 patients of various acuity levels for 24-48 hours. Can be adjunct medical staff to locals with 24 hr. coverage for 72-96 hours.

Task Force: IMERT Task Force
Purpose: Assist local medical providers with extended medical care and stabilization at a casualty collection or alternate medical treatment site. TF meant to supplement IMERT Primary Response Team already on site. If not on site, IMERT command staff will accompany Task Force.

Team: 20-25, (1-2 physician/p.a./nurse practitioners)

Composition: Team Commander, Director, CNO, Logistics Chief, 2-3 Charge RN, 8-10 RN (both ER and other specialty) 6-8 EMT P/B, 3-5 admin.

Arrival Time Frame: 24-36 hours

Equipment: 5-6 response trucks, 5-6 response trailers, ACS equipment package, 25 team support package, additional medical supplies if indicated (immunizations, IV fluids, etc.).

Limitations: Will need all response vehicles or other agency assist with transport of personnel, will need assistance to obtain any additional medical supplies appropriate for incident, will require security, fully loaded trailers travel slow, will require sleeping quarters and may need food and water support.

Capabilities: can provide medical coverage for a 50 bed treatment site in an austere environment for 96 hours, can be an adjunct to local medical for larger patient load, can be self-sufficient for 72-96 hours.

Task Force 2 IMERT-INVENT

Purpose: to provide sustainability of medical capability at a large scale multi-casualty event or to fill an EMAC request.

Team: 15-25 (2-4 physicians, PA or Nurse Practitioners) Skill set to be determined, i.e.: if many pediatric patients will deploy those with pediatric skills.

Composition: Team Commander and command staff (total of 6). 3-4 Charge RN, 3-4 Team Leads, 7-8 EMT P/B, 3-4 logistics/comms.

Arrival time frame:
EMAC: determined by transportation plan, 24-48 hours will be needed just to contact and confirm team member availability. An additional 24 hours will be needed prior to roll-out
In State: TF2 is designed as relief team for TF 1. Arrival will be within 48-72 hours of request.

Equipment:
EMAC: response trucks as needed with 50 patient package and EMAC team support package (supplies for 2 weeks) or other arrangements as determined by EMAC request
In State: response trucks or other transport arranged for personnel and equipment resupply. This will be a function of the planning unit in conjunction with the SEOC.

Limitations:
EMAC: required to be self-sufficient for 2 weeks, may need additional supplies prior to deployment depending on the incident and nature of clinical situation.
In state: transportation of relief team and supplies may require assistance if all IMERT vehicles are on site.

Capabilities:
EMAC: can conduct medical ops for a 50 patient medical treatment site and/or be adjunct medical staff for existing site operations. Can assist with the development or revision of an ACS in an austere environment.
In-state: can provide sustainability to an ongoing medical response.

COORDINATED RESPONDER INFORMATION SYSTEM

IMERT uses the Coordinated Responder Information System (CRIS) as its primary volunteer database. The system maintains responder contact profiles as well as credentialing and training information. The database is held on two redundant servers maintained by IDPH in Springfield and a private contractor, Nology Interactive in Chicago. Having the server housed by IDPH allows the agency primary and 24 hour access to the server and its database.

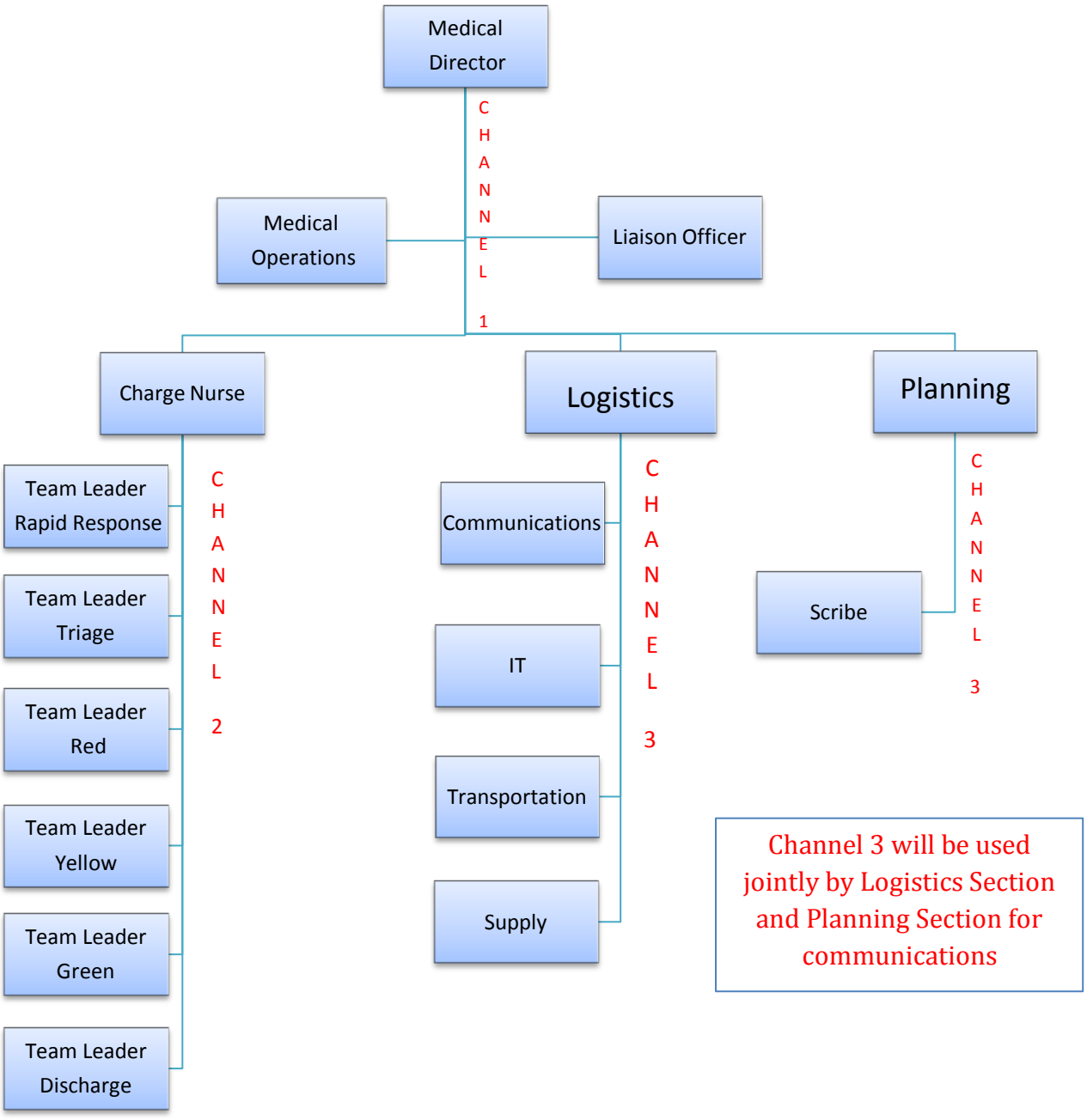
In April of 2011, Nology informed IMERT that they needed to move their CRIS server to a different location. This move required coordination with IDPH support personnel. An assessment of the system with IDPH showed that IMERT's needs and capabilities have changed and the current redundant server system is no longer necessary. Additionally, the system has become outdated as it was first created over ten years ago, and CMS is transitioning to a point where it will no longer be able to support the outdated system the database runs on. Various database solutions for the future are being considered.

It was determined by IMERT and IDPH personnel that going forward, IDPH and CMS would test if the server can be run on an updated operating system. They would also coordinate with Nology to move the Chicago server to a CMS run server facility in Chicago. This would eliminate the vulnerability of having the IMERT responder database housed by an outside agency. As of June 30th, IDPH and CMS personnel are still working to resolve networking issues that will allow the Chicago server to be shut down while still enabling access to the database in Springfield.

COMMUNICATIONS PLAN

In collaboration with the IDPH Radio Coordinator and State Interoperable Executive Committee, IMERT developed a radio communication plan. This plan is compliant with the Statewide Communications Interoperability Plan.

Organizational Chart-IMERT Primary Medical Response Team
RADIO CHANNEL DESIGNATION OUTLINE



HICS 205 (EXTERNAL) INCIDENT COMMUNICATION PLAN

DATE/TIME PREPARED	OPERATIONAL PERIOD DATE/TIME 1-8 Hour Period

SYSTEM	CHANNEL	FUNCTION	FREQUENCY	ASSIGNMENT	COMMENTS
Starcom 21	Zone I Mode 1 IMERT 2	Secure Talk Channel for Medical Operations	ZONE I IMERT2	Charge Nurse Triage Leader Red Zone Leader Yellow Zone Leader Green Zone Leader Discharge Leader	Primary Communications Channel for Medical Operations Alternatively Used for Transportation Talk Channel during mobilization
Starcom 21	Zone I Mode 2 IMERT 3	Secure Talk Channel for Medical Director to Team Leads	ZONE I IMERT3	Medical Director Medical Operations Leader Charge Nurse Liaison Officer Logistics Section Chief Planning Section Chief	Primary Communications for Unit Section Leaders and Medical Director
Starcom 21	Zone I Mode 3 IMERT 1	Unsecured Talk channel for mission support team	ZONE I IMERT1	Logistics Section Chief Transportation Unit Leader Supply Unit Leader IT Support Unit Leader Planning Section Chief Scribe Unit Leader	Primary Communications channel for Mission Support Team including Logistics and Planning

If Starcom is not available, alternatively IMERT would request use of the following channels pending approval of incident Communications Unit Leader for availability of Channels.

7TAC74D Medical Operations
7TAC75D Unit Section Leaders
7TAC76D Mission Support Team (Logistics and Planning)

PREPARED BY : Christopher Jansen Communications Unit	APPROVED BY :

TRAININGS AND EXERCISES

Exercises and trainings developed by IMERT are conducted according to HSEEP protocols. IMERT's organizers and planners have all completed HSEEP training as offered through IEMA.

NIMS compliance is achieved through NIMS implementation in all incident action plans, training exercises, and deployments. Examples include employing the Incident Command system during drills and events and ensuring all participating personnel have completed the ICS 100, 200, and 700 training courses. All primary staff and command staff volunteers have completed the ICS 300 and 400 Command training. Rate of NIMS compliance is 100 percent for all deployable team members.

Records of all training activities and participation are maintained by the IMERT Staff and are available upon request.

IMERT Staff and volunteers sponsored and participated in multiple trainings and throughout the grant cycle. These trainings serve to develop interagency participation and hone staff and volunteer capabilities.

TRAININGS

8/18/10	Interagency After Action for Bensenville Vigilant Guard SWMD Exercise 1 staff attended	Springfield, IL
8/19/10	SWMD-Central Training Exercise, medical support of SWMD exercise 11 attendees	Lincoln, IL
9/17/10	SWMD-South Training Exercise, medical support of SWMD exercise, 8 attendees	Mount Vernon, IL
10/21/2010	SWMD-North Training Exercise, medical support of SWMD exercise 12 team members	Batavia, IL
11/4/10	SWMD Training, review of SWMD operations and response packages 6 attendees	Urbana, IL
12/9/10	SWMD-Central Training Exercise, medical support of SWMD exercise 10 attendees	Lincoln, IL
12/10-11/2010	IMERT Deployment Validation Course, deployment simulation training 17 attendees	Urbana, IL
1/9-10/2011	IMERT Deployment Validation Course, deployment simulation training 10 attendees	Urbana, IL
2/24/11	SWMD-South Training Exercise, medical support of SWMD exercise 5 attendees	Mt. Vernon, IL

3/17/11	SWMD-North Training Exercise, medical support of SWMD exercise 6 attendees	Minooka, IL
4/9/11	MRC Conference, Deployment training for MRCs All Staff and 10 volunteers	Springfield, IL
4/20/11	SWMD-Central Training Exercise, Medical support of SWMD exercise 7 attendees	Lincoln, IL
5/26/11	SWMD-South Training Exercise, Medical support of SWMD exercise 8 attendees	Lincoln, IL
6/16/11	SWMD-Central Training Exercise, Medical support of SWMD exercise 4 attendees	Lincoln, IL

EXERCISES and DRILLS

IMERT staff and volunteers participated in multiple exercises and drills. These included CRIS and SIREN communication drills and tests. HSEEP formatted After Action Reports for IMERT sponsored exercises have been submitted to IDPH. During the grant cycle, exercises and drills took place on the following occasions:

7/15-18/2010	Old Shawnee Town (real-time training exercise) with Illinois State Police 18 attendees	Shawnee, IL
8/31/10	Communications Exercise, Team Member call out for potential deployment	
11/16/2010	Preparing for a Toxic Inhalation Hazard Release, TSA Response Roundtable Dr. Moses Lee roundtable presenter	Wheeling, IL
3/28-29/2011	FEMA Region V Improvised Nuclear Device Event Workshop Medical Director attended	Argonne, IL
4/8/11	IMERT Staff Communications Drill, Testing of Siren system	
4/11/11	IMERT/SIREN Communications Drill 81 Participants	Regions 4, 5, 6, Staff and team Physicians
4/13/11	IMERT/SIREN Communications Drill 88 Participants	Regions 1, 2, 3, 9 and staff
4/20/2011	IMERT/SIREN Communications Drill 242 Participants	Regions 7, 8 10, 11 and staff

4/28/2011	Great Shake Out Communications Drill All IMERT Team 411 Participants	
6/10/2011	Region 1 RHCC Pandemic Flu Tabletop, Flu Preparation Medical Director attended	Rockford, IL

The ASPR deliverables for FY 2011 indicated that monthly radio checks were to be conducted. ICEP retained possession of all radios until the beginning of May. Subsequent radio checks were completed for May and June.

No RHCC sponsored exercises were held during the grant cycle.

No alternate care site exercises were held during the grant cycle.

MEDICAL RESERVE CORPS

On April 9th, 2011, IMERT conducted a skills building training session titled *MRC Challenges of Deployment: Skills Building Training Scenario: Alternate Care Site Post-Earthquake.* The inaugural session was for 62 attendees at the Central Illinois MRC Conference. The session was well received and participants indicated a strong interest in further training. Feedback from attendees is being utilized to enhance the program and additional IMERT sponsored training opportunities will be provided.

Primary Objectives:

- Triage: Discuss START triage concepts
- Pediatric Triage: Discuss JUMPSTART, demonstrate Broselow tapes, demonstrate Intra Osseous drill
- Logistics: Discuss some unique considerations of setting up clinical environment in non-traditional setting
- Operations: Discuss chain of command and roles of authority., Discuss/demonstrate patient care issues i.e., head to toe cot set up, infection control, medical equipment and supplies, Patient tracking and staff tracking
- Responder Rehab and Demob issues: Discuss/demonstrate what to pack wear and carry, discuss impact of fatigue, stress, separation from family and being out of one's comfort zone

IMERT TEAM DEVELOPMENT ACTIVITIES

IMERT sponsored staff and volunteers to participate in several program development trainings throughout the grant cycle. These trainings served to strengthen interagency ties as well as improve the sustainability and viability of the IMERT program.

During the grant cycle, two IMERT staff members obtained their Illinois Professional Development Series certificates as sponsored by IEMA to further IMERT's response capabilities. This program focuses on promoting the ability to interact face-to-face with emergency management professionals from other jurisdictions, and allowing first responders from different disciplines the opportunity to develop a better understanding so they can work together more efficiently during future exercises and real events.

8/25/2010	ITTF Grant Workshop on ITTF grant policy and procedure 2 staff attended	Springfield, IL
9/10/2010	FBI Law Enforcement Air Command Air One Seminar, 2 staff attended	Kenosha, IL
9/20-24/2010	REAC/TS Advanced Radiation Medicine (ARM) Course Medical Director Attended.	Oak Ridge, TN
9/23-24/2010	ITECS Workshop on State Communications, 1 IMERT Planning and Logistics Officer attended	Urbana, IL
10/13/2010	SIREN Training* *All staff have attended SIREN training	Chicago, IL
11/16-17/2010	Public Information in a WMD event, PIO course 1 staff attended	Urbana, IL
12/2/2010	All Hazards Type III Communication Unit Leader Course 1 staff attended	Crystal Lake, IL
12/14-17/2010	DHS Response to Terrorist Bombing 1 SWMD team attendee	New Mexico Tech, NM
1/12-14/2011 1/30-2/2011	DHS Response to Terrorist Bombings 5 SWMD team attendees between December and February	New Mexico Tech, NM
2/10/2011	Leadership and Influence, IEMA PDS course 2 staff attended	Highland Park, IL
3/2/2011	Emergency Planning, IEMA PDS course 2 staff attended	Highland Park, IL
3/15-16/2011	ICS Command: ICS 300 1 staff attended	Urbana, IL

3/28-29/2011	FEMA Region V Improvised Nuclear Device Event Workshop Medical Director attended	Argonne, IL
4/5/2011	Principles of Emergency Management, IEMA PDS course 2 staff attended	Sauk Valley, IL
4/6/2011	Effective Communication, IEMA PDS course 2 staff attended	Sauk Valley, IL
4/19-20/2011	ICS Command: ICS 400 1 staff attended	Urbana, IL
4/28/2011	Great Shake Out Communications Drill 411 Participants	All IMERT Team
5/12/2011	IMERT AAR for Flooding, Volunteer AAR reports 8 Participants	
5/20/2011	ASAP Training, Inventory software training 3 attendees	
6/7-8/2011	Flood Response UAC After Action Review, Interagency AAR Review 1 staff attended	Springfield, IL
6/8/2011	Developing Volunteer Resources, IEMA PDS Course 2 attendees	Sauk Valley, IL
6/14-16/2011	Illinois Public Health Association Conference All Staff	Lombard, IL
6/24/2011	Youth Preparedness Workshop 1 staff attended	Chicago, IL
6/27-29/2011	FEMA/HHS Medical and Public Health Work Group 1 staff attended	Washington, DC
6/29-30/2011	Pre-Hospital Radiation Course, Planning/response to radiation event 1 staff attended	Bolingbrook, IL
6/28-30/2011	HSEEP Training 1 staff attended	Joliet, IL

ADDITIONAL INITIATIVES

IMERT/RMERT INTEGRATION FEASIBILITY ANALYSIS

IMERT conducted a survey of RHCC hospitals to ascertain the status of the RMERT concept state wide. The survey follows. Essentially, one region reports capability to respond within their region with volunteers from hospitals and an equipment cache. A second region reports some volunteer response capability as well.

The biggest barrier expressed by virtually all RHCCs is the liability and workmen's compensation issue. One region has addressed this by getting agreement of participating hospitals to consider responders as "on-duty" thereby extending employer liability and workmen's compensation coverage. There is a perceived lack of support by IDPH for the concept with a concomitant concern of the risk to the RHCC and regional hospitals.

For the most part though there is general consensus that there is value in a regional medical response capability. Many regional coordinators regard the training they have developed as a means to improve a more comprehensive response capability as well as providing some standards of minimum training region wide.

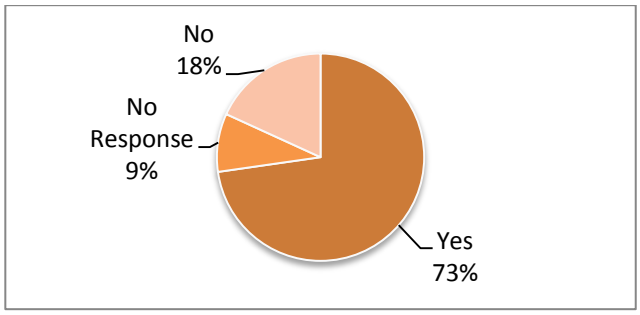
Recommendation:

1. Place this issue on the agenda of the RHCC meeting for further discussion and final resolution. The greatest investment, successful or not, has been on the part of the RHCC reps., the final decision must include the coordinators.
2. Provide an opportunity for those with a robust program to continue.
3. Provide an opportunity for those with some volunteers but lack of response capability to consider joining other groups such as the MRC for local response enhancement.

RMERT Survey Summary

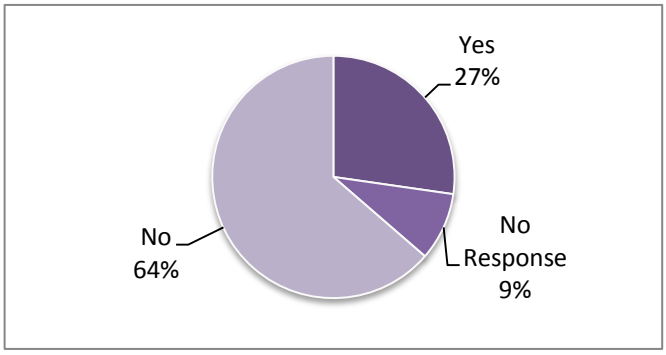
91% participation by RHCCs

Do you have a RMERT in your EMS Region



Yes	**8**
No	**2**
No Response	**1**

Is your RMERT active?

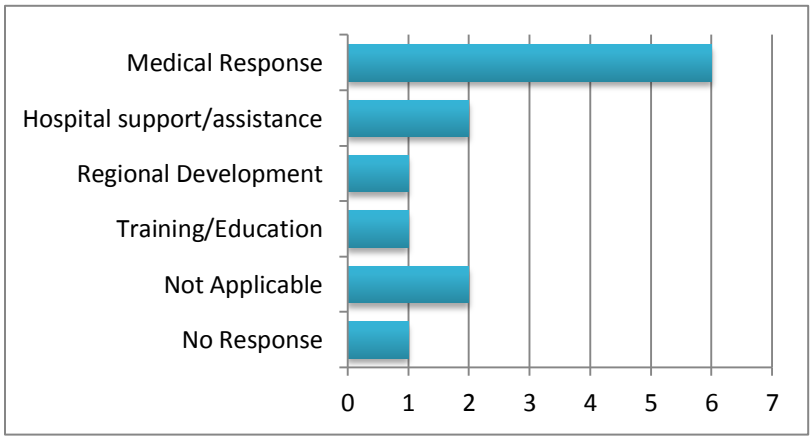


Yes	3
No	7
No Response	1

Comments

- Currently have 82 active members
- Monthly training classes are conducted.
- Outdated roster of persons willing to volunteer. It was never well developed due to the big issues of liability and malpractice protection.
- Yes, but membership is "shrinking".

What is the primary purpose of your RMERT*?



No Response	1	9%
Not Applicable	2	18%
Training/Education	1	9%
Regional Development	1	9%
Hospital support/assistance	2	18%
Medical Response	6	55%

*Respondents may have selected more than one option, so percentages may add up to more than 100%.

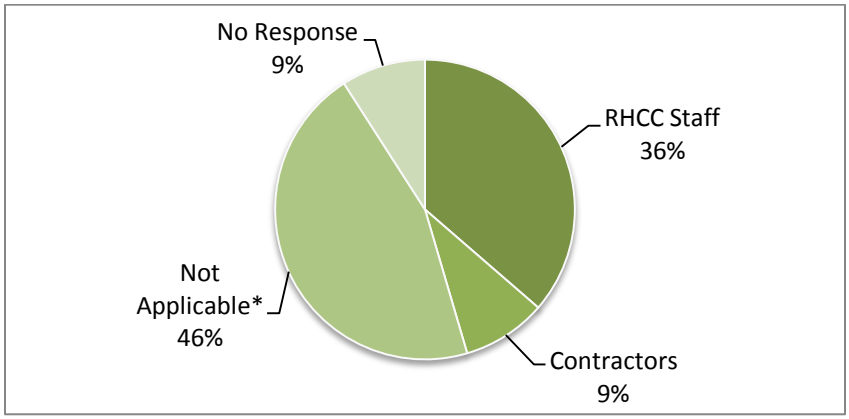
What is your ultimate vision for your RMERT?

- To improve disaster response and augment the existing medical service system for community emergencies in the event of a significant medical disaster involving the central Illinois area. This RMERT is able to provide a variety of services, including on-scene, out-of-hospital, or direct hospital emergency medical care.

In addition, RMERT will assist with decontamination, if HazMat / WMD conditions exist, and augment regional firefighter, rescue, EMS, EMA, ESDA, and Law Enforcement agencies.

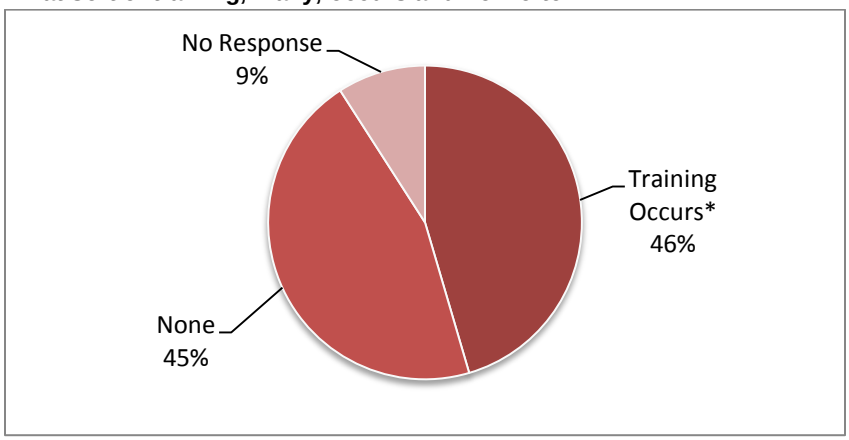
- Rapid deployment of medical assets both personnel and equipment
- Primary response unit to MCI events, medical evacuations, etc. for the region.
- To be a regional IMERT. To be capable of deploying to events and scenes to facilitate medical care.
- Unfortunately, I don't see a future for RMERT. People just don't want to join and train.
- None, until state makes a decision about liability
- Enhance the functions of hospital-to-hospital assistance.
- To have a solid group of medically trained individuals of varying levels that are willing and prepared to respond to local emergencies. The team should represent a variety of hospitals around the region.
- To have robust membership.

Who is responsible for RMERT Training*?



*Of the not applicable respondents, most expressed the RHCC Staff/Coordinators should be responsible for training.

What sort of training, if any, occurs and how often?



- Team members required to have training prior to joining the team (ICS 100, 700, 200, 800, WMD, etc.). Then we require our team to attend quarterly training and demonstrate proficiency on our equipment. We train with our partners (have had FBI, US Marshal's, TEEX's, New Mexico Tech, U of I, etc.). We also train in disaster medicine with residents from SFMC.
- Incident Command. The team physician provides training on medical intervention and MCI Triage.
- Several throughout the year open to everyone in the Region
- 3-hour initial training on existing RMERT policies and team handbook. Last training took place in 2009.
- It is an added component of the ECRN class and will host classes for other staff as the need presents.

Do you feel the state should continue to support the RMERT program in its current form, or should it be transitioned into another format such as a MRC?

- It was a good idea but it never could fully develop.
- I feel that RMERT as a "hospital" based effort can be better sustained if the State can intervene with hospital administration with respect to liability coverage while active / deployed as RMERT (i.e. workman's comp, malpractice, etc.) A municipal / county operated MRC will alleviate the medical liability / workman's comp issues in some ways, but it also create other problems such as trust. Will doctors and nurses respond as MRC if they are required to "shadow" other doctors and nurses and not be left alone to perform what they perform routinely at work?
- The current form is not working in that no one (except maybe Region 2) has a good model and what is working there may not be feasible for everyone. I think the concept that the RHCC is the coordinating agency is good, but we just need additional help on solving the insurance issues.
- Change format to MRC
- This region was able to finally work out the RMERT but, realistically, it is recognized that for most of the RHCCs in Illinois, it has not been successful. Since there is one very successful team mid-state there needs to be a method of integrating the 2 types of medical support teams. MRCs typically are under the control of each individual county, so this would be very difficult to get them to share across county and regional lines. In my region, the MRCs are very turf protective.
- There is no question the state should continue to support regional medical response. Each region may differ in ideas and have different level of regional response, but the state needs to support this. I believe the state should give more support to RHCC's and RMERT teams.
- I would like to see the RMERT program continue but fear it may be too much for the RHCCs to manage without consistent oversight and guidance from the state. The MRC may be an adequate alternative but given the nature of multi-casualty events, individuals that are actively involved in high-acuity medical care may be in higher demand that typical MRC members.
- I would be interested in investigating how an MRC may function as a RMERT. Our Regional stumbling block is that regional hospitals are very concerned re: liability. Hospitals who were active participants have discontinued their support due to unanswered questions that were posed to IDPH.
- Current form. Most of my hospitals do not have an MRC in fact ours was laid off last week.
- No, there are too many unanswered questions in regards to liability.

Any other comments regarding the RMERT program

- If the State is looking to create standards and metrics, I would offer the following suggestion in line w/ resource typing: Set up definitions of a Type 1 - Type 4 Team (similar to Search and Rescue) with specific equipment and capabilities requirements so that hospitals can stand up teams commensurate with their abilities and commitments. A Type 1 Field Response RMERT Team can be ""minimum of 1 physician and 1 nurse; require transportation support; deployment of no more than 3 hours to the field. A Type 3 Field Response RMERT Team can be, in addition to the above, self-supporting transportation; trauma surgeon; self-supporting food / water; deployment of 8 hours, etc.
- I like Region 2's model but not sure if I could get all my hospitals to agree to supply people. Then ability to purchase any required "volunteer" or "employee" protections (i.e. worker's compensation and malpractice insurance) with HPP funds may help. Any guidance on organizing and starting up would be appreciated (like the MRC model where they are supplied with many resources to help get going.
- Great idea, but need support from state
- The greatest issue with support of the RMERT is obtaining workers comp and other liability coverage. Our RMERT is a volunteer organization, much like a volunteer fire department. In case of any injury, whether it be to the team member or the patient, we are not sure who holds the liability. It may reflect back on the RHCC since we are the contracting agency to have the Special Emergency Services provide training. This is a huge issue for team members and the RHCC.
- The State of Illinois needs a regional concept. We need to keep all disaster local and this idea is what IDPH needs to support and help the RHCC's accomplish.
- I would appreciate some firm guidance from IDPH regarding training expectations, certification expectations, and standards that could be applied across the state.
- It's a great concept – but need to answer questions hospitals have to gain their trust & support.

IMERT/DMAT INTEGRATION FEASIBILITY

IMERT began serious and in-depth discussions with FEMA and HHS on the possibility of developing an Illinois DMAT (Disaster Medical Assistance Team) from within the current IMERT.

This would be advantageous for both the state and the nation. This would enhance training and deployment opportunities for IMERT as well as add another medical team to the national cadre.

The next steps include obtaining letters of support from: IDPH, ITTF, and the Governor's Office. Currently, the federal authorities are re-visiting the structure and function of the DMAT in general. We will follow closely and proceed accordingly.

ILLINOIS ALTERNATE CARE SITE STATUS

The IDPH HPP Coordinator indicated that the strategy for the Alternate Care Site (ACS) plan is an executive level function and was being addressed as such in FY 2011. Particularly in that IDPH was working with CDPH to create a comprehensive approach for the state. However, beyond this approach, there have been many meetings and work groups either directly or indirectly identifying many of the outstanding issues involved with alternate care sites. The following is a summary of those sessions.

The concept of an ACS is valid and likely the only real option in certain situations. An epidemic caused by influenza or other infectious disease outbreak, a WMD or naturally occurring catastrophe could result in 'mega casualties'. The customary health care infrastructure may become inefficient or completely incapacitated very quickly. Vital resources of health care personnel as well as materials and equipment will likely be in short supply. One method to manage a massive influx of patients or to decompress saturated hospitals is the utilization of alternate care sites.

An alternate care site is not a shelter or a hospital. It is a space that can be adapted to set up a make-shift clinical environment to provide medical care. The utilization of an ACS should only happen in a worst case scenario. A few were set up in Louisiana and Texas in the wake of Hurricane Katrina and proved to be extremely effective for providing interim medical care for the evacuated population. An evacuation of a population requires a certain management concept; an outbreak situation will require a significantly different application.

There are two distinct situations that could require the utilization of an ACS are as follows:

1. **EMERGENT**
   - Usually a rapid deployment in response to a sudden catastrophe.
   - Mutual aid will likely be available
   - Scenarios include: evacuation of the population, infrastructure paralyzed or destroyed.

- Scope of care provided will be fluid and based on responder medical skill level and organizational capability, supplies, as well as needs of patients. The extent of the mission will likely be short termed, with the acute phase lasting less than 2 weeks.
- An evolution of increased capability can be anticipated as more resources and personnel arrive.

2. STRATEGIC

- Last step in managing an extended medical surge due to an outbreak, BT event or situation that resulted in the actual destruction of existing medical structures
- Mutual aid will likely be nonexistent in a wide spread infectious scenario*
- Mutual aid should be available in the event of most other situations
- Scope of care should be pre-determined and based on a well-defined mission (lowest acuity or palliative for instance). Mission may last for many weeks to months.

Current Status:

The Regional Hospital Coordination Centers (RHCC) coordinators have identified 10 alternate care sites in the state that have adequate space for 250-300 patients. There is one in each EMS region (excluding Chicago). Completed site evaluation forms are on record with IDPH. Discussions, meetings and work-shops have helped us accumulate the following information.

Remaining Areas of Concern:

Legal

Without question the primary area of concern and confusion for all of the participants revolved around legal issues, primarily, jurisdiction questions and liability. Initially the RHCC hospitals were asked to identify an alternate care site within their region in concert with their regional partners and utilizing the site selection tool to ascertain critical infrastructure information. However, a private entity like a hospital really does not have authority as a singular entity to set up and operate an ACS. Similarly, hospitals do not have the wherewithal to provide insurance coverage for liability and workman's comp in an off campus environment staffed by non-employees. The first legal question that needs to be addressed is who has the authority/responsibility to set up an ACS. *California has resolved this issue, the concepts can be found in the document: "GOVERNMENT AUTHORIZED ALTERNATE CARE SITES". This information has been forwarded to IDPH legal department.

Hospitals repeatedly expressed the desire for regulatory support to allow the ability to maintain as many patients on-campus before opening any offsite venue, e.g. patient overflow to cafeteria and other unconventional areas as was done in Canada during the SARS outbreak. The current hospital licensing act does not allow for this. Hospital reps requested that hospital licensing regulators examine the option of modifying the allowable number of beds a hospital can utilize during a public health emergency or disaster.

Additional legal guidance should be provided regarding:

- Triggers and Declarations
- Suspension of EMTALA, HIPPA, etc.
- Expansion of scope of practice for health care providers

Altered Standards of Care/Utilization of Scarce Resources:

Guidelines and strategies for utilization of scarce resources need to be developed for a consistent statewide approach to these extremely complex and difficult decisions. Though these issues are really more hospital related there is a secondary implication for alternate care sites. The focus should be on ethical norms and principles of transparency and fairness.

It has been determined that at least two neighboring states (Missouri and Indiana) have advanced drafts for implementing a variation of the SOFA* tool. Other states including: New York, Utah, and Florida have already published their guidelines. These documents address the allocation of ventilators when the need is greater than the supply.

*SOFA (sequential organ failure assessment score) is a scoring system to determine the extent of a person's organ function or rate of failure. The score is based on six different measures, one each for the respiratory, cardiovascular, hepatic, coagulation, renal and neurological systems.

There is some discussion in the ethical papers that the ventilator supply questions might be remedied by the early utilization of CPAP/BiPAP devices (those used for sleep apnea) to help prevent acute respiratory distress. There is some scientific evidence to back this up but these issues need to be explored further by both medical and ethical experts.

Recommendation: The recommendation for addressing the altered standards/utilization of scarce resources is to formally appoint subject matter experts, faith based groups, community leaders, and clinicians to a special committee to address these issues and report directly to the Director of the Illinois Department of Public Health. These issues like the legal concerns are directly linked to the ability to advance the concept of operations for mass casualties no matter the impetus or cause of the incident.

Medical Operations

The set-up and operation of an alternate care site is not intuitive. Essentially, a space not designed for patient care needs to be adapted into a suitable environment to provide adequate medical care to displaced patients, provide for their families, and support the medical and non-medical volunteers and staff who provide assistance at the site. There are many available resources for guidance but none have been specifically adapted for utilization in an Illinois ACS.

Additionally, IMERT has participated in multiple deployments and pre-deployments wherein the primary mission is set up and operation of an alternate care site. However, a trained response team accustomed to working with each other is considerably different than a relatively ad hoc group of medical care providers within a community.

General guidance needs to be developed for generic applications that would fit in both an emergent and strategic ACS situation. At a minimum the following concepts should be defined:

- Chain of Command
- Staffing Resources
- Clinical organization and operations
- Just in time training
- Documentation and standing medical orders
- Rapid response (or code team) capability
- Sustainability, medical supplies, medical equipment and family/caregiver roles
- Special medical needs issues: dialysis, cognitive disorders, hospice etc.
- Policies and procedures

Recommendation: a special working group consisting of IDPH, IMERT, EMS, Hospital representatives, social workers, EMSC, state and local health department agencies, and others should be charged with developing operational guidelines. These guidelines would ideally be region specific to account for the unique assets and resources within the region.

Site Support

Given that medical care will be provided in an unorthodox environment, creative logistics support is essential for start-up, sustainability, and demobilization. Guidance needs to be developed for initial set up and maintenance of operations including: life safety issues, mechanical/electrical/HVAC operations, waste management, supply reception, inventory and par levels, security, infrastructure support, food and nutrition, water supply, communications, transportation, etc.

Likewise, a concerted effort to find a labor pool that can provide both problem resolution and muscle to physically move durable goods, patients, and medical supplies. The ideal labor pool is young adults, with picture IDs and preferably a commitment to the community, college students for instance. There are many community resources that can be tapped for assistance from the Chamber of Commerce to local colleges and universities.

Exit Strategy

A specific mission for the ACS should be developed before it is opened, including an exit strategy. A threshold should be established for when to transfer patients out of the ACS. This threshold should be clear to all as early as possible in the implementation phase. Included in the exit strategy should be guidance for follow up for any responders who worked at the ACS. Similarly, guidance should be developed for the appropriate decontamination and cleansing of the ACS in order for the site to return to normal use. Finally, though fatality management should not be a focus of the ACS, the management of human remains will need to be coordinated with the existing state plan.

Recommendation: Identify Additional Alternate Care Sites

The current sites (10 large sites for 250-500 patients) are located in 10 EMS regions, excluding Chicago. While these sites will be particularly useful in an emergent scenario, the geographical challenges of actually getting patients and personnel to the site may prove to be impractical.

Additional sites, smaller in scope should be identified through-out the state. The Site Selection Tool has been modified for smaller venues that could hold 50-100 patients. A responsible party should be found within the community (local EMA or health department might be appropriate) to identify and evaluate potential sites. Ideally, there would be one site per county. This would provide emergency planners and managers with crucial infrastructure information that would enhance the capability to rapidly respond to overflow medical needs.

Recommendation: Identify additional diagnostics and special services resources

There are hundreds of free-standing clinics, acute care centers, surgery sites, out-patient laboratory and other diagnostic facilities. These resources could be crucial in coordinating medical and diagnostic capabilities in the event of a catastrophe such as an earthquake. A patient flow plan could be developed wherein access to these non-traditional providers can allow for specific medical interventions not currently addressed in any plan. This would be particularly useful in the event patients have substantial orthopedic or burn injuries.

Recommendation: Identify additional skilled medical providers and support personnel

An effort should be made to identify and train skilled medical providers and administrative support personnel who do not currently have a direct role in disaster response. Many nurses, doctors, technicians and administrative personnel do not work in hospitals. This population is undercounted and underutilized in terms of disaster response. They could be the crucial link that sustains the ESF-8 capability of the state if we actually ever sustain a true catastrophe.

ESAR-VHP

IMERT has been coordinating with CredentialSmart and the ESAR-VHP coordinator to properly upload its membership since 2007.

Barriers to uploading IMERT's current database to date have included:

- The need for programming changes in the CredentialSmart system to accommodate IMERT's credentialing information
- Responsiveness on the part of the CredentialSmart programmers
- Questions regarding liability and IMERT responder deployment
- Incorrect access given to IMERT's administrator account, which is maintained by staff member Elizabeth Lee.
- IMERT's CRIS database system unavailability due to technical issues
- Delays in deleting outdated responder information to allow for updated contact information to be entered.

IMERT staff has coordinated with CredentialSmart and Illinois Helps staff to resolve these issues. Additional cooperation during the current grant cycle has included providing consultation regarding the system's features and deployment protocols, and reviewing the iHelps user manuals.

Two IMERT staff members have attended training on CredentialSmart use and implementation during the previous grant cycle.

As of June 30th, 2011, IMERT is still working to resolve technical issues with the CRIS database system. Once these issues are resolved, IMERT, CredentialSmart, and IDPH staff will be able to begin uploading the current deployable volunteer database of around 500 volunteers.

ADDENDUMS: MEDICAL UNIT REPORTS

IMERT MEDICAL UNIT REPORT: OLD SHAWNEE TOWN, July 2010

IMERT was requested by the Illinois State Police to provide medical coverage for a special detail in Old Shawnee Town July 15 thru July 17. The request was made due to the large contingent of Illinois State Police on site in an area with sparse medical resources.

Hours of operation: 6pm to 4am.

The deployment lasted for 5 days, 2 travel days and 3 days on site. IEMA mission number: 2010-0789.

18 IMERT personnel participated. No significant injuries/illness occurred.

A situational assessment was conducted that included; an evaluation of local and regional medical resources, notification of the regional hospital coordinating center, contact with the local medical helicopter unit, contact with the local health department and local EMS coordinators. Additionally, local weather forecasts were obtained.

The site was located in a remote area of the state, in a small town adjacent to the Ohio River on the border of Kentucky.

Local/Regional hospitals
Ferrell Hospital, El Dorado IL. 52 total beds, 4 ER beds
Harrisburg Hospital, Harrisburg, IL. 78 beds, 8 ER beds
Deaconess, Evansville, Indiana, Level 2 trauma
Saint Louis Medical Center, St. Louis, MO Level 1 trauma

Emergency Medical Transportation
Local EMS; one volunteer BLS ambulance. IMERT made direct contact by phone upon arrival on the scene.
Medical Helicopters: Air Evac and Arch Air. Both were contacted to verify emergency dispatch procedures. Landing coordinates were provided by the RHCC coordinator.

Local Health Department
The local health department reported some West Nile virus activity.

Operational Priorities
An IAP (Incident Action Plan was developed for each operational period)

The weather was dangerously hot and humid. Heat warnings were issued by the National Weather Service for each day. High temps in the mid to upper 90's with humidity in the upper 80's. The temperature humidity index ranged from 99 to 104.

Measures were instituted to prevent heat related illness. Hydration techniques were discussed with ISP command. IMERT made available the following: cold water, electrolyte replacement fluids, and cold wet towels to cool down skin surfaces. Law Enforcement personnel were well informed of these resources and frequently accessed them. Additionally, IMERT medical personnel conducted observational assessments to determine if law enforcement officers were showing signs of heat exhaustion/heat stroke. No heat related illness occurred.

On two occasions IMERT medical responders were escorted by law enforcement to assist citizens with medical issues. One was transported from the scene by local EMS. The other refused treatment.

ILEAS provided IMERT with an air conditioned camper to provide shelter from the elements. No heat related illness occurred with IMERT personnel.

Site Set-up

The medical unit area was set up directly behind the ISP Command trailer next to a levee on the Ohio River.

This set up worked very well, providing a separate treatment area easily accessible by law enforcement.

IMERT set up a screen tent for minor patient care and set up 2 critical care stations inside Response Trailer 5.

Demobilization

All personnel reported they had arrived safely at home. All equipment was returned.

Mary Connelly BSN RN

Director

IMERT MEDICAL UNIT REPORT: SOUTHERN ILLINOIS FLOODING

Duration: The deployment lasted for 8 days, 2 travel days and 6 days on site

IMERT Staffing: 21 IMERT personnel participated.

Site Set-up: IMERT's main operation center was located in a classroom near the shelter area at Shawnee Community College

AREA HEALTH CARE RESOURCE ASSESSMENT:

Local/Regional Hospitals

Memorial Hospital of Carbondale in Carbondale, IL RHCC Region 5
Union County Hospital in Anna, IL- Nearest hospital
Massac Memorial Hospital in Metropolis, IL
Saint Louis University Hospitals in St. Louis, MO – Level I Trauma Center
SSM Cardinal Glennon Children's Medical Center in St. Louis, MO Level I Trauma Center
Status: all hospitals reported to be operating under normal operating procedures. 6 shelter occupants were transported via EMS to local hospitals during this deployment.

Local EMS: primarily BLS, normal operations with potential for substantially longer ETAs due to road closures during the first 3 days with the continuing rainfall. ETAs returned to normal by day 4.

Local Health Department: Southern 7 Health Department. Community clinic services in Cairo, provided by Community Health Emergency Services. The clinic in Cairo had to be closed as were some local health department offices due to flooding. The clinic was able to resume operations within 4 days right next to the Shawnee College campus. Subsequently, medical care by the primary care givers for most of the evacuated individuals was re-established. LHD staff worked in concert with the clinic providers to expedite this capability.

SUMMARY

IMERT was notified by IDPH on April 30 of a deployment order to send an assessment team to southern Illinois in response to significant flooding that resulted in the evacuation of the town of Cairo, IL. IMERT started the deployment process with notification of the Medical Director, staff and appropriate team members. A forward assessment team arrived at the UAC on May 1 at 1300, then proceeded to the campus of Shawnee College where there was an American Red Cross Shelter populated by about 120 displaced flood victims.

An initial discussion with: IDPH, RHCC Region 5, Massac EMS liaison, ARC shelter managers and local health department personnel determined the primary IMERT mission would be to assist with the assessment and response to acute illness or injury in collaboration with the ARC medical team on site. The weather conditions were poor with continuous rain, leaving many roads impassable resulting in an absolute increase in EMS response time. Additionally, occupants of the shelter had complicated medical needs and the ARC staff was unaccustomed to managing some of these issues. Likewise, the Army Corps of Engineers had plans to blow a downstream levee to possibly alleviate the flooding of Cairo. Having IMERT in place prior to this provided the region with additional medical providers in the event a drastic situation developed requiring the evacuation of hospitals and other medical facilities.

Once a process for the Shawnee Community College shelter was in place, IDPH instructed IMERT to evaluate other shelters in Pulaski and Massac counties. The next largest shelter established was in Massac County at the Waldo Baptist Church where about 40 displaced individuals and families were sheltered. After contact was made with shelter managers and municipal authorities, IMERT made rounds to the shelters daily and provided resources and contact information for resolution of issues. IMERT also checked in with EMA authorities in Metropolis, though the municipal shelter was only needed for 2 days with no overnight activity. Other sites in the region had been identified as potential shelters but were not opened.

Census at the shelters varied, with the highest number at 140 on the second night at the Shawnee College shelter. The Southern Baptist Disaster Response group provided food, additional showers and a laundry truck at Shawnee. On another note, there were ineffective practices in controlling ingress and egress within the shelter area itself. Likewise, there was lack of enforcement of shelter rules such as "lights out" and no alcohol. There was one incident when a scuffle broke out between several young men who were shelter occupants resulting in the need for campus security, the local sheriff and subsequently the Illinois State Police to intervene and remove those involved, banning them from returning. ILEAS provided security the following night.

After a few days the efforts to relieve the pressure on the downstream levees by the Army Corp of Engineers proved successful. The weather started to improve with no further rain forecast for many days. The health care infrastructure was intact and there were ample American Red Cross staff to manage the shelter at Shawnee. The population at the Massac County shelter was decreasing, and there were ample support people there as well.

Demobilization

Exit details for Mike Maddox/RHCC Coordinator

- Updated on current shelter status
  - Pulaski County, Shawnee Community College
  - Massac County, Waldo Baptist Church
- Updated on equipment/logistics issues
  - Keys for Hospital trailer will be given to Nancy Holt (LHD)
  - 2 Hill ROM beds had arrived at shelter, ARC staff were instructed on use
  - RHCC disaster cots had initially been distributed on a first come basis. Subsequently the use of these cots was rearranged to ensure they were utilized by those with underlying medical/functional needs.

Exit details for Nancy Holt, Southern Seven Health Department Exec. Director included the following.

- Updated on current shelter status at Shawnee and Waldo as well as community shelter in Metropolis.
- Review of pertinent events over the past week and subsequent resolution of issues. Provided with rounding form and reported adequate staffing for shelter visits.

- Security issues. Security had been ramped up after an altercation. First covered by ILEAS responders from Rockford, and subsequently by Illinois State Police.
- Provided with info for continued medical coverage by Community Health Emergency Services (the primary clinic that serves the Cairo community that has subsequently set up near the shelter campus). The CEO and Medical Director had been included in the planning, and operations discussions throughout the week.
- Provided with IMERT contact info as well as a list of nurse volunteers from the region.
- Review of ARC shelter management changes and ARC medical coverage.
- Discussed transportation to clinic with SMART Transport Company.
- Children at the Waldo shelter were expected to return to school on Tuesday.
- Advised to monitor for potential shelter community illness (i.e.: respiratory virus, GI virus etc.) All shelter staff briefed on encouraging the use of hand sanitizer, encouraging daily hygiene, and separate areas for eating away from sleeping areas.

IMERT vehicles and equipment were returned and prepared for immediate redeployment. All staff reported arrival at home on Sunday May 8 by 1700 hours.