National Capitol Region

Homeland Security Target Capabilities Workshop

January 9-11, 2006

Summary Report

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National Capitol Region's Program and Capability Review

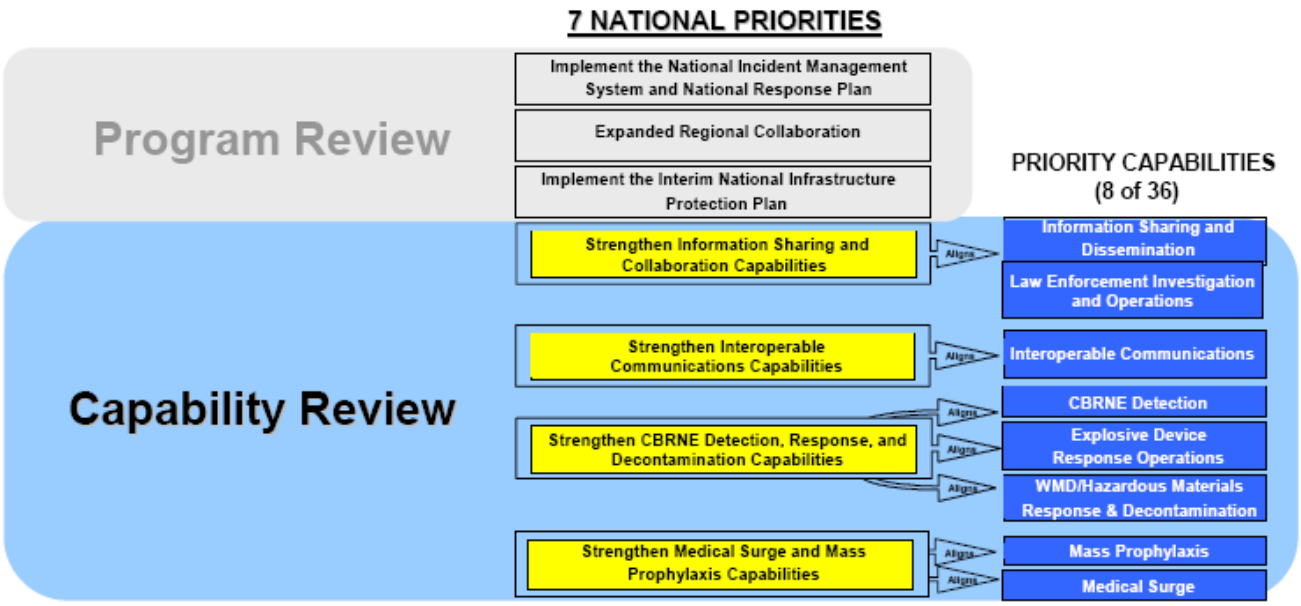
"How prepared are we?"
"How prepared do we need to be?"
"How do we prioritize efforts to close the gap?"

Introduction

On January 9-11, 2006, the National Capital Region (NCR) held the Homeland Security Target Capabilities Workshop, a collaborative meeting with the Regional Emergency Support Functions (RESFs) from its member jurisdictions, to assess the NCR's current homeland security program capability and future program needs. This meeting was designed to fulfill the Program and Capability Review sections of the 2006 State Homeland Security grant request for the U.S. Department of Homeland Security (DHS).

Under the DHS Program and Capability Review, states are requested to focus on seven (7) overarching National Priorities and eight (8) specific Priority Capabilities that flow from them (see Figure 1).

Figure 1– National Priorities and Priority Target Capabilities



Under the DHS grant provisions, assessment of the 8 Priority Capabilities at the right of the chart was mandatory for all jurisdictions.

- Information Sharing and Dissemination
- Law Enforcement Investigation and Operations
- Interoperable Communications
- CBRNE Detection
- Explosive Device Response Operations
- WMD/Hazardous Materials Response and Decontamination

- Mass Prophylaxis
- Medical Surge

In addition, the NCR has elected to address six (6) additional capabilities in its review:

- Citizen Preparedness and Participation;
- Citizen Protection: Evacuation and/or In-Place Protection;
- Critical Infrastructure Protection;
- Critical Resource Logistics and Distribution;
- Mass Care (Sheltering, Feeding and Related Services); and
- Planning.

The Homeland Security Target Capabilities Workshop

During the Homeland Security Target Capabilities Workshop conducted 9-11 January 2006, each RESF representative in the NCR was assigned one to four selected target capabilities to review (see Table 1).

Lead RESF	Support RESFs	RPWG	Target Capabilities
RESF 2	RESFs 3, 5, 8, 13	Interoperability & Health	Interoperable Communications*
RESF 4	RESFs 1, 3, 5, 8, 9, 10, 13		CBRNE Detection*
RESF 4	RESFs 1, 3, 5, 8, 9, 10, 13		Explosive Device Response Operations*
RESF 4	RESFs 1, 3, 5, 8, 9, 10, 13		WMD/Hazardous Materials Response & Decontamination*
RESF 5	RESF 3	Rail Transit & Human Service	Citizen Protection: Evacuation and/or In-Place Protection
RESF 5	RESFs 1, 3, 4, 7, 8, 12	CIP	Critical Infrastructure Protection
RESF 5	RESFs 1, 3, 4, 7, 8, 12	CIP	Critical Resource Logistics and Distribution
RESF 5	All RESFs		Planning
RESF 6	RESF 3	Rail Transit & Human Service	Mass Care (Sheltering, Feeding and Related Services)
RESF 8	RESFs 4, 5, 13	Health	Mass Prophylaxis*
RESF 8	RESFs 4, 5, 13	Health	Medical Surge*

RESF 13	RESFs 4, 5, 8	ETOP	Intelligence/Information Sharing and Dissemination*
RESF 13	RESFs 4, 5, 8	ETOP	Law Enforcement Investigation and Operations*
RESF 14	RESF 3	Rail Transit & Human Service	Citizen Preparedness and Participation

* Eight National Priority Capabilities

RESF representatives reviewed their assigned target capability summary sheets. They reflected on whether or not the National Capital Region has the ability to meet the desired outcomes of the Target Capabilities, citing "strengths" or "weaknesses" in the regional capability. Each RESF representative identified regional resource needs to meet or maintain the target capabilities. The resource needs were identified by the following five (5) resource categories: People; Equipment; Training; Exercises/Evaluation; and Plans, Policies and Procedures.

The responses from the RESF representatives were consolidated and are presented in the report in the same fashion in which they were collected. In cases where there were replicate responses, there is a number next to the response signifying how many times that response was received. The responses are organized by Target Capability. The chart is divided into Resources (People; Equipment; Training; Exercises/Evaluation; and Plans, Policies and Procedures); Strength or Weakness (S/W); and the RESF representatives comments.

At the conclusion of the workshop, participants were requested to prepare "Concept Papers/Initiative Plans" based upon a prescribed format, to identify specific projects that were supportive of sustaining/maintaining current strengths or correcting identified weaknesses. They were asked to link these concept papers to one or more of the 14 NCR Priority Capabilities. These Concept Papers/Initiative Plans will be submitted to the NCR on 27 January for review and prioritization.

CBRNE Detection

Resource	S/W	Comments
People	S	• Staff is well trained. (5) • There are adequate personnel within NCR to confront the overall response needs to a CBRNE event. (3) • We have an excellent bio-surveillance system – Essence (3) • We have people who monitor and screen waste material collection and disposal sites. (2) • There is adequate personnel and security in hospitals. • Major water utilities have needed personnel. • Have ability to respond to venue specific event.
	W	• There is a lack of trained decontamination. and detection staff both generally and in hospitals. (4) • Need more personnel dedicated to the regional level and in the field (e.g., on the scene) (3) • There is a lack of coordination between functional areas (e.g., hospital decontamination personnel and fire decontamination personnel). (3) • There is insufficient staff and funding. (2) • Need more K-9 and bomb squad personnel. (2) • Need increased personnel to cover mass care activities including behavioral health activities, non-traditional populations' needs, and public information and outreach, during CBRNE incidents. (2) • There are not enough personnel (police, forensic pathologist, epidemiologists, and micro-biologists) in the NCR. (2) • There are not enough personnel (police, forensic pathologist, epidemiologists, and micro-biologists) in the NCR. (2) • Small water utilities do not have number of personnel needed and rely on large utilities for support. • We have a problem with staff turnover and subsequent training needs. • There are not enough staff in hospitals to provide adequate care for surge from CBRNE. • Need maintenance staff and software foe regional and state Essence program. • There is no consistent standard for interpreting data. • We lake level 4 lab in the NCR. • Public health surveillance is not well integrated with

Resource	S/W	Comments
		colleagues in public safety. • Need Quarantine and detection capabilities at airports. • There are a limited number of first responders who can be deployed in support of healthcare facilities. • We have multi-disciplinary IMT trained personnel, but we lack the ability to maintain the IMT. • Not enough people available to go through trash. • Health sector is not communicating with other disciplines. • People are in regular communication with others but the communication is still "stove piped". • The medical examiners are not utilized enough in regional CBRNE incidents. • Existing surveillance systems are not adequately coordinated with NCR responders.
Equipment	S	• Have some detection equipment in place, (e.g., biomonitors) (3) • Existence of promising new technologies, e.g., *Essence* • Chemical warfare (transit network) • Computer Assisted Telephone Interview (CATI) system being tested in NCR to aid detection of bio agent in at-risk community populations (quarantined) • NCR has enhanced equipment capabilities • PPE and decontamination equipment are available • Have chemical decontamination PPE for first 24 hours; need to increase to 72 hours • Quarantine area initiated at Dulles but not Reagan
	W	• Need specific CBRNE testing equipment such as Mach I, CATI, radiological mobile testing, chem/bio detection equipment, and additional water monitoring such as GC/MS. (14) • Hospitals are vulnerable infrastructure and lack perimeter security and detection (e.g., bio, rad, etc.) (6) • NCR doesn't have the ability to access and utilize existing CCTV capability in WMATA metro • Need additional PPE (3) • Need warehouse capability to store equipment (3) • Interoperable communications intelligence of health/public safety (3) • Lack of mass care supplies e.g., towels, blankets, clothes, etc. (3) • Not enough testing validation of new technologies;

Resource	S/W	Comments
		need uniform (2) • Not enough protective equipment for long term/multi-incident (2) • First responder not adequately trained on equipment (2) • Mechanism to determine equipment interoperability (2) • Lack of coverage of monitors • Toxic industrial detection • Lack of post incident protection personnel • IMT is in need to support its ops • Lack of standardization of equipment • Decontamination capabilities • Public notification systems • Communication from HazMat to mass care and PIO • Not all equipment is compatible • NCR hospitals lack level C and B decontamination PPE for victims • Not enough detection and identification equipment for the law enforcement personnel of NCR • Need funds to upgrade equipment • Lack of integration within NCR • First responders not aware of available resources • Need additional funding for software
Training	S	• Well educated staffs at major water utilities (3) • CBRNE training is available • Good training program funded (Washington Hospital Group) to address limited healthcare staff knowledge
	W	• Need more of an ongoing regional training exercises and coordination components (11) • Training of professional community and non-professional people in decontamination exercises and equipment (9) • CBRNE symptoms training (6) • Training for chem. and biomonitors protocols needed (3) • Awareness training → traditional and non-traditional responders (3) • LE WMD personnel need to train with their FD counterparts (2) • Cross training between EMS and hospitals (2) • Lack of knowledge about training programs • Lack of money to provide training opportunities to

Resource	S/W	Comments
		staff • NCR personnel are not adequately trained in surveillance capabilities • Lack of training for laboratory personnel • A need to train public safety on capabilities of ESSENCE • Training needs to be ongoing to be proficient • Regional IMTs is limited, does not include other disciplines
Exercises/Evaluation	S	• Many local are regional exercises. (4) • ESSENCE is evaluated daily within RESF8
	W	• Need more Local and regional exercise. These exercises should include the health care sector and WMATA/Metro and the coordination between different the different stages of response to a CBRNE incident (e.g., post-decontamination handoff between hazmat/CBRNE and mass care/EMS.) (24) • RESF 3 (debris) has not implemented an exercise/evaluation program. (3) • First responders lack adequate detection equipment and therefore do not exercise adequately with detection equipment. (2) • Need to identify skills that need to be improved via evaluation/after action of exercises and practice those weak skills identified. (2) • Very limited evaluation of "ability to detect." • Lack of critical structure vulnerability assessment. • Need to exercise ESSENCE and CATI systems outside of RESF8 alone. • Lack of awareness regarding capabilities of medical examiners offices and lack of involvement of medical examiner during exercises. • Need increased funding to conduct exercised to test surveillance capabilities.
Plans, Policies and Procedures	S	• Potomac has good detectors for chemicals • Have federal quarantine station at Dulles, but need resources for quarantine stations at BWI and Regan
	W	• Regional plans and procedures must be developed, updated, distributed and exercised across jurisdictions/coordinate federal response plans with local and regional plans (17) • Need to incorporate public health, medical examiner, hospitals, first responders at local level in planning and training. Detection gaps contribute to significant

Resource	S/W	Comments
		risk to healthcare infrastructure (6) • No NCR area has capability to confirm identification or detection of CBRNE with state or private lab system – only federal lab system has this capability (3) • Lack of a NCR interdisciplinary surveillance system/lack of system for biological assessments/toxic materials in the transportation sector (2) • Lack of funds to hire staff to develop policies and procedures for radiation monitoring and surveillance • Phone Georges and Montgomery Counties all not part of the NCR FBI JTTF • Need a regional terrorism tip line • Need to integrate CBRNE planning and response with mass care, HazMat decontamination • Distribution system models not yet fully implemented and tested for NCR water system • Hospitals need to do a better job of reporting trends and distribute related information

Citizen Preparedness and Participation

Resource	S/W	Comments
People	S	• MRC recruiting and training volunteers. (5) • Have lots of volunteers and utilize non-profits and volunteer centers. (3) • Have excellent PIOs in all counties that work collaboratively on preparedness issues
	W	• Need staff and resources to do citizen outreach. (13) • Need to better include special needs populations in preparedness planning. (6) • Need more volunteers as an education resource. (4) • Insufficient number of MRC volunteers. (4) • Need a volunteer management and training process. (3) • Need increased capacity to communicate with non-English speakers. (3) • Need to increase the number of health PIOs in the area. (2) • Need contractor assistance for ongoing regional media relations and public education. (2) • Need regional organizational structure. (2) • Need to prepare for an influx of spontaneous volunteers. (2) • Need a volunteer credentialing process. (2) • Need to continue to fund MRC. (2) • Need to increase outreach to NGOs that support or advocate for SNPs so they can make their own preparedness plans. • Need more staff to develop and implement plans and programs for SNPs. • Need more pre-affiliated volunteers. • Not sure how many volunteers needed to support different RESFs. • Need characterization of areas SNPs to plan. • Regional citizens know they can be targeted.
Equipment	S	• Regional collaboration/information sharing has increased with equipment and technology from prior UASI funds (2) • The NCR has plenty of equipment and platforms to perform outreach programs news media and academia (2) • Training for responders is in place, but needs to be expanded

Resource	S/W	Comments
		• NCR is able to provide adequate equipment from both public and private resources to support TCL capability outcome • <40% of the population have citizen kits • Very difficult complicated message -- pamphlets, brochures, etc. are available • We have the equipment we need with a few enhancements
	W	• Region needs technology to rapidly contact populace with uniform message; need to take into account the special needs population and include in the realm of such areas as translation services (12) • Volunteer community needs IT capability to identify, track, credential volunteers (4) • Need more mass care equipment including supplies for special needs population (3) • Need regional emergency supply caches for citizen response • Need additional training equipment • Additional equipment is needed to protect citizens from attack • Need preparedness kits for those who can't afford them • Need special preparedness kits for those with special needs • Need better connectivity between 211 and emergency management for emergency information and referral • Weather/radios/all hazard radios for responders and the public • Need a tie between the phone system and on-line systems • Additional power supplies (generator) are required to ensure shelters can provide for the needs persons with special needs (refrigerator for medication, oxygen power source, etc.) Facilities should be pre-wired • Difficult to have targeted message with various populations • Need regional 211 funding • On-line training modules with NCR specific information • Accessible transportation equipment insufficient for evacuation • Medical equipment and medicine crucial for persons with special needs to survive

Resource	S/W	Comments
		• 211 systems need to be fully accessible • Need database of volunteers in NCR; must include multiple emergency response roles
Training	S	• Training programs exists e.g. citizen corp (2) • MRC volunteers also provide just in time responder training to spontaneous volunteers, and have been utilized during non-event times to spread public info messages for the health departments. • Is this training curriculum in line with national curriculum • Some, but not adequate numbers of citizens educated and volunteers trained • Pros receive regular training • Some citizens have CPR training and first aid training
	W	• Training opportunities – citizens aren't aware of all available opportunities (6) • No training available which embraces or enhances emergency preparedness information (4) • Although some training efforts "CERT", "MRC", citizen academies, etc. not enough people or resources (3) • More attention must be placed on handling and addressing the needs of people with disabilities, appropriate assistive technologies, and the needs of these communities. (3) • Not regionally coordinated (3) • Funding for MRC training staff (3) • The NCR's Citizen Corps train volunteers for their CERT and MCR programs However, there are not enough trainers for these programs. (3) • Region needs better understanding of how public health works – answers/ info is not instantaneous and often not visible (lab test, for example). People → non-health people, volunteers, media, general public etc.. – don't seem to understand this (2) • Training coordination MRCs • Training is minimal as opposed to emphasis on information and notification activities. Training requires focuses on differential training activities and inclusion of credible sources (such as faith based organizations) • Support and develop training for self – preparedness PNSN • Develop and support training for PNSN to be done by

Resource	S/W	Comments
		advocacy groups, service providers and other non-emergency agencies knowledgeable about training PNSN • People need to train regularly • Critical service delivery organizations (e.g. home health agencies) and mediating organizations (NGOs) need additional training to assist respective populations. • Also focus on low income and LEP populations • Improve coordination of public inquiry call centers. Establish a regional system • Trainers are needed for special populations. • Getting the people who were trained to be responsive to continues education responsibility • Need to develop just in time training for spontaneous volunteers. • Need to increase opportunities for RESFs 6, 11, 14, and ,15 to train with the other RESFs • Need to cross train between volunteer cadres across RESFs 6, 11, 14, and 15 • Need to increase public education and preparedness training • NCR public/non-profit agencies are severely under funded and do not have the capacity to get or give education training. The do not have the capacity to help NCR's most vulnerable achievement "an appropriately higher level of preparedness." • More training need with specific health issues and components • Need better/more innovative types of communication methods to train/educate public (web, etc.) • Need additional specialized training for surge capacity and community education – sheltering in place • Public training on responding to an anthrax attack – coordination with public schools • No one I know in the NCR has taken any training, participated in any exercises or is a volunteer.
Exercises/Evaluation	S	• MRC/city corps provide training to citizen volunteers • Conducted regularly and PIOs/health PIOs are routinely involved • Pros regularly exercise in their own jurisdictions and regionally • We have exercises and designed to give citizens opportunities to practice what they have learned

Resource	S/W	Comments
		(evaluation is a part of exercise) • Members of RESF-14 regularly participate in their own jurisdictional exercises, as well as regional exercises like "Patriot Challenge" or "Capital Shield."
	W	• Need to use volunteers more and better (CERT, MRC, RACES, mobilization centers, call-up and processing, etc.) (8) • Exercises and evaluation lack the appropriate inclusion of people with disabilities, not as a separate population, but as a part of the general population (8) • Lack of citizen involvement in planning and execution of exercises, except as patients in multi-casualty drills (5) • Need for additional region-wide, multi-disciplinary and multi-jurisdictional training (5) • No significant exercise has been conducted to evaluate citizen preparedness in the NCR (shelter/shelter-in-place drills) (3) • Volunteer management needs to be better integrated in larger exercises • Exercises not publicized in advance to increase participation • Private sector inadequately involved in exercises • Exercises and evaluation should include hospitals • Media/communication is not fully exercised; drilling vertical JIC regionally shared • Capabilities assessment needs to be done to see how things might work during an emergency • Too many of the planning/training components are still in their infancy and have not progressed to the point where they can be adequately practiced • Need to include RESFs 6, 11, 14, and 15 in all major exercises where appropriate throughout the NCR • Weakness in bringing in federal agencies so they better understand local estate issues • Faith community involvement • Pet safety plan and shelters • Difficult on a large, regional scale; better done with small, targeted efforts with businesses, neighborhoods, etc.
Plans, Policies and Procedures	W	• Public health entities, private sector efforts, citizen volunteers, need to be included in planning – particularly at the regional level (7) • Standardize alert notification and public involvement

Resource	S/W	Comments
		in development of associated policies and procedures (3) • Better coordination of volunteers and planning for their needs (3) • Pets need to be considered/addressed in training, exercises, and evaluations. • Need more coordination between government and non-profits, particularly when planning involvement with and response directed toward vulnerable populations/Need to add to the knowledge base that defines NCR's most vulnerable (who they are, agencies, that serve them, where they are in the neighborhoods, and what their needs are) • Need to complete regional NCR communications plan • Need more extensive, inclusive citizen preparedness plans • NCR strategic planning process requires standard policies and procedures for alert notification before, during, and after emergencies

Citizen Protection: Evacuation and/or In-Place Protection

Resource	S/W	Comments
People	S	• Non-profits have a roundtable that works through shared challenges regarding post-evacuations.
	W	• Need staff to prepare shelters; activities include training SNP accessibility, the SNP trained staff and SNP preparedness kits. (9) • Need staff to facilitate evacuation/ shelters. (5) • Need to increase funding for public outreach. (4) • Need to coordinate with the Federal government. (2) • Need a regional plan that increases regional RESF coordination during evacuation. (2) • Need feeding/ shelter teams to deal with evacuated populations. • Need to identify SNP. • Need increased coverage of surveillance CCTV cameras on the road. • Need to have staff to find the homeless. • Need better integrated planning efforts between all RESFs. • Need more people across jurisdictions and disciplines to help develop evacuation plans. • Need a plan to mobilize volunteers who are stuck away from home jurisdictions during emergencies. • Need to increase supplies for emergencies from three (3) to ten (10) days. • Need better understanding of area personnel capabilities. • Need to know military capabilities.
Equipment	S	• Have detour signs and variable message boards but would need these supplies in greater quantities in the event of a major incident (2) • Good transportation infrastructure for evacuation • Few vulnerable structures allowing for more shelters • CATI equipment allows/facilitates monitoring of quarantined population for health/infectiousness needs • NCR is a CAN pilot area; has had access for three years, but needs to test program to ensure its effectiveness at case management • Notification procedures for mass evaluation can be broadcast through current communication methods • EOC and communication links have been streamlined
	W	• Accessible transportation for evacuation is lacking (7)

Resource	S/W	Comments
		• Not enough mass care equipment (4) • Need an adequate communication system that must accommodate all people including persons with special needs (4) • Need generators for shelter (4) • People with few resources can't accumulate the supplies needed to shelter in place for days or weeks without assistance (2) • Emergency preparedness kits should be prepared for special needs populations (2) • Need regional evacuation support caches e.g., cots, blankets, food, water supplies • No sheltering equipment in temporary shelter sites (schools, universities) • Prescription/medication/DMG access is negligible • Need food and other resources for quarantined/isolated and "community shielded" healthy shelter in place • Lack of gates type of equipment for quick road closure for channeling evacuees to certain routes • Need shelters capable of housing special needs populace • Not enough available PPE • Security cameras for shelter sites (e.g. schools) allowing for in supply of shelter residence with potential need for safety personnel on site. • Need fuel trucks to fuel busses and people who run out of fuel while evacuating.
Training	S	• See RESF 14 - Having a coordinated and fully accessible plan with buses for providing training and practice • DC conducted an evacuation exercise that went smoothly • Katrina taught valuable lessons and provided real training • There are many excellent, available pamphlets on family plans/personal plans. More needs to be done for SNPs, including those who economically can't afford to stockpile.
	W	• Involvement/Communication of special needs populations in the development and execution of training and evacuation (4) • Need to train/educate residents at large initiating organizations/gatekeepers" such as home health agencies, meals on wheels, resident and property

Resource	S/W	Comments
		managers or high rise (NORCS) public housing, low income (3) • Training needs to stress shelter-in-place (3) • Need plan that is coordinated and fully accessible/ universal as basis for training and practice • Better training/planning for quarantine and isolations → care, feeding • Working with non – profits, personal care agencies, residential property manages, senior citizens mangers, etc. • Insufficient attention/emphasis is placed on appropriately setting up evacuation and sheltering plans to be accessible before there is a problem • There has not been a strong enough outreach to individuals with disabilities and provider agencies to train people appropriately to handle emergency situations • Public awareness campaigns in multiple mediums. Braille, video, etc…needed. Involve of Special Needs People (SNP) in creation • NCR emergency responders are not sufficiently trained to support mass evacuation – specifically transportation systems such as the metro system • Table top exercises that will flush out those gaps • Metro managers need more training for crowd control during emergencies • We haven't done much training on "continuity of governments" – "reconstitution of government services" and all the other complexities of evacuation. We've "verbalized" shelter-in-place training/exercise, but the complex aspects haven't been trained • Police, fire and emergency and DOT manager train but additional training required • Pet plans • Business community shelter in place • Need training opportunities for business • Need to train mass care volunteers for evacuation and sheltering plans • Need to train RESF in isolation quarantine requirements including CDC/NSC public health emergency law • Staff perform their regular jobs well, but not well trained on emergency response • Need online (as well as offline and special needs)

Resource	S/W	Comments
		• Modules for citizen education on these subjects; as part of public education campaign • Public training information on how to respond to an anthrax attack - integration with public schools • Limited training in the process of conducting staged evacuations • Volunteers (MRC, e.g.) transportation plan is not developed
Exercises/Evaluation	S	• Many exercises and real-life events have occurred • Public exercise of evacuation plan demonstrated feasibility of larger-scale evacuation • DC has done an OK job of exercising and publicizing evacuation plans--during July Fourth, for example
	W	• Insufficient region-wide exercise and evaluation (for responders and citizens) of evacuation and shelter-in-place protection (9) • Must include special needs populations in exercises and evaluations (8) o Need to train and prepare special needs organizations to conduct and evaluate their own areas o Need exercises & evaluations involving high use, senior, and disabled dense housing units, NGO/nonprofits serving at-risk population o Limited-English-proficiency and low-income populations especially need education, outreach, training re: sheltering-in-place • No exercises to practice how outlying jurisdictions will handle influx of evacuees from the NCR (2) • Need regional table-top exercise (2) • No evacuation scenario involving the Metro system (2) • Lack of funding and resources to exercise mass evacuation scenarios • Test traffic management centers • Strong need for scenario-based planning (i.e., model the ISDHS scenarios for response and recovery)
Plans, Policies and Procedures	W	• Need a viable evacuation plan for regional evacuation including visitors and special populations (15) • Manage expectations regarding shelter in place v evacuation (4) • Need to include and consider people with disabilities and relevant organization in planning and training (3) • Need to regionally coordinate evacuation traffic

Resource	S/W	Comments
		monitoring tools/models that incorporate GIS/Plan traffic evacuation routes (2) • Coordinate evacuation messaging among regional PIOs (2) • Need adequate security staff and equipment for shelters

Critical Infrastructure Protection

Resource	S/W	Comments
People	S	• Key personnel are available for the CI assessments needed since 911. • COG NCR CIP committee was established to address issues related to infrastructure protection. • Utility personnel have expertise and experience in emergency response. • Groups like utility companies and hospitals historically give priority to SNP.
	W	• Hospitals, dispensing centers, and medication caches need increased personnel with arrest powers and security abilities. (6) • Need more staff for CIP such as regional cyber security and the NOC. (4) • Need funding to sustain CIP at NCR. (2) • Need to better engage private sector. (2) • Lack of ability for NCR emergency responders to utilize existing metro CCTV capabilities. • Need to include SNP in the decision making process because they are more vulnerable by the loss of critical infrastructure. • Need to integrate non-profit CIP leads into the NCR. • Hospitals should be classified as "Critical Infrastructure." • Need a critical infrastructure program in DC.
Equipment	S	• Radio cache can restore communications on a limited basis
	W	• NCR needs to ensure rapidly deployable back-up power generators and transformers and for major facilities (8) • Hospital security and hardening needs to be emphasized so hospitals don't close as a result of an emergency (4) • We need back up systems to support communications (2) • NCR has single points of failure that could lead to system wide breakdowns; need redundant control capability and enhanced monitoring systems. (2) • Need to secure server and cache sites (2) • Single point of communication failure in DC metro radio station (2) • Single points of failure are known to be taken care of (need common secure analysis)

Resource	S/W	Comments
		• We are vulnerable because of our cyber-security weaknesses • Resources are not available in a critical time; need more stockpiles, etc. • Need back up systems to support transportation requirements • Inventory of existing equipment and supporting fuels. • Need to secure network ops center • Lack of CBRNE detection equipment • Lack of equipment/system mitigation (hospitals) • Lack of reliable communications in the metro system • Lack of sufficient resources to mitigate and restore CIS-metro • Need standardized software program for risk assessment and threat assessment • PLOSN need critical infrastructure, power, transportation, emergency healthcare, etc., more that non-disabled populations, especially if they used equipment like power wheelchairs, accessible communication devices, dialysis equipment, etc. • Standardized assessment tools • Standardized protection tools • Secure equipment and information exchange • PCJJ certification for NCR • Trucked radio system outage at risk • Lack of ability to reconstruct a system that has been lost • Information protection • Fusion/analysis center • Databases • "Acamsand Ramcap" • VDOT smart traffic center software platform, computer hardware, etc, are all legacy equipment and in need of replacement, before the region can be effectively integrated. New software systems would enable us to more effectively and efficiently, identify incidents, verify situations, form response, deploy right resource, inform road users, etc. • Need more protective equipment
Training	W	• Lack of comprehensive NCR training program for METRO system (2) • Regional training in infrastructure protection including dams aw well as electrical or water supply • Management level understand what ability is their

Resource	S/W	Comments
		(capability) → communication resources • Need training of facility staff on roles and responsibilities degree of force – and legal issues surrounding protection • Regional assessment training • No set regional training piece • Training of critical infrastructure personnel needs to include the needs of PLOSN, especially the higher risks they face with loss of power, transportation, and other critical infrastructure. • Need to standardize the risk assessment process between feds, state and local • Need for enhanced reliability of existing communications capability in transit tunnels both for first responders and train operations • Joint communications training with Red Cross techs and other communications techs. • COOP training for key VOAD organizations • Do not train private sector folks who are responsible for critical facilities • Create and implement a test plan • The NCR has trained for natural and man-made events, but the consequences of losing power, water, communications, transportation are unclear • Fortify energy responders with the appropriate training. Establish a minimum level of training for RESF-12 respondents on ELD's in all jurisdictions in NCR • Need integration with law enforcement to have response teams to protect "critical" buildings
Exercises/Evaluation	W	• Need exercises to perform recovery/restoration exercises with emphasis on decontamination, communication, etc. (4) • Need an exercise/evaluation component (3) • Need to practice responses, evacuations, shelter in place, etc. • Unsure as to whether we can prevent water born attacks • Have not exercised a communication failure • Need more exercises on targeting • Need exercises to take into account people with special needs • Lack of PPE training and exercises (hospitals) • Need to exercise equipment at run at load and beyond

Resource	S/W	Comments
		maintenance test levels • Need to perform COOP exercises, including key government, non-profit, and homeland security partners. • Need to exercise whether generators can run under load and be refueled. • Need to create and implement exercises that assume communications capability is compromised. • Need utility participation in active exercises.
Plans, Policies and Procedures	S	• Formation of NCR – CIP working group • Established agreement between NCR jurisdictions and WMATA • Redundancy in some systems in some areas • Utility, transportation, sectors have good vulnerability assessments → government mandate • Extensive back-up generator capability/requirements • Learned that solar technology was very beneficial in Rita • Hospitals have in house plans to maintain power, water, and food
	W	• Recovery needs more emphasis in terms of plans and procedures for restoring services with emphasis on decontamination → also equipment issue (9) • CIP must be expanded to include healthcare facilities (hospitals). Target hardening and law enforcement perimeter security must be prioritized. Fire/hazmat support (including WMD detection) and response to events requiring mass decontamination operations occurring at hospitals. (4) • Lack of reliable communication system (4) • Need for regional methodology for prioritizing risk across CIP sectors within NCR (4) • Communications infrastructure needs to be protected and secured → highly reliant on electricity (3) • No coordination between DHS and NCR planning organizations (2) • How are we implementing private sector (2) • Need a process and means for emergency notification • Not specified in most plans for security reasons • Plan implementation for CIPP • Focus on identifying gaps in the fire services infrastructure, resources and its protection • Lack planning to maintain fuel for response vehicles • What will you do if you loose an entire service?

Resource	S/W	Comments
		• There are no plans in place to harden targets that result from an event • Need a governing council to push regional policies and regulations and M.O.U. • Need to address special needs and prison population needs in regional policies and procedures for CIP in the NCR! • Regional T.I. P.P. program, tip line! • Need to better recognize the needs of LOSN and management and analysis should include the heightened risk to PLOSN who are more vulnerable to the effects of losing critical infrastructure services. • Agreement needs to be reviewed and revised • Hospitals have plans however they do not have personnel • Prioritization and I.D. of critical infrastructure needs to e developed using a common tool→ help from DHS? • Reliance solely on grid system • Command and control • Lack of resources for training on emergency response, response mitigation, etc. with Metro (esp. Underground) • Need to test back-up generators more regularly also testing protocols need to be enforced. • Region's population is underutilized and capable of being an effective threat evaluator • Need regional plan for generators to move fuel • Monitor transportation infrastructure → then communicating threats to different RESFs • Mandate of COOP/COG plan for critical infrastructure in the NCR (private sector) • Develop a plan to har5den the targets that relate to critical facilities • Notification of RESF 5 during outages utilities • Develop a standardized way to analyze the critical facilities • Daily security at hospitals is very lax with the exception of obstetrics • Failure to include private sector in planning process • Failure to link regional and national reporting system for cyber attacks • Failure to link terrorism databases with CRO personnel databases

Resource	S/W	Comments
		• Failure to include no – CI/KA private sector in vulnerability assessments • In place emergency generation equipment 1) inventory with details 2) maintenance 3) upkeep in operating mode 4) fuel source(s)/re-fueling • Inclusion of potential mass care facilities within CIP plans • Generators → inventory, where are they, what can they support • In the process of identifying a CONOPS and governance structure • Need to complete a risk assessment • Need to create an IT security policy • Need to create an IT architecture • Implement IT security tools • Create a continuity of operations plan for voice/data systems • Unaware of plans for a complete break –down of the critical infrastructure • Minimum standard of readiness for plans • Mutual (regional) standard operating procedures

Critical Resource Logistics and Distribution

Resource	S/W	Comments
People	S	• We have professional material management personnel in each jurisdiction of the NCR. • IMT personnel are assigned to logistics functions.
	W	• Need more staff to manage to supplies and regional systems. (5) • Need better volunteer management process takes advantage of volunteers' skill sets and sends clear messages to volunteers. (3) • Need better continuity of operations in management of regional supplies. (2) • Need to integrate mass care and other VOAD logistics personnel into the other NCR logistics constructs. • Need personnel to manage a warehouse in MD, VA and DC to house a mortuary. • Need a plan for when people do not show up for work during an emergency. • Need to develop the bench strength to meet the IT needs of long term incidents. • IMT is a critical resource and needs to be maintained. • Need a NCR management system for medical supplies and pharmaceutical cache management. • Need family reunification process. • Should use businesses to provide surge capacity. • Need a regional plan to provide first responders family support.
Equipment	S	• Radio cache can restore communications on a limited basis (2) • Petroleum products are dispersed around the region • Plenty of transport for petroleum • Have begun the process to identify these data sets • Stockpiles exist for 24 to 48 hours response • Strategic partners have been identified and contracted • Resources are shared across region with some limitations
	W	• Not enough useable storage space for equipment and supplies, (including medical storage supply) (4) • A shared software program for managing the NCR medical cache is needed (2) • Petroleum vulnerabilities in central storage, pipelines, parts • DC vulnerable because of reliance on natural gas

Resource	S/W	Comments
		• No central warehousing of disaster associated equipment • No standardized equipment list across region • Transportation sector does not know expectations or needs of the region • Need a mix of both equipment and people to be managed properly • Equipment to get people out of trains/underground is obsolete • Need to look at ways to move people off metro to areas that are close • Too many individual systems must be interoperable across jurisdictional boundaries • Need to enter FEMA 120 resource list into WebEOC • Need a central system for the availability and dispatch of resources • Need a gap analysis across RESFs on available resources • Inventory for recovering • No written MOU • Inventories of our RESF 1 equipment have been cross-shared among the jurisdictions. What does RESF-5 expect/need? • Ways to reach the public to manage demand (e.g., among alerts) • Awareness training of personnel to serve in logistics roles or non-traditional roles • Need logistical support for storing and distributing mass care supplies and equipment
Training	W	• Allow for joint training of mass care and other VOAD logistics personnel with other logistics personnel • Cross training (e.g., military personnel driving buses) • Awareness training of personnel to serve in logistics roles or non-traditional roles • Need to develop additional and baseline training on regional communications systems (data). • Need training on replacement/movement resources • Adequate resources to mitigate an event • Training for health incident commander on utilization of the system (as soon as it is created) • No training to date regarding acquisition of Strategic National Stockpile (SNS) supplies • All involved staff must be cross trained on systems and interfaces.

Resource	S/W	Comments
		• Need to understand jurisdictional operations • No regional training on liquid fuels
Exercises/Evaluation	S	• A lot of regional exercises
	W	• Need regional exercises focused on logistics and materials management (15) o Joint exercises between mass care and other Voluntary Organizations Active in Disaster (VOAD) logistics personnel and other logistics personnel o No exercises or evaluation regarding acquisition of SNS supplies o Exercises needed for resource acquisition of supplies o No exercises in resource partition o Must bring in disciplines from various sectors to identify location of resources o Regional exercises have not gone beyond immediate response when personnel and resources are thin o No practice for shortfall of petroleum fuel (liquid) o Recovery phase exercises! o Assessment of regional resources o Access to sites (road, identification) o Never exercised finance portion of regional IMT o Never tested complete [unintelligible] failure o Not enough drills (e.g., mass fatality) • Need exercises with scenarios that are not "going to plan" • No exercise that stresses infrastructure and communications for a sustained period of time • Not enough exercises that focus exclusively on one specific parameter • Need ongoing training for energy liaison officers on all energy types and the associated emergencies • No exercises for cross-trained IT staff • Need more participation and input from the private sector
Plans, Policies and Procedures	S	• Have a start with the tri-state agreement
	W	• Definitions need to be standardized (4) • Need to develop a regional strategy to manage/disseminate resources (3) • There need to be mutual aid agreements; models are already in place (2) • No plan for prioritizing fuel reserves

Resource	S/W	Comments
		• Jurisdictions have little idea of other jurisdictions' resources • Labor laws need to be examined • Not enough focus on personnel that are rarely utilized • Need to increase capabilities in logistics and finance • Need to expand "211" • Lack methods and alternatives for resource distribution • Need to increase credentialing capabilities • Need to develop tracking system to manage volunteer workforce • Difference in mentality of first responders and peripheral volunteers • Mass care/VOAD logistics needs to be incorporated into other NCR plans for logistics • Need to inventory resources across NCR • Need to develop family support planning during an event • Lack regional logistics sharing and information; ADD finance ICS function to IMT with spending authority • Need to ensure facility capabilities throughout the NCR; WH space, MM equipment, loading docs. • Region is competing for vendor inventory and 24/7 access to vendors • Need to maintain resource databases that are established • Need regional monitoring of all liquid fuels; need regional coordination of fuel supply; need updated regional plans. • We don't know what RESF 5 expects of RESF 1 • Deployment of resource in non-daily use ways (RESF 1)

Explosive Device Response Operations

Resource	S/W	Comments
People	S	• We have equipment operations who can assist in recovery efforts. (2) • Individual bomb squads can handle an incident with limited LVB counter measures and CBRNE capabilities. • We have a good response capability in the EOD. • We have knowledgeable personnel in analysis and identification in lab systems.
	W	• There are deficiencies in the bomb squad response teams. (3) • Need additional EOD and K-9 personnel. (2) • Need more mental health support for volunteers/staff responders/ and victims. (2) • Not enough equipment operators who can assist in recovery efforts. • Not enough equipment operators to handle long term operations. • Need more overall staff and people trained in the area. • We need the ability to mobilize analysts knowledgeable in lab systems during a response. • There are deficiencies in police response teams.
Equipment	S	• Equipment employed in threat assessments and render safe procedures is largely standardized and interoperable • Equipment and expertise to analyze and identify explosives
	W	• Do not have appropriate equipment or contracts in place (cranes/grapple trucks) (2) • Need for continued support to maintain and provide support for IED operations • Ability to maintain interoperability • Lack of reserve equipment/additional equipment to handle multiple events • Bomb squad unable to meet response times and render safe timelines due to equipment to hand large vehicle bomb and CBRNE • Not equipped to handle more than one incident at a time • Bomb squads responsible for all jurisdictions lack robust large vehicle bomb countermeasures/CBRNE • Lack of robotic (remote) capability • Lack of adequate PPE

Resource	S/W	Comments
		• Bomb squads lack mission critical equipment capabilities • Cart to take things in/out of metro tunnels on track • Communication equipment between RESF and EOD • Need more mass care equipment to support responders and victims • We need more detection devices for prevention • We need more equipment for the first responders use for the incident.
Training	S	• Hired operators • Formal training in analysis
	W	• Need to train operators (4) • Lack regional standardized training (2) • Inadequate training for pre and post blast • Awareness level to identify bombs • More education and training to reach citizens, volunteers, staff regionally • No labs in DC to train or analyze evidence
Exercises/Evaluation	W	• Need to include Medical Examiner agencies in exercised, training, planning, etc. (3) • Coordinated exercises with EOD regarding supporting responders and victims, especially WMD/T. (2) • Need to test, identify, and improve on weaknesses. (2) • Need to incorporated Mass care functions in exercise. (2) • Need for regional tabletop exercises involving multiple RESFs. (2)
Plans, Policies and Procedures	S	• Medical examiner has in house mass fatality plan that is being extended to other agencies, but medical examiner is not involved in other agency plans.
	W	• Water system (MD treatment) needs to remain operational in times of threat/have limited capability to operate remotely/cannot shut down for extended periods because water is key to response and recovery activities/dams and chlorine storage facilities are potential WMD (5) • Coordination among fire and rescue and state and federal agencies/bomb squads coordination at scene/connect, communicate and coordinate with massacre functions (4) • Regional plan and standard for joint assistance is needed/same is true human impact of WMDs • Need protocols in place for RESFs to collaborate on recovery/decoration of fatalities or incendiary

Resource	S/W	Comments
		fragments as well as preserve evidence and/or identifying clothing/jewelry

Intelligence/Information Sharing and Dissemination

Resource	S/W	Comments
People	S	• Well trained and qualified staff. (3) • Good regional communications. Good communication flow. (2) • Hospitals are working collaboratively with law enforcement to facilitate communication. • The next phase of the AFIS protect is underway.
	W	• Need to increase the number of staff dedicated to intelligence gathering and dissemination across disciplines. All intelligence staff need to be linked electronically. (6) • Need a centralized, regional location for intelligence agencies to vet and organize intelligence information. (5) • Need to increase the number of medical/fire personnel with security clearance to help develop intelligence information systems and processes. (3) • Need to increase depth of disciplines in intelligence fields. (3) • Need to establish expedited means for performing security clearances in order to get more technical experts involved in planning process. (2) • Need to continue NCR surveillance – Essence • Not enough staff to send people to RIC – there is no one left to do the job at home. • Currently, some agencies are relying on individual personal contact rather than agency relationships or official communications between agencies. • Need to increase support for LINX data sharing. • Need trained technical experts and managers for the radio cache. • Need WMATA communications upgrade.
Equipment	S	• 3 radio caches have been established with deployment • Basic start up equipment purchased for IMT • Initial procurement of communications for WMATA • Current system in place is functional • Funding to upgrade new AFIS is in place • Information sharing is easily obtained; AFIS approach works better against jurisdictional boundaries. • Current information is actionable and timely • We have invested in regional data messaging infrastructure – work is in process

Resource	S/W	Comments
		• NCR has sophisticated communications system • COG's efforts grant application enable COG agencies to garner. M/S related equipment in a manner that allows for widespread response capabilities • Have equipment to deal with day-to-day activities and small surges
	W	• NCR secure communications network (5) • Lack multi-discipline secure warehouse for communication equipment (2) • Too many fractured and repetitive unverified databases that repeat some intelligence as each other; not enough effort to verify validity, not enough follow-up or accountability (2) • Determining communication devices, i.e., phone card or satellite (2) • To effectively/efficiently share information to other jurisdictions and disciplines, we will need to have state-of-the-art operating software and platform and common standardization. It's critical to replace/upgrade legacy system prior to integration (e.g. VDOT smart traffic center) • No long term program to sustain operational readiness (maintenance parts etc.) • Full compliment of support equipment required for readiness/deployment • Not enough secure telephone units • Addition of uniform intelligence databases/analysis on a county wide network would enhance current sharing capabilities • Health not well integrated in interdisciplinary communication system • Current system is obsolete • Mobile and facial recognition phase of AFIS is not funded • Funding exists for equipment (computers etc.) to bring 15 of the more than 70+ law enforcement agencies within the NCR, not counting federal agencies • No equipment in place for back up redundancy • Ability to monitor all NCR critical infrastructure sites. A traffic management center with room to handle analysis work. • DOT by nature do a lot of monitoring and information gathering. We need to get plugged into ensure information.

Resource	S/W	Comments
		• DDOT have incident managers who do not plug into law enforcement on a daily basis. • DDOT have traffic monitors that are not plugged into law enforcement • RMS and MDT capable software that enable electronic dissemination of critical infrastructure blue prints, schematics, contacts and tactical plans to responder units and EOCs • Lack equipment for large surge (deaths) • Need mobile AFIS compliment
Training	S	• Initial basic training provided for radio cache program start-up • IMT training provided for basic program and some positions • Well trained in medical activities • Fingerprint analysis won't change • Technical support won't change • New upgrade will require minimal training for officers
	W	• Training should be on a regional level (4) • Additional training needed for new personnel and maintenance of skills (2) • Additional basic and position specific training • Training should be simplified to make it more practical • Training first, policies second • Back training in federal-local emergency management systems • Actionable intelligence is held to long • Public health people need training on use of communication equipment • No forum in place for training department • Need tools to develop multi-disciplinary training • No law enforcement representatives on regional IMT • Lack of qualified analysts individual jurisdictions and no intelligence analysts to serve the region • Need information sharing training outside of Law Enforcement • Need full time training assets • No established information sharing protocols • No in depth training exists • Continued mainland and strengthening of the system to include utilization of system in pandemic flu • Additional advanced intelligence gathering need

Resource	S/W	Comments
		• System training for any acquired database systems • Very little involvement of healthcare delivery system • More POC training
Exercises/Evaluation	S	• Current system is functional and used by the NCR • Upgrade is a refresh and enhanced capabilities within NCR
	W	• Need for a regional, multidisciplinary exercise program, including: o Exercise/evaluate established protocols o Incorporate intelligence function and workflow as a significant part of exercises o Continued funds for maintenance to enhance exercises to public safety/emergency managers o Phase 2 (mobile AFIS) will require exercises and evaluation o Tools to develop multi-disciplinary exercises/evaluation o Inter-agency exercises necessary to test plans and equipment capabilities. o Joint BFO/WFO (FBI) collaboration/participation to ensure information flow across jurisdictional boundaries o Focus on communication and information sharing between federal, state, and local officials with the public health and healthcare community o Formal evaluation of the NCR-LINX o DC Medical Examiner's Office is rarely asked to attend exercises, despite many of them involving fatalities and medical issues o Table-tops and practicals
Plans, Policies and Procedures	S	• Regional deployment procedures has been developed for radio cache • There is good information and intelligence from jurisdictions; needs central gathering point and inter-regional sharing/vetting mechanisms
	W	• Development of uniform intelligence gathering and investigational dissemination policies/basic validity vetting requirements/security clearance for health officials (10) • Need to implement regional information management procedures/link regional communication to WMATA communication (5) • Need to develop health information group with high level participation of law enforcement, fire/EMS, public health, hospital medical community to

Resource	S/W	Comments
		coordinate information sharing and provide basis for forensic epidemiology response/health intelligence MOUs/include medical examiner's office in emergency planning and training. (3) • Need more personnel to write plans, policies, and procedures/conduct audit of MOAs, MOUS and mutual aid agreements in NCR • FBIs jurisdictional boundaries are in conflict with COG boundaries in Montgomery County – hinders timely dissemination of information and actionable intelligence (3)

Interoperable Communications

Resource	S/W	Comments
People	S	• We have a core group of people that have been trained and have experience in interoperable communications. (6) • There is a common goal shared regionally. There are no opposing views. (3) • The entire region (except PG county) has all emergency agencies on 800MHZ. (3) • In interoperability projects we have identified and secured good communication, networking, enterprise and architecture for building new systems. (2) • Mobile Afis has technical people in place throughout NCR. • With the radio cache, we have begun training people as communication leaders in the incident management system • Data entry (within individual jurisdictions) • Agreements have been in place and people know/work with each other so that operationally when things happen there is commitment to get things done. • Technical leaders, day-to-day leaders, CIOs, etc., have a good strength of community. Have years of experience working together.
	W	• Need more people from the health care sector to work on interoperable communications activities. (5) • There is not enough staff to carryout regional efforts. (5) • Need to train new staff to replace those who will retire and beef-up overall capabilities. (3) • The health and transportation sectors also need to get on the 800MHZ. (2) • We need more trained people to evaluate our capabilities (gap analysis). (2) • There are no dedicated resources for dealing with regional emergencies. (2) • Need to win over technologies. • Need to increase number of personnel getting security clearance to increase information sharing. • Need more VOID partners to be included in interoperable communication activities. • Data transmission side of interoperable communications • Still relatively few, and not in very diverse

Resource	S/W	Comments
		geographical locations • Communication, networking, enterprise and architecture skill sets are (potentially) not maintained. • User knowledge and therefore habits of using these new procedures and interoperable systems not pervasive.
Equipment	S	• Radio cache (5) • Many (most) EMS, fire, police etc. agencies have/are spending to upgrade equipment to increase interoperability (4) • Computerized assisted telephone interviewing (CATI) system that helps public health manage isolation and quarantine situations., e.g., pandemic flu terror attacks, etc., is being piloted/developed; requires continuous funding (3) • Collection of data (2) • WebEOC being widely used to share emergency management information among jurisdictions, helping provide common operational picture. (2) • For voice communications, have obtained equipment from past years grants; have radio caches, trunk patching systems. • Interoperability is usually available with Feds • Equipment has been deployed • Some filter links have been built • Voice communication equipment is in place but needs to be maintained and updated • Will have enhanced fingerprint system in place throughout the NCR • Will have new mug shot system in place • EMS, fire, police, have compatible, interoperable systems • Have a network for public safety (voice) • Have 1250 radios, 5 future com repeaters, 6 Acute, ICRI • *Essence* is functions well and links all NCR hospitals with public health, local, state, epidemiologists • Hospitals funded for 800 Mhz radio network with linkages to all NCR hospitals; funded for WebEOC • Transportation include management plans and practices that follow NIMS • Transparent operating data would be integrated by the regional transportation information systems (RITI)
	W	• No redundancy; very little capability to rebuild

Resource	S/W	Comments
		communications abilities if it was lost. (6) • Need additional equipment, e.g., servers, fiber, 700 Mhz overlay capacity (4) • The region invests in a lot of equipment, but not all systems can talk the same language; need common platform (4) • Will require maintenance costs (4) • Reliance on commercial communication networks (e.g., Verizon) creates potential failure point due to heavy customer loads in a crisis. (3) • Don't have ongoing funding stream to maintain/sustain radio cache (2) • Communications unreliable in WMATA tunnels, trains. Need ongoing funding; absent that fix; is major communication gap. (2) • State and local level Law Enforcement is lacking secure telephone equipment (STE)-- hardline, cellular, fax, etc. • Don't have sufficient equipment to meet a regional incident; information and communications end users are at different levels, with different needs, in different jurisdictions. • Voice communications is still lacking some equipment. • Current capabilities don't meet "business requirement" (pg 39 workbook) • When resources from outside the region support, interoperability is very weak because don't have Mutual aid agreement/joint planning.. • Ability to communicate with WV, PA, etc., limited or absent. • Limited cellular coverage in Metro limits ability of customers to call 911 for help • Planning focused exclusively on response; Prevention and mitigation lacking • No overarching secure communications network and equipment to share classified information for prevention and mitigation. • WAMATA agency crosses all jurisdictional lines; belongs to all. Major deficiency in communications design; Many "single points of failure" in its design. • Lack of ownership of solution. • WAMATA deficiencies would affect ability to work in incident

Resource	S/W	Comments
		• Continuing concern: potential loss of interoperability because of FCC frequency re-banding • Dependent as a region on commercial services for data; mobile data units in cars rely on 1xrtt; in event of major incident, all on one system for both data and voice. • Need to tailor hardware and software to requirements of each of the RESFs. Input of users needs to be incorporated into what is planned. • Public health is using paper and pen to function on quarantine system at this point; does not work. CATI still in early stages. • WebEOC has multiple applications that can be shared with regions. Recipients of "sharing" must be able to open, read, use. • Digital vs. analog (inconsistent) • Data sharing is incomplete and needs additional capabilities • Procurement to replace system is five years out • Buying of equipment for equipment sake; just for "bells and whistles" • Protocols are too specialized and not necessarily for the benefit of the group • Lack of transparency across agencies and jurisdictions • Will require grant funding to obtain hardware and software • Will require wireless communication throughout NCR, phone cards on NCR wireless system • Lack of systems and equipment which allows IC within DC among agencies (MPD, Fire, DPW, DDOT, etc.) and with other NCR partners except by telephone, is a major problem • NCR stakeholders currently lack an overarching secure communications network and equipment for sharing of classified information across multiple jurisdictions and levels of government. RESF 13 has been turned down for technical assistance in the past • Red cross and other key VOAD partners under RESF 6, 11, and 15 need appropriate interoperable communications equipment and have adequate equipment to respond appropriately • Need mobile computering devices on every response vehicle • Patient tracking capabilities need to be increased

Resource	S/W	Comments
		• Equipment needs to be tailored to the needs of each RESF • Need to bring legacy systems up to date • CATI system needs turn over forward; currently looking at jurisdictional on same platform; next cycle needs to look at disparate platforms
Training	S	• Good training network in place (4) • Had initial training COM–T course (3) • Current technology experts will be able to train and update NCR as needed (2) • Radio cache • Will require minimal training throughout the NCR • Voice 800 mhz system is good on day to day operations
	W	• Training in communication types/protocols (6) • Cache training (3) • Need COM-L training but need to modify (3) • Limited familiarity in equipment (3) • Information availability/sensitivity need to understand the available systems (2) • Include health and transportation (2) • Need to incorporate data side of WebEOC (2) • Need training in SOA • Quick just in time response training • Availability understanding • Advance training for architectural personnel • Training needs to follow creation of incident command system • Enhance training for data communications • Not enough qualified people operate the system • Use of technology incorporated into training • Volunteer organizations need training • Health intelligence • Training needs to be tailored to urban settings • Equipment/systems need to be used everyday to reduce training
Exercises/Evaluation	S	• Incorporating communications among jurisdictions into exercises. (3) • Continued training for ESSENCE users after policies and procedures established. (2) • Large events (e.g. inaugurations) afford good opportunities for interoperable communications evaluation. (2)

Resource	S/W	Comments
		• Have monthly tests and we do a lot of trainings. (2) • Voice and data interoperable communications are capabilities that can be measured during exercises. (2) • Added EOC 1,2, and 3 to 800MHZ. Regularly exercise to practice patching into EOC communication center.
	W	• We need more training and more exercises. These exercises should include VOAD partners, incorporate lessons learned from after action reports, focus on integrating data, communications, and tracking systems into common use and help assess how interoperable communications will be involved/interact with other RESFs' activities. (36) • Planning, development, and operations throughout NCR should include exercises and evaluations. (2) • Need more protocol development. • Need to retest communications after policies and procedures established. • Need to know how interoperability affects bottom line. • Infrequent training/exercise schedule. • Exercise gaps are almost never addressed. • Only exercises to date have been internal of in a support role. • Minimal training in NIMS done in DC OCME • Many exercises are too big to have value; need smaller exercised to allow participants to identify pieces that are not working effectively. • Not good at measuring the effectiveness of non-exercise activities (e.g., inauguration.) • Need better communication and coordination with federal government. • Need to establish a common voice and data network across all RESFs. • Need to do a better job sharing critical AARs. • Need to create a health information group that draws together interoperable issues.
Plans, Policies and Procedures	S	• Executive agreements, MOUs, and mutual aid are in place and are multi-jurisdictional (police, EMS, fire) (9)
	W	• Keystone interoperability is a planned exchange of voice and data across traditional boundaries (it is not everyone talking to everyone)/governance is underdeveloped for voice and data/need master plan for network in region/path is clear, execution is

Resource	S/W	Comments
		weak/planned exchange includes filtering of key information (14) • Communication systems and processes need to integrate hospitals, first responders, and support (including public works, RESF #3 agencies), transportation function. (6) • Managing secure communications/sharing classified information across multiple jurisdictions and levels of government (2) • Don't have MOU in place for radio cache deployment (2) • Need regional standards for content of messages/information • Need to expand definition of "critical information" to include health intelligence (threat ID, patient tracking, resource availability)/3 medical communication centers need to share procedures/implement health information group (public health, hospitals, law enforcement, EMS, Medical examiner)/include Red Cross and similar organizations involved in RESFs 6, 11, 15 in interoperable communications planning. • Mortuary surge must be considered – include medical examiner jurisdictions in all exercises and planning • Need more practice in field • Information must be understandable/useful to end users – have not been successful with this in the past.

Law Enforcement Investigation and Operations

Resource	S/W	Comments
People	S	• Good communications and interactions with relevant agencies. (2) • Law enforcement is in good shape. • JIFTS helps with flow. • We have qualified forensic investigators • The team responsible for design and completion of the current and next phase of AFIS is functioning.
	W	• Need more staff including intelligence analysts, forensic epidemiologist. (4) • There is a lack of dedicated personnel. (3) • Additional personnel need security clearance but the process is very slow. (2) • Need to better integrate fire investigators with law enforcement. • LINX and AFIS enhancements will require staff and resources. • There is no contact with special operation or incident related personnel. • We need a designated intelligence office in each jurisdiction. • Should have additional cross-designated staff to assist in terrorism investigation ad evidence gathering. • Need to dedicate personnel to WMATA • Need for IMT trained law enforcement personnel.
Equipment	S	• Some IMT equipment procured • Initial installation of WMATA communication equipment to help support law enforcement operations • Current systems is in place and functional • Funding to complete upgrade of new AFIS in place • NCR has shown good coordination in acquisition of equipment for participating agencies
	W	• Interoperable computer systems for investigation of suspicious activity. Communication systems to allow for timely sharing of information. (2) • Lack of depth in PPE • Lack of warehouse space • Specialized response and work equipment needed for evidence collection technicians • Need to increase secure/interoperable communications network • Support LINX program

Resource	S/W	Comments
		• Law enforcement/operations are unaware of the equipment/we can effect in an event/incident/forensic aspect • Lack of knowledge of what equipment there is/utilization of that equipment • Fire investigators not equipped to handle investigations in a contaminated area • Specialized equipment needed to ease investigations/operations in the metro tunnel • Lack of equipment to handle investigations in a contaminated environment • Completed compliment of IMT CD needed to support operations • Out year completion of communication equipment is not defined • Current system is obsolete • Mobile facial recognition of AFIS is not funded. • Technology weakness prevents efficient regional investigations, secure data, voice, video technology LINX system • Maintenance of SCBA/cascade system/APR SCBA breathing
Training	S	• Fingerprint analysis will not change • Technical support will not change • New upgrade will require minimal training • Mobile AFIS will require minimal training • Initial IMT training provided to a few law enforcement personnel • Training in crime scene, forensic and bioterrorism investigations
	W	• Forensic Epidemiology Training (2) • Awareness level training for law enforcement in the metro system and WMD (2) • Public Health (PH) need training on the law enforcement systems currently in use. • Additional personnel need to be trained • Fire investigators need to be trained in contaminated areas • Lacking law enforcement participation in IMT • No coordination regionally on training • No one asks us to be involved in training in specific BIO/CHEM investigation • Need to find dedicated personnel, establish investigation protocols and train to them

Resource	S/W	Comments
		• Additional terrorism training as it pertains to the investigation of CBRNE incidents • Need more on PPE and response protocols • Interdisciplinary training • Train on a regional level
Exercises/Evaluation	S	• Some limited exercise were conducted involving IMT. • Current system is functional and used by the NCR. • Upgrade is a refresh and enhanced capabilities within the NCR.
	W	• Exercises must be coordinated across RESFs and jurisdictions. (2) • Exercised and evaluations of IMT need to be developed. • Lack of exercised and evaluations involving WMATA communications. • Need to establish accepted roles and conduct exercises accordingly. • Need to better include the DC Medical Examiners office in exercises. • Need to limit the scope of exercises. • Need exercises that focus solely on the investigation of a biological event related to suspicious activity. • Phase 2 mobile AFIS will require exercises and evaluations. • Need more multi-disciplinary training including heath investigations. • Specific exercises needed for technicians responding for evidence collection purposes.
Plans, Policies and Procedures	S	• Have policies, procedures, plans in place for what we do/who is responsible, but they need to be updated (3)
	W	• Law enforcement agencies are not incorporated so roles, procedures and boundaries are not defined when it comes to forensics. Need forensic epidemiology training, exercise, and protocols in NCR and in cooperation with FBI. (2) • Public health, hospital and healthcare officials need security clearances for health officers, risk managers, and deputies/policies and procedures are constantly updated as new intelligence is received. (2) • NCR boundaries conflict with FBI boundaries – results in delay in information exchange and weakness investigative thoroughness • Need basic procedures for regional tip line reporting, documentation, sharing of intelligence and

Resource	S/W	Comments
		information. • Support of LINX data sharing initiative

Mass Care

Resource	S/W	Comments
People	S	• The ARC is the mass care provider for the NRC and they have ample volunteers to handle mass care situations. (2) • There are established partnerships with in NCR to provide coordinated training recruitment, and retention activities for volunteers. (1)
	W	• Need to dramatically increase mass care capability, including volunteer staff. • Shelters are not special needs accessible and staff do not know how to accommodate people with special needs. (8) • Need to recruit, train, and credential volunteers to help in mass care situations such as staffing shelters. (8) • Need to work more closely with NGO's (Red Cross, etc.) to make sure all resources are coordinated. (5) • Need to increase number of behavior health specialist trained in stress management techniques in shelter situations. This staff should undergo cross jurisdictional credentialing. (2) • Further outreach to community based medical personnel to get them to engage in surveillance activity is important. • Need to increase MRC levels to provide medical care for short term and home visits. • Need to integrate private sector resources. • Need to educate people on how to access mass care services during time of emergency. • Need better understanding of exact needs of agencies. • Need trained animal care teams for pets. • Need to support drinking water stockpiles with additional staff. • Need continuation of UASI'05 funding to prepare for spontaneous volunteers. • MRC resources are inadequate. We need more volunteers.
Equipment	S	• HAN and other information disbursement systems are in place, but need to be maintained and expanded • Room secure system could be adapted to meet missing person tracking/recertification needs
	W	• Need basic supplies for mass sheltering; there is presently a shortfall (11) • Need safe and adequate food supply for populace,

Resource	S/W	Comments
		including special needs populations (6) • Lack of suitable shelters for potential numbers of people, especially those with special needs (6) • Need to ensure back-up generation for shelters (3) • Need to replace left-behind wheelchairs other durable medical equipment (3) • Tracking systems need to be implemented for people and supplies (2) • Need infrastructure to coordinate and recruit the thousands of volunteers needed to respond to the needs of the masses. (2) • Need alert and information system (2) • Need equipment to focus on public education; there needs to be a greater focus on self sufficiency and a partnership with the business community • Inadequate security staff funding • Need plan for medication supply and access • Many of special population do not have means to shelter in place • Need communications equipment to connect RESF 6 with emergency management and incident commanders • Need family reunification system • Need equipment and facilities to shelter pets and take care of service animals • Need child care equipment and supplies • Need greater capacity to transport people with special needs to shelters • Need system to credential volunteers • Vehicles needed/identified for gaps supporting department of human services • Need to include companion animals/pets in facility planning • Need better, regular sources of medicines special diets • Need accessible communication in shelters for PLOSN (blind, deaf, other disabilities) • Stockpile of supplies for PLOSN • NCR has limited capability to provide emergency drinking water supplies during the first 72 hours • More assistive technology is needed to meet the mass care needs of people with disabilities. • Need a real-time system that allows for management • Storage and capacity for food and shelter • Need all types of additional equipment in order to

Resource	S/W	Comments
		shelter and feed a large number of people • ND centralized system for citizens to register and assist selves with locating missing persons and/or recertification.
Training	S	• Updated and on-going training on WMD for community based physicians and other medical professionals is necessary. Some initial work has been done. • American Red Cross (ARC) has developed a regional training initiative to train ARC personnel in mass care related activities. Geared towards the capacity building of 'leaders' to supervise spontaneous volunteers. • MCR volunteers and Citizen Corp volunteers are trained and ready to be demobilized in each NCR • DC Armory provided good training but there were still problems with communication, there many messages sent out each based on its own protocol • Training is available year round
	W	• It is not possible to train people where to seek help if these locations are yet to be identified. (3) • Need Joint Training with RESF 6 and other RESFs (2) • To support this capability outcome. The NCR emergency responders require sufficient training to support transportation systems and resources. Currently sufficient training has not occurred due to a lack of sufficient resources. • Shelters are not available for pre-training use, for individuals who are the most difficult to serve • Training for providers in NCR to understand and use FAC Plan developed for NCR with 03 funds • Same as before – more training is needed in all-hazards environment NCR must work • Information not shared with SNP • No training specifically for SNP • Training volunteers/staff on what is necessary to provide mass care at a 15% population number • Those responsible for organizing and providing mass care lack the training to identify needs of people with disabilities and provide for accessibility • Need to exp and use of special need NGO's in preparing PLOSN to shelter and evacuation, and to provide planned, practiced transportation to shelters. • There have been no regional training for mass care

Resource	S/W	Comments
		• There haven't been much on local levels even on training for sheltering operations • Limit duplication • Good base, but need for greater supply of trained volunteers • Need to have ongoing volunteer training. Need to better define what we need people to do and develop training. • Need for integrated training opportunities across RESFs and across jurisdictions throughout NCR. To exercise opening multiple shelters across NCR. • Most training centers focus around response and immediate needs, not long term. • Need additional training in mass care feeding and sheltering • Need just in time training in mass care for spontaneous volunteers • Need cross training of RESF 6 and other VOAD and citizen corps programs • Must be able to credential volunteers to utilize volunteers ASAP across the NCR. • Not ready to deploy MRC volunteers across the region need for regional coordinator • Universal design and procedures are need to ensure full accessibility • Train many more staff (local government, NGO, faith communities, volunteer) in shelter management/operations • Do not have training of people working in shelters and training for shelterees • Not enough focus on training • After action report is out soon and will be helpful • Communities represented need to be included in the major exercises – mass care, health services • Business sector needs to be better utilized and included into the planning phase • Lack of access during surge situations • Training to address behavioral health impacts of disaster victims living in shelters need be provided to those staffing the shelters
Exercises/Evaluation	S	• ARC currently exercises with MWAA at Dulles Airport, Regan National Airport, and the Pentagon yearly • Exercises are available

Resource	S/W	Comments
	W	• Have not held any regional, multi-disciplinary mass care exercises (don't even have a framework) (4) • Insufficient inclusion of special needs populations in planning and execution of exercises (3) • Exercises insufficiently frequent (2) • Need accessible multiple practice events, plans for accessing multiple shelters and evacuating communities/locales (2) • Draw on all RESF6 partners to exercise and test mutually developed plans both via table-top and full-scale exercises (2) • People do not take advantage of available exercises • No general population exercise • No system-wide HAN test has been done since 2003 • NCR emergency responders have not exercised the Metro system mass care scenario due to lack of sufficient resources • Evaluations don't include realistic after-action • Exercises focus on response, not long-term (i.e., post-24 hours) events that require mass care • Exercises need to include provisions for drinking water and sanitation • Pets are a significant reason people do not evacuate; must be a component of exercises (60% of people have pets) • 211 system is not advertised as an emergency information system • No funds for exercise and evaluation of NCR FAC plan • Call-up and processing exercise for spontaneous volunteers • More training needed in all-hazards environment NCR must work • Need to encourage NGOs to conduct exercises on their own • Need joint exercises within RESF6 • Involve consumers/customers in planning and execution • Include volunteers in exercises
Plans, Policies and Procedures	W	• Incorporate the following groups into mass care plans; business sector, nonprofits, American Red Cross, Medical Reserve Corp, and hospitals and public health, MWAA, Loudon and Fairfax cities, federal government, military, non-affiliated volunteers. Need

Resource	S/W	Comments
		mutual support and consistency. (14) • Need a coordinated mass care plan for a diverse population including special needs population (disabled, non-English speakers, etc.) (8) • Family assistance centers and reunification systems are identified, but not implemented in the NCR. Also require funding (7) • Pet friendly shelters or alternative pet arrangements needed/MOUs with humane society, etc. (4) • 211 centralized call center with connection to emergency information is needed (2) • Need patient tracking integrated with family assistance plans (2) • Need to work on logistics, basic supplies, location for mass sheltering. Need a solid cohesive regional plan/rely heavily on American Red Cross for sheltering • Need food, bottled water, and ice plans (acquisition, storage, and distribution)/transport plans for supplies including pharmaceutical stockpiles/backup power plan for shelters • Need a transition plan from mass care to long-term care/recovery (1-5 years)

Mass Prophylaxis

Resource	S/W	Comments
People	S	• The MRC. (6) • Full time staff time is well trained, committed, and have participated in exercises (5) • Strong core group of planners working on regional coordination; well exercised. (3) • Curriculum is in place to train volunteers in mass prophylaxis activities (e.g., distribution). • Strength of people in area; know how to handle emergencies. • Successfully developed public information sharing mechanisms and messages. • SNS planners are very knowledgeable and dedicated. • Have good plans in place. • Working well with all levels of the government to coordinate activities.
	W	• Need to continue recruiting, training, and credentialing volunteers for mass prophylaxis activities including PODs, home quarantine, etc. It is important to keep volunteers committed. (22) • Priority needs to be placed on hospital staff and family receiving prophylaxis. (12) • MRC needs to be funded. Number of volunteers need to be increased and there needs to be standardized training for volunteers across all jurisdictions. (8) • Increase regional coordination of all relevant entities and planning for mass prophylaxis activities. (8) • Increased number of health care staff (MDs, RNs, and pharmacy) is needed to be trained in mass prophylaxis activities. This will increase all capabilities and decrease competition for staff in emergency. (9) • Need to perform study "gap analysis" to identify current number and skill level of MDs, RNs and pharmacy personnel in the region. (4) • Need clear identification of EMS/fire role in distribution of mass prophylaxis. (4) • Increased training needed in all areas, e.g. special needs response, dispersal, PPE training. (2) • Need better way of sharing information in advance. Need a regional message. Need a coordinated communication process for all emergency agencies. (2) • Need to increase the number of planners and staff to

Resource	S/W	Comments
		support mass prophylaxis. Need to incorporate lessons learned onto plans. (2) • Need full time trainers and exercisers to support teaching mass prophylaxis activities in NCR. (2) • Need to increase security and security training for non-law enforcement personnel to secure PODs. • Need to consider special populations. • Need system for credentialing volunteers • Need to increase number of emergency preparedness staff. • Need larger support from skilled volunteer force; can not rely on unskilled volunteers. • Need system to identify credentialed people. • Need to increase risk communication capabilities. • Need increase support from other RESFs. • Need to train more SNS planners for the NCR. • Need increase in assessment • Insufficient resources to support for staff of mass prophylaxis activities. • Increase patient tracking is needed.
Equipment	S	• Much of needed equipment has been identified (3) • Most prophylaxis equipment has been obtained (3) • This is one of the easier categories to apply funding and this has been done in the NCR (2) • Fit testing in place in some counties • Have satellite phones/pagers/cells – all useful; had regional JIC, but I believe funding is going away
	W	• Lack of adequate storage for antibiotics, antivirals, vaccines, and other supplies (13) • Need additional medical supplies for PODs and hospitals (13) • Need tracking system for patients and supplies (10) • Transportation capabilities for supplies and personnel is limited (7) • There is inadequate communications equipment established (7) • Pharmaceuticals need a better re-supply process (6) • Need standardization of/distribution of equipment (6) • No clear regional set of expectations for equipment; needs to be standardized across region (5) • Need more PPE (4) • Have not identified physical space to handle large number of patients (4)

Resource	S/W	Comments
		• Need stronger logistical capabilities (4) • Priority prophylaxis for first responders and fires receivers has not been adequately ensured (2) • Lack of emergency power supplies (2) • Need to address special needs, e.g., translation services (2) • Lack of effective serialized equipment • PODs are not interconnected • Need to enhance and integrate response capability • Need more money for management and prophylaxis • Need database of volunteers • Need laptops • Lack of common decision making tools • Need mobile unit to be available • Lack interoperability • Lack of equipment to support quarantine • There is not a common decision support tool/no place to go to monitor equipment/coordinate resources/people etc. • Do not have adequate number of hospital beds. • PIO can only provide information once it is provided • Volunteer supplies needed for MRC members, e.g., medical equipment, etc.
Training	S	• Training is on-going • Progressive MRC training on-going • Developing exercises • People are resilient in the NCR • Some hospitals in WHC have invested a lot of time in developing methods • full time staff well trained • Training/forums have been developed but we need more • Have been able to conduct some small scale events
	W	• Have not optimized regional approach (23) • Need behavioral health training (6) • Not all resources are known by all groups (5) • Need outline of what is required for volunteers (4) • EMS roles (3) • Educate staff/volunteers on operations of dispensing sites and hospital staff on recognition of disaster (3) • Encourage disciplines to learn different skills (2) • Many first responders can't get overtime for training (2)

Resource	S/W	Comments
		• Keeping volunteers trained/ready is challenging; needs to be addressed (2) • Training needs to be available to all RESF-8 (2) • Need to train non & quasi-medical staff (2) • Drills don't include Special Needs persons (2) • Maryland law does allow governor to suspend licenses. Need to pre-train some in the event of an emergency • More flexible methods to develop training • Don't have training academy for public health • Need "Just-in-time" training for spontaneous volunteers • Insufficient Training in IMS • Not provided in hospital environment • Special needs requirements • Backfill approach does not apply well to public health • No public awareness campaigns • No conference held for Special Needs Person • Don't have training to run multiple events • POD volunteer disciplines • POD security techniques training
Exercises/Evaluation	S	• Carrying out exercises. (8) • Coordination of exercises increase propensity of volunteer sharing. • PIOs are at the table while planning table-tops.
	W	• Need for different jurisdictions to train and exercise together to smooth out communication processes in case of an emergency. (9) • Need to have joint (multi-RESFs or discipline) drills on a regular basis to implement plans for working together. (7) • Infectious disease should be included in all other RESFs exercises. (5) • Need an exercise for process volunteers and MRCs. (4) • DAP analysis and other evaluation guidance needed to identify exercise needs. (4) • Need training for SNPs. (2) • Undefined roles for fire/ EMS. (2) • No plan for IMT to help facilitate management of public health emergencies. • Health care staff and agencies need training. • Need table-top with top-level officials for

Resource	S/W	Comments
		appropriating antibiotics needed. • Need exercises to test preparedness in hospital environments. • Need regional exercise to evaluate where first receivers really stand. • Need more exercises on public messaging. • Need to include medical examiners in exercises. • Need joint state and local drills. • Need incident management training for public health personnel. • Need more functional POD exercises. • Need regional SNS. • Need to exercise use of NCR triage barcode as a means to track victims from scene to hospital to communication of placement at the Red Cross. • Need to improve after-action reports.
Plans, Policies and Procedures	S	• Have a solid all-hazards response plan and local plans (4) • Jurisdictions have plans for operation of individual dispensing sites
	W	• Need for coordinated public information plan and public education plan that includes a medical component and reaches special populations (11) • Need to transport volunteers – plan to do so/transport of people and drugs, e.g., flu vaccine, to PODs (including special populations) require planning and security (8) • Dispensing plans are not fully developed and do not use a medical model/Need to develop baseline SOPs and mutual aid agreements/many legal questions with regional response that crosses state lines/need exercises as well (7) • Lack of transparency in development of plans particularly at federal level (4) • Medical Reserve Corps need to be connected to RESF #8 (3) • Need to adopt IM (ICS) to ensure organizational approach to mass prophylaxis is in compliance with NIMS (2) • Need to improve planning with hospitals and healthcare systems/need clear plan for provision of mass prophylaxis to health workers preferentially/plan for staffing sufficient to fully execute regional mass prophylaxis response/plan for hospital

Resource	S/W	Comments
		support/consistency among different health care providers and institutions • Lack of clear authority regarding quarantine decisions

Medical Surge

Resource	S/W	Comments
People	S	• Jurisdictional monitoring and surveillance for epidemiologists, *Essence*, are solid.
	W	• Having enough licensed providers is the limiting factor in surge response (4) • Need to connect surge plans and Medical Reserve Corp. volunteers who have medical training but are not integrated into planning (including credentialing, training, liability, IMS) (3) • Not enough qualified staff available to care for all special needs populations – particularly at their homes (3) • There is a severe and chronic shortage of healthcare professionals in the NCR (2) • Fire and EMS have a large role in dealing with medical surge (2) • Who is involved with a regional plan for responding to a jurisdictional event? • Virginia Medical Examiner's Office and hospital infection control/triage staff have limited ability to surge • Surge capacity depends on private sector response which may not be available • Need to provide for families of healthcare providers • Patient tracking and sustaining tracking systems like *Essence*
Equipment	S	• PPE has been obtained for employees through HRSA, but still need more (9) • Making headway in meaningful capability expansion (4) • CATI, *Essence*, patient tracking in effect, but requires additional funding (4) • Equipment needed mainly for communication can occur through EOC/NIMS (3) • UASI grant funding of equipment and supplies. Have begun to scratch the surface to put those supplies in place. • Equipment to be able to track people in non-traditional environments • Huge need to connect with people who are isolated/quarantined. Are systems in place, but need to be maintained and grown. • Disease surveillance capability. Utilizing essence.

Resource	S/W	Comments
		Been in place since around 2004. • Hospitals have approximately 72 hours worth of supplies to sustain normal operations. • Have more major medical educational facilities than other regions. • There has been some increase in the number of hospital beds and labs • The adult detention center in FX is identified as a potential site for alternative care
	W	• Need additional funds to procure equipment to supply critical care medical beds (24) • Need additional storage capacity; must be able to survive on our own for 72 hours. (9) • Need to track patients and equipment. (9) • Regionally lack the physical space to handle large number of patients (6) • Transportation (5) • Need increased capacity for safe storage of remains. (3) • Need to harden hospital facilities to withstand environmental assault, e.g., flood (3) • In worse case scenario have to plan for assistance that comes. Need to identify how would expand beyond your physical space. (2) • We need specific scenario oriented equipment such as burn, chemical, and Mark I kits (2) • Need to in crease maintenance and testing of special HVAC equipment (2) • Have received some funding but only around a million dollars which has provided some equipment, but not enough to meet the need of the area. Have major shortcomings that need to be addressed. • Sustainment and replacement issues. • Medical gases are a limiting factors. • Lab surge. • Physical space requirements for storage/triage/patient overflow for massive flow • Costs of preparedness are astronomical. • Need to keep in mind what constitutes a “bed.” • In a CBRNE event would need detection equipment at a hospitals. • Need a system that will allow the tracking of patients no matter where they are until they are released. • Need funding for evaluation and validation of this

Resource	S/W	Comments
		system to determine its efficiency/effectiveness. Will be useful for e.g., pandemic flu, etc. • Supplies are budgeted for 72 hours and for normal operations; unrealistic level of supplies for a crisis. Need to budget for surge and for longer period of time. • Plans do not have contingencies for communications failures. • Have limited if any surge capacity. • Shortage of healthcare personnel in this region. • Will not have capability to build surge capacity • Not aware whether or not medical personnel would be willing/able to assist in medical surge. • Cannot rely national resources to be available. • In national event can't expect federal help. • NDMS etc., need facility for federal resources to work. Will bring resources place., etc • Don't have appropriate infrastructure to mobilize. • Communication capacities for PIO need to be increased. • Need additional PPE equipment. (depending on what the CDC standard is) • DC 211, referral system. People need to be able to find out what to/not to do. Needs to be improved. • Need enhanced communications interoperability, e.g., CBDA, satellite, amateur radio, etc. • Hospital pharmaceutical supplies will expire • Equipment needs to be provided to other "non-hospital" organizations • Lack of NCR Plan/Resources to support decontamination at hospitals • No or limited capability for CBRNE detection at hospitals • Need to increase credentialing capabilities • Lack of logisticians to stockpile medical treatment equipment • Need real time or near real time alerting system (current is 48 hours) • Need technology to support *Essence* • Need to support Special needs population • Need to equip labs (agricultural etc.) to provide medical lab surge • Unaware as to whether equipment can handle constant use
Training	S	• Staff is adequately trained because of their license (5)

Resource	S/W	Comments
		• WHC has internet based educational system that could be increasingly helpful to all disciplines • Competency based training • Online resources • A lot of training curriculum available
	W	• A standardized training for scenario based training which involves live and web based training with trackable competency (18) • Staff may not handle mass casualty well because training size and nature is not on that scale (10) • Lack of PPE Training for community MDs and office (7) • Training for medical volunteers (6) • Disaster behavioral health (6) • Training on ESSENCE for public health/hospital personnel (5) • Support of Special Needs Citizens (5) • Training in management and systems for alternate care facilities (4) • Public education (4) • What is needed to support decontamination needs at hospitals (3) • Integration of roles between first responders and health (2) • Hospital/PH-HD/interface (2) • No training model for surge capacity (2) • Training for additional people (2) • Lack of rapid air monitoring for ID of CBRNE attacks and characterization of plans (2) • EMS role of assisting hospitals • What will fire department need to support quarantine plan • Training for non-medical volunteers • Need to practice NIMS-incident command • Epidemiological training/surveillance • Training on desired plan practices • No framework for JITT • Assigning local staff and training in roles • Lack of information exchange • Online resources have not been tapped effectively • Need blast fax/contact info • Backfilling staff while they are being trained • Need more creativity in training

Resource	S/W	Comments
		• Sustainability
Exercises/Evaluation	S	• Currently exercise regularly. (2) • Hospitals are required to train and exercise on an ongoing basis (JACHO). • Value of standardizations • IC is the same no matter the scenario. • Hospitals have twice yearly requirements need. • Northern Virginia military is beginning to consistently include behavioral healthcare. • Planning an exercise for 2006. • Have exercised decontaminations.
	W	• Need more regional, multi-RESF trainings that, among other things, exercises/tests mobilizations, procedures for handling hospital surge outside hospitals, handoff form hazmat to EMS, volunteers, behavioral healthcare abilities, capabilities regarding special needs populations, federal involvement in response, and surveillance systems. (51) • Need to centralize all evaluated weaknesses so that they can be prioritized and addressed. (4) • Hospitals and public health do not practice ICS and NIMS to the same extent as police and fire. (2) • Massive staffing required to conduct a real-time exercise since hospitals operate 24/7. • Need more creative or non-traditional exercise methodology. • Need to fill positions in order to train personnel. • Need a MRC exercise. • Never held a real surge exercise of a significant number of victims to stress the NCR, DOH, EMA, and hospital plans and systems. • Need to institutionalize new HSEEP exercise guidelines. • Exercises should reward identification of deficiencies instead of rewarding success. • Need public awareness campaign. • Need performance metrics related to requirements of electronic systems effectiveness.
Plans, Policies and Procedures	W	• Need to develop integrated plans to include: understanding of HIPAA as it applies to sharing information across agencies or jurisdictions, development of a coordinated public education campaign, coordinate mass transport, addressing legal and credentialing issues, development of mass fatality

Resource	S/W	Comments
		management plans, surge planning beyond hospitals, incorporation of insurance providers, develop detailed scenario specific plans, include medical examiners in planning. (18) • Family planning for health care providers so that they can come to work (2) • Standards of care decisions under different scenarios need to be developed (major shift for health professionals) • Need to develop plans to help with local implementation of federal orders as they apply to quarantine • Plan to communicate with public on what to expect • Need a gap analysis to identify issues like the need for alternative care facilities and staffing, special populations sheltering, medical care for people in quarantine

Planning

Resource	S/W	Comments
People	S	• We have qualified, experienced subject matter experts. (2) • Health and hospitals have great plans and collaboration processes. (3) • All jurisdictions have planners. • Have ETOP exercise training oversight panel
	W	• Need more planners to address regional issues. (10) • Need to have discipline (law/fire/public health) integration. (5) • Need subject matter experts to be funded to participate in various planning processes such as exercises and drills. (4) • Need to incorporate experts into planning process. (3) • Need to integrate traffic management systems with operating procedures. (2) • ESSF8/Public Health is continually confronted with new threats. To combat this, there needs to be augmentation planning, training, and management personnel from public health in the NCR. • We need to model the 15 DHS scenarios to ID the extent of recovery requirements for the NCR to learn what we don't know about recovery planning. • Need to develop an NCR plan coordination committee. • Need to designate planning staff to support operational functions. Cannot write plans by committee. • Need an organizational structure to apply specialists. • Need better agreement between Feds, states, and local governments to operate together. • Do not have designated regional planners for fire. • Need a process to decide what plan is needed during an emergency. • Lack of health personnel on planning panel. • Need to integrate non-profits and private sectors.
Equipment	S	• Inventory of assists deployment methods • These meetings helps organize and gather ideas to use equipment for multiple projects
	W	• Need inventory management system in the region that reflects what critical assets exist (5) • Need dedicated planning equipment for NCR; need computer databases scenario driven programs connected to critical infrastructure (4)

Resource	S/W	Comments
		• Need to validate effectiveness of first responders PPE (4) • Need to improve communications (2) • Need video conferences and other tools to bring people together • There need to be tools available to aid in the response that all agencies can share • Need continued funding for *Essence* to enable downloading of exercises • Debris equipment usually not considered essential in planning/UASI process; first responders dominate all discussions of equipment • Standardization of specifications of detection equipment • Need online infrastructure that can support training and credentialing/tracking of all RESF 8 responders (hospital, public health, MRC, EMS, private physicians)
Training	S	• Training can be funded by DHS • Training in RICCS and virtual J/C (VJIC) • NCR does an excellent job of training
	W	• Cross RESF training opportunities • Coordination of training to respond to after action items from events, exercises • Unlike other responder groups, RESF 8 does not have a training curriculum, academy, nor can make use of overtime or backfill. RESF 8 is forming a steering committee and work group to set regionally standard curriculum and leverage online trainings, but need personnel (planning, training, technology) and technology equipment to support this. → not all needed courses currently available • No coordinated NCR training for planning exists that is consistent across all region • Training on plans, continuous effort to include follow up on daily basis to include other disciplines • Capacity of disciplines to train and keep people abreast on changes. • Need to better define the goals to establish training that will facilitate exercises. (need connection between training and exercises). Evaluation should lead to new planning exercises. • No methods for "work place" training exercises • Lack of "feedback" methods to change

Resource	S/W	Comments
		• Need training on planning • Need to conduct trainings on regional energy emergency plan for emergency liaison officers • New training modalities to enable health participation • Development of resources and materials for implementing emergency transportation – plans/procedures • When coordinated – complete plans are developed, the regional partners will need training • If/when training – what plans are you training to? • Have not developed a plan to train field-level personnel • Development of resources and materials for implementing emergency transportation plans and procedures • Training of fire/police related to hazard detection devises. • Need integration of health in to training of other RESFs → need higher level training on health, medical and behavioral health
Exercises/Evaluation	S	• UASI '05 funds being used to develop a debris-specific tabletop exercise • Continued funding for ESSENCE that will enable system evolution and exercises • Training can be funded by DHS • Individual agencies have their plans and discipline; specific planning seems to be in-place • Standardization of template for exercises to include all disciplines • Plans are well integrated within individual jurisdictions • Development of health subject matter • Coordinated regional medical prophylaxis exercises and real-life experiences • New delivery methods of exercise for using own "workplace" exercises
	W	• Greater integration of health and medical agencies into exercises (including participation of health matter experts) (3) o Health and hospitals need membership on ETOP o Participation of health matter experts • Lack effective incorporation and implementation of lessons learned from exercises (3) o System to track action items from After Action

Resource	S/W	Comments
		Reports, including tracking solutions and resolutions o Accountability for making certain gaps and weaknesses are fixed o Corrective action program needs to be managed more effectively at regional level • Exercises and plans do not comprise the entire NCR and all functional disciplines (3) • Testing of jurisdictional assumptions to identify gaps (i.e., signal timing strategies) (2) • Integrate RESF-15 into all exercises (2) • Incorporate all RESFs (including 6, 14, and 15) and nonprofit and business sectors (2) • More training with media (2) • No capacity of people or support adequately to integrate plans across jurisdictions (2) • We need to model the 15 DHS scenarios to ID the extent of recovery requirements for the NCR to learn what we don't know about recovery planning. • Debris removal not included in most exercises • Sharing of best practices • Funding needed • Real-life events as case studies • Need regional exercise to test the regional energy emergency plan • Federal involvement in all exercises • Joint exercises on planning and response, similar to events like the inaugural • Objectives need to be thoroughly defined and matched to training
Plans, Policies and Procedures	S	• Good health care plans in place- ESSANCE will help with continued function of this plan. (3) • The NCR has a strategic plan. (2) • Individual agencies have their plans in place. (2) • Have local mutual aid agreements for fire.
	W	• Need to integrate plans cross-jurisdictionally and cross-disciplinarily. (8) • Need to establish a plan/ procedure for regional NCR. (8) • Lack of overall integration plan architecture. (3) • Need new RESF-15 planning. (3) • Need new RESF-14 planning. (3) • Need RESF-6-wide planning. (2) • Need RESF-11 planning. (2)

Resource	S/W	Comments
		• Need an integration of all regional transportation plans and the incident management plan and procedure. (2) • Need to integrate RESF15 into pandemic flu plan. (2) • Unclear how NCR strategic plan will be integrated. (2) • Need decreased disconnect between federal, state and local needs. (2) • Need more plans to communicate with SNPs. (2) • Need help developing mutual aid agreements for public works department. (2) • Need cross RESF planning. • Need to develop strategic plan for emergency preparedness training. • Identify what plans are needed. • Assign ownership to plans so someone/ some organization is responsible for development and maintenance. • Need development of "clearinghouse for tools." • Need to update the regional emergency energy plan on a regular basis. • Need to better consider recovery plans (and debris function) in other plans. • Need more local-to-local sharing of exercises, trainings, and best practices. • Need to refine COOP plan. • Need adequate plan for first responders' families whose family is on extended work hours. • Need regional logistics maintenance plan. • Need plan to go beyond RESF to include NIMS. • Need new planning for community engagement working group. • Health needs to be included in multi-disciplinary exercises.

WMD/Hazardous Materials Response and Decontamination

Resource	S/W	Comments
People	S	• We have well trained staff that can handle and decontamination. response. (5) • There are multiple levels of trained personnel for living casualties.
	W	• Need better coordination between field decontamination and hospital responders as well as better management of contaminated points. (3) • There is not enough staff to cover all shifts during a disaster. (3) • Need more Regional coordination of training, response, and equipment purchase. • Personnel shortfalls lead to weakness in ability to meet response targets • Need more NGO's and volunteer staff to conduct mass care response within WND incidents. • The current decision making model does not allow for quick, cross-jurisdictional decisions during hazmat incidents. • Need to train non-emergency staff of decontamination. • Need more decontamination staff for human remains. • Can not act quickly: 1) rapid assessment teams do not meet the 15 minute window of response and 2) we are unable to deploy the Type II IMT team in less than two hours. • Need to invest more in staff for mass care activities. Specifically we need more behavioral health, and public information specialists while responding to and recovering from WMD incidents. • Outside of law enforcement few L.E.O. are properly trained in hazmat response. • There is a limited cadre of healthcare staff trained in decontamination. • Do not have adequate police personnel in NCR based on the required mission. • Need more coordination between federal and state governments.
Equipment	S	• Many hospitals have response trailers with decontamination equipment • Many hospitals funded for intelligence and decontamination equipment and PPE • Equipment available in house for response-refrigerators

Resource	S/W	Comments
		• Good to excellent equipment in the NCR • Each jurisdiction has HazMat response capabilities • Have structured level B PPE and A • Robust regional communications • Interoperable communication surge capacity • Through HRSA have purchased basic equipment • Fire and EMS has coordinated well on the regional level (not necessarily with the feds though)
	W	• Need Additional PPE Equipment (8) • Note enough decontamination equipment for sustained response (4) • Need additional storage space (3) • Need regional standards for equipment (3) • Mass care equipment and supplies (2) • Not enough detection equipment for sustained response (2) • Chemical antidote equipment • Unequal capabilities amongst healthcare facilities • Upgrades in equipment lacking • NCR needs better inventory and coordination of its equipment • Lack communication equipment between HazMat to mass care • Lack of towels blankets and clothes to receive and handle people coming from decontamination • Public notification and warning system • Not enough radiological detection capability • Inability to quickly determine release • Need long term breathing apparatus • Initial response complement unable to detect hazard (HazMat, CBRNE) • Ability to decontamination large numbers in cold weather • Sustaining current response capability • Ability to quickly triage during a mass casualty event • Mechanism to determine equipment priorities and interoperability • Bomb squads lack appropriate equipment to address explosive aspect WMD response and multiple WMD incident especially when combined with required times to contain, mitigate events and/or limit affected area. • Availability of equipment for mortuary surge

Resource	S/W	Comments
		• Not enough Mask I kits or treatment • Shelf life of many supplies and equipment –need for replacement/maintenance • Region has not fully identified the equipment and resources needed. • NCR emergency responders lack equipment to effectively respond to incidents in the metro system • Need more capacity and specialized equipment and coordinating resources • Need more focus on inventory and resources that are not used everyday
Training	S	• Medical training available in house and at conferences and institutes • Mechanism to deliver programs
	W	• Regional standardized training (8) • Training need for water and wastewater personnel • Training across RESFs to address decontamination expectations • Only minimal training of personnel • Not training with agencies • Training between RESF-10 and RESF-6/8 for post decontamination • Training for public on how detect hazmat situation • Insufficient training and awareness for first responders • Ability to maintain IMT • More training for handing off remains to mortuary responder • Financial assistance for training • Constant change of hospital staff • Training how to secure mass care facilities • Training for the public • Training for hospital staff on victims that self present • Uniformed metro system training • Need exercises show the gaps and deficiencies and the best to improve ; we need more • More focus on recovery training • Need trained microbiologists
Exercises/Evaluation	S	• DC Medical Examiner conducts in-house exercises. • Some NCR exercises in CBRNE have been done.

Resource	S/W	Comments
	W	• Need more exercises that incorporate detection, decontamination, post-decontamination handoff, and mass care response. (8) • Need multiple RESF integration and coordination. (5) • Individual disciplines need to practice their responses and skill with equipment to reinforce lessons learned in training. (2) • Need to include Medical Examiner in exercises. (2) • No continuous regional exercise or evaluation process for the NCR (lack of consistency). (2) • Lack of funding for appropriate evaluation of routine training exercises. • Need to test emergency responders and mass transit employees' capability to respond to an incident involving the metro system. • Few staff have experience with PPE. • Need cross-jurisdictional exercises involving fire and hospitals. • Do not know what support will be needed from public works.
Plans, Policies and Procedures	S	• Have existing efforts in place to handle the mass casualty gap
	W	• While first responders have SOPs in place to indicate who's in charge, recovery procedures do not identify/define what is clean or who is in charge/lack of on the ground recovery plan/for NCR/WMD and HazMat operations plans/regional consistency particularly in dealing with jurisdictional issue. (7) • Must plan for dealing with contaminated water treatment systems and disposal of decontamination material and contaminated infrastructure./Integrated, standardized decontamination plans for recovery personnel at hospitals and in the field (7) • Lack of coordination with fire, rescue, state, and federal agencies/ MOUs between EMS and healthcare facilities/Medical Examiner/WMATA (6) • Protection response for general public/what to do in case of HazMat incident • Lack of protection in place/evacuation criteria in place • Incorporation of appropriate professional organizational planning • Plans to minimize panic/hysteria following CBRN incident and relative to re-occupancy/recovery operations planning

Resource	S/W	Comments
		• Death and WMD is a reality – dealing with this result needs to be part of planning for a response • Law enforcement need to establish mutual aid similar to Fire • Enhance timely communication with mass care leaders/law enforcement/EMS hospitals • No regional standard for detection capability