ALIGNING ACTION FOR HEALTH

Emergency Management & Community Resilience:

A Capacity-Building Toolkit for Health Centers*

Updated: November 2017

RAND CORPORATION

PRIMARY CARE DEVELOPMENT CORPORATION

* This toolkit is a working document and being updated electronically.

Contents

About LPHI
The Louisiana Public Health Institute (LPHI), founded in 1997, is a statewide 501(c)(3) nonprofit and public health institute that translates evidence into strategy to optimize health ecosystems. Our work focuses on uncovering complementary connections across sectors to combine the social, economic, and human capital needed to align action for health. We champion health for people, within systems, and throughout communities because we envision a world where everyone has the opportunity to be healthy. For more information, visit www.lphi.org.

Acknowledgements

The Louisiana Public Health Institute (LPHI) administers the Primary Care Capacity Project (PCCP), a project of the Gulf Region Health Outreach Program (www.grhop.org), which is designed to strengthen healthcare in the Gulf Coast communities of Louisiana, Mississippi, Alabama and the Florida Panhandle after the Deepwater Horizon oil spill. The purpose of PCCP is to expand access to integrated high quality, sustainable, community-based primary care with linkages to specialty mental and behavioral health, and environmental and occupational health services.

In order to create a network of shared learning and collaboration among these coastal health care providers, PCCP designed the Regional Care Collaborative. The Collaborative is a cross-sector partnership including over 25 organizations compromised of coastal primary care practices, state primary care associations, and many strategic project partners, including universities, public health institutes and health departments. This coastal network quickly identified emergency management as a shared priority among the partners and raised the question– how can the Gulf Coast primary care system be optimally prepared for emergencies, and coordinate to speed recovery efforts in the aftermath of an event?

In response to this special interest, the Louisiana Public Health Institute developed the Emergency Management Initiative (EMI) with the following key project partners:

- RAND Corporation – to provide expertise, tools, and resources in community resilience
- Primary Care Development Corporation (PCDC) – to provide expertise, tools, and resources in primary care emergency management programming
- Four Primary Care Associations (PCAs) – to support and lead capacity building efforts for primary care practices.
  - Louisiana Primary Care Association (LPCA)
  - Mississippi Primary Health Care Association (MPHCA)
  - Alabama Primary Health Care Association (APHCA)
  - Florida Association of Community Health Centers (FACHC)

The project partners were selected to create a comprehensive approach to emergency management design by providing both primary care emergency management and community resilience expertise, spanning from planning to response to recovery. The overall goal of the EMI is to build the capacity of the PCAs and community health centers across the Gulf Coast through network collaboration, resources, toolkit development and coaching.

The Louisiana Public Health Institute supports the *Emergency Management and Community Resilience: A Capacity-Building Toolkit for Health Centers* and would like to acknowledge the following individuals and organizations for their contribution to EMI and development of this toolkit.

Barrie Black, LPHI
Dr. Anita Chandra, RAND Corporation
Jamie Giepert, LPHI
Lauren Gordon, APHCA
Lori Hinga, Nurse Consultant with LPHI
Tom Knox, FACHC
Tiffany Netters, LPCA
Dr. Alex Priebe, formerly LPHI
Kristin Stevens, PCDC Consultant
Elizabeth Thornton, RAND Corporation
Shermaile Williams, MPHCA
Wanda Rose, JCHCC

Introduction

Community Health Centers (CHCs) have been engaged in emergency management activities to varying degrees for many years. For some, the engagement has been due to experience with actual disasters, while for others, it has been the results of regulatory recommendations.

The Centers for Medicare and Medicaid Services (CMS) new requirements effective November 2017, *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers*[1], significantly enhance the existing regulatory requirements. CHCs are well-positioned to implement new CMS requirements, as HRSA PIN 2007-15 language is echoed in CMS. As a result, many of the activities required by CMS are already in place. These new requirements offer participating providers with guidance to safeguard human resources, maintain business continuity, protect physical resources, and establish a more coordinated response to disasters. It is important to note that CMS provides requirements for maintaining, not just creating a preparedness program. Program maintenance through plan updates, training, and exercises, is essential to the safeguarding of patient health, supporting community response, and continuing essential services.

To offer high quality health services to patients and community members during and post-disaster, it is critical for emergency management and planning efforts to be integrated into internal operations. The NCQA Patient-Centered Medical Home (PCMH)[2] is a model of care that emphasizes the importance of care coordination and communication in transforming primary care putting the patients at the forefront. In the rapidly evolving health care environment, it is essential for organizations to maximize resources to ensure compliance with the requirements and/or responsibilities of various programs/projects.

To promote the implementation of a well-designed emergency management program, operational strategies have been developed to encourage integration of PCMH requirements into the emergency management plan. Quality Improvement/ Performance Improvement is an ongoing organizational process involving a multi-disciplinary team and/or committee very similar to that of the Emergency Management (EM) committee requirements.

With natural and man-made disasters becoming more frequent and increasing in cost of recovery, the need for CHCs to plan and work together with other community stakeholders has never been more important. Since CHCs are integral parts of the communities in which they serve, they are uniquely positioned to harness community strengths and resources, identify community vulnerabilities, and support the development of broader community resilience approaches.

[1] Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers; Final Rule, 42§CFR 403,416,418 et al. September 16, 2016.

[2] http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh

Strategies for addressing community needs should not only be developed, but also continuously updated in collaboration with external planning efforts throughout the community, as well as at the state, regional, and national levels. Adopting and integrating strategies that increase community resilience will optimize and supplement CHCs' emergency management activities and overall disaster recovery capacity. Because resources are limited in the wake of disaster, it is increasingly recognized that resilience is critical to a community's ability to reduce long recovery periods after an emergency.

Community resilience is defined as a community's ability to prepare for, respond to, and recover from adverse events—both natural and manmade—such as a hurricane or an oil spill, which can have impacts that threaten the health of all. Community resilience, particularly in the context of public health, entails the ongoing and developing capacity of a community to account for its vulnerabilities and develop capabilities, which aid in: (1) preventing, withstanding, and mitigating the stress of a health incident; (2) recovering in a way that restores the community to a state of self-sufficiency and at least the same level of health and social functioning after a health incident; and (3) using knowledge from a past response to strengthen the community's ability to withstand the next health incident.[3]

Achieving community resilience uses community engagement and cross-sector stakeholder collaboration for planning, preparedness, and response activities, while also promoting the inclusion of vulnerable populations that need additional support. Community resilience requires involvement from a range of community members, community-based organizations, and faith-based organizations during emergency planning activities and working together with public health, first responders, and other government agencies to broaden the understanding of disaster preparedness to include community health and well-being. Additionally, recent emphasis on healthcare coalitions and partnerships supports a broader, community-based focus. When compared to traditional emergency management frameworks, the resilience framework places less emphasis on individually-focused preparedness efforts. Community resilience is about transitioning disaster planning and response from the "me" to the "we," and from the "we" to the "us."[4]

[3] Chandra, A., Acosta, J., Stern, S., Uscher-Pines, L., Williams, M., Yeung, D., Garnett, J., and Meredith L., *Building Community Resilience to Disasters: A Way Forward to Enhance National Health Security*, Santa Monica, Calif.: RAND Corporation, TR-915-DHHS, 2011. As of September 21, 2017: http://www.rand.org/pubs/technical_reports/TR915.html

[4] Chandra, A., Charles, A., Hung, P., Lopez, A., Magana, A., Rodriguez, Y., Williams, M. *Resilience Builder: Tools for Strengthening Disaster Resilience in Your Community.* [Online Toolkit result of a collaboration between the Los Angeles County Department of Public Health, Emergency Preparedness and Response Program, RAND Corporation, and Community Partners]. As of September 21, 2017: http://www.laresilience.org/documents/resilience-builder.pdf

Using the Toolkit

This toolkit is intended to be used by Federally Qualified Health Centers (FQHCs) and Primary Care Associations (PCAs). However, the tools and concepts are relevant to any primary care center, especially Look-Alikes, Rural Health Centers, and other CHCs. This resource is not just a series of templates but rather it is a coaching tool designed to help create a well-prepared primary care system that supports the timely recovery of a health center's community and operations. Emergency Management does not have to be seen as an additional task, but can be integrated in both clinic operations and community outreach.

It is recommended that an individual employed by the organization serve as project lead responsible for ensuring completion of toolkit and final review, while a team completes assigned activities. Note that not all activities will be relevant for every CHC. At a minimum, the activity checklist should be used to review program status. The toolkit should be reviewed in its entirety before beginning. Based on a CHCs needs, some may find it helpful to determine their own order for completing activities.

This toolkit is a guide designed to reflect elements of regulatory requirements as well as best practices for preparedness. Users are advised that this guide does not substitute for any formal guidance for meeting regulatory requirements.

Common Acronymns

APHCA	Alabama Primary Health Care Association
ASPR	Assistant Secretary for Preparedness and Response
CHC	Community Health Center
COOP	Continuity of Operations Plan
CMS	Centers for Medicare and Medicaid Services
EHR	Electronic Health Record
EM	Emergency Management
EMC	Emergency Management Committee
EMI	Emergency Management Initiative
EOC	Emergency Operations Center
EOP	Emergency Operation Plan
FACHC	Florida Association of Community Health Centers
FQHC	Federally Qualified Health Center
GRHOP	Gulf Region Health Outreach Program
HRSA	Health Resources and Services Administration
HVA	Hazard Vulnerability Analysis
ICS	Incident Command System
LPCA	Louisiana Primary Care Association
LPHI	Louisiana Public Health Institute
MOU	Memorandum of Understanding
MPHCA	Mississippi Primary Health Care Association
NACHC	National Association of Community Health Centers
NCQA	National Committee for Quality Assurance
PCA	Primary Care Association
PCCP	Primary Care Capacity Project
PCDC	Primary Care Development Corporation
PCMH	Patient-Centered Medical Home
QI/PI	Quality Improvement/Performance Improvement
TRACIE	Technical Resources, Assistance Center, and Information Exchange

Work Plan Sections (1-14)

1. Developing and Maintaining an Emergency Plan

<table>
<tr><td colspan="2">Purpose
An emergency plan provides the basic framework that your Community Health Center (CHC) will use in responding to emergencies. Both the CMS Rule and the HRSA PIN 2007-15 lay out requirements and recommendations for emergency planning. Some states and accrediting bodies such as The Joint Commission have planning requirements as well. The emergency plan not only provides the framework for emergency response, it also serves as a guide for trainings and exercises. It is the foundation of any emergency management program.</td></tr>
<tr><td>Activities (A-D)</td><td>A. Review Existing Plans
Identify, obtain, and review any existing facility emergency preparedness protocols, procedures, or policies. This may include:
Emergency plan (also: emergency operations plan, disaster plan)
Continuity of operations plan (also: business continuity plan)
Infection control protocol
Evacuation plan
Shelter in place policies and procedures
Emergency agreements with community partners
B. Review CMS Rule
Review CMS rule[5] (pg. 183-184 or 64041—Part 491-Certification of Certain Health Facilities) and general resources found below:
Develop and maintain plan that must be reviewed at least annually
Plan should be based on and include a documented, facility-based, and community-based risk assessment, utilizing an all hazards approach
Include strategies for addressing emergency events identified by the risk assessment
Address patient population, including but not limited to the type of services the CHC has ability to provide in an emergency and continuity of operations, including delegation of authority and succession plans
Include a process for cooperation and collaboration with local, tribal, regional, state, and federal emergency preparedness officials’ efforts to maintain an integrated response during a disaster or emergency situation, including documentation of efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts</td></tr>
</table>

[5] Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers https://www.federalregister.gov/documents/2016/09/16/2016-21404/medicare-and-medicaid-programs-emergency-preparedness-requirements-for-medicare-and-medicaid

	C. Maintain Plan Develop protocol for reviewing Emergency Operations Plan (EOP) and associated policies on an annual basis**.** This may include: • Plan maintenance section of EOP • Integration of clinic policy review protocols • Document as required by CMS **D. Plan Update/Development** Using checklists, tools, and sample language in resources below, review CHC's current plan. Identify gaps in existing plans and make appropriate updates. Note: Some elements of the emergency plan are included in other parts of this curriculum. Putting in placeholders in the plan or skipping ahead in the curriculum may be necessary.
Tools and Templates	1.1 New CMS Rule Check 1.2 Sample EOP Table of Contents 1.3 Plan Maintenance Policy Language 1.4 Interim Plan Updates Tracking 1.5 Hospital Emergency Management Program Checklist 1.6 Hospital Evacuation Plan Checklist 1.7 Hospital Shelter in Place Planning Checklist
Outcome	☐ Emergency plan has been developed/updated annually
Additional Resources	**General Resources** National Association of Community Health Centers http://www.nachc.org/health-center-issues/emergency-management/ *Emergencies Happen: An In-Depth Guide to Emergency Management for Health Centers*: http://www.aachc.org/wp-content/uploads/2014/01/Emergencies_Happen_-_Prepared_Now_FINAL.pdf **Gulf Coast Primary Care Associations** Louisiana: http://www.lpca.net/main/programs-and-services/emergency-preparedness Mississippi: http://www.mphca.com/resources/emergency_preparedness.htm Alabama: http://www.alphca.com/trainings/emergency-preparedness Florida: http://www.fachc.org/emergency-management **CDC Guidance** https://www.cdc.gov/phpr/healthcare/documents/hah_508_compliant_final.pdf • Staffing Considerations – Pages 27-29, Patient Reception – Pages 35-37, Evacuating Horizontally and Vertically – Pages 38-41 **CMS Resources:** http://bparati.com/Healthcare-Emergency-Preparedness-Risk-Assessment-and-Planning-Resources https://asprtracie.hhs.gov/documents/cms-ep-rule-resources-at-your-fingertips.pdf https://asprtracie.hhs.gov/cmsrule **HRSA PIN 2007-15:** https://bphc.hrsa.gov/about/pdf/pin200715.pdf

2. Formation and Management of a Multidisciplinary Emergency Management Committee (EMC)

<table>
<tr><td colspan="2">Purpose
A multidisciplinary committee is essential for an all-hazards approach to emergency management, ensuring that different areas of expertise are represented and incorporated into planning and response. A well-functioning team will be crucial to integrating EM into the daily practice operations. Team members may overlap with your quality improvement team.</td></tr>
<tr><td>Activities (A-C)</td><td>A. Determine EMC Membership
Review and update committee roster. Ensure multidisciplinary approach by recruiting members with diverse job functions to include on committee. Ensure there is a lead determined to manage committee meetings and activities. Refer to CMS guidelines for further guidance on who should participate.

B. Integrate EMC Committee
Consider integrating Emergency Management Committee responsibilities into the existing QI/PI Committee accountabilities. Managing patient care is a team effort that involves clinical and nonclinical staff interacting with patients and working as a team to achieve stated objectives. The clinician leading the team is integral to determining and enacting the processes established by the practice. The emphasis is on ongoing interactions of team members to discuss roles, responsibilities and communication. Having the Emergency Management Committee report into the QI/PI Committee or otherwise coordinate with that committee ensures that emergency management will have regular and frequent exposure to a broader range of stakeholders. It also serves to reinforce the importance emergency management to safe patient care.

C. Create EMC Meeting Agenda
Having a standard meeting agenda will ensure a consistent approach to emergency management. Review past meeting agendas to determine major topics covered. Review the sample meeting agenda and modify as needed to suit organizational needs to create standard meeting agenda template.</td></tr>
<tr><td>Tools and Templates</td><td>2.1 Sample Emergency Management Committee Roster
2.2 Sample Emergency Management Committee Meeting Agenda</td></tr>
<tr><td>Outcomes</td><td>☐ Committee roster has been reviewed and new members have been added as needed
☐ A standard meeting agenda has been adopted</td></tr>
</table>

3. Incident Command System (ICS)

<table>
<tr><td colspan="2">Purpose
Having a structured command system is one of the most critical components of emergency management. The Incident Command System is the standard structure used in emergency response across sectors nationwide. It provides a flexible, scalable structure, supports an organized and effective response, and ensures integration with outside agencies.</td></tr>
<tr><td>Activities (A-C)</td><td>A. Develop/ Update Incident Command System
Develop/update an Incident Command System for your facility. Using the sample chart below provided in the Tools section of this document, develop and/or update an ICS organizational chart for the health center. Note that not every position on a standard ICS chart will be necessary for a CHC. At a minimum, all positions at the Section Chief level and above (Command Staff) should be filled. It is strongly recommended that key ICS leadership also be present on the Emergency Management Committee.

B. Plan ICS Successions
Create an ICS succession list for each Command Staff position within the health center. The ICS chart and succession list will support an orderly response by ensuring that all know who is responsible for what. A succession list is important for ensuring coverage during staff absences and can also be used for developing a rotation schedule during prolonged emergencies.

C. Create/ Update Job Action Sheets
Job Actions Sheets are an effective aid in helping individuals carry out their responsibilities by delineating major responsibilities. At a minimum, Job Action Sheets should be developed for all Command Staff.</td></tr>
<tr><td>Tools and Templates</td><td>3.1 Simplified ICS Chart
3.2 HICS207 – Hospital Incident Management Team Chart
3.3 Potential Candidates for Major ICS Positions
3.4 ICS Succession Planning</td></tr>
<tr><td>Outcomes</td><td>☐ The ICS Organizational Chart has been developed/updated.
☐ An ICS Succession List for all work shifts has been developed/updated
☐ Job Action Sheets have been developed</td></tr>
<tr><td>Additional Resources</td><td>Sample Job Action Sheets can be found
http://www.emsa.ca.gov/hospital_incident_command_system_job_action_sheets_2014

Emergency Preparedness Resource page includes free online FEMA training programs for ICS and National Management Systems Concepts, as well as Active Shooter Resources.
https://www.aachc.org/resources/emergency-preparedness/</td></tr>
</table>

4. Establish Emergency Operations Center (EOC)

<table>
<tr><td colspan="2">Purpose
The Emergency Operations Center (EOC) is a central location that will serve as a base of operations for facility's Incident Command System. A pre-identified and equipped EOC will ensure more rapid and effective response. For most organizations, the EOC will simply be a conference room, break room, or large office. The most important thing is to have a place pre-identified with necessary supplies readily available.</td></tr>
<tr><td>Activities (A-B)</td><td>A. Develop EOC policy
Develop and implement a policy regarding the Emergency Operations Center (EOC). The protocols should address the following:
Identify the location of a primary EOC based on specified criteria
Identify an alternate EOC site in case the primary EOC is not accessible/available
Determine who will activate the EOC (ex. administrator or other designated staff available)
Create supply list to stock EOC
Locate or develop copies (paper and electronic) of facility floor plan and place in EOC
Determine use of volunteers and process for role integration to address surge needs, if applicable
B. Equip EOC with Equipment and Supplies
Equip EOC with appropriate supplies per needs identified in tool below.</td></tr>
<tr><td>Tools and Templates</td><td>4.1 Sample Emergency Operations Center Activation and Deactivation Protocols
4.2 Emergency Operations Center Site Considerations
4.3 Sample EOC Equipment and Supplies List</td></tr>
<tr><td>Outcomes</td><td>☐ Emergency Operations Center Policy developed/updated
☐ EOC identified and equipped</td></tr>
</table>

5. Integration of Emergency Management Activities

Purpose

By integrating emergency preparedness activities into regular work, CHCs can ensure that emergency management efforts remain current and engaged on an ongoing basis. Doing so will ensure more effective outcomes during actual emergencies.

Defined team member roles and incorporating specific emergency responsibilities into individual job descriptions supports emergency management accountability and understanding. Adding emergency management planning/training as a standing item on team meeting agendas provides an opportunity for organizations/health centers to continuously address specific areas of the emergency management plan including but not limited to essential services and business continuity.

Involving team members and patients/families/caregivers in the quality improvement process is an opportunity to review any previous occurrences and contribute to the planned improvement process. Introducing emergency management planning into patient/family/caregiver self-management activities provides a significant opportunity to educate patients (particularly those at high risk).

Activities (A-E)	**A. Integrate Emergency Management into Practice Operations** Incorporate emergency management activities into larger organizational calendar. For example, update emergency policies when other policies are being updated. Complete the hazard vulnerability analysis when other risk activities are being conducted. **B. Conduct Discussion-based Exercises** Incorporate discussion-based exercises into staff and leadership meetings or daily huddles when appropriate. Getting personnel comfortable with talking about potential disaster is essential in helping people feel comfortable with responding to disasters. Additionally, these discussions can help identify planning gaps. **C. Clarify Staff Roles** Review job descriptions, and incorporate emergency roles as appropriate to position and qualifications. **D. Use Electronic Health Record (EHR)** Maximize use of EHR and other technology capabilities effectively, especially patient information and demographics. Accurate patient demographics will be necessary in an emergency and can be incorporated into the EM Plan. **E. Train** EM training program developed and updated at least annually. EM can be incorporated into new employee orientation, as part of continuing education, and existing meetings.

Tools and Templates	5.1 Discussion-based Exercises 5.2 PCMH Matrix for Emergency Management Fundamentals Appendix: Training and Exercises[6]
Outcomes	☐ Emergency management activities are integrated into CHC annual planning activities ☐ Leadership and staff engage in discussions around emergency management on a regular basis ☐ Staff job descriptions are updated with emergency roles ☐ Use of EHR is evaluated for use in emergencies ☐ Emergency management training is incorporated into annual training calendar
Additional Resources	How to write roles and responsibilities on a job description http://work.chron.com/write-roles-responsibilities-job-description-14172.html Difference between Role, Position, and Designation http://www.differencebetween.info/difference-between-role-position-and-designation *Emergency Management Program Training and Exercise Guide for FQHCs* Full resources: http://www.mpca.net/events/EventDetails.aspx?id=996858 Guide:http://www.mpca.net/resource/resmgr/CMS_Virtual_Table_Top_Webinar_Templates_on_9_6_2017/FQHC_Emergency_Management_T.docx

[6] Resources can be found at http://www.mpca.net/events/EventDetails.aspx?id=996858

6. Integrated Risk Approach

Purpose
All effective emergency management plans incorporate risk assessment. Traditional emergency preparedness frameworks often focus on addressing risks to infrastructure, physical facilities, and operations. Although these areas are critical to all emergency management plans, it is also important to include and prioritize threats and risks at the community-level, such as identifying groups that may need extra help or are more exposed during a disaster.

CHCs regularly engage in risk assessment activities. For example, the PCMH Model challenges primary care providers to manage the health of their patient populations based on complete patient and clinical information that is updated regularly. The collection of this data into structured fields within an electronic health record (EHR) provides the opportunity to identify individuals most at risk during an emergency/disaster through data extraction and reporting. PCMH requires organizations/health centers to proactively identify populations of high-risk patients and remind them, or their families/caregivers, of needed care at least annually. Patients with chronic and/or complex conditions may be at elevated risk during an emergency/disaster and will therefore require proactive monitoring.

Activities (A-C)	**A. Define Organizational Risk Activities** Define and identify all organizational risk activities. This may include: • Patient risk assessment • Hazard Vulnerability Analysis (defined in section 7) **B. Address risk of patient population** through risk stratification, if applicable • Develop a plan to identify and contact patients with complex communication and health needs and include it in the EM Plan. • Refer to population health management initiatives (e.g. population risk stratification) and care management initiatives when planning. **C. Assess broader community resources and needs** may be beneficial before engaging in more formalized risk assessment activities • Refer to *Know Your Community*, provided in the tools section for information and activities to help you and your staff learn more about your community, including its risks for emergencies, disasters, or other threats that can affect community strengths and resources, as well as vulnerable populations you serve.
Tools and Templates	6.1 *Know Your Community*[7]
Outcome	☐ All risk-related activities have been identified. ☐ A deeper understanding of community and risk has been gained

[7] *Know Your Community* is section 2, pages 23-38 of the *Resilience Builder Toolkit*.

Additional Resources	Risk Stratification: Predict, Prioritize, and Prevent https://www.rmhpcommunity.org/content/predict-prioritize-preventnine-things-practices-should-know-about-risk-stratification-and A toolkit to identify vulnerable populations and specific needs associated with each which should be considered when developing the organizational EM Plan http://www.cidrap.umn.edu/practice/kansas-vulnerable-populations-outreach A web-based library of resources, information and planning tools on disaster preparedness for culturally diverse communities and other at-risk populations. http://www.diversitypreparedness.org/ Examples of initiatives that aim to increase emergency preparedness in vulnerable and diverse communities can provide ideas and help establish best practices for organizational Emergency Planning. http://www.emergencymgmt.com/disaster/Diverse-Vulnerable-Populations-Preparedness-041111.html?page=2 Disaster Response Guidance/Toolkit for Health Care Providers: Identifying and Understanding the Health Care Needs of Individuals Experiencing Homelessness http://www.phe.gov/Preparedness/planning/abc/Documents/clinical-guidance-toolkit060615.pdf A convenient checklist that contains all of the essential items those with diabetes need to have readily available in the event of an emergency. http://mydiabetesemergencyplan.com/ Teaching patients how to plan and prepare to manage chronic conditions prior to and/or during a disaster. http://www.phila.gov/health/diseasecontrol/chronic_conditions_php.html *Resilience Builder Toolkit*, including *Know Your Community* http://www.laresilience.org/documents/resilience-builder.pdf

7. Hazard Vulnerability Analysis (HVA)

<table>
<tr><td colspan="2">Purpose
In emergency management, risk assessment is conducted using a Hazard Vulnerability Analysis (HVA). An HVA allows organization to assess risks based on probability, potential impact, and level of preparedness. Top scoring risks should be prioritized in planning and mitigation activities.

The HVA should be conducted on an annual basis as completing planning and mitigation activities can decrease risk thereby lower scores. Equally, changes in hazards or decreased attention to preparedness for specific hazards may increase risk thereby increasing scores.</td></tr>
<tr><td>Activities</td><td>A. Identify Hazard Vulnerability Analysis Team
Identify multidisciplinary team for completing HVA. A multidisciplinary approach ensures the best assessment of preparedness and consequences of hazards by bringing in individuals with expertise in various areas. Use the sample HVA team roster provided in the Tools section of this document to assess your organization’s current roster and make updates as needed. Depending on the composition of your emergency management committee, it may be the same team or you may need to make modifications.

B. Gather Information
You can begin with the information gathered in Know Your Community exercises in section 6. Consider reaching out to local emergency management department for information on local hazards. They may be able to provide data on likely hazards, frequency, and information on mitigation, preparedness, and response. After-action reports from both the organization and the community may be helpful as well in understanding the impact of specific hazards.

C. Conduct the HVA.
Allow at least two hours for team to conduct HVA and ensure that the appropriate team is present.</td></tr>
<tr><td>Tools and Templates</td><td>7.1 Hazard Vulnerability Analysis Team
7.2 Kaiser Permanente’s Hazard Vulnerability Analysis Tool
http://www.calhospitalprepare.org/hazard-vulnerability-analysis
7.3 Kaiser Permanente Hazard Vulnerability Analysis Instructions</td></tr>
<tr><td>Outcome</td><td>☐ HVA team reviewed and updated as needed
☐ HVA completed</td></tr>
<tr><td>Additional Resources</td><td>Red Cross Ready Rating for self-assessment www.readyrating.org/

ASPR TRACIE Tools on Hazard Vulnerability and Risk Assessments
https://asprtracie.hhs.gov/technical-resources/3/hazard-vulnerability-risk-assessment/1#toolkits</td></tr>
</table>

8. Integrated Notification and Communication Plan

Purpose
The ability for a health center to communicate with patients is crucial. A key requirement of the PCMH Model is the ability of an organization/health center to communicate via an electronic system such as a website, patient portal, or secure email system that allows two-way communication between patients/families/caregivers and the health center. CHCs can integrate these systems into their emergency management notification and communication plans.

The PCMH Model encourages health care providers to use an electronic system to record specific patient information in structured data fields making the information extractable and reportable. The CHC's ability to access this data is essential to emergency management and can be easily integrated into the notification and communication plan.

Activities	**A. Assess Notification and Communication Plans and Options** Review and assess current technology options and when they are triggered. This may include: • EHR/ Business Intelligence Tool • Plan to identify and communicate with patients with special linguistic needs. • Voicemail system • Mass notification system • Patient Portal - Providing specific information for accessing care outside of normal business hours is usually an option. Some portals can initiate email address collection and verify cell numbers for text alerts. • Staff phone tree **B. Update Plan** Update emergency plan, protocols, and systems to include: • Communication with staff • Communication with patients • Communication with community partners • Communication between CHC and state primary care association (PCA) • Communication with local and state public health authorities • Infectious disease reporting protocol • Protocols for technology usage **C. Develop and Maintain Contact Lists** (electronic and paper) for all staff, partners, agencies and authorities in Communication Plan
Tools and Templates	8.1 Technology Assessment
Outcomes	☐ Essential contact information and means of communicating are updated ☐ Communications plan has been updated/integrated with emergency plan ☐ Protocols for use of emergency technology have been developed/updated

9. Risk Communication

Purpose
During disasters, effective communication and messaging is critical. As healthcare providers, health centers need to be able to provide various types of information to patients, partners, and the community. Some of this communication is straightforward - such as hours of operation or site status. Other communications are more complicated such as providing information that impacts decision-making around health. This is referred to as risk communication.

Risk communication is a dialogue among partners and the public that provides critical information, counters harmful behaviors, and supports best outcomes. Adding to the challenge, is the fact that risk communication is frequently performed under pressure and sometimes with limited information.

Key staff should be trained on risk communication techniques to ensure effective messaging that supports patient care and organizational reputation management

Activities	**A. Identify Core Staff for Risk Communication Training** Identify core staff for training. Ensure multiple people are included from both clinical and administrative sides. Include senior staff and communication staff. **B. Assign Training** Assign training to appropriate staff and track completion.
Tools and Templates	9.1 Risk Communication Training List
Outcome	☐ Staff is trained in risk communication
Additional Resources	CDC Crisis and Risk Communication Training https://emergency.cdc.gov/cerc/ Johns Hopkins Crisis Communication Training http://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-public-health-preparedness/training/online/crisis_communication.html CDC's information and resources disasters and weather emergencies, health and safety concerns, and information for specific groups https://www.cdc.gov/disasters/index.html *Hurricane Season Public Health Preparedness, Response, and Recovery Guidance for Health Care Providers, Response Recovery Workers, and Affected Communities*-CDC, 2017 https://www.cdc.gov/mmwr/volumes/66/wr/mm6637e1.htm?s_cid=mm6637e1_e

10. Develop Essential Services and Business Continuity Strategy

Purpose

To ensure that your health center can maintain essential services to your community and sustain business during an emergency or after a disaster, it is important to think about potential challenges you could experience (or have experienced in the past) both from within your organization as well as your community. Challenges that could impact your organization's ability to provide services during a disaster event could include lack of partnerships and collaboration, lack of communication and engagement with various stakeholder groups or client populations, lack of coordination in terms of services, resources, and support, and lack of access to services by vulnerable populations.

Identification of essential services will support more rapid decision-making and help eliminate confusion. It will also allow for more strategic resource management and provide guidance in building partnerships.

An essential component in ensuring continuity of services is staff. The PCMH model recommends that health centers define roles for clinical and non-clinical team members, identify team structure, and train all members of the team to support patients/families/caregivers in self-management and management of patient populations. Health centers should maintain scheduled team meetings to address practice functioning and involve team members and patients/families/caregivers in quality improvement activities. Each of these steps provides opportunity for a health center to ensure access to essential services and business continuity during an emergency/disaster through integration into emergency management planning.

Activities (A-B)	**A. Assess Essential Functions** In assessing essential functions, consider the following: • Scope of services • Daily functions of departments • Requirements for supporting patients (urgent medical needs) • Requirements for supporting staff (ex: payroll) • Requirements for maintaining facility (ex: electricity) • Regulatory requirements (ex: pharmaceutical protection and preservation) Complete the Essential Services and Staff Planning Tool by identifying: • Which functions should be maintained? • Which functions should be temporarily stopped? • Which functions should be expanded? • What kind of functions should the health center never do? **B. Determine Critical Staffing** It is important to have the correct balance of staff to carry out critical functions. Even if a function is deemed critical, if there is not sufficient staff or the correct balance of staff, the function cannot be carried out. Refer to role of care teams, referral tracking, and risk stratification elements when determining staffing needs.

	Complete the staffing requirements using current staff roster. Consider all staff and potential barriers they may have to performing duties during emergencies. Review essential functions and determine if those functions can still be met. Modify essential functions list as needed.
Tools and Templates	10.1 Essential Services and Staff Planning Tool 10.2 Hospital Continuity Checklist
Outcomes	☐ List of essential services ☐ List of staffing requirements
Additional Resources	The Americares *Disaster Preparedness Planning Guide for Free and Charitable Clinics* has more on identification of essential services and strategizing for continuity planning http://www.safetynetcenter.org/globalassets/_snc/eduresources/emergencyresponse/americares-disaster-preparedness-planning-fcc-ep-guide.pdf Recommendations based on the lessons learned from recent disasters have been developed, and they provide practical and essential steps to prevent treatment interruption during and after a disaster. https://www.dovepress.com/emergency-and-disaster-preparedness-for-chronically-ill-patients-a-rev-peer-reviewed-fulltext-article-OAEM

11. Emergency Resources

Purpose
Community resilience planning starts by understanding what your community is already doing and the resources you have set in place. This work plan will help you identify what strengths and resources are available not just within your own organization, but also within your community as a whole. You will be able to use this list later when you are establishing partnerships to share and leverage resources.

Resource management is part of the daily activities of any CHC. During an emergency, this function is even more critical. Supply chains may be disrupted due to hazards resulting from natural disasters or may be impacted by their own personnel shortages. Having a clear understanding of the resources available and resources that may be needed will allow for more effective planning and response. Connecting resources in your community builds resilience.

Activities (A-B)	**A. Assess Emergency Resources** Assess emergency resources needed for essential functions against standard resources available at health center. Review: • Assets Table (refer to section 2 of the *ENGAGED Toolkit*[8]) provided in the Tools section of this document to conduct an assessment of resources (e.g., competencies, relationships, data, funding, etc.) that your organization can contribute to disaster response and recovery • Current inventory • Seasonal changes in inventories **B. Develop supply chain strategies** and updated emergency plan as needed. This may include: • Stockpiling resources • Working with vendors • Enrolling in emergency supply programs • Working with community partners
Tools and Templates	11.1 Disaster Skills Self-Assessment: Assets Table[9] 11.2 Resource Management Planning Tool
Outcome	☐ List of resources typically available and resources that would need to be acquired ☐ Strategy for acquiring emergency resources by resource type

[8] Acosta, Joie D., Anita Chandra, Vivian L. Towe, Yandong Zhao and Yangxu Lu. ENGAGED Toolkit: Improving the Role of Nongovernmental Organizations in Disaster Response and Recovery. Santa Monica, CA: RAND Corporation, 2016. https://www.rand.org/pubs/tools/TL202.html.

[9] Pages 24-27 of RAND Corporation's *ENGAGED Toolkit: Improving the Role of Nongovernmental Organizations in Disaster Response and Recovery*

Additional Resources	*ENGAGED Toolkit: Improving the Role of Nongovernmental Organizations in Disaster Response and Recovery* assists public health and emergency planners and nongovernmental organizations (NGOs) stakeholders in determining the capacity and capability of particular NGOs for disaster response and recovery. In addition, the toolkit fills an important gap in knowledge and understanding about the key elements that drive NGO participation. https://www.rand.org/pubs/tools/TL202.html

12. Building Community Resilience

<table>
<tr><td colspan="2">Purpose
Communities and organizations can better prepare for, respond to, and bounce back from adverse events—both natural and human-caused disaster—by pooling resources, adapting to change, organizing action, and learning from past experience. CHCs are integral parts of their communities and are therefore integral players in enhancing the resilience of their communities. Adopting community resilience-building principles as organizational best practices will optimize and supplement your emergency management activities and overall disaster preparedness capacity. In addition, your employees and the population that you serve will increase their abilities to withstand and recover from disasters, as well as to learn from past disasters and strengthen future preparedness efforts.</td></tr>
<tr><td>Activity</td><td>A. Introduction to Community Resilience
Study the resources below as an introduction to principles and concepts of community resilience. Think about what it means in terms of CHCs' activities and preparedness efforts.

B. Consider how to integrate community resilience strategies into your organizational best practices to optimize and supplement emergency management activities and overall disaster preparedness. Review:
RAND Corporation's Community Resilience Action List for Organizations to assist you and your staff with thinking through how to leverage existing organizational assets and improve your organization's preparedness and recovery planning processes
RAND Corporation's Community Resilience Talking Points to assist you in effectively communicating what community resilience is and how it can benefit your organization, population you serve, and community as a whole.</td></tr>
<tr><td>Tools and Templates</td><td>12.1 Why Community Resilience is Important[10]
12.2 Community Resilience Action List[11]
12.3 Community Resilience Talking Points</td></tr>
<tr><td>Outcome</td><td>☐ Community Resilience readings and exercises complete</td></tr>
<tr><td>Additional Resources</td><td>Resilience Builder Toolkit is a community toolkit that builds upon existing resources in your community to strengthen resilience. It is presented in six sections and offers strategies to increase resilience. This toolkit is the result of a collaboration between the Los Angeles County Department of Public Health, Emergency Preparedness and Response Program, RAND Corporation, and Community Partners.
http://www.laresilience.org/documents/resilience-builder.pdf</td></tr>
</table>

[10] Why Community Resilience Is Important? is located in section 1, pages 11-22 of the Resilience Builder Toolkit.

[11] Community Resilience Action List is a supplemental file from RAND Corporation's *Building Resilient Communities: An Online Training*.

	RAND Corporation's *Resilience in Action* Resources Page*:* http://www.rand.org/multi/resilience-in-action.html A series of the RAND Corporation's community resilience-related research and resources for individuals and community organizations to learn more about resilience and to implement strategies to help communities prepare, withstand, and recover from disasters. Key sub-pages on this webpage include: • Community Resilience Toolkits: https://www.rand.org/multi/resilience-in action/community-resilience-toolkits.html • Community Resilience Trainings: https://www.rand.org/multi/resilience-in-action/resilience-trainings.html RAND Corporation's *Building Resilient Communities: An Online Training*[12] https://www.rand.org/pubs/tools/TL109.html This easy-to-use, self-guided online training shows organizations and communities how to strengthen their resilience. When you complete this training, you will have a real action plan to use that will help you build resilience in your organization or across your community, bolstering your capacity to respond to and recover from disaster. As part of this training, you may download supplemental files, which include: • *User's Guide and Audio Transcript* • *Community Resilience Action List (for Organizations)—Tool 12.2* • *Asset Chart*

[12] Chandra, A. *Building Resilient Communities: An Online Training,* Santa Monica, Calif.: RAND Corporation, TL-109. As of September 21, 2017: https://www.rand.org/pubs/tools/TL109.html

13. Partnerships and Community Coordination

<table>
<tr><td colspan="2">Purpose
Establishing partnerships and community coordination is critical to the development of resilient communities as well as optimizing your organization’s emergency management capacity. In order to effectively identify and address the full spectrum of community threats and potential areas of vulnerability, a variety of approaches and perspectives are needed. Thus, combining and leveraging efforts of other organizations and individuals in your community is critical during emergency management planning.

To be successful, coalitions or committees that address emergency management in your community need to be inclusive, set specific goals, and act together. Partnerships and community coordination are important because they can minimize duplicative efforts, maximize power of individual organizations, provide settings to reach diverse populations, and leverage more resources, skills, and strategies.

Health centers have developed relationships with numerous community partners, including but not limited to, specialty care providers, hospitals, behavioral healthcare providers, housing authorities, transportation providers, urgent/emergent care clinics, free and charitable clinics, health departments, social service agencies, and food banks. The PCMH model encourages health centers to maintain formal and informal agreements with a subset of these resources including behavioral health providers. These connections present an opportunity to incorporate emergency management planning into discussions and/or agreements with established community resources/partners.</td></tr>
<tr><td>Activities (A-D)</td><td>A. Identify and Build Community Partners
Identify, review, and document existing partnerships and agreements. This may include:
Networks
Coalitions
Formal agreements
Informal/historical agreements
B. Document how these partnerships support essential functions in terms of resource needs as well as emergency preparedness, relief, and/or recovery efforts.

C. Join your Healthcare Coalition
If you have not already done so, join a local healthcare coalition.</td></tr>
</table>

	D. Identify Needs for Additional Partnerships, Collaboration, and Inclusion Identify needs to enhance your capacity to: • Create and maintain partnerships • Review resource gaps to identify additional partners to engage with • Contact existing partners to strengthen community-wide disaster response and recovery • Establish relationships with partners in diverse sectors and build coalitions to engage new and existing partners, including community members
Tools and Templates	13.1 Partnership Development 13.2 *Partnership, Collaboration and Inclusion*[13] 13.3 Talking with Diverse Sectors
Outcomes	☐ Roster of current partnerships has been developed ☐ Strategy of how partnerships can be leveraged has been developed ☐ Potential new partners have been identified
Additional Resources	*Partnerships for Recovery Across The Sectors (PRACTIS) Toolkit*[14] (E-Book & Support Files for download): http://www.rand.org/pubs/tools/TL188.html RAND's *Partnerships for Recovery Across The Sectors (PRACTIS) Toolkit* strengthens disaster recovery partnerships between local health departments (LHDs) and community-based organizations (CBOs). It contains a sample survey to help LHDs identify CBOs that contribute to disaster response and recovery, a quality improvement guide to identify partnership strengths and weaknesses, and a tabletop recovery exercise to improve partnerships. This toolkit can be used as a guide to see how organizations utilized the PARTNER Tool (see below) to conduct a Social Network Analysis. *PARTNER Tool:* http://partnertool.net/ PARTNER is a social network analysis tool designed to measure and monitor collaboration among people/organizations including how members are connected, how resources are leveraged and exchanged, the levels of trust, and to link outcomes to the process of collaboration. The tool includes an online survey that you can administer to collect data and an analysis program that analyzes these data. By using the tool, you will be able to demonstrate to stakeholders, partners, evaluators, and funders how your collaborative activity has changed over time and progress made in regard to how community members and organizations participate. *Community Resilience: Learn and Tell Toolkit*[15]*:*http://www.rand.org/pubs/tools/TL163.html This toolkit is intended to teach people about community resilience so that they can then educate others about how to build resilience. This toolkit has tips, information, games, and exercises about resilience for anyone in the community interested in this topic. In addition

[13] Partnership, Collaboration, and Inclusion tool is found in section 3, pages 39-46 of the Resilience Builder Toolkit.
[14] Acosta, Joie D., Anita Chandra, Lea Xenakis, Danielle M. Varda, Monika Eros-Sarnyai, David Eisenman, Ingrid Gonzalez, Jaime Gutierrez, Deborah C. Glik and Sara Sprong. Partnerships for Recovery Across The Sectors (PRACTIS) Toolkit. Santa Monica, CA: RAND Corporation, 2015. https://www.rand.org/pubs/tools/TL188.html.
[15] Towe, Vivian L., Anita Chandra, Joie D. Acosta, Ramya Chari, Lori Uscher-Pines and Clarissa Sellers. Community Resilience: Learn and Tell Toolkit. Santa Monica, CA: RAND Corporation, 2015. https://www.rand.org/pubs/tools/TL163.html.

	to community members, organizations can also use this toolkit to communicate with their staff and service populations about resilience.

14. Create Memorandums of Understanding (MOUs) with Partners

Purpose Formal documentation will help solidify partnerships by ensuring that partners identify and discuss needs and how they can best support each other. For a community health center, an MOU might help document where and how a surge of patients will be managed, where a stockpile of supplies will be stored, or how staff will be assigned to support emergency operations.	
Activities	**A. MOU Development** Develop standard MOU form and review language with legal counsel as necessary. Note that partners may have their own forms to use. Engage partners in signing MOUs and document in MOU tracking tool. Note that not all partners can or will sign documentation. Even without a formally documented agreement, organizations can still be considered partners in preparedness and response.
Tools and Templates	14.1 MOU Tracking 14.2 Sample MOU 1 14.3 Sample MOU 2
Outcome	☐ Development of basic emergency management MOU

Tools

EMI Outcome Checklist

Outcome	Updated
☐ Emergency plan developed/updated	
☐ Emergency Management Committee roster has been reviewed and new members have been added as needed	
☐ A standard Emergency Management meeting agenda has been adopted	
☐ The Incident Command System (ICS) Organizational Chart has been developed/updated	
☐ An ICS Succession List for all work shifts has been developed/updated	
☐ Job Action Sheets have been developed	
☐ Job descriptions updated with roles	
☐ Staff engage in regular discussion-based exercises	
☐ Emergency Operations Center (EOC) Policy developed/updated	
☐ EOC identified and equipped	
☐ Emergency management activities are integration into CHC's annual planning activities	
☐ Leadership and staff engage in discussions around emergency management on a regular basis	
☐ Staff job descriptions are updated with emergency roles	
☐ Electronic health record (EHR) is evaluated for use in emergencies	
☐ Emergency management training is incorporated with annual training calendar	
☐ All risk-related activities have been identified	
☐ A deeper understanding of community and risk has been gained	
☐ Hazard Vulnerability Assessment (HVA) team reviewed and updated as needed	
☐ HVA completed	
☐ Essential contact information and means of communicating are updated	
☐ Communications plan has been updated/integrated with emergency plan	
☐ Protocols for use of emergency technology have been developed/updated	
☐ Staff is trained in risk communication	
☐ List of essential services	
☐ List of staffing requirements	
☐ List of resources typically available and resources that would need to be acquired	
☐ Strategy for acquiring emergency resources by resource type	
☐ Community Resilience readings complete	
☐ Roster of current partnerships has been developed	
☐ Strategy of how partnerships can be leveraged has been developed	
☐ Potential new partners have been identified	
☐ Development of basic emergency management MOU	

1.1 New CMS Rule Check

Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers

Core requirements for all, each tailored to specific type of entity. Requirements specifically tailored for CHCs are included in Ambulatory and Federally Qualified Health Centers. Requirements must be implemented by November 15, 2017

Disclaimer: The information provided below is only intended to be a general summary. It is not intended to take the place of regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Topic	Status
1. Risk Assessment and Emergency Planning Requirements	
☐ All hazards risk assessment-focuses on the capacities and capabilities that are critical for EM. Allows each facility to tailor to hazards that are most likely to occur in their locales (ie facility and community based) o Equipment/ power failure o Care related crisis o Interruptions in communications (e.g. cyber-attack) o Interruptions in normal supplies (e.g. water or food)	
☐ Be based on and include a documented, facility based and community based risk assessment, utilizing all hazards approach	
☐ Include strategies for addressing emergency events identified by the risk assessment	
☐ Address patient populations, including, but not limited to o Types of services the FQHC has the ability to provide in an emergency o Continuity of operations, including delegation of authority and cessation plans	
☐ Include process for cooperation and collaboration with local, tribal, regional, state, and Federal EP officials' efforts to maintain integrated response during a disaster or emergency situation	
☐ **Frequency**: Plan must be updated annually- reviewed and/ or revised	

2. Policies and Procedures	
☐ Each facility must develop policies and procedures to support execution of emergency response plan. At minimum must address o Safe evacuation (including staff responsibilities and patient needs o A means to shelter in place for patients, staff, and volunteers, who remain in the facility o A system of medical documentation that preserves patient information, protects confidentiality of patient, and secures and maintains the availability of records (Want to include, If out of building or out of EMR) o The use of volunteers in an emergency or other emergency staffing strategies, including the process for integration of state and federally designated health care professionals to address surge needs during an emergency	
☐ Policies and procedures must respond to risks identified in the risk assessment. Must be specific to your plan and your needs.	
☐ **Frequency**: Each facility's policies and procedures must be updated at least annually	

3. Communications Plan	
☐ Designed to ensure the continuity of patient care in the event of a disaster	
☐ Ensures patient care is coordinated with o The facility itself o Other local providers o Local health departments o Emergency management agencies	
☐ Names and contact Information for the following: o Staff o Entities providing services under arrangement o Patients' physicians o Other FQHCs o Volunteers	
☐ Contact information for the following o Federal, state, tribal, regional, and local emergency preparedness staff o Other sources of assistance	
☐ Primary and alternate means for communicating with the following o FQHC staff o Federal, state, tribal, regional, and local emergency management agencies	
☐ A means of providing information about the general condition and location of patients under facility's care as under HIPAA Privacy rule (45 CFR 164.510)(b)(4))	
☐ A means of providing information about the FQHCs needs and its ability to provide assistance to the authority having jurisdiction or the Incident Command Center, or designee	

4. Training and Testing	
☐ Training requirements: o All employees must be trained on every aspect of the emergency preparedness plan o **Frequency for review:** training program needs to be reviewed and updated annually o Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role o **Frequency of trainings**: Provide emergency preparedness training at least annually o Maintain documentation of the trainings (ideas, attendance sheets,) o Demonstrate staff knowledge of Emergency Management	
☐ Testing/ Exercise requirements o Participate in full-scale exercise that is community based or when a community based is not accessible, an individual facility based exercise. ▪ If the FQHC has to activate its emergency plan, it is exempt from testing for one year o Conduct an additional exercise that may include, but is not limited to: ▪ A second full-scale exercise that is community or facility based ▪ A table top exercise including a group discussion led by a facilitator o Analyze the FQHCs response to and maintain documentation of all drills, table top exercises, and emergency events, and revise the emergency plan as needed.	

Additional CMS requirement for FQHCs: Integrated health system
☐ If FQHC is part of healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated EP program, the FQHC may choose to participate in the healthcare system's coordinated EP program ☐ If FQHC elects to have a unified program, the program must demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated EP program. See rule for more details.

1.2 Sample EOP Table of Contents

Base Plan	
Amendment Record	
Executive Summary, Purpose, and Scope	
Planning Assumption	
Emergency Management Committee	
Concept of Operations • Alert • Notification • Activation	
Hazard Vulnerability Analysis Results	
Incident Command System (ICS)	
Emergency Operations Center (EOC)	
Emergency Communications • Alerting Staff • Alerting Patients • Alerting Patients' Next of Kin	
Local and State Public Health Alerts	
Disaster and Mental Health	
Community Integration	
Continuity of Operations	
Recovery	
Staff Training	
Drills and Exercises	
Sample Hazard-Specific Protocols	
Emergency Evacuation of the Facility	
Shelter in Place (SIP)	
Severe Weather and Natural disasters	
Utility Failure	
Infectious or Chemical Agent	
Bomb Threat	
Aggressive or Violent person; Hostage Situation	
Internal Fire	

External Fire	
Fire Alarm Failure	
Flood	
Mass Casualty Incident	
Structural Damage / Collapse, Building Damage	
External Civil Disturbance	
Labor Action	
Extreme Temperatures	
Information Technology Failure	
Sample Appendices	
Completed HVA	
ICS Chart	
ICS Job Action Sheets	
First and Second Tier ICS Positions for all Shifts	
Agency Emergency Contact Numbers	
Mutual Aid Agreements	
Facility Floor Plans	
Authorities, References & information Sources	
Generators and Utilities	
Glossary of Common Terms and Acronyms	
Inventory of Emergency Supplies	

1.3 Plan Maintenance Policy Language

Maintenance and Storage of the Plan

1. _____ shall retain a hard copy and an electronic copy of the most up-to-date version of the [organization] Plan
2. A hard copy of the plan will be stored in the EOC.
3. An electronic copy of the plan will be published on [organization] intranet website.
4. This plan is reviewed and updated as needed on an annual basis and/or after actual events as needed.
5. Sources for annual evaluation and updates:
    a. Reports from internal policy and procedure review
    b. Exercises and actual emergencies
    c. EMC meeting minutes
    d. Compliance with regulations
6. Emergency Management Committee is responsible for overseeing the implementation of the recommendations from internal policy reports and after-action reports as part of the improvement process.

1.4 Interim Plan Updates Tracking

EOP Maintenance Interim Updates

This document should be used to record minor plan updates made between annual reviews. These updates should be approved by EM Committee.

Plan Section	Addition	Deletion	Date

1.5 Hospital Emergency Management Program Checklist

Purpose - Overview: There is no one standard format for an Emergency Management Program (EMP). The Emergency Operations Plan (EOP) is one component of the EMP. This tool provides guidance for hospitals regarding the components included in an EMP. The order of the components is not mandated. Some of the documentation may be in annexes or separate binders, and can be referenced in the "Location" column. It is not the intent of this document to address every element of performance in The Joint Commission (TJC) Emergency Management Standards or other accreditation requirements. Some CHCs may find this thorough checklist useful for their own planning efforts.

Program Component		
Program Description	**Reference/Location**	**Status**
A. Policy and Purpose		
B. Approval Signatures (CEO and Chief of Medical Staff)		
C. Scope and Applicability		
D. Planning Assumptions		
E. Authority and Responsibility		
• Safety Committee/Program Organization Chart		
• Program Responsibilities		
F. Program Evaluation		
• Goals and Objectives		
• Annual Review		
1. Mitigation	**Reference/Location**	**Status**
A. Mitigation Program Overview		
B. Background and Community Description/Demographics		
C. Hazard Vulnerability Analysis (HVA)		
• Top 3-5 vulnerabilities clearly identified		
• HVA integrated with community wide HVAs		
• Annual review of HVA		
D. Summary of mitigation activities to address the top 3-5 identified risks		
2. Preparedness	**Reference/Location**	**Status**
A. Preparedness Program Overview • Activities based on the HVA		
B. Adoption of National Incident Management System (NIMS) healthcare objectives		
C. Adoption of Incident Command System (ICS), such as Hospital Incident Command System (HICS)		
D. Integration of hospital plans with community wide plans		

[16] For more tools from California Hospital Association Emergency Preparedness, visit https://www.calhospitalprepare.org/about-us

Program Component		
E. Minutes from meetings attended (such as Emergency Management Committee, Hospital Preparedness Program (HPP) Committee, and other Community Planning groups)		
F. Memoranda of Understanding (MOUs) and other Agreements		
G. Training Programs, (such as new employee orientation, NIMS training [IS course records], HICS training records, decontamination training records, community training, and other)		
H. Documentation of Drills/Exercises		
• Exercise summaries		
• Incident Action Plans		
• Evaluation (After Action Reports)		
• Improvement Plans (Corrective Action Plans)		
I. Business Continuity/Continuity of Operations Plan (COOP)		
• Identify essential functions, systems, skill sets and response assignments		
• COOP for essential functions and systems (such as back-up facilities/systems, telecommuting, etc) Note: The hospital COOP does not have to be incorporated into the EMP but should be referenced)		
3. Response (EOP)	**Reference/Location**	**Status**
A. Response Program Overview		
B. Initiation and Termination of the Emergency Operations Plan		
C. Activation of the Hospital Command Center (HCC)		
D. HICS reference materials		
• Job Action Sheets		
• Incident Planning Guides		
• Incident Response Guides		
• HICS forms - Incident Action Plan and Incident Documentation		
E. Hospital Emergency Codes		
F. Specific Response Plans including top 3-5 HVA vulnerabilities (such as earthquake, evacuation, pandemic). Event specific plans may be incorporated into the EOP, be an addendum to the EOP, or may include a series of policies, procedures and protocols referenced in the EOP		
G. Hospital Surge/Expansion plans (see CHA Surge Planning Checklist)		
H. Describe plans/agreements, if any, the hospital has to deploy clinical resources outside of the hospital (such as field triage/treatment teams)		
I. 96-Hour Capability (can be incorporated into the 6 critical areas sections)		

Program Component		
• Identify hospital capabilities and establish response procedures when the hospital cannot be supported by the local community for at least 96 hours (capabilities may include communication, resources, utilities, staff, safety and security)		
• Document response procedures (such as maintaining/expanding services, conservation of resources, curtailment of services, supplementing resources from outside disaster area, partial/staged evacuation, or full evacuation, as necessary)		
J. Communications Systems (primary and redundant) (may be incorporated into the Communications Strategies sections)		
• California Health Alert Network (CAHAN)		
• HAM radio		
• EMSystem, Reddinet		
• Other tools (phones, cell phones, satellite, email, pagers, radios, etc.)		
K. Emergency Communications Strategies		
1. Staff notification that emergency response procedures have been initiated		
2. Ongoing communications with Staff/Medical Staff		
3. Communication with community (EOC/DOC, other healthcare facilities, etc.)		
• Hospital status/capacity		
• Event management		
• Patient management		
• Resource requesting/sharing		
• Patient/Victim tracking		
4. Communication with patients and their families (including patient relocation information)		
5. Communication with the Media		
6. Communication with supply, service and equipment vendors (including afterhours/holidays)		
7. Communication and contact information for other healthcare organizations		
8. Circumstances in which patient names/information will be shared with Third Parties (community partners) and how		
9. Communication with Alternative Care Sites (such as hospital expansion sites and government authorized Alternate Care Sites)		
L. Management of Resources and Assets		

Program Component		
1. Inventory/acquisition/monitor/replenishment of assets and resources from vendors, partners or caches(such as fuel, food/water, pharmaceuticals, medical supplies/equipment, linens, personal protective equipment)		
2. Sustainability of operations with external support		
3. How the organization will share resources and assets with other healthcare organizations		
4. Hospital Resource Directory (HICS Form 258)		
5. Transporting patients, records, staff, supplies during an evacuation		
M. Management of Safety and Security		
1. Establishment of internal safety and security		
2. Control access and movement (people and vehicles)		
3. Roles and coordination of security activities with community agencies (Private Security Services, Law Enforcement, National Guard)		
4. Management of hazardous materials and waste		
5. Provision for Radioactive Biological/Chemical isolation and decontamination		
N. Management of Workforce Roles and Responsibilities		
1. Define Staff/Medical Staff roles and responsibilities during an activation		
2. Process for assigning staff to essential functions		
3. Reporting instructions		
4. Staff support (such as food, water, hygiene, respite, medical, behavioral health, dependent care, housing/shelter, family plans, pet care)		
5. Staff Training		
6. Written communication with Medical Staff regarding their roles and reporting instructions		
7. Emergency credentialing of Licensed Independent Practitioners		
8. Acceptance and use of staff from other healthcare organizations		
9. Acceptance and use of volunteers (clinical and non-clinical)		
10. Identification of workforce (such as ID badges, vests, wristbands)		
O. Management of Utilities, provision, sustainability, and alternate means of providing:		
1. Electricity		
2. Potable Water		
3. Non-Potable Water		
4. Fuel		

Program Component		
5. Medical Gas/Vacuum systems		
6. Other essential utilities (vertical and horizontal transport, heating and cooling systems, steam for sterilization)		
P. Management of Clinical and Support Activities		
1. Management of patient clinical activities (such as Triage, Treatment Areas, Scheduling, Admission, Potential rapid discharge and transfer)		
2. Evacuation (see CHA Evacuation Checklist)		
3. Surge activities such as creating surge beds, cohorting patients, canceling elective procedures, etc. (see CHA Surge Planning Checklist)		
4. Clinical services for Vulnerable Populations		
5. Patient hygiene and sanitation needs		
6. Patient behavioral health needs		
7. Decedent management/Mass Fatality procedures (see CHA Mass Fatality Checklist)		
8. Documentation and tracking of patient clinical and other information		
4. Recovery	**Reference/Location**	**Status**
A. Initiation of demobilization/recovery activities (planning may be initiated during Response Phase)		
B. Return to normal operations (phased, approvals, priorities, checklists)		
C. Event Evaluation		
1. Multi-disciplinary Incident Debriefing		
2. Evaluation of Response Plans (After Action Reports)		
3. Improvement plans/EOP update (Corrective Action Plans)		

Note: There is no requirement for hospitals to reorganize their plans to coincide with the checklists; this document is provided to assist hospitals in assessing and updating their Emergency Management Program.

Version: August 3, 2011

1.6 Hospital Evacuation Plan Checklist

PURPOSE - OVERVIEW:
To provide guidance in the development or update of a hospital evacuation plan containing detailed information, instructions, and procedures that can be engaged in any emergency situation necessitating either full or partial hospital evacuation, as well as sheltering in place.

The expectation will be that staff may need to accompany patients and work in staging areas, in local government Alternative Care Sites (ACS) and/or at receiving facilities, subject to receiving proper emergency credentials. Drills, training and reviews must be conducted to ensure that staff have a working knowledge of the plan and to ensure that the plan is workable.

The plan should be consistent with federal requirements and may be helpful for larger CHCs.

Template Element	Reference
1. General Plan Requirements	
• Integrated with other pertinent protocols in facility's comprehensive Emergency Operations Plan (EOP), including activation of hospital incident command system (ICS)	
• Identify back-up measures for key infrastructure components/resources as appropriate	
• Assigned responsibilities and formal process for review and update of Evacuation Plan (Plan), including incorporation of after action report results	
• Staff training including Plan overview, specific roles and responsibilities, utilization of evacuation equipment, techniques for lifting and carrying patients, and knowledge of primary/alternate evacuation routes	
• Uses standard terminology in common and consistent plain English language and emphasizes its use by staff during an evacuation	
2. Activation	
• Define criteria and authority for decision to activate the Plan	
• Define how the Plan is activated and how it integrates with the hospital incident command system (ICS) and EOP. Define the plan for communication and coordination with the Multi-Agency Coordination (MAC) System and/or the operational area ICS (e.g., EMS, PH DOC or City/County EOC)	
• Document how Shelter in Place critical decision making (*Exhibit 1*) has been integrated into Evacuation Plan including a determination whether State Program Flexibility would allow hospital to avoid full evacuation (e.g., alternate use of facilities)	
• Identify and/or reference Public Information Plan (PIO, JIC coordination as appropriate)	
• Identify alert and notifications to local (e.g., EMS, PH, Fire) and state agencies (e.g., L&C) regarding potential and/or intent to evacuate facilities and how communication will be maintained during and after evacuation	
• Define the type/level of evacuation that could occur (shelter in place, partial horizontal/vertical/ external, full)	

[17] For more tools from California Hospital Association Emergency Preparedness, visit https://www.calhospitalprepare.org/about-us

Template Element	Reference
• Describe the phases of implementation (i.e. staff notification, accessing available resources and equipment, preparation of patients and essential patient supplies and equipment)	
• Define routes and exits identified for evacuation, including area, facility and campus diagrams	
• Describe the protocols for accepting and orienting staff and volunteers from other facilities to assist with evacuation	
• Describe the plan for the order of removal of patients and planned route of movement (prioritization) as relevant to event and evacuation type	
3. Securing Hospital Site	
• Define the hospital security access (e.g., lockdown) plan, including ambulance diversion	
• Describe the alternate sites identified for media center and labor pool, including nursing and medical staff	
• Define the procedures for securing the facility and perimeter	
• Describe procedures for security and/or management of controlled substances	
• Describe procedures for securing utilities, including shutting down/controlling gas, medical gases, water and electricity as appropriate to event (potentially shutting down or activating generators); consideration should be given to potential impact on equipment and systems and potential for spoilage of food and pharmaceuticals.	
• Describe how coordination with local public safety for determination of inner and outer perimeters for hospital and staging area sites will be established	
4. Identification of the Alternate Site(s) – Receiving Facilities	
• Identify receiving facilities and government sponsored alternative care sites and contact information	
• Identify/reference any written documentation that confirms the commitment of these facilities (Memorandum of Understanding, Contract, Local Emergency Plans, etc.)	
• Define process for reaffirming/updating agreements	
• Define the process for contacting Operational Area Emergency Medical Services – Departmental Operations Center (DOC) and/or facilities to:	
o ascertain availability at the time of the evacuation and assist with transport	
o notify identified facilities that patients will be evacuated to their facilities	
5. Resources/Evacuation	
• Identify resources/equipment available to move patients from rooms/floors and the procedure in place for inventory control	
• Identify the location of additional resources needed such as additional lighting sources, i.e., flashlights and batteries and portable monitors and ventilators	
• Identify a clearly marked storage area available 24/7 for this equipment	
• Define the protocol for staff training on equipment use	
• Define the protocol to be utilized for on-going assessment of the patient status for equipment and transportation needs in the event of an evacuation	
• Describe how communication will be maintained, and documented, for staff and outside resources	
6. Resources/Continuity of Care	
The Plan must address how continuity of care will be maintained during an evacuation for patients at all levels of clinical complexity and disability including:	
• How to maintain continuity of care if the usual equipment is not available during the evacuation process	

Template Element	Reference
• How equipment identified as necessary to provide continuity of care can be moved with the patient, how you will identify and track patient's own equipment, and meet requirements for providing power to electrical equipment (e.g., beds, wheelchairs, ventilators, etc)	
• What resources are available to maintain isolation precautions for the safety of staff and patients, including communication of need for precautions above Standard Precautions	
• How staff will be trained and drilled on the evacuation process/Plan	
• Identify how services that may need to continue will be provided or arranged for while repairs to facilities are being made as necessary (e.g., day treatment, dialysis)	
7. External Transportation Resources	
• Identify pre-designated areas to congregate patients according to predetermined criteria (i.e., event, acuity, mobility levels)	
• List and numbers of patients by type and/or transportation resources needed (buses, vans, ALS and BLS ambulances, ambulettes, trucks, wheelchair vans, etc.)	
• Describe the process for contacting EMS (e.g., DOC/EOC) to request and to coordinate transportation vehicle needs/resources with patient needs (i.e. patient acuity level, wheelchairs, life support, bariatric)	
• Identify hospitals primary and secondary/alternate transportation resources to be available if needed, including contact information	
• Reference documentation that confirms the commitment of required transportation resources (e.g., Memorandum of Understanding, Contract, County Emergency Plans or Protocols)	
• Define the process for reaffirming and updating agreements and plans	
8. Patient Evacuation	
• Specify the protocol to assure that the patient destination is compatible to patient acuity and health care needs, as possible	
• Provide evacuees with standardized visual identifiers, such as a color-coded wristband or evacuation tag, to help personnel rapidly identify special needs for high risk conditions that, if not easily identified, could lead to injury or death of an evacuee.	
• Establish protocols for sharing special needs information, as appropriate, with personnel participating in the evacuation, including transport agencies, receiving facilities, alternative care sites, shelters and others involved in evacuee patient care.	
• Identify the resources necessary to address patient needs during transport, how to access and responsibility for acquiring and sending with the patient (e.g., "go bags", food, water, medications, etc.)	
• Document staff training and exercises on the traffic flow and the movement of patients to a staging area	
9. Tracking Destination/Arrival of Patients	
• A patient identification wrist band (or equivalent identification) must be intact on all patients	
• Describe the process to be utilized to track the arrival of each patient at the destination	
• The tracking form* should contain key patient information, including the following:	
o Medical Record Number	
o Time left the facility	
o Name of transporting agency	
o Original chart sent with patient (yes or no)	

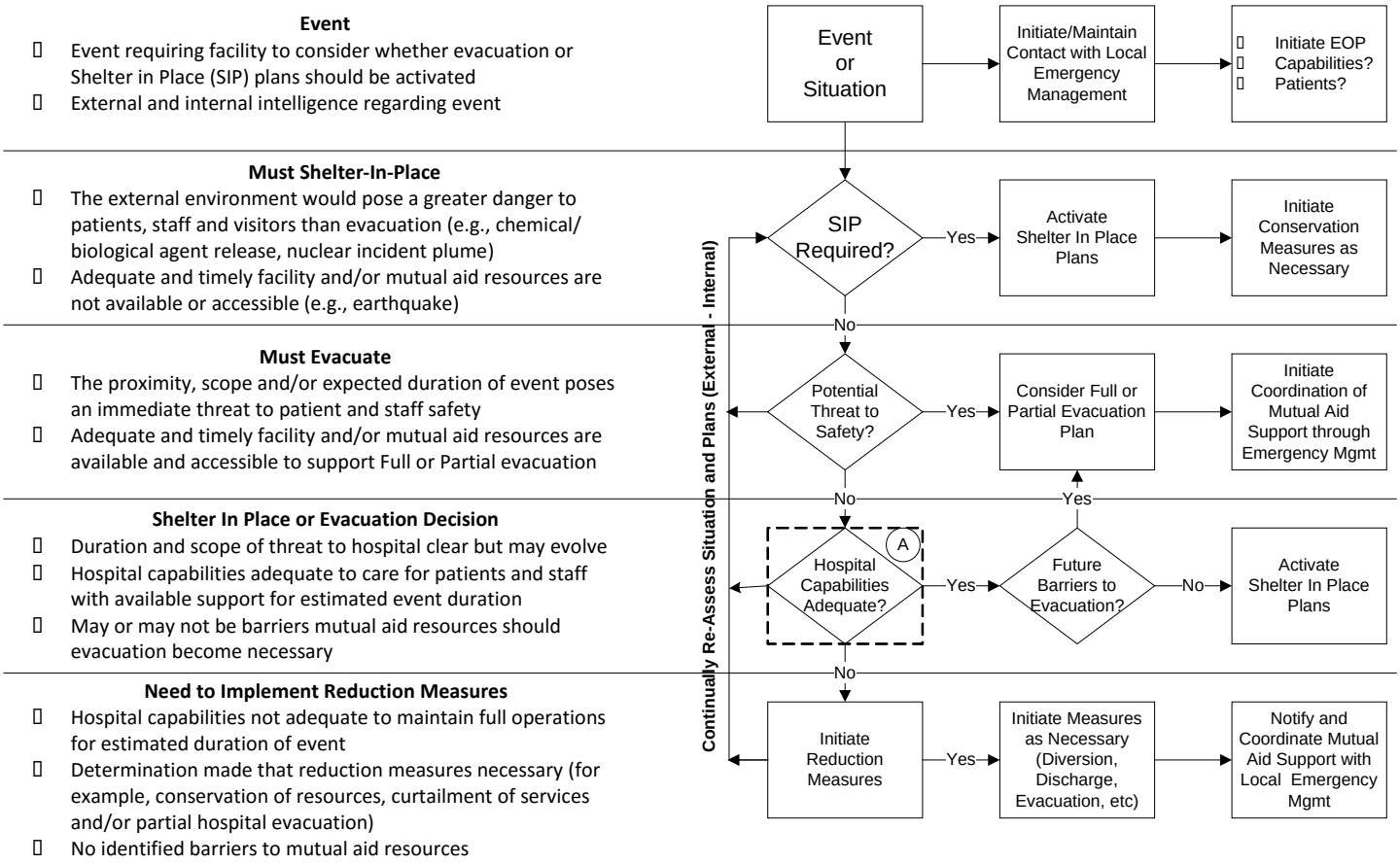
Template Element	Reference
o Critical medical record information (orders, medications list, face sheet) (yes or no)	
o Meds sent with patient (List)	
o Equipment sent with patient (list)	
o Family notified of transfer (yes or no)	
o Private MD notified of transfer (yes or no)	
**Note: Example HICS tracking forms are available*	
• Identify protocol for linking and reuniting patients and personal possessions not taken with patients during evacuation	
10. Family/Responsible Party Notification	
• Describe the process for assignment of staff members to conduct and track family/responsible party notification	
• Define the procedure to notify patient emergency contacts/family of an evacuation and the patient's destination including protocols to communicate if initial contact attempts are not feasible or successful (e.g., Hot Line, Red Cross, Police, etc.)	
11. Additional Governmental Agency Notification	
• Protocol for emergency notification to public safety for immediate response must be clearly written and educated to staff	
• Protocol for emergency notification of patient evacuation to CDPH Licensing and Certification and Local Emergency Medical Services must be clearly written and educated to staff	
• Define position title responsible for maintaining contact numbers in an accessible location	
12. Facility Evacuation Confirmation	
• Define the protocol to verify that patient care and non-patient care areas have been evacuated (i.e. orange tags, chalk on door)	
• Define orientation and annual staff training for room evacuation provided to all staff	
• Describe how the protocols will be tested during drills and/or exercises	
• Describe the mechanism used to communicate the evacuation confirmation protocol to the responding fire department and other facility first responders	
• Describe the protocol to track and account for staff, visitors and non-employees (i.e., vendors, contractors) that may be on site during an evacuation	
13. Transport of Records, Supplies and Equipment	
• Describe the procedure for transport of Medication Administration Records (MARs) patient care/medical records	
• Describe measures taken to protect patient confidentiality	
• Describe the process to transport essential patient equipment and supplies	
• Define protocol for transfer of patient specific medications and records to receiving facility	
• Protocol for the transfer of patient specific controlled substances sent with patients and procedure to record receipt, full count and signature of transferring and receiving personnel	
14. Recovery, Reopening and Repopulation of Evacuated Facilities	
• Criteria and responsibilities for preparing facilities for reopening and assuring resources and ability to provide appropriate patient care	
• Steps to be taken to ensure a safe environment (e.g., facilities, fire and safety, etc., as appropriate). See *CHA Hospital Repopulation After Evacuation Guidelines and Checklist*	

Template Element	Reference
• Process for securing government/regulatory agency approvals (e.g., Licensing and Certification, State Pharmacy Board)	
• Protocols for coordination and collaboration of transportation through County ICS (e.g., EMS DOC or EOC) or directly with transport vendors	
• Protocols for repatriation of staff and patients back to evacuated facilities, including facility access and staff identification, communication with receiving facilities, documentation, etc.	
• Protocols for communication with family regarding patient status/location	
• Protocols for communication and coordination with EMS ICS regarding status of facilities and repatriation/repopulation.	

Source**:** CHA Hospital Preparedness Program modifications to San Diego HPP Workgroup checklist adapted and updated from the State of New York, Department of Health checklist published in November 2005.

Note: this document does not represent a requirement for hospitals to reorganize their plans to coincide with the checklists; it is provided to assist hospitals in assessing and updating their evacuation plans. Rev: October 27, 2010

Figure 1: Hospital Evacuation and Shelter in Place (SIP) Decision Tree



Section 1: Tools
Developing and Maintaining an Emergency Plan
Adapted from California Hospital Association[18]

1.7 Hospital Shelter in Place Planning Checklist

Hospitals are required to incorporate Shelter in Place (SIP) planning into their Emergency Management Program (EMP). Sheltering in place is a rapid and effective means of protecting facility occupants from an external or internal threat. In some circumstances, the external environment could pose a significant danger to patients, staff and visitors (for example, chemical, biological or nuclear event). In others, community infrastructure damage and/or limitations and a lack of timely evacuation support resources may make immediate evacuation impossible (for example, earthquake, wildfire, and flood). It is not the intent of this document to address every aspect of SIP planning, but to prompt the development and documentation of criteria, critical decision-making factors, and SIP plans. SIP planning should be addressed in mitigation strategies, preparedness activities, and response and recovery plans.

Plan Component		
Overview	**Reference/Location**	**Status**
A. Document Shelter in Place (SIP) Policy and Purpose		
B. Define Scope and Applicability		
C. Identify Activation Authority (immediate)		
D. Define Activation Criteria and Decision-Making (1)		
1. Mitigation	**Reference/Location**	**Status**
A. As appropriate, reference SIP as potential response to hazard (for example, chemical spill or release)		
B. Reference mitigation activities that may support SIP plans (for example, CO2 scrubbers, expand fuel for generator, expand water storage)		
2. Preparedness	**Reference/Location**	**Status**
A. Response plans incorporate SIP option, as appropriate		
B. Communication Plans • Risk Communication (Pre-event) • Internal alert/notification (staff, patients and visitors) • External communications plan		
C. SIP Training records (such as, new employee orientation, SIP codes, SIP plans)		
D. Drills/Exercises Incorporate SIP Decision-Making and Plans		
3. Response (SIP)	**Reference/Location**	**Status**
A. Initiation and Termination of Shelter In Place activities/plan • Criteria and Decision Making Process • Assessment/Reassessment of External Factors • Assessment/Reassessment of Internal Capabilities • Assessment/Reassessment of Needs		
B. Issuance of Alert for Hospital Emergency Code for SIP Activation(s)		
C. Activation of the Hospital Command Center (HCC) for SIP		
D. Initiate/Maintain communication and coordination with community response partners, such as, Emergency Medical Services (EMS), Emergency Operations Center (EOC), Fire, Safety, other healthcare facilities, media, etc).		

[18] For more tools from California Hospital Association Emergency Preparedness, visit https://www.calhospitalprepare.org/about-us

Plan Component		
E. Identify relevant HICS Forms and Documentation • Job Action Sheets • Incident Planning Guides (specific to SIP scenario) (2) • Incident Response Guides (specific to SIP scenario) (2)		
F. Initiate and Maintain Internal Communication (all facilities on grounds) • Staff/Medical Staff Alerts and Notifications • Patients and Visitors • Signage and Other Means		
G. Event-Specific Planning Guides and Response Plans clearly identify SIP activities, as appropriate to event (for example, chemical or biological release, internal disaster, wildfires) (2)		
H. Identification of SIP Patient Care and Non-Patient Care Locations to provide best protection from threat (such as, interior hallways, rooms without windows, alternative treatment areas) with access to essential resources and patient care supplies.		
I. Document operational response procedures (what, who, where, how), such as immediate protocols for: • Shutting down HVAC, • Sealing facilities (for example, sealing vents, doors and windows with tape and plastic) • Lock-down and access control • Movement of patients, staff and visitors to SIP/safe locations • Providing supplies, equipment, pharmaceuticals, water and food to SIP/safe location(s)		
J. Assess Available Resources and Assets (Capabilities) • Identify hospital capabilities and establish response procedures when the hospital cannot be supported by the local community for estimated duration of the event (capabilities may include communication, resources, utilities, staff, food, water, safety and security) • Document response procedures (such as maintaining/expanding services, conservation of resources, curtailment of services, supplementing resources from outside disaster zone, partial/staged evacuation, or full evacuation, as necessary)		
K. Management of Resources and Assets • Inventory/monitor/conservation or replenishment of assets and resources (such as, food/water, pharmaceuticals, medical supplies/equipment, linens, personal protective equipment) • Maintain Hospital Resource Directory (HICS 258) • Plan for staff support (such as food, water, respite, medical, mental health)		
L. Monitor, conservation and alternatives for utilities (such as electricity, water, fuel, medical gasses and other essential utilities)		

Plan Component		
M. Management of Safety and Security • Establish internal safety and security • Control access and movement in and between facilities • Coordinate security/safety with community agencies • Reference Radioactive/ Biological/ Chemical isolation and decontamination plans		
N. Management of Clinical and Support Activities • Implement patient management plans in coordination with local emergency management (cancellations, diversion, emergency care, patient tracking) • Management of patient clinical activities (such as Decontamination, Triage, Treatment Areas) • Full or partial evacuation (see CHA Evacuation Checklist) • Documentation and tracking of patient clinical information • Specific responsibilities by department or identified need (such as HazMat, Labor Pool, Auxiliary/Volunteers, Emergency Department, Dietary, Environmental Services, Plant Operations, Pharmacy, Respiratory Therapy, Social Services)		
4. Recovery	**Reference/Location**	**Status**
A. Initiation of recovery activities initiated during Response Phase		
B. Secure and initiate clean-up and decontamination of contaminated facilities and grounds in coordination with Fire and Safety		
C. Return to normal operations (phased, approvals, priorities, checklists)		
D. Event Evaluation • Multi-disciplinary Incident Debriefing • Evaluation of Response Plans (After Action Reports) • Improvement plans/EOP update (Corrective Action Plans)		

Endnotes:

(1) SIP Decision Tree (Exhibit 1)

(2) HICS Incident Planning Guides (such as, Chemical, Biological, Severe Weather, Radiologic/Nuclear)
HICS Incident Response Guides (such as, Chemical, Biological, Severe Weather, Radiologic/Nuclear)

Figure 1: Hospital Evacuation and Shelter in Place Decision Tree

Event

- Event requiring facility to consider whether evacuation or Shelter in Place (SIP) plans should be activated
- External and internal intelligence regarding event

Must Shelter-In-Place

- The external environment would pose a greater danger to patients, staff and visitors than evacuation (e.g., chemical/ biological agent release, nuclear incident plume)
- Adequate and timely facility and/or mutual aid resources are not available or accessible (e.g., earthquake)

Must Evacuate

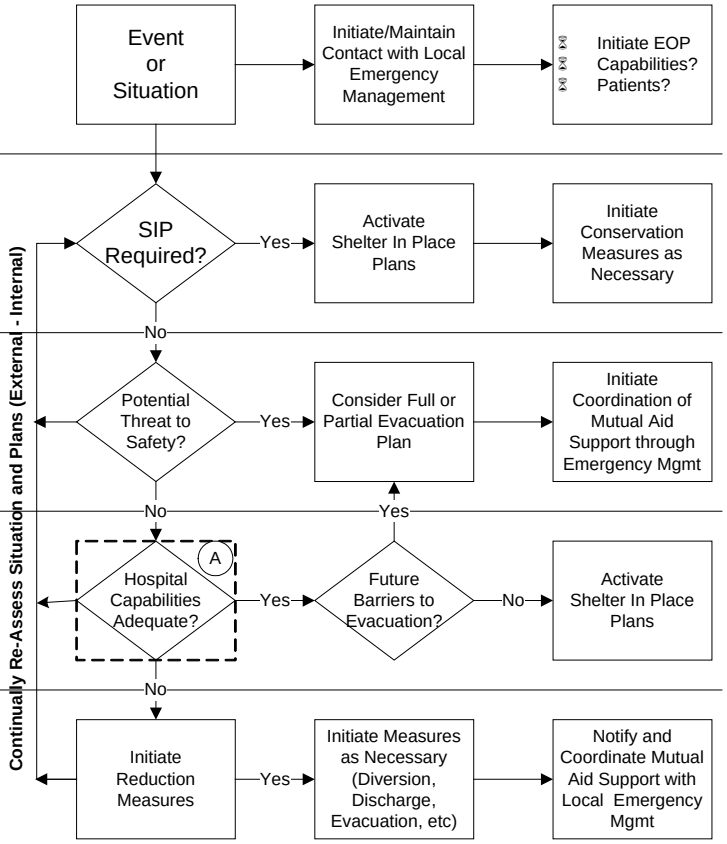
- The proximity, scope and/or expected duration of event poses an immediate threat to patient and staff safety
- Adequate and timely facility and/or mutual aid resources are available and accessible to support Full or Partial evacuation

Shelter In Place or Evacuation Decision

- Duration and scope of threat to hospital clear but may evolve
- Hospital capabilities adequate to care for patients and staff with available support for estimated event duration
- May or may not be barriers mutual aid resources should evacuation become necessary

Need to Implement Reduction Measures

- Hospital capabilities not adequate to maintain full operations for estimated duration of event
- Determination made that reduction measures necessary (for example, conservation of resources, curtailment of services and/or partial hospital evacuation)
- No identified barriers to mutual aid resources



(A) Hospital Capabilities may include communication, resources (medical/non-medical supplies and equipment), utilities, staff, food, water, safety and security (including safety of facilities).

2.1 Sample Emergency Management Committee Roster

Emergency Management Committee

The role of the facility's Emergency Management Committee is to coordinate the development and maintenance of the Emergency Operations Plan, ensure the emergency preparedness program meets relevant standards and requirements, and provide and/or coordinate training and drilling exercises.

It is strongly recommended that members of your Incident Command Team participate on the Emergency Management Committee.

The committee will be chaired by the Administrator or designee and will meet on a monthly basis.

The committee should have representation from:

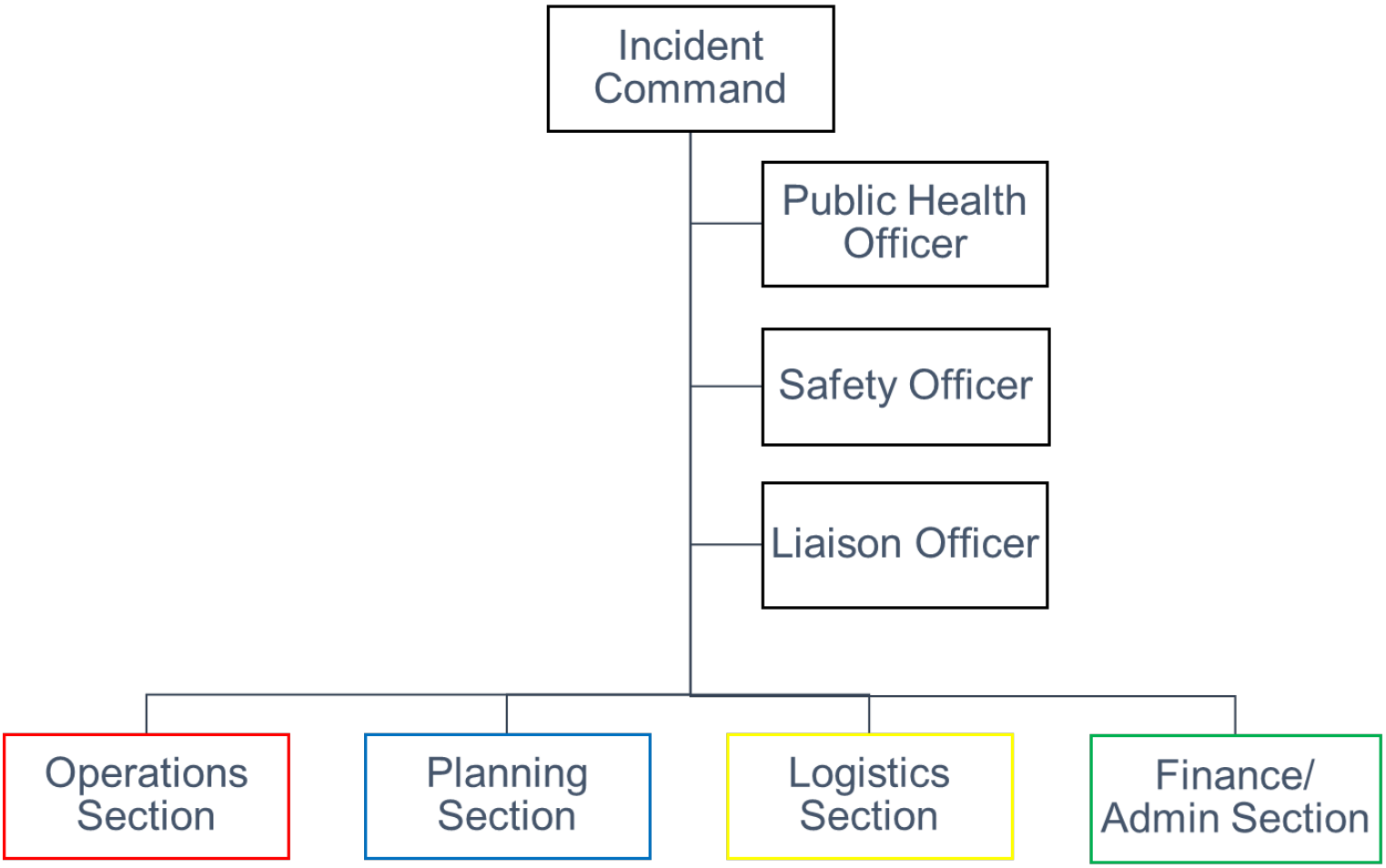
- Administration
- Quality or Process Improvement
- Facilities/Engineering
- Information Technology
- Clinical administration (Chief Medical Officer, Nurse, Nursing Administrator, Physician)
- Infection Control
- Security
- Safety
- Human Resources
- Social Work

2.2 Sample Emergency Management Committee Agenda

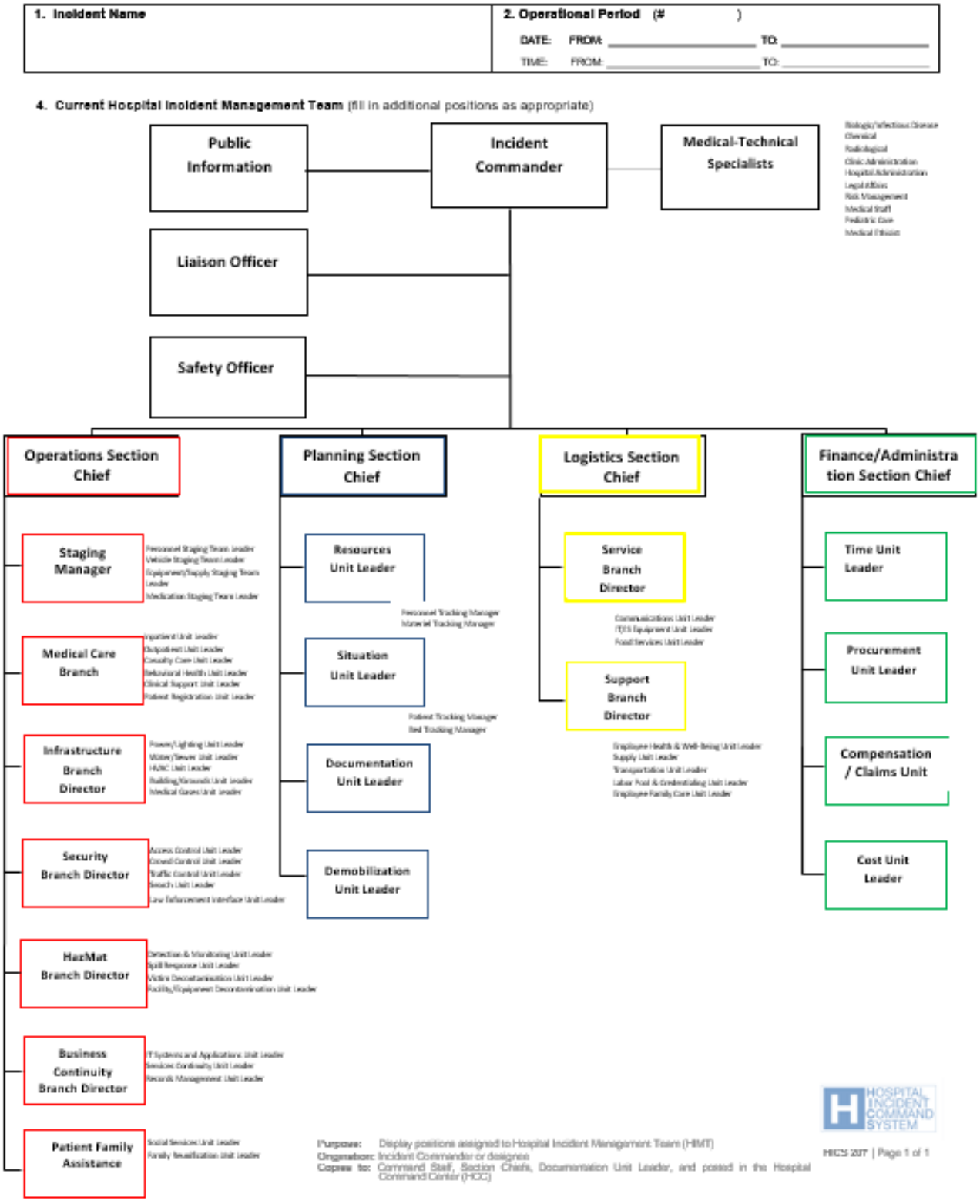
EM Committee Agenda
[Date]

1. Welcome and Sign-in
2. Incident Review
    a. Review of any incidents since prior meeting
    b. Update on corrective actions
3. Review of progress toward meeting annual regulatory requirements
4. Review of progress toward annual program goals
5. Update on current projects
6. Updates from sub-committees
7. Review of action items from meeting
8. Adjournment

3.1 Simplified ICS Chart



3.2 HICS207-Hospital Incident Management Team Chart



A fillable ICS chart can be found http://www.emsa.ca.gov/Media/default/HICS/HIMT%20Chart_02.pdf

PURPOSE: The HICS 207 – Hospital Incident Management Team (HIMT) Chart provides a visual display of personnel assigned to the HIMT positions.

ORIGINATION: Prepared by the Incident Commander or designee (Resources Unit Leader) at the incident onset and continually updated throughout an incident.

COPIES TO: Distributed to the Command and General Staff and the Documentation Unit Leader. The HICS 207 is intended to be projected or wall mounted at the Hospital Command Center (HCC) and is not intended to be part of the Incident Action Plan (IAP).

NOTES: Additions may be made to the form to meet the organization's needs. Additional pages may be added based on need (such as to distinguish more branches or units as they are activated). Three versions of the HIMT Chart are available in the 2014 Hospital Incident Command System (HICS) Appendix C: Adobe Acrobat fillable PDF, Microsoft Word, and Microsoft Visio Drawing.

NUMBER	TITLE	INSTRUCTIONS
1	**Incident Name**	Enter the name assigned to the incident.
2	**Operational Period**	Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.
3	**Current Hospital Incident Management Team Chart**	Enter the names of the individuals assigned to each position on the Hospital Incident Management Team (HIMT) chart. Modify the chart as necessary, and add any lines/spaces needed for Command Staff assistants, agency representatives, and the organization of each of the General Staff sections.

3.3 Potential Candidates for Major ICS Positions

Note: The Incident Commander position is the only one required. The others should be assigned as needed for the response. It is recommended that health centers identify primary and secondary personnel to fill each role in case the full roster is required.

Incident Commander
- Administrator
- Chief Medical Officer
- Clinical leadership

Safety Officer
- Individual responsible for environmental health and safety
- Individual responsible for infection control

Liaison Officer
- Individual who develops and maintains community relationships and partnerships
- Administrator

Public Information Officer
- Individual responsible for media outreach
- Individual responsible for communications

Operations Section Chief
- Administrator
- Clinical leadership

Planning Section Chief
- Strategic planner
- Administrator

Logistics Section Chief
- Supply chain manager
- Human resources manager

Finance Section Chief
- Finance manager
- Human resources manager

3.4 Incident Command System Succession Planning

Position	Primary (Name and phone)	Secondary (Name and phone)
Incident Commander		
Safety Officer		
Public Information Officer		
Liaison Officer		
Operations Section Chief		
Planning Section Chief		
Logistics Section Chief		
Finance Section Chief		

4.1 Sample Emergency Operations Center (EOC) Activation and Deactivation Protocols

Activation

1. The EOC will be activated when there is a known or potential threat to the health center or community
2. The Incident Commander will order the activation
3. Upon activation, the Incident Command Team will report to the EOC
4. Communication equipment and other technology will be tested
5. Supplies will be distributed as needed
6. Admission to the EOC will be limited to the Incident Command team and invited participants
7. The Incident Commander will conduct a situation briefing
8. Assignments will be issued and a staffing plan will be developed
9. Incident objectives will be developed and implemented

Deactivation

1. The EOC will be deactivated at the conclusion of major activities
    a. Depending on the nature and scope of the emergency, deactivation may take place at the end of response, during recovery, or at the end of recovery.
2. The Incident Commander will order the deactivation
3. All equipment and supplies will be returned to the EOC
4. Communication equipment and other technology will be tested and repairs will be made/ordered as necessary
5. Supplies will be replenished as needed
6. The EOC will be returned to full working order in anticipation of the next emergency

4.2 Emergency Operations Center (EOC) Site Considerations

- ☐ A room that can be secured with a door and lock
- ☐ A room large enough to hold the Incident Management Team
- ☐ Equipped with a closet or cabinet that can be locked
- ☐ Fully connected to internet
- ☐ Equipped with telephone landlines
- ☐ Able to be connected to back-up power system

4.3 Sample EOC Equipment and Supplies Checklist

- ☐ Communications equipment – telephones, radios
- ☐ Furniture – Table and chairs
- ☐ Computers and printers
- ☐ EOC forms and logs
- ☐ Copier and copy paper
- ☐ Office supplies (pens, pencils, staplers/staples, note paper)
- ☐ Emergency generator
- ☐ Flashlights
- ☐ Uninterruptible Power Supply (UPS) for computers
- ☐ Local maps
- ☐ Hard copies of essential contact information, plans, and policies
- ☐ Cleaning supplies
- ☐ Kitchen equipment and supplies
- ☐ Food and water

5.1 Discussion-based Exercises

Instructions: These are meant to be 5-minute discussions with staff and/or leadership to maintain awareness of emergency management and enhance critical thinking skills. This is a no-fault exercise.

1. We have just been ordered to evacuate the premises immediately. What actions should be taken first? Who are our most vulnerable patients and how would we assist them? How would we confirm that everyone has evacuated?

2. A worldwide pandemic flu has been declared but it has not reached our community yet. Patients and staff are very concerned. We are receiving very high-volumes of phone calls. How do we handle this? What are our options?

3. There is insufficient flu vaccine and the vaccine that is available is being prioritized to the hospitals. What do you do? How do you care for your patients and staff? Do you try to acquire vaccine? If so, how?

4. A major storm is predicted and roads and schools may be closed. How do you identify and support your most critical patients?

5. Due to widespread flu, you only have 50% of your normal staff and you cannot get any temporary staff. What do you do?

6. A tornado has touched down in the neighboring community. Your facility, staff, and patients are all safe. How do you respond?

7. There is a new highly contagious disease present in the community. The disease can be fatal in some. There are no known treatments but appropriate PPE has been identified and is available. How would you handle staff concerns?

8. A cyberattack on your IT vendor has left your EHR system vulnerable. It works but you are not sure if you can trust the information or if the information is secure. What do you do?

9. There was a major HazMat incident in the neighboring community. Patients with no symptoms and no potential exposure are calling up concerned and they want to be seen. How do you handle this?

10. It has been weeks since a major tornado devastated the community. You are concerned with rising cases of anxiety and depression in patients and staff. You do not have sufficient mental health staff to manage. What do you do?

5.2 PCMH Matrix for Emergency Management Fundamentals

PCMH CONCEPTS FOR EMERGENCY MANAGEMENT FUNDAMENTALS			
PCMH Concept	**PCMH Activities**	**Connection to EM**	**Example**
Care Management	Use patient data to identify vulnerable populations.	Demographic and health data that is captured in structured, searchable fields can be used to identify patients at high risk.	Use address information to prioritize outreach to patients in areas experiencing the most severe impacts of an emergency.
	Medication management	Up-to-date medication lists can provide critical information for patient care during and after an emergency.	Practice uses medication list to prioritize outreach after an emergency (eg. patients taking insulin).
	Referral management	Co-management agreements specify how patients will be managed and how information will be exchanged in an emergency.	Formal co-management agreement includes emergency contact information for specialty practice.
Team-Based Care	Clinician-led care teams have discrete roles and defined protocols for efficient care delivery.	The EM plan clearly defines protocols for patient care and the roles of each care team member during an emergency.	EM plan includes protocol for handling prescription requests during an emergency.
Access to Care	Provide access to care based on the needs and preferences of its patient population.	Needs and preferences of patient population are taken into account when planning for emergency operations.	Information on emergency operations and communications plans is included in patient education material about accessing care at the practice.
Self-Management Support	Work with patients/families/ caregivers to develop an individualized self-management plan. Self-management resources are provided (directly or via referral) as needed.	Incorporate emergency preparedness into individual self-management plans.	Educate patients on how and when to obtain refills of medication during/after an emergency.

Electronic Access to Patient Information	Provide two-way communication between patients and practice via a secure electronic system.	The ability to communicate with patients directly via a secure electronic system provides the ability communicate with patients before, during, and after an emergency.	Use patient portal to send patients information on how to access care during emergency recovery.
	Connection to a health information exchange	Health information exchange can facilitate continuity of care.	Providers at other facilities that care for patient during an emergency use HIE to access current diagnoses and medications.
Culturally and Linguistically Appropriate Services	Assess the cultural and linguistic needs of the patient population and provide verbal and written communication options that meet those needs.	Provide emergency-related communications that are culturally appropriate and meet the linguistic needs of the patient. Determine how patients' linguistic needs will be met during emergencies.	Practice obtains professional translations of emergency preparedness materials for the preferred languages of its patient population.
Patient Experience	Involve patients/families/ caregivers in quality improvement activities.	Incorporate EM into current QI activities, including those that involve patients/families/ caregivers.	Patients/families/ caregivers are encouraged to identify and evaluate QI issues related to EM.
	Obtain feedback from patients/families/ caregivers on their care and experiences with the practice.	Use existing process for obtaining feedback to assess patient perceptions and preferences for emergency management.	Conduct focus groups to validate effectiveness of emergency communication messages.

6.1 *Know Your Community*

Refer to Section 2, pages 23-38, of the *Resilience Builder Toolkit.* Complete electronic file of toolkit:

http://www.laresilience.org/documents/resilience-builder.pdf

Assess your resources and needs: This tool provides information and activities to help you learn more about your community including its risks for emergencies, disasters, or other threats or risks that can affect the community and its strengths and resources. The activities in this section (outlined below) are meant to help you identify and map community issues, groups at risk, and community resources.

By completing the activities in this tool, you will be able to:

- Identify and prioritize threats and risks in your community
- Identify community strengths and resources including people, agencies, organizations and services
- Identify community challenges including gaps in partnership, communication and resources
- Identify groups that may need extra help or are more exposed to community threats and risks
- Use mapping tools that help you record all of the above and support planning activities

Sample Activities found in the tool include:

Activity 2.1 Community portrait

Activity 2.2 Identify your community's strengths and resources

Activity 2.3 Identify your community's challenges

Activity 2.4 Identify potential threats or risks in your community

Activity 2.5 Prioritize community threats or risks

Activity 2.6 What groups in your community may need more help?

Activity 2.7 Making a map- Knowing your community

7.1 Hazard Vulnerability Analysis Team

A multidisciplinary team is crucial in developing a Hazard Vulnerability Analysis. Different individuals bring different levels of expertise in assessing risk and impact of various hazards. Many participants will already be on the emergency management committee but other individuals may need to be included as well.

The team meeting will be chaired by the Administrator or designee. One person should be designated as the recorder for the team's assessment.

The team should have representation from:

- Administration
- Facilities/Engineering
    - If the health center rents space in the building, someone representing facilities from the building should be included in the discussion
- Risk management
- Information Technology
- Clinical administration (Chief Medical Officer, Nurse, Nursing Administrator, Physician)
- Infection Control
- Security
- Safety
- Human Resources
- Social Work

7.2 Kaiser Permanente's Hazard Vulnerability Analysis Tool

Find the interactive tool available in excel http://www.calhospitalprepare.org/hazard-vulnerability-analysis

Kaiser Permanente

Emergency Management

Harzards - Enter Name of Hospital
Harzard Vulnerability Assessment Tool
Emergenct Occurring Events

Event	PROBABILITY	ALERTS	ACTIVATIONS	SEVERITY = (MAGNITUDE - MITGATION)						RISK
				HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur			Possibility of death or injury	Physical losses and damages	Interuption of services	Preplanning	Time, effectiveness, resources	Community/Mutual Aid staff and supplies	* Relative threat
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	Number of Alerts	Number of Activations	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low	0 = N/A 1 = High 2 = Moderate 3 = Low	0 = N/A 1 =High 2 = Moderate 3 = Low	0 - 100%
Active Shooter	2	1	0	3	1	3	2	2	2	36%
Acts of Intent	1	0	0	3	3	3	2	2	2	17%
Bomb Threat	2	0	0	3	3	3	2	2	2	33%
Building Move	2	0	0	1	2	1	2	2	2	22%
Chemical Exposure, External	1	0	0	2	2	1	2	2	2	12%
Civil Unrest	2	0	0	2	2	2	2	2	2	27%
Communication / TelephonyFailure	3	0	0	1	1	2	2	2	2	33%
Dam Failure	0	0	0	2	3	2	3	3	3	0%
Drought	2	0	0	1	1	1	2	2	2	20%
Earthquake	3	10	6	3	3	3	1	1	1	60%
Epidemic	3	0	0	3	1	2	2	2	2	40%
Evacuation	2	12	8	1	1	2	2	2	2	49%
Explosion	2	2	2	2	3	2	2	2	2	48%
External Flood	3	0	0	1	2	2	2	2	2	37%
Fire	3	4	2	2	3	3	2	2	2	64%
Flood	3	12	8	2	2	3	2	2	2	66%

7.3 Kaiser Permanente Hazard Vulnerability Analysis Instructions

Incident Log HVA Instructions

Input Tab – Under Report For, enter the name of the hospital or organization this tool will be used for and it will carry over to all other tabs

Data Tab – Use this tab to input data on all events you would like captured in your log (i.e., disaster, emergencies, and disruptions)

HVA Tab – Consistent with the traditional HVA, use the drop-down options to populate information for Probability, Magnitude, and Mitigation. Alerts and Activations will automatically populate as a result of data inputted from the corresponding Incident Log. Subsequently, a score will be generated under Risk in the form of a percentage. The higher the score, the higher the priority.

*Note, risk score will only appear once the Probability, Magnitude, and Mitigation ratings have been completed.

Summary Tab – As a result of information captured in the Data and HVA tabs, the summary report tab will provide a snapshot of the total alerts, Top 10 HVA Threats, and a list of the Top 10 Actual Occurrences.

8.1 Technology Assessment

Questions for consideration:

1. Who are your primary audiences? Staff, patients, community, partners?
2. What are your options for reaching them?
3. Do you have a minimum of two ways of reaching each audience?
4. What does each form of technology depend on? Are these dependencies limitations?

Technology	Target Audience	Advantages	Limitations

9.1 Risk Communication Training List

Risk communication requires specialized training to be done effectively. Poor risk communication can result in negative health outcomes, poor patient care, and harm to the organization's reputation.

The following positions should be trained in risk communication:

- Administration
- Clinical leadership
- Public information/media

10.1 Essential Services and Staff Planning Tool

Emergency Functions and Essential Services	**Staff Required by Number and Type**
Services to Expand	Services to Expand
Services to Maintain	Services to Maintain
Services to Temporarily Suspend	Services to Temporarily Suspend
Services That Will Not Be Provided	Services That Will Not Be Provided

10.2 Hospital Continuity Checklist

This checklist is intended to provide hospitals with guidance on Hospital Continuity Program components. Hospitals may elect to integrate their Continuity Plan with their Emergency Operations Plan (EOP), or create and maintain a separate document. However, during an event, it is assumed that both will be activated and, ultimately, managed through a similar structure and process. The order of the components listed here is suggested, not mandated. Supporting documentation may be kept in annexes or within separate binders and can be referenced in the "Reference/Location" column. This document is not intended to address every business continuity standard. To assist with planning, also see the Continuity 101 PowerPoint, the Hospital Continuity Planning Toolkit, and Business Continuity Plan Tool (Appendix D of the Toolkit).

Program Component		
1. Governance	**Reference/Location**	**Status**
A. Policy and Purpose: Consider augmenting existing Emergency Management Program (EMP) policies with Hospital Continuity Program components		
B. Scope and Applicability: Align with organizational priorities		
C. Planning Assumptions		
D. Authority and Responsibility		
• Hospital continuity program organization chart		
• Hospital continuity program responsibilities		
E. Program Evaluation (See also Execution section of this checklist tool, below)		
2. Data: Identifying Essential Services and Applications	**Reference/Location**	**Status**
A. Business Impact Analysis (BIA) Identify essential services and applications (both IT and non-IT supported) that must be continued to maintain essential operations (e.g., supply chain, payroll, research) and healthcare delivery (patient care) following a disaster. (See "How to Conduct a Hospital Business Impact Analysis" and "BIA Excel Tool")		
• Design questionnaire		
• Conduct business impact analysis		
• Perform analysis and summarize findings		
• Complete report		
3. Integration: Developing Business Continuity Strategies	**Reference/Location**	**Status**
A. Analytics and Strategy: Review BIA and Hazard Vulnerability Analysis (HVA) findings to understand what risks pose the greatest threat to essential functions. Use data to make decisions to reduce risks that will have the greatest adverse patient care and financial impacts.		
B. Develop Business Continuity Strategies		
• Clinical: Examine 96-hour capabilities and identify and finalize strategies for ensuring continuity of essential clinical services		

[19] For more tools from California Hospital Association Emergency Preparedness, visit https://www.calhospitalprepare.org/about-us

Program Component		
• Research: Identify strategies for continuity during an interruption of essential services. Determine alternate locations for continuity of research operations in the event the primary location is unavailable (For academic medical centers/facilities with research functions)		
• Administrative: Identify strategies for continuity during an interruption of essential services. Determine alternate locations for continuity of business and finance operations in the event the primary location is unavailable		
C. Develop format and approach to align and/or integrate emergency operations and hospital continuity plans (See EOP/Continuity Plan Table)		
4. Planning: Developing and Integrating Business Continuity Plans	**Reference/Location**	**Status**
A. Align initiation and termination procedures associated with business continuity with existing procedures in the EOP		
B. Incorporate Hospital Incident Command System (HICS) reference materials for the business continuity branch director and associated unit leaders such as:		
• Job action sheets		
• Incident response guides		
• HICS forms - Financial tracking and incident action plan documentation to ensure cost recovery and resumption of operations		
C. Management of Clinical and Support Activities		
• Align plans for relocation and continuity of essential clinical services with hospital surge/expansion plans (See CHA Surge Planning Checklist). Include procedures for alternate site set up and operations.		
• Departmental Plans o Department Status Forms/Summary (see Appendix E, Business Continuity Planning Toolkit) o Identify/document infrastructure/other Interdependencies o Criteria and steps for closing and relocating a department/unit o Resumption of operations of essential clinical functions o Downtime procedures for an extended IT outage		
D. Information Technology and Communications Systems		
• Plans for downtime/workaround procedures for long-term disruptions		
• Alignment with disaster recovery planning for IT & communications		
• Document IT interdependencies		
E. Management of Resources and Assets		
• Augment procedures for the Management of Resources and Assets in EOP with plans for continuity of essential services during supply chain interruptions		
• Establish plans and agreements for mobile capabilities to ensure continuity of essential support functions such as mobile kitchens, pharmacy and radiology		

Program Component		
• Coordinate Just in Time or immediately on-hand inventories and protocol to preserve critical care capacity. Define procedures (e.g., curtail non-essential services) to expand and extend capacity to provide essential services as needed		
• Document vital records		
• Document vital equipment		
F. Management of Workforce Roles and Responsibilities		
• Process for assessment of staff availability and address up to 30% reduction in staff availability, with considerations of an ongoing surge of patients		
• Process for post-event staff rotation		
• Process for assigning staff to essential functions (align with HICS labor pool procedures) and the management of spontaneous volunteers		
• Process for telecommuting to maintain continuity of business functions		
• Identification of requirements (e.g., space, equipment, technology) and the process for relocation and resumption of responsibilities if at an alternate worksite		
G. Management of Utilities		
• Review plans for provision, sustainability, and alternate means of providing utilities when primary source of essential utilities are unavailable		
• Process for continuity of essential services during the loss of utilities		
H. Recovery and Resumption of Normal Operations		
• Process for assessing and evaluating the facility for recovery and resumption of operations		
• Process for testing functionality of equipment and identifying remaining needs for recovery		
• Identification and establishment of agreements (MOUs/MOAs) with vendors and suppliers for recovery and resumption activities (e.g., debris removal, vital record recovery)		
• Process for return of employee's to normal workspace and resumption of normal operations		
5. Execution: Testing and Measuring Business Continuity Programs	**Reference/Location**	**Status**
A. Testing and exercises		
• Expand current exercises to include scenarios with operational impacts (e.g., supply chain operations, critical infrastructure, technology)		
• Conduct department specific exercises (e.g., operating department using downtime procedures, department closure/relocation/resumption of operations)		

Program Component		
B. Results monitoring: Data collection of gaps and results to drive future priorities		
• Track and monitor number continuity metrics (e.g., number of BIA's completed, number of departmental continuity plans completed, number of exercises completed)		

Resources

1. The Joint Commission EM.02.01.01 EP 4 and IM.01.01.03
2. NFPA 1600 Standard on Disaster/Emergency Management and Business Continuity Programs
3. NFPA 99, Chapter 12
4. HIPAA requirements that address BCP: http://www.training-hipaa.net/compliance/Security_Contingency_Planning.htm
5. HPP Performance Measures
6. BIA Excel Tool
7. How to Conduct a Hospital Business Impact Analysis
8. Hospital Continuity Planning Toolkit

11.1 Disaster Skills Self-Assessment: Assets Table

Complete electronic file of toolkit: https://www.rand.org/pubs/tools/TL202.html

Assets in Action

This Assets Table (section 2, pages 24-27, of RAND's *ENGAGED Toolkit: Improving the Role of Nongovernmental Organizations in Disaster Response and Recovery*) will help you conduct an assessment of the resources (e.g., competencies, relationships, data, funding, etc.) that your organization can contribute to disaster response and recovery.

Sector *Brief definition*	**Competencies** *Knowledge, skills, and expertise*	**Money** *Financial or economic assets*	**Infrastructure or Equipment** *Physical assets and constructed facilities*	**Services** *Help or aid supplied*	**Relationships** *Social or professional ties, or connective organizations*	**Data** *Information collected*
Business	Financial and organizational management, local supply chains	Investors and customers	Warehouses, transportation, trucks, goods (supplies, food, etc.)	Supply a variety of goods or services to local residents	With supply chains, transport, customers, connector to chambers of commerce, employees	Purchasing patterns, supply chain disruptions
Community leadership	Policy development/ enforcement, advocacy	Community funds or foundations	Public buildings, local government, local law enforcement	Advocate for community change, develop and enforce policies	With constituency and other local leaders, connector to national leaders	Pending policies
Cultural and faith-based groups and organizations	Community values, spiritual and emotional support	Philanthropic support	Congregations or constituencies, churches or cultural centers, religious texts, donations of food or clothes	Provide donations and volunteer management, spiritual and emotional care, translation support	With congregations or constituencies, and other cultural and faith-based groups, connector to HHS OFBNP	Needs and assets of congregations and constituents
Emergency management	ICS, disaster resources and financing, emergency plans	Disaster financing	ICS, operations or command center, emergency communication systems, surveillance systems	Manage emergency operations, conduct surveillance	With public health, government, connector to FEMA and DHS	Risks and hazards, damage and threat assessment

Sector *Brief definition* 	**Competencies** *Knowledge, skills, and expertise* 	**Money** *Financial or economic assets* 	**Infrastructure or Equipment** *Physical assets and constructed facilities* 	**Services** *Help or aid supplied* 	**Relationships** *Social or professional ties, or connective organizations* 	**Data** *Information collected* 
Mental/ behavioral health	Assessment of problems, inpatient and outpatient care	Government programs (Medicare and Medicaid) and private insurance companies	Assessment centers, emergency or after-hours care, mobile care units, inpatient facilities, outpatient clinics or private practice offices, psychotropic and other medications, evidence-based therapeutic approaches	Provide mental health care, substance abuse prevention and treatment	With clients, behavioral health providers, pharma, connector to SAMHSA	Client needs, service access and utilization
Social services	Case management, employment, child protection, disability services	Primarily government programs	Intake centers, service agencies	Coordinate and deliver social services	With clients, social service providers and case managers, connector to ACF, DSS	Client needs, service access and utilization
Housing and sheltering	Assessment of housing needs (permanent and temporary), housing and shelter services	Primarily government programs	Temporary and permanent dwellings, intake center, cots, blankets, etc.	Provide short- and long-term housing	With builders, construction, lenders, and mortgage insurers, connector to HUD	Availability of housing (e.g., waiting lists, transition lists)

Sector *Brief definition* 	**Competencies** *Knowledge, skills, and expertise* 	**Money** *Financial or economic assets* 	**Infrastructure or Equipment** *Physical assets and constructed facilities* 	**Services** *Help or aid supplied* 	**Relationships** *Social or professional ties, or connective organizations* 	**Data** *Information collected* 
Media	Communication, information dissemination	Investors and customers	Print or networking center, broadcast center (video and radio), offices, mass printing, web capabilities, microphones, cameras, and computers	Disseminate information	With other print/ web/radio media, connector to national media	Circulation statistics (e.g., demographics, reach)
Healthcare	Patient triage, care, management, and transfer	Government programs (Medicare and Medicaid) and private insurance companies	Hospitals, community health centers, private practices, urgent care facilities, medical equipment, vaccines, and other countermeasures	Coordinate and deliver physical health care	With patients, providers, pharma, medical suppliers, insurers, connector to HPP	Patient needs, service access and utilization, medical supplies, pharma supplies

Sector *Brief definition*	**Competencies** *Knowledge, skills, and expertise*	**Money** *Financial or economic assets*	**Infrastructure or Equipment** *Physical assets and constructed facilities*	**Services** *Help or aid supplied*	**Relationships** *Social or professional ties, or connective organizations*	**Data** *Information collected*
Aging	Surveillance, non-medical services, education, and resources for seniors, caregiver education	Primarily government programs	Government office, local service providers (transport, civic, nutrition, etc.), transport vehicles, senior resources directory, senior educational materials	Provide nonmedical services for seniors	With seniors and senior service providers	Senior needs, senior service access and utilization
Education and childcare settings	Child development, multi-modal education, child transport and food service	Local tax base	Schools (pre-college) that house gyms and kitchens, daycares (commercial and residential), program-specific providers (e.g., Gymboree), books and toys, duplication and audio-visual equipment, desks and chairs	Provide educational programming, Head Start, nutrition programs (e.g., free or reduced school lunch)	With children, parents, childcare providers, and educators	Student needs, academic performance, rates of students receiving free/reduced lunch, shifts in student demographics or enrollment

11.2 Resource Management Planning Tool

Resource Management			
Resources On-Hand			
Type	Quantity	Source/Vendor	Known/Potential Limitations of Source
Resources to Procure in Emergency			
Type	Quantity	Potential Source(s)	Known/Potential Limitations of Source

12.1 Why Community Resilience Is Important

Refer to Section 1, pages 11-22, of the *Resilience Builder Toolkit.* Complete electronic file of toolkit: http://www.laresilience.org/documents/resilience-builder.pdf

Overview: When a traumatic or difficult event occurs in a community, many of us want to do what we can to help. A community resilience approach will help you work with other organizations and your neighbors to develop a community response and recovery plan that is effective and efficient as possible. Community resilience strategies offer you the opportunity to harness your community's strengths, knowledge, commitment, and resources.

This tool, *Why Community Resilience Is Important* (section 1, pages 11-22, of the *Resilience Builder Toolkit),* provides information and capacity building activities, which will help you to:

- Understand how community resilience is different from traditional preparedness
- Know the "levers" that contribute to increasing community resilience
- Discuss what community resilience looks like in your community
- Discuss strategies that have been used in your community and how they could be improved
- Define community resilience in your own words
- Identify how community resilience applies to your current work

12.2 Community Resilience Action List

This tool will help you start the process of integrating community resilience strategies into your organizational best practices to optimize and supplement emergency management activities and overall disaster preparedness. This exercise can be used to assist you and your staff with thinking through how to leverage existing organizational assets and improve your organization's preparedness and recovery planning processes.

RAND CORPORATION

Community Resilience Action List

Action List for Organization Track

1. Focus on Assets

☐ Consider the following the assets available to your organization:

- ☐ Competencies
- ☐ Money
- ☐ Infrastructure
- ☐ Equipment
- ☐ Services
- ☐ Relationships
- ☐ Data

What else can I do? ***Are there assets that my organization has, which have not been identified in these areas?***

☐ Contact my local emergency planner.

Contact your local emergency planner to let them know about your organization's assets. An important part of organizational asset planning is making sure those assets are readily visible to the broader community.

2. Improve household preparedness of consumers, employees, and suppliers

☐ Include the following items in my plan:

- ☐ Provide training to employees to improve their household preparedness.
- ☐ Disseminate information on household preparedness to consumers, employees, and suppliers.
- ☐ Set time aside for employees to develop a family reunification plan.

3. Improve the organization's plan for long-term recovery

☐ Include the following items in my plan:

- ☐ First Responders
- ☐ Workforce Competencies
- ☐ Transition to Routine Care
- ☐ Financing

*What else can I do **to prepare members or staff in my organization**?*

☐ Exercise and improve your organization's long-term recovery plan.

Follow these steps:

1. Plan an exercise.
2. Conduct the exercise.
3. Use findings to improve plan.

4. Consider the effects of climate change

☐ Include the following items in my plan:

- ☐ Information for employees on the economic, health, and social impacts of disasters, including those that may be associated with changes in climate.
- ☐ Plans for mitigation or adaptation strategies (for example, relocation or floodproofing in response to rising sea levels).

*What else can I do **to address climate change**?*

☐ Communicate with employees and stakeholders about climate change.

Share information about the health and social effects of climate change, as well as offering training to employees on how climate change may affect how the organization does and the demographics of the community.

For communication tips, check out climatechangecommunication.org.

☐ Develop a long-term strategic plan.

This may involve several steps, such as conducting an emissions profile assessment; gauging risks and opportunities based on your operations, products, and service lines; and exploring technological solutions to help address the risks and leverage the opportunities.

5. Link the organization's daily routine to disaster resilience

☐ Include the following items in my plan:

- ☐ Disseminate preparedness information (e.g., during a regular visit).
- ☐ Identify at-risk or vulnerable constituents (e.g., during regular screening or personnel updates).
- ☐ Test or exercise components of your emergency plan (e.g., test constituents' ability to work remotely during a snowstorm).

*What else can I do **to build resilience day to day**?*

☐ Invest time and resources into improving routine coordination with consumers and between your organization and other community organizations.

Follow these steps:

1. Assess consumers' satisfaction.
2. Identify areas for improvement.
3. Develop a plan.
4. Implement the plan.

6. Address behavioral health issues before, during, and after disaster

☐ Include the following items in my plan:

- ☐ A plan for organization employee/member health promotion.
- ☐ Health insurance coverage for both physical and mental health needs.
- ☐ A training or professional-development agenda with psychoeducation about disaster mental health and resilience.
- ☐ An employee assistance program.

*What else can I do **to support the behavioral health of staff in my organization**?*

☐

- ☐ Assess self-care practices within your organization and work to increase opportunities for those types of events.
- ☐ Educate employees about behavioral health promotion opportunities within your organization as well as the plans for accessing those resources during a disaster.
- ☐ Offer activities on how to create supportive work environments.

7. Help constituents plan for the social and economic impacts of disaster

☐ Include the following items in my plan:

- ☐ Information on rapidly providing economic supports to disaster-affected employees.
- ☐ Support for those who may be considered socially isolated (via distance, vulnerabilities, etc.).

What else can I do ***to prepare members or staff in my organization for the social and economic impacts of disaster?***

☐

- ☐ Communicate with your employees and consumers about how to obtain disaster recovery support.
- ☐ Conduct financial literacy training for employees and consumers.
- ☐ Promote connections of employees to voluntary or other community-based organizations.

8. Determine how to work with the broader community around disaster resilience

☐ Include the following items in my plan:

- ☐ Plans to improve team-building and ensure strong relationships are developed among employees.
- ☐ Plans to engage employees and other community residents in the development of preparedness plans and in disaster exercises.

What else can my organization do ***to partner with other community groups to strengthen community resilience?***

☐ Engage in community emergency planning teams.

This can include identifying ways for staff to volunteer to support local response and recovery efforts.

This also entails making sure your organization's plans are connected with the overall community plan, including improving coordination and alignment so that roles and responsibilities are clearly outlined.

☐ Incentivize employees and consumers to participate in community emergency planning.

Providing some reward or honor for employees who participate in these activities helps align organization members with broader community plans and shows that your organization values employee engagement as part of whole community emergency planning.

9. Develop data systems to track preparedness and recovery planning

☐ Include the following items in my plan:

- ☐ Plans for contacting employees and consumers as needed during emergency situations.
- ☐ A process for capturing information on employee and consumer needs after a disaster from relevant data systems (e.g., whether there are more insurance claims or health needs).
- ☐ Information on employee readiness (e.g., whether employees have a personal preparedness plan and whether they know the organization's emergency operations protocol).
- ☐ Tracking of resources (e.g., materials and/or capabilities) that the organization can contribute to the community in response and recovery.

*What else can my organization do **to build data systems to track disaster recovery**?*

☐

- ☐ Ensure that consumer emergency contact information is up to date.
- ☐ Identify a process of tracking the needs of employees after a disaster.
- ☐ Log information on what resources the organization plans to or does provide in disaster response and recovery.

12.3 Community Resilience Talking Points

What is resilience?

Resilience is WHAT…

- Helps communities to stay strong during emergencies
- Gets people in a community back on their feet quickly
- Keeps communities from making the same mistakes during an emergency (they learn and get smarter and stronger!)

Why is resilience important?

- **Emergencies will happen!** Emergencies and stressful events are happening every day, and more often.
- **A lot can happen in 72 hours!** Preparedness guidelines say your community should be prepared to take care of itself for up to 72 hours after a disaster.
- **Preparedness is not enough!** Even though we've been working on helping families get emergency plans and kits (with food, water, flashlights, etc.) for over 10 years, not everyone has a plan or a kit.
- **You are your community's first lifeline for help!** Things you do at home are things you can do to help get the community back on its feet. Baby-sitting, texting for communication, or helping to clean up are all needed after a disaster.

What can I do to build resilience?

- **Get to know your neighbors.** They might be the fastest people to reach you in an emergency.
- **Talk to your friends and family.** Figure out how you will communicate and help each other during an emergency.
- **Use your talents.** Can you speak another language? Do you help your grandmother use her cellphone? Can you drive? Do you know how to take care of a dog or cat? These are all skills needed during emergencies. Think about your skills now, so you know how you can help if an emergency happens.
- **Get yourself ready.** Make plans to help yourself. For example, list the things you can't live without. Then put those things in a bag so they are ready to take with you if an emergency happens. It could be chocolate, medicine, your favorite song, a photo you like to look at.
- **Get to know your community.** Find the places that you could go for help, if needed. This could be your church, a health clinic, or an emergency shelter.
- **Do something every day.** You have probably noticed that building resilience is not something you can do all at once. It is something that you work on every day. Today you might share your talents with family and friends. Tomorrow you might talk to your neighbors. What's important is to connect today with others so that you and your community will be stronger tomorrow.

13.1 Partnership Development

Community Partners	
Health Center Will Need	
Partner Name	Service Needed
Health Center Can Provide	
Partner Name	Service Provided

13.2 Partnerships, Collaboration, and Inclusion

Refer to Section 3, pages 39-46, of the *Resilience Builder Toolkit.* Complete electronic file of toolkit: http://www.laresilience.org/documents/resilience-builder.pdf

Create and maintain partnerships: This tool covers how to build membership of a community coalition, summarizes the importance of partnerships, and how to enhance representation in your coalition of different sectors from your community. It also includes ways to define and record the roles and responsibilities of each coalition member in building resilience.

After implementing the activities in this tool, you will be able to:

- Understand the importance of including building a coalition
- Identify community partners- including community members and representatives from different sectors
- Assess partner roles and contributions
- Take steps to outreach to potential partners and invite them into the coalition

13.3 Talking with Diverse Sectors

Below are some reasons why organizational partners from each sector could be interested in building community resilience. These may be helpful to think about conversation starters.

Business
If you own a business, disaster resilience is important for a number of reasons.
During a disaster, it is estimated that one in four businesses will have to close. This will impact you directly and disrupt your bottom line. You also want to consider your employees and customers.

Community leadership/Social services/Housing and shelter
As a community leader you are probably interested in increasing our ability to prepare, respond, and recover from disaster. The next step is to build community capacity and identify what resources are available in our community.

Cultural and faith-based groups and organizations
After a disaster, community members typically turn to cultural or faith-based organizations first. It is important for you to be prepared. During this time people will be in need of multiple resources and knowing how to direct them is important.

Emergency management
As an emergency responder, you are probably aware of the importance of emergency preparedness, knowing community vulnerabilities, and knowing community resources.

Healthcare
As a healthcare professional, your role after a disaster is critical and you will want to know what resources are available to your patients and help them prepare prior to a disaster. You'll be able to incorporate questions such as asking patients if they have anyone in their neighborhood to help them.

Older Adults/Aging organizations
The aging population is a population at risk and will likely need extra help after a disaster.

14.1 MOU Tracking

MOU Reference

The purpose of this document is to be a quick reference guide during emergencies. It should capture all current MOUs and the nature of the agreement in terms of resources the health center can provide and resources the partner can provide. Note that MOUs are not binding legal agreements.

Partner	Contact Name	Contact Number	Date of MOU	Resources to be Provided by Health Center	Resources to be Provided by Partner

14.2 Sample MOU 1

Emergency Management Memorandum of Understanding Template

Emergency Management Memorandum of Understanding (MOU) between _____ (Health Center) and (Partner) _____ which calls for both authorities to establish and maintain a coordinated program for enhancing Emergency Management

WHEREAS, _____ (Health Center) and (Partner) _____ are subject to danger and damage anytime from flooding, tornadoes, high winds, lightning, hazardous material incidents and other acts of nature or terrorism; and

WHEREAS, _____ (Health Center) and (Partner) _____ propose this Emergency Management Memorandum of Understanding (MOU) to establish a formal working Mutual-Aid relationship between (Partner) _____ and the _____ (Health Center) in support of Emergency Management planning, response and recovery programs; and

WHEREAS, (Partner) _____ and _____ (Health Center) have established emergency response plans to reduce the loss of life and property and protect citizens from all types of hazards through a comprehensive, risk-based, all-hazards emergency management program of mitigation, preparedness, response and recovery; and

WHEREAS, in light of their respective common goals to reduce the loss of life and property from natural or man-made emergencies or disasters, _____ (Health Center) and (Partner) _____ recognize the need to maintain a strong coordination at a level that ensures efficient use of all available resources, consistent with the principles of each entity; and

WHEREAS, _____ (Health Center) and (Partner) _____ agree to encourage, coordinate, promote, and support an ongoing relationship between both entities and to hold periodic partnership meetings to focus on, but not limited to, identifying and assessing an all- hazards approach and associated risks, particularly as they relate to _____ (Health Center) and (Partner) _____; and

WHEREAS, _____ (Health Center) and (Partner) _____ would benefit from the development and adoption of this MOU; and

WHEREAS, both parties agree, but not limited to the following:

- *Cooperate in all areas of mutual interest as it relates to Emergency Management: sharing data, information, planning, response, recovery, and other operational support programs;*

- *Enhance and maximize both Emergency Management program capabilities of both participants for the purpose of protecting the public health and safety, the (Health Center) environment, and to preserve and safeguard property;*

- *In the event of an emergency or disaster declared by the jurisdiction, provide a rapid coordinated and effective response with full utilization of all resources of both participant jurisdictions, including any resources on hand or available that are essential to the safety, care and welfare of those impacted.*

- *Each jurisdiction shall appoint an individual representative to serve as a point of contact for matters relevant to this MOU.*

- *This MOU becomes effective on the date of execution and shall remain in effect unless terminated, by written notification, by either jurisdiction to the other.*

- *This MOU may be amended by written mutual agreement. WHEREAS, _____ (Health Center) has considered this MOU and has determined that it is in the best interest of the (Health Center) to approve such an MOU, NOW, THEREFORE, BY THOSE PRESENT BE IT HEREBY CONFIRMED BY THE _____ (HEALTH CENTER) IN _____ THAT (Partner) _____ and the _____ (Health Center) Memorandum of Understanding (herein referred to as the "Emergency Management MOU") therein is hereby approved and that upon adoption of the MOU by (Partner) _____ and all previous versions are hereby abrogated. EXECUTED THIS _____ DAY OF _____ 20__.*

Name, (Executive Director/Owner/Responsible Party)
_____ *(Health Center)*

Name, (Executive Director/Owner/Responsible Party)
_____ *(Partner).*

14.3 Sample MOU 2

SAN DIEGO County Area Hospitals
Hospital Emergency Mutual Aid
Memorandum of Understanding

This Hospital Emergency Mutual Aid Memorandum of Understanding ("MOU") is dated for reference purposes only as of April 11, 2012, and is entered into voluntarily by and among the undersigned San Diego County Hospitals ("Hospital(s)" or "party(ies)") that have for the purpose of providing mutual aid at the time of a disaster).

Nothing in this MOU is intended to create any relationship among the Hospitals other than that of independent entities agreeing with each other solely for the purposes set forth in this MOU.

This MOU is not a legally binding on the parties, but rather is a voluntary agreement based on the belief and commitment of the undersigned Hospitals that as a result of any community emergency or disaster, regardless of cause, which exceed the effective response capabilities of a hospital, an affected hospital may request assistance from the other hospitals that are parties hereto as more generally described below

This document is intended to (i) augment, not replace, each hospital's disaster plan and (ii) supplement the rules and procedures governing interaction with other hospitals during a disaster. Each Hospital shall have full and absolute discretion to determine the extent, if any, to which it wishes to provide resources to assist another Hospital under this MOU. Accordingly, no Hospital shall be required to provide medical supplies, equipment, services, personnel or bed capacity to another Hospital, either during a disaster or emergency or at any other time, regardless of available capacity or other conditions at the requesting or donating Hospital. For purposes of this MOU, the disaster may be an "external" or "internal" event for one or more hospitals and is subject to an affected hospital's emergency management plan being fully implemented. The terms of this MOU are intended to be incorporated into each hospital's emergency management plans.

By signing this MOU each hospital is evidencing its intent to abide by the terms of the MOU in the event of a disaster. The hospitals agree to make reasonable efforts to comply with the following:

1. Term of the MOU

The term of this MOU shall be effective from October 1, 2008, through September 30, 2011.
The term of this MOU shall be renewed for 3-year periods upon the terms and conditions then in effect, unless a party gives the other parties written notice of its intention not to renew, which notice shall be given no less than thirty (30) days prior to the expiration date of the then current term.

2. Evacuation of an Undersigned Hospital:

2.1 If a disaster affects one or more of the hospital(s) resulting in partial or complete facility evacuation, upon request of the affected hospital(s), the other Hospitals agree to confer with the affected hospital(s) and determine the extent to which the Hospitals are willing to participate in the distribution of patients from the affected hospital to their respective hospitals.

2.2 In the event of an evacuation, the hospital with an evacuating facility will contact EMSDOC, Medical Operations Center (aka MOC), per established hospital protocol, policy and guidelines.

2.3 Request for the Transfer of Patients: The request for the transfer of patients by a hospital initially can be made verbally. The request, however, must be followed up with a written communication. The transferring hospital, to the extent possible in an emergency situation, will identify to the accepting hospital:

- ☐ The number of patients needing to be transferred
- ☐ The general nature of their illness or condition
- ☐ Any type of specialized services required
- ☐ Patient medications, and/or specialized equipment needed

2.4 Documentation: The transferring hospital, to the extent possible in an emergency situation and in accordance with governing state and federal law, is responsible for providing the receiving hospital with:

- ☐ The patient's medical records
- ☐ Insurance information
- ☐ Other patient information necessary for the care of the patient
- ☐ Patient medications
- ☐ Specialized equipment necessary for the care of the patient

2.5 Transfer of Patients: The transferring hospital is responsible for tracking the destination of all patients transferred out. The transferring hospital is responsible for notifying both the patient's family or guardian and the patient's attending or personal physician of the situation.

2.6 Supervision: The receiving hospital will designate the admitting service, the admitting physician for each patient, and, if requested, will provide at least temporary courtesy privileges to the patient's original attending physician per receiving hospital's policy and procedure. (Emergency privileges for physicians and other health care providers will be granted in accordance with The Joint Commission and the California Department of Health Services standards.)

3. Medical Supplies and Pharmaceuticals

3.1 In the event that medical supplies and/or pharmaceuticals and equipment are requested by a recipient hospital, the other hospitals will share the requested supplies to help ensure that patients in the San Diego area receive necessary treatment during a disaster.

3.2 The supply-sharing will occur, in cooperation between the Hospital Command Centers, at the involved hospitals. Requests initially can be made verbally but must be followed up with a written request

3.3 Documentation: Documentation should detail the items involved in the transaction, condition of the material prior to the loan or transfer (if applicable), and the party responsible for the material.

3.4 Authorization: The recipient hospital will have supervisory direction over the borrowed medical supplies, pharmaceuticals, and equipment, once they are received by the recipient hospital.

3.5 Compensation: All compensation for equipment or supplies provided to a recipient hospital pursuant to this MOU will be paid by the recipient hospital within 90 days of its receipt of an invoice from the transferring hospital for such supplies.

4. Medical Operations/Loaning Personnel

4.1 Communication of Request: The request for the "transfer" of personnel can initially be made verbally followed by written or Web Emergency Operations Center (WebEOC) documentation of the request. Requests will be made in a standardized format. [This should be included in the standard development of forms, under Section 7.] A request and documented response will occur prior to the arrival of personnel at the recipient healthcare facility. A Hospital is not obligated under this MOU to provide the requested personnel if the Hospital does not have available personnel, or if the personnel are unwilling to provide the services under this MOU. The recipient healthcare facility will identify to the donor healthcare facility the following:

- ☐ The type and number of requested personnel
- ☐ An estimate of how quickly the request is needed
- ☐ The location where they are to report
- ☐ An estimate of how long the personnel will be needed

4.2 Documentation: The "transferred" personnel will be required to present their identification badge from their employer hospital at the check-in site designated by the recipient hospital's facility command center. The recipient hospital's facility will be responsible for the following: Meeting the "transferred" personnel (usually by the recipient hospital's facility's security department or designated employee) and providing adequate identification, e.g., "visiting personnel" badge, to the "transferred" personnel.

4.3 Staff Support: The recipient hospital shall provide food, housing and/or transportation for “transferred” personnel asked to work for extended periods and for multiple shifts. The costs associated with these forms of support will be borne by the recipient hospital.

4.4 Financial Liability: The recipient hospital will reimburse the hospital lending its personnel for the actual salaries and benefits of such personnel if the personnel are employees of the hospital lending the employees. The reimbursement will be made within ninety days following receipt of the invoice.

4.5 The Medical Director/Medical Staff Office: The recipient hospital will be responsible for providing a mechanism for granting emergency privileges for physicians, and other licensed healthcare providers to provide services at the recipient hospital’s facility.

4.6 Demobilization procedures: The recipient hospital will provide and coordinate any necessary demobilization procedures and post-event stress debriefing.

5. Miscellaneous Provisions:

5.1 In the event of an emergency situation the hospitals will voluntarily provide staff assistance, if feasible, to participating hospitals.

5.2 Amendments to this MOU must be in writing and signed by all participating hospitals.

6. Financial & Legal Liability

6.1 The recipient hospital shall assume legal and financial responsibility for the personnel, equipment, medical supplies, and pharmaceuticals from the donor hospital during the time the personnel, equipment, supplies, and pharmaceuticals are at the recipient hospital. The recipient hospital will reimburse the donor hospital, to the extent permitted by federal law, for all of the donor hospital's costs determined by the donor hospital’s regular rate. Costs includes all use, breakage, damage, replacement, and return costs of borrowed materials, for personnel injuries that result in disability, loss of salary, and reasonable expenses, and for reasonable costs of defending any liability claims, except where the donor hospital has not provided preventive maintenance or proper repair of loaned equipment which resulted in patient injury. Reimbursement will be made within 90 days following receipt of the invoice.

6.2 The recipient hospital shall assume the legal and financial responsibility for transferred patients upon arrival at its hospital facility. Upon admission the recipient hospital is responsible for liability claims originating from the time the patient is admitted to the recipient hospital. Reimbursement for care should be negotiated with each hospital’s insurer under the conditions for admissions without pre-certification requirements in the event of emergencies.

6.3 The donor hospital is responsible for appropriate credentialing of personnel and for the safety and integrity of the equipment and supplies provided for use at the recipient hospital.

6.4 Liability, malpractice and disability claims, attorneys’ fees, and other incurred costs are the responsibility of the recipient hospital. An extension of liability coverage will be provided by the recipient hospital, to the extent permitted by federal law, insofar as the donated personnel are operating within their scope of practice.

7. Effective Date, Future Amendment and Construction

Development of operational procedures, forms, and other tools to operationalize this MOU shall be conducted by the “owner” and participants through the San Diego Health Care Disaster Council. Updates to those procedures, forms, or tools do not require revision of this MOU.

Participation by the Department of Veterans Affairs (VA) is limited by certain statutory obligations that take precedence over the responsibilities under this MOU. The Stafford Act (42 U.S.C. 5121 et seq.) requires the Federal Government to respond to major disasters and emergencies initiated by Presidential declaration and may direct any Federal agency to

use its authorities and resources to support State and local assistance efforts. The FEMA Interim Federal Response Plan [42 U.S.C.5170a (1) and 5192(a) (1); Executive orders 12148, 12673] requires Federal agencies to respond to the FEMA Directors request to provide assistance to support State and local efforts. The VA's ability to assist the local facility under this MOU is also subject to participation in the National Disaster Medical Systems which provides resources for natural and man-made disasters and supports patient treatment requirements for armed conflict. Under 38 USC 8111(a) (1), the Secretary of Veterans Affairs is required to maintain a contingency capacity of hospital beds to assist the Department of Defense in a time of war or national emergency. Finally, 38 USC 1784 requires VA to assist non-veteran patients referred to a VA facility on a humanitarian basis outside the Stafford Act.

This MOU is in no way meant to affect any of the participating hospitals' rights, privileges, titles, claims, or defenses provided under federal or state law or common law.

The participating hospitals shall maintain the confidentiality of patient and other records as required by law.

IN WITNESS WHEREOF, we have set our hands and seals that date below written.

Participant Hospital Name: VA San Diego Health Care System

_____	_____
Signed	Dated
Robert M Smith, MD	
Acting Director/CEO	_____
Title	Receive

Contacts

For information regarding this Toolkit or the Emergency Management Initiative contact:

Barrie Black, MPH
Program Manager, Louisiana Public Health Institute
1515 Poydras St., New Orleans, LA 70112
P: 504.301.9852, ablack@lphi.org

For more information regarding emergency management contact:

Dane K. Ligoure, MA, MBA
Director of Operations, Primary Care Development Corporation
45 Broadway, Suite 530, New York, NY 10006
P: 212.437.3926, dligoure@pcdc.org

For more information regarding community resilience contact:

Elizabeth Thorton
Policy Analyst, RAND Corporation
650 Poydras St., New Orleans, LA 70130
P: 504.299.3492, ethorto@rand.org

The Gulf Region Health Outreach Program (GRHOP) is funded from the Deepwater Horizon Medical Benefits Class Action Settlement which was approved by the U.S. District Court in New Orleans on January 11, 2013.