

# Medical Surge Capacity and Capability:

## The Healthcare Coalition in Emergency Response and Recovery



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## The Healthcare Coalition in Emergency Response and Recovery

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## Executive Summary

This handbook was developed to serve as a companion to *Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources during Large-Scale Emergencies*, also known as the MSCC Handbook. Originally published in 2004 and revised in 2007, the MSCC Handbook proposed a management structure and processes for the medical and public health response to emergencies and disasters. Within this management construct, the *Tier 2 Healthcare Coalition* was defined as a group of individual healthcare organizations in a specified geographic area that agree to work together to maximize surge capacity and capability during medical and public health emergencies by facilitating information sharing, mutual aid, and response coordination.

The purpose of this handbook is to provide guidance to healthcare planners on how to develop, implement, and maintain cost-effective and *response-oriented* Healthcare Coalitions. It describes the common elements of an effective Healthcare Coalition that may be applied in any locale to operationally support individual healthcare organizations and the larger community response to emergencies or disasters. The Coalition is highlighted as an emergency *response organization* in order to distinguish this handbook from other efforts that are underway across the U.S. that primarily coordinate emergency preparedness.

For the Healthcare Coalition to achieve its desired functionality during incident response, it must have the capability to address the time stresses and uncertainty of major healthcare emergencies. The processes used to coordinate preparedness activities often are not conducive to the emergency context. Instead, response methods in this handbook are based upon those set forth in the Incident Command System (ICS) and the National Incident Management System (NIMS). The recommended *response* platform for the Healthcare Coalition can become immediately operational at all times, can focus on the Healthcare Coalition's tasks as its primary mission, can expand as necessary to support its member organizations, and can sustain operations over time.

The Healthcare Coalition must have a baseline operational capability that is always available to receive initial information about an emergency (one that is already occurring or an imminent threat) and rapidly notify Coalition member organizations. This baseline capability does not need to be time or resource intensive. The Healthcare Coalition then mobilizes and activates processes for response using a medical Multiagency

Coordination System (MAC System) that *supports, but does not supplant*, the incident response activities of individual healthcare organizations (Tier 1) and jurisdictional authorities (Tier 3). Within this handbook, the terms Healthcare Coalition Response Team and Senior Policy Group are used to describe the primary elements of the Coalition's MAC System. Provided below is a general description of each element; however, the specific objectives, construct, and procedures for each element are expected to vary from Coalition to Coalition.

- **Healthcare Coalition Response Team (HCRT):** The HCRT coordinates response activities between individual healthcare organizations (Tier 1) and between the Healthcare Coalition and jurisdictional authorities (Tier 3). A primary purpose for any Healthcare Coalition is to promote optimal situational awareness for its member organizations through the collection, aggregation, and dissemination of incident information. The HCRT can also facilitate resource support (mutual aid) between Coalition members, as well as assist with the acquisition and distribution of aid from other sources (e.g., jurisdictional authorities). An ICS-based organizational model is recommended for the HCRT because of its proven effectiveness in managing complex activities during incident response. *However, despite this proposed model, it is important to emphasize that the HCRT serves principally as a coordinating entity in support of Coalition member organizations. It does not "command" the actions of Coalition members or any other response entities it might interact with during an emergency.*
- **Senior Policy Group:** This group represents the executive leadership of the Coalition's member organizations. The Senior Policy Group convenes only as needed during an emergency to make high-level strategic or policy decisions, maintain situational awareness for senior executives, and monitor the strategic effectiveness of the HCRT.

*The guidance contained in this handbook is not prescriptive.* Because each local jurisdiction or regional area is unique, the Coalition's structure and/or the processes that it uses may vary based on myriad factors. For example, Coalitions based in different geographical regions may choose to address a different set of response issues. The common elements described in this handbook should be adapted to reflect the realities of emergency management in a locale and to enhance (not replace) existing structures and processes used to prepare for, respond to, and recover from major healthcare emergencies and disasters.

When effectively implemented, the Healthcare Coalition provides the mechanisms for individual healthcare organizations to coordinate information sharing and other response actions using efficient response processes and procedures. A side benefit of the Healthcare Coalition for its member organizations may be an improved ability to project visible competency to the public during emergencies. In addition, participation in a Healthcare Coalition addresses accreditation and regulatory requirements for community emergency planning and other emergency preparedness activities. These benefits make the Healthcare Coalition an attractive vehicle for preparedness within the healthcare industry.

The success and long-term sustainability of a Healthcare Coalition will depend largely on the ability to develop a cost-effective system that is supported by senior executives of member organizations and by the relevant jurisdictional authorities. To overcome the day-to-day business competition that exists between healthcare organizations, the Coalition must promote open and fair representation for all its members. At the same time, the Coalition must respect the management sovereignty of each organization during incident response and recovery, as well as the inherent governmental authority of Emergency Management, Public Health, Emergency Medical Services, and other relevant public agencies.

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# Introduction

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# Background on the MSCC Handbook

The 9/11 terrorist attacks and the anthrax mailings in October 2001 focused significant attention on mass casualty response systems in the United States. Analyses of these incidents revealed deficiencies in many important preparedness areas that adversely affected the medical and public health response. It was apparent that many preparedness actions (pharmaceutical stockpiling, training to care for contaminated victims, etc.) were occurring in narrow stovepipes created by traditional healthcare disciplines and delivery systems.

In 2003, the U.S. Department of Health and Human Services (HHS) funded a study to describe an operational management structure for medical and public health emergency response. At the request of HHS, this initiative was designed to expand on guidance contained in the Medical and Health Incident Management (MaHIM) System.<sup>1</sup> MaHIM described a functional organization to prepare for and respond to mass casualty incidents. While MaHIM focused at the local jurisdiction and regional levels, the 2003 study extended similar guidance to healthcare organizations and proposed methods for improved coordination across all levels of a healthcare emergency response.

CNA conducted the 2003 study in collaboration with the MaHIM System researchers at The George Washington University. They applied established principles of the Incident Command System (ICS) and incorporated input from a multidisciplinary panel of subject matter experts. The resultant Medical Surge Capacity and Capability (MSCC) Handbook was published in August 2004. A revised edition was published in 2007 to describe changes that had occurred in the Federal public health and medical response following Hurricane Katrina and to clarify concepts from the National Incident Management System (NIMS).<sup>2</sup> The revised version also placed greater emphasis on effective response to hazards that impact healthcare organizations themselves (e.g., continuity of operations).

The MSCC Handbook described a six-tier model for organizing healthcare response to emergencies or disasters. The tiers demonstrate the integration of responding healthcare resources through a response

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<sup>1</sup> Barbera JA, Macintyre AG. Medical and Health Incident Management System: A Comprehensive Functional System Description for Mass Casualty Medical Incident Management (December 2002); Available at: <http://www.gwu.edu/~icdrm/>.

<sup>2</sup> The revised edition of the MSCC Handbook is currently available at: <http://www.hhs.gov/disasters/discussion/planners/mscc/index.html>.

management system that extends from individual healthcare organizations (Tier 1) through local jurisdiction (Tier 3), State, including sub-State regions (Tier 4), inter-State regions (Tier 5), and Federal (Tier 6) levels of response. The second tier – known as the Healthcare Coalition – was briefly described as a group of individual healthcare organizations in a specified geographic area that have partnered to respond to emergencies or disasters in a coordinated manner. During an incident, the Coalition’s response organization helps enhance the collective surge capacity and capability of its members by facilitating information sharing, resource support, and response coordination. The Coalition’s response organization functions as a supporting entity (similar to a Multiagency Coordination System) rather than as a command and control or Area Command organization.

Since its release, the MSCC Handbook has been widely read and used. Its overarching concepts and management strategy for healthcare system emergency response became the basis of guidance for HHS’ Hospital Preparedness Program (HPP) in 2006.<sup>3</sup> HPP awardees are expected to work within the MSCC framework to ensure integration of the healthcare system response from the local through the State level.<sup>4</sup>

## **WHY THE HEALTHCARE COALITION FOCUS?**

Following the adoption of MSCC concepts into HPP guidance, HPP personnel received feedback from participating healthcare organizations and local jurisdictions revealing difficulties with implementing the Healthcare Coalition (Tier 2) construct. The lack of published, well described models for establishing the required relationships, authorities, and responsibilities for a Healthcare Coalition contributed to the implementation challenges.

Despite these challenges, there is evidence that efforts are underway across the U.S. to develop Healthcare Coalitions.<sup>5</sup> This is very encouraging and many locales have developed, or are in the process

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<sup>3</sup> The HPP was formerly known as the National Bioterrorism Hospital Preparedness Program (NBHPP). In 2007, the NBHPP moved from the Health Resources and Services Administration (HRSA) to the Office of the Assistant Secretary for Preparedness and Response at HHS as a result of the Pandemic and All-Hazards Preparedness Act (Public Law 109-147).

<sup>4</sup> U.S. Department of Health and Human Services, FY09 Hospital Preparedness Program Funding Opportunity Announcement.

<sup>5</sup> Maldin B, Lam C, Franco C, et al., Regional Approaches to Hospital Preparedness. Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science, Volume 5, (2007).



of developing, some form of a Healthcare Coalition. Much of this development has focused on building “preparedness organizations,” as defined by NIMS.<sup>6</sup> This work is important for establishing relationships and conducting preparedness planning. However, it is only a preliminary step to operational readiness for healthcare organizations to coordinate effectively during incident response. The desired goal for Healthcare Coalition development should be a “response organization”<sup>7</sup> that can provide effective actions in a no-notice, sudden onset incident under the most adverse conditions.

## PROJECT GOAL AND OBJECTIVES

The goal of this project is to provide guidance to healthcare planners on how to develop and implement cost-effective, sustainable, and response-oriented Healthcare Coalitions in rural, suburban, and urban areas of the U.S. and its territories. The following objectives were delineated for this handbook:

1. Present a System Description (including an organizational chart) and Concept of Operations for a Healthcare Coalition response organization.
2. Provide an operational understanding for how the Healthcare Coalition can promote optimal medical surge capacity and capability, as well as healthcare organization resiliency, in the face of overwhelming casualties and/or direct hazard impact.<sup>8</sup>
3. Define the essential elements of situational awareness for the Healthcare Coalition during emergency medical and public health response. This includes real-time information collection, processing, and dissemination to support informed and coordinated decision-making for the healthcare response.
4. Describe the Healthcare Coalition’s potential role in supporting mutual aid and other resource sharing arrangements between healthcare organizations (Tier 1). The Healthcare Coalition may also

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<sup>6</sup> The NIMS definition of a “preparedness organization” is provided in Appendix B.

<sup>7</sup> NIMS describes the “ICS organization” for emergency response and distinguishes it from the preparedness organization. Since the Coalition is not the “command” authority during a major incident, the term “response organization” is used to avoid confusion.

<sup>8</sup> In this handbook, healthcare system resiliency refers to the ability of healthcare organizations to survive a hazard impact and rapidly recover compromised services. This ensures that a reliable platform is available to address medical surge needs and minimize any interruption of routine healthcare service delivery.

facilitate resource acquisition from local jurisdictional authorities (Tier 3) or other sources. Efficiency is promoted by establishing consistent methods for requesting and offering assistance when medical needs extend beyond the capacity and capability of Coalition member organizations.

5. Provide guidance on how to coordinate response objectives and strategy among Healthcare Coalition members and integrate the Healthcare Coalition into other MSCC response tiers.

## PROJECT SCOPE

*Rather than provide prescriptive guidance on how to develop and maintain a Healthcare Coalition, the intent of this handbook is to describe the common elements of an effective Healthcare Coalition that may be applied in any locale.* The handbook is intended to help medical and public health planners integrate these elements when they establish or revise a local and/or regional Healthcare Coalition. This handbook is also intended to:

- Serve as a companion to the 2007 MSCC Handbook.
- Demonstrate the importance of the Healthcare Coalition in addressing healthcare system resiliency and medical surge.
- Describe the internal mechanisms required to develop, implement, and maintain a Healthcare Coalition response organization.
- Describe the external mechanisms required to integrate the Healthcare Coalition with other MSCC response tiers.
- Ensure consistency with NIMS concepts and terminology.
- Highlight the benefits of a NIMS-consistent Multiagency Coordination System (MAC System) that is composed of participating healthcare organizations.

This handbook does not offer detailed guidance on the development and implementation of an individual healthcare organization's Emergency Management Program (EMP) or Emergency Operations Plan (EOP). Discussion at the healthcare organization level (Tier 1) is limited to the elements necessary for an organization to effectively participate in a Healthcare Coalition.

This handbook also does not provide extensive guidance on how to develop and implement a Public Health Department or jurisdiction-wide EOP. Discussion at the jurisdiction level (MSCC Tier 3) *is limited to the interface with the Tier 2 Healthcare Coalition. It is important to emphasize*

*that Healthcare Coalition activities during incident response do not supplant or subvert the authority of public officials acting as the incident command or area command authority for the overall incident. Rather, the Healthcare Coalition supports the response by enhancing the integration and performance of responding healthcare organizations.*

***Important Point of Clarification:***

The authors of this handbook recognize that some jurisdictions have established organizational structures for emergency preparedness and response that incorporate elements of MSCC Tiers 1, 2, and 3. This approach is perfectly valid as long as the critical Tier 2 response issues presented in this handbook are addressed. It is important to note, however, that these multi-tier organizational structures almost always incorporate an element of command and control of medical and public health assets during response. In contrast, Tier 2 Healthcare Coalitions, as defined in this handbook, do not have command and control authorities and provide only support to healthcare organizations (Tier 1) and jurisdictional authorities (Tier 3). While Healthcare Coalitions must coordinate and integrate closely with governmental agencies, they are not composed of organizations with statutory command authority.

It is beyond the scope of this handbook to describe the full range of emergency response models that incorporate public sector organizations that conduct command and control or area command. This handbook focuses on the key MSCC Tier 2 issues and the organizational structure, processes, and procedures that address these issues through a Tier 2 Healthcare Coalition. The reader may find utility in adopting the tenets proposed in this handbook regardless of the organizational structures used in their home jurisdiction(s).

## **ORGANIZATION OF THIS HANDBOOK**

Chapter 1 describes the need for the Healthcare Coalition and presents an overview of the concepts on which the Healthcare Coalition is based. The handbook then presents the Healthcare Coalition as a response organization that supports local and regional medical response and promotes healthcare system resiliency.

Chapters 2 and 3 present a System Description and a Concept of Operations for the Healthcare Coalition response organization. The end state of the Healthcare Coalition is presented upfront because the authors believe it is important to fully understand the desired response functionality of the Healthcare Coalition before undertaking initial Coalition development and implementation activities.

Chapter 4 discusses how the Tier 2 Healthcare Coalition response organization integrates with other MSCC tiers, and offers strategies to promote integration. Chapters 5-7 then focus on the preparedness and mitigation issues in establishing and sustaining a response-oriented Healthcare Coalition.

# **NOTES**

## **NOTES**

# Chapter 1:

## Healthcare Emergency Response and the Need for a Healthcare Coalition

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## 1.1 MASS CASUALTY AND MASS EFFECT INCIDENTS: IMPLICATIONS FOR HEALTHCARE ORGANIZATIONS

The first step in developing a healthcare emergency response system is to fully understand the range of potential hazards and their impact, the complexities of healthcare emergency response, and the difficulties of delivering healthcare services during a disaster.

### 1.1.1 The Range of Hazard Impacts on Healthcare Organizations

In emergency management, “hazard” refers to the underlying etiology for any type of emergency. A wide range of actual or potential hazards is relevant to healthcare organizations in any locale. Using a Hazard Vulnerability Analysis (HVA – see Chapter 5), healthcare organizations may identify and characterize hazards according to the following attributes:

- The general probability of hazard occurrence in the community and in the specific location of the healthcare organization that is performing the HVA.
- The general impact of the hazard, should it occur, on both the community and the healthcare organization. “Risk” can then be calculated, since it is a function of the probability (likelihood) of a hazard occurrence and the impact (consequences) of a hazard on the target.<sup>1</sup>
- The specific vulnerabilities of the healthcare organization to the hazard impact. This is a primary concern since the safety of staff, patients, and visitors, and the maintenance of critical healthcare services to patients currently being treated, are paramount.
- The specific vulnerabilities of the community to the hazard. This can be used to project the potential service demands that may be placed on healthcare organizations during emergencies. Service demands may extend beyond traditional medical services to include treating first responders, providing preventive medical information to the public, or establishing large-volume medical screening capabilities.

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<sup>1</sup> Adapted from Ansell J, and Wharton F. Risk: Analysis, Assessment, and Management. John Wiley & Sons, Chichester, 1992.



In a detailed HVA, vulnerability is examined and characterized for the healthcare organization in a manner that provides information for all four phases of Comprehensive Emergency Management – mitigation, preparedness, response, and recovery.<sup>2</sup> Vulnerability is multifaceted and involves the following:

- Disruption from the hazard impact directly on the healthcare organization (e.g., flooding of a hospital), thereby affecting its normal healthcare service delivery
- Disruption of the healthcare organization’s function indirectly from a hazard impact on infrastructure and support services, including utilities and re-supply (e.g., power outage after a storm)
- Impact on the healthcare organization’s operations from unusual service demands (e.g., treating even a few patients with Severe Acute Respiratory Syndrome (SARS) or multiple burn patients in a non-burn facility).

For these reasons, healthcare organizations may characterize hazards as primarily “mass casualty,”<sup>3</sup> and/or “mass effect” (Exhibit 1-1).

### **Exhibit 1-1. Mass Casualty and Mass Effect Incidents**

**Mass Casualty Incident:**An incident that generates a sufficiently large number of casualties whereby the available healthcare resources, or their management systems, are severely challenged or unable to meet the healthcare needs of the affected population.

**Mass Effect Incident:**An incident that primarily affects the ability of an organization to continue its normal operations. For healthcare organizations, this can disrupt the delivery of routine healthcare services and hinder their ability to provide needed surge capacity. For example, a hospital’s ability to provide medical care to the victims of an earthquake is compromised if it must focus on relocating current patients because a section of the facility was destroyed.

Adapted from Barbera JA, Macintyre, AG, Shaw G, et al, Emergency Management Principles and Practices for Healthcare Systems (2006); Available at: [www1.va.gov/emshg/page.cfm?pg=122](http://www1.va.gov/emshg/page.cfm?pg=122).

<sup>2</sup> Drabek TE, Hoetmer GJ (Eds). Emergency Management: Principles and Practice for Local Government. International City Management Association, Washington, D.C.; (1991).

<sup>3</sup> Within this text, casualty refers to any human accessing public health or medical services, including mental health services and medical forensics/mortuary care (for fatalities), as a result of a hazard impact.

## 1.1.2 Characteristics of Incidents Confronting Healthcare Organizations

Incident characteristics vary across hazards and even within a specific hazard type.<sup>4</sup> These characteristics should be considered when assessing the value of a Healthcare Coalition to participating healthcare organizations and the local jurisdiction. The following is a partial list of incident characteristics that are relevant to Coalition operations.

**Sudden versus slow onset:** Mass casualty and mass effect incidents may occur suddenly with extraordinary medical resource needs, or they may evolve slowly and with warning, allowing for more extensive evaluation before instituting response measures. In a slow onset incident (e.g., heat wave), a Healthcare Coalition may facilitate inter-facility action planning and enable healthcare organizations to anticipate mutual aid and other resource needs. In sudden onset incidents, rapid notification to all local and regional healthcare organizations through the Healthcare Coalition may be critical so organizations can respond effectively, support each other, and interact with local jurisdictional authorities.

During sudden onset incidents, many victims reach hospitals (or other healthcare providers) on their own or through the assistance of bystanders, and not by way of Emergency Medical Services (EMS). Therefore, victims may arrive with little or no prior notification and without being matched with the most appropriate facility. The ability of healthcare organizations to rapidly obtain additional resources, provide input to EMS for appropriate patient distribution, and assist each other in matching resources to patient needs may best be addressed through a Healthcare Coalition.

**Insidious versus obvious onset:** Incident onset may be obvious or insidious, requiring adequate surveillance systems for recognition and determination of the incident size and scope. In the case of the latter, the ability to rapidly gather and synthesize data from healthcare organizations may be important to determining that a dangerous incident is evolving.

**Short duration versus prolonged incidents:** Preparedness planning and exercises often focus on short duration, high intensity incidents.

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<sup>4</sup> Within this text, incident refers to any unexpected situation that requires an organization to activate its Emergency Operations Plan and commence emergency response operations. NIMS designates a planned non-emergency situation (e.g., a mass gathering) that activates emergency operations as an "event."

However, healthcare emergencies can be prolonged with ongoing service needs and continuity of operations issues. It is important for healthcare planners to recognize that a prolonged incident (days to weeks) will almost always have a major impact on the healthcare organization. Increased personnel commitment during a prolonged response can be difficult to sustain given the manpower constraints faced by many healthcare organizations. The financial impact of a prolonged response on a healthcare organization, due to disruption of normal healthcare service delivery, must also be addressed. The Healthcare Coalition can promote access to resources that may be critical to sustaining continuity of operations in addition to addressing surge needs.

**Terrorism and other fear-generating hazards:** Some mass casualty or mass effect incidents, particularly acts of terrorism such as the anthrax mailings in 2001, result in a large population of concerned, potentially exposed persons. Substantial medical and public health resources must be devoted to evaluate these patients. Victims may require specialized medical and public health capabilities, ranging from population-based mental health interventions to treatment for such issues as chemical burns, inhalational respiratory failure, or radiation syndromes. The ability to share expert advice and establish uniform diagnostic and treatment protocols during response may be as important as acquiring adequate equipment and supplies.

### **Exhibit I-2. Example of how expert medical advice can be shared during an emergency**

During the 2001 anthrax attacks in the Washington, D.C. metropolitan region, members of the medical community initiated a series of teleconferences to coordinate the clinical management of patients with suspected anthrax across the affected jurisdictions (Washington, D.C., suburban Maryland, and northern Virginia). The calls provided a forum to exchange information on diagnosis and treatment, such as the usefulness of chest CTs in detecting early signs of inhalational anthrax, the lack of value of nasal swabs in making a diagnosis, and the effectiveness of certain antibiotic treatments. The calls also helped to dispel rumors circulating in the media.

Gursky E, Inglesby TV, and O'Toole T. Anthrax 2001: Observations on the Medical and Public Health Response. *Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science*, Volume 1, (2003).

### 1.1.3 Critical Issues in Healthcare Organization Emergency Response

Healthcare organizations' actions during an emergency or disaster can be complicated by a range of response issues. While the primary responsibility for emergency response lies with the executive leadership of each healthcare organization, the support activities performed by an effective Healthcare Coalition may be very helpful. The following issues should be considered when examining the Healthcare Coalition's potential roles during incident response.

**The need for continuity of healthcare operations despite a hazard impact:** Because of the critical services they provide, healthcare organizations can rarely halt operations before or after a hazard impact. They must continue to provide a safe environment for current patients, staff, and visitors.

**The need to maintain adequate healthcare service delivery while addressing all aspects of medical surge:** Any hazard that directly impacts a healthcare organization will likely produce a range of response issues. Medical care must be provided to hazard victims while maintaining operations for the usual patient population. The organization may also be required to perform other activities, such as participating in risk reduction for potential victims (through advice, prophylaxis, and other health interventions), assisting with mass fatality response, and addressing the psychological needs of patients, staff, and visitors.

**The fragility of healthcare organizations' physical facilities:** The following physical attributes of healthcare organizations make them somewhat "fragile" compared to other emergency resources:

- The structural layout and supporting infrastructure is often complex and of varying age and reliability.
- Building occupancy remains relatively high 24/7, with the associated maintenance requirements.
- Environment of care, healthcare operations, and patient/staff safety depend heavily on facility infrastructure (e.g., electricity, water, HVAC, communications). The loss of water, electricity, and HVAC created life-threatening conditions in hospitals after Hurricane Katrina, even in patient care locations that otherwise were undamaged.

- Multiple hazards may exist within the facility (e.g., chemicals used in medical diagnostics, radiation emitters used in cancer therapy, cleaning and sterilizing materials).

**The business environment in which healthcare organizations operate day-to-day poses challenges after a hazard impact.** Some characteristics of this environment include the following:

- Healthcare organizations rely heavily on specific equipment and supplies (e.g., pharmacy, sterile supplies) where just-in-time inventory is common and surge resources are limited. Few alternative suppliers or substitute resources may be readily available.
- Seeking efficiencies, the U.S. healthcare industry generally relies on “just-enough” staffing and space for everyday operations. This business practice adds to the difficulties in achieving adequate surge capacity and capability. Current professional staffing shortages (e.g., nurses) may further exacerbate resource constraints.
- Required patient care documentation and other regulatory compliance requirements are very labor intensive.
- Many healthcare organizations regularly experience deficits in operating income. Future income for services is relatively fixed even while expenses increase, and there is a near complete dependency on third party payers to maintain the income stream. Any additional uncompensated emergency care can pose a significant financial risk.
- The business viability of a healthcare organization is tied in part to its reputation in the community, which can be affected by how the healthcare organization performs in an emergency or disaster.
- Unlike many businesses, only a limited amount of the work performed by healthcare organizations can be done from an off-site location. This limits the value of “work from home” strategies that are common in business continuity planning.

**The “public-private sector divide” during response:** Most healthcare organizations in the U.S. are privately owned. While the overall management of healthcare emergencies is typically a public sector responsibility, the delivery of emergency healthcare services is usually performed by private healthcare organizations. This distinction can complicate the response if not adequately addressed through response planning between the public and private sectors.

The following issues should be considered:

- Privately owned healthcare organizations usually maintain their respective decision-making sovereignty during emergencies, except in extreme or unusual circumstances (e.g., enactment of isolation or quarantine orders by public health authorities). This emphasizes the need for voluntary coordination of decision-making among individual healthcare organizations.
- For the reasons stated earlier, healthcare organizations need to consider financial solvency and other business continuity issues when determining emergency response actions. These issues will need to be addressed with public agencies during incident response, as well as during preparedness planning. *This is one of the most critical reasons for establishing a separate Tier 2 capability, even if it is within an existing multi-tiered organization established by a local or State jurisdiction.*
- Public sector entities also operate under budget constraints that may affect preparedness initiatives (e.g., their ability to stockpile resources). This may also affect their capacity to respond to the needs of private entities, such as healthcare organizations.
- Regulatory and legal issues may impede public funding to for-profit healthcare organizations that provide disaster services. Historically, it has been difficult for healthcare organizations to recoup their expenditures under the Robert T. Stafford Act or other disaster declarations. This reality should be recognized and addressed fairly for all Coalition member organizations.
- Private healthcare organizations have not always included public sector agencies in their preparedness planning. Likewise, jurisdictional authorities (Tier 3) have not always demonstrated that they consider healthcare organizations to be essential partners in emergency response. This can adversely affect response if healthcare organizations are not represented in decision-making, resource coordination, and information sharing activities.

**The need for a visibly competent healthcare emergency response:**

In order to maintain the public's confidence and promote cooperation during extreme emergencies, the public must be assured that healthcare services are being provided in an equitable and ethically sound manner. The importance of maintaining the public's confidence has several implications for healthcare systems:

- Ideally, the response strategies, tactics, and public messages developed by healthcare organizations should be consistent with the public sector emergency response.
- Healthcare providers should be briefed on potentially controversial messages prior to their public release so their questions or concerns can be addressed before they interact with patients or the public.
- Healthcare providers must manage the fear component of a public health crisis by demystifying any unusual hazard (e.g., anthrax) through a clear explanation of medical tactics to the public, and by promoting consistency in strategy and tactics across all healthcare organizations in the area.

The aforementioned issues should be considered by healthcare emergency planners and public authorities during preparedness planning. None of the issues will likely be obvious to or accepted by the public as legitimate obstacles to effective emergency response.

## 1.2 SYSTEMS-BASED APPROACH TO HEALTHCARE INCIDENT MANAGEMENT

A systems-based approach to emergency response means that the disparate elements that are required to perform response operations are viewed as interrelated components of a single system. This is relevant to Healthcare Coalitions since they may involve different organizations working together to achieve a common goal (see Chapter 5). A systems-based approach uses a standardized set of management steps that are sequential and may be applied to any major undertaking.<sup>5</sup> This dictates that overarching objectives, strategies, and tactics are established to promote effective response management and consistency.<sup>6</sup>

The following sections relate how this management methodology might be applied during the initial development of a Healthcare Coalition's Emergency Operations Plan (EOP). The same methodology might be applied to other major Coalition efforts (e.g., training).

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<sup>5</sup> Barbera JA, Macintyre AG, Shaw G, et al, *Emergency Management Principles and Practices for Healthcare Systems* (2006); Available at: [www1.va.gov/emshg/page.cfm?pg=122](http://www1.va.gov/emshg/page.cfm?pg=122).

<sup>6</sup> Chapter 5 provides more detail on applying a systems-based approach during design and implementation of a Healthcare Coalition.

## 1.2.1 Healthcare Response Goal and Objectives

The application of a systems-based approach for the Healthcare Coalition begins with understanding an overarching goal and supporting objectives for the entire healthcare response – from individual healthcare organizations through local, State, and Federal assistance. An example goal statement and objectives for all levels of MSCC incident response and recovery are stated below.

**Goal:** To promote healthcare system resiliency and adequate surge capacity and capability across the affected community during a mass casualty and/or mass effect incident.

**Objectives** to support this goal may include the following:

- Protect healthcare personnel, current patients, visitors, and the integrity of the healthcare system
- Provide the best available medical care for responders, victims, and affected families
- Manage costs, regulatory compliance, and other issues so they do not compromise higher priority objectives
- Develop and use processes that enhance the integration of healthcare organizations into the community response.

## 1.2.2 Healthcare Response Strategies

Response strategies are established to facilitate achievement of the response goal and objectives. The overarching MSCC priority strategy is presented in Exhibit 1-3. Implementing a Healthcare Coalition, as described in this manual, can be an important step in accomplishing this strategy during emergencies.

### Exhibit 1-3. Prioritization of MSCC actions

1. Maximize medical surge capability and capacity for individual healthcare organizations (adequate EOP for each medical and healthcare resource).
2. Maximize community capacity and capability (situational awareness, mutual aid and other resource sharing arrangements, patient distribution and redistribution, and other support).
3. Maximize regional, State, and national capabilities and capacities.
4. Institute modified delivery of healthcare to maintain critical medical services.



### 1.2.3 Healthcare Response as an Overarching System

Using the ICS and Multiagency Coordination principles described in NIMS, the six-tier MSCC model was developed to incorporate the preceding goal, objectives, and strategies for optimal healthcare system resiliency and medical surge.

The tiered model presented in the MSCC Handbook (see Figure 1-1 below) demonstrates the relational arrangement of individual healthcare response assets within the local, State, regional, and Federal government construct. Each tier is summarized below.

**Tier 1:** Encompasses all individual healthcare organizations in a geographic area that deliver “point of service” medical care during emergencies or disasters.

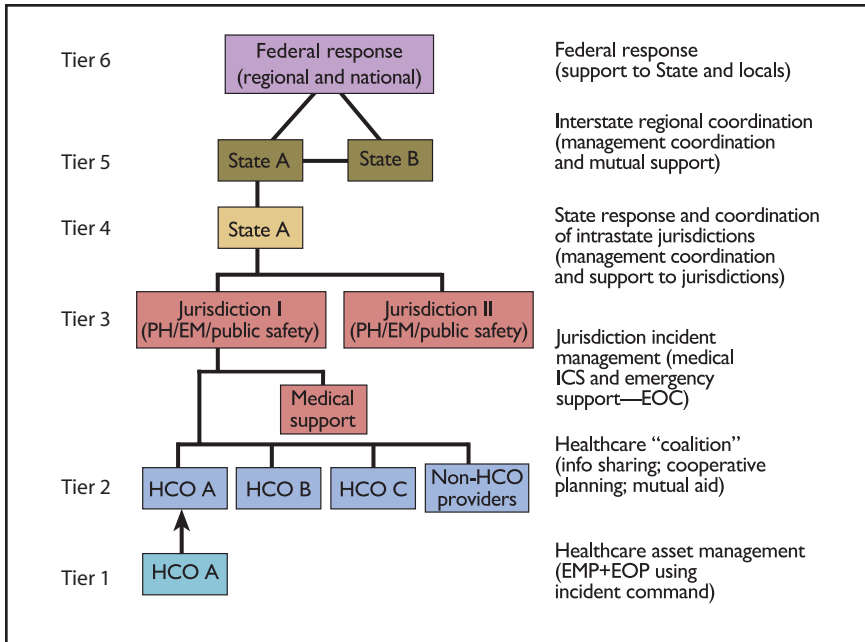
**Tier 2:** Tier 1 assets that have formed a Healthcare Coalition to share incident information, exchange resource status information that supports mutual aid, coordinate response strategies and tactics, and use a common interface with local jurisdictional authorities to exchange information and request assistance.

**Tier 3:** Municipal, county, or similar agencies with jurisdiction over the impacted areas and responsibility for the local government response. *They are referred to as “Jurisdictional Agencies” throughout this handbook.*

**Tier 4:** State-level response that supports Tiers 1-3 by managing statewide and *sub-State* regional coordination of the healthcare response.

**Tier 5:** State-level response that manages *inter-State* regional coordination of response to support Tiers 1-3 healthcare response assets.

**Tier 6:** Federal assistance to State, Tribal, local, and non-governmental healthcare response at Tiers 1-5, as managed through a Joint Field Office and/or other Federal coordinating center.

**Figure I-1. MSCC Management Organization Strategy**

### I.3 THE MSCC HEALTHCARE COALITION (TIER 2)

The Healthcare Coalition supports the emergency response of individual healthcare organizations (Tier 1) by connecting them through an effective information processing and communications system. This facilitates the sharing of incident and emergency response information. It can also facilitate resource sharing between healthcare organizations, promote coordinated response strategies, and support effective interface between healthcare organizations and the relevant Jurisdictional Agency(s) (Tier 3).<sup>7</sup> The complexity of any Healthcare Coalition, and the response objectives it sets for itself, will depend in part on the level of services provided by jurisdictional authorities in its geographic area.

<sup>7</sup> Jurisdictional Agency is the NIMS term referring to the “agency having jurisdiction” and responsibility for a specific geographical area or mandated function. Usually, this is a public agency representing a local, State, or Federal government that has direct authority for emergency response and recovery (NIMS, December 18, 2008).

### 1.3.1 Defining the MSCC Healthcare Coalition

A Healthcare Coalition is a group of healthcare organizations in a specified geographic area that agree to work together to enhance their response to emergencies or disasters. The response objectives of the Coalition will vary depending on how the Coalition is constructed in a particular area. Example objectives include promoting situational awareness, facilitating resource sharing, and coordinating response actions among its member organizations. The Coalition also promotes the efficient interface of its member organizations with jurisdictional authorities (Tier 3). *As noted earlier, the Coalition serves as a coordinating entity during incident response; it does not supplant the relevant incident command authority.*

The Healthcare Coalition has both a preparedness and a response element. The response element is described in Chapters 2-4 of this handbook, while the preparedness element is discussed in Chapters 5-7. The Coalition response element is presented first to provide the reader with a clear understanding of the end goal for the Healthcare Coalition preparedness program.

## 1.4 RELEVANT NIMS PRINCIPLES FOR THE HEALTHCARE COALITION

The National Incident Management System (NIMS) was released by the U.S. Department of Homeland Security (DHS) on March 1, 2004, and a formal revision was published on December 18, 2008.<sup>8</sup> NIMS provides national guidance for government agencies, non-governmental organizations, and the private sector to prevent, protect against, respond to, and recover from all hazards. All domestic response organizations are required to follow its guidance to be eligible for Federal preparedness funding and to participate in emergency response in the U.S. The remainder of this chapter explains NIMS concepts that are relevant to the functions of a Healthcare Coalition during emergency response.<sup>9</sup>

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<sup>8</sup> The National Incident Management System (NIMS) and related guidance are available at <http://www.fema.gov/emergency/nims/>.

<sup>9</sup> Additional information on NIMS implementation guidance for healthcare organizations is available at: [http://www.fema.gov/pdf/emergency/nims/imp\\_hos.pdf](http://www.fema.gov/pdf/emergency/nims/imp_hos.pdf).

### 1.4.1 Preparedness versus Response Organizations

A major focus of NIMS is on preparedness. Many organizations are involved in initiatives to enhance preparedness within and across levels of government. These initiatives often rely on committee meetings, teleconferences, and e-mail communications. Hospital associations, EMS councils, non-profit organizations, local emergency planning committees (LEPC), and public health/public safety agencies have all served as coordinating mechanisms for preparedness.<sup>10</sup> While these platforms, which are generally referred to in NIMS as “preparedness organizations” (see Exhibit 1-4), can be effective for preparedness planning, they can be problematic if used for emergency response due to their non-emergency nature and lack of 24/7 availability.

#### Exhibit 1-4. Definition of a Preparedness Organization

According to NIMS, a preparedness organization “provides coordination for emergency management and incident response activities **before** a potential incident. These organizations range from groups of individuals to small committees to large standing organizations that represent a wide variety of committees, planning groups, and other organizations (e.g., Citizen Corps, Local Emergency Planning Committees, Critical Infrastructure Sector Coordinating Councils).

U.S. Department of Homeland Security, National Incident Management System (NIMS), December 18, 2008; Available at: [http://www.fema.gov/pdf/emergency/nims/NIMS\\_core.pdf](http://www.fema.gov/pdf/emergency/nims/NIMS_core.pdf).

For healthcare planners and participants in a Healthcare Coalition, it is important to distinguish the Coalition’s “preparedness organization” from the “response organization” that is needed for emergency response and recovery (Exhibit 1-5). The latter uses the structure and processes required to “get things done” under emergency conditions.

NIMS does not define a response organization, instead focusing on the ICS organization that commands incident response. However, the National Response Framework (NRF) uses “response organization” as the title of a chapter that highlights the importance of understanding “how we as a Nation are organized to implement response actions.”<sup>11</sup>

<sup>10</sup> Maldin-Morgenthau B, Toner E, Waldhorn R, et al, Roundtable: Promoting Partnerships for Regional Healthcare Preparedness and Response. Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science, Volume 5; 2007.

<sup>11</sup> U.S. Department of Homeland Security, National Response Framework (January 2008); Available at: <http://www.fema.gov/pdf/emergency/nrf/nrf-core.pdf>.

It emphasizes the need to define how an organization will be configured to effectively manage its emergency response. Exhibit 1-5 highlights the contrast between a *preparedness* and a *response* organization.

### **Exhibit 1-5. Preparedness versus Response Organization**

#### **Preparedness Organization:**

- Provides a structure and function to manage the coordination of emergency management activities, which take place in a non-emergency context.
- Conducts emergency management program activities, including committee meetings, EOP development, preparedness planning, training, exercises, resource management, and program evaluation and improvement.

#### **Response Organization:**

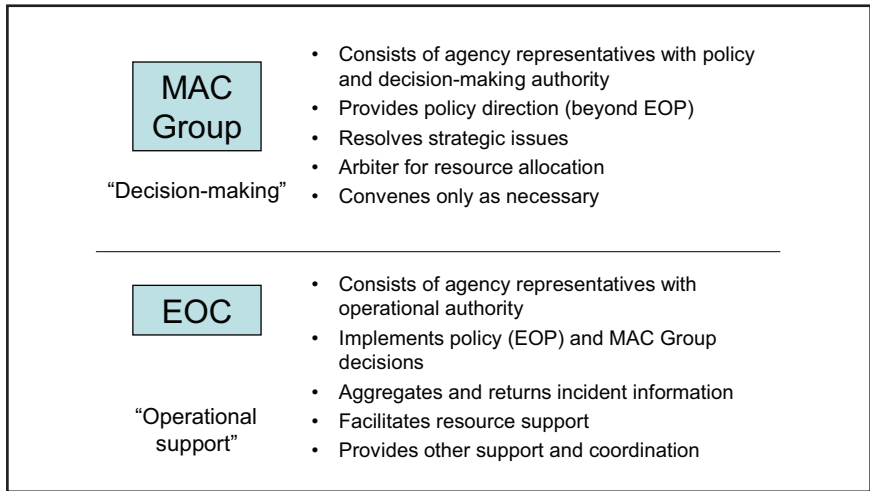
- Provides a structure and function to manage the coordination of actions to achieve objectives under emergency conditions.
- Conducts information management, emergency decision-making, incident planning, actions to implement decisions, and coordination of resources.

## **1.4.2 Multiagency Coordination System (MAC System)**

According to NIMS, “the primary function of a MAC System is to coordinate activities above the field level and to prioritize the incident demands for critical or competing resources, thereby assisting the coordination of the operations in the field.”<sup>12</sup> A common example of a MAC System is the traditional local jurisdiction or State Emergency Operations Center (EOC), which provides high-level support to the incident command entities. The MAC System coordinates the various organizations that are supporting the Incident Management Team (IMT). Since this is the intended function for the Healthcare Coalition, MAC System concepts should be understood by Coalition planners.

A MAC System can consist of a range of elements, but the most commonly referenced are the EOC and the Multiagency Coordination Group (MAC Group). Figure 1-2 highlights the contrast between the MAC Group and the EOC.

<sup>12</sup> NIMS Component IV: Command and Management, Section B. Multiagency Coordination Systems. The NIMS definition of a MAC System is provided in Appendix B.

**Figure 1-2. Comparison of the Central Elements of the MAC System**

While other models may be considered for the Healthcare Coalition response organization, the concepts inherent to a MAC System – specifically the EOC function and the MAC Group – are widely accepted and validated. They also conform to the national mandate that response organizations use NIMS principles. NIMS recognizes that these concepts are flexible and may be applied in the private sector.

## 1.5 THE MSCC HEALTHCARE COALITION AS A MAC SYSTEM

Applying MAC System concepts, the Healthcare Coalition response organization has two major components:

- The MAC Center<sup>13</sup> or EOC-like function (referred to in this text as the Healthcare Coalition Response Team or HCRT), which is generally staffed with personnel from the participating healthcare organizations.
- The MAC Group (referred to in this handbook as the Senior Policy Group) representing the leadership of the participating healthcare organizations.

<sup>13</sup> In the original NIMS (March 2004), the EOC and DOC-type entities were referred to as a “Multiagency Coordination Centers.”

The actual titles “Healthcare Coalition Response Team” and “Senior Policy Group” may vary from one Coalition to the next, but they should accurately reflect the respective roles of these components. Healthcare Coalitions may want to avoid using “EOC” in the title of their response organization in order to distinguish this EOC-like function from local jurisdiction (Tier 3) and State (Tier 4) response elements. The term EOC, as defined by NIMS, also describes a physical location rather than simply a functional entity. Typically, the HCRT may have a very small primary physical location. Most of its work may be conducted by team members who remain at their “home” facility and communicate virtually.

**NOTES**



# Chapter 2:

## The Healthcare Coalition as a Response Organization: System Description

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## 2.1 THE HEALTHCARE COALITION OVERVIEW

The Healthcare Coalition is useful for all phases of Comprehensive Emergency Management, but its primary mission should be to support healthcare organizations during emergency response and recovery. An element of this mission is promoting integration of Coalition member organizations into the broader community response.

In emergency management, the response organization is typically described in an Emergency Operations Plan (EOP). The comprehensive EOP incorporates a System Description, which presents the elements of the response organization (including an organizational chart) and how they are related to each other. This chapter presents a System Description for the Healthcare Coalition response organization based on MAC System concepts summarized by NIMS (see Sections 1.4 and 1.5).

### 2.1.1 Healthcare Coalition Response Objectives

The specific objectives for a Healthcare Coalition during emergency response and recovery may vary from one Coalition to another. It is up to the healthcare system planners to establish what the Coalition should achieve during response. Therefore, response objectives may be simple or complex depending upon the individual Coalition. Sample response objectives for a robust Healthcare Coalition include:

- Facilitate information sharing among participating healthcare organizations (Tier 1) and with jurisdictional authorities (Tier 3) to promote common situational awareness.<sup>1</sup>
- Facilitate resource support by expediting the mutual aid process or other resource sharing arrangements among Coalition members, and supporting the request and receipt of assistance from local, State, and Federal authorities.
- Facilitate the coordination of incident response actions for the participating healthcare organizations so incident objectives, strategy, and tactics are consistent for the healthcare response.
- Facilitate the interface between the Healthcare Coalition and relevant jurisdictional authorities (Tier 3) to establish effective support for healthcare system resiliency and medical surge.

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<sup>1</sup> Throughout this handbook, emphasis is placed on the need for the Healthcare Coalition to integrate with public sector agencies at the local jurisdictional level (Tier 3). In areas of the country with limited or no local public health capabilities, the Healthcare Coalition may coordinate directly with the relevant State authorities (Tier 4).

## 2.1.2 Healthcare Coalition Scope

### Coalition Participants

The Healthcare Coalition may include the full range of healthcare assets that provide “point of service” medical care and other medically related services during a mass casualty and/or mass effect incident. Depending on how a particular Healthcare Coalition is constructed, this may include hospitals, community health centers, integrated healthcare systems, private physician offices, outpatient clinics, dialysis and other specialty treatment centers, and long-term care facilities (nursing homes, other skilled nursing facilities), and home care/hospice.

### Coalition Activities

During emergency response, the Coalition’s response organization conducts a range of activities to achieve its stated objectives. Some examples of possible activities for the Coalition’s response organization are provided below.

- Provide notification to member organizations that an actual or potential incident is developing. This allows for very rapid response (i.e., within minutes) on a 24/7 basis. The notification threshold is set by Coalition member organizations such that if one member knows an incident is happening, all learn of it rapidly.
- Provide a mechanism to rapidly disseminate information from Incident Command and other authorities to Coalition member organizations so that they can effectively and safely participate in emergency response.
- Rapidly disseminate information from Coalition member organizations to Incident Command and other authorities, at their request.
- Convene (often virtually) specific personnel (senior executives, technical specialists, etc.) from Coalition member organizations at the request of incident command authorities to discuss strategic issues or make policy recommendations related to the healthcare response.
- Help Coalition member organizations obtain incident-related information that is not otherwise readily available. The Coalition response organization can serve as the official representative of member organizations to seek incident details that are important to the healthcare response.

- Disseminate resource needs to member organizations and help match organizations that request mutual aid or other assistance with organizations that can provide the needed assistance.
- Facilitate the coordination of response actions among member organizations if this is requested by the Coalition’s responding members and/or by jurisdictional authorities.

## Coalition Authorities

The Healthcare Coalition’s authority to operate is based on the voluntary endorsement and support of its member organizations and relevant Jurisdictional Agencies in its geographic area. It is primarily responsive to its member organizations’ concerns.

The Healthcare Coalition’s member organizations are responsible to the Jurisdictional Agency(s) in the geographic area in which each operates. Thus, if the Healthcare Coalition spans the borders of multiple jurisdictions, the Coalition’s response organization must coordinate closely with all relevant Jurisdictional Agencies. The Coalition’s actions supplement the authority of the local and State governments that are responsible for the geographic area covered by the Healthcare Coalition. In some situations, the Jurisdictional Agency may issue a “Delegation of Authority” that authorizes the Coalition on behalf of the jurisdiction to address medical and public health related response matters.

Because of these considerations, the emergency response and recovery authority of the Healthcare Coalition may be limited, but this does not obviate the importance of the Coalition’s mission.

### 2.1.3 Healthcare Coalition Assumptions

The design and function of the Healthcare Coalition response organization is based on the following assumptions:

- Participating organizations maintain their respective decision-making sovereignty during incident response, except in unusual circumstances that warrant the implementation of local or state health authorities (e.g., enactment of isolation or quarantine).
- Participating organizations determine individually how they will respond to an incident and whether they will activate any emergency response procedures. The Coalition does not supplant this responsibility.

- The Healthcare Coalition response organization may convene (often virtually) representatives from its member organizations to discuss response issues. Decisions made by the Coalition during incident response are made on a consensus basis or are recommendations only.
- Healthcare Coalition partners will work together for a common good despite day-to-day competition, especially if a fair platform with transparent decision-making is provided for this functional relationship.
- Support from the administrative leadership of each participating organization can be achieved with proper attention to the design and function of the Coalition.
- The use of NIMS-consistent concepts and procedures will promote integration with public sector response efforts; NIMS consistency is also required to be eligible for Federal funding.
- During emergency response, personnel staffing the Healthcare Coalition Response Team (HCRT) are still employed by their “home” organization and often are responsible for some element of their home organization’s response. Therefore, HCRT staffing must be as lean and efficient as possible. In some Coalitions, this may mean enabling HCRT staff to conduct response tasks remotely rather than from one centralized location. In addition, personnel from the most affected organizations should be able to rapidly “hand off” Coalition duties to other qualified personnel.

## 2.2 HEALTHCARE COALITION BASELINE OPERATIONS

For the Healthcare Coalition to be immediately available to conduct response actions in a no-notice, sudden onset emergency, two functions must be continuously operational even during times of non-response: 1) the ability to rapidly receive information and notify Coalition members of an emergency,<sup>2</sup> and 2) a decision-making process to determine whether additional Healthcare Coalition actions are necessary.

The manner in which these functions are addressed may vary from one Coalition to another. What does not vary is the need for a continuous baseline capability to conduct these two functions so they are operational

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<sup>2</sup> Some Coalitions may rely on public sector notification systems being activated. These Coalitions are encouraged to develop notification processes and procedures (even if using public sector technology) that are immediately available to the Coalition for incidents that do not reach the level of public sector emergencies (e.g., power outage at a hospital).

at the outset of any incident. The authors of this handbook propose two entities to help the Coalition maintain readiness for immediate response: *Healthcare Coalition Notification Center and Healthcare Coalition Duty Officer*. These functions constitute the baseline operations of the Healthcare Coalition and may be conducted at minimal expense and burden to the Coalition.

## 2.2.1 Healthcare Coalition Notification Center

The Healthcare Coalition Notification Center provides notifications (both initial and ongoing) to Coalition member organizations regarding an emergency. It may also notify Jurisdictional Agencies (Tier 3) about a developing situation within a healthcare organization. The information that prompts notifications may originate within the healthcare community, public sector authorities, or other sources (e.g., the media). The Notification Center's roles and responsibilities include:

- To receive information that a situation is occurring that might affect Coalition member organizations (Tier 1) and convey emergency notification to members and relevant Jurisdictional Agencies (Tier 3)
- To receive specific messages from Jurisdictional Agencies (Tier 3) for transmission to healthcare organizations (e.g., notification of a large transportation incident)
- To receive messages from a Coalition member organization for transmission to other members or to Jurisdictional Agencies (e.g., power outage at a hospital)
- To maintain connectivity with relevant organizations, including other Healthcare Coalitions in nearby jurisdictions
- To contact the Healthcare Coalition Duty Officer, as appropriate, to clarify message content and message urgency, or to determine the most appropriate method for sending notifications.

To accomplish these roles, the following requirements are proposed for the Healthcare Coalition Notification Center:

- The Notification Center must be staffed 24/7 by trained and qualified personnel. The position that conducts the Center's actions is designated in this text as the Coalition Notification Center Technician, but some other title may be substituted.<sup>3</sup>

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<sup>3</sup> The Healthcare Coalition should establish training requirements for this position during preparedness activities (see Chapter 6).

- The capability to receive and send information via telephone, radio, e-mail, facsimile (fax), and other redundant messaging modalities.
- Ability to receive television and commercial radio broadcasts.
- Rapid connectivity with jurisdictional authorities (Public Health, EMS, Emergency Management, Law Enforcement, etc.) as well as Coalition member organizations.
- Ability to conduct large capacity teleconferencing.
- Redundant communications with primary and emergency backup power.

The authors use the word “center” to emphasize that this should be a physical location with the ability to perform these critical functions. *At the same time, the Healthcare Coalition Notification Center typically should not be an expensive, stand-alone facility dedicated only to this purpose.* To promote cost-effectiveness, the Healthcare Coalition Notification Center may best be collocated at an already continuously staffed facility that can meet the information and communications requirements noted above. For example, a private ambulance dispatch center has been successfully used for this purpose in several Coalitions. Healthcare facilities that operate as the regional hospital resource have also performed this function. Alternatively, Coalitions may use an established public sector resource, such as a municipal communications center, for this function; however, the Coalition must be able to access these systems when needed and not just when the public sector has declared an emergency.

An alternate Coalition Notification Center should be identified so these functions can be maintained if the primary center is affected by a hazard impact or if the center’s other responsibilities during a disaster prevent it from performing Coalition activities. Backup centers must be able to perform the same functions as the primary center. To maintain this backup capability, the alternate site may intermittently assume the role of the primary Notification Center during baseline operations.

## **Healthcare Coalition Notification Center Technician**

This position operates the Coalition Notification Center and monitors baseline information 24/7 for any health-related anomalies that might signal the need for a response by the Healthcare Coalition. The Coalition may establish protocols to help the technician identify incident parameters that require immediate notification to Coalition member organizations and the Coalition’s Duty Officer. When initial incident information does not clearly indicate the need for a notification,

the technician contacts the Coalition's Duty Officer (see below) to further discuss whether a notification is required. These procedures are described in greater detail in Chapter 3.

Personnel serving as the Coalition Notification Center Technician should have the following qualifications:

- Expert ability to operate the communication equipment for Coalition notification activities
- Operational level of understanding about the Healthcare Coalition's purpose and its emergency response mechanisms
- Operational knowledge and skill for developing and transmitting straightforward notification messages using Coalition templates (see Section 3.3).

The technician position must be staffed 24/7; however, it may be performed by a trained and qualified professional whose primary job is private sector EMS dispatch, poison center operations, or other position that is always immediately available. It is important to identify a backup for this position so notifications to the Coalition can be maintained despite a surge in other duties.

## 2.2.2 Healthcare Coalition Duty Officer

This on-call position must be available for initial consultation to the Notification Center Technician, to Coalition members, and to jurisdictional authorities (Tier 3) as the representative of the Healthcare Coalition. The Duty Officer serves as the Coalition's liaison to Jurisdictional Agencies during the *initial stages* of an incident and may contact Jurisdictional Agencies to obtain relevant information about an incident to share with the Coalition member organizations.

Potential responsibilities of the Duty Officer include:

- Provide consultation to the Notification Center Technician (upon the technician's request) regarding whether a potential or actual situation warrants a notification to Coalition members. The Duty Officer also provides advice on the content or urgency of the notifications being disseminated.
- Obtain incident information (pre-HCRT activation) that is relevant to healthcare organizations and disseminate it to the Coalition member organizations.



- Determine whether to activate the HCRT and the initial staffing plan for an activated HCRT.
- Upon activation of the HCRT, the Duty Officer may become the HCRT Leader or assume another position and brief personnel as they are assigned to the HCRT.

Personnel staffing the Healthcare Coalition Duty Officer position should have the following qualifications:

- Expert knowledge of their home organization's emergency management program and EOP.
- Operational knowledge of the Healthcare Coalition's EOP and methods for interacting with relevant jurisdictional authorities.
- An operational understanding of NIMS and MAC System operations (NIMS compliance requires successful completion of IS 100.a, 200.a, and 700.a web-based courses through FEMA's Emergency Management Institute). Additional courses focused on MAC System concepts are also recommended, such as IS 701.<sup>4</sup>
- Endorsement for this role from their home organization.
- Ability to take calls for a defined period of time (e.g., a week) and respond to all potentially emergent communications requests.
- Ability to carry a reliable, mobile contact method (cellular telephone, two-way pager, text messaging device) at all times while staffing the Duty Officer position.<sup>5</sup>

## 2.3 THE HEALTHCARE COALITION RESPONSE TEAM

The Healthcare Coalition Response Team (HCRT) conducts the response activities for the Coalition and provides a more robust operational capability than the Duty Officer and Notification Center Technician functions alone. The HCRT accomplishes the Coalition's response objectives (see Section 2.1.2) during an emergency.

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<sup>4</sup> FEMA Emergency Management Institute, IS 701, NIMS Multiagency Coordination System. Available at: <http://training.fema.gov/EMIWeb/IS/is701.asp>.

<sup>5</sup> Established Healthcare Coalitions usually roster backup Duty Officers in case there is a problem contacting the primary Duty Officer.

### 2.3.1 Composition of the HCRT

The HCRT is composed of personnel from Coalition member organizations who perform the key response functions of the Coalition, and an organizational liaison from each Coalition member to directly represent the healthcare organization. It is important to recognize that the staffing arrangement for the HCRT will vary based on the complexity of the Coalition and the needs of a specific incident. In many situations, the HCRT functions can be performed by a minimal number of staff.

### 2.3.2 Scope of HCRT Activities

The scope of response activities performed by the HCRT will vary from one Coalition to another depending on the response objectives established during Coalition development (see Chapters 5 and 6). The HCRT's activities do not inhibit any individual organization's response and recovery actions. The responding organizations conduct whatever actions they need to during an emergency, but they share information and develop common efforts where indicated and advantageous to the Coalition members. Similarly, the Coalition does not supplant the local public health agency's response activities.

### 2.3.3 Recommended Management Strategy for the HCRT

NIMS does not specify any one structure for managing MAC System activities. Emergency Management Institute (FEMA) training (IS 701) presents several models that have been used by government agencies for establishing and managing EOCs. These models may be examined for relevance in managing the HCRT.<sup>6</sup>

The authors of this handbook recommend an ICS-based model for managing the HCRT because this approach has been validated in managing many types of complex activities under emergency conditions. *It is important to understand that using ICS in a MAC System does not mean that the EOC-like function (i.e., the HCRT) is managing the incident itself.* The HCRT supports the incident managers, whether the incident is based at the jurisdictional level (Tier 3) or a member organization (Tier 1). Using an ICS-based structure also ensures

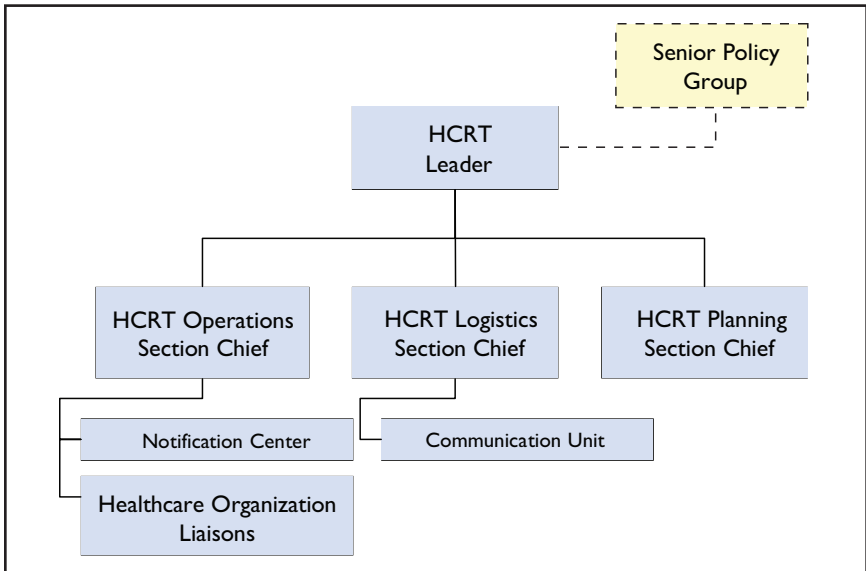
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<sup>6</sup> FEMA Emergency Management Institute, IS 701, NIMS Multiagency Coordination System. Accessed May 7, 2009 at: <http://training.fema.gov/EMIWeb/IS/is701.asp>.

consistency with NIMS and with the organizing strategy used by most healthcare organizations for their own EOPs. The Hospital Incident Command System (HICS), which has been adopted by many healthcare organizations for incident response, is based on ICS.<sup>7</sup>

While the ICS-based model employs the traditional IMT structure (Figure 2-2), the responsibilities and processes addressed in the HCRT may be somewhat simplified. For example, because the Administration/Finance Section may have minimal responsibility in a Healthcare Coalition response, it may be subsumed as a supporting function within the Planning or Logistics Sections (this is consistent with NIMS guidance).

**Figure 2-2. Basic configuration for the HCRT**



As with traditional ICS descriptions, only the HCRT positions that are required to respond to an incident are activated. The size and complexity of the HCRT may vary significantly in each locale. In fact, it is expected that most Healthcare Coalitions will respond to a majority of incidents with one to three individuals conducting all HCRT functions. Conversely, complex Coalitions or those responding to very complex incidents could require a more robust response organization. The key functions of the HCRT are outlined below for consideration.

<sup>7</sup> State of California Emergency Medical Services Authority, Hospital Incident Command System Guidebook, (August 2006); Available at: <http://www.emsa.ca.gov/hics/hics.asp>.

## Leader (equivalent to Command in traditional ICS)

This function oversees all HCRT activities. Because there is no inherent “command” authority within the Healthcare Coalition and the Coalition does not directly manage the incident, the term “Leader” is more appropriate to describe this function within the HCRT. Since this function is responsible for all HCRT activities, it is the one function that must always be staffed for any incident.

## Operations Section

Depending on a Coalition’s response objectives, the Operations Section of the HCRT would be responsible for several activities. If response activities are particularly complex for an incident, this Section may be subdivided into branches, divisions, or groups, but this usually will not be necessary. Factors that may influence the branch construct include the number and size of the organizations within the Coalition, and the complexity of the data and information being processed.<sup>8</sup> Example activities for the HCRT Operations Section include:

**Information management:** Provide an information “clearinghouse” to promote enhanced situational awareness. The term clearinghouse is used to emphasize that information is collected, aggregated, and transmitted to healthcare organizations with only transparent processing of the data. All member organizations are treated equally and provided with a common operating picture of the incident. This promotes consistency in decision-making across the organizations.

**Resource coordination and support:** Facilitate the ability of member organizations to obtain resource support under the time urgency, uncertainty, and logistical constraints of emergency response. It does not preclude the use of day-to-day resource acquisition methods, nor does it supplant the importance of developing resource acquisition and management methods at each healthcare organization (Tier 1). Rather, it provides a platform for disseminating resource requests from impacted organizations. In addition, the HCRT may facilitate communications between requesting organizations and those willing to provide resource support.

**Response coordination:** Promote comprehensive and consistent incident action planning by Coalition member organizations through the sharing of response objectives, strategy, and major tactics. Task forces may be established to address unusual response issues, such as

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<sup>8</sup> The organization of Operations Section branches is further discussed in Chapters 3 and 4.

urgently needed, consensus-based diagnostic or treatment guidelines, patient transfer protocols, tracking of evaluated patients, or other actions.

**Community response integration:** Facilitate the integration of the healthcare response into the general community response by promoting exchange of information between member organizations and responding Jurisdictional Agencies (Tier 3).

During response, the HCRT Operations Section interfaces with the member organizations through their designated HCRT Organizational Liaison within the member organization's IMT.<sup>9</sup> This liaison position must be established to ensure efficient Coalition response activities. Depending upon how the Coalition is constructed, the Organizational Liaison could be responsible for:

- Receiving information from the HCRT and acknowledging receipt of the information
- Transmitting information from the HCRT to decision makers within the organization (e.g., the organization's IMT)
- Supervising the response to requests for information or resource assistance that comes through the HCRT
- Participating in meetings or teleconferences convened by the HCRT to bring together healthcare organizations.

## Support Functions

Consistent with the ICS model, the HCRT may wish to develop the following Sections to support its response operations. Even if a Coalition defines specific positions for HCRT response functions, it is important to recognize that the positions are only staffed as needed. Position descriptions should be developed, and training and exercises conducted, to develop the knowledge, skills, and abilities for staff.

**Planning Section:** Depending upon the complexity of the Healthcare Coalition, the Planning Section could perform a number of response activities focused on aggregating incoming data and formatting information reports to return to member organizations. This collated information is usually conveyed to jurisdictional authorities (Tier 3). The following responsibilities for the Planning Section are presented for consideration:

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<sup>9</sup> Another title, such as Point of Contact or "POC," may be used for this staffed position at each Healthcare Coalition member organization.

- Aggregate, analyze, format, and document relevant incident information in standard reports. For example, the Planning Section may document incident details or the resource status of member organizations, such as available patient beds.<sup>10</sup> The data should be captured in a standardized format and provided to all Coalition member organizations and relevant Jurisdictional Agency(s) (Tier 3).
- Facilitate internal HCRT meetings. The Planning Section can facilitate meetings or teleconferences for internal HCRT planning. For meetings involving Coalition member organizations (Tier 1), it may be more appropriate for the HCRT Operations Section to facilitate, since these discussions support achievement of the HCRT response objectives. The purpose, format, and ground rules for each type of meeting should be pre-determined.
- Oversee action planning for the HCRT: In robust Coalitions, the HCRT may wish to conduct formal action planning when indicated by incident circumstances. Action planning is well accepted in MAC Systems even though these systems do not command an incident. The Planning Section could be tasked with assembling and completing the action plan for the Healthcare Coalition. If created, the HCRT action plan should be shared with Coalition member organizations and jurisdictional authorities. The plan itself may be shared or it may be discussed in an operations briefing (often conducted virtually) with relevant organizations.

**Logistics Section:** Per ICS principles, this Section provides logistical support to the HCRT and is distinguished from support that is provided to Coalition members, which is a function of the HCRT Operations Section. Because many of the HCRT’s activities during emergency response and recovery can be conducted virtually, the key logistical issue will be supporting the information and communications technology that is used by the HCRT and its member organizations. For example, the Logistics Section may address a Coalition member organization’s difficulty accessing web-based programs or troubleshoot issues with radio equipment. Other types of support that may be performed by the Logistics Section include:

- Staff scheduling for HCRT positions during prolonged incidents

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<sup>10</sup> The actual collection of data and dissemination to individual healthcare organizations (Tier 1) and jurisdictional authorities (Tier 3) is an Operations Section function. The actual collection of data and dissemination to individual healthcare organizations (Tier 1) and jurisdictional authorities (Tier 3) is an Operations Section function.

- Resource support to the HCRT and the Coalition’s Notification Center, including facilities, transportation, and other resources
- Services support, such as food and drinks, communications and information technology support, sleeping quarters, etc.

**Administration/Finance Section:** Per ICS, this Section focuses on administrative and finance support to the HCRT and is staffed only as needed. This becomes important if there is an expectation for reimbursement for some of the distributed HCRT activities, such as reimbursing member organizations for employee time devoted to HCRT positions staffed during an emergency. Other cost tracking may include any expenses assumed by an organization that provides a physical location for HCRT operations or the Coalition Notification Center. This Section notes when spending may be approaching limits set by the Coalition Senior Policy Group and brings this to the attention of the HCRT Leader. This function is expected to be rarely staffed as a separate HCRT Section.

### 2.3.4 HCRT Requirements

In order for the HCRT to function as intended, the following requirements must be met:

- Communications and information technology must be available 24/7 for use by the Healthcare Coalition. This may include a messaging system (text and/or voice), a radio system, relatively secure teleconferencing methods, satellite phones, Voice Over Internet Protocol (VoIP), and technology to support web-based interaction between Coalition member organizations and between the Coalition and jurisdictional authorities (Tier 3). A good cost-saving measure is to use technologies established for other purposes (e.g., using a web-based system established for a Jurisdictional Agency). However, it is important that the technology is always available for dedicated use by the HCRT during emergency response.
- Personnel must be identified to staff the HCRT during incident response. These individuals will usually be employees of the Coalition’s member organizations. Because these organizations may be impacted by a hazard, candidates for the HCRT should be identified from as many organizations as possible and focus should be on streamlining the staffing of the HCRT during emergency response and recovery.

- Procedures should be established to maintain HCRT activities despite a hazard impact, with backup resources identified for each essential HCRT function.

Exhibit 2-1 highlights some of these requirements as applied to a Healthcare Coalition in Minnesota.

### **Exhibit 2-1: Regional Hospital Resource Center (RHRC) in the State of Minnesota**

The State of Minnesota has been divided into eight regions, each having developed a response organization that coordinates the efforts of healthcare assets within its respective geographic region. Though the regions align with Public Health and Emergency Medical Services (EMS) regions within the State, they do differ from State Patrol and Homeland Security and Emergency Management (HSEM) regions.

Each Healthcare Coalition spans multiple independent jurisdictions and coordinates response information among its participating healthcare organizations, including hospitals, healthcare systems, and clinics (clinic coordination is less formal at present and variable between regions). This requires direct communications with each individual jurisdiction covered by the Coalition when coordinating healthcare assets during incident response. This important activity ensures a common operating picture for all local authorities.

The Healthcare Coalition that includes Minneapolis is based at Hennepin County Medical Center. Its day-to-day communications center is utilized to coordinate healthcare assets located within this response Coalition. Communications to individual healthcare assets are based on internet, 800 MHz radio, and telephonic communications. A Duty Officer is always available to receive notifications and this contact method is disseminated to public safety agencies. If the Healthcare Coalition response organization is to be activated, the staffing typically involves 3-4 personnel to cover all the functions of the response organization. These personnel are “donated” by individual healthcare organizations and may be supplemented by staffing from the local Medical Reserve Corps (MRC).

The response activities can be conducted from the communications center or in a more distributed fashion (personnel remain at their location of regular employment). In addition, Coalition personnel have the capability to deploy to the Emergency Operations Center (EOC) where they can more directly interface with Public Health, Emergency Management, and EMS. The Coalition has the capability of convening regular teleconferences as required for its participating organizations.



## **Exhibit 2-1: Regional Hospital Resource Center (RHRC) in the State of Minnesota (continued)**

After the Interstate 35W Bridge collapse in Minneapolis on August 1, 2007, the RHRC assisted EMS with organizing patient lists, tracking delayed casualties, and providing Family Support Center staff and support. The RHRC also coordinated with Minnesota Department of Health and other agencies to provide awareness of available healthcare assets.

## **2.4 THE HEALTHCARE COALITION SENIOR POLICY GROUP**

It is important for Coalition developers to consider how executive-level input from Coalition members will be incorporated into the HCRT during emergency response. In accordance with NIMS principles, this can be achieved through a MAC Group-like entity, which is named the Healthcare Coalition Senior Policy Group in this handbook. Example objectives for the Senior Policy Group include:

- Develop policy-level decisions as indicated by the situation or as requested by the HCRT Leader.
- Address major resource commitments that Coalition members may be asked to provide. For example, the Senior Policy Group could convene to approve hospital commitment of beds to support the evacuation of a facility that is not a member of the Healthcare Coalition.
- Approve risk reduction strategies and other strategic issues that may arise during emergencies and disasters. For example, the Senior Policy Group could be used to approve a common public statement distributed to the media describing patient safety measures during an infectious outbreak.
- Maintain optimal situational awareness for senior executives for sensitive information that may not be available to the HCRT. For example, law enforcement and intelligence authorities may wish to brief senior leaders of healthcare organizations on sensitive security threat details that are not released to the general public.
- Monitor the HCRT for strategic effectiveness in its response and recovery roles.

## 2.4.1 Composition of the Senior Policy Group

The Senior Policy Group is composed of the Chief Executive Officer, senior administrator, or their designee from each member organization, who has authority to make decisions, commit resources, and accept high-level risk for their organization. In a large Coalition, a process may be established to select representatives for the Senior Policy Group. The jurisdiction's Public Health authority, EMS chief, and/or other Tier 3 authority may be invited to participate in advisory positions.

## 2.4.2 Scope of Senior Policy Group Activities

The Senior Policy Group assembles (often virtually) only as needed during incident response for briefings and to deliberate on strategic and policy-level issues. It may also assemble if concern arises regarding the functional effectiveness of the HCRT.

Senior Policy Group activities during emergency response and recovery generally include participating in briefings given by the HCRT Leader to maintain situational awareness among senior executives. The Senior Policy Group may provide strategic and policy guidance that the HCRT can implement. The Senior Policy Group does not become involved in operational management, tactical decision-making, or other issues addressed by the HCRT unless a strategic or policy imperative arises.

## 2.4.3 Senior Policy Group Requirements

Support requirements for the Senior Policy Group are relatively simple and most will be accomplished through capabilities that support the HCRT. The additional requirements include the following:

- Senior Policy Group briefings and meetings should be tightly facilitated to limit time commitments and keep the focus on policy and strategic issues.
- Meeting space should be identified for the Senior Policy Group, although most Senior Policy Group meetings will be conducted via teleconference or video conference. Protocols for conducting these meetings should be pre-established and shared with the appropriate participants.

- If these meetings are conducted via teleconference or video conference, the information technology and communications system used for Senior Policy Group meetings should ensure that sensitive information may be discussed and protected.

## **NOTES**

## Chapter 3:

# The Healthcare Coalition during Emergency Response and Recovery: Concept of Operations

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## 3.1 ESTABLISHING PROCEDURES FOR THE PROGRESSIVE STAGES OF RESPONSE AND RECOVERY

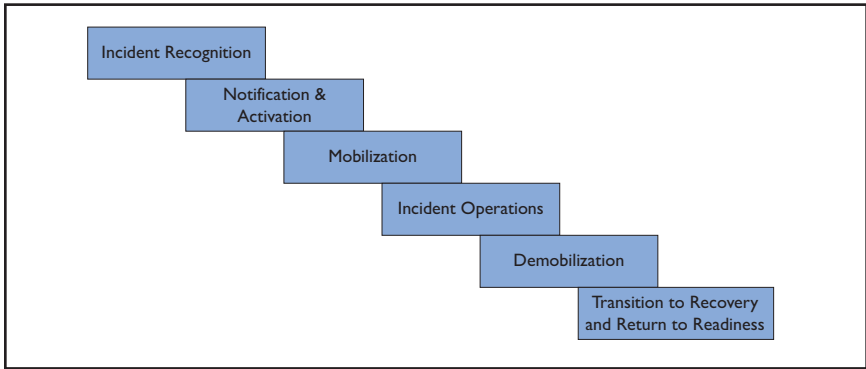
Many emergency response organizations have found it useful to conceptualize incident response and recovery in distinct stages that occur sequentially as an incident evolves. By grouping activities that have a common purpose, these stages provide a framework for the response organization's "Concept of Operations" (i.e., how the components of the response system function and interact through the successive stages of emergency response and recovery). This approach helps ensure that emergency response guidance is well organized and sequenced through specific intervals in the evolution of an incident.

Although the stages used by organizations may vary, they generally entail the same broad categorization of activities. Healthcare planners developing a Healthcare Coalition are encouraged to examine the stages presented here within the context of their own situations when they are developing the Coalition's Concept of Operations. It is also helpful to examine the planned actions of individual healthcare organizations (Tier 1) and appropriate jurisdictional entities (Tier 3) during these stages of emergency response and recovery.

### 3.1.1 Stages of Incident Response and Recovery

The following general stages of emergency response and recovery are presented for consideration, along with the critical actions that the Healthcare Coalition should consider in each stage. By examining response actions in this manner, a comprehensive Concept of Operations for the Healthcare Coalition's Emergency Operations Plan (EOP) can be developed. These stages typically have significant overlap in their actual time of occurrence, especially early in emergency response (Figure 3-1).

**Stage 1: Incident recognition.** This is the interval when an organization determines whether emergency response actions are needed. The incident recognition process identifies an anomaly (either independently or through communication with others), develops a rapid situation assessment, and determines whether a response by the organization may be necessary. An "incident" exists for the Healthcare Coalition whenever an actual or potential need arises to provide emergency-related support to healthcare organizations.

**Figure 3-1. Stages of incident response and early recovery**

**Stage 2: Initial notification/activation.** Initial notification and activation occur in a relatively simultaneous fashion. “Notification” refers to the actions required to inform appropriate organizations within the response system about the onset of an incident or an important change in incident parameters. Notification conveys important details (if available) and may indicate whether the notified organizations should undertake response actions. An initial notification message accomplishes the following:

- Provides urgent information about a hazard occurrence or threat of a hazard occurrence
- Commonly suggests actionable guidance for the notified entity for protective and initial response actions
- Conveys the activation decision regarding the HCRT.

“Activation” refers to determining the response level for the system. As applied to the Healthcare Coalition, activation refers to the decision to transition from baseline operations to HCRT operations with a designated staffing level as described in the Coalition’s EOP. Activation levels may be *partial or full* (see Section 3.3.1). It is important to note that an activation order is binding only for personnel designated to staff the HCRT and does not require (but may request) individual member organizations to activate their emergency response procedures. Each organization determines its response actions independently based on information received through the Coalition and other sources.

**Stage 3: Mobilization.** This refers to the transition of the HCRT from a state of inactivity or baseline operations to the designated response level.<sup>1</sup> Each Coalition member organization mobilizes its own response

<sup>1</sup>Drabek TE, Hoetmer GJ (Eds). Emergency Management: Principles and Practice for Local Government, International City Management Association, Washington, D.C.; (1991).



(based on its EOP) independent of the HCRT activation. Coalition members are only required to make available an Organizational Liaison to interface with the HCRT and this activity may be performed by each member organization's Liaison Officer in their activated IMT.

**Stage 4: Incident operations.** This stage refers to all actions that address the Healthcare Coalition's response objectives following activation of the Coalition's EOP (other than mobilization and demobilization). Actions in this stage may be divided into "initial" (or "immediate") and "on-going" categories.

**Stage 5: Demobilization.** This stage addresses the transition of resources, and eventually the HCRT itself, from response activities back to baseline operations. Demobilization procedures are triggered as response objectives are achieved and resources are relieved of incident responsibilities.

**Stage 6: Transition to recovery and return to readiness.** This stage encompasses the Healthcare Coalition's recovery activities and actions that return the Coalition to a state of readiness for the next emergency.

### 3.1.2 All-Hazards Applications

If the Healthcare Coalition's EOP is written to be "all-hazards," then many of the processes and procedures will be applicable regardless of the type of emergency or the response assets that are used (see Exhibit 3-1). Personnel developing a Healthcare Coalition should focus first on all-hazards processes before addressing hazard-specific issues.

#### **Exhibit 3-1. Example of an "all-hazards" response process**

A critical response action in any emergency is to document the structure of the team that is managing the incident for the organization. The team's structure should be clearly understood both internally and by external entities that must interact with the team. Documenting and disseminating the names of staff who are assigned to specific positions on the team is important, even if the organizational structure is rather simple.

The remainder of this chapter describes the actions that the Healthcare Coalition should consider in each stage of emergency response and recovery.

## 3.2 INCIDENT RECOGNITION

The ability to recognize circumstances that may indicate the need for emergency response has importance not only for the Healthcare Coalition, but for individual organizations as well. *Optimal recognition of the need to activate the HCRT and determine the earliest possible and appropriate response actions may be the most important factor in a successful outcome.* A specific process for incident recognition and supporting procedures should be established.

### 3.2.1 What Constitutes an Incident for the Healthcare Coalition?

As discussed in Chapter 1, a situation becomes an “incident” for a healthcare organization when it requires the organization to activate its EOP. Activation of response systems by public health and medicine is commonly delayed due to narrow incident definitions based on casualty numbers. There are many situations in which few or no incident patients can be expected and yet activation of the EOP is warranted (e.g., utility disruption or other challenges to continuity of operations). Although it is important, the casualty count is not the sole indicator of the severity of issues that healthcare organizations will face during an incident.

In determining whether response action is warranted for the HCRT, it is important to remember that the Coalition’s response is scalable. Initial incident parameters may not warrant a full activation, but partial activation may be enough to address the anticipated response functions. With this concept integrated into Healthcare Coalition procedures, early activation will have only limited cost and minimal operational impact. Thus, more frequent activations of the Coalition are justifiable *in anticipating* potential support needs of healthcare organizations.

Provided below is *general* guidance on whether a situation is an incident for a Healthcare Coalition. Each Healthcare Coalition should develop its own *specific* guidance based on its situation.

**Activation of a healthcare organization (Tier 1):** Almost any declared incident (and subsequent EOP activation) for a Healthcare Coalition member organization is, by default, an incident for the Coalition. Although the affected organization may not immediately request assistance, the Healthcare Coalition should consider partial activation of the HCRT to promote situational awareness and to be ready to assist as needed.

**Activation of a Jurisdictional Agency (Tier 3):** The activation of a Jurisdictional Agency's EOP may indicate the need for activation of the HCRT. The Healthcare Coalition Notification Center Technician should notify the Coalition's Duty Officer to determine whether the HCRT should be activated. Even when an incident will not likely have a major impact on individual healthcare organizations, there is often merit in providing advisories or alerts to the Healthcare Coalition. For example, if the Jurisdictional Agency activates its EOP for a brush fire, an "alert" may be issued to healthcare organizations. This promotes readiness to rapidly transition into more robust operations, if needed.

**Activation of a nearby Healthcare Coalition:** In regions where multiple Healthcare Coalitions exist, activation of the EOP by one Coalition may suggest partial activation by less directly impacted Coalitions. This will enable the neighboring Coalition to maintain situational awareness for its healthcare organizations and anticipate requests for assistance.

Additional criteria for considering Healthcare Coalition activation include the following:

- If the Jurisdictional Agency (Tier 3) requests activation of the HCRT
- If there is evidence that incident circumstances could expand, especially in an intentional situation, such as terrorism, or if incident details are unclear
- If a similar incident in the past required activation of the HCRT
- If the Coalition's Senior Policy Group requests HCRT activation.

### **3.2.2 Methodology and Requirements for Incident Recognition**

To determine whether an incident exists for a Healthcare Coalition, the Coalition needs a method to be alerted about an anomaly, gather information, and conduct a balanced decision-making process. Decision makers should have well defined, incremental activation options. They should not be constrained to an "all-or-none" decision tool, which can be detrimental to timely incident recognition. Exhibit 3-2 provides several considerations for the Healthcare Coalition.

### Exhibit 3-2. Healthcare Coalition Incident Recognition

To simplify decision-making processes, the Healthcare Coalition may establish two categories for initial incident information:

- 1) Incident details that *clearly indicate* the need for notifications to Coalition member organizations and/or activation of the HCRT. Large-scale, sudden onset incidents, such as earthquakes, transportation accidents, or terrorist attacks qualify as potential incidents that warrant notifications to Coalition members and activation of the HCRT, even if only limited initial information is available. The Coalition may establish a list of incident types to facilitate decision-making processes.
  - Requests from certain entities, such as a local or State Public Health department, may warrant notifications to Coalition member organizations and activation of the HCRT.
- 2) Incident information that does *not clearly indicate* the need for notifications to Coalition member organizations or activation of the HCRT.
  - A process should be established for making decisions under these circumstances. For example, the information may be vetted by the Coalition Duty Officer to determine whether a notification should be sent out and what it should include. Alternatively, the Duty Officer could attempt to obtain more information to determine next steps.

The Healthcare Coalition should strive to maintain a low threshold for recognizing anomalies as “incidents” for the Coalition. Early recognition has critical implications for the remaining stages of incident response. A low threshold is defensible if it triggers only a low-impact, limited HCRT activation until more information is known.

There are many sources that can provide relevant information to help determine whether an incident exists for the Coalition. Connectivity to these sources, which are highlighted below, should be addressed during preparedness planning to ensure the Coalition’s ability to rapidly share information.

- Individual healthcare organizations (Tier 1) may provide initial information indicating the need for HCRT activation.
- Jurisdictional authorities (Tier 3), such as Fire, EMS, Emergency Management, Law Enforcement, and Public Health may have critical information for healthcare organizations during the early stages of an incident.

- Other public sector entities, including State or Federal agencies (Tiers 4 and 6, respectively), may provide relevant information (e.g., public health advisory) to the Healthcare Coalition. This is often (but not always) communicated to the Coalition through the appropriate jurisdictional authorities (Tier 3).
- Other regional Healthcare Coalitions may share information about an evolving hazard, such as an infectious disease, that prompts incident recognition.
- Media may broadcast information that helps the Coalition Duty Officer decide whether to activate the HCRT. Information verification is critical when media reports are used for decision-making.
- Utility services providers (e.g., water, electricity, gas) may be a valuable source of information about a hazard impact and the extent and projected length of a utility outage.
- Alarm systems that exist in some regions may warn of the possibility of an actual or impending hazard impact. Examples include weather warning systems, flash flood warning systems, and environmental surveillance systems such as Bio-Watch.<sup>2</sup> Having specific points of contact available to the Coalition and established reporting mechanisms is critical to timely incident recognition.

### 3.3 INITIAL NOTIFICATION/ACTIVATION

Once it is determined that an incident exists for the Healthcare Coalition, initial notifications must be made and the appropriate level of activation for the HCRT should be determined. These steps occur almost simultaneously, so initial notification/activation is presented here as a single response “stage.”

The decision to activate the HCRT may best reside with the Coalition Duty Officer, with the authority having been conferred by the Coalition member organizations. The initial HCRT activation level may range from a single staffed position (HCRT Leader) to the staffing of all positions in the HCRT. Activation of the HCRT Leader position is differentiated from the baseline Duty Officer position by increased liaison activity between the HCRT and Coalition member organizations (Exhibit 3-3), as well as additional responsibilities.

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<sup>2</sup>Shea DA, Lister SA. The BioWatch Program: Detection of Bioterrorism (November 19, 2003). Congressional Research Service Report No. RL 32152, Available at: <http://www.fas.org/sgp/crs/terror/RL32152.html>.

### Exhibit 3-3. Example of incident recognition and activation of the HCRT for an anticipated need

In late summer 2008, a long-term care facility in Washington, D.C. experienced a failure of its HVAC system on a warm day. It was unclear when repairs could be made and so the long-term care facility notified the Washington, D.C. Emergency Healthcare Coalition Duty Officer. An “alert” message was sent to Coalition member organizations, and the HCRT was activated with only the HCRT Leader and organizational liaison positions staffed. Coalition members were canvassed for possible bed availability in case patient evacuation was initiated at the impacted facility. Bed numbers were aggregated by location and bed-type, formatted, and provided to the affected organization. Multiple situation updates were provided to Coalition members before, fortunately, the HVAC repairs were completed. Evacuation was not necessary, and the HCRT demobilized.

### 3.3.1 Definition and Implications of “Activation” for the Healthcare Coalition

Activation of the Healthcare Coalition requires rapidly staffing the designated HCRT positions. It begins with the Coalition Duty Officer either transitioning to the HCRT Leader position, or assigning another qualified individual for that role. The HCRT Leader designates which HCRT positions should be initially staffed based on the parameters of the incident. Activation messages to the personnel designated for these positions can occur in multiple ways but may best be handled via the Coalition Notification Center.

Pre-established HCRT activation levels, with the HCRT positions required for each level, may expedite the decision process. Candidate activation levels for the HCRT are:

- **Partial HCRT Activation:** This entails minimal staffing of the HCRT at a pre-established level, but is less robust than a “full” activation. It may include activation of only a single position within the HCRT (HCRT Leader, see Exhibit 3-3).
- **Full HCRT Activation:** Personnel are assigned to all defined HCRT positions. Because the Coalition’s response is scalable, the HCRT may initially activate only a single position and rapidly scale to full activation as specific response needs are identified. Conversely, an initial full activation of the HCRT may be scaled back if the situation is less complex than first indicated.
- **HCRT Alert:** This level requires no specific *response* actions by notified personnel. The requested activity could be as simple as

monitoring an incident for further developments and ensuring availability for immediate activation, if indicated. In this way, a more rapid activation can be accomplished. In addition, some limited contingency planning could be conducted by the Duty Officer in case the situation evolves.

### 3.3.2 Notification Messages and Recipients

Notification messages provide information about the situation, describe current Coalition actions, such as HCRT activation, and include recommended or requested actions on the part of the notified entity.

Notification is best conducted when using pre-established urgency categories and message templates. The message should convey the relative importance of the situation and specify the need for any relevant response actions on the part of the recipient. Exhibit 3-4 presents sample categories for notification messages to *Coalition member organizations*. This specific categorization is also used by Federal and other response agencies. It is most important, however, that the Coalition consider using categories that are consistent with its local jurisdictional authorities (Tier 3) and its member organizations (Tier 1).

#### Exhibit 3-4. Sample notification categories for information provided to Coalition member organizations.

- **Advisory:** Provides urgent information about an unusual occurrence or threat of an occurrence, but no action by the message recipient is expected. An advisory may include actionable information for individual personnel at Coalition member organizations even though the organizations may not need to take emergency action (e.g., a weather advisory that includes travel precautions for individuals).
- **Alert:** Provides urgent information and indicates that some response action on the part of the message recipient may be necessary. An alert may also be used to notify Coalition member organizations that the HCRT has been activated. This category may also be used for ongoing notification during an emergency to convey urgent information and recommended actions from the HCRT or incident command authorities.
- **Update:** Provides non-urgent incident information and suggests no urgent actions. This category is used in both emergency and non-emergency times (e.g., notification of a preparedness meeting may be sent as a Coalition update message.)

Adapted from Barbera JA, Macintyre AG, Shaw G, et al, Emergency Management Principles and Practices for Healthcare Systems. Department of Veterans Affairs, Veterans Health Administration (2006); Available at: <http://www1.va.gov/emshg/page.cfm?pg=122>.

The recipients of initial and follow-on notifications can be easily pre-identified and categorized into call groups. During any HCRT activation, the following should receive an initial notification message:

- Personnel expected to staff the HCRT or who are placed on standby status.
- Coalition members (Tier 1) should be notified of any HCRT activation through an Alert message, even if there is no request for information from them. The Alert message should request that each member organization designate a liaison to be a point of contact for the HCRT (i.e., the Organizational Liaison). The liaison monitors HCRT messages and responds to any information requests. *Healthcare organizations are responsible for disseminating these notifications within their own institution.*
- Jurisdictional authorities (Tier 3) should also be notified when the HCRT is activated. This helps integrate the Coalition's response with the larger community response and may provide Tier 3 entities with critical information they don't already possess. Methods for notifying Jurisdictional Agencies (Tier 3) should be established during preparedness and accomplished through a single point of contact (e.g., jurisdictional EOC, Dispatch Center, or Department of Health Operations Center). Because not all communities have well integrated communications between public sector entities, individual notification to specific entities may be required.
- Other regional Healthcare Coalitions should be notified if the HCRT is activated to enhance regional situational awareness.

Notification messages should be concise and provide the appropriate urgency category. Methods can be established to convey more detailed information as it becomes available, such as posting this information to a password protected web page. Important elements in the notification message include the following:

- Brief description of the threat or hazard impact
- Brief description of the implications of the incident for Coalition member organizations, including any projected response actions (e.g., "healthcare facilities should anticipate significant numbers of casualties")
- Specific recommended actions for individual Coalition member organizations and/or HCRT staff (e.g., requests for initial information about the hazard impact on member organizations)



- Request for confirmation that the message was received by the intended recipient
- Indication of when the next message will be provided, if known
- Time and date stamp indicating when a message was sent.

Exhibit 3-5 provides an example template and notification message that a Healthcare Coalition might send to its member organizations.

### **Exhibit 3-5. Example Healthcare Coalition Alert for a train derailment**

“This is an Any City Healthcare Coalition Alert (3/29/09 1630 hours). Train derailment with release of hazardous materials, including chlorine gas, near intersection of Route XX and Highway YY at 1610 hours. Area residences are being evacuated. No casualties have been reported at this time. The evacuation order may extend to Happy Times Chronic Care Facility. All Coalition member organizations are asked to provide bed count in case this facility is evacuated. Situation update message anticipated at 1700. Confirm message receipt at [web site address] and provide operational status.”

### **3.3.3 Notification Methodologies and Requirements**

Appropriate technology that is fast and reliable is required to send emergency notifications. It is important that the notification message is not easily overlooked by the intended recipient or buried in similar appearing but less urgent messages. This can be a common issue when fax is used for notifications, since fax machines are rarely monitored closely during normal operations. When using text or voice messaging, the Coalition’s name and the urgency level of the notification should be given at the beginning of the message to distinguish it from other messages. Another issue to consider is the truncation of messages by pager systems, since Coalition participants may have different pager vendors with varying message capability.

Available technologies for emergency notification include:

- Radio systems in which receivers are always on and near permanently staffed areas
- Mass text messaging systems (e.g., Health Alert Network (HAN) systems)
- Reverse 911 and other mass telephone dialing with recorded voice messaging technology

- Web-based messaging services that target computers that are always staffed
- Mobile web receiving devices and other emerging technology.

Because initial notifications are so important, ideal solutions may combine several technologies that offer redundant capabilities. For example, an initial Alert message may be transmitted using the HAN or other messaging system that transmits messages through multiple modalities (text, email, and telephone voice message). The message may refer the recipient to a password protected web site for further information and prompt the recipient to confirm receipt of message and convey a current operational status. Any targeted individuals and organizations not confirming message receipt in a specified time period may then be contacted through alternate methods.

### 3.4 MOBILIZATION

The HCRT should be operational very rapidly at the onset of an incident. The use of pre-established procedures or a mobilization checklist can expedite and prioritize the actions that are required to transition from baseline operations to HCRT activation for emergency response. Mobilization procedures should address the following:

- **HCRT personnel:** Personnel staffing the HCRT must receive activation notification, mobilize themselves to “assemble” (even if virtually) and be briefed. Accountability is important not only from a safety and operational standpoint, but also potentially from a financial perspective (i.e., if compensation, liability coverage, and/or other benefits are included).
- **Senior Policy Group personnel:** Even if the services of the Senior Policy Group are not immediately needed, mobilization procedures might include verifying the contact information for Senior Policy Group personnel to ensure they can be rapidly contacted, if necessary
- **Coalition Notification Center Technician:** For a full HCRT activation, additional staffing or a change in the configuration of the Coalition Notification Center may be needed so that incident information is adequately processed and notification and other messaging can occur. Mobilization procedures for fully staffing and accessing the Coalition Notification Center should be pre-established.

- **Other physical locations:** Any facilities that may be used for the HCRT and/or Senior Policy Group operations should have established procedures for mobilization. Meeting space may be at these locations or distributed among Coalition members, whichever is most efficient for the specific Healthcare Coalition. Mobilization considerations are presented in Exhibit 3-6.

### **Exhibit 3-6. Considerations for facility mobilization**

If a Healthcare Coalition will utilize fixed facilities to support HCRT operations, the following should be considered when developing mobilization procedures:

- Access to the facility must be available 24/7 and procedures should be in place to comply with security requirements. For example, activated HCRT personnel may need keys, access cards, or special identification badges to access the facility.
- Maps to reach the facility may be important, including the designated 24-hour entry points.
- The facility that is designated for HCRT operations may have a different purpose during everyday operations. Guidance for rapid conversion of the space to allow efficient HCRT operations could include instructions on set-up of the operational space.
- Procedures should include the set-up of required technology and supplies to support HCRT operations (see Section 6.2.1). This may include primary and backup telephones, cellular or satellite phones, teleconference microphone/speaker systems, computers with Internet access, radios, and direct connect devices.
- In some situations, power, water, and other utilities may need to be addressed for facilities that are rarely used for emergency purposes. Availability of backup electrical, water, and other support should be verified during the mobilization process.
- Potential backup locations for the HCRT operations should be identified in the event that the primary location is impacted by the hazard or is otherwise unavailable.

Mobilization procedures should be documented in the Healthcare Coalition EOP and its attachments, implemented via education, training, and drills, and evaluated through exercises or after action analyses of real-world emergencies.

## 3.5 INCIDENT OPERATIONS

This section describes important activities that the HCRT may conduct during incident operations. These activities are relevant to the Healthcare Coalition regardless of whether the HCRT operates from a single physical location or via a distributed network.

### 3.5.1 HCRT “Leader” Function

As noted in Chapter 2, the HCRT position that performs the ICS “Command” function is more aptly referred to as an HCRT “Leader.” Key activities of this position during HCRT incident operations are described below.

#### **Managing the Coalition’s emergency response**

The HCRT Leader provides oversight and maintenance of the HCRT. *Even during minimal HCRT activation, it is mandatory to designate the HCRT Leader.* During initial activation, the Coalition Duty Officer transitions to the HCRT Leader position until he/she is relieved by another qualified individual. It is expected that other traditional ICS Command staff positions will be unassigned during most HCRT activations. The functions of these unstaffed positions are assumed by the HCRT Leader.

Important initial management actions include the following:

- Conduct an initial situation assessment.
- Designate the structure of the HCRT and which positions will be staffed for the emergency. This should be documented and disseminated to Coalition member organizations, jurisdictional authorities (Tier 3), and other relevant response organizations (e.g., regional Healthcare Coalitions). This may be accomplished using an HCRT ICS Form 207 (Figure 3-2). Because the HCRT may evolve as the incident progresses, the structure should be updated as necessary. This level of transparency is critical to integrating the HCRT with other response entities.
- Establish initial objectives for the HCRT, then develop strategies and assign resources to achieve the objectives (Exhibit 3-7). Setting objectives for the HCRT, even if formal action planning is not conducted, fosters proactive team management and is important for overall response success.

**Figure 3-2. Example of an HCRT ICS Form 207**

HCRT ORGANIZATIONAL CHART		HCRT 207 REV. 07/24//2008
This form is used to document personnel assigned to positions in the Healthcare Coalition Response Team (HCRT). Initial assignments may change and this form should be updated as necessary (even within an operational period).		<b>COMMAND STAFF GENERAL STAFF</b>
1. INCIDENT NAME:	2. DATE/TIME PREPARED:	3. OPERATIONAL PERIOD:
<b>4. ORGANIZATIONAL STRUCTURE:</b>		
<div style="border: 1px solid black; padding: 5px; margin: 10px auto; width: 60%;"> <u>HCRT Leader:</u>                      Home organization:                      Cell/contact:                 </div>		
<div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="border: 1px solid black; padding: 5px; width: 30%;"> <u>HCRT Operations Section Chief:</u>                      Home organization:                      Cell/contact:                 </div> <div style="border: 1px solid black; padding: 5px; width: 30%;"> <u>HCRT Logistics Section Chief:</u>                      Home organization:                      Cell/contact:                 </div> <div style="border: 1px solid black; padding: 5px; width: 30%;"> <u>HCRT Planning Section Chief:</u>                      Home organization:                      Cell/contact:                 </div> </div>		
<div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="border: 1px solid black; padding: 5px; width: 30%;"> <u>CNC Technician:</u>                      Home organization:                      Cell/contact:                 </div> <div style="border: 1px solid black; padding: 5px; width: 30%;"> <u>HCRT Communications Unit:</u>                      Home organization:                      Cell/contact:                 </div> </div>		
<div style="border: 1px solid black; padding: 5px; margin-top: 10px; width: 30%;"> <u>Organizational Liaisons:</u>                      See List                 </div>		
<b>5. PREPARED BY (print and sign)</b>		

### Exhibit 3-7. Example incident and initial operational period objectives for the HCRT

#### Incident (Control) Objectives\*

- Facilitate situational awareness for Healthcare Coalition member organizations
- Provide resource support to Coalition member organizations
- Facilitate coordination across participating Coalition organizations
- Facilitate the interface between jurisdictional authorities (Tier 3) and Coalition member organizations

#### Operational Period Objectives\*\*

- Obtain and aggregate initial situation and resource assessments at individual healthcare organizations (Tier 1)
- Obtain initial situation and resource assessment from jurisdictional authorities (Tier 3) and regional sources
- Facilitate early, critical requests for assistance from impacted Coalition member organizations
- Obtain initial response strategies used by Coalition member organizations and assess these to identify potential conflicts or gaps

\* Incident or control objective is the NIMS term for overall incident response goals and are not limited to any single operational period.

\*\* Operational period objectives are more specific objectives (compared to incident or control objectives) for the organization to accomplish during a specific operational period, contributing towards achieving the incident objectives.

- Address safety issues for the Healthcare Coalition. If a Safety Officer is not assigned to the HCRT, this responsibility falls to the HCRT Leader. Safety issues for the Coalition include:
  - Safety issues for HCRT personnel. These will depend on the type of incident, but may include the use of Personal Protective Equipment (PPE) during a contagious disease outbreak, or addressing irregular sleep cycles for staff who are working during a prolonged incident.
  - Safety issues for Coalition member organizations. Collective issues related to response safety for Coalition member organizations should be addressed as well. However, this is typically addressed through the HCRT Operations Section, if established.
- Address public information issues for the Healthcare Coalition. If a traditional Public Information Officer is not assigned to the HCRT, this responsibility falls to the HCRT Leader unless it is specifically assigned elsewhere (e.g., to a member of the Senior Policy Group). Public information issues for the Coalition may include:

- Media inquiries about the Coalition's response during an emergency. It is important to identify an individual who can be interviewed and appropriately answer questions. Care must be taken to limit the message only to the Coalition's activities.<sup>3</sup> The message should not attempt to address the activities occurring at individual healthcare organizations, unless requested to do so by those assets.
- Public information consistency across Coalition member organizations. The public message may need to be coordinated across healthcare organizations, if this is not specifically addressed by the relevant Jurisdictional Agency (Tier 3). This activity is best accomplished by the HCRT Operations Section (Section 3.5.2) with HCRT Leader oversight.
- Conduct liaison activities. Depending on the complexity of the Healthcare Coalition and the demands of an incident, a liaison position may or may not be staffed in the HCRT during incident operations. Liaison activities, however, must still occur. An essential liaison activity is with the Jurisdictional Agency (Tier 3) or regional Jurisdictional Agencies (multiple Tier 3s). The HCRT should ensure the following:
  - Appropriate information exchange with the jurisdictional response. This would commonly be the Tier 3 Medical or Public Health authority through the jurisdiction's IMT, Emergency Support Function, or a Department Operations Center (e.g., Public Health Department Operations Center).
  - Effective interface with other regional Healthcare Coalitions (other Tier 2s), if warranted.
  - Interface with other response agencies that may be operating in parallel with the Jurisdictional Agency (Tier 3) that is directly supporting the Healthcare Coalition. For example, Federal Law Enforcement may be onsite at healthcare facilities to identify possible perpetrators among the incident victims. While formal interface should occur through the Jurisdictional Agency (Tier 3), direct liaison with the agency that is operating at the healthcare organization is beneficial.

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<sup>3</sup> Global assessments of the situation are the role of the Public Information Officer from the relevant Jurisdictional Agency.

## Healthcare Coalition incident action planning

Incident Action Planning is an important activity for any response organization and is well described in NIMS.<sup>4</sup> Essentially, it is the methodology that response organizations use to proactively manage an incident by establishing incident objectives, developing strategies and tactics, and assigning resources to accomplish the objectives. It is meant to be an iterative process that continuously evaluates the success of the organization and determines whether objectives, strategies, and tactics need to be revised.

Incident action planning is often a formal process that involves a series of steps (including meetings) and documentation of the resultant action plan for dissemination.<sup>5</sup> Used appropriately, incident action planning can effectively coordinate the efforts of an organization and integrate those efforts with other response organizations. The following considerations related to incident action planning are relevant for the Healthcare Coalition response:

- *When is formal action planning indicated for the Healthcare Coalition?*  
Despite its benefits, formal action planning can be time and labor intensive. In addition, its intra-organizational benefits are most evident to organizations conducting tactical operations (as compared to coordinating entities like EOCs). Often, an HCRT may be able to address the benefits of action planning following the response objectives set for the Coalition and simply ensuring that appropriate information is disseminated (see Section 3.5.2). If resources are available to conduct action planning, the initial incident parameters that indicate formal action planning may be beneficial include:
  - An incident involves or impacts a significant number of Coalition member organizations
  - An incident is projected to be long in duration
  - Incident response appears exceptionally complex, such as after a large-scale bioterrorism incident.

Moreover, if the Coalition conducts formal action planning, much of the material that is required to develop the action plan may be available

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<sup>4</sup> Department of Homeland Security, National Incident Management System (NIMS), December 18, 2008. Available at: <http://www.fema.gov/emergency/nims/>.

<sup>5</sup> Commonly known as “ICS forms,” there are numbered document templates that are used to form the basic Incident Action Plan. ICS forms 202, 203, 204, 205, and 206 form the core components of the Incident Action Plan.



by incorporating elements of the individual action plans from Coalition member organizations (Tier 1).

- *Who conducts formal action planning for the Healthcare Coalition?* The Planning Section of the HCRT supervises the action planning process (see Section 3.5.2).
- *What terminology should be used for Coalition action planning efforts?* Traditional ICS dictates that there is only one “Incident Action Plan” for an incident. This is usually the responsibility of the incident command authority directly managing the primary incident. The HCRT may prefer to use “Healthcare Coalition Action Plan” to distinguish this planning from both incident command authorities and planning conducted by individual healthcare organizations.
- *What is the scope of this formal HCRT action planning?* This “Healthcare Coalition Action Plan” only addresses the scope of its activities in supporting Coalition member organizations and facilitating interface with jurisdictional authorities. To avoid confusion, the action plan should recognize activated entities such as the medical emergency support function in a local EOC or a Public Health Department Operations Center, and briefly describe how they interface.

## **Strategic planning and linkages to the Senior Policy Group**

The HCRT Leader also manages the interface between the HCRT and the Senior Policy Group. This includes establishing a reporting cycle to provide situational awareness and HCRT performance information to the Senior Policy Group. In addition, the HCRT Leader should receive strategic or policy direction from the Senior Policy Group and supervise the implementation of the Senior Policy Group’s decisions.

### **3.5.2 Operations Section**

The organization of the HCRT Operations Section may vary based on the overall complexity of the Coalition and the specific incident requirements. Positions are staffed according to the projected tasks for that incident. The following major functions within the Operations Section are presented for consideration.

## Information processing

A key response function of the HCRT could be to collect and process incident information for Coalition member organizations. The type of information processed by the HCRT may vary based upon the type and duration of an incident and by the response objectives that each Coalition seeks to achieve. It can also involve reporting the *same* type of information (e.g., number of incident victims by specific categories) as a response evolves. In accordance with ICS guidance, the information is captured and archived by the HCRT Planning Section.

Examples of the information categories that could be collected *from Coalition organizations* (Tier 1) during an incident include:

- Situation reports on the operating status of healthcare organizations (Tier 1). This refers to both patient load and any hazard impact on the organization. Ideally, a template developed during preparedness will standardize information provided to the HCRT so it can be efficiently aggregated by the HCRT. The template should be somewhat flexible to capture specific information based on the incident. Common types of information that can be included in situation reports include:
  - The number of incident patients and types of casualties. Pre-established patient categories may be used by all Healthcare Coalition members to standardize reports on the severity of patients receiving care at each facility (Exhibit 3-8). These categories may not match up exactly with categories used by EMS to triage and prioritize patients for transport, since they serve a different purpose (i.e., projecting resource need).

### Exhibit 3-8. Examples of patient categorizations

The Washington, D.C. Hospital Mutual Aid System established two simple patient categories (based upon projected resource needs) for use in reporting patient data during emergencies. The simplicity works well, especially during incidents where the exact needs of the individual patients may not be rapidly discernable. All hospitals understand and utilize the following categories when reporting.

- **Major:** patients expected to require admission and/or significant medical or hospital resources (e.g., operating room, critical care, extensive orthopedic intervention)
- **Minor:** patients expected to be treated and released, or who require very little medical or hospital resources.

- Patient identifiers. This can be important for helping family members locate loved ones and for other tracking purposes (e.g., epidemiological investigation of an infectious disease outbreak). The Coalition must ensure that this information is captured in a manner that complies with relevant Health Insurance Portability and Accountability Act (HIPAA) and relevant State or local regulations.<sup>6</sup>
- Resource reports that describe the operating status at each healthcare organization. Coalition members may be affected directly by impacts on personnel and facilities or indirectly by impacts on utilities or road access. A collective picture of the impact on healthcare delivery may offer stark evidence that priority assistance is needed through mutual aid or the Jurisdiction Agency (Tier 3). Reporting this aggregated information to incident authorities and back to Coalition members enhances situational awareness.

Examples of the information that could be collected *from the Jurisdiction Agency(s) or other response organizations* to convey to Coalition members include:

- Situation reports describing the hazard impact on the community and public sector response assets.
- Transportation disruptions, projected length of utility loss, EMS issues, and 911 call volumes. These are valuable data for projecting resource need and identifying barriers to resource acquisition.
- Specific public health information, such as case definitions, during an infectious disease outbreak. Case definitions provided early during an incident can be critical in helping healthcare organizations collect and report epidemiological data. Rapid aggregation of these data and dissemination to Coalition members and relevant Public Health authorities may increase reporting compliance among Coalition member organizations.
- Other epidemiological data collected and analyzed by public health authorities to establish situational awareness. For example, data on work absenteeism or trends in the use of specific medications can be helpful to distribute to member organizations.
- Treatment protocols or guidelines promoting consistent patient care. These may be developed by expert personnel from Coalition

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<sup>6</sup> Healthcare Coalitions may find it helpful to work closely with local and State public health authorities to formally address these concerns.

member organizations using a consensus approach that incorporates public health recommendations. This is valuable not just for unique infectious diseases, but also when traditional medical issues must be addressed in non-traditional (alternate care) facilities. For example, general guidelines for the first 24 hours of care for burn patients who are being treated in non-burn facilities may facilitate appropriate medical care until additional assets can be mustered.

- The Incident Action Plan generated by the Jurisdictional Agency (Tier 3) with command authority for the incident response. Relevant information from the Incident Action Plan should be conveyed to Coalition members, such as the projected schedule for restoring utilities or clearing debris from roadways.
- Other updates, advisories, or alerts, such as an alert issued by the Centers for Disease Control and Prevention (CDC) or an “action plan” produced by a nearby Healthcare Coalition that may be dealing with a similar crisis.

What should the HCRT do with all of this information once it has been collected? This may vary from one Coalition to another, but some general next steps include:

- Information provided by Coalition member organizations (Tier 1) may be aggregated or summarized into a usable format, then disseminated back to members and the relevant Jurisdictional Agency(s) (Tier 3).
- The data may require some analysis to improve its value for recipients. For example, individual experts or a task force formed from within the Coalition organizations may briefly review and clarify the information before it is disseminated. Usually, the information can be distributed with minimal processing.
- The HCRT Planning Section should archive all information or data collected during HCRT response and recovery.

The Operations Section can also promote situational awareness by conducting a Situation Update teleconference. This can be particularly useful during complex or rapidly evolving incidents. The objective is to provide a balanced understanding of what has occurred so healthcare organizations can make informed decisions and anticipate future actions. Participants may include HCRT personnel, Organizational Liaisons from Coalition members (Tier 1), and representatives from relevant Jurisdictional Agencies (Tier 3) and other regional Healthcare Coalitions (Tier 2s). These calls generally include an incident summary followed by

short briefings from jurisdictional authorities, heavily involved Coalition members, and informed experts invited by the HCRT to participate.

## Resource support

Depending on the robustness of the Coalition, another key function of the Operations Section is to facilitate resource support for responding healthcare organizations (Tier 1). *It is important to note that the Coalition only facilitates the established processes for resource support. It does not direct or control these activities between member organizations or between healthcare organizations and jurisdictional response entities (Tier 3) unless specifically delegated this authority from the proper Jurisdictional Agency.* Coalition actions may entail the following:

- Facilitating mutual aid:** The HCRT can notify Coalition member organizations when assistance is needed or anticipated by one or several Coalition members. The specific needs can be obtained from the requesting organization(s) and conveyed through the HCRT. Likewise, organizations that are able and willing to assist can respond through the HCRT so that offers of assistance can be rapidly aggregated. The HCRT can also facilitate the application of mutual aid instruments between organizations (see Chapters 4 and 7). Depending on how the Coalition has been constructed, assistance may include tracking resources shared between the organizations.<sup>7</sup> *The HCRT must always keep Jurisdictional Agencies (Tier 3) managing the incident informed about resource requests and actions to meet the requests. Jurisdictional Agencies can then anticipate where additional assistance may be needed.*
- Facilitating outside assistance:** Requests for assistance to entities outside of the Coalition membership can be expedited by HCRT actions. Requests from member organizations may be rapidly aggregated and transmitted to the Jurisdictional Agency (Tier 3). *When a Healthcare Coalition crosses jurisdictional boundaries (e.g., the Coalition covers organizations in adjoining cities, counties, or regions), the Coalition must coordinate these requests through the respective jurisdictional authorities (Tier 3).*
- Facilitating requests to other regional Coalitions, whether assets are being sent to or received from these entities.** Keeping relevant Jurisdictional Agency(s) informed of the situation is critical.

<sup>7</sup> Resource tracking may occur at the healthcare organization level; however, the HCRT should still confirm that the resource tracking is actually occurring.

- **Facilitating the placement of specialty patients:** For example, after an incident with multiple burn patients, initial care can be started at local healthcare facilities while the HCRT assists hospitals and jurisdictional authorities (Tier 3) in locating burn beds in the region, State, or country. This promotes the placement of patients via a medically sound priority scheme.
- **Facilitating resource support from Coalition organizations to jurisdictional authorities (Tier 3):** During incidents in which the jurisdictional response entities require healthcare assistance, such as a mass biological exposure of first responders, the HCRT Operations Section can facilitate assistance from available healthcare organizations.

## **Facilitating a coordinated response among healthcare organizations**

Certain incidents highlight the need for consistency in response actions across Coalition member organizations. This is often necessary during the response to an unusual infectious or toxic agent (evaluation and treatment protocols, case reporting, etc.). The HCRT may promote consistency across “Healthcare Organization Action Plans” by facilitating brief discussions among Coalition members and the sharing of *draft* action planning products as the incident evolves. Any perceived or actual conflict in the intended response actions of the organizations can then be addressed directly by the involved entities, either by producing a joint explanation for the perceived conflict or by resolving the conflicting material before it is distributed or put into action. This is a facilitating function only and does not subvert the incident command authority of Jurisdictional Agencies or the autonomy of Coalition member organizations.

## **Methodology**

The HCRT Operations Section may establish an iterative information sharing process to facilitate coordination between the incident management elements within the responding healthcare organizations. Consistent with the ICS “management by objectives” approach, this process may entail:

- An operational period (i.e., the time during which one Coalition Action Plan is applicable) is established along with a reporting schedule for Coalition member organizations.

- Elements of individual organization action plans, such as patient screening protocols, may be collected and compared. Any major conflicting strategies are identified (see Exhibit 3-9).
- A response coordination teleconference may be conducted. Any differences in response tactics or actions between healthcare organizations can be identified and discussed. In this manner, healthcare providers will be better prepared to address issues related to consistency in the healthcare services provided to incident patients.
- An aggregated report of specific items from healthcare organization action plans may be developed. The aggregated report is forwarded to relevant Jurisdictional Agency(s) (Tier 3) while simultaneously being returned to member organizations.

### **Exhibit 3-9. Example of the importance of coordinating strategies of individual healthcare organizations**

During the anthrax attacks in 2001, hospitals in the Washington, D.C. area did not initially coordinate their efforts for screening and evaluating potentially exposed patients. For example, some hospitals conducted nasal swabbing as a diagnostic test despite evidence that it was useful only for epidemiological purposes. The resultant confusion led to “hospital shopping” by some patients until they found a facility that would conduct the test for them. Criteria to determine which patients received prophylaxis also varied between health facilities. The lack of a consistent approach further increased the anxiety of the public and led to speculation of “class disparities” in evaluation and treatment recommendations.

Authors’ observations; Gursky E, Inglesby TV, and O’Toole T. “Anthrax 2001: Observations on the Medical and Public Health Response.” *Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science*, Volume 1, (2003).

The information contained in the Coalition members’ action plans will help formulate the Healthcare Coalition’s Action Plan. A consensus among the organizations may be reached for incident and operational period objectives, strategies, and major tactics. While specific tactics may vary somewhat at each organization, it is ideal to have general consistency across the Coalition.

If the Coalition elects not to conduct formal action planning, it may still be valuable to establish regular reporting times and data categories for member organizations in order to maintain situational awareness and strategy consistency. In addition, the Coalition may want to conduct the

equivalent of an operations briefing at least once during each operational period. Updates on the incident and the HCRT's response actions can be provided. Participants should include the organizational liaisons to the HCRT and liaisons from relevant Jurisdictional Agencies (Tier 3).

## Requirements

For the Healthcare Coalition to support these activities it must have the ability to effectively send and receive information from Coalition member organizations (Tier 1) and Jurisdictional Agencies (Tier 3). The HCRT should be able to link its member organizations in real-time for teleconferences, web-based information sharing, and other activities. Ideally, these communication methods should be available independent of Jurisdictional Agencies or any Coalition organization to ensure they are available to the Coalition during any type of major emergency.

### 3.5.3 HCRT: Support Sections

If the HCRT is structured according to ICS principles, staffing of the various support functions (Logistics, Planning, Administration/Finance) may be necessary depending on the incident parameters and the robustness of the Coalition. To keep the Coalition as lean as possible, these functions should only be staffed as necessary for the specific emergency (see Section 2.3).

### 3.5.4 Healthcare Coalition Senior Policy Group

In many emergencies, the services of the Healthcare Coalition Senior Policy Group may not be needed. However, when their services are needed, the Senior Policy Group will typically meet via teleconferencing. These meetings should be managed by the HCRT Leader to keep them focused and concise. A record should be kept of the discussions and any directives from the proceedings should be disseminated to the Coalition member organizations.

The Coalition should define a process during preparedness planning for how the Senior Policy Group will make decisions during an emergency. Personnel staffing the Senior Policy Group should be trained and exercised on this decision process. For example, a majority vote may be adequate in most cases; however, if there are multiple organizations within the Coalition owned by one parent company, then consideration



may be given to “weighted” votes to maintain fairness across the Coalition. The Senior Policy Group should have access to technical experts within the Coalition (Exhibit 3-10) to help them make informed decisions. At the invitation of the Senior Policy Group, representatives from Public Health, EMS, and other local Jurisdictional Agencies (Tier 3) may serve in an advisory capacity.

### **Exhibit 3-10. An example of a notional Senior Policy Group decision**

During response to the intentional release of anthrax, the Strategic National Stockpile has been distributed according to pre-established protocols within the jurisdiction. However, due to the pattern of release, Hospital X has been screening more patients than the larger Hospital Y. A request for re-distributing pharmaceuticals has met resistance by some Coalition member organizations. To resolve the discord, an emergency meeting of the Senior Policy Group is conducted.

During the meeting, which is facilitated by the HCRT Leader, a decision is made to redistribute the medications based on an agreed-upon projection of need. A follow-up Senior Policy Group meeting is scheduled for further review and distribution revision, if indicated.

## **3.6 DEMOBILIZATION**

Given the important services that healthcare organizations provide, responding resources should be demobilized as soon as they are no longer needed for emergency response. The process for returning them to their day-to-day function should be expedited. Some organizations, as well as elements of the HCRT, may be demobilized while other elements are still operational. Individual organizations manage their own demobilization actions, but they should inform the HCRT of their status so that situational awareness can be maintained across the Coalition.

The HCRT should define procedures for demobilizing its resources. These procedures can be listed in a checklist and included as a tool in the Healthcare Coalition’s EOP. Some examples of issues that could be included in a Coalition’s demobilization checklist include the following:

- **Decision to demobilize:** Guidelines for how the decision would be made and what factors should be considered (e.g., completion of response objectives) can be helpful.

- **Announcement of demobilization:** As the Healthcare Coalition demobilizes elements from its response organization, it is important to formally notify Coalition members and the relevant Jurisdictional Agency(s) (Tier 3).
- **Transition to Healthcare Coalition baseline operations:** As the HCRT Leader is demobilized, consultation and decision-making authority is transferred to the staffed Healthcare Coalition Duty Officer. The Coalition Notification Center resumes its role in baseline operations.
- **Resources:** HCRT demobilization procedures can initiate the rehabilitation of HCRT resources used during the emergency. This is further addressed in Section 3.7.
- **Document preservation:** Relevant incident-related documents for the HCRT should be archived, including ICS forms and documentation collected from external sources (Tier 1, regional Tier 2s, or Tier 3). These can be helpful for the HCRT After Action Report (AAR) process (see Chapter 6) and also serve as historical references.

### 3.7 TRANSITION TO RECOVERY AND RETURN TO READINESS

As the Healthcare Coalition demobilizes, important HCRT objectives may remain, such as supporting remaining recovery objectives for member organizations and returning the HCRT to a state of readiness for the next emergency.

#### 3.7.1 Managing the Healthcare Coalition through Recovery

There are additional management considerations for the Healthcare Coalition as its response to an incident draws to a close, including:

- The HCRT Leader and the Planning Section Chief (if this position is staffed) should be the last positions to demobilize.
- If the HCRT needs to support the recovery of member organizations or the jurisdiction, the staffed positions may vary from the HCRT response configuration. It may be more limited or staffed by different personnel than those who worked during HCRT emergency operations.

- In addition to incident recovery objectives, the Coalition may find it useful to address mitigation or improvement in its response capabilities during recovery. Funding opportunities often arise after an emergency. The Coalition should be ready with targeted initiatives that will increase HCRT resiliency and/or improve its response capabilities.
- The HCRT may assign personnel to assist with the Coalition's AAR process or other organizational learning activities. When the HCRT demobilizes, the supervision of the AAR process transitions to the Coalition's Emergency Management Committee (see Chapter 5).

### 3.7.2 Resource and Personnel Rehabilitation for the Healthcare Coalition

All resources used during emergency response should be rehabilitated to their pre-response state. Rapid return to readiness of key resources, such as the Coalition Notification Center, should be a primary focus. Any facilities used by the Healthcare Coalition should be returned to their normal configuration. Durable equipment must be rehabilitated and non-durable supplies should be re-stocked. Information collected and processed by the HCRT should be appropriately archived.

Rehabilitation for personnel who conducted incident operations for the HCRT may entail the following:

- Establishing a formal process for "out-processing" personnel and returning any issued equipment (e.g., radios)
- Debriefing personnel as they are out-processed and use their feedback to inform the AAR process
- Recognizing the efforts of personnel who staffed the HCRT and consider giving them personal time to recover before returning to their regular duties
- Conducting performance evaluations for personnel who staffed HCRT positions during emergency operations.

### 3.7.3 Reimbursement for Healthcare Coalition Response

Chapter 5 addresses funding of the Coalition's preparedness activities. The funding of response activities is approached differently. The primary cost for operating the HCRT and Senior Policy Group is usually personnel time, which is often donated by the Coalition member organizations. However, it is still important to keep records of personnel time (or other Coalition expenses), since reimbursement mechanisms may be available. In some situations, established mechanisms may exist for reimbursing Coalition expenses (Exhibit 3-11).

#### **Exhibit 3-11: Regional Hospital Preparedness Council and the Catastrophic Medical Operations Center\***

A variety of medical organizations within 18 counties of Southeast Texas have organized to develop a Coalition that addresses common emergency preparedness and response issues. The Regional Hospital Preparedness Council is a 501c3 independently chartered organization that functions as a preparedness platform for these organizations. During emergency response, the associated Catastrophic Medical Operations Center (CMOC) is staffed to address many of the response objectives listed for Coalitions in section 2.2 of this handbook. For example, as Hurricane Ike approached Texas in 2008, the CMOC facilitated patient tracking for the evacuation of 56 hospitals and 220 nursing homes over a 60-hour period.

The CMOC is organized using a NIMS-consistent Incident Management Team structure with subject matter experts covering traditional ICS functions. Additional liaisons have included representatives of agencies such as HHS, Department of Aging and Disability, EMS, and Medical Societies.

The council currently receives no direct State or Federal preparedness funding. However, when the CMOC is activated by the State or a local jurisdiction during a declared emergency or disaster, it is financially supported through contract. Funds reimburse the costs of personnel staffing the CMOC as well as specified other expenses.

\*Personal communication between the author (AGM) and Lori A. Upton, RN, BSN, MS; January 28, 2009.

## NOTES

# NOTES

# Chapter 4:

## Integration of the Healthcare Coalition into Overall Emergency Response and Recovery

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## 4.1 HEALTHCARE COALITION STRATEGIES FOR INTEGRATING WITH COALITION MEMBER ORGANIZATIONS (TIER 1)

The mechanisms that the HCRT uses to interface with Coalition member organizations (Tier 1) and the relevant Jurisdictional Agency(s) (Tier 3) during emergency response should be designed to maximize efficiency. While multiple examples are presented in this chapter, they are not intended to be prescriptive. They are provided to stimulate discussion among those responsible for developing a Coalition.

### 4.1.1 Response Strategies for Supporting Coalition Member Organizations (Tier 1)

In Section 2.1.1, candidate incident response and recovery objectives were presented for the Healthcare Coalition. If these objectives are adopted by a Coalition, then the strategies used to achieve them can be grouped according to the following categories:

- Promote situational awareness and consistent response actions among Coalition member organizations by facilitating information sharing.<sup>1</sup>
- Represent the collective interests of the Coalition member organizations in addressing issues with incident command and jurisdictional authorities (Tier 3).
- Facilitate resource support to Coalition organizations through mutual aid and other assistance mechanisms.
- Enhance support to Coalition member organizations from the Jurisdictional Agency (Tier 3) directly or from other entities (e.g., State or Federal government) through the Jurisdictional Agency.

Examples of response strategies that a Healthcare Coalition may incorporate into its EOP are provided below.

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<sup>1</sup>It is anticipated that this will be the most frequent activity that any Coalition will be engaged in during emergency response.



## Promoting situational awareness and consistent response actions among Healthcare Coalition member organizations

The information processing function of the HCRT plays a key role in providing situational awareness among Coalition members. As an extension of this strategy, the HCRT can also promote consistency in response actions among its member organizations without impinging on their independent decision-making authority. The Coalition can achieve this support through the following actions:

- Collecting, compiling, and reporting situation updates and other data from Coalition members. Reported data may include how the hazard has affected each healthcare organization in terms of patient volume, patient types, or direct impact on the healthcare organization itself. Information collected and disseminated can also include how Coalition members are responding.
- Facilitating patient tracking for Coalition member organizations and providing this information back to healthcare organizations so they can assist families searching for loved ones.
- Collecting, compiling, and reporting information about each Coalition member's response strategy.
- Collecting (from Public Health authorities or subject matter experts) and disseminating recommendations related to specific response actions for unusual patient cases. These recommendations could include information related to changes in the understanding of a disease or injury pattern or protocols for the evaluation or treatment of incident patients. These efforts require close coordination with Public Health authorities.<sup>2</sup>
- Promoting consistent public messaging for Coalition member organizations. This can be achieved, in part, by disseminating public information guidance from the Jurisdictional Agency (Tier 3), which has lead responsibility for public information. As discussed in Chapter 3, it may entail convening individuals from member organizations to promote consistency of public messages. The Coalition may also monitor the media for erroneous or alarming messages that could impact the public perception of the healthcare response.

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<sup>2</sup> At the same time, the Coalition's information collection efforts from member organizations could assist public health authorities with rapid epidemiological investigations and disease characterizations.

## Representing the collective interests of Coalition members to the Jurisdictional Agency (Tier 3)

The HCRT can represent Coalition members in their interactions with the Jurisdictional Agency (Tier 3) during response and recovery. Examples of activities the Coalition could engage in include:

**Addressing public sector actions that might adversely impact healthcare organizations:** Public safety, public health, and other agencies may implement response tactics that inadvertently compromise operations at healthcare organizations. For example, roadblocks used to secure an area during a mass gathering can hinder healthcare personnel from reporting to their workstations. The HCRT can bring these types of issues to the attention of the jurisdictional authorities in an effort to resolve them.

**Promoting financial support to healthcare organizations for response services and expenses:** Because of the fiscal environment in which many healthcare organizations operate, they are especially vulnerable to interruptions in reimbursement for services, increased expenses related to medical surge, or other service obligations, such as mass decontamination. These activities often do not have a clear mechanism to recoup expenses, especially when the specific patient population is not insured. The Healthcare Coalition, working with its members and jurisdictional authorities, can facilitate solutions in conjunction with third party payers and government funding sources. Potential issues that the Coalition may address include:

- Payment for emergency response services that do not have a billing code. As noted above, some emergency actions may not have assigned billing codes, but may generate significant costs for the Coalition member organizations (e.g., decontamination, preparations for a large security event). The HCRT can facilitate meetings between Coalition member organizations and the appropriate authorities to promote fair reimbursement for these services.
- Payment for services provided in “non-participating” and “non-traditional” healthcare settings. Third party payers may have contracts for services that are provided only at certain preferred (“participating”) healthcare organizations, or facilities with a designated level of service (e.g., pediatric care at a hospital licensed and accredited for pediatric services). During emergency response and recovery, it may be helpful to modify these restrictions when the healthcare system is severely challenged. The HCRT can facilitate

meetings to bring this issue to the attention of the appropriate authorities to seek resolution.

**Addressing uneven patient distribution:** Given the likely influx of victim “walk-ins” during a mass casualty incident and the potential for a direct hazard impact on healthcare delivery, strategies for patient distribution may need to be adjusted in real-time. The HCRT can assist with this by collating data (status reports) from individual healthcare organizations and transmitting the data to EMS or other authorities managing patient distribution. In addition, returning the aggregate data to Coalition member organizations enables them to anticipate response actions and develop contingency plans.

## Facilitating mutual aid and other resource support between Coalition member organizations

As noted earlier, Healthcare Coalitions can serve an important role in facilitating mutual aid and other resource support between healthcare organizations. Key roles for the Coalition are described below.

**Facilitating requests for and offers of assistance:** The HCRT can receive and disseminate requests for assistance; receive *offers* of assistance from all legitimate sources (other Coalition members, jurisdictional authorities, etc.) and convey them to the impacted organization; connect the organizations offering assistance to the requesting organization; assist the requesting organization with determining which resources are best suited to fulfill the need;<sup>3</sup> and transmit all mutual aid requests and related actions to the relevant Jurisdictional Agency(s) (Tier 3). In some instances, the most important assistance may be to screen the deluge of assistance offers (at the request of the impacted organizations) and convey only those offers relevant to the described needs, thus lightening the burden on facility managers at the impacted organizations.

The process for requesting and offering assistance should be based on a written instrument that is adopted by all Coalition members during preparedness planning (see Section 7.3). This enables the HCRT to assist with the resource sharing process *while avoiding any command decision-making role*.

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<sup>3</sup>The term “resource” should not be limited only to personnel, supplies, or facilities directly related to patient care. Healthcare organizations may require assistance with management services, technical advice, infrastructure support (e.g., engineering, security) or supplies for continuity of operations (e.g., water, food).

**Trouble-shooting issues related to mutual aid:** Despite the best intentions, conflicts related to resource support may arise between Coalition members. The Coalition may establish procedures for resolving these conflicts. In some situations, the Coalition’s Senior Policy Group may become involved. However, the Coalition only facilitates the interface between the involved parties; it typically has no authority to be the arbiter or determine a resolution.

## **Facilitating resource support from jurisdictional authorities**

The HCRT may facilitate external resource requests and assistance for its member organizations when mutual aid from within the Coalition is unavailable or insufficient. Much of this is conducted through a process similar to the facilitation of mutual aid between Coalition members. Specific concepts for consideration are described below.

**Coordination of resource requests:** When resources are needed by multiple healthcare organizations simultaneously, the requests can be processed more efficiently if they are received by the Jurisdictional Agency(s) (Tier 3) through one source (i.e., the HCRT). The HCRT can provide a “needs picture” to the Jurisdictional Agency(s). The HCRT can also standardize the format and wording of requests to improve the accuracy of their interpretation by the Jurisdictional Agency (Tier 3) or by State (Tier 4) or Federal officials (Tier 6) who receive requests through the Jurisdictional Agency.

**Distribution of resource assistance:** The Healthcare Coalition can promote a “level playing field” for its members by facilitating how resources are best distributed to meet patient need. For example, the HCRT might hold a teleconference between organizations that are requesting the same scarce resource (e.g., ventilators) from a medical equipment cache. The HCRT can help the requesting organizations reach an agreement on the most appropriate way to distribute the scarce resource. The Senior Policy Group may be asked to assist with any particularly contentious or controversial allocation decisions.

**Emergency patient transfer out of the area:** If patient transfers are required outside of the Coalition’s geographic area, the Healthcare Coalition may support its member organizations through direct interface with the Jurisdictional Agency (Tier 3). The HCRT may serve as a coordinating point in conjunction with the Jurisdictional Agency as it prioritizes and allocates these transfers.

## 4.1.2 The Emergency Response Relationship between Tier 1 and Tier 2

The healthcare organizations that participate in the Healthcare Coalition must have robust incident management capabilities within their respective institutions to effectively interface with the HCRT.

The management element that is responsible for emergency response at a healthcare organization is commonly called an Incident Management Team (IMT). How the healthcare facility's IMT interfaces with the HCRT should be clearly defined using ICS principles and terminology. For example, the position within the healthcare organization's IMT that interfaces with the HCRT would be the organization's Liaison Officer. If that position is not staffed, the responsibility falls to the IMT Leader (e.g., hospital incident commander) unless delegated elsewhere. *It is recommended that Coalition members identify this individual to the HCRT at the start of any incident.* Personnel assigned to this position must be prepared to:

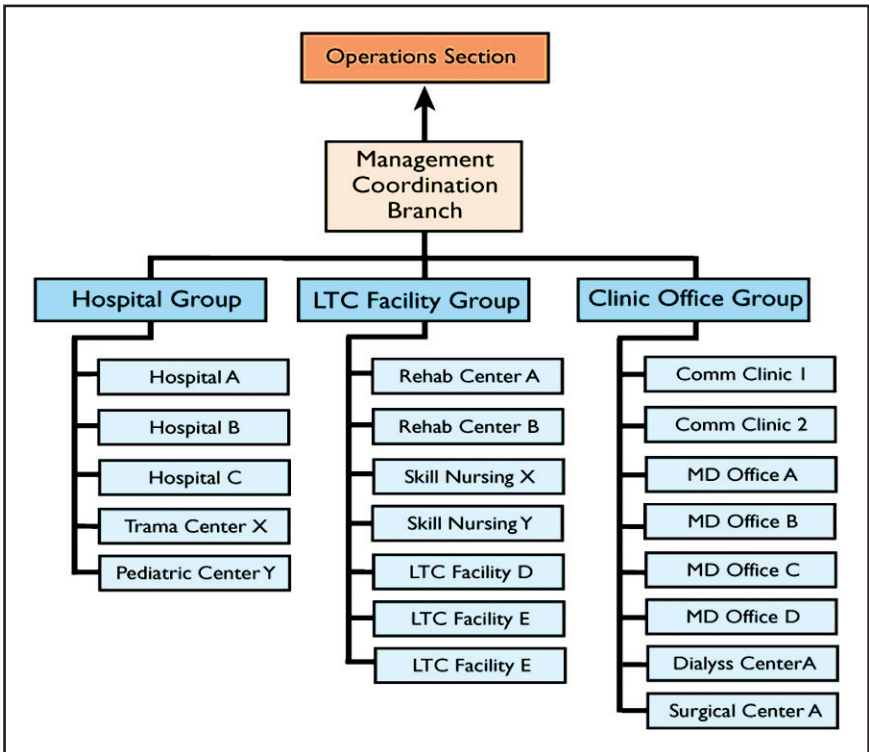
- Participate in Healthcare Coalition meetings or teleconferences and provide any information that is requested by the HCRT
- Disseminate information provided by the HCRT to appropriate decision makers within their own organization
- Participate in their respective organization's action planning in order to convey relevant information received from the HCRT, such as requests for resource support
- Notify the HCRT when being relieved of duties and provide the name and contact information for his/her replacement.

In some Healthcare Coalitions, the Organizational Liaisons to the HCRT could perform additional tasks during incident response. One example might be forming a task force (under the HCRT Operations Section) to achieve consensus on patient evaluation and treatment protocols.

The formal interface between the HCRT and Coalition member organizations generally occurs through the HCRT Operations Section if one is established (otherwise, the interface is directly with the HCRT Leader). This linkage with the HCRT Operations Section may be directly with the Operations Section Chief for a small Coalition or when addressing a straightforward incident. During complex incidents, the reporting relationship could be subdivided to facilitate the reporting requirements. For example, the HCRT could consider utilizing

branches, divisions, or groups to assist with an orderly process. These considerations are entirely up to the Coalition in question and may vary from incident to incident. An example reporting relationship for a robust Coalition responding to a complex incident is shown in Figure 4-1.

**Figure 4-1. Structure for the interface between the Healthcare Coalition and participating healthcare organizations based on functional groupings**



Smaller Coalition members and those with minimal administrative capabilities (e.g., physician office, community health centers) may interface with the HCRT in various fashions (see Chapter 5). Typically, these arrangements are limited to receiving and sharing information.

## 4.2 HEALTHCARE COALITION INTEGRATION WITH JURISDICTIONAL COMMAND (TIER 3)

The Healthcare Coalition is effective only when it is closely coordinated with the relevant Jurisdictional Agency(s) (Tier 3) in its geographical area.<sup>4</sup> *This coordination is imperative during response even if the issues faced by the Coalition can be resolved internally among the various Tier 1 healthcare assets.*

### 4.2.1 Response Strategies Supporting Coalition Integration with Jurisdictional Authorities

Potential response strategies for the Healthcare Coalition in relation to jurisdictional authorities include:

- Promote a common operating picture (situational awareness) between Coalition member organizations and the community response<sup>5</sup>
- Supplement, but not supplant, the ability of the Jurisdictional Agency to execute its incident management responsibilities (i.e., support the interests of the Jurisdiction in relation to relevant healthcare organization response activities)
- Facilitate the delivery of external support by the Jurisdictional Agency to Healthcare Coalition member organizations.

The Healthcare Coalition's activities benefit jurisdictional authorities (Tier 3) by providing an efficient conduit for the jurisdiction's authorities to disseminate guidance, acquire information, and coordinate activities between public health and the private healthcare sector.

### **Promote a common operating picture between healthcare organizations (Tier 1) and the community response (Tier 3)**

The information processing function of the HCRT may be critical in helping the Jurisdictional Agency establish a common operating picture

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<sup>4</sup>As noted in Chapter 1, the term "Jurisdictional Agency" in NIMS refers to the agency having jurisdiction and responsibility for a specific geographical area or a mandated function. Usually, this is a local, State, Tribal, or Federal government agency that has direct authority for emergency response and recovery (NIMS, December 18, 2008).

<sup>5</sup>Similar to strategies for integrating with member organizations, this is predicted to be one of the more common activities for any Healthcare Coalition.

for the community response. Much of the data that a Coalition collects and disseminates is useful to Jurisdictional Agencies. Similar to activities listed in 4.1.1, the Coalition might select the following strategies:

- Collect, compile, and report situation updates and other data from Coalition members to the relevant Jurisdiction Agency(s) to enhance situational awareness. Reported data can include how the hazard has impacted Coalition member organizations.
- Facilitate the tracking of incident patients treated by Coalition organizations to maintain accountability for patients and facilitate family reunification efforts by Jurisdictional Agencies.
- Collect, compile, and report elements of Coalition members' response strategies, which may vary across organizations. This could help shape recommendations given by the jurisdiction.
- Provide an outlet for recommendations from the Jurisdictional Agency(s) to Coalition members (e.g., treatment protocols).

## Supplementing, not supplanting, jurisdictional incident command

Many of the Healthcare Coalition's information processing activities can assist the overall management of the incident by the relevant Jurisdictional Agency(s) if the products are appropriately disseminated to these agencies. Exhibit 4-1 provides one example.

### Exhibit 4-1. Assistance with rapid epidemiological investigation

Public health authorities often have the difficult task of developing an accurate and complete epidemiological picture of an incident. This may require them to rapidly collect data and information from many disparate sources.<sup>6</sup> The ability of the HCRT to acquire, aggregate, and transmit epidemiological data from its member organizations can markedly assist with this task and be mutually beneficial.

It is important that the Healthcare Coalition is not perceived as competing with or intruding on the incident management responsibilities of jurisdictional authorities (Tier 3). The Healthcare Coalition should make every effort to prevent this perception by ensuring the following:

<sup>6</sup> Barbera JA, Macintyre AG. Medical and Health Incident Management System: a comprehensive functional system description for mass casualty medical incident management (December 2002); Available at: <http://www.gwu.edu/~icdrm/>.



- **Timely notification to jurisdictional authorities (Tier 3).** The Notification Center Technician or Duty Officer may be the first to receive a report that a potential incident is occurring. There must be a reporting mechanism in place to rapidly notify jurisdictional authorities (Tier 3).
- **Participation in Incident Action Planning conducted by the relevant Jurisdictional Agency(s).** The response of the HCRT and Coalition member organizations should be consistent with the overarching response objectives, strategy, and tactics of the Jurisdictional Agency. This coordination may require, at the request of the Jurisdictional Agency, the participation of the HCRT or select personnel from Coalition member organizations in local Incident Action Planning activities. HCRT personnel should be available to participate in planning meetings or operations briefings with the Jurisdictional Agency.
- **Availability of medical and other advice to the Jurisdictional Agency.** Even if not participating in the Jurisdictional Agency's Incident Action Planning, the HCRT may be asked to provide expert advice related to medical issues. This could include identifying subject matter experts from Coalition members to provide advice to jurisdictional authorities on issues such as protective measures and other safety issues for responders encountering an unusual infectious agent.
- **Adjusting to the strengths and weaknesses of the Jurisdictional Agency.** Some Healthcare Coalitions may reside in areas with robust public health and medical resources in the public sector. This does not obviate the need for the Healthcare Coalition; it merely reshapes its operational focus. For example, a jurisdiction may already have an efficient process to collect response data from local healthcare organizations. The HCRT might still enhance response coordination between Coalition members by providing a forum for direct information exchange. Alternatively, if few public health and medical resources reside in the local public sector, the Healthcare Coalition, through the HCRT, may develop more robust processes to support the public sector's incident management responsibilities. This should be defined in collaboration with local public agencies during preparedness activities.

## **Facilitating support from Jurisdictional Agencies to Coalition partners and from the Coalition to the jurisdictional response**

When resource support is requested through mutual aid within the Healthcare Coalition, the relevant Jurisdictional Agency(s) managing the overall response should be informed. The Coalition can also facilitate the provision of support from Jurisdictional Agencies to healthcare organizations by facilitating equitable assistance based on actual need. Jurisdictional Agencies may provide the following types of assistance to Coalition members during incident response:

- Medical equipment and supplies
- Medical personnel (including solicited volunteers)
- Facilities (e.g., public facilities to address surge capacity)
- Assistance with infrastructure support, such as utilities
- Requesting, from appropriate authorities, modification of day-to-day healthcare regulations to fit the needs of the specific incident (e.g., temporarily modifying the permissible number of licensed beds in a residential healthcare facility)
- Emergency funding for unusual services (e.g., decontamination) or an unusual level of service delivery (e.g., increasing staffing for a mass demonstration or other type of planned event)
- Police augmentation of healthcare organization security departments and traffic control
- Strategic and tactical guidance to healthcare organizations on such issues as victim evaluation or treatment (e.g., conveying new protocols for assessing patient exposure as additional risk information is obtained from a chemical release site)
- Morgue resources and guidance for mass fatality incidents.

### **4.2.2 The Emergency Response Relationship between Tier 2 and Tier 3**

It is critically important that the HCRT coordinates closely with all relevant Jurisdictional Agency(s) (Tier 3) during incident response to exchange information and facilitate requests for and receipt of external assistance. This requires examining the jurisdiction's organizational structure and Concept of Operations for incident response to determine the most effective interface with the HCRT. It is important to recognize

that there are different potential “lead agencies” for the jurisdiction depending on the type of incident. In some situations, the appropriate relationship between the Coalition and Jurisdictional Agency is an interface with an Emergency Support Function 8 (ESF 8, Public Health and Medical) position in the jurisdiction’s EOC. ESF 8 is often operated under the authority of the local Public Health department.

Alternatively, the HCRT’s primary interface may be directly with a Department Operations Center (DOC).<sup>7</sup> Local and State Public Health departments use DOCs to manage their emergency response. Other examples of DOCs that could be relevant to a Healthcare Coalition include those established by Fire, EMS, and Law Enforcement. In many situations, EOCs and DOCs will not be activated and the Coalition may be required to interface directly with the jurisdiction’s incident command authority (i.e., IMT), which may be located at or near the incident site.

### *Important Point of Clarification*

Some States may be configured by sub-State regions without a local agency to support Tiers 1 and 2. In these cases, the State may request that the Healthcare Coalition interface directly at the Tier 4 level with a regional Department or Agency Operations Center that is managed by a State agency.

As described in Chapter 2, the Coalition may exist as an integrated response organization that combines elements of Tiers 1, 2, and 3. This configuration is considered a Tier 3 response organization under the MSCC Tiers, but it may incorporate many of the Tier 2 activities that are described in this handbook. Typically, these models are more expansive and include elements of command and control or area command. In these models, it is important to preserve the capability of the Coalition to conduct actions on its own (e.g., initiate internal teleconferences with healthcare organizations) or to address specific response issues internally (e.g., consensus decisions on allocation of specific resources across the Healthcare Coalition).

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<sup>7</sup> According to NIMS, “Governmental departments (or agencies, bureaus, etc.) or private organizations may also have operations centers (referred to here as Department Operations Centers, or DOCs) that serve as the interface between the ongoing operations of that organization and the emergency operations it is supporting. The DOC may directly support the incident and receive information relative to its operations.”

The Healthcare Coalition should establish a flexible response interface with the relevant Jurisdictional Agency(s) that is consistent with the reporting line and authority structure of the jurisdiction's EOP. In many locales, a formal position has been established for a healthcare representative in the jurisdiction's EOC (often at the ESF 8 desk), who reports to the Public Health authority leading ESF 8. This function may be filled by a representative of the Healthcare Coalition as the HCRT liaison. In some areas of the U.S., a regional EOC performs this function collectively for several local jurisdictions and the Coalition liaison could be collocated with that entity. It may also be helpful to have a similar liaison position staffed at the Incident Command Post to coordinate directly with the primary IMT for the incident.

Standard operating procedures (SOPs) may be established for the HCRT to enhance coordination with the Jurisdictional Agency (Tier 3). Any activation of the Coalition's EOP, request for assistance, or other significant occurrence must be rapidly communicated to the appropriate Jurisdictional Agency(s). This will allow the local authorities to monitor the situation, address their legal responsibilities, and anticipate resource needs by Coalition member organizations.

*As previously noted, the geographical area of a Healthcare Coalition may extend beyond the boundaries of a single local government. When this occurs, the Healthcare Coalition must effectively interface with each local government in which Coalition member organizations reside, through the relevant Jurisdictional Agency(s).*

## **4.3 HEALTHCARE COALITION REGIONAL ROLES**

The Healthcare Coalition may coordinate with other Coalitions (other Tier 2s) that are established in the region.

### **4.3.1 Response Strategies Between Regional Healthcare Coalitions**

Response strategies for the Healthcare Coalition with regard to other Healthcare Coalitions include the following:

- Coordinate information sharing with other regional Healthcare Coalitions to enhance situational awareness about an incident and promote a common operating picture regarding the regional healthcare response.

- Facilitate assistance through regional mutual aid so that all healthcare organizations can optimally contribute to or benefit from available regional, State, and Federal response assistance.
- Promote consistent and effective healthcare response actions between Healthcare Coalitions across the affected region(s).

Each of these response strategies, and the major actions required to accomplish them, are described below.

## **Coordinate information sharing between Healthcare Coalitions**

A common operating picture of the regional response to a healthcare emergency may be achieved by exchanging incident related information between Healthcare Coalitions. This may include aggregate data that has been collected by the HCRT from its member organizations, as well as information provided by the Jurisdictional Agency(s). Protocols for how this information will be shared between Healthcare Coalitions should be established during preparedness.

## **Facilitate regional resource support**

The resource pool available for meeting requests for assistance may be expanded if there is good coordination between regional Coalitions. This ideally should be established through preparedness initiatives and addressed using instruments and processes described in Chapter 6.

Mutual aid and cooperative assistance between Healthcare Coalitions may include more than just physical resources. For example, experienced HCRT personnel from one Coalition may assist with the emergency response of another Coalition.<sup>8</sup> This type of assistance may help beyond the actual incident by promoting future relationships and advancing preparedness initiatives. In addition, newer Coalitions may benefit greatly from sharing tools and SOPs from a well-established Coalition.

## **Promote effective and consistent regional healthcare response**

Regional coordination of healthcare response objectives, strategy, and major tactics can promote consistency in the healthcare response across

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<sup>8</sup>This is similar to the Emergency Management Mutual Aid (EMMA) concept, in which Emergency Management professionals are shared between jurisdictions through mutual aid mechanisms. A common form for this may be found at: [http://www.scemd.org/Library/mutual\\_aid/EM\\_Mutual\\_Aid\\_Assistance\\_request\\_Form.doc](http://www.scemd.org/Library/mutual_aid/EM_Mutual_Aid_Assistance_request_Form.doc).

the region and enhance public cooperation. This may occur by sharing action plans between Tier 2 Coalitions or exchanging other pertinent information, such as patient evaluation and treatment protocols. These actions can help promote and maintain consistency even as incident information and follow-on directives evolve.

### **4.3.2 Regional Relationships Between Healthcare Coalitions**

The interface between regional Healthcare Coalitions may occur via the liaison function in each HCRT. Qualified individuals from participating healthcare organizations may be assigned to HCRT liaison positions specifically for this purpose. The liaison could work from his/her respective Coalition or home organization, but reports back on all relevant issues, such as requests for assistance. This assures that the coordination is formally “managed” by each Coalition’s HCRT. *The appropriate Jurisdictional Agency in each affected region must be kept closely informed of the coordination activities between the Healthcare Coalitions.*

## NOTES

# NOTES



## Chapter 5:

# The Healthcare Coalition Emergency Management Program: Implementing Sustainable Solutions

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## 5.1 DEVELOPING THE HEALTHCARE COALITION

The preceding chapters described potential roles for the Healthcare Coalition during an emergency to support its member organizations and promote integration of their efforts with the jurisdictional response (Tier 3). Achieving this desired capability requires specific developmental and preparedness efforts. The organizational structure and processes used to prepare the Coalition for an emergency will vary from the structure and processes used by the Coalition during emergency response.

The remaining chapters of this handbook examine strategies and actions that the preparedness element of the Healthcare Coalition can use to prepare the Coalition for effective emergency response.<sup>1</sup>

### 5.1.1 Coalition Development Strategies

The initial steps in Coalition development should focus on defining the Coalition's intended function during emergency response.<sup>2</sup> The authors of this handbook recommend that planners who are developing a Healthcare Coalition or enhancing an existing one first describe the response objectives for the Coalition (see Section 2.1.2). A new Coalition with limited resources may decide to limit its initial response objectives to the following:

- Provide initial and ongoing notifications regarding incident activity to relevant Coalition member organizations.
- Provide a structured<sup>3</sup> ability to teleconference the liaisons from Coalition member organizations to share information.

In designing the Healthcare Coalition, it is important to consider the workload and expense that establishing and maintaining a Coalition places on its member organizations. The following characteristics for the Coalition are intended to minimize this burden while not compromising the Coalition's effectiveness during emergencies.

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<sup>1</sup>While the structure and processes differ, healthcare planners may consider using specific response procedures during preparedness to enhance familiarity with response methods. For example, notifications for Coalition preparedness meetings may be conveyed via the notification messaging procedures used for response, but with a lower level of assigned urgency.

<sup>2</sup>Defining what the Healthcare Coalition will do during emergency response will help guide preparedness efforts. This is the primary reason why the initial chapters of this handbook focus on the Coalition response organization.

<sup>3</sup>"Structured" refers to supporting with an agenda, facilitation, and minute taking.

- **Simplicity:** The preparedness and response configurations of the Coalition should be constructed as simply as possible to meet the Coalition's objectives. This might mean limiting the number and types of healthcare organizations included in a single Healthcare Coalition. Other Coalitions could then be established to cover the non-participating healthcare organizations.
- **Cost-effective:** Development and maintenance costs should be controlled as much as possible. The Healthcare Coalition should be designed to be financially viable without depending heavily on short-term financial streams, such as grants. Cost-effective processes could include distributing preparedness assignments among the member organizations rather than having a large number of full-time, dedicated preparedness positions within the Coalition. Use of existing facilities and personnel from member organizations for both preparedness and response will provide cost savings by limiting bureaucracy and personnel expenses.
- **Sustainable:** Following initial development, some level of effort is required to sustain and improve the Coalition's capabilities over time, including training personnel, conducting exercises, and implementing corrective actions. However, maintenance activities should be designed so they are not overly burdensome to Coalition members. Sustainability can be promoted by factoring in maintenance and replacement costs for equipment and supplies purchased by the Coalition. Doing this prior to any major equipment or supply purchase promotes the optimal long-term investment of resources and funding.

### 5.1.2 Determining the Geographic Boundaries

An important early step in developing the Coalition is determining the geographic boundaries for the Healthcare Coalition. Factors to be considered include local government boundaries, physical impediments to coordination (rivers, mountains, etc.), as well as the number and type of potential member organizations. Other factors to consider include contractual obligations, integrated healthcare system relationships, and patient referral patterns. The critical point is that there is often no one controlling factor for defining the boundaries of the Coalition. The most important considerations should be those that have the greatest effect on the Coalition's ability to effectively respond under emergency conditions.

The following options can be used to help determine the geographic boundaries of a Healthcare Coalition.

- **Bounding the Healthcare Coalition within a single political jurisdiction.** For example, healthcare organizations in a medium-sized city may decide to form a Coalition to support their needs during response.
- **Creating geographic subdivisions within a single jurisdiction due to the number of organizations and inherent complexities of the area.** The number and types of potential Coalition members in a large metropolitan area may preclude the use of a single Healthcare Coalition response organization. Multiple Coalitions in any single jurisdiction should coordinate with each other and may consider joint preparedness activities (committee meetings, document development) for efficiency.
- **Creating functional divisions within a jurisdiction.** In a large, complex jurisdiction, Healthcare Coalitions may form along functional lines: one for hospitals, one for health centers and other outpatient treatment facilities, and so on. Again, these Coalitions must coordinate with each other closely during both preparedness and emergency response.
- **Including healthcare organizations from multiple jurisdictions to form a regional Healthcare Coalition.** Some Coalitions may have boundaries that stretch across two or more local governments. For example, a group of hospitals may be closely situated in neighboring counties or cities. *Healthcare organizations that participate in an inter-jurisdictional Coalition must maintain their relationship with their respective Jurisdictional Agencies (Tier 3) and in some instances, they may form relationships directly with the State (Tier 4) if no Tier 3 entities exist.*
- **Bounding the Coalition in a large, sparsely populated region to provide a network of remotely located healthcare organizations.** In some sparsely populated regions, a Healthcare Coalition may be established to support healthcare organizations across many jurisdictional boundaries. In this scenario, the distinction between MSCC tiers could be much less prominent. For example, many rural jurisdictions have little public health or other medical representation at the local government level and, therefore, little command and control authority in this sector. In these situations, a single collocated arrangement may be preferred in which local jurisdictional authorities (Tier 3) and the Healthcare Coalition (Tier 2) work together as a single healthcare MAC System to address emergency

response issues.<sup>4</sup> The newly formed MAC System may also have a direct relationship with the State (Tier 4) through regional entities.

Issues that healthcare planners may consider in determining the size and scope of the Healthcare Coalition include the following:

- The more jurisdictional boundaries crossed by the Healthcare Coalition, the more complex and difficult it can be to maintain.
- The complexity of managing the Coalition typically increases with the number and diversity of participating organizations.
- A politically-defined jurisdiction (city, county, etc.) is responsible for the health and well being of its citizens. Aligning the Coalition within that area of responsibility may be beneficial in terms of receiving funding and other support. In addition, municipal, public safety, and other emergency services are often situated along these same political divisions.
- The Coalition may be defined by the pre-selected sponsoring organization. These administrative bodies may already have a select set of participants. For example, a hospital association that exists within or across jurisdictional boundaries may serve as the administrative body for the Coalition (see Section 5.3.1).
- Coalition planners should be mindful of geographic boundaries that have been established for preparedness purposes rather than specifically for emergency response. For example, many States have created sub-divisions to distribute preparedness funding (e.g., Hospital Preparedness Program, Urban Area Security Initiative, Metropolitan Medical Response System). While these sub-divisions can help bring healthcare planners into contact with other stakeholders, they may conflict with how healthcare organizations actually interact during emergency response (e.g., patient referral patterns). Their value in shaping the structure of the Coalition must be evaluated on an individual basis.

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<sup>4</sup>It is important to distinguish this Tier 2 Coalition arrangement from a jurisdictional Tier 3 organization that carries local government authority to operate as command and control, or as area command. The Tier 3 local authority or Tier 4 regional organization (i.e., with State command authority) may set incident objectives and specify resource priorities. This is common in many areas of the U.S. and appears to work well, and may be the primary interface for the Tier 2 Healthcare Coalition.

### 5.1.3 Determining the Participating Organizations

The following principles can be used to guide decisions on which organizations should be included as official members with decision-making (i.e., voting) authority of the Healthcare Coalition:

- Participation may involve a variety of organizations, but each should have a primary role in medical care delivery (or some element thereof) during incident response.
- Participants must be able and willing to commit the necessary preparedness resources and establish the response requirements to fully participate during incident response.
- Participant organizations may be day-to-day business competitors, but must agree that fair representation should be assured for all Coalition member organizations.
- Participation in the Healthcare Coalition must be voluntary.

Using these criteria, the following types of healthcare organizations could potentially participate in the Healthcare Coalition:

- Hospitals, integrated healthcare systems, managed care groups that deliver healthcare services, community health centers, outpatient clinics, specialty healthcare services such as dialysis and surgery centers, and other point of service healthcare organizations.
- Specialty hospitals that provide services in a geographic area (e.g., a “Woman’s Hospital” that focuses on obstetrics and gynecology can provide support services during an emergency, such as offering to accept transfer of stable hospitalized female patients from impacted healthcare organizations).
- Federal medical facilities that operate in a geographic area, including Department of Defense and Veterans Administration (VA) medical centers, as well as Federally-funded community health centers, clinics, or other facilities (Exhibit 5-2).

## Exhibit 5-2. Participation of Federal healthcare assets in the Healthcare Coalition

Although Federal healthcare assets have demonstrated a willingness to participate in Healthcare Coalitions based on their geographic area, they have unique restrictions compared to private healthcare organizations. Potential issues include the following:

- Participation cannot compromise their Federal mission(s). For example, VA Medical Centers have a primary responsibility for providing healthcare to veterans, plus they have secondary Federal missions during disasters (e.g., to the National Disaster Medical System (NDMS) and to the Department of Defense).
- Participation is at the discretion of the Commanding Officer or executive leader of the organization.
- Participation can occur during both Federally-declared and non-declared disasters, but it is subject to specific legislation and/or agency specific rules or standards. For example, VA Medical Center Directors are authorized under Title 38, U.S.C., Section 1711(b) to provide emergency care in mass casualty situations; however, patients must be charged for these services at rates established by the Secretary of Veterans Affairs.\*

The mutual benefit of participation by Federal facilities has been demonstrated in many incidents. After Hurricane Katrina's landfall in 2005, the Biloxi, MSVA Hospital received veterans as well as private citizens needing healthcare. During a power failure in the primary and backup electrical systems at Walter Reed Army Medical Center in 2001, intensive care unit and medical-surgical beds were rapidly committed by other hospitals in Washington D.C. when Walter Reed was considering whether to evacuate critical care patients. Ultimately, backup power was restored and the transfer beds were never needed.

\* Barbera JA, Macintyre AG, Shaw G, et al, Emergency Management Principles and Practices for Healthcare Systems, Glossary (2006); Available at: [www1.va.gov/emshg/page.cfm?pg=122](http://www1.va.gov/emshg/page.cfm?pg=122)

- Long-term care facilities, including skilled nursing and assisted living facilities, rehabilitation centers, chronic and hospice care, and others, should be considered for inclusion in the Healthcare Coalition. These organizations can serve as important resources to assist the more traditional healthcare organizations, and promoting their resiliency to avoid the need for evacuation is in the best interest of hospitals. The information processed by the Healthcare Coalition and other support during emergencies (such as facilitating mutual aid and other resource assistance) can be valuable for these organizations as well.

- Healthcare assets that provide outpatient services, including community health clinics, private practitioner offices, and home healthcare organizations, could all be contributing members of a Coalition. While these entities may not have the infrastructure or personnel available to develop complex procedures for incident response, they should be considered for inclusion for the following reasons:
  - During an emergency, patients will seek care in the most familiar settings.
  - Hospitals may become severely challenged or crowded, leading patients to seek care in other settings.
  - Some patients may have treatment needs that can be adequately managed by outpatient-oriented assets, thus relieving the burden on hospitals.
  - Hazards that impact these organizations may lead to patients presenting to similarly impacted hospitals.

The approach to incorporating these resources into the Coalition's preparedness and response can be relatively simple. They may elect to integrate with the Healthcare Coalition in one of two ways:

- Associate within a larger organizational structure that represents them in the Coalition. Mechanisms for this coordination can be established through the Coalition. For example, individual practitioners or a small group practice could organize under the umbrella of a(n):
  - Hospital
  - Integrated healthcare system
  - Large outpatient facility where they have professional privileges
  - Professional society or association (e.g., local Medical Society), if practitioners within the society provide the representation.

The organizing body for these assets must be able to conduct Coalition preparedness activities, such as attending meetings and keeping member organizations informed. It must also be able to perform emergency response services, such as collecting and disseminating information to the organizations that it represents.

- Participate only in the Coalition's situational awareness activities. In lieu of the arrangement described in the preceding bullet, individual providers or group practices may benefit primarily by participating in the information exchange function of the HCRT.



### Exhibit 5-3. Participation of smaller healthcare assets in the Healthcare Coalition

The emergency response planning that is conducted by an individual practitioner's office may be limited. Procedures that most effectively allow a private practitioner to integrate into the jurisdictional response focus on information issues, such as:

#### *Obtaining information:*

- Obtaining incident-specific guidance on personal protection and other safety measures for practitioners, their staff, and other patients (e.g., appropriate Personal Protective Equipment for an infectious agent).
- Obtaining information on the specific medical evaluation of incident cases, such as the availability of confirmatory lab tests and the specific limitations of these tests.
- Obtaining pertinent information on population risk (e.g., for a biological exposure, understanding the community-wide approach to risk stratification for potentially exposed patients).
- Obtaining reliable incident information on medical needs such as unusual patient treatment requirements.

#### *Reporting information:*

- Knowing where to report and what information to transmit on patients who have been evaluated or treated at the practitioner's location (to help the jurisdiction authorities define the size and scope of the affected population).
- Knowing whether public health emergency powers have been invoked (e.g., allowing release of private patient information).

In some jurisdictions, these issues may already be addressed by an effective public health response system (e.g., advisory for the providers in the jurisdiction). This does not negate the utility of a Coalition, which can facilitate delivery of messages or collect responses for the public health system.

- Other potential participants in the Healthcare Coalition include specific public sector assets that provide direct medical care (e.g., medical care units in non-medical agencies) and home health organizations. As an example, the Washington, D.C. Healthcare Coalition includes the Office of the Attending Physician at the U.S. Capitol. Although this office has few resources that can be shared with other Coalition members, it actively participates in information exchange. This is important since this office provides medical services and recommendations to the Capitol Hill workforce in the D.C. area.

In addition, other organizations that do not typically provide “point of service” medical care may be considered for inclusion in a Healthcare Coalition. For example, the King County Healthcare Coalition in the State of Washington includes Airlift Northwest (an air medical transport service), Puget Sound Blood Center, American Red Cross, Washington Poison Center, and many other entities.<sup>5</sup> *Other organizations, such as local public health departments, have different primary responsibilities and may report directly to State (Tier 4) authorities. They also have statutory “command and control” authorities that would be restricted in a Tier 2 Healthcare Coalition. Therefore, these entities may best relate to the Healthcare Coalition through interface at the jurisdictional level (Tier 3), but still provide advice and support to Coalition preparedness activities.*

It may be helpful to establish requirements for participation in the Healthcare Coalition at the outset of Coalition development. Defining requirements that are too prescriptive, however, can inadvertently leave some vital partners out. For example, not all participants may be able or willing to enter into a Mutual Aid commitment to share resources, yet they can still play an important role by sharing information. The lack of potentially available resources for sharing should not preclude participation in the Healthcare Coalition.

The following are two reasonable requirements for participation in the Coalition:

- Participants must be able to commit personnel time to Coalition preparedness meetings. For many healthcare assets, this could mean simply having a representative present for the Coalition’s preparedness meetings. Smaller assets may be represented by an umbrella organization. They maintain awareness by reviewing and commenting on the proceedings of the Coalition’s preparedness efforts.
- Participants must be willing to share information (strategic and tactical) related to their activities during emergency response. It is up to the HCRT to establish the format and methods for sharing this information. The requirements may be as simple as reporting bed availability or more complex, such as reporting patient evaluation strategies. This will depend on the complexity of the Coalition and the incident.

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<sup>5</sup>King County Healthcare Coalition, Members, Partners, and Staff: Accessed February 9, 2009 at: <http://www.kingcounty.gov/healthservices/health/preparedness/hccoalition/staff.aspx>.

In some situations, organizations deemed “highly valuable” to the Healthcare Coalition may decline participation. Though ultimately their prerogative, it is important to clearly explain the benefits of Coalition participation and address their specific concerns. The following concepts should be conveyed to potential participants to demonstrate the value of participating in the Healthcare Coalition.

- Participation does not deter from or change the participant’s inherent and autonomous decision-making authority.
- Participation may enhance the organization’s emergency preparedness efforts through a collaborative Hazard Vulnerability Analysis (HVA) and by sharing strategies for mitigation and preparedness.
- Participation may improve the organization’s performance during emergencies because information shared between Coalition organizations promotes situational awareness for responding healthcare organizations.
- Participation may facilitate access to resources through mutual aid arrangements that otherwise could take more time to access if pursued through other channels.
- Participation may assist in meeting standards and regulations (e.g., The Joint Commission accreditation standards and others) related to community preparedness and integration into emergency response.

## **5.2 ESTABLISHING THE HEALTHCARE COALITION EMERGENCY MANAGEMENT PROGRAM (EMP)**

When establishing processes to sustain and enhance the Coalition’s response capability, it is important to consider the need to address recurring issues, such as training staff and evaluating performance. The Healthcare Coalition’s Emergency Management Program (EMP) provides the structure and guidance for preparedness activities.

### **5.2.1 Defining the Healthcare Coalition EMP**

One of the most important concepts in Comprehensive Emergency Management is organizing the EMP by the four phases of emergency

management: mitigation, preparedness, response, and recovery. These phases are summarized below.<sup>6</sup>

- **Mitigation:** Activities that are performed to reduce or eliminate the probability of a hazard occurrence or to eliminate or reduce the impact from a hazard if it should occur. Mitigation activities are generally performed prior to an imminent or actual hazard impact.
- **Preparedness:** Actions that are designed to build organizational resiliency and/or foster capacity and capabilities for response to and recovery from disasters and emergencies.
- **Response:** Activities performed to address the immediate and short-term effects of the emergency. It includes activities immediately before (for an imminent threat), during, and after a hazard impact.
- **Recovery:** Activities and programs implemented during and after response to return the organization to its usual state or to a “new normal.” For response organizations, this includes return-to-readiness status and resumption of baseline operations.

The Hazard Vulnerability Assessment (HVA) provides the basis for informed planning in all phases of emergency management. The HVA process is described in relation to the Healthcare Coalition at the end of this chapter.

## 5.2.2 Establishing the Healthcare Coalition Emergency Management Committee (EMC)

A coordinating or organizing body should be created to conduct the Healthcare Coalition’s preparedness and mitigation activities (Chapter 6). Maintaining consistency with emergency management terminology, this can be addressed through an Emergency Management Committee (EMC). The EMC assures a fair and balanced process for Coalition preparedness and mitigation activities among all member organizations. For this to occur, the following requirements must be in place:

- There should be balanced representation of Coalition members on the EMC. Similar types of healthcare organizations should have the same level of representation on the EMC if desired by the organizations. While ceding control or influence to one or

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<sup>6</sup>Barbera JA, Macintyre AG, Shaw G, et al, Emergency Management Principles and Practices for Healthcare Systems (2006); Available at: [www1.va.gov/emshg/page.cfm?pg=122](http://www1.va.gov/emshg/page.cfm?pg=122).

several organizations may seem like the fastest way to establish the Coalition, this approach can lead to future problems.

- Decision-making by the Coalition must be transparent. Processes used for making decisions should be pre-established and conveyed to Coalition organizations. It may necessitate that minutes are taken during meetings and that preparedness meetings are open to all Coalition participants. Moreover, the Coalition may draft and adopt a Charter and Bylaws for the EMC.
- There may be situations in which individual organizations cannot agree to a majority decision that has been made by the EMC. This should be expected and opt-out policies for the individual organizations should be established.
- Actual or perceived conflicts of interest should be recognized and addressed. An example might be the award of a large grant or appropriation earmarked “for the Coalition” but used to primarily benefit only a few partners. This could create distrust among the Coalition members and compromise the effectiveness of the Coalition.

The desired construct of the EMC includes representation from each organization in the Coalition. In very large or complex Coalitions, this may not always be feasible and the actual composition may reflect a fair and balanced representation of the different types of organizations. To ensure fairness, a process to rotate EMC participation should be designed into the Coalition’s EMP.

The participants on the EMC should have the delegated authority to represent their respective organizations. This does not mean that they can make all decisions on behalf of the organization, especially decisions with major financial or legal implications. But it does mean that they can speak for their institution within defined parameters and are responsible for communicating information related to Coalition preparedness activities back to the leadership of their respective organization. It is up to the organization to establish the level of decision-making authority that its representative has on the EMC.

Representatives on the EMC should also have some level of expertise in healthcare system emergency management. The ideal representative is knowledgeable of emergency management principles and practices, including NIMS and ICS, and understands the organization that they are representing.

How the EMC operates is another area to address during the initial development of the Coalition. The following concepts may be helpful in establishing the EMC:

- **Strategic planning:** One way to focus the EMC's efforts is to define strategic guidance, including goals and objectives, for the EMC itself. Objectives should be constructed with a specific, measurable end-point and a timeframe.
- **Leadership:** A Committee Chair is usually elected by Coalition participants to lead the EMC's efforts. To promote a sense of fairness, the Committee Chair may be determined on a rotating schedule. This can also help enhance the long-term sustainability of the EMC.
- **Conduct of the EMC:** Pre-established rules for the EMC should address issues such as voting on initiatives and how meeting minutes will be preserved. Rules that promote response-oriented procedures can be beneficial. For example, conduct of meetings using protocols established for response teleconferences can promote familiarity with these processes and keep the meetings efficient.
- **Structure:** The EMC forms the core structure for EMP activities outside of emergency response. Subcommittees or work groups may be established to address specific issues, such as on-going exercises for the Coalition or ad hoc subcommittees stood up to coordinate the purchasing of a specific item.
- **Document control:** An agreed upon process for managing the EMC's documents (e.g., Coalition's EOP, training plan) is essential. These documents should be stored so they are easily accessible.
- **Corrective action process:** A corrective action process for the Healthcare Coalition response organization is described in Chapter 6. Similarly, the EMC itself should undergo periodic evaluation to ensure it is meeting its goals and objectives.

### 5.2.3 Establishing Executive Oversight to the EMC

It may be beneficial to establish some level of executive oversight to the EMC. An executive committee can be established that is composed of executive administrators or their designees from Coalition organizations. This committee can review the development of Coalition elements as they evolve, provide strategic input into the EMC, and approve major financial commitments. While meetings to address these tasks are expected to be less frequent than EMC meetings (e.g., bi-annually), they require significant preparation to efficiently inform the representatives.

## 5.3 PROGRAMMATIC ISSUES FOR THE HEALTHCARE COALITION

Additional programmatic issues relevant to the Coalition EMP and EMC should be addressed before examining preparedness and mitigation activities.

### 5.3.1 Determining the Preparedness Administrative Body

An administrative body for the Coalition should be established concurrently with the selection of member organizations. It is important to distinguish the role of this body from the decision-making role of the EMC. The administrative body supports the Healthcare Coalition during mitigation and preparedness by fulfilling specific administrative needs that are distinct from those required during emergency response and recovery. For example, the administrative body may:

- Provide meeting space and administrative support for regularly scheduled meetings of the EMC
- Serve as a repository and financial controller for Coalition funds
- Manage document control and archiving for the EMC.

Options for the Coalition's administrative body will vary by region, but may include the following:

- **Hospital associations:** Because they usually include all of the hospitals in a defined area, they already provide some measure of a "level playing field." At the same time, they are limited by the fact that they lack representation of long-term care facilities, outpatient centers, private practitioners, and other potential Coalition participants.
- **Local Emergency Planning Committees (LEPCs):**<sup>7</sup> While the original intent of LEPCs was to increase community awareness and response capabilities for hazardous materials, LEPCs have served in some jurisdictions as a valuable multidisciplinary platform to coordinate preparedness of medical resources. The Healthcare Coalition could be organized under the auspices of an existing LEPC.

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<sup>7</sup>The Emergency Planning and Community Right-to-Know Act, also known as Title III of the Superfund Amendments and Reauthorization Act (SARA), established the requirements of LEPCs.

- **Administrative bodies constructed de novo for this role:** Another option is to establish a non-profit organization to serve as the administrative body for the Coalition. While this may require more effort and cost to establish and maintain, it has the benefit of allowing specific by-laws for the organization to focus primarily on this preparedness role rather than attempting to piggy back onto existing missions (Exhibit 5-4).
- **Individual partners of the Healthcare Coalition:** A member organization within the Coalition may volunteer to serve as the administrative body. In such cases, care should be taken to prevent potential conflicts of interest.

#### **Exhibit 5-4. Example of a non-profit organization serving as the preparedness body for a Healthcare Coalition\***

The Northern Virginia Hospital Alliance (NVHA) is a non-profit organization that was formed in October 2002 for the purpose of improving community-wide preparedness for and response to mass casualty incidents. The NVHA serves approximately 12 acute-care hospitals (including one military hospital) and several free-standing emergency care centers in the region. The NVHA collaborates with hospitals and other emergency response entities from Washington, D.C., Maryland, and Virginia to address mass casualty medical response.

\* Northern Virginia Hospital Alliance, Information about the NVHA, Accessed November 29, 2007 at: <http://www.novaha.org>.

### **5.3.2 Establishing Political and Financial Support**

Certain types of “political” support may be necessary to ensure the success of the Healthcare Coalition. This may be particularly important during the initial development stage and may be addressed at both the healthcare organization (Tier 1) and jurisdiction (Tier 3) levels.

The executive leadership of Coalition member organizations will need to agree to the proposed principles (the membership, structure, and methodologies) for the Coalition during preparedness *and* response. This may require buy-in from their parent corporations and boards. Executive level briefings on the purpose, vision, and potential value of the Healthcare Coalition during emergency response can help secure buy-in and commitment from senior leadership at member organizations.



At the jurisdictional level (Tier 3), endorsement from public agency executives and elected officials should be sought. This can provide the “push” that is needed for the Healthcare Coalition initiative to succeed. Support from political leaders can be demonstrated in multiple ways, such as providing funding for Coalition development and maintenance or sharing information for preparedness. It may be helpful to conduct presentations for these officials on the mission of the Coalition and how it can benefit the community response. Some Coalitions may elect to invite public health and other public sector officials to participate in advisory positions.

As noted earlier, every effort should be taken to keep the Coalition as lean as possible and many Coalitions will not require significant amounts of direct financial support. The main costs for developing and maintaining the Coalition will be the personnel time contributed by member organizations.<sup>8</sup> Equipment costs may vary substantially based on the technological requirements of the particular Coalition. Radio communications, computer software, and paging systems could add development and maintenance costs. It is important to establish financial management processes in order to track costs and ensure transparency in how funding for the Coalition is spent. Some representative sources for funding of the Coalition are presented in Exhibit 5-5.

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<sup>8</sup>The contribution of personnel time is a significant issue that Coalition organizations should address at the outset. Those who contribute significantly to the development and maintenance of the Coalition should have their efforts recognized and acknowledged by their employer as an important cost of doing business.

### Exhibit 5-5. Potential sources of funding for development and maintenance of the Healthcare Coalition

- Federal programs: Federal programs and grants for emergency preparedness, emergency management, and homeland security may provide one source of funding for Coalitions. Grants made to jurisdictions to increase hospital preparedness can be distributed fairly to Coalition members, thus enhancing the “team” concept of the Coalition.<sup>9</sup>
- Public sector support: Jurisdictional (Tier 3) or State (Tier 4) authorities may be able to provide some financial support for Coalition development and maintenance.
- Private sector internal support: In some situations, Coalition member organizations may provide direct or indirect funding support for elements of the Healthcare Coalition.
- Private sector external support: Donations from corporations may be available to assist with Coalition financing as a public service initiative.

### 5.3.3 Establishing Key External Relationships

Healthcare Coalitions should establish collaborative relationships with any external entities in their geographic area that are involved in emergency response. Coordination with these entities can enhance preparedness, improve service integration, and avoid perceptions that the Coalition is acting independent of the community response.<sup>10</sup> The Coalition should consider relationships with the following types of external entities:

- **Public health:** Public health departments vary considerably from State to State and even between intra-State regions in their construct, capabilities, and procedures. Depending on where the Coalition is located and the public health capabilities in the area, it may be beneficial to have public health personnel participate as advisors in the Healthcare Coalition’s preparedness meetings.
- **EMS:** Emergency Medical Services are an important partner, like public health, in establishing viable processes and procedures for the Coalition’s response activities. Individuals representing EMS may provide key insights for the Coalition’s preparedness efforts.

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<sup>9</sup> An example is The Hospital Preparedness Program, which is administered by the Office of the Assistant Secretary for Preparedness and Response within HHS. Additional information on this program is available at: <http://www.hhs.gov/aspr/oepo/hpp/>.

<sup>10</sup> The participation of these entities in Coalition preparedness may vary from full participation (e.g., assistance in developing work products and attendance at all meetings) to more limited participation (e.g., review of select work products).

- **Fire Service:** Fire and rescue services should be considered as well for advisory participation in the Coalition’s preparedness efforts. These services can play multiple roles during response, including providing direct support to healthcare organizations.
- **Law Enforcement:** Coordination with Law Enforcement can be critical for many reasons. For example, collaborating with Law Enforcement about which healthcare personnel should be allowed to cross security perimeters in an area of police action may be essential to maintain an adequate healthcare workforce during civil unrest, mass gatherings, and other incidents.
- **Federal partners:** The Healthcare Coalition should include appropriate regionally-based Federal personnel (e.g., HHS Regional Emergency Coordinator) in the Coalition’s preparedness and response efforts, even if just on an “information-only” basis.<sup>11</sup>
- **Nearby Healthcare Coalitions:** Inviting a representative from a nearby Coalition to participate as an observer or advisory in preparedness efforts may strengthen regional coordination. This builds trust and familiarity that can be helpful in an emergency.
- **Other medical support entities:** Included in this group may be large vendors, laboratories, or other businesses that support multiple healthcare assets in the Coalition. Establishing formal relationships with these entities may promote a more robust commitment to support Coalition member organizations during emergency response.

### 5.3.4 Systems-Based Methods

Section 1.2 briefly described a systems-based approach to program development. This approach has tremendous utility for the Healthcare Coalition EMP. Establishing a set of sequential management steps to use during any major undertakings (e.g., EOP development) helps keep the projects focused and “on track” while evolving in a logical manner.

An example series of management steps as applied to development of the Coalition EMP is presented below for consideration:<sup>12,13</sup>

<sup>11</sup> Contact information for HHS Regional Emergency Coordinators is available at: <http://www.hhs.gov/aspr/opeo/regions/index.html>.

<sup>12</sup> Barbera JA, Macintyre AG, Shaw G, et al, *Emergency Management Principles and Practices for Healthcare Systems* (2006); Available at: <http://www1.va.gov/emshg/page.cfm?pg=122>.

<sup>13</sup> It should be noted that these same steps can be used to develop the Coalition EOP or other major EMP products.

**Step 1: Establish goals and objectives.** The goal of the Healthcare Coalition EMP process should be explicitly described. For example, a candidate goal statement might be to “establish and maintain a robust Healthcare Coalition response organization that is supported by a comprehensive and inclusive method to coordinate Healthcare Coalition partners across the phases of mitigation, preparedness, response, and recovery.” Objectives are then developed representing the interim steps necessary to achieve the goal (Exhibit 5-6).

#### **Exhibit 5-6. Sample programmatic objectives for the Healthcare Coalition EMP**

- Establish a Healthcare Coalition response organization to effectively manage the coordination between healthcare organizations and the Jurisdictional Agency(s) during incident response and recovery.
- Create and maintain a preparedness organization (EMC) to manage Healthcare Coalition participants’ mitigation and preparedness activities.
- Conduct a joint Hazard Vulnerability Analysis and share the information as a basis for coordinated, consistent preparedness and response efforts.
- Establish guidance for participating healthcare organizations to enhance their individual EOPs so they can fully participate in Healthcare Coalition actions during incident response.
- Conduct joint training, exercises, and other preparedness activities with local response agencies to integrate the Healthcare Coalition into the local emergency response community.

**Step 2: List key assumptions** about the environment, organizations, and other factors that might influence development of the Coalition. Sample assumptions may include the following:

- Incidents that could impact Healthcare Coalition member organizations may occur suddenly and without warning.
- Each Coalition member retains decision-making authorities inherent to their organization.
- Jurisdictional authorities (Tier 3) have responsibilities in supporting the Healthcare Coalition, and the Coalition has responsibility for supporting these authorities, as indicated by incident circumstances.

- Funding will be necessary from government or non-government sources, as well as the member organizations themselves, to establish and maintain the Coalition.
- Long-term funding may be limited and sustainability is an important consideration in designing the Healthcare Coalition. The Coalition should be as lean as possible while maintaining the ability to fulfill its mission requirements.

### **Step 3: Develop a System Description and Concept of Operations.**

The System Description outlines how an effort will be organized. For the Coalition EMP, it is worth first considering the intended function of the Coalition during emergency response (i.e., defining the Coalition's response objectives). Then, the programmatic issues can be delineated, such as the construct of the EMC, how representatives are selected, and who the EMC reports to beyond the administrators at the individual organizations. The Concept of Operations describes the processes and procedures that the Coalition will use to achieve its goals. For the Healthcare Coalition EMP, this may entail outlining the specific methods for meetings, response coordination, and interaction with senior executives at member organizations (Tier 1) and jurisdictional authorities (Tier 3).

**Step 4: Identify resource needs (personnel, facilities, equipment, supplies, etc.).** Needs are identified to staff, equip, and operate the EMP, including the organizing body or support organization(s).

**Step 5: Implement the system.** Upon completion of the preceding steps, the Coalition EMP must be implemented and maintained.

**Step 6: Develop and conduct education and training** designed to familiarize personnel with the system. For the Healthcare Coalition EMP, implementation may require briefings to executive leaders of member organizations and public agency officials supporting the effort.

**Step 7: Exercise, evaluate, and revise the system.** A process should be established to continually exercise, evaluate, and improve the Coalition EMP.

## 5.4 HAZARD VULNERABILITY ANALYSIS

A Hazard Vulnerability Analysis (HVA) provides the Coalition with a common understanding about the hazard risks that it faces and helps to prioritize issues for the EMP to address.<sup>14</sup> In other words, a properly developed HVA provides the “needs assessment” for the EMP and guides its direction. The basic components of an HVA for healthcare organizations are well described elsewhere, but general steps related to Healthcare Coalitions are presented below.<sup>15</sup>

- The first step in a comprehensive HVA is to identify and prioritize the likely hazards that the Coalition could face. These will often overlap with the hazards confronted by the Coalition member organizations and are typically identified using historical and current data from multiple sources.
- Based on the list of hazards generated, the general vulnerabilities for Coalition member organizations and the specific vulnerabilities for the Coalition itself are identified.
- The product of the likely hazards and associated vulnerabilities constitutes “risks” to the Coalition and its member organizations. These are then sorted and prioritized. Significant impact on personnel and mission critical elements contributes to the ranking of the risk for each hazard.
- Steps are taken to prevent or reduce the risks (mitigation) or to address the consequences post-impact (preparedness). For example, a backup notification system can be developed (mitigation) or procedures established that will guide participants if the notification system fails (preparedness). This demonstrates the important link between the HVA process and other EMP activities.
- The HVA process is iterative and should be reviewed on an annual basis or after major incidents.

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<sup>14</sup> The definition of a Hazard Vulnerability Analysis is provided in Appendix B.

<sup>15</sup> Barbera JA, Macintyre AG, Shaw G, et al, Emergency Management Principles and Practices for Healthcare Systems. Department of Veterans Affairs, Veterans Health Administration (2004); Available at: <http://www1.va.gov/emshg/page.cfm?pg=122>.

Because the HVA is typically discussed within the context of one organization, the HVA for the Coalition is somewhat unique. Provided below are some considerations for the Coalition's HVA:

- While there will likely be significant overlap between the HVA for the Coalition and the HVA for an individual healthcare organization, these must be separate and distinct processes. A specific *vulnerability* may not exist across all Coalition member organizations; however, Coalition members will generally face many of the same hazards. The Healthcare Coalition EMC can conduct an HVA for the Coalition and each organization could use the findings to inform their respective HVA. A benefit of this approach is that it helps to satisfy certain standards, such as The Joint Commission criteria for coordinating HVA efforts with external partners.<sup>16</sup>
- The Coalition may start by examining the HVAs at individual member organizations and its respective local jurisdiction (Tier 3) before conducting its own.
- The external organizations listed in Section 5.3.3 should be given an opportunity to participate in and/or review the Coalition's HVA efforts. They can provide important information related to hazards and vulnerabilities, as well as guidance on risk interventions. In addition, public sector organizations can factor these HVA results into their respective planning efforts.
- The outputs of the Coalition HVA (hazards, vulnerabilities, risk interventions) should be used by the EMC to structure and prioritize its efforts. This can range from modifying the EOP to improving resource management (e.g., collective purchases).

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<sup>16</sup> The Joint Commission, Emergency Management Standards, Hospital Accreditation Program (2008). Accessed October 13, 2008 at: [http://www.jointcommission.org/NR/rdonlyres/DCA586BD-1915-49AD-AC6E-C88F6AEA706D/0/HAP\\_EM.pdf](http://www.jointcommission.org/NR/rdonlyres/DCA586BD-1915-49AD-AC6E-C88F6AEA706D/0/HAP_EM.pdf).

# NOTES



# Chapter 6:

## The Healthcare Coalition Emergency Management Program: Mitigation and Preparedness Activities

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## 6.1 IMPLEMENTATION OF THE HEALTHCARE COALITION RESPONSE ORGANIZATION

This chapter focuses on mitigation and preparedness planning activities performed by the Healthcare Coalition preparedness organization. These activities should supplement the mitigation and preparedness planning that is required of each Coalition member.

One of the most important preparedness activities for a Healthcare Coalition will be establishing and implementing the Coalition's emergency response plans. Whether a Coalition is starting this process for the first time or seeking to enhance existing response plans, this chapter offers several concepts for consideration

### 6.1.1 Developing the Healthcare Coalition's EOP

A central focus of any preparedness organization is the development of an Emergency Operations Plan (EOP). The EOP is an "all hazards" guidance document that specifies actions to be taken in response to an emergency or disaster.<sup>1</sup> Exhibit 6-1 presents the primary uses for the Healthcare Coalition EOP.

#### Exhibit 6-1. Primary uses of the Healthcare Coalition EOP

The EOP describes how the Healthcare Coalition response organization is structured and how it will respond during an emergency. The EOP is helpful in developing and conducting education, training, and exercises, as well as in evaluating the Healthcare Coalition's performance in exercises or actual emergencies.

The EOP must be usable under emergency conditions to guide response actions, demobilization, recovery, and return to readiness. The components of an EOP designed for use during response are the specific "tools," including call-down lists, operational checklists, mobilization and demobilization procedure checklists, reporting templates, and other standard operating procedures (SOPs).

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<sup>1</sup> Blanchard, BW, Dictionary of Emergency Management and Related Terms, Definitions, Legislation and Acronyms. FEMA Higher Education Project (January, 2008); Available at: <http://training.fema.gov/EMIWeb/edu/docs/Select%20EM-Related%20Terms%20and%20Definitions.doc>.

Regardless of the Healthcare Coalition's size or complexity, the following considerations are important for developing the EOP:

- **Establish the EOP writing team:** Personnel developing the EOP should include representatives from the various members of the Coalition. If the development team is large (i.e., greater than 5-7 individuals), it may be advisable to break down the EOP into its component parts, have sub-groups address these parts, with the work products then reviewed by the larger group.
- **Establish a review process:** Each Coalition member should have the opportunity to review and comment on EOP products as they are developed. In addition, it may be helpful to get feedback from external reviewers – most notably all relevant Jurisdictional Agencies (Tier 3), key vendors (e.g., hospital suppliers), or other stakeholders.
- **Promote buy-in from Coalition members and jurisdictional authorities:** Executive leaders at each member organization, as well as key Jurisdictional Agencies, should be briefed whenever major elements of the EOP are completed. The briefings should highlight the advantages of participating in or supporting the Healthcare Coalition.
- **Incorporate NIMS principles:** NIMS principles should be incorporated into the Coalition's EOP so that personnel are training on and using a response plan that is specific to the Coalition rather than one containing generic ICS. The HVA provides the foundation for developing and refining the Coalition's EOP (through the development of incident specific SOPs, etc.).

At a minimum, the Healthcare Coalition EOP should describe the structure of the Healthcare Coalition Response Team (HCRT), including an organizational chart with response positions, and the processes and procedures (“Concept of Operations”) that the Coalition follows through the progressive stages of response and recovery. It should also describe the specific interactions with Coalition member organizations and jurisdictional authorities (see Chapter 4).

FEMA resources offer widely accepted guidance on the format of an EOP.<sup>2,3</sup> Key elements to consider for the EOP are summarized below.

<sup>2</sup>FEMA, Producing Emergency Plans: A guide for All-Hazard Emergency Operations Planning for State, Territorial, Local and Tribal Governments; Comprehensive Preparedness Guide (CPG) 101, Interim Version 1.0, (August 1, 2008); Available at: [http://www.fema.gov/pdf/about/divisions/npd/cpg\\_101\\_interim.pdf](http://www.fema.gov/pdf/about/divisions/npd/cpg_101_interim.pdf).

<sup>3</sup>FEMA, IS-1 Emergency Manager: An Orientation to the Position, Emergency Management Institute (October, 2007); Available at: <http://training.fema.gov/EMIWeb/IS/is1st.asp>.

- **Goals and objectives:** The EOP should describe the goals and objectives of the Healthcare Coalition response organization (those presented in Chapter 2 may serve as a template that can be adapted to a specific Coalition). These objectives can be relatively simple or robust depending on the type of support that the Coalition will provide in an emergency. In addition to providing strategic guidance, these statements can serve as outcome (goal) and output (objectives) metrics when evaluating the Coalition's performance.
- **Scope:** This includes a brief description of the emergency conditions when the EOP would be used, a list of Coalition partners, and a statement that the Coalition EOP does not supplant the plans, authorities, and responsibilities of the Coalition member organizations.
- **Authorities:** Relevant authorities upon which the Healthcare Coalition is based should be cited. Generally, the authority is derived from the voluntary commitment of member organizations to participate in the Coalition. At the same time, the independent decision-making authority of Coalition members may be recognized. This section may also reference any formal instruments that establish or maintain the Coalition, such as a Memorandum of Understanding (see Chapter 7).
- **Base Plan:** The EOP should contain a basic description of how the Coalition will be organized during emergency response. This is often addressed in a Concept of Operations and a separate System Description is not developed. However, Coalitions with a more complex structure may benefit from writing a detailed System Description.<sup>4</sup> The Concept of Operations focuses on the processes and procedures that the Coalition will follow during response and may be organized by the successive stages of response outlined in Chapter 3.
- **Functional Annexes:** This section contains emergency response and recovery guidance that addresses sections of the Coalition's response in greater detail than the Base Plan. Often, this section is written to address the five "functions" of ICS (i.e., Command, Operations, Planning, Logistics, and Finance/Administration). Functional annexes may not be necessary for a basic Coalition if the appropriate information is contained within the Base Plan. For Coalition EOPs that use functional annexes, the number and types

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<sup>4</sup> In many EOP documents, the Systems Description is included within the Concept of Operations. Whether included within the Concept of Operations or not, the System Description should include an organizational chart with defined response positions.

will vary based on the complexity of the Coalition. As an example, a public information annex might be developed, which outlines how the Coalition will integrate the public message of Coalition members with the Jurisdictional Agency (Tier 3).

- **Hazard or Incident Specific Annexes:** Concise guidance for priority hazards or specific situations should be outlined in these annexes. The hazards addressed should be determined by the Coalition's HVA and the material should not duplicate information covered in the Base Plan or functional annexes. Potential examples might include a widespread power outage or the emergency evacuation of patients from one of the Coalition member's facilities.
- **Tools/attachments:** The most useful portions of an EOP during response are often the tools and attachments that can be included (as appendices) in the above listed sections. Job action sheets or operational checklists, mobilization checklists, call down lists, and pre-formatted forms for Coalition members to submit incident information can promote an effective HCRT response.

### 6.1.2 Establishing Standard Operating Procedures (SOPs)

SOPs are useful to include in the Healthcare Coalition's EOP and may be used in both functional and hazard specific annexes. Potential SOPs for the functional annexes of the EOP may include:

- **Resource support:** Describes specific procedures for assisting member organizations in sharing resources between them during emergencies. Attachments to this SOP might include a Memorandum of Understanding for a Strategic National Stockpile distribution plan.
- **Patient tracking:** Describes specific procedures for tracking patients among different healthcare facilities and the actions that Coalition member organizations should conduct (e.g., reporting patient lists) to facilitate patient tracking.
- **Public information:** Describes processes for coordinating the public message among Coalition member organizations (Tier 1) and the relevant Jurisdictional Agency(s) (Tier 3).
- **Volunteer management:** Describes how a Healthcare Coalition might facilitate the management of solicited and unsolicited volunteers for integration into healthcare organizations (Tier 1) and coordinate this with the Jurisdictional Agency(s) (Tier 3).

Two examples of SOPs that might be included in hazard or incident specific annexes of the Coalition's EOP are provided below. While the format of an SOP may vary, Exhibit 6-2 presents a template that captures the key elements.

- **Patient evacuation from a healthcare facility:** Most Coalitions face the potential of a hazard impact that would require the evacuation of a healthcare facility. Clearly defined procedures for how the Coalition might support this should be included within the context of a hazard or incident specific annex. This material should be presented in a format that is useful during response operations.
- **Mass fatality:** Describes procedures that will be used when the number of fatalities exceeds the normal capacity for managing fatalities at individual healthcare organizations. The SOP may address issues such as how the Coalition could facilitate victim tracking or the acquisition of storage sites for human remains through appropriate jurisdictional channels.

### Exhibit 6-2 Sample format for a Standard Operating Procedure (SOP)\*

Standard Operating Procedure No. \_\_\_\_

Subject: (insert hazard, threat, or event\*\* name)

1. Description of the threat/event (may include related symptoms, potential impact, etc.)
2. Impact on mission critical systems (e.g., any potential adverse impacts within the Coalition or individual organizations).
3. Key personnel with responsibility for managing the threat/event
4. Response/Recovery from the threat/event, including objectives and strategies for the following:
  - a. Hazard control and resource issues
  - b. Hazard monitoring
  - c. Recovery
5. Notification procedures addressing such issues as:
  - a. If a threat/event occurs, who within the Coalition should be notified?
  - b. Which community agencies should be notified?
  - c. What other agencies should be notified (e.g., nearby Healthcare Coalitions, etc.)?
6. Review Date

\*Adapted from the Veterans Health Administration, Emergency Management Guidebook (2005); Available at: <http://www1.va.gov/emshg/page.cfm?pg=114>.

\*\*An "event" is a scheduled activity where the EOP is used to provide incident management. It is distinguished from an "incident," which is when the EOP is activated for an unscheduled activity.

Once the EOP is written, it must be implemented and regularly evaluated for adequacy, with organizational improvement actions conducted as necessary. Most Coalitions should develop a Base Plan first and then address other components of the EOP using a priority scheme that is based upon identified risks. The remaining sections of this chapter address other critical activities that provide a truly effective EOP (i.e., resource management, training).

### 6.1.3 Resource Management during Preparedness

In the context of emergency management, “resources” generally include personnel, facilities, equipment, and supplies. According to NIMS, “efficient and effective deployment of resources requires that resource management concepts and principles be used in all phases of emergency management and incident response.”<sup>5</sup>

#### Personnel

Chapter 2 described specific positions within the HCRT. For these positions to function as intended, the EOP requires the following:

- **Documented position descriptions:** The qualifications, roles, and responsibilities of Healthcare Coalition personnel during response should be clearly established, as well as the instructional activity they should complete to effectively staff specific positions. This is applicable whether the HCRT will be staffed by a relatively small number of positions (1 or 2) or significantly more.
- **Recruitment of qualified personnel:** A roster with primary and backup assignments for each key position should be developed, with rotation at defined intervals for the on-call individual at each position.
- **Education and training to promote operational proficiency in a specified role:** This education and training does not have to be technically advanced or time consuming, but it should be formal training that is tracked by the preparedness organization. Only fully qualified and trained personnel should be on the activation roster. A “just-in-time” training may be helpful and can take the form of a quick briefing to remind individuals of their specific roles in an emergency.

<sup>5</sup> U.S. Department of Homeland Security, National Incident Management System (NIMS) (December 18, 2008); Available at: [http://www.fema.gov/pdf/emergency/nims/NIMS\\_core.pdf](http://www.fema.gov/pdf/emergency/nims/NIMS_core.pdf).

These requirements should also be applied to personnel who are staffing the Organizational Liaison positions for each Coalition member organization.

The Healthcare Coalition preparedness organization may also address how volunteers or other “donated” personnel will be integrated into the Healthcare Coalition during emergency response. Examples of preparedness activities related to personnel management include:

- **Establishing common credentialing, privileging, and badging requirements.** Credentialing should be distinguished from privileging and badging (Exhibit 6-3). The Healthcare Coalition may establish common requirements for its member organizations, but these efforts must be coordinated with similar efforts being conducted by jurisdictional (Tier 3) or State (Tier 4) authorities (e.g., credentialing for MRC or ESAR-VHP).

### **Exhibit 6-3. Differentiating credentialing, privileging, and badging for personnel\***

**Credentialing:** According to NIMS, “the credentialing process entails the objective evaluation and documentation of an individual’s current certification, license, or degree; training and experience; and competence or proficiency to meet nationally accepted standards, provide particular services and/or functions, or perform specific tasks under specific conditions during an incident.”

**Privileging:** The process where appropriately credentialed personnel are granted permission to provide specified services within the healthcare organization.

**Badging:** The process of providing outside personnel with identification that gives them access (usually limited) to the designated facilities of the organization requesting assistance.

\* Credentialing the Nation’s Emergency Responders: Working Group Guidelines – Draft Version 1.6 (November 2005), NIMS Integration Center, Federal Emergency Management Agency, Washington D.C.

- **Developing a volunteer processing and management capability:** The Healthcare Coalition may support Volunteer Management Centers that process and assign spontaneous medical volunteers. This can be a complex activity<sup>6</sup> and should only be done by the

<sup>6</sup> Fernandez LS, Barbera JA, van Dorp JR, Strategies for Managing Volunteers during Incident Response: A Systems Approach. Homeland Security Affairs (October 2006); Available at: <http://www.gwu.edu/~icdrm/publications/index.html>.



Coalition if a methodology is well established during preparedness planning. It is imperative that such activity, if undertaken by the Coalition, is coordinated closely with the appropriate authorities (e.g., Jurisdictional Agency(s), State authority).

## Facilities

The response functions of the HCRT may occur at multiple facilities (i.e., in a distributed manner) rather than at one location like a typical EOC. For some Coalitions, this may be the most cost-effective approach. Integration is accomplished through voice and Internet links. At a minimum, a fixed location should be identified for information gathering and distribution (i.e., Coalition Notification Center function). Other locations convenient to Coalition members (usually hosted by a Coalition member) can be used as meeting space for Coalition action planning, for Coalition task forces, or for additional data collection and analysis. Issues to consider when selecting facilities for the Healthcare Coalition include:

- The facility host may vary across Healthcare Coalitions. In some situations, public sector emergency facilities (e.g., from EMS or a public health organization) may be offered to host the HCRT. A potential benefit of this arrangement is the ability to co-locate the HCRT with other emergency response managers. However, care should be taken to ensure that the HCRT has access to adequate facility space, equipment, and other required support at all times, not just when the jurisdiction activates its response.
- The facility should be able to support rapid mobilization for the HCRT, particularly the Coalition Notification Center function. Having these locations hosted in a facility that serves everyday as a communications center that can address Coalition actions may be very beneficial.
- The “resiliency” of the facility (or its ability to survive a hazard impact) is an important factor to examine. Public or private facilities that have backup power (e.g., fire stations, healthcare facilities) may be good options. In addition, a good continuity of operations practice is to identify backup facilities that the Healthcare Coalition can use.
- Potential facilities should be examined for whether they have adequate parking and meeting space, communications linkages, restrooms, furniture, and other basic support requirements.

## Equipment

The basic critical equipment is the information and communications technology required for healthcare organizations (Tier 1) to communicate with the HCRT and vice versa. The ability of the Coalition to connect with the relevant Jurisdictional Agency(s) (Tier 3) and other external organizations is also critical.

The specific technological solutions to these communications issues are beyond the scope of this handbook. Modalities include telephone landlines, text and cellular technology, Internet, and radios. The use of fax machines has been common in the past, but can be unreliable and should be avoided if possible or combined with other modalities that enable confirmation of message receipt by the intended recipient. Important concepts to consider when establishing communications equipment for response activities include the following:

- **Redundancy:** Multiple communications methods may be used simultaneously to accomplish Coalition response objectives. For example, radio notification of an emergency may be ideal for ensuring the receipt of information by participants, but Internet programs that can begin to collate information minimizes radio traffic and makes more efficient use of responders' time.
- **Route Diversity:** Telephone lines and wired or wireless Internet connectivity often have a single point of failure that if disrupted brings down the entire system. Back-up systems that work around these potential failure points are desirable.
- **Established protocols:** Communications and other technologies provide optimal benefit if protocols for their use are established, implemented, and sustained through training and drills. In addition, using trained facilitators and adhering to meeting agendas promotes efficient utilization.
- **Availability of established products:** Coalition planners are encouraged to develop their response requirements, based upon their response objectives, before selecting particular technologies to support their system. If a Coalition defines what information will be collected and in what manner, it may be easier to select the most appropriate product to meet the Coalition's needs.

### 6.1.4 Education, Training, and Drills

Implementation of the Coalition's EOP requires that personnel at the MSCC Tiers 1, 2, 3, and 4 levels fully understand the response role of the Healthcare Coalition. This can be achieved through specific instructional activities. The following personnel should receive training:

- **Personnel staffing the Coalition response organization (e.g., HCRT, Senior Policy Group, and Organizational Liaisons):** Position roles, responsibilities, and procedures should be clearly described for personnel staffing the HCRT, Organizational Liaisons to the HCRT, and the Senior Policy Group. For the latter, instructional activity may be brief and include just-in-time training.
- **Personnel managing the response of Coalition member organizations:** Personnel expected to staff senior IMT positions at Coalition member organizations should have an operational knowledge of the HCRT's role during emergency response and recovery. Personnel trained to staff the Organizational Liaison position for the specific Coalition member organization may be best positioned to provide this training.
- **Public sector personnel interfacing with the Coalition:** Public sector personnel (Tier 3) who interface with the Coalition during response should be offered training on the Coalition's roles and procedures for coordinating with the HCRT.

Drills focus on the execution of specific skills that might be required during response. Examples of drills that a Coalition might regularly conduct are provided below.

- **Notification procedures:** Regular testing of the notification and initial confirmation procedure is important to verify that the equipment is functioning, that contact lists are current, and that personnel understand the appropriate response to the notification message. This can become a routine procedure that ensures effectiveness and may include regular radio checks or sending text messages to the notification groups.
- **Resource requests:** Drills focusing on the availability of specific Coalition resources (e.g., patient beds, equipment, and supplies) can promote an understanding of the range of potentially available resources. These resource request drills may be combined with notification drills.

- **Mobilization of personnel:** Drills focusing on the mobilization of personnel can ensure that procedures are in place to rapidly activate the HCRT during an incident.

Education and training may be provided in a variety of formats and include web-based modules or other forms of “distance learning.” Classroom training, particularly when first establishing the Healthcare Coalition, provides an opportunity for personnel from different organizations to meet each other and establish a working relationship.

## 6.2 OTHER HEALTHCARE COALITION PREPAREDNESS ACTIVITIES

The remaining preparedness activities for the Coalition focus on evaluation and improvement of the Coalition’s response capabilities.

### 6.2.1 Exercises

The Healthcare Coalition should use exercises to evaluate the Coalition’s EOP once the EOP has been implemented and personnel have received appropriate education and training. Exercises may evaluate specific elements of a Coalition’s EOP or evaluate the EOP in a broader context. Common elements that may be evaluated during an exercise include SOPs, organizational structure, or the effectiveness of specific technologies used by the Coalition during emergency response. An important consideration in designing an exercise is that the areas to be evaluated are pre-determined and an evaluation plan is established.

The Homeland Security Exercise and Evaluation Program (HSEEP) contains mandatory requirements if Federal emergency preparedness funds are used to develop and conduct the exercise.<sup>7</sup> While a full discussion of exercise preparation is beyond the scope of this handbook, key considerations for healthcare planners are presented in Exhibit 6-4.

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<sup>7</sup> FEMA, Homeland Security Exercise and Evaluation Program (HSEEP); Available at: [https://hseep.dhs.gov/pages/1001\\_HSEEP7.aspx](https://hseep.dhs.gov/pages/1001_HSEEP7.aspx).

### Exhibit 6-4. Key considerations for exercise preparation

- The purpose of the exercise should be clearly stipulated in the Exercise Plan. This drives the scenario to ensure that areas of focus receive proper attention during the exercise. The level of anticipated play by the participating entities should be established. Coalition members that are not able to participate should be kept informed of the exercise development process and the findings from the exercise.
- The exercise scenario should be selected from hazards identified in the Coalition's HVA and should not present a "doomsday" event. This will ensure a realistic test of the Coalition's EOP and avoid a demoralizing "can't win" situation.
- Exercise evaluation should focus on the policies, processes, and procedures defined in the EOP and not on the performance of individuals. An evaluation plan should be developed prior to the exercise describing the evaluative process that will be used. Personnel should be designated to specifically evaluate the systems or processes that are objectives for the exercise.
- The exercise schedule should promote broad participation by Coalition member organizations and any relevant Jurisdictional Agency(s) (Tier 3) or regional Coalitions (Tier 2), if applicable. Representatives from individual healthcare organizations and Jurisdictional Agency(s) should be involved in exercise development and scheduling.
- A team should be designated to manage the exercise while it is being conducted. The size and complexity of this team will likely vary depending on the specific Coalition. The first priority of the management team should be the safety of exercise participants.

Feedback for the exercise evaluation may be gathered in the form of assessments from the evaluators, role players, and the exercise participants. Two methods that are commonly used to obtain input from exercise participants include the following:

- **Post-exercise "hot wash."** This activity is usually conducted immediately following an exercise to identify key successes or challenges while they are still "fresh" in the minds of the participants. Representatives from all entities that participated in the exercise should be included.

- **After Action Report (AAR) process.**<sup>8</sup> The AAR process is a formal and comprehensive process conducted after the exercise to analyze data and observations, positive and negative, related to system performance.

## 6.2.2 Evaluation and the AAR Process

In addition to exercises, the AAR process is used after an actual incident. This process should go beyond the documentation of “lessons learned” and drives system change through a corrective action process that produces true organizational learning. The AAR process may include the following characteristics:

- A management team assigned to oversee the AAR process. This team can vary in size depending on the size and complexity of the Coalition and the incident that is being evaluated.
- Prior to conducting an AAR conference, all exercise-related observations and data should be collected and reviewed to steer the discussion. A short survey from responding organizations that assesses the HCRT performance may also be very beneficial. Incident or exercise-related documents (e.g., ICS forms used during the response, notification messages) should be analyzed to steer the AAR discussion and inform the AAR findings.
- As part of the AAR conference, participants develop an Improvement Plan (IP) that articulates specific corrective actions by addressing issues identified through the AAR process.<sup>9</sup>
- The timing of the AAR conference should provide stakeholders with sufficient time to recover from the incident or exercise and allow adequate preparation by the management team. Too long of a delay, however, may allow critical recollections to be lost.
- The AAR conference should be facilitated in accordance with a pre-established agenda. It may be advisable to have the HCRT Planning Section Chief, or someone trained for that position, facilitate the conference.

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<sup>8</sup> State of California, Governor’s Office of Emergency Services, Standardized Emergency Management Systems (SEMS) Guidelines, Part III. Supporting Documents (December, 1994); Available at: [http://www.oes.ca.gov/Operational/OESHHome.nsf/PDF/SEMS%20Guidelines/\\$file/AAR.pdf](http://www.oes.ca.gov/Operational/OESHHome.nsf/PDF/SEMS%20Guidelines/$file/AAR.pdf).

<sup>9</sup> U.S. Department of Homeland Security, Homeland Security Exercise and Evaluation Program (HSEEP), Volume 3: Exercise Evaluation and Improvement Planning, (February 2007); Available at: <https://hseep.dhs.gov/support/Volumelll.pdf>.

A final report should be developed that documents the findings of the AAR process. The report should document both positive and negative findings, with recommendations on how the former might be incorporated permanently into Coalition processes and procedures. Recommendations should be as specific as possible to highlight steps for system improvement.

### 6.2.3 Organizational Learning

The Healthcare Coalition response organization should be continuously evaluated based on its response to both exercises and real-world emergencies. The goal should be to transform this experience into lasting improvements in Coalition performance.<sup>10</sup> The following concepts are provided for consideration:

- The AAR and IP are finalized as a combined AAR/IP, and IP corrective action items are tracked to completion as part of a continuous Corrective Action Program.<sup>11</sup>
- Individuals should be assigned responsibility for implementing recommendations made in the AAR/IP. This commonly would be a Healthcare Coalition EMC subcommittee.
- Assigned personnel should review proposed changes for clarity and their potential impact on the Coalition. This should include an assessment of the priority of the recommended changes (e.g., life safety issues should be assigned the highest priority).
- Proposed recommendations may be accepted, accepted with revision, declined (with a reason given), or deferred. The latter option may be preferred if a proposed change is contingent on upcoming funding and should be readdressed if/when the funding is obtained.<sup>12</sup>
- Changes in Coalition processes and procedures should then be evaluated during follow-on exercises or actual incidents.

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<sup>10</sup> Adapted from Senge P, *The Fifth Discipline: The Art and Practice of the Learning Organization*; In Ott SJ, Parkes SJ, Simpson RB; *Classic Readings in Organizational Behavior*. Belmont, CA, Thomson Learning, (1990).

<sup>11</sup> U.S. Department of Homeland Security, *Homeland Security Exercise and Evaluation Program (HSEEP), Volume 3: Exercise Evaluation and Improvement Planning*; February 2007. Available at: <https://hseep.dhs.gov/support/VolumeIII.pdf>.

<sup>12</sup> Barbera JA, Macintyre AG, Shaw G, et al, *Emergency Management Principles and Practices for Healthcare Systems*. Department of Veterans Affairs, Veterans Health Administration (2006); Available at: <http://www1.va.gov/emshg/page.cfm?pg=122>.

## 6.3 HEALTHCARE COALITION MITIGATION ACTIVITIES

As defined in Chapter 5, mitigation activities prevent the occurrence of a hazard or minimize the impact of a hazard should it occur. Mitigation establishes resiliency for the Healthcare Coalition. While this handbook acknowledges the unique construct of each Healthcare Coalition, there are common considerations across all Coalitions.

The Coalition Notification Center's function is a critical element to successful response. This entity could be impacted in several ways:

- **Facility:** The facility housing the Coalition Notification Center function could be compromised by hazard impact. For example, a power outage could prevent the Coalition Notification Center from completing its responsibilities if no backup power source is available. The Coalition should evaluate this during their continuity of operations planning activities.
- **Personnel:** Personnel from a Coalition member organization may have other duties in addition to conducting the Coalition Notification Center function, so an emergency may severely challenge that organization's personnel.
- **Technology (equipment):** Hazard impact may affect the technologies used at the facility that conducts the Coalition notification actions (e.g., radio, internet, etc.).

It is recommended that Coalitions examine resources that can provide backup capabilities for the Coalition Notification Center, even if the resource can only conduct the most essential Coalition Notification Center activities. Other mitigation considerations applicable to most Healthcare Coalitions include:

- **Response team personnel:** Individuals rostered to serve on the HCRT may have difficulty being reached or responding, especially during the early stages of an incident. Having backup personnel taking secondary call may address this issue.
- **Communication technologies:** Given the distributed nature in which the HCRT may operate, communications technology is important. Redundancy in communication methods is vital to maintain operations if the primary technology fails.



# NOTES

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# Chapter 7:

## Healthcare Coalition Administrative and Documentation Guidance

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## 7.1 THE NEED FOR HEALTHCARE COALITION OPERATIONAL DOCUMENTS

Many healthcare organizations in the U.S. are privately owned and may view themselves as business competitors with other local healthcare organizations during normal operations. The case can be made, however, that agreeing to work within a common framework during emergency response is a good business practice. It will typically result in both better patient care and reduced risk for the organizations (business, reputation, and service delivery).

A common framework that describes the relationship between healthcare organizations during emergency preparedness and response should be developed and clearly documented when establishing the Healthcare Coalition. This goes beyond the EOP and other operationally oriented documents. It describes the overarching Healthcare Coalition EMP and includes written instruments that address a wide range of issues – operational, legal, and financial –between the participating organizations.

The complexity of the healthcare industry must be addressed when developing the relationship between Coalition member organizations. For example, it is common to have an integrated healthcare system with multiple semi-independent healthcare facilities under its corporate structure. Does each facility receive one Coalition vote in preparedness decisions or does the integrated healthcare system receive a single vote? How is funding (both preparedness and response) equitably distributed between Coalition members? Other examples of special relationships that may exist within a Coalition include the following:

- Healthcare organizations that are independent but maintain close ties due to patient referral patterns, joint projects, or other activities.
- Healthcare organizations that, because of proximity, shared risk, or other factors, have developed “priority” mutual aid or other promises to assist each other before seeking help from the broader Coalition membership.

These and other pre-existing conditions should be acknowledged and addressed through written agreements, policies, and response processes for the Healthcare Coalition. This chapter provides general guidance in sorting through these issues and includes examples of written instruments that may be considered in developing a Coalition. *This should not be construed as legal or liability advice, and each Coalition member organization should involve their legal or liability experts in all facets of developing and implementing a Healthcare Coalition.*

## Exhibit 7-1. Addressing legal issues within the framework of a Healthcare Coalition\*

The King County Healthcare Coalition in the State of Washington has formed a Legal Workgroup, whose members include attorneys representing hospitals and government agencies in King County. The workgroup's primary objectives include:

- Provide guidance to other workgroups, the Executive Council, and Steering Committee about current State and Federal laws/rules that are related to public health emergencies
- Develop products and strategies for education of the legal community, including attorneys who advise Coalition members and members of the judiciary.

\* King County Healthcare Coalition, Special Advisory Groups/Clinical Planning Groups; Available at: <http://www.kingcounty.gov/healthservices/health/preparedness/hccoalition.aspx>.

## 7.2 WRITTEN INSTRUMENT OPTIONS

Documenting the legal relationship created by the Healthcare Coalition and how the Coalition will operate during normal activities and during emergencies provides the following benefits:

- Minimizes misunderstandings among Coalition members.
- Memorializes oral agreements and promotes continuity of systems and organizations' relationships despite changes in personnel or leadership.
- Provides consistent and authoritative materials to serve as a basis for training and education.
- Provides materials that are useful for developing exercises and evaluative instruments, and for performing AARs and achieving organizational change.

Provided below are examples of the different options that are available for establishing the preparedness and response relationship between Healthcare Coalition member organizations.

## 7.2.1 Memorandum of Understanding

A common method used to document concurrence between parties on an intended course of action is a Memorandum of Understanding (MOU). In general terms, an MOU provides the structure and intentions of the understanding between parties, but is not legally binding unless specifically stated (Exhibit 7-2).

### Exhibit 7-2. Memorandum of Understanding (MOU)\*

A Memorandum of Understanding, or MOU, is a formal document embodying the firm commitment of two or more parties to an undertaking, and setting out its general principles, but falling short of constituting a detailed contract or agreement.

\*Oxford Dictionary of Law, Elizabeth A. Martin (Ed.), Oxford University Press, 2006.

Depending on the specific circumstances of the Coalition, an MOU may be an attractive option for memorializing the agreements to participate in the Coalition, with its information sharing, agreed upon mutual aid relationships, and other collaborative commitments. The written instrument should acknowledge that the relationship is directly between the member organizations that comprise the Healthcare Coalition. The Coalition's response organization (HCRT) only facilitates the coordination between them during emergency response. The HCRT never controls or commands the Coalition's member organizations. The following elements should be considered in an MOU:

- **Purpose:** General statements regarding the situations in which the MOU may be used, who the participants are, and what they agree to do to support one another. The voluntary (rather than contractual) nature of the relationship among member organizations should be clearly delineated if that is the intent.
- **Definition of terms:** While it is expected that NIMS-consistent terminology will be used, each geographic area has terms that are specific to their healthcare organizations or current mutual aid construct. The terminology for preparedness and response should be explicitly defined in the written instrument. For example, consistent terminology and definitions for injury severity categories should be established for the purpose of accurately tallying aggregate casualty counts.

- **Information sharing:** The commitment to share incident data and other information necessary for developing the Healthcare Coalition should be described.
- **Principles of mutual aid:** If facilitating mutual aid becomes a Coalition response objective, the document should describe in specific terms how resources will be shared between Coalition member organizations (see mutual aid instruments below). Principles outlining other services facilitated by the Coalition should be described as well.
- **Miscellaneous provisions:** These include statements about the term of the written instrument (indicating when it would need to be renewed and any termination methods), terms of cooperation on addressing liability between members, statements referencing patient privacy, and/or other components that legal advisors believe important to incorporate.
- **Attachments:** Any preformatted tools that the agreement expects to utilize during response are best included as attachments to the agreement itself.

Responsibility for writing the MOU for the Healthcare Coalition may vary by locale. The process may be accomplished by operational level personnel to ensure the MOU addresses the operational details necessary for mutual aid actions under extreme circumstances. Legal advisors from each Coalition member organization should have the opportunity to review, provide input, and approve the document.

## 7.2.2 Memorandum of Agreement

Another written instrument is the Memorandum of Agreement (MOA). In some legal arenas, the MOA is viewed as more binding than the MOU, while in others the terms “agreement” and “understanding” are used interchangeably. The Healthcare Coalition may write an MOA (Exhibit 7-3) specifically to define only “good faith” intent to provide assistance under emergency conditions. The materials that the MOA could cover are the same as those presented above for an MOU.

### Exhibit 7-3. Memorandum of Agreement\*

A Memorandum of Agreement (MOA) defines the general area of conditional agreement between two or more parties, but one party's action depends on the other party's action. The MOA can be complemented with support agreements that detail reimbursement schedules and specific terms and conditions.

\* Adapted from FEMA National Preparedness Directorate, Memorandum of Agreement/Memorandum of Understanding Template and Guidance; March 2009.

Again, healthcare planners who are contemplating the development of a written instrument should consult with their legal advisors to determine the best option to establish their Healthcare Coalition. Because these written instruments define the legal relationship between Coalition members, they must undergo a careful legal review.

## 7.2.3 Contracts and Compacts

A contract is “an agreement between two or more persons to create an obligation to do or not to do a particular thing.”<sup>1</sup> Although they may have little applicability to a mutual aid instrument, contracts can be effective mechanisms for establishing commitment from external entities to individual healthcare organizations (Tier 1) and to the Coalition (Tier 2). For example, emergency contingency contracts can be established in which a vendor promises a specific service or item upon request *after a hazard impact*. An example might be an emergency services contract with the local water authority that can be activated if a water outage impacts healthcare organizations. The Healthcare Coalition may wish to address emergency services contracting through a collaborative approach. This can help avoid unmanaged competition between Coalition members for scarce resources during an emergency. Mechanisms for fair distribution of a critical resource or service can then be established.

A compact is “an agreement or contract between persons, nations or States. A compact is commonly applied to working agreements between and among States concerning matters of mutual concern.”<sup>2</sup> The most widely known compact in emergency management is the Emergency

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<sup>1</sup> Black's Law Dictionary, Sixth Ed., West Publishing Company, 1990.

<sup>2</sup> Black's Law Dictionary, Sixth Ed., West Publishing Company, 1990.



Management Assistance Compact (EMAC),<sup>3</sup> which provides authorities and mechanisms for States to share public sector resources.

Compacts may be valuable written instruments for Healthcare Coalitions that have the following characteristics:

- Coalition that extends across State boundaries: If a Healthcare Coalition has been established in a geographic area that crosses State boundaries, the compact may address mutual aid and cooperative assistance between the States. Issues that could be addressed include healthcare licensure, certifications, liability, and other issues related to personnel crossing State lines. This would be an instrument between State authorities that benefits the Healthcare Coalition, rather than an instrument between Coalition member organizations.
- Coalition that borders State boundaries: If a State boundary separates two Healthcare Coalitions that are pursuing regional cooperation, EMAC or a more specific compact between the involved States may be used to address interstate concerns. Since EMAC has historically covered primarily government-owned assets, a separate compact may be necessary to address sharing of private sector resources across State lines.

## 7.2.4 Mutual Aid and Cooperative Assistance

Written mutual aid instruments frame and document the processes for providing mutual aid, as well as the manner in which resources will be shared between healthcare organizations during emergencies. These instruments should address any expected reimbursement for the costs of assistance (invoicing, timing of payment, etc.).

Healthcare Coalitions may develop mutual aid instruments that provide an initial period (i.e., eight hours) of personnel mutual aid that is uncompensated. Any assistance provided after a certain time interval or preset threshold is then reimbursed. Traditionally, expenses incurred by donor organizations providing uncompensated mutual aid have not been recoverable through Robert T. Stafford Act<sup>4</sup> disaster funds because a documented expense has not been generated by the supported organization. In deciding how to address compensation for mutual aid, Coalition members should consult their legal advisors and consider how this issue is addressed by their local and State governments.

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<sup>3</sup> Information on EMAC is available at: <http://www.emacweb.org/>.

<sup>4</sup> Information on the Robert T. Stafford Disaster Relief and Emergency Assistance Act (PL 100-707) is available at: <http://www.fema.gov/about/stafact.shtm>.

Regardless of the path chosen for a particular Healthcare Coalition, it is important to establish a formal process in which prospective members of the Coalition have input (Exhibit 7-4).

#### **Exhibit 7-4. Example process for establishing a Master Mutual Aid Agreement for a Healthcare Coalition\***

A regional Healthcare Coalition in the State of Oregon employed a multistep process in developing its Master Mutual Aid Agreement, which is briefly outlined below.

- 1) Research “best practices” for mutual aid agreements that have been developed and used in other areas
- 2) Select models from best practices and modify as necessary to fit existing structure
- 3) Refine the end document
- 4) Gather stakeholders and present the concept, explain the mission, and seek buy-in or suggested improvement
- 5) Model in a single hospital that is representative of the region
- 6) Seek legal review from model hospital with feedback
- 7) Refine the end document
- 8) Distribute the end product and communicate date due back once executed
- 9) Provide continuous follow-up and support, as needed
- 10) Remind stakeholders of due date periodically and check status of process on their end
- 11) Share what other hospitals have signed once a few are onboard to encourage broader participation
- 12) Once all executed copies of the document are secured, plan a signing or celebratory ceremony to recognize the collaborative process

\* Personal communication with regional coordinator for Oregon HPP Region 2. All hospitals in Oregon HPP Region 2 have executed a Master Mutual Aid Agreement that defines sharing, reimbursement, and other legal aspects including that the provision of resources is done on a voluntary, not mandatory basis.

### **7.3 RESOURCE ASSISTANCE ISSUES IN HEALTHCARE COALITION INSTRUMENTS**

If resource sharing is an objective of the Coalition, issues should be identified and addressed during the development of any mutual aid or cooperative assistance instrument. Documenting the types of resources that may be shared and the process and expectations of the sharing arrangement enhances the potential for response success.

### 7.3.1 Personnel

The resource category that may require the most attention in written mutual aid and cooperative assistance instruments is the sharing of personnel. A range of healthcare professionals could be shared between Coalition members during emergency response. In addition to the usual attention to healthcare providers, important assistance may be obtained through the sharing of security officers, facility engineers, mid-level managers, and others. The following issues should be addressed:

#### Credentialing, Licensure, and Privileges

The differences between credentialing, privileging, and badging were explained in Section 6.2.1. Healthcare organizations typically use a credentialing and privileging process on a day-to-day basis before allowing healthcare providers to practice in the organization. During normal operations, the verification of credentials is designated “primary source verification,” since it involves contacting each credential granting organization directly and verifying credentials submitted by the applicant. This process is time and labor intensive, and for these reasons it is prohibitive for granting emergency privileges during the response to an emergency. The following alternative processes may be incorporated into the Coalition’s mutual aid documents:

- Procedures may be established to expedite the credentialing and privileging process for donated personnel. These processes rely on “secondary source verification” in which the work performed by another accredited healthcare organization is temporarily used as adequate verification for granting privileges. Thus, verification that an individual is credentialed and privileged at a similar accredited healthcare organization within the Coalition may suffice for granting emergency privileges. The Joint Commission has addressed this issue in its standards and requires primary verification of licensure within 72 hours of granting emergency privileges.<sup>5</sup>
- Primary source verification of basic healthcare credentials may be accomplished pre-incident for people who enroll in volunteer registration programs (e.g., Medical Reserve Corps, State ESAR-VHP programs). However, the receiving organization must still grant emergency privileges to donated personnel. *A method must be established to verify the credentials before clinical privileges are granted.*

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<sup>5</sup>The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Human Resources HR 1.25 and HR 4.35, July 2006.

For example, the organization donating personnel may verify that they are currently employed with full clinical privileges and without pending investigation or sanctions.

## **Liability Coverage**

Mutual aid instruments should stipulate how tort liability coverage will be maintained for healthcare providers that are shared between Coalition organizations. As this can be a complex issue, the emergency managers for Coalition members should seek advice from their legal counsel when writing these instruments.

One potential method to address tort liability coverage is to extend liability coverage from the assisting organization to its personnel who are working at the supported organization. This may be accomplished by including mutual aid services within the organization's scope of practice for that category of healthcare providers. The mutual aid instrument may stipulate that the costs of addressing legal issues under this liability coverage will be borne by the requesting organization for actions incurred during the emergency.

Other methods for addressing liability issues may be through State legislation. It is recommended that Coalitions consult their legal advisors when examining this area.

## **Worker's Compensation**

Worker's compensation should also be addressed in the Healthcare Coalition's written agreements. Similar to tort liability, this may involve extending coverage from the donating organization, but with reimbursement of costs if an adverse event occurs (e.g., medical bills, lost wages). Relevant insurance carriers who provide this coverage should be involved when examining solutions for a specific Coalition. It may become important to detail the safety practices that should be employed with personnel donated for emergency tasking (maximum shift length, safety supervision, etc.) when establishing this section of the written mutual aid agreement.

## **Supervision of Deployed Personnel**

The Healthcare Coalition should consider the supervision of deployed personnel when developing the terms of mutual aid. Some issues that may be addressed include the following:

- Establishing the location where deployed personnel should initially report to in a supported institution
- Mandating briefing procedures to provide orientation and tasking for deployed personnel
- Badging procedures for deployed personnel
- Assigning a supervisor for donated personnel and establishing reporting requirements so the supported organization maintains control through its incident management processes
- Out-briefing donated personnel, which may include addressing any medical issues related to disease exposure or work-related injury
- Performance evaluations provided by an immediate supervisor.

## Pre-Deployment Preparation

It may be useful for the Healthcare Coalition mutual aid instrument to stipulate a minimum level of preparedness for personnel who may be deployed, including training and pre-deployment briefing requirements. The following information should be provided to deploying personnel:

- Known details about the incident
- Expected roles for deployed personnel (e.g., specific assignment if known, the supervised nature of the assignment, the reporting requirements)
- Safety issues specific to the incident and a review of general safety measures
- Review of some of the protections afforded (e.g., tort liability and worker's compensation coverage)
- Review of deployment checklists that may be developed to address items that personnel should have when deploying (bottled water, several changes of universal precautions equipment, other PPE, change of clothes, personal medications and toiletries, etc.).

### 7.3.2 Equipment/Supplies

When developing mutual aid instruments, the following categories of items should be considered:

- Pharmaceuticals
- Sterile supplies
- Blood products (many regions already have established agreements through the American Red Cross)

- Critical care equipment (e.g., ventilators, suction)
- Decontamination equipment and supplies (e.g., Personal Protective Equipment and other supplies)
- Equipment for evacuation (e.g., stretchers, chairs)
- Infrastructure equipment (e.g., generators, water purification equipment)
- Others (e.g., potable water stores, linen supplies).

An important resource distinction is differentiating between durable and non-durable supplies. The mutual aid instrument should address whether non-durable supplies (e.g., pharmaceuticals, sterile supplies) will be returned to the donating organization if unused and what storage conditions are necessary for the supplies to remain suitable for return. For durable items, the mutual aid instrument should specify any rehabilitation requirements or reimbursement to the donor organization for rehabilitation and the time frame for when durable items are to be returned after use.

### 7.3.3 Facilities

“Facilities” for healthcare mutual aid usually refers to staffed beds available for accepting patient transfers. The Healthcare Coalition’s mutual aid instrument should address the “typing” of staffed beds so Coalition members use consistent terminology when tracking the availability of beds. The Agency for Healthcare Research and Quality (AHRQ) has developed standardized hospital bed definitions.<sup>6</sup> It is important to ensure consistency with national standards.

In rare situations, the management of an entire facility or a portion of a facility might be turned over to another organization. For example, an outpatient care center could be used by another healthcare organization to screen patients who have been potentially exposed to an infectious agent. The Healthcare Coalition may want to address the following issues in its mutual aid instrument:

- How the facility could be used?
- What support from the facility’s owners will be required?

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<sup>6</sup> AHRQ Releases Standardized Hospital Bed Definitions to Aid Katrina Responders. September 2005. Agency for Healthcare Research and Quality, Rockville, MD. Available at: <http://www.ahrq.gov/research/havbed/definitions.htm>.

- How costs will be reimbursed?
- How rehabilitation of the facility will occur?

## 7.4 PROCEDURAL GUIDANCE FOR HEALTHCARE COALITION WRITTEN INSTRUMENTS

Healthcare Coalition mutual aid instruments should also include guidance on how to acquire and manage resources during an emergency. This may include procedures for requesting, deploying, tracking, managing, demobilizing, and rehabilitating resources.

### 7.4.1 Resource Requests and Offers of Assistance

The following issues should be considered in developing procedural guidance for resource requests:

- **Resource descriptions:** Resource typing is the methodology used in ICS to provide standardized descriptions of resources that may be shared. This helps to assure accuracy in meeting resource requirements. It is especially relevant to the medical profession, as there can be subtle yet important differences between similarly sounding requests. A Federal initiative is underway to address healthcare resource typing and credentialing, and a limited list of resource types currently exist for medical and public health teams.<sup>7</sup> Mutual aid instruments should delineate the process in which resources will be described to minimize inaccuracies, particularly for resources that are not described in the FEMA listing.
- **Format for resource requests:** This should be kept simple and include the name, response position title, and contact information of the individual making the request, along with the name of the requesting organization. The request should specify a reporting location for deployed personnel, a brief description of duties, and the start time and anticipated length of service.
- **Authority to request or offer resources:** This involves specifying who within a Healthcare Coalition member organization has the authority to request and offer resources.

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<sup>7</sup>FEMA. Resource Management: Resource Typing; Available at: <http://www.fema.gov/emergency/nims/ResourceMngmnt.shtm#item4>.

- **Transmission of requests:** This involves specifying how requests are transmitted to the HCRT for rapid dissemination to other Coalition members. Donor organizations can contact the requesting organization directly or any offers of assistance can be aggregated by the HCRT Operations Section and provided to the requesting organization.
- **Completing the resource sharing arrangement:** The specific agreement for assistance is made directly between the requesting and the donating organizations, facilitated by the HCRT if desired by the involved parties. An agreement template for this purpose may be helpful.

## 7.4.2 Transportation of Resources

Transportation of resources should be considered when developing the mutual aid instrument. Stipulations should include how the resources will be delivered to the supported organization and returned to the assisting organization (as appropriate). A range of transportation options may be available, including the following:

- Healthcare organizations may own adequate transportation assets that can be used during incident response (e.g., hospital based ambulance services).
- Arrangements may be made during preparedness planning with public sector agencies, such as EMS, departments of transportation, or mass transit agencies to supply transportation assets for emergency assistance.
- Similarly, private sector assets may exist within the community that could be engaged in contingency contracts or other written mutual aid instruments.

## 7.4.3 Transferring Patients

Procedures governing the day-to-day transfer of patients between healthcare organizations are typically well delineated, but can be time and labor intensive. Modifications may be needed to expedite this process during an emergency and should address the following:

- **Assigning receiving facilities:** For routine patient transfer, it is usually the responsibility of the individual practitioner or healthcare organization to locate an appropriate and available receiving



facility and care provider. During emergencies, this may be better coordinated through the HCRT by communicating requests for assistance to all participating organizations at one time. The HCRT Operations Section may then aggregate offers of assistance and connect the most appropriate to the requesting organization. This takes on critical importance in situations such as the emergency evacuation of a healthcare facility.

- **Transfer procedures and related details:** Issues related to the transfer of patients should be addressed during preparedness and may include the following:
  - Who is responsible for arranging patient transport?
  - When does responsibility for the transferred patient transition from the sending organization to the patient receiving facility?
  - What patient records (including family contact information) will be included? Is remote access to electronic medical records an option?
  - What other minimum documentation is required to accompany patients being transferred?
  - How will patient transfer actually occur?
  - What authority does the patient receiving facility have to assign a new medical provider?
  - Will courtesy or temporary privileges be assigned to the patient's regular treating physician?
  - What procedures will be used to confirm arrival and acceptance of transferred patients?
  - What equipment, supplies, or medication should be transferred with the patient?
  - How will payment for care at the new facility be processed and submitted to third party payers (see below)
- **Notification of transfer:** This includes messages to the receiving facility that a patient is en route, confirmation by the receiving facility that the patient has arrived, responsibility for notification of patients' families regarding the emergency transfer and points of contact at the receiving facility, and confirmation by the patient receiving facility to the patient's family that the transfer has been completed.
- **Integration with other organizations:** During large incidents, mechanisms such as the National Disaster Medical System (NDMS)

and its associated Federal Coordinating Centers (FCC) may become active. Coalitions should consider including regional representatives from NDMS and the regional FCC in discussions of these issues during Coalition preparedness.

#### 7.4.4 Physician Admitting Privileges

After emergency evacuation of a healthcare facility, it may be appropriate to grant courtesy privileges at receiving facilities so that the personal physician of a transferred patient can provide continuity of care *in the receiving facility*. The methodology to address this could be similar to granting emergency privileges. This may need to be addressed through medical staff by-laws and other administrative avenues.

#### 7.4.5 Healthcare Third Party Payment Coverage

Payment for healthcare services rendered in the care of patients who are transferred in an emergency may be another consideration to address in the Coalition's mutual aid instrument. Resolution of issues may require discussion with major regional insurers, relevant government health insurance, and consumer advocacy agencies to address:

- Payment for services when the patient(s) is transferred to a facility that is not "approved" by the involved insurer.
- Insurance policies that do not recognize an emergency transfer as a "new" hospitalization for the patient.
- Timely payments to healthcare providers not typically within the provider coverage of the third party payer.
- During a large-scale or complex incident, certain government authorized waivers may be enacted.<sup>8</sup> The HCRT should work closely with its government representatives to understand these implications before any emergency. Coalitions should also be prepared for incidents that do not meet this level of governmental action/declaration.

During a large-scale incident, certain government authorized waivers may take precedent. The HCRT should work closely with its government partners to understand these implications prior to any emergency.

<sup>8</sup>U.S. Department of Health and Human Services, Legal Authority for Implementation of a Federal Public Health and Medical Services Response; Available at: <http://www.hhs.gov/disasters/discussion/planners/legalauthority.html>.

## 7.4.6 Rehabilitating Resources and Costs

When establishing resource-sharing procedures, it is important to consider at least general guidance for rehabilitation and return of the shared assets. Issues for the Coalition to consider include:

- Responsibility for arranging and paying for return transportation
- Timeframe in which reimbursement to the donor organizations should occur
- Special vendors for servicing durable equipment
- Re-order information for non-durable goods
- Procedures related to employee health for evaluating and “rehabbing” deployed personnel or providing long-term tracking and follow-up of deployed personnel potentially exposed to a health hazard
- Recertification procedures before facilities that have been used for a special purpose can return to their normal function.

Finally, a dispute resolution method should be established to address difficult issues that could arise between donor and requesting organizations during emergency response and recovery.

## 7.5 RELEVANT STANDARDS AND GUIDANCE FOR THE HEALTHCARE COALITION

A wide range of standards and regulations are applicable to healthcare organizations during everyday operations and many remain in place during emergencies. It is important for those developing written instruments for a Healthcare Coalition to understand these standards and regulations and address them as appropriate. Examples of relevant healthcare standards are provided below.

- The Joint Commission: Although not all members of a Coalition may be accredited by The Joint Commission, their accreditation standards are relevant to many hospitals, long-term care facilities, behavioral health care facilities, and other Coalition partners. These include standards specific to emergency response.<sup>9</sup>

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<sup>9</sup>Additional information on The Joint Commission’s standards, including Emergency Management Standards, is available at: <http://www.jointcommission.org/Standards/>.

- Centers for Medicare and Medicaid Services (CMS) and other Federal regulations: CMS has multiple regulations that impact reimbursement for patients enrolled in their programs.<sup>10</sup> Federal regulations, such as the Emergency Medical Treatment and Labor Act (EMTALA)<sup>11</sup> and the Health Insurance Portability and Accountability Act (HIPAA),<sup>12</sup> also have significant relevance to Healthcare Coalition operations.
- State and local regulations: States and local jurisdictions may have standards or regulations that impact Healthcare Coalitions operating in their area. These will necessarily vary among geographic regions and should also be addressed in conjunction with the Jurisdictional Agency (Tier 3).
- NIMS, NFPA 1600 and others: Multiple standards relevant to emergency response organizations should be examined by the Healthcare Coalition in structuring its plans and agreements. These include NIMS and the National Fire Protection Agency's Standard 1600.<sup>13</sup>

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<sup>10</sup> Centers for Medicare and Medicaid Services (CMS), Regulations and Guidance. Accessed January 19, 2009 at: <http://www.cms.hhs.gov/home/regsguidance.asp>.

<sup>11</sup> Centers for Medicare and Medicaid Services (CMS), Emergency Medical Treatment and Labor Act (EMTALA). Accessed January 19, 2009 at: <http://www.cms.hhs.gov/emtala/>.

<sup>12</sup> U.S. Department of Health and Human Services, Health Insurance Portability and Accountability Act (HIPAA), "Understanding HIPAA Privacy." Accessed January 19, 2009 at: <http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html>.

<sup>13</sup> National Fire Protection Agency Standard 1600, 2007 Edition: Standard on Disaster/Emergency Management and Business Continuity Programs. Accessed January 19, 2009 at: <http://www.nfpa.org/assets/files/PDF/NFPA1600.pdf>.

## NOTES

# NOTES

# Appendix A Acronyms

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# Appendix B

## Glossary

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## GLOSSARY

**Adequate:** Denotes the quality or quantity of a system, process, procedure, or resource that will achieve the relevant incident response objective.

**Administrative body:** As used in this handbook, the organization that provides preparedness support to the Healthcare Coalition. This can include, but is not limited to, activities such as arranging meeting space, providing financial accounting, and/or supporting document archiving and control.

**Area Command:** An organization established to oversee the management of multiple incidents that are each being handled by a separate Incident Command System organization or to oversee the management of a very large or evolving incident that has multiple Incident Management Teams engaged. An Agency Administrator/Executive or other public official with jurisdictional responsibility for the incident usually makes the decision to establish an Area Command. An Area Command is activated only if necessary, depending on the complexity of the incident and incident management span-of-control considerations. (NIMS)

**Badging:** The process of providing outside personnel with identification that gives them access (usually limited) to the designated facilities of the organization requesting assistance.

**Chief:** The Incident Command System title for individuals responsible for management of functional Sections: Operations, Planning, Logistics, Finance/Administration, and Intelligence/Investigations (if established as a separate Section). (NIMS)

**Command Staff:** The staff who report directly to the Incident Commander, including the Public Information Officer, Safety Officer, Liaison Officer, and other positions as required. They may have an assistant or assistants, as needed. (NIMS)

**Common Operating Picture:** An overview of an incident by all relevant parties that provides incident information enabling the Incident Commander/Unified Command and any supporting agencies and organizations to make effective, consistent, and timely decisions. (NIMS)

**Communications/Dispatch Center:** Agency or interagency dispatch centers, 911 call centers, emergency control or command dispatch centers, or any naming convention given to the facility and staff that handles emergency calls from the public and communication with emergency management/response personnel. The center can serve as a primary coordination and support element of the Multiagency Coordination System(s) (MAC System) for an incident until other elements of the MAC System are formally established.

**Compact:** An agreement or contract between persons, nations, or States. (Black's Law Dictionary, Sixth Ed.)

**Contract:** An agreement between two or more persons to create an obligation to do or not to do a particular thing. (Black's Law Dictionary, Sixth Ed.)

**Corrective Actions:** The implementation of procedures that are based on lessons learned from actual incidents or from training and exercises. (NIMS)

**Credentialing:** The authentication and verification of the certification and identity of designated incident managers and emergency responders. The credentialing process entails the objective evaluation and documentation of an individual's current certification, license, or degree; training and experience; and competence or proficiency to meet nationally accepted standards, provide particular services and/or functions, or perform specific tasks under specific conditions during an incident. (NIMS)

**Department Operating Center (DOC):** An Emergency Operations Center (EOC) specific to a single department or agency. The focus of a DOC is on internal agency incident management and response. DOCs are often linked to and, in most cases, are physically represented in a combined agency EOC by authorized agent(s) for the department or agency. (NIMS)

**Disaster ("Major"):** As defined in the Robert T. Stafford Act, a "major disaster" is any natural catastrophe (including any hurricane, tornado, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide,

mudslide, snowstorm, or drought), or, regardless of cause, any fire, flood, or explosion, in any part of the United States, which in the determination of the President causes damage of sufficient severity and magnitude to warrant major disaster assistance under this Act to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby.

***Duty Officer:*** As used in this handbook, an individual position that is available 24/7 to respond to questions and determine initial actions for a response organization, including whether the organizations should be activated. Duty Officers also may seek out additional initial incident information, decide upon the need for activation, and determine initial actions. Upon activation of the response organization, the Duty Officer position is suspended and the individual transitioned to staffing a position in the response organization.

***Emergency (Federal):*** Any incident, whether natural or manmade, that requires responsive action to protect life or property. Under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, an emergency means any occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States. (NIMS)

***Emergency Management:*** Describes the science of managing complex systems and multidisciplinary personnel to address emergencies or disasters, across all hazards, and through the phases of mitigation, preparedness, response, and recovery.

***Emergency Management Assistance Compact (EMAC):*** A congressionally ratified organization that provides form and structure to interstate mutual aid. Through EMAC, a disaster-affected State can request and receive assistance from other member States quickly and efficiently, resolving two key issues up front: liability and reimbursement. (NIMS)

**Emergency Management Committee:** A preparedness entity established by an organization that has the responsibility for emergency management program (EMP) oversight within the organization. As such, the committee would normally have the responsibility to ensure the overall preparation, implementation, evaluation and currency of the EMP. (adapted from the VHA Emergency Management Guidebook, 2005)

**Emergency Management Program (EMP):** A program that implements the organization's mission, vision, management framework, and strategic goals and objectives related to emergencies and disasters. It uses a comprehensive approach to emergency management as a conceptual framework, combining mitigation, preparedness, response, and recovery into a fully integrated set of activities. The "program" applies to all departments and organizational units within the organization that have roles in responding to a potential emergency. (adapted from NFPA 1600 and the VHA Emergency Management Guidebook, 2004)

**Emergency Operations Center (EOC):** The physical location at which the coordination of information and resources to support incident management (on-scene operations) activities normally takes place. An EOC may be a temporary facility or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. EOCs may be organized by major functional disciplines (e.g., Fire, Law Enforcement, Medical Services), by jurisdiction (e.g., Federal, State, regional, Tribal, city, county), or by some combination thereof. (NIMS)

**Emergency Operations Plan (EOP):** The "response" plan that an entity (organization, jurisdiction, State, etc.) maintains for responding to any hazard event. It provides action guidance for management and emergency response personnel, during the response phase of Comprehensive Emergency Management.

**Emergency Support Function (ESF):** As defined in the National Response Framework, an ESF refers to a group of capabilities of Federal departments and agencies to provide the support, resources, program implementation, and services that are most likely to be needed to save lives, protect property, restore essential services and critical infrastructure, and help



victims return to normal following a national incident. An ESF represents the primary operational level mechanism to orchestrate activities to provide assistance to State, Tribal, or local governments, or to Federal departments or agencies conducting missions of primary Federal responsibility.

**Event:** A scheduled non-emergency activity (e.g., sporting event, concert, parade, etc.). (NIMS)

**Federal:** Of or pertaining to the Federal Government of the United States of America.

**Finance/Administration Section:** The ICS functional area that addresses the financial, administrative, and legal/regulatory issues for the incident management system. It monitors costs related to the incident and provides accounting, procurement, time recording, cost analyses, and overall fiscal guidance.

**Functional Area:** A major grouping of the similar tasks that agencies perform in carrying out incident management activities. These are usually all or part of one of the five ICS sections (Command, Operations, Logistics, Planning, Finance/Administration).

**Function:** The five major activities in the Incident Command System: Command, Operations, Planning, Logistics, and Finance/Administration. Intelligence is not considered a separate function under traditional ICS but has been added for consideration as a possible separate function under NIMS. The term function is also used when describing the activity involved (e.g., the Planning function). (adapted from NIMS)

**General Staff:** A group of incident management personnel organized according to function and reporting to the Incident Commander. The General Staff normally consists of the Operations Section Chief, Planning Section Chief, Logistics Section Chief, and Finance/Administration Section Chief. An Intelligence/Investigations Chief may be established, if required, to meet incident management needs. (NIMS)

**Hazard:** A potential or actual force, physical condition, or agent with the ability to cause human injury, illness, and/or death, and significant damage to property, the environment, critical infrastructure, agriculture and business operations, and other types of harm or loss.

**Hazard Vulnerability Analysis (HVA):** A systematic approach to identifying all hazards that may affect an organization, assessing the risk (probability of hazard occurrence and the consequence for the organization) associated with each hazard and analyzing findings to create a prioritized comparison of hazard vulnerabilities. The consequence, or vulnerability, is related to both the impact on organizational function and the likely service demands created by hazard impact.

**Healthcare Coalition:** As used in this handbook, a group of individual healthcare organizations in a specified geographic area that agree to work together to enhance their response to emergencies or disasters. The Healthcare Coalition, being composed of relatively independent organizations that voluntarily coordinate their response, does not conduct command or control. Instead, the Coalition operates consistent with Multiagency Coordination System (MAC System) principles to support and facilitate the response of its participating organizations.

**Healthcare Coalition Notification Center (or Coalition Notification Center):** As used in this handbook, the entity that provides notification services for the Coalition. Requirements include 24/7 staffing and appropriate technologies to support the notification activities. The Coalition Notification Center remains operational during incident operations and is folded under the Operations Section. Establishing independent notification center capabilities can be expensive and existing capabilities (usually private sector) are often the best option for adopting this responsibility.

**Incident:** An actual or impending hazard impact, either human caused or by natural phenomena, that requires action by emergency personnel to prevent or minimize loss of life or damage to property and/or natural resources. An incident is an unplanned occurrence.

***Incident Action Plan (IAP):*** The document in ICS that guides the response for that operational period. It contains the overall incident objectives and strategy, general tactical actions, and supporting information to enable successful completion of objectives. The IAP may be oral or written. When written, the IAP may have a number of supportive plans and information as attachments (e.g., traffic plan, safety plan, communications plan, and maps). There is only one IAP at an incident. All other “action plans” are subsets of the IAP and their titles should be qualified accordingly. For example, the jurisdiction primarily impacted usually develops the IAP. Action plans developed below the level of the jurisdiction may be referred to as “Operations Plans”. (e.g., individual Hospital Operations Plans)

***Incident Commander (IC):*** The individual responsible for all incident activities, including the development of strategies and tactics and the ordering and the release of resources. The IC has overall authority and responsibility for conducting incident operations and is responsible for the management of all incident operations at the incident site. (adapted from NIMS)

***Incident Command System (ICS):*** The combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources for emergency incidents. It may be used for all emergencies and has been successfully employed by multiple response disciplines. ICS is used at all levels of government (local, State, Tribal, and Federal) to organize field level operations. (adapted from NIMS)

***Incident Command Post (ICP):*** The physical location close to the incident site (or elsewhere for a diffuse incident or one with multiple sites), which serves as a base location for managing tactical or “field operations.” Located within the ICP are designated representatives of the major response agencies for the incident, who fill positions in the incident command team. The ICP location is designated by the Incident Commander.

***Incident Management Team (IMT):*** The Incident Commander and appropriate Command and General Staff personnel assigned to an incident.

**Incident Objectives:** Statements of guidance and direction necessary for selecting appropriate strategy(s) and the tactical direction of resources. Incident objectives are based on realistic expectations of what can be accomplished when allocated resources have been effectively deployed. Incident objectives must be achievable and measurable, yet flexible to allow for strategic and tactical alternatives. (adapted from NIMS)

**Joint Information Center (JIC):** A center established to coordinate the public information activities for a large incident. It is the central point of contact for all news media at the scene of the incident. Public information officials from all participating Federal agencies collaborate at the JIC, as well as public information officials from participating State and local agencies. (adapted from NIMS)

**Jurisdictional Agency:** The agency having jurisdiction and responsibility for a specific geographical area or a mandated function. Usually, this is a public agency representing a local, State, or Federal government that has direct authority for emergency response and recovery. (adapted from NIMS)

**Jurisdiction:** A political subdivision (Federal, State, county, parish, and/or municipality) with the responsibility for ensuring public safety, health, and welfare within its legal authorities and geographic boundaries. In the context of this handbook, it refers to a geographic area's local government, which commonly has the primary role in emergency response.

**Liaison:** In ICS, it is a position(s) assigned to establish and maintain direct coordination and information exchange with agencies and organizations outside of the specific incident's ICS structure. (adapted from NIMS)

**Liaison Officer:** A member of the Command Staff responsible for filling the senior liaison function with representatives from cooperating and assisting agencies or organizations (NIMS)

**Logistics Section:** The ICS functional section that provides resources and other support services to incident management, operations, and the other ICS sections. (adapted from NIMS)

**Management by Objectives:** In the ICS, this is a proactive management activity that involves a four-step process to achieve the incident goal. The steps are: establishing the overarching incident objectives; developing and issuing assignments, plans, procedures, and protocols; establishing specific, measurable objectives for various incident command functional activities and directing efforts to fulfill them, in support of defined strategic objectives; and documenting results to measure performance and facilitate corrective action. (adapted from NIMS)

**Management Meeting:** In the incident management process, the meeting that establishes (or revises) the incident goals and objectives and the makeup of the ICS structure. NIMS does not separate this meeting from the Planning meeting, although they are commonly separated in wildland fire and Urban Search and Rescue incident management.

**Mass Casualty Incident:** An incident that generates a sufficiently large number of casualties whereby the available healthcare resources, or their management systems, are severely challenged or unable to meet the healthcare needs of the affected population.

**Mass Effect Incident:** An incident that primarily affects the ability of an organization to continue its normal operations. For healthcare organizations, this can disrupt the delivery of routine healthcare services and hinder their ability to provide needed surge capacity. For example, a hospital's ability to provide medical care to the victims of an earthquake is compromised if it must focus on relocating current patients because a section of the facility was destroyed.

**Measures of Effectiveness:** Defined criteria for determining whether satisfactory progress is being accomplished toward achieving the incident objectives. Similarly, defined criteria can also be utilized to establish the effectiveness of the overall Emergency Management Program in meeting its defined goals across the four phases.

**Medical Surge:** Describes the ability to provide adequate medical evaluation and care in events that severely challenge or exceed the normal medical infrastructure of an affected community (through numbers or types of patients).

**Memorandum of Agreement:** A Memorandum of Agreement (MOA) defines the general area of conditional agreement between two or more parties, but one party's action depends on the other party's action. The MOA can be complemented with support agreements that detail reimbursement schedules and specific terms and conditions. (adapted from FEMA's National Preparedness Directorate, Memorandum of Agreement/Memorandum of Understanding Template and Guidance; March 2009)

**Memorandum of Understanding:** A formal document embodying the firm commitment of two or more parties to an undertaking, and setting out its general principles, but falling short of constituting a detailed contract or agreement. (Oxford Dictionary of Law, 2006)

**Mitigation:** Activities designed to reduce or eliminate risks to persons or property or to lessen the actual or potential effects or consequences of a hazard. Mitigation involves ongoing actions to reduce exposure to, probability of, or potential loss from hazards. Examples include zoning and building codes, floodplain buyouts, and analysis of hazard-related data to determine where it is safe to build or locate temporary facilities. Mitigation can include efforts to educate governments, businesses, and the public on measures they can take to reduce loss and injury. (adapted from NIMS)

**Mobilization:** Activities and procedures carried out that ready an asset to perform incident operations according to the Emergency Operations Plan. During the response phase of Comprehensive Emergency Management, it is the stage that transitions functional elements from a state of inactivity or normal operations to their designated response state. This activity may occur well into the response phase, as additional assets are brought on line or as surge processes are instituted to meet demands.

***Multiagency Coordination Group (MAC Group):*** According to NIMS, a group of administrators or executives or their appointed representatives who are typically authorized to commit agency resources and funds. A MAC Group can provide coordinated decision-making and resource allocation among cooperating agencies and may establish the priorities among incidents, harmonize agency policies, and provide strategic guidance and direction to support incident management activities.

***Multiagency Coordination System (MAC System):*** According to NIMS, the primary function of a MAC System is to coordinate activities above the field level and to prioritize the incident demands for critical or competing resources, thereby assisting the coordination of operations in the field. (NIMS)

***Multijurisdictional Incident:*** An incident that extends across political boundaries and/or response disciplines, requiring action from multiple governments and agencies to manage certain aspects of an incident. These incidents may best be managed under Unified Command. (adapted from NIMS)

***Mutual Aid Agreement:*** Written instrument between agencies and/or jurisdictions in which they agree to assist one another upon request, by furnishing personnel, equipment, supplies, and/or expertise in a specified manner. An “agreement” is generally more legally binding than an “understanding.”

***National Incident Management System (NIMS):*** A system mandated by HSPD-5 that provides a consistent nationwide approach for Federal, State, Tribal, and local governments, the private sector, and nongovernmental organizations to work effectively and efficiently together to prepare for, respond to, and recover from domestic incidents, regardless of cause, size, or complexity. To provide for interoperability and compatibility among Federal, State, and local capabilities, NIMS includes a core set of concepts, principles, and terminology. HSPD-5 identifies these as the Incident Command System; multiagency coordination systems; unified command; training; identification and management of resources (including systems for classifying types of resources); qualifications and certifications; and the collection, tracking, and reporting of incident information and incident resources. (adapted from NIMS)

**Operations Section:** The ICS functional area responsible for all resources and activities that directly address the incident objectives. It develops all tactical operations at the incident, and in ICS, includes branches, divisions and/or groups, Task Forces, Strike Teams, Single Resources, and Staging Areas. As an example, if a Healthcare Coalition decides that one of its response objectives is Coalition notifications, then this function would reside within the Operations Section.

**Participating Organization:** As used in this handbook, any healthcare organization that provides point of service care that has agreed to participate in the preparedness and response activities of a Healthcare Coalition. The minimum commitment is participation in both preparedness and response meetings and providing response information when requested.

**Planning (incident response):** Activities that support the incident management process, including completing the incident action plan and support plans and accomplishing incident information processing. This is in contrast to preparedness planning, which is designed to ready a system for response.

**Planning Meeting:** A meeting held as needed throughout the duration of an incident to select specific strategies and general tactics for incident operations and for service and support planning. In the incident management process, the planning meeting establishes strategy and priorities based upon the goals and objectives developed in the management meeting. Remaining decisions for the action plan are achieved during this meeting. (adapted from NIMS)

**Planning Section:** In ICS, this functional area is responsible for the collection, evaluation, and dissemination of operational information related to the incident and for the preparation and documentation of the incident action plan and its support plans. The Planning Chief is responsible for running the management and planning meetings and the operations briefing, and the Planning Section supports these activities. The Planning Section also maintains information on the current and forecasted situation, the status of resources assigned to the incident, and other incident information. (adapted from NIMS)



**Preparedness:** The range of deliberate, critical tasks and activities necessary to build, sustain, and improve the capability to protect against, respond to, and recover from hazard impacts. Preparedness is a continuous process. Within NIMS, preparedness involves efforts at all levels of government and the private sector to identify threats, to determine vulnerabilities, and to identify required response plans and resources. NIMS preparedness focuses on establishing guidelines, protocols, and standards for planning, training and exercise, personnel qualifications and certification, equipment certification, and publication management. (adapted from NIMS)

**Preparedness Organization:** An organization that provides coordination for emergency management and incident response activities before a potential incident. These organizations range from groups of individuals to small committees to large standing organizations that represent a wide variety of committees, planning groups, and other organizations (e.g., Citizen Corps, Local Emergency Planning Committees, Critical Infrastructure Sector Coordinating Councils). (NIMS)

**Prevention:** Actions to avoid a hazard occurrence or to avoid or minimize the hazard impact (consequences) if it does occur. Prevention involves actions to protect lives and property. Under HSPD-5, it involves applying intelligence and other information to a range of activities that may include such countermeasures as deterrence operations; heightened inspections; improved surveillance and security operations; investigations to determine the full nature and source of the threat; public health and agricultural surveillance and testing processes; immunizations, isolation, or quarantine; and as appropriate specific law enforcement operations aimed at deterring, preempting, interdicting, or disrupting illegal activity and apprehending potential perpetrators and bringing them to justice. (adapted from NIMS)

**Private Sector:** Organizations and entities that are not part of any governmental structure. It includes for-profit and not-for-profit, and formal and informal structures, including commerce and industry, non-governmental organizations, and private voluntary organizations. (adapted from NIMS)

**Processes:** Systems of operations that incorporate standardized procedures, methodologies, and functions necessary to effectively and efficiently accomplish objectives. (adapted from NIMS)

**Public Health Emergency:** Defined by the Model State Emergency Health Powers Act (MSEHPA): An occurrence or imminent threat of an illness or health condition that is believed to be caused by: (1) bioterrorism; (2) the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin; (3) a natural disaster; (4) a chemical attack or accidental release; or (5) a nuclear attack or accident. It must pose a high probability of a large number of deaths in the affected population, or a large number of serious or long-term disabilities in the affected population, or widespread exposure to an infectious or toxic agent that poses a significant risk of substantial future harm to a large number of people in the affected population. (The Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities)

**Public Information Officer:** Official at headquarters or in the field responsible for preparing and coordinating the dissemination of public information in cooperation with other responding Federal, State, Tribal, and local agencies. In ICS, the term refers to a member of the Command Staff responsible for interfacing with the public and media and the Joint Information Center.

**Recovery:** The phase of Comprehensive Emergency Management that encompasses activities and programs implemented during and after response that are designed to return the entity to its usual state or to a "new normal." For response organizations, this includes return to readiness activities.

**Resiliency:** The ability of an individual or organization to quickly recover from change or misfortune.

**Resources:** All personnel and major items of equipment, supplies, and facilities available, or potentially available, for assignment to incident or event tasks on which status is maintained.

**Response:** Activities that address the direct effects of an incident. Response includes immediate actions to save lives, protect property, and meet basic human needs. Response also includes the execution of emergency operations plans as well as activities designed to limit the loss of life, personal injury, property damage, and other unfavorable outcomes. As indicated by the situation, response activities may include applying intelligence and other information to lessen the effects or consequences of an incident; increased security operations; continuing investigations into the nature and source of the threat; ongoing public health and agricultural surveillance and testing processes; immunizations, isolation, or quarantine; and specific law enforcement operations aimed at pre-empting, interdicting, or disrupting illegal activity and apprehending actual perpetrators and bringing them to justice. (adapted from NIMS)

**Response Organization:** A response organization provides a structure and functions to manage emergency decision-making, decision implementation, and overarching coordination of resources and actions in the emergency context. Response organizations can include entities that conduct response management for a larger organization (private and for-profit or not-for profit), an agency or department, a government jurisdiction, or a collection of like organizations such as a Healthcare Coalition or a regional response center. Most response organizations are organized under NIMS as an Incident Management Team or as a Multiagency Coordination System. (ICDRM/GWU Emergency Management Glossary of Terms, Available at: [www.gwu.edu/~icdrm/](http://www.gwu.edu/~icdrm/))

**Safety Officer:** A member of the Command Staff responsible for monitoring and assessing safety hazards or unsafe situations and for developing measures for ensuring personnel safety. The Safety Officer may have assistants.

**Span of Control:** The number of individuals a supervisor is responsible for, usually expressed as the ratio of supervisors to individuals (under NIMS, an appropriate span of control is

between 1:3 and 1:7). (adapted from NIMS)

**Senior Policy Group:** As used in this handbook, a MAC Group consisting of executives, senior administrators, or their designees from participating organizations in a Healthcare Coalition. The Senior Policy Group provides strategic guidance to the HCRT, among other things, and is convened only as needed.

**State:** When capitalized, refers to any State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, and any possession of the United States. (as defined in section 2 (14) of them Homeland Security Act of 2002, Pub. L. 107-296, 116 Stat. 2135, et seq.(2002).)

**Strategic:** Strategic elements of incident management are characterized by continuous long-term, high-level planning by senior level organizations. They involve the adoption of long-range goals and objectives; the setting of priorities; the establishment of budgets and other fiscal decisions; policy development; and the application of measures of performance or effectiveness. (adapted from NIMS)

**Strategy:** The general plan or direction selected to accomplish incident objectives. (NIMS)

**Surge Capability:** The ability to manage patients requiring unusual or very specialized medical evaluation and care. Requirements span the range of specialized medical and public health services (expertise, information, procedures, equipment, or personnel) that are not normally available at the location where they are needed. It also includes patient problems that require special intervention to protect medical providers, other patients, and the integrity of the healthcare organization.

**Surge Capacity:** The ability to evaluate and care for a markedly increased volume of patients – one that challenges or exceeds normal operating capacity. Requirements may extend beyond direct patient care to include other medical tasks, such as extensive laboratory studies or epidemiologic investigations.

**System:** A clearly described functional structure, including defined processes, that coordinates otherwise diverse parts to achieve a common goal.

**Tactical:** Tactical elements of ICS are characterized by the execution of specific actions or plans in response to an actual incident or, prior to an incident, the implementation of individual or small unit activities, such as training or exercises.

**Tactics:** The deployment and directing of resources on an incident to accomplish the objectives designated by strategy. (NIMS)

**Terrorism:** Any premeditated, unlawful act dangerous to human life or public welfare that is intended to intimidate or coerce civilian populations or governments (National Strategy for Homeland Security, July 2002). It includes activity potentially destructive of critical infrastructure or key resources. It is a violation of the criminal laws of the United States or of any State or other subdivision of the United States in which it occurs. It can include activities to affect the conduct of a government by mass destruction, assassination, or kidnapping. (Section 2 (15), Homeland Security Act of 2002, Pub. L. 107-296, 116 Stat. 2135, (2002).)

**Threat:** An indication of possible violence, harm, or danger. (adapted from NIMS)

**Unified Command:** An application of ICS used when there is more than one agency with incident jurisdiction. Agencies work together through their designated Incident Commanders or Managers at a single location to establish a common set of objectives and strategies and a single incident action plan. (adapted from NIMS)

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