Partnering to Achieve Rural Emergency Preparedness:
A Workbook for Healthcare Providers in Rural Communities

I. Executive Summary

It is vital for healthcare providers and organizations in rural areas to have all-hazards emergency plans in place and be involved in community-wide, integrated emergency planning and response efforts. The purpose of this workbook is to provide an interactive, user-friendly tool to assist Rural Health Clinics and rural-based hospitals, Community Health Centers and Migrant Health Centers in: 1) creating an all-hazards emergency plan, 2) updating or expanding an existing plan, 3) strengthening collaborations with emergency planning and response partners, and 4) encouraging the integration and coordination of emergency response plans, planning efforts, and other activities.

Effective emergency planning requires a team effort**.** It is important to communicate and network with all parties involved in preparedness planning within your town, county, surrounding towns and counties and region to improve collaboration. Coordinated planning efforts and integrated planning involves both horizontal and vertical coordination and integration. Coordinated efforts may include creating Memorandums of Understanding, joint planning, integrating plans, joint training and exercising of plans, working collaboratively to decrease conflict and mistrust and creating a culture of preparedness in your community.

There are four phases in a disaster: prevention or mitigation, preparedness, response and recovery. Prevention or mitigation activities lessen the severity and impact a potential disaster, large-scale outbreak or other emergency might have on a health center's operations. Efforts established prior to an event will lessen the probability of an incident occurring or minimize effects of an incident. Prevention activities include conducting a Hazard Vulnerability Assessment and a Clinic Readiness Assessment and being aware of and responsible for disease surveillance and reporting functions.

Preparedness or planning activities build capacity and identify resources that may be used should a disaster or emergency occur. These efforts are undertaken to enhance the response capabilities in order to effectively handle an emergency. Preparedness includes the creation of plans that will protect staff, patients, and the facility while serving the community. The preparedness phase assures that you are ready to deal with a disaster in your area from the onset. Preparation includes training and exercises as well as reviewing and updating existing plans to fit changing needs. It is essential that healthcare organizations as well as their staff have role assignments and the opportunity practice those roles and associated responsibilities prior to the occurrence of a disaster through an exercise. Communications are important during the preparedness phase, which includes having multiple communications methods or modalities; ability to notify and reach healthcare staff during an emergency; communicating with patients and the public to ensure they are prepared, know what to expect and have their own home/family emergency plan in place; and locating at-risk, vulnerable populations. Healthcare organizations should also have

plans in place for triage, surge capacity, continuity of operations, Alternate Care Sites, Point of Distribution sites, hospital / clinic security, volunteers and the mental health needs of the staff, patients, their families, first responders and the community-at-large.

Response refers to the actual emergency and controls the negative effects of emergency situations. Response efforts occur during an event to improve the outcome through a comprehensive, well-developed and practiced plan that will activate needed resources within the emergency response system. This includes actions taken to save lives and prevent further property damage in an emergency situation. The response phase addresses the immediate unmet needs of the affected population. Some of the important elements of the response phase are communication with staff, media, public, patients and their families, triage, surge capacity, patient tracking and transportation, infection control and decontamination, isolation and quarantine and laboratory response. Additionally, legal, liability and ethical considerations exist, which hospitals, clinics and health centers should discuss with both internal and external partners prior to the occurrence of an incident. Other aspects of the response phase include financial tracking, acquiring resources, hospital / clinic security, securing mental health services for patients and staff, and managing volunteers and donations.

Recovery actions should begin almost concurrently with response activities and are directed at restoring essential services and resuming normal operations. Recovery planning should be considered an essential aspect to sustaining the long term viability of the hospital, clinic or health center. Short-term recovery will allow the healthcare providers to resume a business as usual posture. Long-term recovery may take months or years to complete. Rural healthcare organizations should track disaster-related expenses during the response phase and account for damages or losses during the recovery phase to maintain financial viability. Mental health needs of patients and staff are likely to persist or appear for the first time after federal, state and voluntary mental health resources have left the community. It is important to monitor behavioral health needs and make referrals in the recovery phase. Healthcare services should be restored and resumed as soon as possible and efforts should be made in each phase to ensure operations are reestablished quickly. Undergoing a structured de-briefing process, or After Action Review, following an exercise or an actual emergency can provide organizations and communities with vital information to help them improve their response for the next exercise or actual event.

All public health experts agree that a pandemic influenza is inevitable and to some extent, everyone will be affected by the pandemic. Due to the impact pandemic influenza will have on communities worldwide, rural healthcare organizations must incorporate pandemic plans into their all-hazard disaster plans. This workbook identifies pandemic influenza considerations that rural healthcare providers and organizations should consider.

II. Introduction and Overview

Introduction

This workbook is a practical guide created to assist Rural Health Clinics and Community Health Centers, Migrant Health Centers and hospitals in rural areas that have limited healthcare resources, in preparing for and responding to emergency incidents. Because rural areas are likely to have fewer resources, rural healthcare providers and organizations are critical assets to their communities in emergencies, whether the emergencies occur within the healthcare facility, within the community or outside of the community. A particular emphasis is placed on collaborating with partners and integrating plans in this workbook, as prevention, planning, response and recovery efforts cannot take place in a vacuum.

While rural healthcare providers and organizations, such as Rural Health Clinics, Community Health Centers, Migrant Health Centers and rural hospitals may lack the time, personnel and financial resources to become involved in the planning process, no jurisdiction is immune to emergencies. Whether it is a tornado or hurricane, a hazardous spill from a train or truck passing through, a pandemic flu outbreak or an influx of evacuees fleeing an urban-based emergency, your community will count on your clinic or hospital to be ready. Roles and responsibilities might include caring for sick or injured, pacifying the worried well, volunteering your staff for a surge of patients or your facility for triage, providing decontamination or infection control, operating an Alternate Care Site or Point of Distribution (POD) site, or reaching special, vulnerable populations and providing culturally competent and linguistically proficient providers and support staff.

In fact, the HRSA Bureau of Primary Health Care has issued a draft Program Information Notice (PIN) that all Community Health Centers, Migrant Health Centers, Federally Qualified Health Center Look-Alikes, Health Care for the Homeless, and Public Housing Primary Care Programs adhere to standards for emergency management. This PIN, *Emergency Management Program Expectations*, recognizes that "health centers play an important role in delivering critical services and assisting local communities during an emergency. To do so, they must be adequately prepared to deal with emergencies and should be fully integrated into the local emergency planning and response." These standards, which are a condition of their grant, include the following components:

- Health Center should develop and implement an emergency management plan based on a thorough risk assessment, such as a Hazard Vulnerability Analysis.
- All Health Center staff are strongly encouraged to be National Incident Management System (NIMS) compliant and have an all hazards command structure, such as standard Incident Command System (ICS), that links with the community's command structure.
- Health Centers should have policies and procedures for communicating with Federal, State, and local agencies, staff, patients (including special populations), and the public during emergencies (redundant communication systems).

- Health Centers should collaborate with State and local agencies, health care and community organizations.
- Health Centers should provide requested/required data to Federal, State and local agencies during emergencies to the extent possible.
- The Health Center's business plan should address financial recovery measures and maintaining financial viability in the event of an emergency

Source: Draft HRSA Program Information Notices (PINs), *Emergency Management Program Expectations*, http://bphc.hrsa.gov/draftsforcomment/emergencymanagement.htm

This workbook is a revision of and variation on the guidance document, *Development of Regional Emergency Response Plans for Rural Health Care Systems*, developed in 2005 for rural counties without hospitals in the State of Texas. This original document was a component of the *Rural Ready Communities* project, a collaboration between the Texas Department of State Health Services (DSHS), the School of Rural Public Health (SRPH) at the Texas A&M Health Science Center and the Texas Institute for Health Policy Research (TIHPR).

The original document was created in part through Rural Preparedness Roundtables (RPRs) conducted with various stakeholders in the 65 Texas counties without hospitals to discuss current preparedness activities, identify "best practices" regarding successful preparedness efforts that have occurred in rural communities, and gain a rural perspective for preparedness planning and response activities. Most of the best practices and lessons learned, unless otherwise noted, were gathered from rural Texas community members.

Target Audience

The target audience of this workbook includes Rural Health Clinics and rural-based hospitals, Community Health Centers, and Migrant Health Centers. These entities are commonly the only providers of healthcare services in rural areas and are uniquely positioned to monitor changes and trends in disease frequency and provide reports to public health departments when suspicious trends arise. Rural healthcare providers and organizations have assets and resources that are critical in emergencies and they have or can develop linkages with local and/or regional hospitals for additional resources, including personnel, equipment, supplies, and pharmaceuticals.

These entities have a strong community presence. Rural healthcare organizations, such as Community Health Centers and Migrant Health Centers, frequently serve and have linkages to special, underserved populations that might not be English proficient or might be more difficult to reach in an emergency situation. The language skills, cultural competency and ability to reach underserved clients, neighborhoods and communities is a particularly valuable resource.

While the focus of the original document was limited to rural Texas, this workbook should be applicable to rural areas throughout the United States.

What are the special attributes or assets of your healthcare organization that can help your community's disaster planning?

Outcomes of Using this Workbook

The desired outcome of this workbook is that the target audience will utilize the guidelines, tools, best practices and resources to: 1) create an all-hazards emergency plan for those that do not have one, 2) update and/or expand an existing emergency plan, 3) strengthen collaborations with local, regional and state partners, and 4) encourage the integration and coordination of emergency response plans, planning efforts, and other activities.

This workbook is not meant to provide a step-by-step, how-to for developing a rural healthcare organization's emergency plan, as there are existing resources that provide clinic emergency plan templates (see California Primary Care Association Clinic Emergency Preparedness at: www.cpca.org/resources/cepp/ and Community Health Care Association of New York State Community Health Center Emergency Management Plan at: www.chcanys.org/index.php?src=gendocs&link=ep_forcenters&category=Main). Rather, this workbook will provide descriptions of topics rural healthcare providers and organizations should consider in preventing, planning for, responding to and recovering from emergency incidents, what their role might be in such a situation and possible considerations or items that should be discussed with partners. Various resources and tools are included that can be incorporated into a new or existing plan. Best practices and lessons learned that have been identified through other rural communities' experiences are also included to learn from, provide discussion items, and apply new or change existing practices or strategies where appropriate.

How would you like to use this workbook? Name three activities you would like to accomplish or people with whom you would like to create or strengthen relationships.

1.

2.

3.

Why Collaborative Planning?

A common misconception among many jurisdictions has been that an immediate state and federal level response will occur if there is a disaster. This may well be the case in the advent of a catastrophic incident, where there is usually sufficient forewarning of the impact to activate and mobilize state and federal assets for an almost immediate response into the disaster area. However, most disasters will not have an immediate state or federal response, particularly if there is no notice or if a large-scale incident occurs where resources are unavailable. Further, more recent experiences have told us that, even with forewarning, communities ***must*** be prepared at the local level. *Most disasters will not have an immediate state or federal response*. Collaborative planning leads to increased availability of resources, sharing of responsibility, expertise and skills, better communication, helps eliminate duplication of efforts, improves consistency of information and results in a more effective and efficient response.

It has been repeatedly demonstrated that pre-planning and exercising saves time in getting operations underway, facilitates integrated effort, and helps ensure that essential activities are carried out efficiently. Rural healthcare providers and organizations play a critical role in the planning for an emergency incident and must coordinate their planning with local and regional public health, local government, emergency management, local and regional hospitals and other resources within the emergency management and healthcare system. A properly prepared and integrated emergency response plan will provide responding entities with a clear understanding of each individual's and entity's role and the expectations you have for one another in a community-wide response.

> In your local jurisdiction, make sure you know what is expected of your staff and facility. If an emergency manager or local official expects your organization to play a role, make sure you know what that role is.

Much of the federal funding for emergency preparedness and response is going to urban areas. The key to successful prevention, preparedness, response and recovery for rural areas is in strong partnerships and collaboration. This might include the development of joint protocols and Memorandums of Understanding and participating in collaborative activities such as training and exercises.

It is essential that rural healthcare providers and organizations understand the emergency management system at the State, regional and local levels. You should establish relationships with key decision makers and understand how to effectively navigate State, regional and local systems to obtain needed resources well in advance of an emergency. Your organization should collaborate with state, regional and local emergency management agencies, professional volunteer registries housed in State Departments of Health, emergency medical services systems, public health departments, hospitals, mental health agencies, penal institutions, national organizations, State Primary Care Associations and other primary care organizations.

Rural healthcare providers and organizations should also be prepared to work with organizations that may not be part of their usual network. These include local businesses, law enforcement, fire services, schools, and faith-based organizations. Your organization is encouraged to develop a plan describing how they will respond and recovery from emergencies as well as how they will work with local, regional and State communities and integrate their efforts and plans with their own.

Rural Health Perspective: Challenges and Benefits

In the United States, 2,305 or 76% of our nation's 3,043 counties are rural. Eighty-three percent of our nation's land is in a rural area. Twenty-five percent of our nation's population resides in a rural area. Rural communities face challenges and limitations not faced by urban communities that impact the manner in which they are able to respond to emergencies such as natural disasters and other public health emergencies. Challenges faced by rural communities include geographic location, personnel, infrastructure, communications, and funding. These challenges will be discussed separately in the sections which follow, but are closely interrelated and dependent upon each other. Also discussed below are some of the benefits to rural communities in preparing for and responding to emergencies.

Rural Challenges and Limitations

Geographical Challenges:
Rural areas, by definition, are widely dispersed throughout the United States. Rural communities may be geographically quite distant from major urban areas, and even from other large rural communities. These challenges are compounded when one considers that the great majority of the U.S. international border is located in rural areas, creating special emergency preparedness challenges. Other geographic challenges may include broad deserts, mountain ranges, rivers and marshy areas which make travel and communication difficult.

While geographic isolation may have some benefits, it may also introduce a level of complacency. Most rural residents feel relatively safe and at a lower risk from terrorism or large scale disaster scenarios as compared to their urban counterparts. Exceptions are in communities near nuclear or hydroelectric plants. Complacency reduces the community's sense of urgency in emergency preparedness. Rural hospital and clinic administrators in particular express ambivalence about investing time and resources into emergency preparedness, when they face other pressures in finance, staffing, quality and regulatory compliance.

Personnel Challenges:
Rural communities in the United States face unique personnel restrictions which most urban areas do not encounter. Rural communities often find it difficult to attract qualified personnel and as a result, shortages in healthcare personnel are more severe. To make up for these shortages, rural communities often rely heavily on volunteer first responders and other part-time help or share healthcare staff with other neighboring communities. Highly specialized staffs such as epidemiologists and laboratory technicians are extremely difficult to recruit and have

historically been deployed by a state health department on an 'as-needed' basis. Consequently, professional and volunteer staff in rural communities may also have limited experience with large-scale disasters, emergencies, surveillance or outbreak monitoring. This inexperience is particularly widespread in rural local public health departments, hospital and clinic staff, first responders, mental health providers, and even among Red Cross and other volunteers.

The dispersed nature of rural communities also creates special challenges for training personnel. In order to 'fill a class,' training programs must be held in central areas that may require participants to travel much greater distances than their urban counterparts. During their absence, backup personnel to cover the workload are scarce. Time and distance also impacts the ability of rural health professionals to interact with and develop close working relationships with urban counterparts. In addition, many rural public health offices have limited hours of operation, and too few staff to provide "deep" on-call coverage in case of emergencies.

Infrastructure Challenges:
Public health and health care infrastructure also presents special challenges to rural communities. Across the nation, rural communities differ from their urban and suburban counterparts in a number of ways. For example, emergency first responders are often volunteer-based and have less advanced training on HAZMAT equipment utilization and repair and less advanced preparedness education. As a result, the ability to decontaminate, isolate, and quarantine even small numbers of people, much less large numbers, is very limited. Decontamination capacity is severely limited in rural hospitals and clinics and there is virtually no local experience with decontaminating procedures, with the exception of rural communities located near nuclear plants.

Due to limited numbers of facilities, rural communities lack the ability to respond to "surge capacity" or accommodate large numbers of patients. This is especially true in communities served by Critical Access Hospitals, which downsized to minimum levels of emergency and inpatient capacity and staff. Urban flight or the rapid exodus of people from urban areas to safer rural communities during emergency incidents would simply exacerbate an already serious capacity issue. Many counties and local jurisdictions throughout the United States do not have a hospital. In these rural areas, primary care is most frequently delivered through Community Health Centers, Rural Health Clinics and isolated practitioners that may not be formally part of emergency preparedness planning.

Communications:
Communications also present a special challenge to rural communities. Rural public health and health services offices often suffer serious deficiencies in reliable and redundant information and communication systems. While many rural communities were among the first to use distance technologies in healthcare and communication, some forms of communication are not available or simply do not work. Some rural areas still lack internet capacity, which could support notification in the event of a health alert or bioterrorism emergency. Other rural areas find that phone service is limited. Some rural public health facilities are still reliant on rotary phones and cell phone coverage is very limited in many rural areas.

Funding:
The Rural Health System is also strained by its ability to absorb "unfunded mandates." In general, the fiscal status of rural hospitals, health systems, and local health departments are more fragile and less elastic than their urban counterparts. There are fewer financial and staff resources to employ in order to comply with the numerous federal and state-level emergency preparedness activities. Scant (if any) resources actually reach the rural communities, which must devote untold numbers of staff time and energy to emergency preparedness. While most rural communities recognize the importance of emergency preparedness, some emergency preparedness planning and associated activities are viewed as an "unfunded mandate" in many rural communities.

In summary, rural communities face significant challenges. Rural communities have smaller public health departments (if they have one at all), with less capacity, fewer resources, including electronic communication capabilities. Rural emergency medical services often rely on volunteers and are less likely to have a sufficient number of well-equipped ambulances, HAZMAT equipment and other adequate life support equipment. There are likely to be fewer heath care providers overall and, specifically, few specialists such as mental health professionals, infectious disease specialists or burn care physicians.

Rural hospitals are less likely to have surge capacity because of their relatively small size and recent pressures to downsize. The paradigm of rural hospital emergency departments is often to stabilize and transfer, depending on larger facilities to provide a higher level of care. Rural clinics frequently don't have the equipment to stabilize a patient and are therefore bypassed completely. Rural communities are also located at greater distances from needed resources and these distances can delay assistance. The challenges faced by rural communities, which are not shared by urban centers, may affect their ability to prepare for or react in an emergency and will likely necessitate different strategies for preparation and response.

Rural Benefits and Assets

Community Members & Relationships:
Members of rural communities are often required be particularly creative due to lack of resources when addressing emergency preparedness issues. However, rural communities have coped effectively with disasters in the past and will continue to meet the challenges of responding to new types of emergencies such as bioterrorism or other public health threats, utilizing the resources that are unique to rural areas. Rural communities appear to have stronger relationships and denser networks, as exhibited between and among the community members and the organizations within the community, such as the schools and churches. The community members themselves are considered the most valued asset. Despite personnel shortages, community members are willing to spend their free time helping the community through volunteer activities. In rural communities, most Emergency Medical Service providers and fire department positions are held by volunteers.

Community members, particularly in rural areas, must be the driving force in not only developing the plan, but also in continually updating the plan, tapping into existing planning structures, exercising the plan and sustaining the interest and commitment of those involved. With fewer human resources in rural communities, residents cannot necessarily rely on "professionals" to assume planning responsibilities. Because the community as a whole depends upon one another for the common good, residents hold one another accountable. This accountability and trust in each other help facilitate the planning process. Many rural residents wear multiple hats, with the same individuals taking part in various committees and community projects. These shared associations help facilitate better collaboration and cooperation. Common membership in organizations such as PTA, PTO, faith-based organizations and committees, athletic leagues, and civic organizations also encourage communication and the dissemination of information. Key stakeholders, or those known for "getting things done," are easily identified in rural communities. This designation carries with it a credibility that allows the key stakeholders to lead, delegate and/or accomplish necessary tasks.

Communications:
Despite the communication and technology barriers rural communities face, there are potential advantages for a rural response in emergency situations. Historically, rural communities have relied on alternative methods of communication such as word of mouth, door-to-door notification, or the use of mega phones or PA systems in law enforcement vehicles while driving around rural areas. Typical communication systems such as land lines, cell phones, fax machines and the Internet might fail in emergency situations, in which these traditional methods would be of great value. The stronger relationships and denser networks previously mentioned would also contribute to improved communication in an emergency situation.

Disease Trends:
While health resources are often lacking in rural communities, disease trends may be more easily detected in small towns with a single practicing physician or other local health provider. If an infectious disease outbreak was to occur in a rural community, symptoms and school or work absences would be easily recognized. Illnesses occurring in an urban community, with multiple physicians and schools, might be more difficult to detect.

Name two challenges you face in emergency planning, as a rural healthcare organizations:

Name two benefits or assets you have in emergency planning, as a rural healthcare organizations:

What is an All-Hazards Approach?

An all-hazards approach allows you to provide for an effective coordination of activities among the agencies and organizations with an emergency management and response role; early warning and clear instructions to all concerned if a crisis occurs; continued assessment of actual and potential consequences of the crisis; and continuity of healthcare operations during and immediately after the crisis. Depending on where you work and live, some disasters may be more likely than others. Using an all-hazards planning approach allows you to consider all eventualities.

The U.S. Department of Health and Human Services provides resources at the websites below for various natural and man-made disasters. Additionally, the California Primary Care Association Clinic Emergency Preparedness Project created an *Emergency Preparedness Flipchart for Community Clinics & Health Centers*. The information in the flipchart is a quick reference guide for community clinics and health centers in their response to most threats, including threats of biological, chemical and radiological terrorism. This guide is not intended to serve as an exhaustive reference for all emergency situations, but rather as a starting point for emergency response. Actual responses to an emergency should be appropriate for the situation and based on the most current information available from the Centers for Disease Control and Prevention, and other emergency response sources. The flipchart can be downloaded at: www.cpca.org/resources/cepp/documents/appendices/pdf/CEPP_Appendices_H_05-24-04.pdf.

Natural Disasters

Earthquake
www.hhs.gov/disasters/emergency/naturaldisasters/earthquake/index.html
Fire or Wildfire
www.hhs.gov/disasters/emergency/naturaldisasters/fire/index.html
Flood & Dam Failure
www.hhs.gov/disasters/emergency/naturaldisasters/flood/index.html
Hurricane & High Wind
www.hhs.gov/disasters/emergency/naturaldisasters/hurricanes/index.html
Landslide
www.hhs.gov/disasters/emergency/naturaldisasters/landslide/index.html
Thunderstorm
www.hhs.gov/disasters/emergency/naturaldisasters/thunderstorm/index.html
Tornadoes
www.hhs.gov/disasters/emergency/naturaldisasters/tornadoes/index.html
Tsunami
www.hhs.gov/disasters/emergency/naturaldisasters/tsunami/index.html
Volcano
www.hhs.gov/disasters/emergency/naturaldisasters/volcano/index.html
Extreme Cold and Winter Storms
www.hhs.gov/disasters/emergency/naturaldisasters/cold/index.html

Extreme Heat
www.hhs.gov/disasters/emergency/naturaldisasters/heat/index.html

Man-made Disasters

Bioterrorism
www.hhs.gov/disasters/emergency/manmadedisasters/bioterorism/index.html
Chemical Agents
www.hhs.gov/disasters/emergency/manmadedisasters/chemical/index.html
Pandemic Influenza and Diseases
www.hhs.gov/disasters/emergency/manmadedisasters/panflu/pandemicflu.html
Radiation Emergencies
www.hhs.gov/disasters/emergency/manmadedisasters/radiation/index.html
Terrorism
www.hhs.gov/disasters/emergency/manmadedisasters/terrorism/index.html

Name two disasters that have occurred or are likely to occur in your community:

1. _____

2. _____

Workbook Format

This workbook is organized by the phases of emergency management: prevention (mitigation), preparedness, response and recovery. Within each emergency management phase are topic areas that rural hospitals and clinics should consider in collaborative planning. Each topic area includes: 1) definitions or descriptions, 2) possible rural healthcare provider or organization roles, 3) items to be discussed within your organization and among external community partners, 4) best practices and / or lessons learned and 5) related resources and practical tools.

III. Overview of Emergency Management Structure

Description

National Incident Management System (NIMS):

National Incident Management System (NIMS) was created after 9/11 to help improve coordination between the Federal, State and local government and private industry response to emergencies and to illustrate how these agencies and organizations should work together to

prepare for emergencies. It is the first-ever standardized approach to incident management and response. Developed by the Department of Homeland Security and released in March 2004, it establishes a uniform set of processes and procedures that emergency responders at all levels of government will use to conduct response operations and integrates effective practices in emergency response into a comprehensive national framework for incident management.

NIMS will enable responders at all levels to work together more effectively and efficiently to manage domestic incidents no matter what the cause, size or complexity, including catastrophic acts of terrorism and natural disasters. Federal agencies also are required to use the NIMS framework in domestic incident management and in support of state and local incident response and recovery activities.

The benefits of and expectations for NIMS compliance include:

- Standards for planning, training and exercising;
- Personnel qualification standards;
- Equipment acquisition and certification standards;
- Interoperable communications processes, procedures and systems;
- Information management systems with a commonly accepted architecture;
- Supporting technologies - voice and data communications systems, information systems, data display systems, specialized technologies; and
- Publication management processes and activities.

Source: NIMS on-line – www.nimsonline.com

Incident Command System (ICS):

Incident Command System (ICS) is an all-hazards incident management system that should be utilized in communities and healthcare organizations to result in greater efficiency, better coordination and more effective communication during emergencies. Hospital Emergency Incident Command System (HEICS) or Hospital Incident Command System (HICS) is an example of how ICS can be adapted for hospitals and healthcare organizations. NIMS compliance includes the incorporation of the ICS structure.

The Incident Command System has the following additional characteristics:

- Organization Flexibility / Modular Organization – The specific functions that are activated and their relationship to one another will depend upon the size and nature of the incident. Only those functional elements that are required to meet current objectives will be activated. A single individual may perform multiple functional elements, e.g., safety and security or finance and logistics.
- Management of Personnel / Hierarchy of Command and Span-of-Control – Each activated function will have a person in charge of it, but a supervisor may be in charge of

more than one functional element. Every individual will have a supervisor, except the Incident Manager.

ICS organizational structure is a flexible, top-down size, and varies based on the size, complexity and specifics of the incident. There is no correlation between ICS structure and the normal administrative or organizational structure, so emergency roles and responsibilities are frequently different than day-to-day. The five major management functions of ICS are Incident Command, Operations Section, Planning Section, Logistics Section and Finance/Administration Section. Command Staff is also described below.

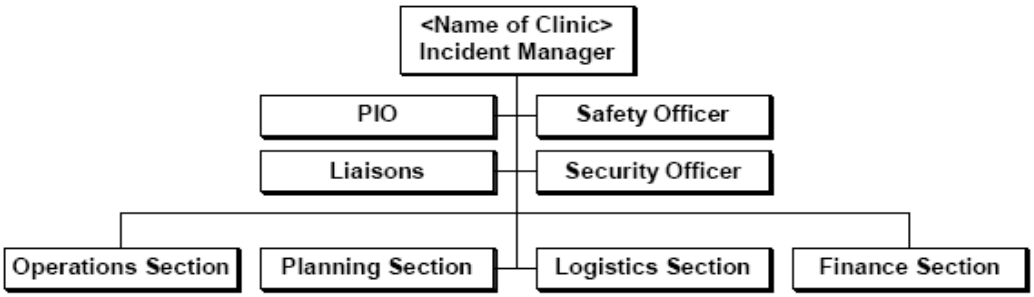
- Incident Command – Sets the incident objectives, priorities and strategies and has overall responsibility at the incident or event.

- Command Staff:
    - Public Information Officer – Serves as the conduit for information to internal and external stakeholders including the media or other organizations seeking information directly from the incident of event.
    - Safety Officer – Monitors safety conditions and develops measures for assuring safety of all assigned personnel.
    - Liaison Officer – Serves as the primary contact for supporting organizations that are assisting at an incident but are not participating within the ICS structure.

- General Staff:
    - Operations – Conducts tactical operations such as patient care or clean-up to carry out the plan. Develops the defined objectives and organization and directs tactical resources.
    - Planning – Prepares and documents the Incident Action Plan to accomplish the objectives, collects and evaluates information, maintains resource status, maintains documentation for incident records.
    - Logistics – Provides support, resources and all other services needed to meet the operational objectives.
    - Finance and Administration – Monitors cost related to the incident. Provides accounting, procurement, time recording and cost analyses.

Source: DHS FEMA Emergency Management Institute

Possible Clinic ICS Structure



In a community-wide event, such as an exercise or an actual emergency that requires a multidisciplinary response, individuals from different organizations/agencies that do not routinely work together may be incorporated into the ICS structure. It is important to plan and practice your plans with your community partners.

Emergency Operations Center (EOC) Action Plans:

Action Plans provide the Emergency Operations Center (EOC) and other response personnel with knowledge of the objectives to be achieved and the steps required for their achievement. They also provide a basis for measuring achievement of objectives and overall response performance. The action planning process should involve the EOC Incident Manager, management staff and other EOC sections.

Action plans are developed for a specified operational period which may range from a few hours to 24 hours. The operational period is determined by first establishing a set of priority actions that need to be performed. A reasonable time frame is then established for accomplishing those actions. The action plans need not be complex, but should be sufficiently detailed to guide EOC elements in implementing the priority actions. See the Response Section, "Activation of Plan" for further information.

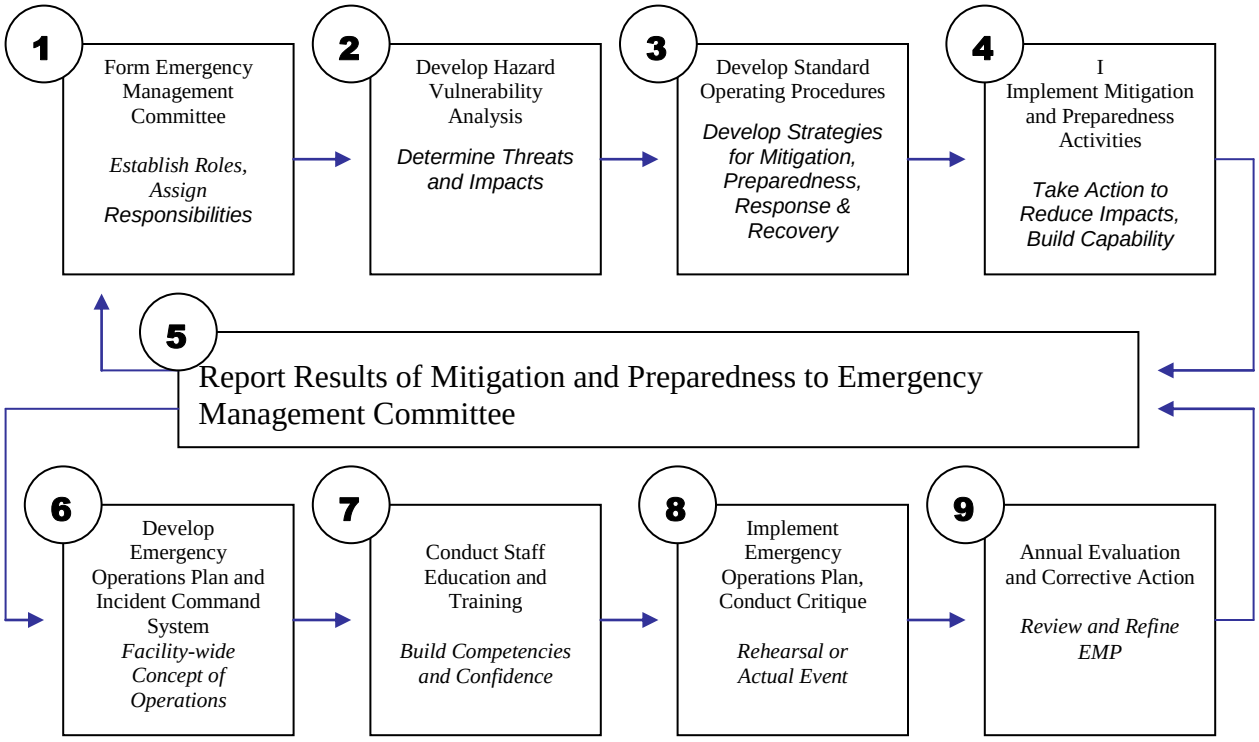
Possible Healthcare Role

Hospital Incident Command System (HICS) functions just as well in a small facility as it does in a large one. This is a true testament to the plan's expandability and contractility. Jobs are only to be activated if the function is required or anticipated being needed. Even then, sometimes there may not be enough managers to assume the most important roles. In that case, priorities must be identified and goals should be established.

To be successful, your healthcare organization's emergency management plan should be deliberate and follow an organized process. The hospital or clinic Executive Director (ED) should establish his/her direction for your organization's plan and provide oversight for the program development. The ED, however, does not realistically become involved in every detail of the program. Instead, the ED should assign trusted staff members to organize the program and provide oversight for its development.

Below is a nine step model, developed by the Indiana Primary Health Care Association, essential in developing an Emergency Management Plan.

Program Development Process:

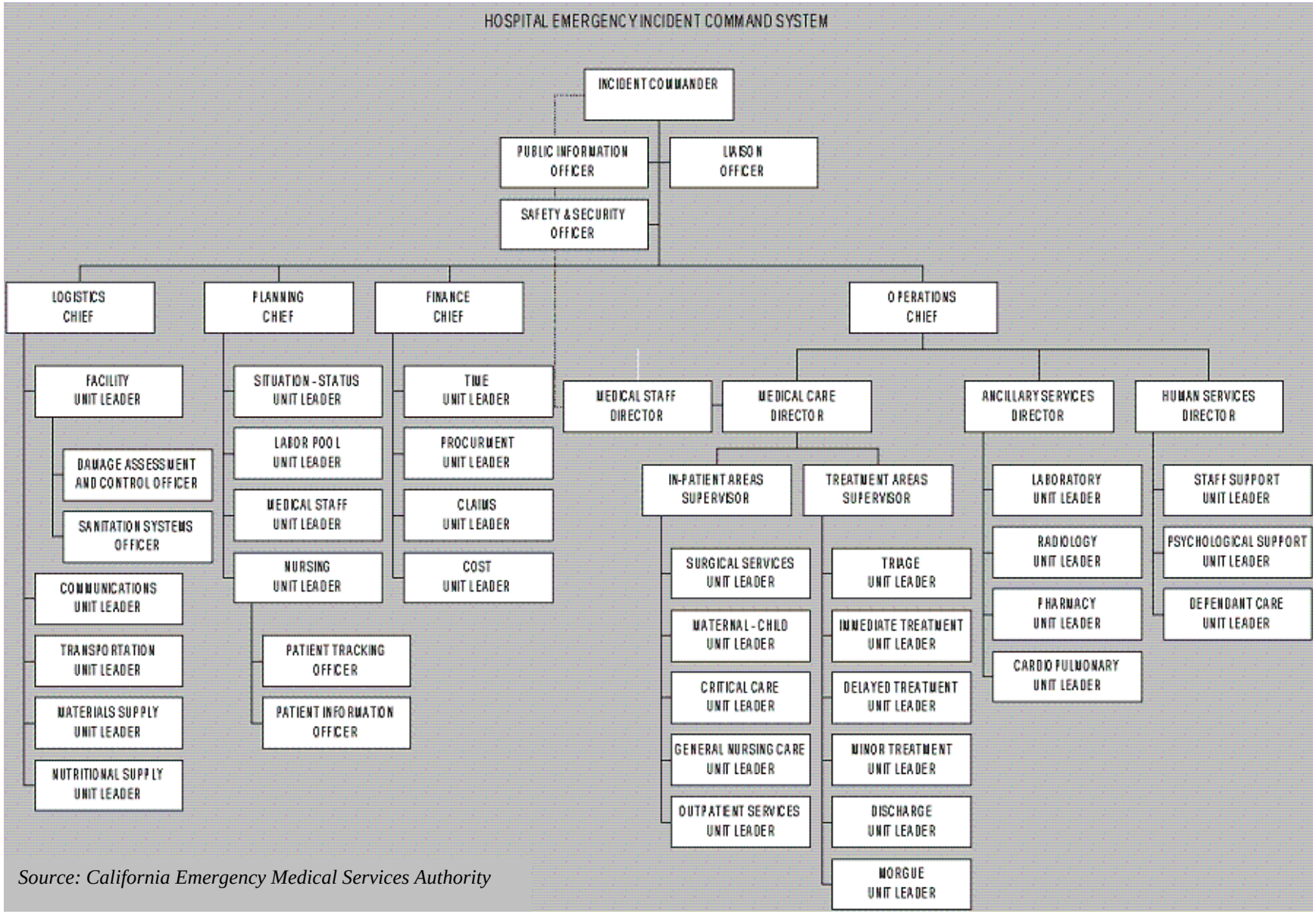


Source: Bioterrorism and Emergency Management, Indiana Primary Health Care Association
www.indianapca.org/htm/bioterrorism-plans-templates.php

Resources

- Frequently Asked Questions About the Hospital Emergency Incident Command System http://www.emsa.ca.gov/Dms2/faqs.htm
- For more information on the National Incident Management System: www.dhs.gov and www.nimsonline.com
- FEMA offers training online for HISC and NIMS at no cost. It is recommended that all healthcare organization staff take the following online courses:
    - IS-100.HC Introduction to the Incident Command System for Healthcare/Hospitals
    - IS-700 National Incident Management System (NIMS), An Introduction

  Go to: http://training.fema.gov/NIMS/
- Hospital Emergency Incident Command System Model



Source: California Emergency Medical Services Authority

IV. Collaboration with Partners

Outreach to Partners

Description

In an emergency, your community will need to work together as a team under stressful conditions. If you take the time to get to know your community and its available resources in advance, you will be able to mobilize them effectively when a disaster takes place. Develop relationships with identified organizations in your area with the intent of developing a comprehensive community-wide emergency response plan. Your primary goal should be to establish good working relationships with a variety of community leaders and organizations so that you can all work together more easily when emergencies take place.

Begin the process before a disaster or emergency occurs so that the structure will already be in place to communicate effectively and respond efficiently during times of crisis. When you establish relationships in a non-stressful environment first, lines of communication will be more open during a crisis situation.

When thinking about the emergency preparedness process, it is often broken down into four phases: 1) prevention (mitigation), 2) preparedness, 3) response, and 4) recovery. The relationships you foster with organizations outside your rural healthcare organization such as local government, local schools, social service agencies, faith-based organizations, health department, fire and police departments and other healthcare providers can have an impact in all four of these emergency preparedness areas.

Effective emergency planning requires a team effort**.** It is important to communicate and network with all parties involved in preparedness planning within your town, county, surrounding towns and counties and region to improve collaboration. The most realistic and complete plans are prepared by using a team with representatives of the departments, agencies, organizations and groups that will have to execute the plan.

In the rural disaster planning process, there should be representatives from rural healthcare systems, local or regional public health, law enforcement, emergency management and others that will be part of the response. Among the benefits of a team approach to planning are:

- The plan is more likely to pass a common sense check and be accepted and used if the individuals and organizations tasked in the plan have participated in the planning process and their views were considered and incorporated.
- Involving individuals from the rural provider network, local public health, emergency management, and local government on the planning team brings expert experience, information, and insights to the planning effort.
- Coordination among response organizations in the planning process should translate into better coordination and teamwork in emergencies.

Sources: Working With Your Community: Preparing for Emergency Response, Community Health Care Association of New York State

Development of Regional Emergency Response Plans for Rural Health Care Systems, Texas Department of State Health Services, Texas A&M University Health Science Center School of Rural Public Health and Texas Institute for Health Policy Research

Possible Healthcare Role

Rural healthcare organizations can take the lead role in creating partnerships or linkages between different agencies (for example, a health center and a neighboring hospital, nonprofit organization, or fire department) to establish a shared expectation for working together in emergency response. These partnerships usually work best when they have been formalized in writing so that everyone understands the expectations and responsibilities of those involved. A linkage is generally formalized in writing through a Memorandum of Understanding (MOU) agreement that outlines each party's expectations and responsibilities and is signed by all parties involved (MOUs will be covered in greater detail below).

Other collaboration recommendations include:

- Educate disaster planning partners on what Rural Health Clinics, Community Health Centers, Migrant Health Centers and rural hospitals can and cannot do and what resource rural clinics and hospitals do and do not have in and for emergency situations.

- After your hospital or clinic has created your internal plan, provide copies to the appropriate local and/or regional partners, including emergency management planner or coordinator, health director, regional hospital, etc. for their review and feedback. Stay in touch with them and make sure you are involved in any preparedness activities that are taking place.

- Lack of resources, particularly staffing, is frequently a problem in rural healthcare organizations. If seasonal staff are available (e.g., staff at a school-based health clinic that have more time during the summer), assign them to begin or continue planning efforts and coordinating with local, regional and state partners. Also, create or use an existing safety committee to work on the plan and create linkages to local partners.

Collaboration Considerations

Every individual and organization brings different perspectives and expertise to emergency planning. For example, community clinics may bring an important focus on public health and healthcare issues into the discussion and offer expertise in working with diverse community populations. But having different perspectives and priorities can sometimes be a challenge when

different organizations work together. Coming to the table with the understanding that these different perspectives exist can help everyone keep focused on the goals of collaborating. Normal hospital or clinic operations can become overwhelmed during an emergency. Rural hospitals and clinics may have to rely on other community organizations for assistance and, possibly, for assuming some aspects of patient care. Coordinated efforts are necessary to provide comprehensive care during this time. Integration into the local community response can also increase the health center's ability to obtain needed resources for continuing care.

Rural healthcare organizations should define their role with their local community prior to an emergency and become integrated into the development of the local community response plans. The organization's role should be described in their emergency plan. Rural healthcare organizations are encouraged to be proactive in engaging community leaders, identifying key organizations and developing ongoing relationships. Health centers should participate in community drills to evaluate their role and work with the local community to incorporate lessons learned from these drills.

As mentioned previously, because resources are frequently lacking in rural areas, it is particularly important to share personnel, resources, equipment and assets among and between organizations and agencies within and adjacent to the community and county.

Draft HRSA Program Information Notices (PINs), *Emergency Management Program Expectations*, http://bphc.hrsa.gov/draftsforcomment/emergencymanagement.htm

Best Practices / Lessons Learned

Best Practices

After a hurricane, several rural communities relied solely on Wal-Mart ready to eat meals, because all other food resources in the counties had been depleted. Other local grocery and convenient stores had run out of the staple foods.

The greatest resource in a rural area is the community itself. “Our strength is our people, the willingness to help even at their own expense. We are a very resilient culture of rural people.”

Create a statewide document outlining the collective inventory of supplies, personnel and equipment.

A non-profit health system that serves a predominantly rural region has contracted with a local warehouse to store a 2-month supply of resources.

Lessons Learned

In such tight knit communities, you will inevitably be dealing with friends and neighbors. Do not assume that just because you know individuals responsible for planning activities personally that they have everything under control. Sit down with them and discuss each of your plans and roles.

Rural communities frequently do not have local health departments like larger cities – local healthcare organizations will have to take on a greater collective responsibility in these communities.

Local, Regional and State Response

Local Government Response

The first response in an emergency falls to local government, which is most familiar with local conditions. Its responsibilities include planning and prior arrangements for evacuation, shelter and first response by police, fire, healthcare and public health personnel. Local government should make sure that it has resources to sustain a response to an emergency for up to 72 hours.

Rural healthcare providers and organizations can make sure that local government officials are aware of emergency planning and their role in the process. Explain what you are doing and why; outline your proposed schedule and the assistance you need. This can include local elected officials, appointed officials, and government groups, such as Councils of Government.

State Government Response

When local resources are overtaxed, the state steps in with logistical help and manpower. The state's main resource is the National Guard, which is under the control of the governor. The state also is a source of matching funds that, combined with federal money, can provide additional resources. State government stakeholders include the Governor, State Emergency Management, and State Health Department.

Federal Government Response

The federal government is the final stop when disasters outstrip state and local resources. When called upon, the Federal Emergency Management Agency (FEMA) takes the lead in coordinating the response, providing supplies and helping with aid, cleanup, etc. It can also enlist the Defense Department for troops, air and sealift help. Federal government stakeholders include FEMA, National Guard, Department of Homeland Security (DHS), Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (DHHS), and the Federal Bureau of Investigation (FBI).

Other stakeholders might include Trauma Service Regions, Disaster Regions or Districts, Public Health Regions, and Public Safety Regions and Tribal government and leaders.

Stakeholder Listing

In Appendix A is a table listing rural community stakeholders that you might contact and partner with in the preparedness planning process. Because local jurisdictions among different states have varying organizational structures, tailor and apply the following stakeholder listing to your jurisdiction. Feel free to add in partner contact information, add other partners and make this part of your emergency plan. This can also be used as an external partner contact list in an emergency situation.

Who are three partners you are already working with in your disaster planning activities?

1.

2.

3.

Name three partners with whom you would like to arrange a meeting:

1.

2.

3.

Partnering with Local, Regional and State Level Planning Efforts

Description

Coordination with planning efforts and integration of plans involves both horizontal and vertical coordination and integration. Horizontal partners include local emergency management, local public health officials, law enforcement, first responders, and mental health personnel. Horizontal partnerships also consist of those between towns, cities and counties, within a region, and between states. Vertical partners include the federal, state and local levels of government and with larger, regional hospitals.

Possible Healthcare Role

In coordinating planning efforts and integrating plans, partners should place emphasis on mutual goals and objectives and creating **Memorandums of Understanding** (MOUs) (also known as Mutual Aid Agreements). The development of a disaster response plan frequently involves establishing relationships with government, the private sector or other community-based organizations. Memorandums of Understanding (MOUs) are written agreements between two or more parties that articulate a specific relationship, define how entities will work together in emergencies and *formalize and institutionalize* these relationships so that they will withstand the loss of key personnel or other disruptive effects of a disaster.

In disaster or emergency response planning, an MOU can serve to provide additional or alternative resources for your organization and it can be used to clearly establish the protocols, roles and responsibilities of organizations that are coordinating their efforts in response to disaster. MOUs can range from simple and informal, to ceremonial, to complex and legally binding formal agreements. MOUs should not be created lightly. A sample MOU template and instructional guidance for creating MOUs can be found in Appendix B.

KEY ELEMENTS OF A MEMORANDUM OF UNDERSTANDING

- **Purpose**
  An MOU should clearly articulate the desired outcome of entering the agreement. This outcome should result in tangible and reliable benefits to your organization. This outcome should be clear to both parties. A third party should be able to clearly understand the commitments and promises in the MOU.

- **Mission Statements**
  An MOU should include a brief description of the respective organizations and their fundamental mission.

- **Activation Protocols**
  Clearly define the situations under which the MOU will be activated and the individuals with the authority to activate it.

- **Response Procedures and Obligations**
  An MOU that merely outlines the potential for cooperation can be beneficial, but it is not strong enough to depend on in your response plan. A truly helpful MOU would be strong enough to oblige the respective parties to respond in a prescribed manner and answer some basic questions:

  1) What is going to be done?
  2) Who is going to do it?
  3) Under what conditions / when will it happen?
  4) Who pays for what?

- **Out Clause**
  There may be circumstances under which one of the parties is unable to meet the obligations outlined in the MOU. These circumstances should be recognized and included in the document.

- **Financial Relations**
  If the MOU includes a fee for service arrangement or other financial obligations, a method for determining financial payments should be clearly established. Any and all financial commitments should be spelled out clearly, with appropriate approvals and monitoring systems in place.

KEY ELEMENTS OF A MEMORANDUM OF UNDERSTANDING (continued)

- **Annual Review**
  MOUs should be reviewed and updated annually, or as necessary, to account for staff turnover etc. We recommend reviewing it when you set your clock forward.

- **Termination Clause**
  MOUs should allow for any party involved to terminate the agreement unilaterally with an agreed upon notification period.

- **Signature and Date**
  An MOU should always have signatures of the parties involved and it should be dated.

- **Internal Review and Approval**

While different agencies and entities have individual emergency plans, it is imperative that all are aware of what each other are doing, what other plans include and overall roles and responsibilities. Rural healthcare organizations should consider MOUs with the following:

- Closest local or regional hospital
- Medical personnel from other facilities
- Vendors (pharmaceutical, medical supplies, linens)
- Laboratories
- Health Departments (city, county, regional, state resource for laboratory testing, surveillance and isolation/quarantine)
- City / County Officials and Agencies (county judge, mayor, emergency management coordinators/planners, city manager, chiefs of police, sheriff, fire EMS/Ambulance Service)
- Voluntary Organizations such as Red Cross, Salvation Army

LIKELY PARTNERS FOR MOUs
• Local Agencies
• Other healthcare organizations (local or regional hospital, clinic, private providers)
• Voluntary Organizations / Non-governmental Organization: American Red Cross, Salvation Army
• Churches, mosques, synagogues, temples and other faith-based organizations
• Businesses: grocers, restaurants, drugstores, hardware stores, sports stores
• Public space: school, libraries, community or recreation centers
• Emergency Preparedness and Response Agencies: Police, Fire, EMS, Emergency Management

RESOURCES TO SECURE WITH AN MOU
• Volunteers
• Expertise
• Specialized equipment
• Food and water
• Repair and mitigation supplies
• Sheltering space (indoors or outdoors)
• Alternate office space

ALTERNATE USES FOR AN MOU
• Acknowledgement of support
• Grants – proof of partnership
• Media Attention

Best Practices / Lessons Learned

Lesson Learned

Organizations and individual responders may not understand how mutual aid agreements function. It is not enough to insert a name into your plan without discussing their intended roles and responsibilities.

Resources

- Sample template for Memorandum of Understanding (MOU) mutual aid agreements (Appendix B)
- Guidance for using the MOU template (Appendix B)
- Other sample MOUs can be found at NIMS Online: http://www.nimsonline.com/download_center/index.htm#mutual.

Collaboration Guidelines / Tips

Below are guidelines, tips and suggestions from a document created by the Community Health Care Association of New York State entitled, *Working with Your Community: Preparing for Emergency Response*. For more information, visit: www.chcanys.org/index.php?src=gendocs&link=ep_forcenters&category=Main.

Working with First Responder Agencies

First responder agencies, such as fire departments, police, and hospitals, are the most important organizations for you to develop formal linkage partnerships with. Tips for making connections with fire departments, police, and hospitals:

I. **Start Local**
The best way to start is to make contact at the local level. You likely already know which police stations, fire stations, and hospitals are near your Center site. These are the best sites to get in touch with first.

II. **Try to Meet Face-to-Face**
Use personal contacts to start the dialogue. This networking can take place in a variety of ways. If you are already in contact with staff members at these agencies, give them a call and ask who coordinates emergency preparedness for them. If you don't already have contacts, try to meet agency staff at meetings, conferences, or social events, and talk to them one-on-one so they can get to know who you are and what your Center provides to the community.

III. Offer to Help Them

One of the best ways to establish a good working relationship with these agencies is to offer to incorporate their own community outreach efforts into some of your own work. If you hold community health fairs in your area, they may want to offer a demonstration or distribute literature at your event. If you hold workshops at your center, you may want to ask them if they are interested in conducting one on a topic they are concerned with such as fire safety or child abduction prevention. You may also want to offer to distribute their written materials to patients in your waiting areas. These kinds of collaborations can solidify your relationship and pave the way for working together on emergency preparedness.

IV. Conduct Drills Together

When your Center plans emergency preparedness drills where external participation could be part of the scenario, ask these agencies if they would be willing to take part in your drill. If police or fire departments already conduct larger local or regional emergency preparedness drills that involve external organizations, find out if your Center can be a participant. Your local hospitals probably already conduct drills to meet JCAHO accreditation requirements; find out if you can coordinate with them in their next drill by offering triage or surge capacity assistance.

V. Make Expectations Clear

When the relationship is in place and everyone's expectations are clear, draw up a written Memorandum of Understanding (MOU).

Coordinating with Your Local/Regional Hospital(s):

You and your neighboring hospitals may need to coordinate patient care in an emergency—you may need to get severely injured patients to emergency rooms or you may want to offer to take non-urgent care cases off of their hands. It may be helpful to note that many JCAHO-accredited hospitals are encouraged to partner with community organizations like Community Health Centers when formulating their emergency preparedness plans. State Hospital or Health Care Associations (see listing for states below) and similar hospital-related organizations may be able to provide more information on this issue. You are probably already familiar with hospitals in your area. Most hospitals have an emergency preparedness coordinator (or bioterrorism coordinator). Call the hospital(s) nearest to your organization and ask to speak with their emergency preparedness coordinator. Explain that you are in charge of your healthcare organization's emergency planning and that you would like to discuss ways in which your efforts might be coordinated.

If you are not already in contact with specific individuals at the hospital, local or regional conferences on emergency planning (or even on public health issues) where hospital representatives are likely to attend are a good place to start making contact. Send a representative from your center to conferences and meetings; while they are there they may be able to talk one-on-one with hospital representatives about coordinating emergency preparedness efforts and get the dialogue started.

Hospitals may be particularly interested in seeing whether your hospital or clinic could help them with surge capacity issues during an incident. You may want to bring this up early on in the emergency preparedness dialogue to illustrate how they can benefit by working with your clinic. You may also want to discuss triage, medications transfer, patient transport, and other issues where collaboration could be beneficial. In addition, you should be sure to ask if your center is already included in the hospital's emergency management plan, since some hospitals may have included you in the plan based on emergency planning guidelines without necessarily working out a detailed agreement with you—you'll want to be sure everyone has the same expectations.

Meeting With Your Local Law Enforcement:

When you develop relationships with police officers and decision makers within the police force, you help to ensure added security or support for your community in the event of a disaster. The first step is to contact your local police department or sheriff's office to determine which staff members there work with the community. Find out which departments or staff members can lend support to your clinic or community in an emergency. When you get in touch with the person or department who is responsible for community outreach, let them know who you are, why you are contacting them, and what you hope to begin fostering. When you are in extended dialogue with them, explain how you perceive your role (your organization's role) in emergency response. Take the time to build a contact list of the staff at your local police department and understand the different roles each staff member plays.

Many police departments also sponsor their own training on emergency preparedness, bioterrorism, and other topics that are available to the public. Participate in these trainings if they are available. Also, invite local officers to help your organization develop its emergency response drills. Regular emergency preparedness drilling, especially with the participation of outside agencies such as the police, is the best thing you can do for your organization's preparedness—as your organization becomes more accustomed to responding to different scenarios, it will help solidify your staff's confidence in their response. Having the police involved in drill exercises on an ongoing basis makes working together more routine when emergencies take place.

Most police departments either host or attend regular community meetings where community groups, local business owners, elected officials, and local residents can voice concerns or discuss issues with police community liaison staff. If you don't already have a relationship with your local police, these meetings are a great way to make contact. You can find out when and where such meetings are held by contacting your local police force or your city or county government. You can even use this forum to introduce your own new emergency preparedness initiatives or to promote services provided by your facility. At these meetings you will be able to find out about different programs implemented in the community and how they may relate to your own activities.

Your local police may also regularly attend or sponsor community social events. Those forums may not be the best place to get involved in emergency planning details, but they can be great ways to make initial contact with police department staff Utilize the community affairs contacts to introduce your healthcare organization to the other departments in the precinct.

Meeting With Your Local Fire Department:

Developing relationships with local fire departments is also an essential component in developing a comprehensive response plan. Developing a relationship with the local firehouse can help facilitate the training process for your staff relating to fire safety issues and concerns. You may already know your local firefighters through coordinating with them for EMS services for patient transport or from your own fire drill procedures. If you don't yet have the contacts you need, start by calling your local fire department, volunteer fire department, or fire safety office and asking who the best contact is for emergency preparedness issues. Keep in mind that volunteer fire departments may be more strapped for resources outside of actual fire response activities—be sure to be sensitive to their time constraints.

Keep an eye out for social events regularly attended by or sponsored by your local fire department, such as fundraisers for the department or fire safety demonstrations. Social events are great ways to make initial contact with your local firefighters, start developing relationships, and get the right contacts for emergency preparedness activities.

Working with Community Organizations

Community organizations can be important and effective partners in health center emergency management. Creating linkages with businesses, faith-based organizations, schools, and non-profit organizations can play an important role in emergency response.

Here are a few of the resources community organizations may be able to provide and the roles they may be able to play in emergency response. As you review this list, think about which of these resources and roles you are likely to find most valuable and start prioritizing the community linkages you would like to foster.

VI. Preparedness Promotion
Even before an emergency situation takes place, local community organizations can do a lot to help your neighborhood prepare for disasters. For example, they can work with the public to promote household and family emergency preparedness or provide information on topics the public is anxious about, such as pandemic flu or bioterrorism.

VII. Meeting Places or Temporary Work Space
In some instances, organizations may be able to offer meeting space, sites for Points of Dispensing (PODs), or temporary work space during or after a disaster. Community enters (YMCAs, other neighborhood community centers, after-school programs, etc.) may be particularly well-suited to offer space as a resource.

VIII. Getting Information to the Community

During an emergency and its aftermath, your staff will be extremely busy. Local organizations can help provide information to the community. Announcements and updates may be distributed at local schools, places of worship, community centers, and senior centers.

IX. Contacts with Specialized, At-Risk or Hard to Reach Populations

Community-based organizations may be in touch with specific populations that your hospital or clinic might have difficulty contacting. If you need to get word out to the public about infection control precautions or vaccine availability, these organizations may be able to help contact people outside of your regular patient base.

X. Established Communication Linkages with Large Groups

Some organizations such as schools or unions may have regular contact with large groups of residents and may therefore have contact information for significant portions of the local population. Some may even have the auto-dialing services that could send out a recorded message to the phone numbers of their constituents.

XI. Translations

You may need to communicate disaster information in multiple languages or to hard-of-hearing populations. If there are languages used in your community that your staff are not able to communicate in easily, look for organizations you could partner with for possible volunteer translators.

XII. Providing Your Staff with Food or Services

Consider asking local restaurants to provide food, water and support to your staff or local residents during an emergency or its aftermath.

XIII. Referring Patients to Your Center

Mental health services may be needed in communities that have experienced a disaster. In the aftermath of an event, you may want to reach out beyond your usual patient base to offer counseling, treatment, or referrals to mental health resources; local organizations can help direct people to your center for these services or referrals. Distributing patient education materials that explain what depression, anxiety, and post traumatic stress disorder are and how to recognize the signs of these conditions can also be very helpful to your community; local organizations can help with this distribution. The more they know about what services your center provides, the more effectively they will be able to connect patients to you.

XIV. Social and Spiritual Support

Your patients may find significant mental health support after a disaster through connecting with their faith communities or social groups. You may want to encourage faith-based organizations and social organizations to prepare post-disaster programs for their constituents.

XV. Providing Needed Services Your Center Can't

Nonprofit organizations in your area may be able to help your patients with their non-medical needs following a disaster, such as housing assistance or food assistance. You can refer patients who need such services to the appropriate agency.

XVI. Connections with Potential Volunteers

If you are interested in connecting with potential volunteers to aid your organization in an emergency (or at other times), you may find natural partnerships with some organizations

in your community. Organizations that run volunteer placement programs, clubs or scouting programs, faith-based organizations, and senior centers may be particularly well-suited to offer volunteers. In addition, colleges with medical, EMT, or health education programs may even be able to offer volunteers with clinical skills to your Center. Also, AmeriCorps/HealthCorps/VISTA volunteers may be able to assist your center in these areas; they may be available to your site for a full term of service or to help for a shorter period as a service project.

XVII. Drill Participation

Large organizations that are an integral part of your community may be interested in joining in your drill exercises. Schools, in particular, are likely to have comprehensive emergency plans already in place, and may be interested in participating in community emergency preparedness drills along with your Center.

Identifying Potential Organizational Partners & Community Leaders:

A good first step in identifying both community leaders and organizations with which to start establishing linkages is to get your staff together and create a list of all the community organizations and community leaders you are already in contact with. Your existing relationships are your greatest asset in building linkages. The organizations with which you want to establish partnerships may vary depending on your Center's location and patient population. Here are some ideas for organizations and community leaders you may want to partner with:

I. Large nonprofit organizations (e.g., American Red Cross, Salvation Army, Meals on Wheels)
II. Grassroots community-based nonprofit organizations, particularly those serving special, hard-to-reach populations (e.g., elderly, non-English speaking)
III. Schools
IV. Faith-based organizations
V. Community centers (e.g., YMCAs, neighborhood community centers, after-school programs)
VI. Volunteer Groups (e.g., Community Emergency Response Team (CERT), Medical Reserve Corp)
VII. City Councils, Community Councils, Community Boards, Neighborhood Associations, or other regional groups
VIII. Local public officials' offices/staff
IX. Unions
X. Large membership organizations or Civic Organizations (e.g., Rotary Club, Lion's Club)
XI. Local businesses
XII. Senior citizen groups and retirement communities

How to Make Contact:

- Utilize current relationships and associations
- Know your community resources in advance: keep an up-to-date contact list
- Get ideas from your staff members who make referrals or connect patients with social services
- Network in the community
- Research who is/which organizations are active in emergency preparedness
- Attend local Community Council or Community Board meetings

Keys to Success

- **Formal your connections with MOUs**
  Once relationships are in place, you will likely want to create a formal agreement on paper between your rural clinic or hospital and the organization you plan to work with. Having a formal agreement is especially important with hospital, police, and fire department agencies to clarify your relationship and mutual expectations. Written agreements are also helpful when staff turnover takes place at either site so that it is clear to everyone what has been agreed upon in the past. Memorandums of Understanding (MOU) were discussed previously and a sample MOU template was provided.
- **Build on existing relationships.**
  If you or your staff are already in contact with these organizations, contact the people you already know and ask them who you should reach out to in regards to emergency preparedness issues at their agency.
- **Don't let slow progress discourage you.**
  Building relationships is a long-term process and a long-term investment. It may take more work than anticipated to make these kinds of connections and develop rapport with different organizations, but the benefits pay off when unexpected incidents happen. Keep reaching out!
- **Try to meet face-to-face at least once in a while.**
  Face-to-face contact, especially in the early stages of getting to know each other's organizations, can really help build relationships.
- **Remember that everyone is coming to the table with their own perspectives and priorities.**
  Not every organization or agency will have public health as their first priority; you can offer a public health perspective to the emergency planning process.
- **Give them a sense of your Center's emergency preparedness plan.**
  Make sure they have at least a general understanding of how your Center expects to operate in an emergency and a sense of your emergency plan strategy for working with external agencies (Do you expect to help hospitals with surge capacity? What patient

transport options do you have? Are you willing to be a POD site for mass immunization?, etc.).

Other Tips and Guidelines

The Basics: What to Set Up at Your Center to Facilitate Linkages:

Putting these basic structures in place will help facilitate creating and maintaining your community linkage relationships:

- Set up an emergency preparedness committee.
- Have regular emergency preparedness committee meetings.
- Assign one or two staff members to be responsible for creating and maintaining linkage relationships. All staff may be able to contribute contacts and resources, but one or two should be responsible for follow up actions.
- Have a written emergency plan that includes procedures for how you will work with external agencies.
- Think about how you will communicate with your organizational partners if power or phone lines are interrupted during an incident.
- Include emergency preparedness issues in your employee orientation and ongoing staff training — let staff know which community organizations and leaders you are partnering with.

Maintaining the Connection:

Make contact regularly with community organizations and first responder agencies to keep relationships fresh. Your emergency preparedness coordinator(s) should:

- Invite community agencies to emergency preparedness meetings on a regular basis.
- Keep contact names and information current:
  - Distribute printed copies and electronic copies of contact information to all relevant staff. (Remember that you may not have access to your work computer or even your clinic building during an emergency, so duplicate copies of contact information and emergency plans should be stored off site.)
  - Identify redundant forms of communication with each contact (for example, phone, fax, email, and cell phone number).
- Incorporate new staff members into your emergency preparedness plans—make emergency preparedness a part of every employee orientation.
- Formalize your linkages by putting them in writing—draw up an MOU for both parties to sign.

Stay in Touch With Other Partners:

The state Primary Care Association (PCA) and your state, regional and / or local Departments of Health are also important resources in your emergency management planning. They may offer trainings and guidelines in emergency preparedness or convene regional meetings to coordinate health-related emergency response. Stay informed of the emergency preparedness resources and trainings that they provide.

Developing a Culture of Preparedness:

Emergency preparedness takes time, resources, and energy, but, just as primary health care is crucial to an individual's health, preparedness activities are an investment in your Center's organizational health that have clear long-term benefits. Engaging in regional emergency planning is about building a culture of preparedness, a culture that can help your entire community work as a team. Not only can building community linkages result in effective disaster response, it can bring community organizations closer together and help you work on everyday issues as well.

Keep in mind that the resources indicated in this report are only suggestions. It is recommended that you use this report as a guideline, but your decisions should be based upon available resources in your community and the capabilities of your site. It is these relationships that you and local community organizations build together that will ultimately strengthen the disaster response of your entire community.

Sources: Community Health Care Association of New York State – Working With Your Community: Preparing for Emergency Response

Tips for Overcoming Conflict & Mistrust

Some community agencies and organizations may have a history of conflict or mistrust, which can hinder or prevent collaboration efforts. Some agencies or organizations may have a tendency to feel territorial about activities for which they feel they have sole responsibility. For other organizations and agencies, competition for limited funds can create conflict. Remember that collaboration is a democratic process and can sometimes be messy.

Some guidelines you and your partners might follow to reduce conflict or mistrust include:

- Be inclusive rather than exclusive
- Agree on and establish ground rules
- Practice joint decision-making
- Agree on an independent, objective facilitator or committee chair
- Agree on roles and responsibilities, the general processes and structure and next steps
- Break into smaller task groups to complete larger tasks or projects

- Throughout the process, try to look beyond your agency's or organization's goals and create joint prevention, preparedness, response and recovery goals and objectives for your community
- Maintain good communication with all partners so that no one feels left out
- Assume collective responsibility
- Anticipate problems
- Attempt to understand the point of view other others, even if you disagree – try to see where they are coming from
- Listen to and appreciate others' perspectives and areas of expertise – remember that you will have a better process or end-product by having partners that think differently than you, rather than the same
- Agree to disagree
- Try to eliminate territorial feelings between agencies and organizations – agree that it doesn't matter who gets credit, because your efforts will take place in collaboration
- Funding to particular agencies or organizations tend to perpetuate feelings of resentment and mistrust – recognize and agree that joint planning and response efforts are for the good of the community

Models for Collaboration

Models for Collaboration

During Hurricane Katrina and after 9/11 community- and faith-based organizations and businesses pitched in to respond to these crises. For example:

- The Louisiana Environmental Action Network, a nonprofit organization in New Orleans, helped acquire and coordinate donations of medical supplies to the trapped residents of St. Bernard, Plaquemine, and Washington Parish.
- Christus Victor Lutheran Church in Ocean Springs, Mississippi, provided work space for over 200 Lutheran/Episcopal Disaster Response (LEDR) volunteers who coordinated efforts to bring food, free medical care, home repairs, and casework to hurricane victims.
- One private-sector business that played an active role in supporting responding agencies during a disaster was the McDonald's restaurant franchise. During recovery work after the World Trade Center disaster, McDonald's provided over 750,000 meals to responders and generated over 2 million dollars in financial support.

Working with Your Community: Preparing for Emergency Response, Community Health Care Association of New York State

The following "Models for Collaboration" were highlighted in the January 2007 Association of State and Territorial Health Officials (ASTHO) newsletter article, *Developing Partnerships with Community Health Centers for Emergency Preparedness Planning*. This newsletter article can be found at:
http://www.astho.org/pubs/EffePartnershipswithCHCsinPreparednessPlanningFinal01-19.pdf

Model for Collaboration - Alabama

A collaboration between **Alabama Department of Public Health**, **Alabama Primary Care Association** and the **University of South Alabama** has enabled them to:

- Include 114 Community Health Centers the ability to act as critical partners to hospitals during a disaster by providing non-emergent care and triage.

- Create a common information sharing system was created for use during an emergency that allows organizations to receive real-time updates on the available number of beds and site conditions, including damage, as well as identify providers that have the capacity to care for critical and non-critical patients. Hospitals, Community Health Centers, nursing homes, public health clinics, medical need shelters and Emergency Medical Services all participate in this system.

During Hurricanes Katrina and Rita, a web-based prescription record system was established to retain records for individuals displaced by the hurricanes. Patients who had prescriptions filled at particular pharmacy chains were merged into a single online record. A new database is underway that can be found at: www.icerx.org.

The Poarch Band of Creek Reservation in Alabama is a model for preparedness through their operation of an FQHC, regular participation in exercises and trainings and emergency responsibility for a major Interstate thoroughfare. They are also a point of dispensing for the Strategic National Stockpile and manage a medical needs shelter.

Developing Partnerships with Community Health Centers for Emergency Preparedness Planning, January 2007, ASHTO Newsletter

Model for Collaboration - California

A collaboration between the **California Department of Health Services**, **California Primary Care Association** and **California Community Health Centers** has enabled them to provide emergency preparedness technical assistance at the clinic level. Local level funding has supported the purchase of equipment, development of a training program and creation of a web-based held desk library for clinic emergency preparedness.

Through the Clinic Emergency Preparedness Project, the California Primary Care Association created comprehensive Emergency Operations Plan template, tools and strategies for Community Health Centers to use in preparedness planning for their own clinics and community partners. The plan template includes job description sheets, hazard assessment tools, inventory checklists, procedure lists, after-action reports and many more helpful tools. Clinics in any state are able to access the template and tools through their website: www.cpca.org/resources/cepp.

Together, these partners have defined the roles required for Primary Care Associations and Community Health Centers to be successful in both preparation and response to an emergency.

PCA Roles:

- Represent CHCs at state emergency planning tables.
- Provide training and technical assistance to CHCs as they develop their emergency operations plan.
- Serve as the communication link between CHCs and government resources.

CHC Roles:

- Serve as an alternative care site.
- Dispatch staff, resources, or mobile medical vans to facilities or locations in need.
- Act as points of distribution sites for pharmaceuticals, vaccines, or antivirals.
- Provide post-event mental health services.

Developing Partnerships with Community Health Centers for Emergency Preparedness Planning, January 2007, ASHTO Newsletter

Model for Collaboration – New York

The **Community Health Center Association of New York State**, the **New York State Department of Health** and **New York State Community Health Centers** are collaborating on several emergency preparedness activities.

- The Community Health Center Association is using funds to expand workforce devoted to preparedness activities to assist their members, CHCs, with emergency preparedness activities.

- Letters are being sent to emergency preparedness planners in each county where an affiliated CHC is located, to demonstrate interest in participating in planning with hospitals, local health departments, and other clinics.

- Hands-on training has been offered to CHC staff to create or improve emergency preparedness plans. The proposed training will encompass:

  • Establishing emergency preparedness teams.
  • Building community relationships.
  • Promoting family preparedness.
  • Hazard vulnerability analysis.
  • Risk communication.

  In addition, regional emergency preparedness training will be offered to all CHC staff.

- CHCs will be offered several opportunities each year to test emergency preparedness plans through drills, tabletops, and other exercises.

- There are plans to create a database of CHC emergency resources to track and share information related to total number of staff, rooms, onsite pharmacies, and medication and stockpile supplies. Directly related to the development of a resource database is the creation of a critical assets survey for CHCs, in part, to inventory key items like ventilators, staff, available space, and pharmaceuticals.

- The partners are also exploring use of CHC staff and facilities for alternative care or triage sites. Long Island Jewish North Shore Hospital and its affiliates plan to implement buffer model alternative care sites to decrease the load on the emergency departments of nearby hospitals and free their inpatient space to care for critical patients in an emergency. Similarly, the hospitals, local health departments and other planning partners in three counties in the Albany area are developing plan for the creation of alternate care sites.

Developing Partnerships with Community Health Centers for Emergency Preparedness Planning, January 2007, ASHTO Newsletter

Resources

- *University of Kansas Community Tool Box*
  The goal of the Community Tool Box is to support the work in promoting community health and development. The Tool Box provides over 7,000 pages of practical skill-building information on over 250 different topics. Topic sections include step-by-step instruction, examples, check-lists, and related resources.
  http://ctb.ku.edu/

V. Prevention (Mitigation)

Prevention (Mitigation) Defined:

Prevention or mitigation activities lessen the severity and impact a potential disaster, large-scale outbreak or other emergency might have on a health center's operations. Efforts established prior to an event will lessen the probability of an incident occurring or minimize effects of an incident.

Hazard Vulnerability Assessment

Description

Each hospital and clinic will need to conduct a **Hazard Vulnerability Analysis** to identify hazards and the direct and indirect effect these hazards may have on your organization and facility. This will provide information needed by the hospital or clinic to minimize losses in a disaster.

Possible Healthcare Role

The **Hazard Vulnerability Assessment (HVA)**, found in Appendix C, is a tool for estimating and ranking the probability of occurrence and potential severity of various events. This assessment should be performed every three to five years. The sample Hazard Vulnerability Assessment spreadsheet is a tool that can be used by rural clinics and hospitals to assess Naturally Occurring Events, Technological Hazards, Human Hazards and Hazardous Materials on the likelihood that each could occur; possibility of death or injury; physical losses and damages; interruption of services; preplanning; time, effectiveness & resources; and Community/Mutual Aid staff and supplies and relative threat.

After conducting the HVA, your healthcare organization will need to develop plans of action for the most likely disaster scenarios. Before you begin, check with local emergency management and first responder personnel to see if they have already conducted such assessments. Work with your community partners to complete external community assessments and share tools that are applicable to other facilities.

The **Hazard Surveillance Form,** found in Appendix C, provides a tool for surveying and ranking internal clinic / hospital problems and setting priorities for remediation. This ongoing remediation contributes to reducing the overall vulnerability of the clinic to various hazards.

The **Structural and Nonstructural Hazard Mitigation Checklists** in Appendix C are *suggested* checklists (list is not all inclusive) of recommended structural and nonstructural mitigation actions for clinics.

Resources

- Hazard Vulnerability Assessment Guidance and Tool (Appendix C)
- Clinic Hazard Surveillance Form (Appendix C)
- Structural and Nonstructural Hazard Mitigation Checklists (Appendix C)

Clinic Readiness Assessment

Description

An important aspect of emergency preparedness is the: 1) evaluation of the clinic's or hospital's overall capacity or readiness to respond to a crisis situation and 2) identification of resources if such a situation were to occur. After completing a hazard vulnerability assessment, a clinic or hospital should evaluate its ability to maintain normal operations during an emergency. The need for uninterrupted service delivery is likely to differ depending on the nature of the disaster as well as the particular resources of the rural community. Clinics and hospitals should attempt to answer the following question: In case of a disaster, to what extent will we seek to maintain normal operations? Whether the crisis is of natural or man-made origins, the following elements need to be considered. These elements include:

- Leadership;
- Staffing requirements;
- Hours of operations;
- Scope of clinical services to be offered during various emergency scenarios;
- Quantities of necessary supplies on hand; and
- Equipment and facilities.

A key component is evaluating the willingness of your clinicians and other staff members to continue to provide healthcare services during an emergency. While many may be willing to continue to provide services, others may not for a variety of reasons. Making this determination will affect the overall capacity of your clinic or hospital during a crisis. After examining the clinic's or hospital's intent and ability to maintain normal service delivery, the extent to which the organization will become involved in community-level emergency response activities can be assessed depending on the nature of the disaster.

Source: *Emergency Preparedness and the Potential Role for Health Centers in Community Response*, HRSA Document - ftp://ftp.hrsa.gov/bphc/docs/2002pals/2002-02.pdf

In addition to the bulleted readiness elements above, the **Clinic Readiness Assessment** tool found in Appendix D can help clinics and hospitals better understand their resources, gaps, and areas that can be improved through collaboration. The assessment covers the following topic areas: emergency management planning, activation and notification, disease surveillance, education and training, staff and community outreach, communication and facility resources.

Possible Healthcare Role

Based on the readiness assessment in Appendix D, rural healthcare providers and organizations should gain a better understanding of their level of preparedness based on organization and management, staffing, existing activities and efforts, education and training, communications capabilities, equipment and supplies, facility, etc. If there are gaps, seek out partnership linkages and MOUs to ensure these gaps or needs are filled.

Resources

- Clinic Readiness Assessment (Appendix D)

Disease Surveillance / Reporting

Description

Public health disease surveillance is the means by which a health department takes the pulse of its community. By knowing the ongoing pattern of disease occurrence and disease potential, a health department can effectively and efficiently investigate, prevent, and control disease in its community. An effective disease surveillance program systematically collects, analyzes, interprets and disseminates health data on an ongoing basis.

Early detection and reporting of infectious diseases are important to ensure local, state and national public health systems are prepared for potential large-scale outbreak which could otherwise overwhelm the system and so that health officials can attempt to contain and control the outbreak. Because many infectious diseases can be prevented or respond to antibiotics administered during the early phase of infection, prompt detection and treatment of an outbreak could save many lives. Rapid containment by isolation and vaccination could prevent further spread.

Possible Healthcare Role

Healthcare providers, including physicians, nurses, and other health care professionals, must be fully integrated into the preparedness planning and response process and know their role in disease surveillance and reporting. Rural healthcare clinical staff should utilize the Centers for Disease Control and Prevention (CDC) and other appropriate clinical information resources on infectious disease to enhance their ability to recognize the signs and symptoms of diseases and toxic agents. In addition, rural healthcare personnel must report unusual diseases or disease trends to public health officials. Clinics and hospitals should contact their local, regional or state health department and be familiar with the appropriate reporting pathways for potential outbreaks of infectious disease.

Name the agencies or individuals you would report unusual diseases or disease trends:

Names: _____
Agencies: _____
Phone: _____

Is your clinical staff aware of your organization's reporting procedures?

Best Practices / Lessons Learned

Best Practice

One Texas Public Health Region had a Tularemia scare – while it turned out to be a false alarm, they were able to successfully test their notification protocol. The Public Health Region notified local health departments in the Region, and following protocol (which had not been test at this point), they notified down the line. Health Alerts, with signs and symptoms to look for, were faxed or hand delivered to every physician in the rural counties.

Lesson Learned

While this untested notification protocol worked, it is best to practice periodically before a scare or an actual outbreak occurs.

Resources

- Listing: Nationally Notifiable Infectious Diseases (CDC) (Appendix E)
- Biological Agents (Appendix E)

VI. Preparedness

Preparedness Defined:

Preparedness or planning activities build capacity and identify resources that may be used should a disaster or emergency occur. These efforts are undertaken to enhance the response capabilities in order to effectively handle an emergency. Preparedness includes the creation of plans that will protect staff, patients, and the facility while serving the community. The preparedness phase assures that you are ready to deal with a disaster in your area from the onset. Do you know the resources, both personnel and materials, you have available? Preparation includes training and exercises as well as reviewing and updating existing plans to fit changing needs.

Community-wide Planning and Plan Integration

Description

It is vital for rural healthcare providers and organizations to actively participate in their local, regional and state disaster planning and preparedness activities. Adequate healthcare services will be critical should an emergency incident occur in your community, region and possibly state. Your healthcare organization's success in responding to an emergency will directly correlate with how well the community, region and state have coordinated its disaster response planning.

Possible Healthcare Role

Establishing or improving protocols and plans will assist hospitals and clinics in response to outbreaks of infectious disease, such as influenza, natural disasters and other threats to the public's health. Rural hospital and clinic roles and responsibilities might include triage, stabilization, diagnosis, surveillance, isolation, treatment and/or transfer of victims.

Some key elements of coordinated planning include:

- Interface with local emergency management planners and first responders
- Identify community and regional resources
- Establish a process for accessing local, state and federal resources through the emergency management system
- Develop or identify of a communications network within your region to share information and resources.

It is essential that rural healthcare providers and organizations are prepared to respond to a large-scale contagious disease outbreak. The impact on the health system, whether it is a man made or a naturally occurring outbreak, will be tremendous. All healthcare facilities, including out patient clinics, must be prepared for a large influx of patients that could potentially overwhelm regional facilities and resources. In order to have a comprehensive, coordinated response plan, it is essential that all healthcare organizations participate in local, as well as regional and state planning efforts with Trauma Centers, other non-trauma hospitals within their region, and state-level associations such as State Primary Health Care, Community Health Center and Rural Health Clinic Associations. This will assure communication among all the healthcare facilities, a comprehensive response throughout a region and access to shared local, state, and federal resources. If there is an organized disaster healthcare planning committee or group in your region or state, your healthcare organization should work within these groups to plan for such events.

It is imperative that there be coordination of planning, response and resources not only between hospitals and clinics, but also between local public health, emergency management and various levels of government. Most states have a well-developed and practiced State Emergency

Management Plan or Standard Operating Guidelines. For hospital and clinic response plans to be properly coordinated within their community and region, it is essential that they be knowledgeable of and follow the fundamentals of the State Emergency Management Plan. The local and regional planning process includes local emergency management planners who can help direct the individual hospital and clinic and regional and state response plan development so it has appropriate interface with the local plans.

Best Practices / Lessons Learned

Best Practices

One rural Texas county brings *all* the "players" (including County Judge, Emergency Management Coordinator, Sheriff, Public Health, healthcare, etc.) to the table quarterly for a meeting and to test their First Call Interactive Network System (Reverse 911). One organization or individual needs to take the lead to initiate periodic gatherings – rural healthcare organizations can serve as this driving force.

In one rural Texas county, a local coalition of residents formed due to concern of arsenic in the drinking water supply; because of a few concerned citizens, the state conducted water testing, a survey and cancer cluster study. This group stressed the importance of the community taking the initiative to get involved and asking questions of their local officials. This group has more recently become concerned about community disaster planning and took the lead of initiating and supporting these activities and efforts.

Rural Healthcare Organization Response Roles / Staff Role Assignments

Description

Assessments completed during the Prevention or Mitigation Phase should inform rural hospitals or clinics about the resources and assets they have available internally and to the external community as well as gaps that should be resolved. This and conversations with community partners should help determine the response role of your rural healthcare organization and its staff. In an emergency, personnel resources will be in short supply. Every hospital or clinic employee should have an assigned role with responsibilities or job actions (See Appendix F).

Possible Healthcare Role

Your healthcare organization's staff-person responsible for emergency planning should begin with your day-to-day organizational chart to provide a starting point for selection of staff to fill emergency response positions and roles. Use the Clinic Response Roles and Requirements and Emergency Response/Recovery Team Job Action Sheets in Appendix F to help assign staff to specific emergency response roles and responsibilities.

Best Practices / Lessons Learned

Best Practices

Emergency Management Coordinators or Planners in your community or region and nearby hospitals may have expectations for your facility and its staff in an emergency. It is vital to plan with partners to ensure they understand the capabilities and limitations of your facility and staff.

Within your rural healthcare organization, assign emergency roles and responsibilities to your staff and then practice these through an internal exercise. It is frequently difficult for people to switch from their everyday roles and lines of reporting to emergency roles and emergency lines of reporting. Practicing will help them become more comfortable with new and different roles and responsibilities.

Resources

- Clinic Response Roles and Requirements (Appendix F)
- Emergency Response/Recovery Team Job Action Sheets (Appendix F)

Staff Education and Training

Description

Health Resources and Services Administration's (HRSAs) Program Information Notice (PIN), recommends that Community Health Centers provide training on emergency management and the implementation of the emergency management plan to employees at all levels of the organization. This includes training in disaster awareness, preparedness and response and practicing the clinic plan and specific staff roles on an annual basis.

Testing your plan is the best way to identify problem areas and evaluate preparedness without actually experiencing a disaster. All drills and emergency management exercises should include some sort of post-exercise critique, such as an After Action Report (AAR), to help identify shortfalls in planning (i.e., problems in organization or operational concepts and procedures that don't work well in practice). These shortfalls should be addressed in the next iteration of the local planning process.

There are five types of exercises generally used:

- Orientation Seminar – Provides instruction to participants about roles, relationships and responsibilities. Has a multi-format (examines all aspects of the plans) and is non-stressful. It is designed for all levels of professionals, the public and special interest groups. It also applies corrective actions resulting from actual events or other exercises.

- Drill – Generally used to practice a single activity. The purpose is to develop skills or to correct a specific process or procedure. It involves physical activities by action or response personnel. It is intended to be non-stressful, but has defined time limits.
- Tabletop Exercise – Usually a non-stressful problem solving exercise. It works out details of generalized operations and applies multi-agency coordination considerations. Usually involves coordinators and policy makers. It is used to evaluate the adequacy of draft Emergency Operations Plans or annexes.
- Functional Exercise – This type evaluates a system or systems in a stressful, time sensitive simulation. A functional exercise requires an understanding of roles, responsibilities and operations by all participants. It usually evaluates one or more functions of the plan and involves coordinators and often will include policy makers. These exercises require extensive preparation and a team for the conduct and evaluation of the exercise. They will also involve a direction and control function and usually some degree of Emergency Operations Center (EOC) activation.
- Full-scale Exercise – This type adds field response units to previously evaluated functions. It requires extensive preparation and exercise team training. A full-scale exercise is intended to be time sensitive and stressful and will usually have high public visibility. It will involve all levels of participation and will involve activation of the EOC.

Below are additional education and training recommendations:

Employees at all levels should attend annual training and updates on emergency preparedness, which include the following:

- Clinician Bioterrorism Training
    - All physician and nursing staff should receive documented training on procedures to treat and respond to patients infected with biological agents and those that have sustained injuries due to other emergencies. Training will include:
        - Recognition of potential epidemic events.
        - Information about most likely agents, including possible behavioral responses of patients.
        - Infection control practices.
        - Use of Personal Protective Equipment (PPE).
        - Reporting requirements.
        - Patient management.
        - Behavioral responses of patients to biological and chemical agents.
    - General staff training should include:
        - Roles and responsibilities in an emergency incident.
        - Information and skills required to perform their assigned duties during the event.

- Awareness of the backup communications systems used in a emergency incident event.
- The location of and how to obtain supplies, including Personal Protective Equipment (PPE).

  - Clinicians and other staff should receive periodic updates as new information becomes available.

- Mental Health Team Training

  Mental health team members, in hospitals and clinics where they are available, should receive training that promotes understanding of the normal human response to disasters. The training for the Mental Health Coordinator and other mental health professional team members should include delineating the difference between traditional mental health therapy and crisis counseling. Training should also address cultural considerations of the service population and how they are affected by disasters.

- Drills and Exercises

  Staff should rehearse this disaster plan at least twice a year. All drills should include an after-action debriefing and report evaluating the drill or exercise. JCAHO Environment of Care Standard 4.20 also requires healthcare organizations to regularly test the emergency management plan through planned drills and exercises. The plan must be executed twice a year, either in response to an actual emergency or in planned drills.

  Exercises should include one or more of the following response issues in their scenarios:

  - Clinic evacuation
  - Biological Agent response
  - Mental Health response
  - Coordination with government emergency responders
  - Continuity of operations
  - Expanding clinic surge capacity

Rural healthcare organizations should participate in community-wide drills with partner organizations and agencies that assess communication, coordination, and the effectiveness of the clinic's and the community's command structures.

Possible Healthcare Role

Rural healthcare organizations should train their staff and continually test and evaluate the effectiveness of their emergency plan and make adjustments, as necessary. The frequency of testing and evaluation should be determined by the organization but should be at least on an annual basis. The plan should be updated and revised based on any lessons learned from

participation in drills or actual emergencies. If your community, local health department or other local agency is holding training, a drill or exercise, request that your clinic / hospital participate and take part in the after action report process.

Best Practices / Lessons Learned

Best Practices

In 2005, Community Health Center, Inc. in Connecticut tested the ability of its staff to care for non-English speaking patients during a TOPOFF disaster preparedness drill, a large-scale mock terrorism attack being coordinated by U.S. Department of Homeland Security. The multi-day event featured a simulated chemical attack. The focus of the CHC's exercise was on the care of non-English speakers during a crisis. To see the video of the CHC participating in the TOPOFF Drill, go to: http://www.chc1.com/information/top_off_drill/topoffv3b.mpeg.

Just-in-time training has been used for volunteers in past emergencies.

Funeral Home Directors in one West Texas region regularly convened locally for joint training instead of commuting to urban areas.

Training opportunities were leveraged by one rural Texas community by participating in trainings conducted in urban areas.

Some rural areas have effectively used the Community Emergency Response Team (CERT) Program to recruit and train volunteers.

One rural Texas community, created and conducted a survey disseminated to citizens and businesses to determine the community's health and emergency training needs.

Resources

- CDC Emergency Preparedness and Response Training and Education: www.bt.cdc.gov/training
- FEMA Emergency Management Institute Independent Study courses www.training.fema.gov/IS/crslist.asp
- CDC Centers for Public Health Preparedness www.bt.cdc.gov/training/cphp
- Agency for Healthcare Research and Quality (AHRQ) Bioterrorism and Health System Preparedness: Issue Briefs www.ahrq.gov/news/ulp/btbriefs

Communications

Description

In preparedness planning, the following communications issues should be considered:

- Redundant Communications System
- Internal Notification
- Communication with the Public

Redundant Communications System:

Explore options for, and establish, a secure, region-wide common communications network with sufficient redundancy and alternative systems.

Ensure alternate communication systems are in place, such as the following:

- Clinic Phones (landlines)
- FAX
- Cell Phones
- Satellite Phones
- Internet/Email
- Public Pay Phones
- Wireless Messaging
- Amateur Radio System (with an agreement with a local Amateur Radio group to respond to the clinic when requested)
- Handheld Radios / Walkie-Talkies (the clinic can use handheld radios for internal communications in both routine and emergency situations)
- If clinics experience alternate communications failure, runners can be employed to take messages to and from the clinic and appropriate agencies rendering assistance.

Clinics should have a radio, television with an antenna or cable connection and a VCR to monitor television and radio broadcasts to remain up-to-date on official government announcements and other information during a disaster.

Internal Notification:

It is important for rural healthcare organizations to maintain an up-to-date internal Staff Call List (see Appendix G) as well as an External Partner Call List (see Stakeholder Listing in Appendix A), both of which should be kept offsite as well as onsite by key employees and at key locations.

Communication with the Public:

During the planning phase, it is important to provide patients and the larger community with information that will prepare them for an emergency. This may include hospital / clinic education efforts though education and outreach on what the patient population and community-at-large can do to prepare their family and home for an emergency incident and what to expect from their local hospital or clinic.

Possible Healthcare Role

Redundant Communications System:

Rural healthcare organizations should have a clear understanding of the type of communications equipment that is utilized within the organization, as well as among local, state, and national agencies. It is important that rural health providers that are responsible for emergency communications have at least a basic working knowledge of the various types of communication devises that are used by public service and emergency medical service organizations.

At a minimum, an up to date listing of local communications frequencies that are used by law enforcement, emergency medical services, fire and disaster management officials should be maintained in a readily accessible location in each clinic / hospital. This list may include UHF, VHF, 1800 truncated line, and more state of the art communications frequencies. Copies of these communications "directories" should be located in the administrative offices, in the clinic / hospital "command center", and in other designated areas of the facility. Discuss common communication systems with your local and regional partners, such as law enforcement, emergency medical services, fire and disaster management officials, to ensure communication and coordination capabilities in an emergency.

Internal Notification:

Your hospital or clinic should compile and maintain an internal contact list that will include the following information for all staff: name, position title, home phone, cell phone, pager numbers, and preferred method of contact during off hours. The Staff Call List found in Appendix G contains sensitive contact information and will be treated confidentially. The list of staff phone numbers will be kept offsite as well as onsite by key employees and at key locations. The phone list should be provided to the clinic's answering service.

Your hospital or clinic should also develop an email group and a paging group for employees to facilitate rapid staff contact. You might also consider distributing laminated wallet-sized cards with emergency contact information for key staff to keep information readily accessible. Ensure that external community partners have contact information for integral personnel in case of an emergency.

Communication with the Public:

During the Preparedness Phase, rural healthcare providers and organizations should conduct outreach to their patients and the larger community to provide patient / community education. Resources, such as the American Red Cross' Home Preparedness Guidelines, already exist and are provided in Appendix H.

Rural healthcare organizations should initiate public education campaigns for the community using various existing materials (see Family & Community Disaster Planning Resources, American Red Cross in Appendix H). It is especially important for healthcare organizations, such as Community Health Centers and Migrant Health Centers, to place an extra emphasis on outreach efforts targeting special, hard-to-reach populations whom they serve. CDC *Draft* Guidance, *Public Health Workbook to Define, Locate and Reach Special, Vulnerable, and At-Risk Populations in an Emergency*, provides guidance and a resource manual. More information follows below in "Finding and Reaching At-Risk Populations in an Emergency" (see page 56).

Rural healthcare providers and organizations should conduct outreach to various non-profit organizations, faith-communities, neighborhood associations, etc. prior to the occurrence of an emergency to define and locate vulnerable populations and have multiple methods in place to contact these populations in an emergency. For more information, see "Finding and Reaching At-Risk Populations in an Emergency" below.

Best Practices / Lessons Learned

Best Practices

Modes of communication utilized in rural communities include HAM radio operators, word of mouth, police scanners, PA Systems on police, fire, and ambulances, the weather alert system, billboards, civil defense siren, volunteer fire department, pagers, radio, newspapers and church bulletins.

The Community Health Care Association of New York State developed a patient brochure as part of their community and patient education efforts. This brochure, *What to Expect from Your Health Center in an Emergency*, can be found at:
http://www.chcanys.org/clientuploads/downloads/ep_misc/CHCs_in_an_Emergency_PtBrochure_FINAL.pdf

In one rural community, internal communications were streamlined by housing all first responder services in the same building using the same radio system.

Rural communities have conducted community education campaigns to inform the communities of what t expect in an emergency. These efforts educate the community and encourage them to plan as well as decreasing the panic in an emergency. These efforts have been conducted through newspaper articles, programs in schools, at PTA meetings and at churches, pamphlets to the elderly population using Meals-o Wheels, and information sent home with students at schools.

Resources

- Staff Contact List (Appendix G)
- Partner Contact List (Appendix A)
- Family & Community Disaster Planning Resources – American Red Cross (Appendix H)

Finding and Reaching At-Risk Populations in an Emergency

Description

The Centers for Disease Control and Prevention have created a document in draft format, *Public Health Workbook to DEFINE, LOCATE, and REACH Special, Vulnerable, and At-Risk Populations in an Emergency*, intended to help define, locate and reach special, vulnerable and at-risk populations in emergencies. Following are information and tools from the draft CDC Workbook that will help rural healthcare organizations, particularly those that serve special populations, assist their communities in this process. *Please remember, the CDC Workbook has not been formally published and is still in a draft format.*

Effective planning for emergency preparedness and response requires the capacity to reach every person in a community. To do this, a community must know what sub-groups make up its population, where the people in the groups live and work, and how they best receive information. While this may seem like a statement of the obvious, research indicates that although significant accomplishments have been achieved in certain areas of the United States, and planners and community organizations are constantly at work on this issue, many jurisdictions have not comprehensively defined or located their special populations. These populations may be based on characteristics such as economic disadvantages, limited language competency, disabilities, cultural or geographic isolation and age.

These populations in rural areas may include ranchers, farmers and people who live in sparsely populated mountain and hill communities. They are vulnerable due to lack of capacity, resources, equipment and professional personnel needed to respond to a large-scale crisis. Rural areas have some special communication challenges, such as dependence on satellite television, which does not provide local channels or news. Additionally, radio stations have moved to a "canned" commercial feed in many communities and may not be useful for dispensing information in a local emergency.

> While it is important to locate and reach disadvantaged families for communications during an emergency, it is also important to have plans in place prior to an emergency that will assist them in getting food, water, formula, diapers, medications, etc.

Possible Healthcare Role

Begin defining and identifying the at-risk populations in your community using the resources in Appendix I. Included are steps to assist your healthcare organization in defining, locating and reaching vulnerable populations as well as sample templates for phone surveys, questionnaire/script, MOUs, collaboration letter, focus group or roundtable discussion script and an e-mail test template.

In rural and frontier areas, residents within a certain distance usually know each other. It is vital, however, for state, local, county, and tribal health and emergency professionals to know where these people are located in order to create strategies to reach them in day-to-day communication and especially in an emergency, particularly if electric power is lost. In Appendix I, you will find steps and templates that will help you reach out to organizations that serve vulnerable populations and individuals in your community.

Best Practices / Lessons Learned

Best Practices

Many rural Texas communities have efforts in place to locate special populations in rural areas through churches, Meals-on-Wheels, home health agencies, civic groups and agencies and organizations that serve elderly, isolated, disabled and non-English speaking populations. Many efforts have included the dissemination of surveys to help define and locate special populations and ascertain the best methods or channels to reach these people in an emergency.

New Mexico has created tip sheets, "Tips for First Responders," to provide information to first responders on how to assist persons with a wide range of disabilities, including: Seniors, People with Service Animals, People with Mobility Challenges, People with Mental Illness, Blind or Visually Impaired People, Deaf or Hard of Hearing People, People with Autism, People with Multiple Chemical Sensitivities and People with Cognitive Disabilities. You can download the tips sheets at: http://cdd.unm.edu/products/tips_web020205.pdf or you can order color-coded, laminated 4.5 x 5.5-inch field guides at: http://cdd.unm.edu/products/TIPSheetOrderForm.doc.

"Tips for First Responders" was a joint effort by the Center for Development and Disability at the University of New Mexico; American Association on Health and Disability (AAHD); New Mexico Governor's Commission on Disability; the Office of Health Emergency Management, New Mexico Department of Health; and the Research and Training Center on Independent Living at the University of Kansas.

Resources

- At A Glance: Defining At-risk Populations (Appendix I)
- At A Glance: Finding At-risk Populations (Appendix I)

- At a Glance: Reaching At-risk Populations (Appendix I)
- Through the Lens of the Categories: Finding At-risk Populations (Appendix I)
- Through the Lens of the Categories: Reaching At-Risk Populations (Appendix I)
- Sample Telephone Survey Template (Appendix I)
- Questionnaire Template/Phone Script (Appendix I)
- Memorandum of Understanding Template (Appendix I)
- Collaboration Agreement Letter Template (Appendix I)
- Focus Group, Interview, or Roundtable Discussion Template Interview/Survey Template to Learn from Other Agencies and Organizations (Appendix I)
- E-mail Test TEMPLATE (Appendix I)

Triage

Description

Triage is a method of sorting casualties into priorities for treatment based on life-threatening injuries, particularly when the number of ill or injured needing care exceeds available resources. The guiding theory of effective triage is to accomplish the best for the most using the least. Triage utilizes a four-tier color system.

RED Triage Tag Color – Critical, life threatening but treatable injuries requiring immediate medical attention.

- Victim can be helped by immediate intervention and transport
- Requires medical attention within minutes for survival (up to 60 minutes)
- Includes compromise to patient's airway, breathing, and circulation (the ABC's of initial resuscitation)

YELLOW Triage Tag Color – Potentially serious injuries, but are stable enough to wait a short while for medical treatment.

- Victim's transport can be delayed
- Includes serious and potentially life-threatening injuries, but status not expected to deteriorate significantly over several hours

GREEN Triage Tag Color – Minor injuries that can wait for longer periods of time for treatment, emergency transportation not considered necessary.

- Victim with relatively minor injuries
- Status unlikely to deteriorate over days

BLACK Triage Tag Color – Dead or still with life signs but injuries are incompatible with survival in austere conditions.

- Victim unlikely to survive given severity of injuries, level of available care, or both
- Palliative care and pain relief should be provided

Possible Healthcare Role

If healthcare resources are overwhelmed following any type of emergency or disease outbreak, your rural healthcare organization may need to triage patients at the rural hospital or clinic facility or at an Alternate Care Site. Rural healthcare organizations should have a plan in place and clinicians should have the necessary triage training.

Disaster triage may need to be utilized whether an emergency is in your community or a neighboring community, as larger regional hospital resources and facilities become overloaded. Rural healthcare providers and organizations should have a triage plan in place and ensure that staff are trained but should also discuss disaster triage with neighboring healthcare organizations.

The Simple Triage and Rapid Treatment (START) Model was developed in 1983 by the Newport Beach, CA Fire Department and Hoag Memorial Hospital for use in disaster, multi-casualty settings (see model below). For more information, training and materials, visit: www.start-triage.com. Another model, the JumpSTART Pediatric MCI Triage Tool, developed by Dr. Lou Romig in 1995 for the triage of children, parallels the structure of the START system. For more information on the JumpSTART triage model, visit: www.jumpstarttriage.com.

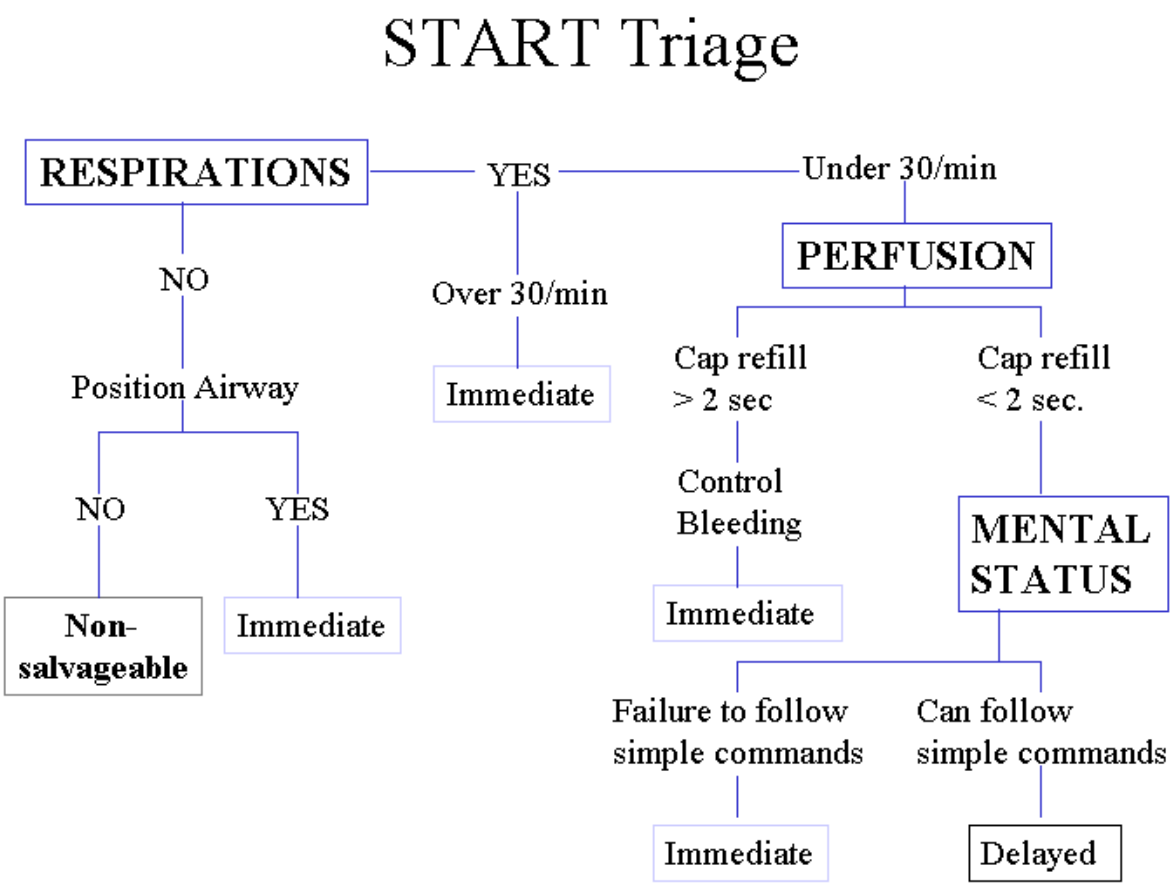
Best Practices / Lessons Learned

Best Practice

Local clinics can be designated as a triage area during a disaster. Urgent care and minor care emergency clinics established in rural areas would relieve urban emergency rooms and could function as a triage facility during an emergency.

Resources

- START Model



Source: Hoag Memorial Hospital, Newport Beach, CA

Surge Planning

Description

Surge capacity encompasses clinic resources required to deliver healthcare services under situations which exceed normal capacity including, potential available space in which patients may be triaged, managed, vaccinated, decontaminated, or simply located; available personnel of all types; necessary medications, supplies and equipment; and even the legal capacity to exceed authorized care capacity.

Possible Healthcare Role

Rural healthcare providers and organizations need to consider such issues as staffing to treat a large influx of patients at a hospital, clinic or other designated site; bed capacity in a rural hospital as well as rural clinics, if designated to serve an overflow of patients; and pharmaceuticals, equipment and supplies that would be required to treat the increased volume or overflow of patients.

It will be critical to discuss with local and regional partners the expectations of your rural hospital or clinic and what they see as the role of the staff and facility in an emergency. Develop MOUs with local organizations, agencies, healthcare providers, vendors, etc. for resources (e.g., personnel, equipment, supplies).

Continuity of Operations

Description

Rural healthcare providers and organizations should maintain service delivery or restore services as rapidly as possible following an emergency that disrupts those services. As soon as the safety of patients, visitors, and staff has been assured, your organization should give priority to providing or ensuring patient access to healthcare.

Possible Healthcare Role

Continuity considerations for rural healthcare organizations might include:

- Safety – Develop, train on and practice a plan for responding to internal emergencies and evacuating clinic staff, patients and visitors when the facility is threatened.
- Resources (staffing, equipment and supplies) –
    - Develop plans to obtain needed medical supplies, equipment and personnel
    - Encourage staff to develop their own family care plans for dependent care (e.g. school closures, snow days)

- Determine the minimum number and categories of personnel necessary to keep the office/clinic open
- Plan for either closing the office/clinic or recruiting temporary personnel during a staffing crisis
- Have a liberal/non-punitive sick leave policy for personnel

- Information Protection:
  - Medical Records – To the extent possible, protect medical records from fire, damage, theft and public exposure. If the clinic is evacuated, provide security to ensure privacy and safety of medical records.
  - Vital records, data and sensitive information –
    - Ensure offsite back-up of financial and other data.
    - Store copies of critical legal and financial documents in an offsite location.
    - Protect financial records, passwords, credit cards, provider numbers and other sensitive financial information.
    - Update plans for addressing interruption of computer processing capability.
    - Maintain a contact list of vendors who can supply replacement equipment.
    - Protect information technology assets from theft, virus attacks and unauthorized intrusion.

- Equipment Protection –
  - Compile a complete inventory list of equipment serial numbers, dates of purchase and costs. Provide list to the CFO, financial administrator or other responsible individual and store a copy offsite.
  - Protect computer equipment against theft through use of security devices.
  - Use surge protectors to protect equipment against electrical spikes.
  - Secure equipment to floors and walls to prevent movement during earthquakes.
  - Place fire extinguishers near critical equipment, train staff in their use, and inspect according to manufacturer's recommendations.

- Maintain Financial Viability –
  - Ensure billing systems are in place for obtaining payment and reimbursement as soon as possible.
  - Ensure a system to track patients being treated as a result of an emergency (i.e., surge patients) that is independent of normal operations which can be used in obtaining any supplemental funding should it become available.

- Consider a back-up billing system to track charges and sustain the flow of reimbursement needed to maintain the financial viability during any response and recovery

For additional information, see "Inventory and Documentation of Damages / Losses" and "Recovery of Revenue Losses" in Recovery Phase Section below.

- Utilities Restoration –
  - Maintain contact list of utility emergency numbers (see Appendix A for Stakeholder Contact List).
  - Ensure availability of phone and phone line that do not rely on functioning electricity service.
  - Request priority status for maintenance and restoration of telephone service from local telephone service provider.
  - Continuous performance or rapid restoration of the clinic's essential services during an emergency.

Rural healthcare providers will need to rely on other organizations, agencies and healthcare facilities, especially those nearby, in responding to a disaster to augment its capacity to meet patient care needs. Make a list of those organizations and agencies and contact and meet with them to discuss roles, resources, etc. In rural areas, private organizations and facilities might include nursing homes, home health and other private providers such as dentists, pharmacists, school nurses and veterinarians

Best Practices / Lessons Learned

Best Practice

Rural healthcare providers will probably become overwhelmed during an emergency. While it is important for your organization to have plans to maintain or quickly restore patient care, you will have to rely on various support services and vendors in the community. Make recommendations to your business partners and other organizations to create their own plan for continuing operations during an emergency. See the American Red Cross, Business & Industry Guide: Preparing Your Business For the Unthinkable at: www.redcross.org/services/disaster/0,1082,0_606_,00.html.

Alternate Care Site

Description

In the aftermath of an emergency, hospitals and clinics may be inundated by a sudden influx of patients. The impact of a mass casualty event of any significant magnitude likely will overwhelm, and even render inoperable, hospitals and other traditional venues for healthcare services. Alternate Care Sites (ACS) can assist in providing care for patients when the existing structure of the healthcare delivery system is no longer functioning under normal operating conditions. They can be defined as alternate operating locations used for healthcare services when existing healthcare facilities are inaccessible due to a disaster or when the volumes of patients exceed the capabilities of those facilities. ACS may also serve as a primary triage point**,** a community-focused ambulatory care clinic, or a low-acuity patient care site.

Possible Healthcare Role

Planning for an Alternate Care Site is a critical part of all-hazards preparedness planning. Rural healthcare providers and organizations, in conjunction with community partners, must conceive of a plan for how the ACSs would deliver wide-ranging healthcare services to the population in need. This planning must be done with existing healthcare facilities (hospitals, outpatient clinics, and multispecialty group offices), home health care and long-term care entities as well as emergency managers, public health (local and State), law enforcement, public safety, and emergency medical services (EMS). ACS planning is particularly important for rural healthcare organizations and rural communities, whose hospitals and clinics may lack space and resources, and due to potential difficulties patients may experience in reaching a rural hospital or clinic during an emergency because of rural geography and transportation limitations.

The **Alternate Care Site Selection Tool** in Appendix J is designed to help planners to locate and rank potential alternative sites—stadiums, schools, recreation centers, motels, and other venues—based on whether they have adequate ventilation, plumbing, food supply and kitchen facilities, and other factors. The biggest challenge that communities will need to plan for is the procurement of the amount and complexity of resources or the level of staffing required to extend hospital or clinic facilities into designated ACSs. For this reason, most ACSs will be located in "buildings of convenience." It is imperative for planners to establish clear operational definitions of what can and cannot be accomplished in the setting of an ACS. It is critical that MOUs for resources and staffing are in place.

Also important to plan for is the determination of ownership, command, and control of the ACS at a local or regional level. This must include the identification of the individual(s) with the authority to decide whether, when, and where an ACS should be opened and the authority to operate the site. The most effective way to make such decisions is to use and build on the organizational and governance structure that is already functioning in the region or State. The administrative structure for operation of an ACS should follow the basic concepts of the Incident Command System (ICS).

Best Practices / Lessons Learned

Lesson Learned

When establishing an ACS or POD (see next section), establish more than one site. One rural Texas community pre-designated a particular a shelter site to transfer nursing home residents during a flood, but that site was cut-off due to road closures.

Resources

- Alternate Care Site Selection Tool (Appendix J)

Point of Distribution Site

Description

A Point of Distribution (POD) site is a facility, which would be utilized to distribute pharmaceuticals, vaccinations, antivirals, supplies, etc. to help control a disease outbreak. These facilities may include schools, large conference centers, recreation/community centers, sports arenas, etc.

Possible Healthcare Role

As with Alternate Care Sites, these sites should be established in advance. While medical supplies and equipment are not as important in PODs, other than the purpose the POD is being utilized, staff will be required. Personnel (staff or volunteer) required for setting up a POD or ACS might include the following:

- Parking assistants
  Able-bodied individuals who can assist in directing the flow of traffic into a parking area. Must be comfortable working outdoors.
- Greeters
  Near entrance of clinic, will direct attendees to proper entrance into facility. Must be comfortable standing for long periods.
- Security
  This function would be limited to law enforcement / security officials
- IT Assistants
  May be asked to assist with set up of computer equipment at clinic sites, under over-site of other community IT Specialist(s).

- Form Distributors
  Will distribute consent forms, information packets and pencils to attendees. Likely sitting at table.
- Registration
  Must be comfortable with basic data entry and sitting for periods of time. Entering basic demographics of attendee. If not done via computer, paper consent forms will be utilized.
- 'Shepherds' / Guides
  Provides directions to attendees, guiding to the next station. Requires standing for extended periods.
- Healthcare Provider (Nurse, MD, PA)
  Variety of potential tasks: conducting medical history; vaccinations; dispensing medication; pre-and post- education.
- Physician Consult
  Well-versed with specific disease and vaccination contraindication. Training may be required to learn computer system.
- Pharmacist
  Dispense medication or provide necessary oversight of distribution by other approved individuals.
- Health Educator
  Help develop and / or disseminate appropriate and necessary information to specific populations and/or the community at large.
- Telephone Monitor
  Contact quarantined individuals, via telephone, to evaluate symptoms and confirm quarantine status (i.e. that individual has remained in the home). May require sitting for extended periods. May also act a member of 'rumor control' phone bank staff.
- Transporters / Couriers
  Driver's License required. Utilized to transport materials / supplies to distribution sites. May assist with food / other essentials delivery to quarantined individuals.
- Mental Health Counselors
  Needed during all clinic operations; available to assist quarantined individuals manage event / disease.
- Translators
  Particularly Spanish-speaking, to translate clinic or quarantine process, preferably with knowledge of medical terminology.
- Spiritual Leaders
  Available to those in need of spiritual counseling.

Source: Somerset County Health Department, New Jersey www.co.somerset.nj.us/Health/

Security

Description

Any type of emergency incident has the potential to result in public panic and may threaten the security of a hospital or clinic. Security precautions and planning should address everything from day-to-day awareness to procedures during an actual incident. Security during an emergency will be critical in maintaining the operating integrity of the clinic/hospital, protection from unauthorized entry and contamination and actual threat against the clinic. Planning for the security of a facility must include resources outside the facility. By integrating hospital / clinic security planning into the emergency planning process, resources can be coordinated and effective security provided within the local Incident Command System.

Possible Healthcare Role

In a clinic or hospital, issues of security during an emergency are of particular concern for the following situations: isolation of a contaminated area, crowd control, triage, decontamination, clinic/hospital evacuation, patient / family disturbances (particularly when patients or families are worried and/or do not have necessary information), and protection of vital resources (e.g., limited supplies, equipment, medical records).

Rural healthcare organizations should consider assessing their facility for the following: precautions a facility must take until help arrives, identification of sensitive areas within the facility that must immediately be protected (secure perimeter, limit facility access), identification of vulnerable areas, handing of the media, location for communication center within the facility, using the facility as a shelter, responding to medical emergencies and identification of security personnel.

Because rural healthcare organizations presumably lack security staffing, it is important to 1) designate clinic/hospital staff to serve in a security capacity in an emergency and / or 2) seek partnerships with outside agencies or organizations that can supplement security needs. Local law enforcement may have other duties during an emergency incident and probably will not be available.

Best Practices / Lessons Learned

Best Practice

Local high school and community college students were trained in security during ROTC and criminal justice classes and then volunteered to serve in security roles at various locations during emergencies.

Volunteers

Description

In a widespread emergency, physicians, nurses and other clinicians may seek to volunteer at the clinic. If possible, during the preparedness planning phase, it is important that volunteers are organized and trained before an actual emergency occurs. In Appendix K a volunteer roster can be found below to help organize and track volunteers.

Possible Healthcare Role

During the preparedness planning process, make sure to include volunteers (Medical Reserve Corp, CERT) in training, exercises and drills.

Community partners that may volunteer at a hospital or clinic, or that you should consider recruiting as volunteers, may include the following:

- Chaplains
- Dentists
- Emergency Medical Technicians (EMT) /Paramedics
- Epidemiologists
- Interpreters
- Legal Advisors
- Nurses
- Office Workers
- Pharmacists
- Physicians
- Veterinarians
- Other Support Roles

In addition to the volunteers listed above, voluntary networks also provide disaster preparedness, response and relief services. These include:

- USA Freedom Corps: Some volunteer initiatives include Community Emergency Response Teams, Neighborhood Watch Programs, Medical Reserve Corps, and Citizen Corps Councils.

- 211 Call Center is a volunteer-based resource that has been developed across the country as a local, one-stop, no-charge, public resource for a wide variety of human service resources and referral information. 211 is recognized by local municipalities and 211 Call Centers are closely integrated into local emergency preparedness planning.

- The American Red Cross operates a Disaster Welfare Inquiry System during disasters to assist victims' family members locate, receive information about and/or reunite with their injured relatives. Procedures should be established to provide information to the local Red Cross chapters to assist in this system.

As rural healthcare organizations work with local leaders, you may find that they are interested in getting more background information on emergency preparedness. Community leaders may also need training and education on specific emergency preparedness issues. There are many resources available that provide organizations with emergency training and education. Programs that cover a wide range of preparedness topics are available, each with a different focus and involving different time commitments. Listed in the resources below are a few education and training resources that rural healthcare organizations can share with both healthcare and non-healthcare partners. Additional resources may be available in your community. Rural healthcare organizations can also link with local partners during various trainings, exercises and drills to ensure there is community-wide, multidisciplinary integration in place prior to an emergency incident.

Best Practices / Lessons Learned

Best Practices

"We have to think outside of the box – one of our guys walked into a church on a Sunday and got over 300 volunteers right then and there."

Utilize the Ministerial Alliance to recruit volunteers from churches.

Rural communities recruited retired nurses from surrounding urban and suburban communities.

Volunteers may need incentives to sign-up. One county in Texas was able to provide retired nurse volunteers with CNEs for training.

Use the Retired Senior Volunteer Program (RSVP) and Area Agency on Aging to recruit volunteers.

It is important to gear volunteer responsibilities to their interests and time constraints. Exhibit flexibility in assigning tasks to volunteers.

During an emergency, emergency management staff teamed 3-4 non-professional volunteers with one paid professional.

Recruit and train high school and community college students. Include them in exercises.

Begin by developing a list of potential volunteers and begin contacting.

Remember to recruit "non-typical" volunteers for non-health-related tasks, such as clerical and administrative tasks.

Keep volunteers enthused with periodic meetings and trainings.

Lessons Learned

Rural communities are very reliant on volunteers to perform first responder roles such as volunteer fire department. The volunteer-base is small and redundant, so it is important to limit burn-out -- don't overdo meetings, trainings or other activities or have unrealistic expectations for volunteers' time. Try to reach out to additional volunteers to distribute the tasks.

Volunteers are often full-time employees, and in rural areas, often work outside of the community. It is important to be organized so valuable time is not wasted.

It is important, when possible, that volunteers have training prior to an emergency and are included in community exercises.

Resources

- Training Resources
- Volunteer Roster (Appendix K)

American Red Cross
The American Red Cross (ARC) has developed several community awareness and emergency response courses. The courses available range from first aid for pets, AED training, and introduction to disaster services. Most of the programs are developed for families and individuals, but they can be adapted for schools, businesses, and healthcare facilities. Most of the programs are available for free, but there are a few trainings which have fees associated with them. To find out more about the available courses and to locate the local office for the American Red Cross visit: http://www.redcross.org.

Interfaith Disaster Services
Many states have Interfaith Disaster planning and response groups that may provide volunteer education and training. A few of these groups with websites are listed below, although this list is far from comprehensive:

Florida – www.findflorida.org
Louisiana – www.lainterchurch.org/LIDRNHomePage
Minnesota – www.mnchurches.org/midr
Mississippi – www.msidtf.org
Missouri – www.umocm.com/midro
New York – www.nydis.org
North Carolina – www.ncidr.org
Texas – www.tidr.org

Community Emergency Response Teams (CERT)
The Community Emergency Response Team (CERT) is a program developed through the Department of Homeland Security (DHS) that helps train people to be better prepared to respond to emergency situations in their communities. When emergencies happen, CERT members can give critical support to first responders, provide immediate assistance to victims, and organize spontaneous volunteers at a disaster site. CERT members can also help with non-emergency projects that help improve the safety of the community.

Numerous CERT groups exist at the state and local level. Got to this website for a directory of CERT programs by state: www.citizencorps.gov/cc/CertIndex.do?submitByState

FEMA Online Training
Online training programs in emergency preparedness are available from FEMA through the FEMA National Emergency Training Center Virtual Campus at:
http://training.fema.gov/VCNew/firstVC.asp

Psychological Health Issues (Behavioral Health Disaster Plan)

Description

Following an emergency incident, anxiety and alarm can be expected from affected patients, their families, healthcare workers, and the worried-well. Psychological responses may include anger, fear, panic, unrealistic concerns about illness or infection, fear of contagion, paranoia, and social isolation. Clinics, hospitals and communities should include mental health workers when developing emergency response plans. Most rural communities have no psychiatrists, psychologists or social workers, and will be more reliant on atypical mental health professionals such as clergy and school counselors.

Possible Healthcare Role

If an emergency situation is the result of an infectious disease outbreak, the following are some points for healthcare providers to consider:

- Communicate clear, concise information about the infection, how it is transmitted, what treatment and preventive options are currently available, when prophylactic antibiotics, antitoxin serum or vaccines will be available, and how prophylaxis will be distributed
- Provide counseling and possible anxiety-reducing medications to the worried-well and the victim's family members
- Provide educational materials in the form of frequently asked questions and answers
- Provide home care instructions
- Provide information on quarantine and isolation
- Information released to the public should be coordinated with local and state health officials
- Many Community Health Centers have standing contracts for mental health services.
- When there are no standing contracts for mental health services, develop MOUs with these organizations, agencies and providers.
- Create or strengthen linkages with local faith-based services, the Ministerial Alliance and school counselors who may provide assistance.
- Develop and maintain a resource list of community mental health resources (local Mental Health Agency, American Red Cross, clergy, community mental health providers, etc.) that could augment the response of the clinic's mental team.

In Appendix L is a Mental Health Preparedness Checklist that can be used during and after an incident.

Determine which other agencies in surrounding communities and regional resources are responsible for responding to mental health needs. The following services should be provided:

- Coordination with other local, State, and Federal mental health care providers to ensure a community wide mental health care program is in place following an incident.
- Individuals with Red Cross Disaster Service Training, who will, in a non-intrusive manner, provide supportive activities for survivors, family members and other support personnel.
- Coordination of the clergy response for those in need to ensure religious support is available. These efforts should include faith-based organizations, places of worship and service agencies, important for effective and coordinated provision of mental health services in rural areas.
- Mental health services for responders, victims and their families.
- Many times, the impact of the emergency situation will not surface until during and after the recovery phase once State, Federal and voluntary mental health provider groups have left the community. Make sure mental health resources are available for referral post-incident.

Source: California Primary Care Association and California EMS Authority

Resources

- Web-based Mental Health Resources
- Mental Health Coordinator Checklist (Appendix L)

Mental Health All-Hazards Disaster Planning Guidance, SAMHSA Center for Mental Health Services
http://mentalhealth.samhsa.gov/publications/allpubs/SMA03-3829/default.asp

Disaster Mental Health Primer: Key Principles, Issues and Questions
www.bt.cdc.gov/mentalhealth/primer.asp

Health Professionals: Coping With a Traumatic Event
www.bt.cdc.gov/masscasualties/copingpro.asp

Disaster Counseling for Patients
http://mentalhealth.samhsa.gov/publications/allpubs/KEN-01-0096/default.asp

For Mental Health and Human Services Workers in Major Disasters
http://mentalhealth.samhsa.gov/disasterrelief/publications/allpubs/ADM90-537/fmskills.asp

Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations
http://mentalhealth.samhsa.gov/publications/allpubs/SMA03-3828/default.asp

VII. Response

Response Defined:

Response refers to the actual emergency and controls the negative effects of emergency situations. Response efforts occur during an event to improve the outcome through a comprehensive, well-developed and practiced plan that will activate needed resources within the emergency response system. This includes actions taken to save lives and prevent further property damage in an emergency situation. The response phase addresses the immediate unmet needs of the affected population. Does your region have the means to determine the needs to address a major disaster and the resources to meet those needs?

One of the top priorities following a major disaster is an assessment of damages to rural providers and other aspects of the community health and medical system. Assessment of critical needs, along with assessments of health and medical resources, equipment and personnel to meet both immediate critical needs and long-term recovery needs of the affected population, are a major part of planning and response activities.

Response Priorities should include:

- Ensure life safety – protect life and provide care for injured patients, staff, and visitors
- Contain hazards to facilitate the protection of life
- Protect critical infrastructure, facilities, vital records and other data
- Resume the delivery of patient care
- Support the overall community response
- Restore essential services/utilities
- Provide accurate and timely crisis public information (special populations)

To the extent possible, your healthcare response should be coordinated with the decisions and actions of the public health, other health care agencies and larger governing authorities involved in the response.

Plan Activation

Description

Your healthcare organization's emergency plan may be activated in response to events occurring within the clinic or external to it. Any employee or staff member who observes an incident or condition which could result in an emergency situation should report it immediately to the appropriate individual (e.g., supervisor, Director, Safety Officer). Fires, serious injuries, threats of violence and other serious emergencies should be reported to fire or police by calling 9-1-1.

Possible Healthcare Role

The steps below are guides to activating your emergency response plan. You may or may not follow each step depending on the situation. Some steps may be skipped in an actual emergency.

- Make decision about Emergency Operations Center (EOC) activation, location, and appropriate staffing.

- The Clinic Executive Director officially activates the Emergency Operations Plan (EOP) by assigning the Incident Manager to activate staff, the EOP, and the Emergency Operations Center (as needed).

- The Incident Manager evaluates whether other Emergency Response Team (ERT) staff are needed immediately, or later, and which key agencies must be notified.

- The Incident Manager ensures notification of staff (as needed for the event) to assist with the recovery operations (or the Incident Manager assigns this duty, but still must ensure it is completed).

- Assign staff to set up an EOC. Ensure security and safety are present to ensure safety of personnel, habitability, and secure operations.

- If using an alternate EOC, contact the alternate sites to ensure the space is available prior to sending staff.

- If not all ERT staff are activated, ensure all other ERT staff are made aware of which EOC is being activated in case they are called for service.

- Once the EOC site is proven safe to activate, direct complete activation.

- Ensure that external safety, parking, and access is appropriate for the EOC operation.

- Direct the Safety Officer to continue habitability assessments, especially in highly variable and dangerous conditions (floods, fires, hazmat, civil disturbance, earthquake, etc.)

- All persons notified will be provided the same, short briefing of the events at hand, including:

    - What is the event?
    - What is it threatening (staff, property, communications, data, fiscal operations, environment, general public)?
    - What is being done and by whom (activation of ERT, EOC, recovery actions, etc.)?

Prior to plan activation, all staff should be are properly trained to know the various incidents or conditions which could result in emergency situations.

Best Practices / Lessons Learned

Lesson Learned

Make sure you are aware of what is expected of your facility and staff if an emergency were to occur. During recent hurricanes, community expectations were not communicated to clinics and the clinics shut down and sent staff home.

Resources

- Open / Close Decision Tool (Appendix M)

Communications

Description

Communications during and after an emergency, and consequently the role of your healthcare organization's Public Information Officer (PIO), are vital to ensure that hospital or clinic staff, the media, patients, family members and the public have the appropriate information and necessary instructions and that information is shared with other response community partners.

Possible Healthcare Role

Communication with Staff:

The PIO should coordinate the delivery of information to staff through flyers, meetings and conference calls. Information provided can include clinic status, impact of the disaster on the community, status of the overall response and clinic management decisions. Under some circumstances, the PIO can request media to broadcast a message specifically for the staff of the hospital or clinic to inform them of the organization's operational status and expected actions.

Communication with Media:

In an emergency, the PIO is designated as the media contact and will receive approval from the Incident Commander or Executive Director prior to any interviews or media releases. Most media inquiries regarding a disaster will be managed by the local government and media requests

and responses should be coordinated through the Public Information Officer in the local government. It is critical that information disseminated by the clinic or hospital be consistent with information disseminated through the local PIO. See Appendix N for additional procedures for managing Public Information activities and for a form for documenting media contacts.

The PIO should establish relationships with community media, especially outlets that are preferred by communities served by the clinic / hospital, including non-English language broadcast media, where appropriate. If your healthcare organization receives a media inquiry, the media relations policy should be put into place. If the clinic / hospital is part of a larger organization, the media relations may be handled by the headquarters.

Communication with Public:

In coordination with the local government, the PIO can provide information to the community that includes recommended actions, protective measures, and locations of various services and resources. Information should be disseminated in the languages spoken in the communities served by the clinic. See page 56, *Finding and Reaching At-Risk Populations in an Emergency*, for more information.

Communications with Patients and Family Members:

The PIO should coordinate release of information on the status of staff, family and friends to the community. Briefings will be held at a safe location away from the designated assembly area to prevent further interruptions with evacuation and treatment efforts. The PIO should participate in media interviews and develop communications strategies to keep patients and community members informed of the situation at the clinic, its operating status and alternatives for receiving services. The PIO will ensure that all public releases of information protect patient confidentiality.

To ensure that accurate information is being communicated to the community-at-large, it is essential that messages be coordinated with local and regional partners.

Best Practices / Lessons Learned

Best Practices

Many communities use Reverse 911 to disseminate an automated message to large groups during an emergency. People with cell phones have to register themselves, otherwise Reverse 911 only reaches landlines.

The postal service should be utilized to disseminate information to the public – in case of a pandemic flu outbreak, postal workers can put information and facemasks in everyone's mail boxes.

Pre-identifying special populations helped one community develop appropriate communication strategies during an emergency.

Prepare in advance clear, accurate, culturally appropriate, multilingual information.

Keep all messages consistent between partners to eliminate any confusion.

Schools have played a big part in the education of children and parents.

It is important to use multiple methods to reach people when educating them and disseminating information.

Resources

- Media Contact Information (Appendix N)
- Media Contact Form (Appendix N)

Healthcare Operations

Triage:

Description

As mentioned previously, when there is a surge of patients and inadequate resources to treatment them, your healthcare organizations should establish a triage area in a designated location of the hospital or clinic that is clearly delineated, secured and with controlled access and exit. An Alternate Care Site in your community may also be selected for triage.

Possible Healthcare Role

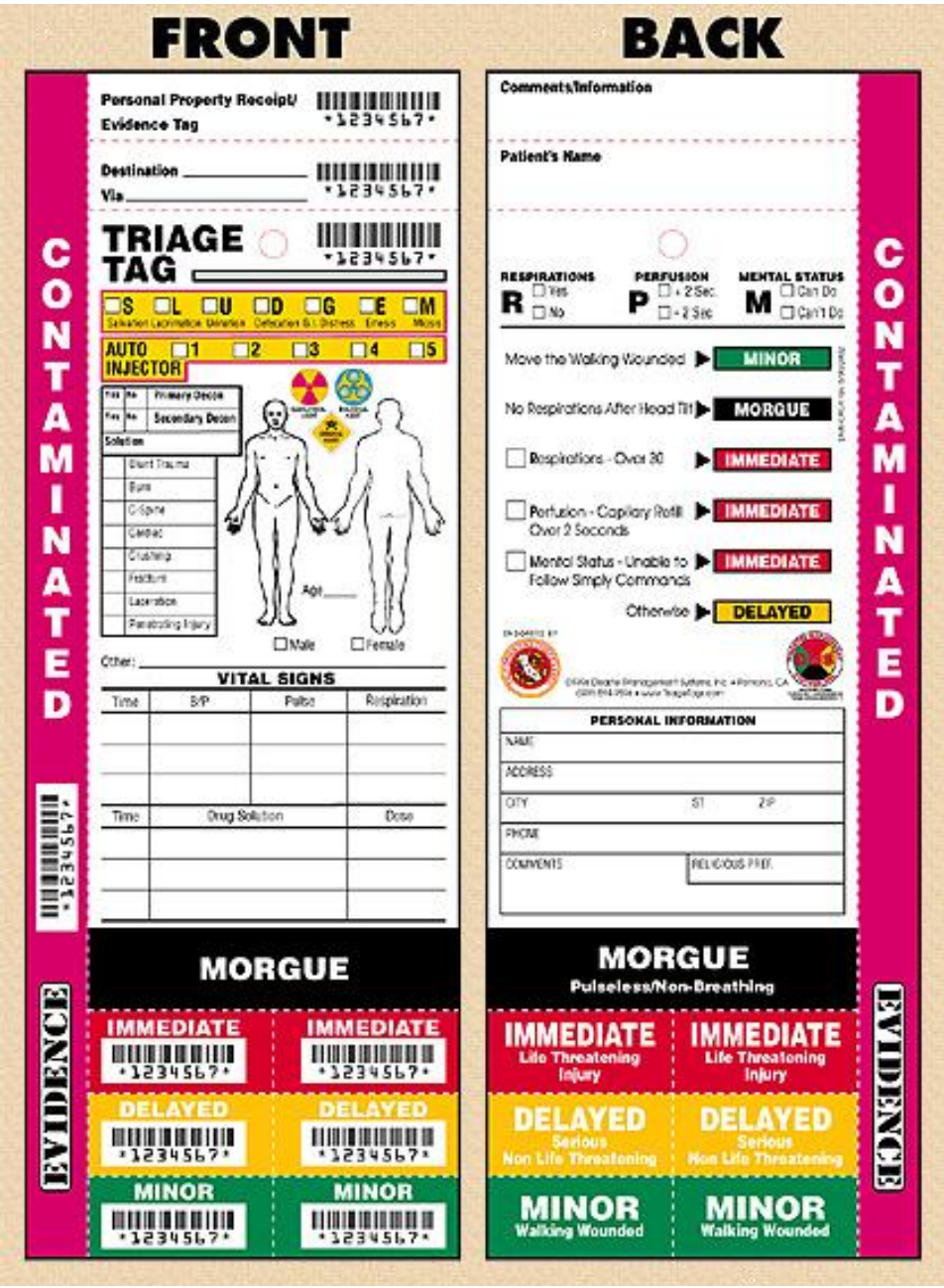
- If an infectious disease outbreak is suspected, all staff in the triage area will wear Personal Protective Equipment (PPE).
- All patients entering the triage area will be tagged and registered. See Resources below for Sample Triage Tag.
- Triage converging patients to immediate and delayed treatment categories.
- In response to suspected or verified infectious disease or bioterrorism attack, isolate infected patients from other patients, especially if suspected agent is human-to-human contagious or is unknown. Use standard infection control standards at a minimum.
- Implement decontamination procedures as appropriate. See page 84 for further information on decontamination.
- Arrange for transport of patients requiring higher levels of care as rapidly as possible through 911 or other arranged transport. More information follows below in "Patient Tracking and Transportation."
- Direct uninjured yet anxious patients to the area designated for counseling and information. Recognize that some chemical and biological agents create symptoms that manifest themselves behaviorally.
- Provide written instructions for non-contagious patients seen and discharged.

Source: California Primary Care Association and California EMS Authority

Resources

- Sample Triage Tag

Sample Triage Tag



Source: California Fire Chief's Triage Tag, California Primary Care Association and California EMS Authority

Increase Surge Capacity:

Description

The Executive Director, Medical Director, or Nursing Director of your hospital or clinic will activate the facility's procedures for increasing surge capacity when 1) civil authorities declare a disaster that affects the community or 2) hospital / clinic utilization or anticipated utilization substantially exceeds day-to-day capacity with or without the occurrence of a disaster.

Possible Healthcare Role

Your hospital or clinic should take the following actions to increase clinic surge capacity:

- Establish a communication link with the appropriate officials (Emergency Operations Center, Health Director or Local Health Official, Emergency Manger, appropriate elected official, etc.).
- Periodically report hospital / clinic status, numbers of ill/injured, types of presenting conditions and resource needs and other information requested by the above officials.
- Reduce patient demand by postponing / rescheduling non-essential visits. Cancel and reschedule non-essential appointments.
- Report status to facilities with which hospital / clinic has patient referral reciprocity or to which patients may be referred. Inform them of types of conditions that presenting patients have.
- Refer patients to alternative facilities.

Patients with symptoms that indicate exposure to infectious, nerve, or other toxic agents will be referred to the following facilities (hospital, clinic):

1. _____

2. _____

Patient Tracking and Transportation:

Description

Circumstances may dictate the need to evacuate patients from a facility. The patient load in your facility despite expansion efforts may also dictate the evacuation of patients to facilities outside the area. Both circumstances will require a great deal of cooperation and integration. An incident may occur where the number of ill or injured patients far exceeds the capacity of the local healthcare system. A portion of the patient population may need to be moved to another in order

to facilitate treatment and recovery. The activation and utilization of the system to move patients out of the clinic or area will take time to set up and function properly.

The Incident Command System (ICS) or the local and state Emergency Operations Centers (EOC) will usually have access to and control the means of transportation assets, such as aircraft and vehicles, to transport patients. During the early moments following an emergency, transportation resources may be very limited and hospitals and clinics may see patients arrive in a variety of ways. Effective use and control of these transportation assets will result in a more effective response.

Possible Healthcare Role

Early recognition of the potential for an excessive number of patients is imperative to allow the necessary components to be mobilized and ready to respond. Events that may lead to a compromised system include:

- A sudden unanticipated incident that has or may result in a large number of patients
- Presumptive diagnosis of patients with an infectious disease that has the likelihood of spreading throughout the population
- A sudden event that compromise clinics and severely diminishes the clinic capacity

Patient transport:
In general, the transport and movement of patients with a potential infectious disease should be limited to movement that is essential to provide patient care, thus reducing the opportunities for transmission within healthcare facilities. If a hospital or clinic director feels that the potential exists for a clinic evacuation, he or she will:

- Notify the local emergency operations center (EOC).
- Give the specifics of the situation including any required assistance.
- Coordinate with the EOC to identify potential destination for the patient.
- The EOC will provide whatever resource support possible to assist the facility in avoiding an evacuation and will alert transport agencies.

Patients will be evacuated to the following destinations:

- Within the existing facility (partial evacuation), if possible
- To facilities within the same clinic system
- To facilities within the geographical area
- To facilities within the region
- To facilities outside the region

Patient Records/Tracking:
One of the most difficult tasks facing healthcare personnel during an incident is tracking patient locations and accurate record keeping. The patient population will arrive at facilities in various manners and at various times and there may be uncertainty as to what exactly constitutes the definition of "patient." Initial documentation will be difficult due to the number of patients arriving at facilities and the demands for movement and rapid interventions. A Patient Tracking Form is in Appendix O.

The compromised hospital or clinic should:

- Make copies of pertinent chart information to accompany the patient to the new location.
- Notify family members of the patients' conditions and new location.

Rural healthcare organizations may consider utilizing local volunteers or volunteer organizations to help with family notification. The primary goal of these organizations is to locate, inform, and accommodate relatives concerned about loved ones or who need to make travel arrangements to be with injured family members. The American Red Cross operates a Disaster Welfare Inquiry System during disasters to assist victims' family members locate, receive information about and/or reunite with their injured relatives. Procedures should be established to provide information to the local or regional Red Cross chapters to assist in this system.

Decision-makers will probably need reliable information, such as casualty estimates and reports**,** immediately following any incident that may compromise the system and to share with the appropriate officials. This information might include:

- Bed capacity
- Staffing levels
- Epidemiological projections
- Casualty estimates
- Facility capabilities

Types and Sources of Transportation Assets:
Prior arrangements with MOUs should have been established with public schools, couriers, taxi services, and public or private ambulances during the emergency planning process to secure local and/or regional sources of transportation. Requests for transportation should be coordinated with the local EOC. Assurances should be made with any transportation resource that arrangements and MOUs are not duplicated. For example, if there is only one ambulance resource in your county, it would not be available to every community or town in the county during an emergency. Healthcare organizations should establish back-up arrangements if this is the case.

Ambulances:

- Ambulances may be operated by city/county hospital districts, public and private
- EMS companies, nearby hospitals, clinics, fire departments, etc.

- Ambulances normally are the primary means of transporting critical patients from a controlled scene.
- The majority of patients from an emergency incident, however, may arrive at clinics via other means (private vehicles or buses).

Sources of Ambulances:

- Responders: These units will have the primary responsibility of scene response and management.
- Private: May augment the public safety response or be utilized for city coverage and/or inter-facility transfer.
- Hospital/Clinic Based: May be used to augment scene response or provide inter-facility transfer.

Buses:

- Provide transportation for a large number of patients either from a scene to a facility, or from one facility to another.
- Public transportation buses, were available, should be available for use during any major disaster through the local Emergency Operations Centers.
- Buses used for the transport of patients will have medical personnel on board to give report to the receiving facility.

Private Vehicles:

- Up to 85% of the patients from a mass casualty incident may self-refer to facilities without utilizing public response agency transportation.
- Clinics need to be prepared to identify and receive patients arriving in privately owned vehicles immediately.
- Due to legal liabilities, staff will never transport patients in private vehicles under any circumstance. In a widespread emergency, governmental agencies may determine how and where to transport victims through already established channels.

Helicopters can be invaluable in a mass casualty incident if their use is regulated and their limitations recognized. Helicopters can provide high-level care and rapid transportation. They also can add an additional risk to a scene and tie up resources forming landing zones.

Helicopters will prove effective in the following instances:

- Augmenting ground transport in scenes with an overwhelming number of critical patients.
- Rapid evacuation of patients from areas where ground transport has difficulty accessing or regressing.
- Transport of patients to facilities away from impacted area.
- Transport of patients to specialized facilities (burn/trauma) located a significant distance away.
- Transfer of patients between facilities.

- Aerial surveillance of scene for ICS.

Name 3 transportation assets in your community or region that can be utilized in an emergency.

1. _____
2. _____
3. _____

Resources

- Patient Tracking Form (Appendix O)

Infection Control / Decontamination:

Description

In most situations, decontamination will not be necessary and will only be considered in cases of gross contamination. The decision to decontaminate should be made in consultation with state and/or local health departments.

Possible Healthcare Role

See Appendix P for Association for Professionals Infection Control and Epidemiology (APIC) Recommendations for Decontamination.

Resources

- Association for Professionals Infection Control and Epidemiology: Decontamination of Patients and Environment (Appendix P)

Isolation / Quarantine:

Description

To contain the spread of a infectious disease, public health authorities rely on many strategies, two of which are isolation and quarantine. Both are common practices in public health, and both aim to control exposure to infected or potentially infected persons. Both may be undertaken voluntarily or compelled by public health authorities. The two strategies differ in that isolation applies to persons who are known to have an illness, and quarantine applies to those who have been exposed to an illness but who may or may not become ill.

Isolation: For people who are ill
Isolation refers to the separation of persons who have a specific infectious illness from those who are healthy and the restriction of their movement to stop the spread of that illness. Isolation allows for the focused delivery of specialized health care to people who are ill, and it protects healthy people from getting sick. People in isolation may be cared for in their homes, in hospitals, or in designated healthcare facilities. Isolation is a standard procedure used in hospitals today for patients with tuberculosis (TB) and certain other infectious diseases. In most cases, isolation is voluntary; however, many levels of government (federal, state, and local) have basic authority to compel isolation of sick people to protect the public.

Quarantine: For people who have been exposed but are not ill
Quarantine refers to the separation and restriction of movement of persons who, while not yet ill, have been exposed to an infectious agent and therefore may become infectious. Quarantine of exposed persons is a public health strategy, like isolation, that is intended to stop the spread of infectious disease. Quarantine is medically very effective in protecting the public from disease.

Source: Centers for Disease Control and Prevention

Possible Healthcare Role

In small-scale incidents, routine facility patient placement and infection control practices should be followed. However, when the number of patients presenting to a healthcare facility is too large to allow routine triage and isolation strategies (if required), it will be necessary to apply practical alternatives. These may include grouping patients with similar syndromes or even setting up a response center at a separate building.

Healthcare staff should have training on the principals of isolation and quarantine. Front desk and registration staff should be observant of symptoms that patients are presenting with to alert clinical staff if necessary.

Laboratories:

Description

Most rural hospitals and clinics are not equipped with extensive laboratory capabilities to identify infectious disease pathogens. Rural healthcare organizations will probably need to rely on regional hospital and regional and state public health laboratories.

The Laboratory Response Network (LRN), a national network of local, state and federal public health, food testing, veterinary diagnostic, and environmental testing laboratories, was established in 1999 to provide the laboratory infrastructure and capacity to respond to biological and chemical terrorism and other public health emergencies. The more than 150 laboratories that make up the LRN are affiliated with federal agencies, military installations, international partners, and state/local public health departments.

The LRN is also a partnership between key stakeholders in the preparation and response to biological and chemical terrorism. The Centers for Disease Control and Prevention (CDC), the Federal Bureau of Investigation (FBI), and the Association of Public Health Laboratories (APHL) were key partners in establishing the LRN. (See "LRN Partners" for information on other LRN partners: www.bt.cdc.gov/lrn/partners.asp.)

Possible Healthcare Role

Rural healthcare providers' and organizations' primary responsibility will be for collecting, packaging and transporting specimens. Each hospital or clinic should have a description of the capability of each lab in the region and have MOUs already in place with these laboratories. Delays can be avoided by ensuring samples are sent to labs with appropriate capabilities.

Legal, Liability and Ethical Considerations

Description

Many legal, liability and ethical considerations exist during the disaster response phase. Some of these issues might include:

- Utilizing volunteers and newly recruited personnel;
- Requesting and obtaining emergency waivers of regulatory requirements (e.g., Health Insurance Portability and Accountability Act, Emergency Medical Treatment and Active Labor Act, staffing ratios, scope of practice restrictions);
- Priority setting and allocating limited resources, such as diagnostics, preventive and therapeutic interventions, personnel, beds, and issues related to the "sufficiency of care;"
- Deferring elective procedures;
- Enforcing isolation, quarantine and non-pharmaceutical community containment protocols;
- Establishing temporary patient care areas and morgue space within the facility;
- Accelerating discharge to alternate care sites or home-based care;
- Interfacing with home health and long-term care facilities; and
- Invoking legal authorities to increase or support availability of surge clinical and hospital staffing and availability of additional acute care beds and alternate care sites, including licensure of and infection control in healthcare facilities.

Possible Healthcare Role

Many of these legal, liability and ethical considerations are currently being addressed at the federal and state levels of government. While resources below may help navigate some of these issues, it will be necessary for your healthcare organization to discuss these issues with the appropriate local, regional and state officials. While some of these resources are related to

specific healthcare emergency (i.e., pandemic influenza) or target specific agencies (i.e., health departments) these considerations apply to all-hazards preparedness and response.

Regulations may vary from state to state, so it is recommended that your organization discuss these issues with the local, regional and/or state health department and state emergency management office. Federal Tort Claims Act (FTCA) provides coverage for Health Resources and Services Administration grantees such as Community Health Centers and Migrant Health Centers. The draft Program Information Notice (PIN), *Federal Tort Claims Act (FTCA) Coverage for Health Center Program Grantees Responding to Emergencies*, below describes and clarifies the circumstances under which FTCA-deemed Health Center Program grantees are covered under the FTCA as they respond to emergencies.

Sources: *Legal & Liability Issues in Health Center Emergency Response*, Community Health Care Association of New York State

Draft Program Information Notice, *Federal Tort Claims Act (FTCA) Coverage for Health Center Program Grantees Responding to Emergencies*, Health Resources and Services Administration

Pandemic Influenza Preparedness and Response Plan, California Department of Health Services

Ethical considerations in preparedness planning for pandemic influenza, University of Toronto Joint Centre for Bioethics

Resources

The Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities was asked to assess Emergency Systems for Advance Registration of Volunteer Health Professionals (ESAR-VHP) legal and regulatory issues through written and other guidance to national and state partners. A comprehensive report, toolkit and other resources were developed and compiled that address many legal issues impacting the development of ESAR-VHP in all 50 states, including (1) state authority to declare public health or general states of emergency; (2) civil and criminal liability of volunteers and entities accepting or providing volunteers; (3) licensing/credentialing of volunteer health professionals; and (4) workers' compensation. Though these issues are examined in their application to volunteers participating in ESAR-VHP, other medical volunteers (including those participating in the Medical Reserve Corps) may find relevance as well (www.publichealthlaw.net/Research/Affprojects.htm#HRSA).

- Report
  www.hrsa.gov/esarvhp/legregissues/default.htm

- Tool Kit
  www.publichealthlaw.net/Research/PDF/ESAR%20VHP%20Toolkit.pdf

- Universal Checklist
  www.publichealthlaw.net/Research/PDF/ESAR%20VHP%20Universal%20Checklist.pdf

Legal & Liability Issues in Health Center Emergency Response, Community Health Care Association of New York State
www.chcanys.org/index.php?src=gendocs&link=ep_forcenters&category=Main

Draft Program Information Notice, *Federal Tort Claims Act (FTCA) Coverage for Health Center, HRSA*
http://bphc.hrsa.gov/draftsforcomment/ftcaemergency.htm

Allocation of Scarce Resources:

Principles of Law and Ethics to Guide Allocation Decisions Involving Scarce Resources in Public Health Emergencies – Discusses: obligations to community; good preparedness practice; and balancing personal autonomy and community well-being/benefit
http://www.publichealthlaw.net/Resources/ResourcesPDFs/Summit%20Allocation%20Principles.pdf

Quarantine:
Proposed Federal Quarantine Regulations, Centers for Disease Control and Prevention
www.cdc.gov/ncidod/dq/nprm/docs/42CFR70_71.pdf

Comments on CDC's Proposed Federal Quarantine Regulations, The Center for Law and the Public's Health
www.publichealthlaw.net/Resources/ResourcesPDFs/Center%20-%20CDC%20QRegs.pdf
Checklists on Legal Preparedness for Public Health Emergencies:

The Centers for Disease Control and Prevention, joined by the Association of State and Territorial Health Officials and the National Association of County and City Health Officials, asked the Center for Law and the Public's Health to prepare additional tools public health agencies could use in assessing their legal preparedness. These three checklists focused on:

- Interjurisdictional legal coordination
  www.publichealthlaw.net/Resources/ResourcesPDFs/Checklist%201.pdf

- Local public health emergency legal preparedness and response
  www.publichealthlaw.net/Resources/ResourcesPDFs/Checklist%202.pdf

- Civil legal liability related to public health emergency response
  www.publichealthlaw.net/Resources/ResourcesPDFs/Checklist%203.pdf

Pandemic Influenza Considerations:

Pandemic Influenza Preparedness and Response Plan, California Department of Health Services
www.dhs.ca.gov/ps/dcdc/pdf/CDHS%20Pandemic%20Influenza%20Plan%20%20Final.pdf

Ethical considerations in preparedness planning for pandemic influenza, University of Toronto Joint Centre for Bioethics
www.utoronto.ca/jcb/home/documents/pandemic.pdf

Financial Tracking

The Finance and Administration Section is responsible for tracking personnel and other resource costs associated with response and recovery and providing administrative support to response operations. See Emergency Response/Recovery Team Job Action Sheets, Finance and Administration Section Chief (Appendix F). See Appendix R Cost Tracking and Finance Forms.

Resource Acquisition

Description

In the response to a disaster, hospital or clinic staff may require additional personnel, supplies or equipment or an executive decision concerning the acquisition or disposition of a resource, or the expenditure of funds. Requests for assistance will be transmitted from the various areas of the hospital or clinic via existing lines of communications to the Emergency Operations Center (EOC). The EOC will acknowledge the receipt of the request and, immediately address the need from current resources or incorporate the request into planning and priority setting processes.

Possible Healthcare Role

The Logistics Section should carefully monitor medical supplies and pharmaceuticals and request augmentation of resources from the appropriate officials at the earliest sign that stocks may become depleted. The hospital / clinic will maximize use of other available hospitals, clinics and other external resource suppliers as is feasible. The Logistics Section staff in the EOC may turn to external vendors for the resources**.** If resources cannot be found and the request is high priority, it will be submitted to Regional, State, and Federal response levels until the requested resource can be obtained.

It is important that MOUs be in place to obtain personnel, supplies or equipment when shortages occur during an emergency response. Rural healthcare organizations should seek out stakeholders and vendors in the preparedness planning phase to secure these agreements.

Best Practices / Lessons Learned

Best Practices

Telemedicine is available in many clinics and prisons and might be useful during disaster response when healthcare personnel resources are limited.

Morgue capacity in rural areas is a major concern. Many communities have MOUS to use refrigerated mobile trucks for mass casualties. One community designated the high school football field as a temporary morgue.

Security

Description

The purpose of security during the response phase will be to ensure unimpeded patient care, staff safety, and continued operations.

Possible Healthcare Role

The hospital or clinic Incident Manager will appoint a Security Officer who will be responsible for ensuring the following security measures are implemented:

- Security should be provided initially by existing security services or by personnel under the direction of the Security Officer. Existing security may be augmented by contract security personnel, law enforcement, clinic staff or, if necessary, by volunteers.
- Checkpoints at building and parking lot entrances should be established as needed to control traffic flow and ensure unimpeded patient care, staff safety and continued operations.
- Supervisors should ensure that all clinic staff wears their ID badges at all times. Temporary ID badges will be issued if needed.
- Security staff may use yellow tape and a bullhorn to assist in crowd control, if needed.
- The Security Officer should ensure that the clinic site is and remains secured following an evacuation.

See Emergency Response/Recovery Team Job Action Sheets, Security Officer (Appendix F).

As mentioned previously, because rural healthcare organizations presumably lack security staffing, it is important to: 1) designate clinic/hospital staff to serve in a security capacity in an emergency and / or 2) seek partnerships with outside agencies or organizations that can supplement security needs. Local law enforcement may have other duties during an emergency incident and may not be available.

Psychological Health for Patients and Staff

Description

During the emergency response phase, the designated Mental Health Coordinator would report to the Medical Care Leader (e.g., Medical Director or Nursing Director) position in the Operations Section of the clinic's emergency organization. When directed by the Incident Manager to activate the clinic mental health response, the Mental Health Coordinator would:

- Assess the immediate and potential mental health needs of clinic patients and staff, considering:
  - The presence of casualties.
  - Magnitude and type of disaster.
  - Use or threat of weapons of mass destruction.
  - Level of uncertainty and rumors.
  - Employee anxiety levels.
  - Level of effectiveness of EOC operations.
  - Convergence of community members.
  - Patient levels of stress and anxiety.
  - Presence of children.
  - Cultural manifestations.
- Request the EOC to notify the Operational Area of the mental health response.
- Communicate community mental health assessments to Operational Area (county) and local jurisdiction contacts.
- Determine need to: call mental health staff or qualified volunteers to the clinic, request the response of contract mental health clinicians, or request mental health assistance from other local and regional resources. Establish communications and alert contract and other mental health providers who may need to support clinic's mental health response. Coordinate with other mental health service responders.
- Establish site for mental health team operations.
- Conduct ongoing monitoring of the mental health status of employees and patients.
- Establish procedures to refer employees or patients to required mental health services beyond the scope that can be delivered by the mental health team.
- Document all mental health encounters with staff and patients. Include information required for follow-up on referrals. Maintain records of events, personnel time and resource expenditures.
- Coordinate any issuance of mental health information with the Incident Manager or PIO.
- Provide reports on the mental health status of clinic employees and patients. Report mental health team actions and resource needs to the clinic EOC.
- Activate procedures to receive and integrate incoming mental health assistance.
- Initiate recovery activities.

Possible Healthcare Role

The following are some steps that can be taken by clinicians and licensed mental health personnel to mitigate and respond to the psychological impact of the disaster:

- Communicate clear, concise information about the infection, how it is transmitted, what treatment and preventive options are currently available, when prophylactic antibiotics, antitoxin serum or vaccines will be available, and how prophylaxis or vaccination will be distributed.
- Provide counseling to the worried well and victims' family members.
- Give important tips to parents and caregivers such as:
    - It is normal to experience anxiety and fear during a disaster.
    - Take care of yourself first. A parent who is calm in an emergency will be able to take better care of a child.
    - Watch for unusual behavior that may suggest your child is having difficulty dealing with disturbing events.
    - Limit television viewing of related events or other disasters and dispel any misconceptions or misinformation.
    - Talk about the event with your child

It is essential to have relationships as well as existing MOUs with organizations, agencies and individuals in your community and region to provide these services during an emergency. The designated Mental Health Coordinator should have a mental health provider contact list to alert others when their services are needed.

Source: California Primary Care Association and the California Emergency Medical Services Authority

Best Practices / Lessons Learned

Lesson Learned

One rural Texas county responded to Hurricanes Katrina and Rita by taking in evacuees, which raised issues that they had not thought of before such as preventing the spread of diseases in close quarters, sanitation, bathrooms, ensuring safety of evacuees, responders and volunteers and how to handle the long-term aspects of people being unable to return home. One of the issues brought to light through this experience was the need to plan for various mental health circumstances, including the worried well, first responders, patients, family members, community-at-large as well as those with existing mental illness.

Resources

- Mental Health Response Checklist (Appendix L)

Volunteers / Donation Management

Description

During a widespread emergency, physicians, nurses and other volunteers may seek to volunteer at the clinic. In an emergency, the Logistics Section should be responsible for establishing a Volunteer and Donations Reception Center. The Center's location would be set-up in a safe location based on existing disaster conditions away from the clinic treatment center.

Possible Healthcare Role

All volunteers who arrive at the clinic will be sent to the Volunteer and Donations Reception Center for verification of identity and credentials and to complete volunteer registration forms. This center will provide for organization of the intake process. The Center will also coordinate the receipt of donations. The Logistics Section Chief will delegate the appropriate staff on site to handle this task:

- All donations should be documented and accounted for by the CFO or delegated staff.
- The Medical Director and clinic Nurse Manager should supervise distribution and disposal of donated medical supplies, equipment and pharmaceuticals.
- All donations should be documented and acknowledged by the CFO or designated staff prior to being handed over to the Medical Care Director for disbursement.

It is recommended that your healthcare organization establish volunteer policies and procedures to grant disaster privileges. The Community Clinic and Health Center Emergency Operations Plan Template, California Clinic Emergency Preparedness Project created "Emergency Preparedness and Response: Volunteer Policies and Procedures," which can be followed to create volunteer guidelines for your hospital or clinic. See Clinic Emergency Operation Plan, EOP Appendices Q.1 at: http://www.cpca.org/resources/cepp.

Best Practices / Lessons Learned

Best Practice

During Hurricane Katrina, volunteers in one rural community were very effective in coordinating donations, including tracking what types of donations and how much are needed, what donations and how much are given, and where to go to make or pick-up donations. For each community, one donations coordinator should be appointed to streamline communications and integrate various donation centers.

Resources

- Donation Tracking Form (Appendix Q)
- Volunteer Roster Form (Appendix K)

VIII. Recovery

Recovery Defined:

Recovery actions should begin almost concurrently with response activities and are directed at restoring essential services and resuming normal operations. Recovery planning should be considered an essential aspect to sustaining the long term viability of the hospital, clinic or health center. Short-term recovery will allow the healthcare providers to resume a business as usual posture. Long-term recovery may take months or years to complete.

Maintaining Financial Viability

Description

To maintain financial viability, rural healthcare organizations must account for disaster-related expenses. The Finance Section Chief will account for disaster related expenses. Documentation will include: direct operating cost; costs from increased use; all damage or destroyed equipment; replacement of capital equipment; and construction related expenses.

Possible Healthcare Role

Document damage and losses of equipment using a current and complete list of equipment serial numbers, costs, and dates of inventory. One copy will be filed with the CFO and another copy in a secure offsite location.

The healthcare organization's CFO or other responsible party will work with the Finance Section to document all expenses incurred from the disaster. An audit trail will be developed to assist with qualifying for any Federal reimbursement or assistance available for costs and losses incurred by the hospital or clinic as a result of the disaster.

Depending on the conditions and the scale of the incident and the type of healthcare organization (e.g., Community Health Center, Rural Health Clinic, Critical Access Hospital) your hospital or clinic may seek financial recovery resources in accordance with the following:

- The eligibility for federal reimbursement for response costs and losses remains ambiguous. It may be possible to gain reimbursement through county channels under certain (largely untested) circumstances.

- Public Assistance (FEMA/OES) – After a disaster occurs and the President has issued a Federal Disaster Declaration, assistance is available to applicants through FEMA and the OES. The Small Business Administration (SBA) provides physical disaster loans to businesses for repairing or replacing disaster damages to property owned by the business. Businesses and Non-profit organizations of any size are eligible.
- Federal Grant - Following a presidential disaster declaration, the Hazard Mitigation Grant Program (HMGP) is activated.
- A private non-profit facility is eligible for emergency protective measures (i.e., emergency access such as provision of shelters or emergency care or provision of food, water, medicine, and other essential needs), and may be eligible for permanent repair work (i.e., repair or replacement of damaged elements restoring the damaged facility's):
    - pre-disaster design
    - pre-disaster function
    - pre-disaster capacity
- Insurance Carriers – your healthcare organization should file claims with its insurance companies for damage to the clinic. The clinic will not receive federal reimbursement for costs or losses that are reimbursed by the insurance carrier. Eligible costs not covered by the insurance carrier such as the insurance deductible may be reimbursable.

Source: California Primary Care Association and the California Emergency Medical Services Authority

Resources

- Equipment Inventory List (Appendix R)
- Cost Tracking and Finance Forms (Appendix R)

Employee and Patient Support System / Referrals (behavioral health needs)

Description

Mental health needs of patients and staff are likely to continue or re-surface during and beyond the recovery phase, frequently after state, federal or voluntary mental health resources have left the community. It is important to continue monitoring staff and patient behavioral health needs and make referrals.

Possible Healthcare Role

The Mental Health Coordinator, clinical staff or other designated individuals will continue to monitor for and respond to the mental health needs of clinic staff and patients. Maintain mental health services MOUs or contracts during the recovery phase of an emergency.

Best Practices / Lessons Learned

Best Practice
If possible, utilize Employee Assistance Programs (EAP) for disaster mental health recovery.

Resources

- Web-based Mental Health Resources

Publications on Mental Health & Disaster Issues for responders, adults, families, schools and older adults.
http://mentalhealth.samhsa.gov/cmhs/katrina/pubs.asp

Disaster Recovery Resources for Substance Abuse Treatment Providers, *Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration*.
www.samhsa.gov/csatdisasterrecovery/resources.htm

Disaster/Trauma Publications, SAMHSA
http://mentalhealth.samhsa.gov/publications/Publications_browse.asp?ID=181&Topic=Disaster%2FTrauma

Resumption / Restoration of Operations

Description

After ensuring the health, safety and care of your organization's patients and staff, the primary objective should be to survive a disaster and to reestablish normal operations as soon as possible. Depending on the event, it may be necessary to expedite resumption of health care services to address unmet community medical needs.

Possible Healthcare Role

Your healthcare organization should take the following steps to restore services as rapidly as possible:

- If necessary, repair your facility or relocate services to a new or temporary facility.
- Replace or repair damaged medical equipment.
- Expedite structural and licensing inspections required to re-open.
- Facilitate the return of medical care and other hospital / clinic staff to work.
- Replenish expended supplies and pharmaceuticals.

- Decontaminate equipment and facilities.
- Attend to the psychological needs of staff and community.
- Follow-up on rescheduled appointments.

After-Action Report

Description

An After-Action Report (AAR) is a structured review or de-briefing process that analyses what happened, why it happened, and how it can be done better, in a forum that includes participants and those responsible for an exercise or an actual emergency. Your organization should conduct after-action debriefings with staff and participate in consortium and Operational Area after-action debriefings.

Possible Healthcare Role

Your hospital or clinic will produce an after-action report describing its activities and corrective action plans including recommendations for modifying the surge capacity expansion procedures, additional training and improved coordination.

Resources

- After Action Report Form/Questionnaire (Appendix S)

IX. Special Considerations in Pandemic Influenza Planning

Description

All public health experts agree that a pandemic influenza is inevitable and to some extent, everyone will be affected by the pandemic. The first wave of a pandemic may last from 1-3 months, while the entire pandemic may last for 2-3 years. According to federal government estimates, the clinical disease attack rate will likely be 30% or higher in the overall population during the pandemic. Illness rates will be highest among school-aged children (about 40%) and decline with age. Among working adults, an average of 20% will become ill during a community outbreak. Of those who become ill with influenza, 50% will seek outpatient medical care. In a severe pandemic, absenteeism attributable to illness, the need to care for ill family members and fear of infection may reach 40% during the peak weeks of a community outbreak.

Due to the impact pandemic influenza will have on your community, including requisite personnel to respond to an outbreak, rural healthcare organizations must incorporate pandemic plans into all-hazard disaster plans.

The World Health Organization (WHO) has developed a global influenza preparedness plan, which defines the stages of a pandemic, outlines the role of WHO, and makes recommendations for national measures before and during a pandemic. The phases are:

Interpandemic period:

Phase 1: No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk of human infection or disease is considered to be low.

Phase 2: No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk of human disease.

Pandemic alert period:

Phase 3: Human infection(s) with a new subtype but no human-to-human spread, or at most rare instances of spread to a close contact.

Phase 4: Small cluster(s) with limited human-to-human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans.

Phase 5: Larger cluster(s) but human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans but may not yet be fully transmissible (substantial pandemic risk).

Pandemic period:

Phase 6: Pandemic: increased and sustained transmission in general population.

Notes: The distinction between **phases 1** and **2** is based on the risk of human infection or disease resulting from circulating strains in animals. The distinction is based on various factors and their relative importance according to current scientific knowledge. Factors may include pathogenicity in animals and humans, occurrence in domesticated animals and livestock or only in wildlife, whether the virus is enzootic or epizootic, geographically localized or widespread, and other scientific parameters.

The distinction among **phases 3**, **4,** and **5** is based on an assessment of the risk of a pandemic. Various factors and their relative importance according to current scientific knowledge may be considered. Factors may include rate of transmission, geographical location and spread, severity of illness, presence of genes from human strains (if derived from an animal strain), and other scientific parameters.

Possible Healthcare Role

Below is a broad outline of pandemic planning for healthcare facilities based on stages of the Homeland Security Council National Strategy for Pandemic Influenza Implementation Plan and the HHS *Pandemic Influenza Plan* recommendations.

Healthcare Facility Responsibilities Before a Pandemic (HSC Stages 0, 1)

- Develop planning and decision making strategies for responding to pandemic influenza.
- Define roles for disaster response, including responsibility for coordination of a pandemic plan.
- Understand how to access state and federal information and supplies, and to ensure communication with local, state, and federal health and security agencies.
- Develop written plans that address disease surveillance, isolation and quarantine practices, hospital capacity criteria, hospital communication, staff education and training, triage, clinical evaluation and diagnosis, security, facility access, facility infrastructure (e.g., isolation rooms), occupational health for employees, use and administration of vaccines and antiviral drugs, facility surge capacity (e.g., durable and consumable supplies), supply chains (purchase, distribution and transportation of supplies), access to critical inventory supplies, and mortuary issues (e.g., storage capacity). This is not a comprehensive list. Planning should be tailored to the specific facility and community.
- Incorporate Pandemic Plans into Disaster Plans
- Work with local, state and national emergency planning committees to integrate with community, state and national pandemic plans and training.
- Participate in pandemic influenza response exercises and drills on local and, if possible, state and federal levels. Incorporate lessons learned into the pandemic disaster response plans.

Healthcare Facility Responsibilities During the Pandemic (HSC Stages 2 – 5)

If there are confirmed human outbreaks overseas (Stages 2 – 3):

- Heighten institutional surveillance of patients and facility/clinic staff for influenza-like illness.
- Prepare to activate institutional pandemic influenza plans, as necessary.
- Establish communications with local, state, and federal agencies regarding surveillance issues and recommendations.

If pandemic influenza begins in or enters the United States (Stages 4 – 5):

- Activate institutional pandemic influenza plans to protect staff and patients.
- Heighten institutional surveillance of patients and facility/clinic staff for influenza-like illness.
- Implement surge capacity plans to sustain healthcare delivery.
- Identify and isolate potential pandemic influenza patients.
- Implement infection control practices to prevent influenza transmission and monitor staff and patients for nosocomial transmission.
- Ensure rapid and frequent communication within healthcare facilities and between healthcare facilities, state health departments, and the federal government.
- Ensure that there is a process for reporting influenza cases and fatalities.

Healthcare Facility Recovery and Preparation for Subsequent Pandemic Waves (HSC Stage 6)

- Continue institutional surveillance of patients and facility/clinic staff for influenza-like illness.
- Return to normal facility operations as soon as possible.
- Review pandemic influenza plan based on experience during the first pandemic wave.
- Incorporate lessons learned into preparation for subsequent pandemic waves.
- Identify and anticipate resource and supply chain issues.
- Continue to emphasize communication within healthcare facilities and between healthcare facilities, state health departments, and the federal government to identify subsequent pandemic waves.

Local, State and Federal Health Officials have been aggressively planning with other healthcare partners for a pandemic influenza. If your organization has not been included in this planning process, contact local officials to get involved. Once involved, as with all-hazards planning and response efforts, ensure that all efforts are coordinated and plans are integrated.

Source: *Pandemic Influenza Preparedness and Response Guidance for Healthcare Workers and Healthcare Employers*, Occupational Safety and Health Administration, U.S. Department of Labor, OSHA 3328-05, 2007

Rural Considerations for Pandemic Influenza Planning

Below are a few pandemic influenza considerations, questions and comments that other rural communities have raised through discussion and planning. When developing your plan and collaborating with community partners, you might think about and address some of these issues. While this list of considerations is far from comprehensive, it may trigger other issues your community has not yet contemplated related both to pandemic influenza and a wider range of public health emergencies.

Healthcare Considerations:

- Hospitals, clinics and health departments will be overwhelmed very quickly.
- Doctors, nurses and other health staff will all be exposed
- Nurses, doctors and support staff will be out sick or will be taking care of family who is sick.
- Healthcare personnel are very limited and already shared between communities.
- Nurses need to be better informed, encouraged and even mandated to protect themselves against exposure. We have possible TB patients come in, and our nurses are not taking the precautions they are supposed to.
- Who will care for the patients at the hospitals that have the chronic illnesses like cancer, those on dialysis, people having heart attacks or strokes?
- Only most critical or those with respiratory failure will be admitted.
- The depth of services will be minimized. Services will have to be much more shallow – do less to treat more people
- We will need to designate triage sites. We could use clinics, schools and churches.
- The SNS is already in place, but distribution is a big issue and question. SNS isn't large enough to cover urban areas let alone the entire state.

Vaccine:

- It will take possibly 6 months to develop a vaccine - there may not be one available to inoculate the people or enough for that matter
- Where will you vaccinate healthy people since you do not want them around sick people at the hospital?
- Need to let people know who will and who won't be getting vaccine before it happens to prepared the public and prevent false assumptions and panic.
- The vaccine won't begin to work for 10-14 days – we must have a plan in place to keep people out of public areas during this time.

Non-pharmaceutical Intervention:

- Basic infection control, social distancing, and universal hygiene (e.g., hand washing) are most important.
- People need to wear masks. Whose responsibility is it to have or provide masks?
- Volunteers or mail carriers can drop masks off for the public

Legal / Ethical Considerations:

- People will need to shelter-in-place if there are asymptomatic. It is their responsibility to do so. How do we enforce this order?
- How do you fairly ration treatment and limited resources?
- Who will get the vaccines if they become available? How will you control people demanding for vaccines?
- What about panic and lawlessness? Law enforcement will be needed to assist. It will be difficult to keep people under control.
- How do we deal with mass casualties? What are the laws regarding disposal in such a case?

Personnel Considerations:

- General personnel are limited in rural areas and many people wear multiple hats. Each department may only be one person – what if they get sick?
- How do you maintain staffing if up to 40% are out?
- There will be no back-up to draw from – no other clinics, businesses and other communities/counties will all be in the same condition.
- When the rural counties are overwhelmed and the urban counties are overwhelmed, who helps whom?
- Will have to be self-reliant – "The cavalry isn't coming"
- It will be important to know where manpower is needed to determine how and where personnel resources are distributed. Offer just-in-time training for those that will require it. Identify the skills or personnel-types that are needed, write a job description and then use the media outlets to disseminate the information to find personnel.
- What if the EOC members get sick? Names are already filled in the slots of the current Emergency Management Plan, but we will need to designate back ups and just-in-time training for those that are being called upon to step into a given role
- Will need to have mental health professionals and counselors to help deal with the stress and situation.
- Veterinarians should be recruited as they have the basic knowledge and supplies/meds to help deal with this.

Resource Considerations:

- Grocery and convenient stores will run out of merchandise, including fuel, water, food, formula, diapers, etc. We need to plan how to manage shortages. Even on holiday weekends, such as the 4th of July, the stores run out of merchandise.
- What about other supplies such as pharmaceuticals? Most insurance plans only cover a just-in-time supply (30 days), and many people cannot stockpile their prescriptions.
- There needs to be a process of establishing a regional person to coordinate resources.

Volunteer Considerations:

- After a long period of time, you may lose volunteers. There is a concern that the volunteer base is not sustainable for 3 months.
- Will volunteers want to help during a pan flu outbreak since this is a communicable disease; it's not like evacuees from a hurricane.
- Our volunteers are mostly the senior population. Since they may be more affected by pan flu, where else can we get people volunteers and will we have enough?

Shelter Considerations:

- Community college could use dorms and other housing to shelter evacuees in the summer, but during the school year our dorms are full.
- What do we do with the influx of evacuees that will need a place to stay? Many rural communities don't have hotels or may only have one – will have to designate a shelter site.

Training Considerations:

- NIMS (National Information Management System) is important to know because it is one standardized system used across the country. All nurses should get NIMS-certified

Community Considerations:

- We have the advantage of being fairly self-sustaining as it is since we are a rural community.
- The effect of the "worried well" on the community needs to be considered. They need to be educated so they don't panic and dominate already limited resources and services.
- Low-income families will not have the money to stockpile water and food.
- What about concerned parents of college students? What do we do with college students, particularly if there are orders to shelter-in-place? Do we send them home or keep them in the dorms?
- How do we reach elderly populations and shut-ins?
- If people are sick, they can't care for their livestock. If there are mass animal deaths, how do we dispose of them?

Community Education:

- We need to educate the public and make them responsible for themselves to some degree.
- Prepare the community through public education campaigns and prevention education prior to and during an outbreak.
- Focus on palliative care (stay hydrated; take aspirin) and prevention (universal hygiene behavior, social distancing, measures to reduce the risk of transmitting infection, disinfection measures, etc.). What will happen during a pandemic (e.g., who will get vaccines). Educate people know to help decrease panic.
- Need to educate and encourage families to be prepared, by have a family disaster plans and a kit.

Business Continuity:

- We need to think about business continuity and the economic impact of pandemic flu. If 40% of the company is out sick, will that company be able to stay open? Need to work with local business and make sure they have and business continuity plan in place.
- It is necessary to plan and have back-ups for those that have vital roles. At one local community college, only one person knows how to do payroll. If they were out sick, no one would get. Another community only has two convenience stores and one gas station, which are run by people from out of town. How does the community get food and supplies if they are not open?
- Can colleges stay operational? Can we continue to conduct classes, possibly through the internet or by mail? Need to cooperate and work with other universities.

Prison Considerations:

- Prisons would be on lock-down
- Would have to implement non-pharmaceutical interventions within the closed prison environment to keep prisoners and staff from getting sick. Use negative pressure machines, social distancing, good hygiene, masks, etc.

Security Considerations:

- Hospitals and clinics would need security and we are not sure we will be able to get it.
- Need to be ready to do some type of screening on who is coming in. Find a way to do criminal background checks to protect safety of staff, volunteers, evacuees and community-at-large.

Transportation / Evacuation Considerations:

- The country could possibly be covered with influenza in a matter of days due to the improved transportation and travel capabilities, compared to the 1918 Spanish Flu.
- Cannot put up roadblocks to keep people from traveling through – rural areas will be flooded with people from urban areas. How do handle them and protect our community?
- Where and how would we evacuate people, if necessary?
- Is there an animal evacuation plan or, if there is a mass community evacuation, are there plans for someone to stay behind to feed and care for livestock/animals in the community?

Communication Considerations:

- During Hurricanes Katrina and Rita, communication across jurisdictional lines was very difficult, particularly related to the receipt of evacuees. How do we make sure this improves with pan flu or other emergencies? It will be necessary for coordinators to communicate information like the number and types of evacuees (children, elderly, disabled, etc.) to make proper arrangements.

Mass Casualty & Funeral/Mortuary Considerations:

- Need to be careful handling the dead bodies, so that they do not further spread the disease (since they still have air in their lungs).
- How do rural communities handle multiple burials?
- Won't be able to hold funerals because of social distancing/quarantining.
- May not have enough fuel to transport bodies. May plan to have scheduled routes to pick up dead in order to conserve fuel. Bodies may not be transported to be buried in the family plot.
- Death certificates are needed in order to bury. People can not probate wills until they have death certificates. That could be a big problem for families.
- Need to know what to do with personal effects. Do we bury them with the bodies or store them for the families to pick up later?
- Funeral homes won't have enough caskets. Need plans for how to make do without them or build them on-site.
- Won't have the refrigeration capabilities for the bodies – will use refrigerated trucks to store bodies (contracts are already in place) or designate a temporary morgue.
- Mortuary and burial services will become overwhelmed. One county has one grave digger that they share with two other counties and one mortician for the county.
- May need to plan for mass graves – where do we get supplies and manpower? Will also need to consider the legal issues involved in doing such a thing.

Resources

- Web-based Pandemic Influenza Planning Resources

There are several checklists, toolkits, and guidelines that will assist healthcare providers and organizations in planning for a pandemic outbreak available at:
www.pandemicflu.gov/plan/healthcare/index.html

World Health Organization global influenza preparedness plan: The role of WHO and recommendations for national measures before and during pandemics
www.who.int/csr/resources/publications/influenza/WHO_CDS_CSR_GIP_2005_5.pdf

Pandemic Influenza Preparedness and Response Guidance for Healthcare Workers and Healthcare Employers, Occupational Safety and Health Administration (OSHA)
www.osha.gov/Publications/OSHA_pandemic_health.pdf
This guidance provides a wide range of information and tools helpful to pandemic planners, including: Internet resources, communication tools, sample infection control programs, and self-

triage and home care resources. It also offers how-to advice on diagnosis and treatment of staff during a pandemic, developing planning and supply checklists, and risk communication.

Community Strategy for Pandemic Influenza Mitigation
www.pandemicflu.gov/plan/community/commitigation.html or
http://www.pandemicflu.gov/plan/community/community_mitigation.pdf
CDC guidelines on actions, designed primarily to reduce contact between people, that community government and health officials can take to try to limit the spread of infection should a pandemic flu develop.

Pandemic Influenza Information for Health Professionals, CDC
www.cdc.gov/flu/pandemic/healthprofessional.htm
A compilation of resources and information provided to clinicians for their use in discussing Pandemic influenza with patients and providing care in case of spread of this agent to the United States.

Medical Offices and Clinics Pandemic Influenza Planning Checklist
www.pandemicflu.gov/plan/pdf/medofficesclinics.pdf
Rural healthcare organizations can use this tool to identify the strengths and weaknesses of current planning efforts.

Providing Mass Medical Care with Scarce Resources: A Community Planning Guide, Agency for Healthcare Research and Quality
www.ahrq.gov/research/mce
For State, local, community, and facility planners, this guide discusses ethical and legal issues, and considerations regarding pre-hospital care, hospital/acute care, palliative care, and alternative care sites. Chapter 8 is a 29-page case study for a flu pandemic.

Flu Terms Defined

Seasonal (or common) flu is a respiratory illness that can be transmitted person to person. Most people have some immunity, and a vaccine is available.

Avian (or bird) flu (AI) is caused by influenza viruses that occur naturally among wild birds. Low pathogenic AI is common in birds and causes few problems. Highly pathogenic H5N1 is deadly to domestic fowl, can be transmitted from birds to humans, and is deadly to humans. There is virtually no human immunity and human vaccine availability is very limited.

Pandemic flu is virulent human flu that causes a global outbreak, or pandemic, of serious illness. Because there is little natural immunity, the disease can spread easily from person to person. Currently, there is no pandemic flu.

X. Resources

Preparedness Glossary
Emergency Management Websites
Emergency Management Publications
Funding Resources
Listing – Emergency Management Agencies and Resources
Listing – National and State Rural Health Associations
Listing – State Offices of Rural Health and Resources
Listing – Rural Health Clinic Associations and Resources
Listing – Community and Migrant Health Center Associations and Resources
Listing – Rural Hospital Resources
Listing – Community Health Worker / Promotora Associations and Resources
Listing – State Primary Care Associations and Resources
Other Rural Resources

Emergency Preparedness Acronyms

A

AAR	After action report
ACS	Alternate Care Site
AHA	American Hospital Association
AMA	American Medical Association
ANSI	American National Standards Institute
APHL	Association of Public Health Laboratories
APIC	Association for Professionals in Infection Control and Epidemiology
ARC	American Red Cross
ART	Assessment and Response Team
ASPR	Assistant Secretary for Preparedness and Response
ASTHO	Association of State and Territorial Health Officers

B

BSL	Bio-safety Level
BT	Bioterrorism

C

CBRN	Chemical, biological, radiological/nuclear
CCC	Citizen Corps Council
CCRF	Commissioned Corp Readiness Force
CCU	Critical Care Unit
CD	Communicable Disease
CDC	Centers for Disease Control and Prevention
CERC	Crisis and Emergency Risk Communication
CERT	Community Emergency Response Teams (CERT)
CFR	Code of Federal Regulations
CNO	Chief Nursing Officer
COG	Council of Government
COTPER	Coordinating Office for Terrorism Preparedness and Emergency Response
CPHP	Center for Public Health Preparedness
CSTE	Council of State and Territorial Epidemiologists

D

DEM	Department of Emergency Management
DFO	Disaster Field Office (Former name of JFO- Joint Field Office)
DHS	Department of Homeland Security
DHHS	Department of Health & Human Services (DHHS or HHS)

DIRC	Disaster Information Resource Center
DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Operational Response Team
DOD	Department of Defense
DOE	Department of Energy
DOH	Department of Health
DOJ	Department of Justice
DVA	Department of Veterans Affairs

E

ED	Emergency Director
EMS	Emergency Medical Services
EMTALA	Emergency Medical Treatment & Active Labor Law
EOC	Emergency Operations Center
EOD	Explosive Ordinance Division ("Bomb Squad")
ED	Emergency Department
EPA	Environmental Protection Agency
EPR	Electronic Patient Record
ER	Emergency Room
ERT-A	FEMA Emergency Response Team- Advance Element
ERT-N	FEMA National Emergency Response Team
ESF	Emergency Support Function

F

FAA	Federal Aviation Administration
FBI	Federal Bureau of Investigation
FCC	Federal Communications Commission
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Agency
FRP	Federal Response Plan

G

GPMRC	Global Patient Movement Requirements Center

H

HAM	Hand Held Amateur Radio
HAN	Health Alert Network
HAZMAT	Hazardous material
HEICS	Hospital Emergency Incident Command Systems
HHS	Department of Health and Human Services (HHS or DHHS)

HIPAA	Health Insurance Portability & Accountability Act
HMRT	Hazardous Materials Response Team
HMRU	Hazardous Materials Response Unit
HRSA	Health Resources and Services Administration
HSAS	Homeland Security Advisory System (Alert Level)
HSEEP	The Homeland Security Exercise and Evaluation Program
HSOC	Homeland Security Operations Center

I

ICP	Infection Control Practitioner
ICS	Incident Command System
ICU	Intensive Care Unit
IF	Intermediate Frequency
IIMG	Interagency Incident Management Group
IMS	Incident Management System

J

JEOC	Joint Emergency Operations Center
JFO	Joint Field Office
JIC	Joint Information Center
JOC	Joint Operations Center
JTTF	Joint Terrorism Task Force

L

LDAP	Leadership Development Action Plan
LHD	Local Health Department
LRN	Laboratory Response Network

M

MHMR	Mental Health and Mental Retardation
MMRS	Metropolitan Medical Response System
MOU	Memorandum of Understanding
MRC	Medical Reserve Corps
MSU	Management Support System

N

NACCHO	National Association of City and County Health Officials
NCID	National Center for Infectious Diseases
NDMS	National Disaster Medical System

NEDSS	National Electronic Disease Surveillance System
NEMA	National Emergency Management Association
NIAID	National Institute of Allergy and Infectious Diseases
NIH	National Institutes of Health
NIMS	National Incident Management System
NIOSH	National Institute for Occupation Safety and Health
NMRT	National Medical Response Teams (Part of NDMS)
NNRT	National Nursing Response Teams (Part of NDMS)
NPRT	National Pharmacy Response Teams (Part of NDMS)
NPS	National Planning Scenarios
NRCC	National Response Coordination Center (Formerly known as FEMA)
NEOC	National Emergency Operations Center
NRP	National Response Plan

O

OEP	Office of Emergency Preparedness
OEM	Office of Emergency Management
OHS	Office of Homeland Security
OSHA	Occupational Safety & Health Administration

P

PH	Public Health
PHIN	Public Health Information Network
PHPPO	CDC's Public Health Practice Program Office
PHS	Public Health Service (also USPHS)
PHTN	Public Health Training Network
PIO	Public Information Officer
POC	Point of Contact
POD	Point of Distribution
PPE	Personal Protective Equipment

R

R&R	Response & Recovery
ROC	Regional Operations Center
RRCC	Regional Response Coordination Center (formerly known as FEMA ROC – Regional Operations Center or RST- Regional Support Team)

S

SAMHSA	Substance Abuse and Mental Health Services Administration
SEMA	State Emergency Management Agency

SNS	Strategic National Stockpile
SOC	HHS Secretary's Operations Center

T

TCL	Target Capabilities List
TEW	Terrorism Early Warning Group
TIFB	Telecommunications Infrastructure Fund Board
TOPOFF	Top Officials (exercise series)
TSA	Transportation Security Agency

U

UCS	Unified Command System
URL	Uniform Resource Locator
USAMRIDD	United States Army Medical Research Institute of Infectious Diseases
USDA	U.S. Department of Agriculture
USMS	U.S. Marshals Service
USPHS	U.S. Public Health Service (also see PHS)
USSS	U.S. Secret Service
UTL	Universal Task List

V

VA	U.S. Department of Veterans Affairs (also see DVA)
VMAT	Veterinary Medical Assistance Teams (Part of NDMS)
VMI	Vendor Managed Inventories

W

WMD	Weapons of Mass Destruction
WMDOU	Weapons of Mass Destruction Operations Unit

Sources: Yale Center for Public Health Preparedness

Community Health Care Association of New York State

Development of Regional Emergency Response Plans for Rural Health Care Systems

Preparedness Glossary

A

Agroterrorism

The deliberate introduction of a chemical or a disease agent, either against livestock/crops or into the food chain, for the purpose of undermining stability and/or generating fear.

All Hazards Planning

Emergency response plans that identify, prioritize, and address all hazards across all functions. Plans are coordinated at all levels of government and address the mitigation of secondary and cascading emergencies.

Antibiotic

A substance produced by bacteria or fungi that destroys or prevents the growth of other bacteria and fungi.

Antiviral

A drug that is used to treat a disease caused by a virus, by interfering with the ability of the virus to multiply in number or spread from cell to cell.

Avian Influenza

An infection caused by avian (bird) influenza (flu) viruses. These influenza viruses occur naturally among birds. Wild birds worldwide carry the viruses in their intestines, but usually do not get sick from them. However, avian influenza is very contagious among birds and can make some domesticated birds, including chickens, ducks, and turkeys, very sick and kill them. The risk from avian influenza is generally low to most people, because the viruses do not usually infect humans. However, confirmed cases of human infection from several subtypes of avian influenza infection have been reported since 1997.

B

Bioterrorism

The intentional use of microorganisms, or toxins, derived from living organisms, to produce death or disease in humans, animals, or plants.

BSL – Bio-safety Level

A method for rating laboratory safety. Laboratories are designated BSL 1, 2, 3, or 4 based on the practices, safety equipment, and standards they employ to protect their workers from infection by the agents they handle. BSL-1 laboratories are suitable for handling low-risk agents; BSL-2 laboratories are suitable for processing moderate risk agents; and BSL-3 laboratories can safely handle high-risk agents. BSL-3 is suitable for work with infectious agents that may cause serious or potentially lethal diseases because of exposure by the inhalation route. BSL-4 is required for work with dangerous and exotic agents that pose a high individual risk of aerosol-transmitted laboratory infections and life-threatening disease. Agents with a close or identical antigenic relationship to Biosafety Level 4 agents are handled at this level until sufficient data are obtained either to confirm continued work at this level, or to work with them at a lower level.

C

Category "A" Agents

The possible biological terrorism agents having the greatest potential for adverse public health impact with mass casualties. The Category "A" agents are:

- Smallpox
- Anthrax
- Plague
- Botulism
- Tularemia
- Viral hemorrhagic fevers (e.g. ebola and lassa viruses)

CDC – Centers for Disease Control and Prevention

The Centers for Disease Control and Prevention, the U.S. government agency at the forefront of public health efforts to prevent and control infectious and chronic diseases, injuries, workplace hazards, disabilities, and environmental health threats. CDC is one of 13 major operating components of the Department of Health and Human Services. CDC's role is to ……. (CDC does not have any regulatory authority.)

CERT – Community Emergency Response Teams

These are teams of volunteers from the community who are trained in basic disaster response skills such as fire safety, light search and rescue, team organization, and disaster medical operations so that they can assist others in their neighborhood or workplace when professional response personnel are not immediately available.

Communicable Diseases

Diseases that can be transmitted from one infected person to another, directly or indirectly.

COTPER – Coordinating Office for Terrorism Preparedness and Emergency Response

Located within the Centers for Disease Control and Prevention (CDC) it provides strategic direction to support CDC's terrorism preparedness and emergency response efforts; manages CDC-wide preparedness and emergency response programs and maintains concerted emergency response operations, including the Strategic National Stockpile (SNS) and the Director's Emergency Operations Center (EOC).

Critical agents

The biological and chemical agents likely to be used in weapons of mass destruction and other bioterrorist attacks. Lists of agents can be found on the Centers for Disease Control and Prevention Web site: http://www.bt.cdc.gov/Agent/Agentlist.asp and http://www.bt.cdc.gov/Agent/AgentlistChem.asp

D

DHS – Department of Homeland Security

In 2002, 22 federal agencies were consolidated into the new Department of Homeland Security to help protect the nation from terrorist threats, assist in natural disaster relief, and provide citizenship services.

Disaster

Any event, typically occurring suddenly, that causes damage, ecological disruption, loss of human life, deterioration of health and health services, and which exceeds the adjustment capacity of the affected community on a scale sufficient to require outside assistance. These events can be caused by nature, equipment failure, human error; or biological hazards and

diseases (e.g., earthquakes, floods, fires, hurricanes, cyclones, major storms, volcanic eruptions, spills, aircraft crashes, droughts, epidemics, food shortages, and civil strife).

Disaster Epidemiology

The study of disaster-related deaths, illnesses, or injuries in humans. Disaster epidemiology includes the study of factors that contribute to death, illness, and injury following a disaster. Epidemiologic investigations provide public health professionals with information on the public health consequences of disasters.

DMAT – Disaster Medical Assistance Team

A DMAT is a group of professional (physicians, nurses, physician assistants) and paraprofessional medical personnel (supported by a cadre of logistical and administrative staff) who provide medical care during a disaster or other event. Each team has a sponsoring organization, such as a major medical center, public health or safety agency, non-profit, public or private organization that signs a Memorandum of Agreement (MOA) with the DHS. The DMAT sponsor organizes the team and recruits members, arranges training, and coordinates the dispatch of the team.

DMORT – Disaster Mortuary Operational Response Team

DMORTs are composed of private citizens, each with a particular field of expertise, who are activated in the event of a disaster. During an emergency response, DMORTs work under the guidance of local authorities by providing technical assistance and personnel to recover, identify, and prepare for the disposition of remains of deceased victims.

E

Emergency Management

A systematic program of activities that governments, organizations and institutions undertake before, during and after a disaster to save lives, prevent injury, and to protect property and the natural environment. Emergency management activities include mitigation, preparedness, response and recovery (see definitions below).

Emergency Support Function (ESF)

A functional area of disaster response activity established to coordinate the delivery of federal assistance during the response phase of an emergency. Each ESF represents the type of federal assistance most needed by states overwhelmed by the impact of a catastrophic event on local and state resources.

EOC – Emergency Operations Center

In the event of an emergency, certain responding agencies would be required to establish and maintain an EOC. Depending on the severity of the emergency, an EOC may be active for 2-3 days. In such situations, considerations for having resources available for members of the EOC must be a priority. Resources for an EOC might include adequate sleeping arrangements, effective communication methods (including analog phone/fax lines), news sources (such as TV and radio), office supplies, and available food and water.

Epidemiology – (abbr. Epi)

The study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to control of health problems.

Epidemic

The occurrence in a community or region of cases of an illness (or an outbreak) with a frequency in excess of what would be expected normally.

Epidemiologist

A person who practices epidemiology. Epidemiologists design and conduct epidemiological studies, analyze data to detect patterns and trends in disease and identify risk factors for disease, establish and maintain surveillance systems, monitor health status and evaluate the performance and cost effectiveness of public health programs.

ESF 8 Health and Medical

Emergency Support Function #8 provides coordinated assistance to supplement local resources in response to public health and medical care needs following a major disaster or emergency, or during a developing potential medical situation.

Evaluation

A detailed review of a program or intervention, designed to determine whether program objectives were met, to assess its impact , and to identify the need for modifications in the design of future projects; conducted during, and at the completion of important milestones, or at the end of a specific period.

F

FDA – U.S. Food and Drug Administration

The government agency responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation. FDA is one of 13 major operating components of the Department of Health and Human Services (DHHS).

First responders

Local fire service, law enforcement, Hazardous Materials Teams (HazMat), emergency medical services.

FRP – Federal Response Plan

The overarching emergency management plan of the US government.

H

H5N1

A variant of avian influenza, which is a type of influenza virulent in birds. It was first identified in Italy in the early 1900s and is now known to exist worldwide.

HAN – Health Alert Network

A communications infrastructure that supports the dissemination of vital health information at the state and local levels. The HAN Messaging System directly and indirectly transmits Health Alerts, Advisories, and Updates to over one million recipients. The current system is being phased into the overall PHIN (Public Health Information Network) messaging component.

Health alerts

Urgent messages from the CDC to health officials requiring immediate action or attention. The CDC also issues health advisories containing less urgent information about a specific health incident or response that may or may not require immediate action, and health updates, which do not require action. These messages are disseminated on state and local levels using the HAN (Health Alert Network).

HRSA – Health Resources and Services Administration
An agency of the U.S. Department of Health and Human Services and is the primary Federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable. www.hrsa.gov
HSEEP – The Homeland Security Exercise and Evaluation Program
HSEEP is a threat- and performance-based exercise program that includes a cycle, mix and range of exercise activities of varying degrees of complexity and interaction.

I
ICS – Incident Command System
ICS is a standardized on-scene incident management concept designed to allow responders to adopt an integrated organizational structure equal to the complexity and demands of any single incident or multiple incidents without being hindered by jurisdictional boundaries. An ICS is part of an IMS.
Immune system
The cells, tissues and organs that help the body to resist infection and disease by producing antibodies and/or altered cells that inhibit the multiplication of an infectious agent.
IMS – Incident management system
Another name for Incident Command System
Infectious agent
Any organism, such as a pathogenic virus, parasite, or bacterium, that is capable of invading body tissues, multiplying, and causing disease.
Influenza (flu)
An acute contagious viral infection characterized by inflammation of the respiratory tract and by fever, chills, muscular pain, and malaise.

J
JIC – Joint Information Center
A central point of contact for all news media near the scene of a large-scale disaster. The center is staffed by public information officials who represent all participating federal, state, and local agencies to provide information to the media in a coordinated and consistent manner.
JOC – Joint Operations Center
The JOC acts as the focal point for the management and direction of onsite response activities, coordination, and establishment of state requirements and priorities, as well as the coordination of the federal response.

L
Laboratory levels (A,B,C,D)
A system for classifying laboratories by their capabilities. Classifications are: A: routine clinical testing. Includes independent clinical labs and those at universities and community hospitals B: more specialized capabilities. Includes many state and local public health laboratories C: More sophisticated public health labs and reference labs such as those run by CDC. D. Possessing sophisticated containment equipment and expertise to deal with the most dangerous, virulent

pathogens and include only CDC and Department of Defense labs, the FBI, and the U.S. Army Medical Research Institute of Infectious Diseases (USAMRIID).

LRN – Laboratory Response Network

A national partnership of public health laboratories designed to coordinate and share resources for an effective response during a health emergency.

M

Mass Dispensing

The dispensing of medications or immunizations to an entire population in a very short period of time to protect them from a naturally occurring or bioterrorism-related epidemic. These medications might be antibiotics or vaccinations.

Mitigation

Eliminating hazards or reducing their potential impact.

MMRS – Metropolitan Medical Response System

A program of the US Department of Health and Human Services (DHHS) Office of Emergency Preparedness intended to increase cities' ability to respond to a terrorist attack by coordinating the efforts of local law enforcement, fire, hazmat, EMS, hospital, public health and other personnel.

MRC – Medical Reserve Corps

The Medical Reserve Corps are teams of local volunteer medical and public health professionals who can contribute their skills and expertise throughout the year and during times of community need.

MOU – Memorandum of Understanding

Written agreement for mutual aid between two or more parties. Used to formally establish a linkage relationship between organizations or agencies.

N

NCID – National Center for Infectious Diseases

A unit within the CDC (Centers for Disease Control and Prevention) that works to prevent illness, disability, and death caused by infectious diseases in the United States and around the world.

NDMS – National Disaster Medical System

A federal program that dispatches out-of-state medical teams to an area that has suffered a disaster and tracks availability of hospital resources in participating institutions..

NIAID – National Institute of Allergy and Infectious Diseases

The NIAID (at the National Institutes of Health) conducts and supports basic and applied research to better understand, treat, and ultimately prevent infectious, immunologic, and allergic diseases. NIAID research has led to new therapies, vaccines, diagnostic tests, and other technologies that have improved the health of millions.

NIH – National Institutes of Health.

A branch of the federal Department of Health and Human Services. The NIH encourages and oversees medical and behavioral research.

NIMS – National Incident Management System

NIMS is the first ever standardized approach to incident management and response. Developed by the Department of Homeland Security and released in March 2004, it establishes a uniform set of processes and procedures that emergency responders at all
levels of government will use to conduct response operations. (You may also find just "IMS" used in emergency planning for non-governmental organizations, which means "Incident Management System" and usually refers to policies and procedures inspired by the national model.) The intent of NIMS is to:

- Be applicable across a full spectrum of potential incidents and hazard scenarios, regardless of size or complexity.
- Improve coordination and cooperation between public and private entities in a variety of domestic incident management activities.

Notifiable conditions
A communicable disease, injury, cancer or other health condition that health care providers are required to report to a central agency within the state.
NPS – National Planning Scenarios
Fifteen scenarios created for use as planning tools in national, state and homeland security preparedness activities.
NRP – National Response Plan
The plan establishes a comprehensive all-hazards approach to enhance the ability of the United States to manage domestic incidents. It incorporates best practices and procedures from incident management disciplines and integrates them into a unified structure. It forms the basis for the coordination of state, local and tribal governments and the private sector with the federal government during emergency events.

P
Pandemic
An epidemic (an outbreak of an infectious disease) that spreads worldwide, or at least across a large region. Pandemic flu Occurs when a new influenza virus emerges for which people have little or no immunity, and for which there is no vaccine. The disease spreads easily from person to person, causes serious illness and can sweep across the country and around the world in a very short time.
Pathogen
Any agent or organism that can cause disease.
PHIN – Public Health Information Network
Standards that provide the basis for developing and implementing information technology projects for CDC-funded programs including NEDSS, HAN (Health Alert Network), and others. PHIN is a national initiative to implement a multi-organizational business and technical architecture for public health information systems. The PHIN is CDC's vision for advancing fully capable and interoperable information systems in the many organizations that participate in public health.
PHTN – Public Health Training Network
The CDC's (Centers for Disease Control and Prevention) distance learning system that uses instructional media ranging from print-based to videotape and multimedia to meet the training needs of the public health workforce nationwide.

POD – Point of Dispensing
A site where medications intended to prevent disease may be given quickly to a large number of people in the event of a public health emergency.
Preparedness
Planning, training, and exercising for disastrous events
Prophylactic
A medical procedure or practice that prevents or protects against a disease or condition (eg, vaccines, antibiotics, drugs).
Push package
A delivery of medical supplies and pharmaceuticals sent from the Strategic National Stockpile to a state undergoing an emergency within 12 hours of federal approval of a request by the state's Governor.

R
Recovery
Restoring normalcy after the disaster. These activities are not the sole responsibility of the designated emergency management agency. Virtually all agencies have a role, but most particularly law enforcement, fire services, public works, and public health.
Response
Taking action when a disaster occurs to save lives, prevent injuries, and prevent or limit property damage.

S
SNS – Strategic National Stockpile (formerly National Pharmaceutical Stockpile)
National cache of drugs, vaccines, and supplies that can be deployed to areas struck by disasters, epidemics or pandemics.
Social Distancing
To help prevent the spread of an infectious disease, social distancing includes measures to increase distance between individuals, such as staying home when ill unless seeking medical care, avoiding large gatherings, telecommuting, and school closures. These measures are sometimes called "focused measures to increase social distance." Depending on the situation, examples of cancellations and building closures might include: cancellation of public events (concerts, sports events, movies, plays) and closure of recreational facilities (community swimming pools, youth clubs, gymnasiums).
Surge capacity
Ability of institutions such as clinics, hospitals, or public health laboratories to respond to sharply increased demand for their services during a public health emergency.
Surveillance
The systematic ongoing collection, collation, and analysis of data that are used to monitor health status and the occurrence of disease and the timely dissemination of information obtained so that action can be taken. Surveillance is the essential feature of epidemiological practice.

T
TOPOFF – Top Officials

The U.S. Department of Homeland Security's Top Officials Exercise is a congressionally mandated exercise designed to strengthen the nation's capacity to prevent, prepare for, respond to, and recover from large-scale terrorist attacks involving weapons of mass destruction (WMDs).

Training Activities

Training can take many forms:

- Orientation and Education Sessions - These are regularly scheduled discussion sessions to provide information, answer questions and identify needs and concerns.
- Tabletop Exercise - Members of the emergency management group meet in a conference room setting to discuss their responsibilities and how they would react to emergency scenarios. This is a cost-effective and efficient way to identify areas of overlap and confusion before conducting more demanding training activities.
- Walk-through Drill - The emergency management group and response teams actually perform their emergency response functions. This activity generally involves more people and is more thorough than a tabletop exercise.
- Functional Drills - These drills test specific functions such as medical response, emergency notifications, warning and communications procedures and equipment, though not necessarily at the same time. Personnel are asked to evaluate the systems and identify problem areas.
- Evacuation Drill - Personnel walk the evacuation route to a designated area where procedures for accounting for all personnel are tested. Participants are asked to make notes as they go along of what might become a hazard during an emergency, e.g., stairways cluttered with debris, smoke in the hallways. Plans are modified accordingly.
- Full-scale Exercise - A real-life emergency situation is simulated as closely as possible. This exercise involves company emergency response personnel, employees, management and community response organizations.

U

USDA – U.S. Department of Agriculture

The government agency responsible for regulating the safety and development of food, agriculture, and natural resources.

UTL – Universal Task List

Defines the tasks that need to be performed to prevent, protect against, respond to and recover from the range of major incidents defined by the national Planning Scenarios. Developed by US Department of Homeland Security with broad stakeholder involvement.

V

Vaccine

A preparation consisting of antigens of a disease-causing organism which, when introduced into the body, stimulates the production of specific antibodies or altered cells. This produces immunity to the disease-causing organism. The antigen in the preparation can be whole disease-causing organisms (killed or weakened) or parts of these organisms.

Vulnerable Population

People who cannot comfortably or safely access and use the standard resources offered in disaster preparedness, relief and recovery. They may include people with sensory impairments (blind, deaf, hard-of-hearing); cognitive disorders; mobility limitations; limited English comprehension or non-English speaking; as well as people who are geographically or culturally isolated, medically or chemically dependent, or homeless.

Virulent

A disease that is highly lethal; causing severe illness or death.

Virus

Any of various simple submicroscopic parasites of plants, animals, and bacteria that often cause disease and that consist essentially of a core of RNA or DNA surrounded by a protein coat. Unable to replicate without a host cell, viruses are typically not considered living organisms.

Z

Zoonoses

Diseases that are transferable from animals to humans.

Sources: Yale Center for Public Health Preparedness

Community Health Care Association of New York State

Emergency Preparedness Agency / Organization Websites

Centers for Disease Control and Prevention (CDC)
www.cdc.gov

Centers for Disease Control (CDC), Bioterrorism Preparedness & Response Network
www.bt.cdc.gov

CDC: Strategic Pharmaceutical Stockpile
www.bt.cdc.gov/stockpile

Office of the Assistant Secretary for Preparedness and Response (formerly the Office of Public Health Emergency Preparedness)
www.hhs.gov/aspr

Department of Homeland Security (DHS)
www.dhs.gov

Ready.gov
www.ready.gov

United States Department of Health and Human Services
www.hhs.gov

Food and Drug Administration (FDA)
www.fda.gov

Federal Emergency Management Agency (FEMA)
www.fema.gov

Federal Bureau of Investigation (FBI)
www.fbi.gov

Department of Justice (DOJ)
www.usdoj.gov

Office of Rural Health Policy, Health Resources and Services Administration
www.ruralhealth.hrsa.gov

National Institute of Environmental Health Sciences
www.niehs.nih.gov

National Foundation for Infectious Diseases
www.nfid.org

NIH, National Institutes of Health, National Institute of Allergy and Infectious Diseases
www.niaid.nih.gov

Mental Health: National Institute of Mental Health
www.nimh.nih.gov

Substance Abuse and Mental Health Services Administration
www.samhsa.gov

American Red Cross – Homeland Security Advisory System
http://www.redcross.org/services/disaster/beprepared/hsas.html

USA Freedom Corp
www.usafreedomcorps.gov

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
www.jointcommission.org

Medical Reserve Corps
www.medicalreservecorps.gov

Community Emergency Response Team (CERT)
www.citizencorps.gov/cert

National Emergency Management Association
www.nemaweb.org

Emergency Management Publications

Rural Emergency Preparedness Publications, Office of Rural Health Policy
www.ruralhealthresearch.org/topics/100000029/publications_date.php

Publications include:

- *Urban-to-Rural Evacuation: Planning for Population Surge,* 2007
- *Attention from the Top? Roles of State Offices of Rural Health Policy in Preparing for Bioterrorism and Other Health System Emergencies,* 2006
- *PTSD and Substance Use: Unrecognized Sequelae of Bioterrorism in Primary Care Providers,* 2006
- *Posttraumatic Stress Disorder in Rural Primary Care: Improving Care for Mental Health Following Bioterrorism,* 2006
- *Perspectives Of Rural Hospitals On Bioterrorism Preparedness Planning*, 2004
- *Understanding The Role Of The Rural Hospital Emergency Department In Responding To Bioterrorist Attacks And Other Emergencies: A Review Of The Literature And Guide To The Issues,* 2004

Are You Ready?: A Guide to Citizen Preparedness, FEMA
http://www.fema.gov/areyouready

Rural Communities and Emergency Preparedness, Office of Rural Health Policy, Health Resources and Services Administration; U.S. Department of Health and Human Services, April 2002
ftp://ftp.hrsa.gov/ruralhealth/RuralPreparedness.pdf

Redefining Readiness: Terrorism Planning Through the Eyes of the Public, Roz D. Lasker, Center for the Advancement of Collaborative Strategies in Health, New York Academy of Medicine, 2004
http://tap.gallaudet.edu/emergency/nov05conference/EmergencyReports/RedefiningReadinessStudy.pdf

Ready or Not? Protecting the Public's Health from Disease, Disasters, and Bioterrorism, 2006
http://healthyamericans.org/reports/bioterror06/

Ready or Not? Protecting the Public's Health from Disease, Disasters, and Bioterrorism, 2005
http://healthyamericans.org/reports/bioterror05/

Ready or Not? Protecting the Public's Health in the Age of Bioterrorism 2004
http://healthyamericans.org/reports/bioterror04/

Ready or Not? 2003 Protecting the Public's Health in the Age of Bioterrorism
http://healthyamericans.org/state/bioterror/

Emergency Preparedness, Response & Recovery Checklist: Beyond the Emergency Management Plan, American Health Lawyer's Association
http://www.healthlawyers.org/Content/NavigationMenu/Public_Interest_and_Affairs/Public_Information_Series/pi_EmergencyPreparedness.pdf

Public Health Emergency Preparedness Publications, Agency for Healthcare Research and Quality
http://www.ahcpr.gov/news/pubcat/c_phep.htm

Funding Resources

Contact Your State Office of Rural Health for possible funding opportunities
(see State Office of Rural Health Contacts List by State)

State Information Sources:

Local/State Funding Report. This weekly publication reports on federal and private sector funding for local and state governments and for nonprofit organizations. Washington, D.C.: Government Information Services. Weekly series.

Federal Information Sources:

Rural Health Services Funding: A Resource Guide
http://www.nal.usda.gov/ric/ricpubs/healthguide.htm

Catalog of Federal Domestic Assistance. The Catalog is an annual listing of funding programs sponsored by the federal government. Information on grant eligibility, application procedures, and selection criteria. Executive Office of the President, Office of Management and Budget, and U.S. General Services Administration. Washington, D.C. U.S. Government Printing Office.
URL: *http://www.cfda.gov*

Community Health Funding Report. Information on both public and private funding programs is outlined in this bimonthly publication.
URL: *http://www.cdpublications.com/pubs/communityhealthfunding.php*

Federal Assistance Monitor. This biweekly newsletter gives a comprehensive review of federal funding announcements, private grants, rule changes, and legislative actions affecting all community programs, including social services, education, and health, plus tips on funding. Silver Spring, MD: CD Publications. Biweekly Series.

Agency for Healthcare Research and Quality (AHRQ): AHRQ's purpose is to enhance the quality and effectiveness of health care services and to improve access to that care. As part of their extramural research program, they fund research investigating the delivery of health services in rural areas.
URL: *http://www.ahrq.gov*

Health Resources and Services Administration (HRSA). HRSA has leadership responsibility for general health service and resource issues to access, equity, quality, and cost of care. It funds a variety of programs supporting primary care.
Office of Rural Health Policy:
URL: *http://www.ruralhealth.hrsa.gov*

Rural Utilities Service, Distance Learning and Telemedicine Grant and Loan Program, U.S. Department of Agriculture. Provides funding for the use of telecommunications, computer networks and related technology in rural communities for improved access to educational resources and medical/health care services.
URL: *http://www.usda.gov/rus/telecom/dlt/dlt.htm*

Private Information Sources:

Annual Register of Grant Support: A Directory of Funding Sources. New Providence, New Jersey: R.R. Bowker. Annual Series Grantsmanship Center Magazine. This publication is distributed free of charge to nonprofit organizations and government agencies. Articles from past issues are also available on the Web. Topics covered include proposal writing/grant seeking, foundation/corporate funding, and government funding.
URL: *http://tgci.com/publications/magazine.htm*

Rural Assistance Center Funding Guide
www.raconline.org/funding

Source: Development of Regional Emergency Response Plans for Rural Health Care Systems,

Listing – Emergency Management Agencies and Resources

Alabama Emergency Management Agency
5898 County Road 41
P.O. Drawer 2160
Clanton, Alabama 35046-2160
(205) 280-2200
(205) 280-2495 FAX
ema.alabama.gov/

Alaska Division of Homeland Security and Emergency Management
P.O. Box 5750
Fort Richardson, Alaska 99505-5750
(907) 428-7000
(907) 428-7009 FAX
www.ak-prepared.com

American Samoa Territorial Emergency Management Coordination
(TEMCO)
American Samoa Government
P.O. Box 1086
Pago Pago, American Samoa 96799
(011)(684) 699-6415
(011)(684) 699-6414 FAX

Arizona Division of Emergency Management
5636 E. McDowell Rd
Phoenix, Arizona 85008
(602) 244-0504 or 1-800-411-2336
www.azdema.gov

Arkansas Department of Emergency Management
Bldg. # 9501
Camp Joseph T. Robinson
North Little Rock, Arkansas 72199-9600
(501) 683-6700
(501) 683-7890 FAX
www.adem.arkansas.gov/

California Governor's Office of Emergency Services
3650 Schriever Ave.
Mather , CA 95655-4203
(916) 845-8510
(916) 845-8511 FAX
www.oes.ca.gov/

Colorado Office of Emergency Management
Division of Local Government
Department of Local Affairs
9195 East Mineral Avenue
Suite 200
Centennial , Colorado 80112
(720) 852-6600
(720) 852-6750 Fax
www.dola.state.co.us/oem/oemindex.htm

Connecticut Office of Emergency Management
Department of Emergency Management and Homeland Security
360 Broad Street
Hartford, Connecticut 06105
(860) 566-3180
(860) 247-0664 FAX
www.ct.gov/demhs/site/default.asp

Delaware Emergency Management Agency
165 Brick Store Landing Road
Smyrna, Delaware 19977
(302) 659-3362
(302) 659-6855 FAX
www.state.de.us/dema/index.htm

District of Columbia Emergency Management Agency
2000 14th Street, NW, 8th Floor
Washington, D.C. 20009
(202) 727-6161
(202) 673-2290 FAX
dcema.dc.gov

Florida Division of Emergency Management
2555 Shumard Oak Blvd.
Tallahassee, Florida 32399-2100
(850) 413-9969
(850) 488-1016 FAX
floridadisaster.org

Georgia Emergency Management Agency
P.O. Box 18055
Atlanta, Georgia 30316-0055
(404) 635-7000
(404) 635-7205 FAX
www.State.Ga.US/GEMA/

Office of Civil Defense
Government of Guam
P.O. Box 2877
Hagatna, Guam 96932
(011)(671) 475-9600
(011)(671) 477-3727 FAX
http://ns.gov.gu/

Guam Homeland Security/Office of Civil Defense
221B Chalan Palasyo
Agana Heights, Guam 96910
Tel:(671)475-9600
Fax:(671)477-3727
www.guamhs.org

Hawaii State Civil Defense
3949 Diamond Head Road
Honolulu, Hawaii 96816-4495
(808) 733-4300
(808) 733-4287 FAX
www.scd.hawaii.gov

Idaho Bureau of Homeland Security
4040 Guard Street, Bldg. 600
Boise, Idaho 83705-5004
(208) 422-3040
(208) 422-3044 FAX
www.bhs.idaho.gov/

Illinois Emergency Management Agency
2200 S. Dirksen Pkwy.
Springfield, Illinois 62703
Office: (217) 782-2700
Fax: (217) 524-7967
www.state.il.us/iema

Indiana Department of Homeland Security
Indiana Government Center South
302 West Washington Street, Room E208
Indianapolis, Indiana 46204-2767
Office: (317) 232-3986
Fax: (317) 232-3895
www.ai.org/sema/index.html

Indiana State Emergency Management Agency
302 West Washington Street
Room E-208 A
Indianapolis, Indiana 46204-2767
(317) 232-3986
(317) 232-3895 FAX
www.ai.org/sema/index.html

Iowa Homeland Security & Emergency Management Division
Department of Public Defense
Hoover Office Building
Des Moines, Iowa 50319
(515) 281-3231
(515) 281-7539 FAX
Iowahomelandsecurity.org.

Kansas Division of Emergency Management
2800 S.W. Topeka Boulevard
Topeka, Kansas 66611-1287
(785) 274-1401
(785) 274-1426 FAX
www.ink.org/public/kdem/

Kentucky Emergency Management
EOC Building
100 Minuteman Parkway Bldg. 100
Frankfort, Kentucky 40601-6168
(502) 607-1682
(502) 607-1614 FAX
kyem.ky.gov/

Louisiana Office of Emergency Preparedness
7667 Independence Blvd.
Baton Rouge, Louisiana 70806
(225) 925-7500
(225) 925-7501 FAX
www.ohsep.louisiana.gov

Maine Emergency Management Agency
45 Commerce Drive, Suite #2
#72 State House Station
Augusta, Maine 04333-0072
207-624-4400
207-287-3180 (FAX)
www.state.me.us/mema/memahome.htm

Homeland Security and Emergency Management Division
Michigan Dept. of State Police
Michigan State Police
4000 Collins Road
Lansing, MI 48910
Office: (517) 333-5042
Fax: (517) 333-4987
www.michigan.gov/emd

CNMI Emergency Management Office
Office of the Governor
Commonwealth of the Northern Mariana Islands
P.O. Box 10007
Saipan, Mariana Islands 96950
(670) 322-9529
(670) 322-7743 FAX
www.cnmiemo.gov.mp

National Disaster Management Office
Office of the Chief Secretary
P.O. Box 15
Majuro, Republic of the Marshall Islands
96960-0015
(011)(692) 625-5181
(011)(692) 625-6896 FAX

Maryland Emergency Management Agency
Camp Fretterd Military Reservation
5401 Rue Saint Lo Drive
Reistertown, Maryland 21136
(410) 517-3600
(877) 636-2872 Toll-Free
(410) 517-3610 FAX
www.mema.state.md.us/

Massachusetts Emergency Management Agency
400 Worcester Road
Framingham, Massachusetts 01702-5399
(508) 820-2000
(508) 820-2030 FAX
www.state.ma.us/mema

Michigan Division of Emergency Management
4000 Collins Road
P.O. Box 30636
Lansing, Michigan 48909-8136
(517) 333-5042
(517) 333-4987 FAX
www.michigan.gov/msp/1,1607,7-123-1593_3507---,00.html

National Disaster Control Officer
Federated States of Micronesia
P.O. Box PS-53
Kolonia, Pohnpei - Micronesia 96941
(011)(691) 320-8815
(001)(691) 320-2785 FAX

Minnesota Homeland Security and Emergency Management Division
Minnesota Dept. of Public Safety
444 Cedar Street, Suite 223
St. Paul, MN 55101-6223
Office: (651) 296-0466
Fax: (651) 296-0459
www.hsem.state.mn.us

Mississippi Emergency Management Agency
P.O. Box 5644
Pearl, MS 39288-5644
(601) 933-6362
(800) 442-6362 Toll Free
(601) 933-6800 FAX
www.msema.org
www.msema.org/mitigate/mssaferoominit.htm

Missouri Emergency Management Agency
P.O. Box 116
2302 Militia Drive
Jefferson City, Missouri 65102
(573) 526-9100
(573) 634-7966 FAX
sema.dps.mo.gov

Montana Division of Disaster & Emergency Services
1900 Williams Street
Helena, Montana 59604-4789
(406) 841-3911
(406) 444-3965 FAX
dma.mt.gov/des/

Nebraska Emergency Management Agency
1300 Military Road
Lincoln, Nebraska 68508-1090
(402) 471-7410
(402) 471-7433 FAX
www.nema.ne.gov

Nevada Division of Emergency Management
2525 South Carson Street
Carson City, Nevada 89711
(775) 687-4240
(775) 687-6788 FAX
dem.state.nv.us/

Governor's Office of Emergency Management
State Office Park South
107 Pleasant Street
Concord, New Hampshire 03301
(603) 271-2231
(603) 225-7341 FAX
www.nhoem.state.nh.us/

New Jersey Office of Emergency Management
Emergency Management Bureau
P.O. Box 7068
West Trenton, New Jersey 08628-0068
(609) 538-6050 Monday-Friday
(609) 882-2000 ext 6311 (24/7)
(609) 538-0345 FAX
www.state.nj.us/oem/county/

New Mexico Department of Public Safety
Office of Emergency Management
P.O. Box 1628
13 Bataan Boulevard
Santa Fe, New Mexico 87505
(505) 476-9600
(505) 476-9635 Emergency
(505) 476-9695 FAX
www.dps.nm.org/emergency/index.htm

Emergency Management Bureau
Department of Public Safety
P.O. Box 1628
13 Bataan Boulevard
Santa Fe, New Mexico 87505
(505) 476-9606
(505) 476-9650
www.dps.nm.org/emc.htm

New York State Emergency Management Office
1220 Washington Avenue
Building 22, Suite 101
Albany, New York 12226-2251
(518) 292-2275
(518) 457-9995 FAX
www.nysemo.state.ny.us/

North Carolina Division of Emergency Management
4713 Mail Service Center
Raleigh, NC 27699-4713
(919) 733-3867
(919) 733-5406 FAX
www.dem.dcc.state.nc.us/

North Dakota Department of Emergency Services
P.O. Box 5511
Bismarck, North Dakota 58506-5511
(701) 328-8100
(701) 328-8181 FAX
www.nd.gov/des

Ohio Emergency Management Agency
2855 West Dublin-Granville Road
Columbus, Ohio 43235-2206
Office: (614) 889-7150
Fax: (614) 889-7183
ema.ohio.gov/ema.asp

Office of Civil Emergency Management
Will Rogers Sequoia Tunnel 2401 N. Lincoln
Oklahoma City, Oklahoma 73152
(405) 521-2481
(405) 521-4053 FAX
www.odcem.state.ok.us/

Oregon Emergency Management
Department of State Police
PO Box 14370
Salem, Oregon 97309-5062
(503) 378-2911
(503) 373-7833 FAX
egov.oregon.gov/OOHS/OEM

Palau NEMO Coordinator
Office of the President
P.O. Box 100
Koror, Republic of Palau 96940
(011)(680) 488-2422
(011)(680) 488-3312

Pennsylvania Emergency Management Agency
2605 Interstate Drive
Harrisburg PA 17110-9463
(717) 651-2001
(717) 651-2040 FAX
www.pema.state.pa.us/

Puerto Rico Emergency Management Agency
P.O. Box 966597
San Juan, Puerto Rico 00906-6597
(787) 724-0124
(787) 725-4244 FAX

Rhode Island Emergency Management Agency
645 New London Ave
Cranston, Rhode Island 02920-3003
(401) 946-9996
(401) 944-1891 FAX
www.riema.ri.gov

South Carolina Emergency Management Division
2779 Fish Hatchery Road
West Columbia South Carolina 29172
(803) 737-8500
(803) 737-8570 FAX
www.scemd.org/

South Dakota Division of Emergency Management
118 West Capitol
Pierre, South Dakota 57501
(605) 773-3231
(605) 773-3580 FAX
www.state.sd.us/dps/sddem/home.htm

Tennessee Emergency Management Agency
3041 Sidco Drive
Nashville, Tennessee 37204-1502
(615) 741-4332
(615) 242-9635 FAX
www.tnema.org

Texas Division of Emergency Management
5805 N. Lamar
Austin, Texas 78752
(512) 424-2138
(512) 424-2444 or 7160 FAX
www.txdps.state.tx.us/dem/

Utah Division of Emergency Services and Homeland Security
1110 State Office Building
P.O. Box 141710
Salt Lake City, Utah 84114-1710
(801) 538-3400
(801) 538-3770 FAX
www.des.utah.gov

Vermont Emergency Management Agency
Department of Public Safety
Waterbury State Complex
103 South Main Street
Waterbury, Vermont 05671-2101
(802) 244-8721
(802) 244-8655 FAX
www.dps.state.vt.us/

Virgin Islands Territorial Emergency Management - VITEMA
2-C Contant, A-Q Building
Virgin Islands 00820
(340) 774-2244
(340) 774-1491

Virginia Department of Emergency Management
10501 Trade Court
Richmond, VA 23236-3713
(804) 897-6502
(804) 897-6506
www.vdem.state.va.us

State of Washington Emergency Management Division
Building 20, M/S: TA-20
Camp Murray, Washington 98430-5122
(253) 512-7000
(253) 512-7200 FAX
www.emd.wa.gov/

West Virginia Office of Emergency Services
Building 1, Room EB-80 1900 Kanawha
Boulevard, East
Charleston, West Virginia 25305-0360
(304) 558-5380
(304) 344-4538 FAX
www.wvdhsem.gov

Wisconsin Emergency Management
2400 Wright Street
P.O. Box 7865
Madison, Wisconsin 53707-7865
Phone: (608) 242-3232
Fax: (608) 242-3247
emergencymanagement.wi.gov/

Wyoming Office of Homeland Security
122 W. 25th Street
Cheyenne, Wyoming 82002
(307) 777-4900
(307) 635-6017 FAX
wyohomelandsecurity.state.wy.us

Listing – National and State Rural Health Associations

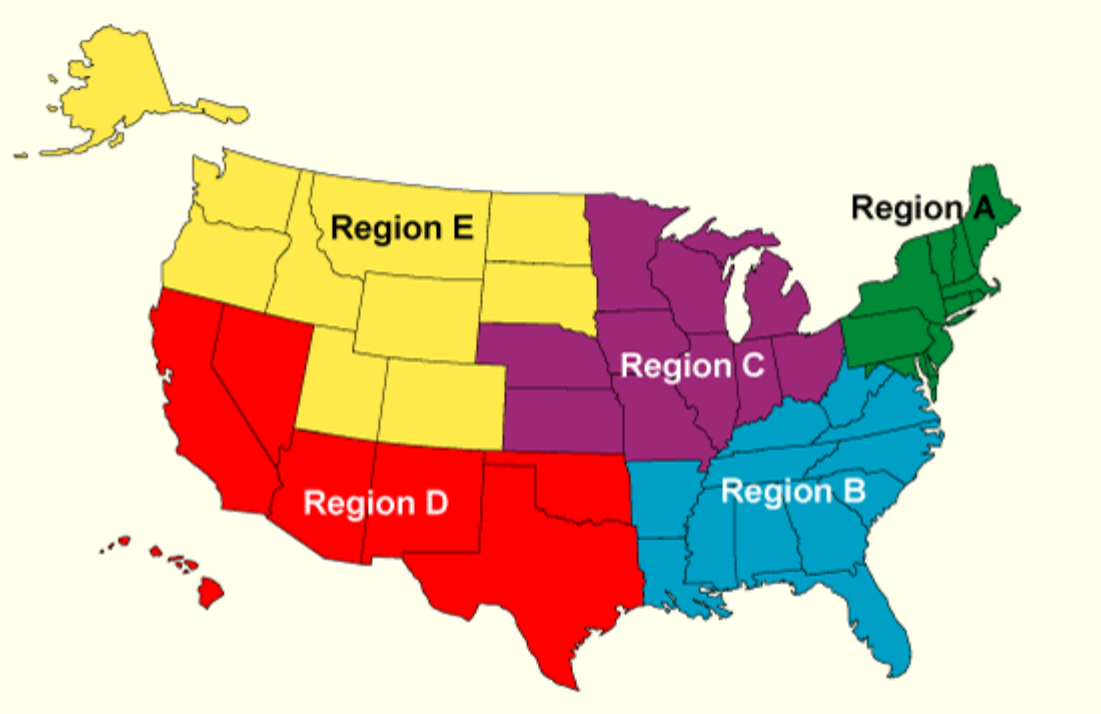
National	www.nrharural.org
Alabama	www.arhaonline.org
Arizona	www.azrha.org
California	www.csrha.org
Colorado	www.coruralhealth.org
Florida	www.flrha.org
Georgia	www.garuralhealth.org
Idaho	www.isu.edu/departments/irh
Illinois	www.ilruralhealth.org
Indiana	www.indianaruralhealth.org
Iowa	www.iaruralhealth.org
Kentucky	www.kyrha.org
Louisiana	www.lrha.org
Maine	www.maineruralhealth.org
Maryland	www.mdruralhealth.org
Michigan	www.miruralhealth.org
Minnesota	www.mnruralhealth.org
Mississippi	www.msrha.org
Missouri	www.morha.org
Nebraska	www.nebraskaruralhealth.org
New England (Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island)	www.newenglandruralhealth.org
New Mexico	www.nmhhsa.org
New York	www.nysarh.org
Oregon	www.orha.org
Pennsylvania	http://porh.psu.edu/prhaweb/prhahome.htm
South Carolina	www.scrha.org
Tennessee	www.rhat.org
Texas	www.trha.org
Utah	www.rhau.org
Virginia	www.vrha.org
Washington	www.wrha.com
West Virginia	www.wvrha.org

Listing – State Offices of Rural Health and Resources

National Office of Rural Health Policy	ruralhealth.hrsa.gov
National Organization of State Offices of Rural Health	www.nosorh.org
Alabama	www.adph.org/ruralhealth
Alaska	www.hss.state.ak.us/commissioner/Healthplanning/ruralhealth/rhfp_home.htm
Arizona	www.rho.arizona.edu
Arkansas	www.healthyarkansas.com/rural_health/orhpc_web_page.htm
California	www.prh.dhs.ca.gov/Programs/CalSORH
Colorado	www.coruralhealth.org
Connecticut	www.ruralhealthct.org
Delaware	www.dhss.delaware.gov/dhss/dph/chca/rural.html
Florida	www.doh.state.fl.us/Workforce/RuralHealth/ruralhealthhome.htm
Georgia	Office of Rural Health Services
Hawaii	www.hawaii.gov/health/family-child-health/rural-health/index.html
Idaho	www.healthandwelfare.idaho.gov/site/3459/default.aspx
Illinois	www.idph.state.il.us/about/rural_health/rural_home.htm
Indiana	www.state.in.us/isdh/publications/llo/rural_health/myfile.htm
Iowa	http://www.idph.state.ia.us/hpcdp/rural_health.asp
Kansas	www.kdhe.state.ks.us/olrh/
Kentucky	www.mc.uky.edu/ruralhealth/SORH/default.htm
Louisiana	www.dhh.louisiana.gov/offices/?ID=88
Maine	www.maine.gov/dhhs/boh/orhpc
Maryland	www.fha.state.md.us/ohpp/ruralhlth/
Massachusetts	Massachusetts Office of Rural Health
Michigan	www.com.msu.edu/micrh
Minnesota	www.health.state.mn.us/divs/cfh/orhpc/rhpc/office/
Mississippi	www.msdh.state.ms.us/msdhsite/_static/44,0,111.html
Missouri	www.dhss.mo.gov/PrimaryCareRuralHealth/
Montana	healthinfo.montana.edu
Nebraska	www.hhss.ne.gov/orh
Nevada	www.unr.edu/med/dept/CEHSO/orh.html
New Hampshire	www.dhhs.state.nh.us/DHHS/RHPC/sorh.htm
New Jersey	www.njpca.org/programs/default.aspx
New Mexico	www.health.state.nm.us

New York	www.health.state.ny.us
North Carolina	www.ncruralhealth.org/
North Dakota	www.med.und.nodak.edu/depts/rural/sorh/index.html
Ohio	www.odh.ohio.gov/odhprograms/chss/rural/ruralhealth1.aspx
Oklahoma	www.healthsciences.okstate.edu/ruralhealth/index.cfm
Oregon	www.ohsu.edu/oregonruralhealth
Pennsylvania	http://porh.cas.psu.edu
Rhode Island	www.health.ri.gov/disease/primarycare/rural-OPC.php
South Carolina	www.scorh.net/
South Dakota	www.state.sd.us/doh/rural/
Tennessee	health.state.tn.us/rural/index.html
Texas	www.orca.state.tx.us/
Utah	health.utah.gov/primary_care/ruralhealth.html
Vermont	healthvermont.gov/local/rural/rural_health.aspx
Virginia	www.vdh.virginia.gov/healthpolicy/ruralhealth
Washington	www.doh.wa.gov/hsqa/ocrh/Default.htm
West Virginia	www.wvochs.org/orhp/default.aspx
Wisconsin	www.worh.org/index.asp
Wyoming	wdh.state.wy.us/rural/index.asp

State Offices of Rural Health - Regional Representatives



Region A: Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont

- Jennifer Hessert
  Pennsylvania Office of Rural Health
  203 Beecher-Dock House
  University Park, PA 16802-2315
  814-863-8214
  juh3@psu.edu
- Alisa Butler-Druzba
  New Hampshire Rural Health and Primary Care
  New Hampshire Department of Health
  6 Hazen Drive
  Concord, NH 03301
  603-271-4741
  butler@dhhs.state.nh.us

Region B: Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, West Virginia

- Kristy Nichols
  Louisiana Office of Rural Health
  1201 Capitol Access Road
  PO Box 2870

Baton Rouge, LA 70821-2870
225-342-9513
knichols@dhh.la.gov

- Larry Allen
  Kentucky Commonwealth Office of Rural Health
  100 Airport Gardens Rd., Ste. 10
  Hazard, KY 41701
  606-439-3557
  lalle2@pop.uky.edu

Region C: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio, Wisconsin

- Chris Tilden
  Kansas Office of Local and Rural Health
  1000 SW Jackson, Suite 340
  Topeka, KS 66612-1365
  785-296-1200
  ctilden@kdhe.state.ks.us
- Mark Schoenbaum
  Minnesota Office of Rural Health and Primary Care
  Minnesota Department of Health
  PO Box 64882
  St. Paul, MN 55164-0882
  651-201-3859
  mark.schoenbaum@health.state.mn.us

Region D: Arizona, California, Hawaii, Nevada, New Mexico, Oklahoma, Texas

- Lynda Bergsma
  Arizona Rural Health Office
  Mel & Enid Zuckerman College of Public Health University of Arizona
  1295 N Martin
  P.O. Box 245177
  Tucson, AZ 85724
  520-626-2401, FAX: 520-626-8716
  lbergsma@u.arizona.edu
- Scott Daniels
  Hawaii State Office of Rural Health Hawaii Department of Health
  Office of Planning, Policy & Program Development
  PO Box 1675
  Honoka, HI 96727
  808-586-4188
  scott.daniels@doh.hawaii.gov

Region E: Alaska, Colorado, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming

- Kenneth Doppenberg
  South Dakota Office of Rural Health
  600 East Capitol Avenue
  Pierre, SD 57501-2536
  615-733-4945
  Kenneth.doppenberg@state.sd.us
- Pat Carr
  Alaska State Office of Rural Health
  PO Box 110601
  Juneau, AK 99811-0601
  907-465-8618
  Pat_Carr@health.state.ak.us

Listing – Rural Health Clinic Associations and Resources

National	www.narhc.org
Missouri	www.marhc.org
Texas	www.tarhc.org

Listing – Community and Migrant Health Center Associations and Resources

National	www.nachc.com
Arizona	www.aachc.org
Florida	www.fachc.org
Mid-Atantic	www.machc.com
Minnesota	www.mnpca.nonprofitoffice.com
Ohio	www.ohiochc.org
Rhode Island	www.rihca.org
Texas	www.tachc.org
Washington	www.wacmhc.org

Listing – Rural Hospital Resources

National – American Hospital Association Section for Small or Rural Hospitals
http://www.aha.org/aha/member-center/constituency-sections/Small-or-Rural/index.html
Illinois Hospital Association Small & Rural Hospital Constituency Section
www.ihatoday.org/membership/smallrural/index.html
Louisiana Hospital Association Small & Rural Hospital Forum
www.lhaonline.org/displaycommon.cfm?an=1&subarticlenbr=35
Mississippi Hospital Association Center for Rural Health www.mhanewsnow.typepad.com/rural
South Carolina Hospital Association Small & Rural Hospital Council
www.scha.org/document.asp?document_id=2,22,1032,97
Tennessee Hospital Association Rural Health Issues Section www.tha.com/rural-health
Texas Organization of Rural and Community Hospitals http://www.torchnet.org/

Listing – Community Health Worker / Promotora Associations and Resources

National CHW Networks and Organizations

The Community Health Worker Special Primary Interest Group
The American Public Health Association
Washington, D.C.
http://www.apha.org
Phone: (202) 777-2742

The Center for Sustainable Health Outreach,
The University of Southern Mississippi
Hattiesburg, Mississippi
http://www.usm.edu/csho/
Phone: (601) 266-5903

Harrison Institute for Public Law
Georgetown University Law Center
Washington, D.C.
http://www.law.georgetown.edu/clinics/hi/ClientsProjects-HealthPolicy.htm
Phone: (202) 662-4229
Contact person: Jackie Scott

Community Health Worker National Network Association
Western Area Health Education Center System
Yuma, Arizona
http://www.chwnna.org/
Phone: (877) 743-1500

National Association of Community Health Representatives
http://chrtriennial.com/index.htm
Phone: (520) 383-6200
Contact person: Cynthia Norris

State CHW Networks and Organizations

Arizona

Arizona Community Health Outreach Workers Network (AzCHOW)
http://www.publichealth.arizona.edu/azchow
Phone: (928) 627-1060
Contact person: Flor Redondo

California

Community Health Worker/Promotoras Network
Vision y Compromiso
El Cerrito, California
Phone: (510) 232-7869

Florida

REACH-Workers - the Community Health Workers of Tampa Bay
Tampa, Florida
Phone: (727) 588-4018

Maryland

Community Outreach Workers Association of Maryland, Inc. (COWAM).
Baltimore, Maryland

Massachusetts

Massachusetts Community Health Worker (MACHW) Network
University of Massachusetts Office of Community Programs
Shrewsbury, Massachusetts
http://www.mphaweb.org
Phone: (508) 856-3255

Michigan

Michigan Community Advocate Association (MICAA)
Grand Rapids, Michigan
Phone: (616) 356-6205
Contact person: Lisa Marie Fisher

Minnesota
Minnesota CHW Peer Network
Minnesota International Health Volunteers
Minneapolis, Minnesota
http://www.heip.org/chw_peer_networking.htm
http://www.mihv.org/chwnetwork
Phone: (612) 871-3759

New Mexico
New Mexico Community Health Workers Association (NMCHWA)
Alburquerque, New Mexico
Phone: (505) 272-4741
Contact person: B.J. Ciesielki

New York
Community Health Worker Network of NYC
New York, New York
http://chwnetwork.org/
Phone: (212) 481-7667
Rochester Outreach Workers Association (ROWA)
Rochester, New York
Phone: (585) 274-8490

Oregon
Oregon Community Health Worker Network
Portland, Oregon
Phone: (503) 988-3366

Texas
South Texas Promotora Association
Weslaco, Texas
Phone: (956) 783-9293
Contact person: Ramona Casas

Listing – State Primary Care Associations and Resources

Alabama Primary Health Care Association
Cyndi Signore, HRSA/APHCA Quality Improvement Coordinator
6008 E Shirley Lane, Suite A
Montgomery, AL 36117
T (334)271-7068 F (334)271-7069
http://adph.org/aphca

Alaska Primary Care Association, Inc.
Marilyn Kasmar, Executive Director
903 W Northern Lights Blvd
Suite 200
Anchorage, AK 99503
T 907-929-2722 F 907-929-2734
akpca@alaskapca.org
www.alaskapca.org

Arizona Association of Community Health Centers
Joseph S. Coatsworth, MBA
Chief Executive Officer
320 E McDowell Rd
Suite #225
Phoenix, AZ 85004
T (602)253-0090 F (602)252-3620
coatsworth@aachc.org
www.aachc.org

Asociacion de Salud Primaria de Puerto Rico
Alicia Suarez, Acting Executive Director
201 De Diego Avenue, Suite 158
Plaza San Francisco
San Juan, PR 00927
T (787)758-3411 F (787)758-1736
acsppr@coqui.net
www.saludprimariapr.org

Bi-State Primary Care Association
Tess Stack Kuenning, Executive Director
61 Elm Street
Montpelier, VT 05602
T 802/229-0002 F 802/223-2336
tkuenning@bistatepca.org
www.bistatepca.org

Bi-State Primary Care Association (Second Office)
Tess Stack Kuenning, Executive Director
3 South Street
Concord, NH 03301
T (603)228-2830 F (603)228-2464
tkuenning@bistatepca.org
www.bistatepca.org

California Primary Care Association
Carmela Castellano, CEO
1215 K Street
Suite 700
Sacramento, CA 95814
T (916)440-8170 F (916)440-8172
ccastellano@cpca.org
www.cpca.org

Colorado Community Health Network
Annette Kowal, Chief Executive Officer
600 Grant Street, Suite #800
Denver, CO 80203
T (303)861-5165x228 F (303)861-5315
annette@cchn.org
www.cchn.org

Community Health Association of Mountain/Plain States (Region VIII)
Julie Hulstein, Executive Director
600 Grant Street, Suite #800
Denver, CO 80203
T (303)861-5165x226 F (303)861-5315
julie@champsonline.org
www.champsonline.org

Community Health Care Association of New York
Elizabeth Swain, Executive Director
254 W. 31st Street
9th Floor
New York, NY 10001
T (212)279-9686 F (212)279-3851
eswain@chcanys.org
www.chcanys.org

Community Health Centers of Arkansas
Sip Mouden, Executive Director
420 W 4th St
Suite A
North Little Rock, AR 72114
T (501)374-8225 F (501)374-9734
sbmouden@chc-ar.org
www.chc-ar.org

Connecticut Primary Care Association
Evelyn Barnum, Executive Director
375 Willard Avenue
Newington, CT 06111
T 860/667-7820 F 860/667-7835
ebarnum@ctpca.org
www.ctpca.org

District of Columbia Primary Care Association
Sharon Baskerville, Executive Director
1411 K Street, NW
Ste 400
Washington, DC 20005
T 202/638-0252 F 202/638-4637
sbaskerville@dcpca.org
www.dcpca.org

Florida Association of Community Health Centers
Andrew Behrman, President & CEO
2340 Hansen Lane
Tallahassee, FL 32301
T (850) 942-1822 F (850)-9902
Abehrman@fachc.org
www.fachc.org

Georgia Association for Primary Health Care
D. A. Kavka, Executive Director
315 West Ponce de Leon Avenue
Suite 1000
Decatur, GA 30030
T 404-659-2861 F 404-659-2801
dkavka@gaphc.org
www.gaphc.org

Great Basin Primary Health Care Association
Patricia Durbin, Executive Director
300 S. Curry Street
Suite 6
Carson City, NV 89703
T 775 887-0417 F 775 887-3562
durbin@gbpca.org
www.gbpca.org

Hawaii Primary Care Association
Elizabeth Giesting, Executive Director
345 Queen Street
Suite 601
Honolulu, HI 96813
T (808) 536-8442 F (808) 524-0347
bgiesting@hawaiipca.net
www.hawaiipca.net

Idaho Primary Care Association
Denise Chuckovich, Executive Director
1276 River Street
Boise, ID 83707
T (208)345-2335 F (208)386-9945
dchuckovich@idahopca.org
www.idahopca.org

Illinois Primary Health Care Association
Bruce A. Johnson, President & CEO
225 S. College Street
Suite 200
Springfield, IL 62704-1815
T (217)541-7305 F (217)541-7306
bjohnson@iphca.org
www.iphca.org

Illinois Primary Health Care Association
(Second Office)
Bruce A. Johnson, President & CEO
542 S. Dearborn Street
Suite 900
Chicago, IL 60605
T 312/692-3020 F 312/692-3021
bjohnson@iphca.org
www.iphca.org

Indiana Primary Health Care Association
Lisa Winternheimer, Executive Director
1006 E Washington St
Ste 200
Indianapolis, IN 46202
T (317)630-0845 F (317)630-0849
lwinternheimer@indianapca.org
www.indianapca.org

Iowa-Nebraska Primary Care Association
Theodore J. Boesen, Executive Director
601 East Locust Street
Suite 102
Des Moines, IA 50309
T 515-244-9610 F 515-243-3566
ianepcatboesen@aol.com
www.ianepca@aol.com

Kansas Association for the Medically Underserved
Karla Finnell, Executive Director
1129 S. Kansas Ave.
Suite B
Topeka, KS 66612
T (785)233-8483 F (785)233-8403
kfinnell@kspca.org
www.kspca.org

Kentucky Primary Care Association
Joseph E. Smith, Executive Director
226 W Main St
Frankfort, KY 40602
T (502)227-4379 F (502)223-7654
jesmith@fewpb.net
www.kypca.net

Louisiana Primary Care Association
Rhonda Litt, Executive Director
4550 North Boulevard
Suite 120
Baton Rouge, LA 70806
T (225)927-7662 F (225)927-7688
rhonda@lpca.org
www.lpca.net

Maine Primary Care Association
Kevin Lewis, Executive Director
73 Winthrop Street
Augusta, ME 04330
T (207)621-0677 F (207)621-0577
KALewis@mepca.org
www.mepca.org

Massachusetts League of Community Health Centers
Jim Hunt, Executive Director
40 Court Street, 10th Floor
Boston, MA 02108
T (617)426-2225 F (617)426-0097
Jhunt@massleague.org
www.massleague.org

Michigan Primary Care Association
Kim Sibilsky, Executive Director
7215 Westshire Drive
Lansing, MI 48917
T (517) 381-8000 F (517) 381-8008
ksibilsky@mpca.net
www.mpca.net

Mid-Atlantic Primary Health Care Association
Miguel McInnis, Executive Director
4483-B Forbes Boulevard
Forbes Center Building II
Lanham, MD 20706
T 301-577-0097 F 301-577-4789
Miguel.McInnis@MACHC.com
www.machc.com

Minnesota Primary Care Association
Rhonda L. Degelau, J.D., Executive Director
1113 East Franklin Avenue
Suite 400
Minneapolis, MN 55404
T (612) 253-4715 F (612) 872-7849
rhonda.degelau@mnpca.org
www.mnpca.nonprofitoffice.com

Mississippi Primary Health Care Association
Robert M. Pugh, MPH, Executive Director
P.O. Box 11745
Jackson, MS 392283-1174
T 601-981-1817 F 601-981-1217
rmpugh@mphca.com
www.mphca.com

Missouri Primary Health Care Association
Joe Pierle, CEO
3325 Emerald Lane
Jefferson City, MO 65109
T (573)636-4222 F (573)636-4585
jpierle@mo-pca.org
www.mo-pca.org

Montana Primary Care Association
Alan Strange, Ph.D., Executive Director
900 N. Montana Ave
Suite B3
Helena, MT 59601
T (406)442-2750 F (406)443-0563
Astrange@mtpca.org
www.mtpca.org

New Jersey Primary Care Association
Kathy Grant-Davis, Executive Director
14 Washington Road
Suite 211
Princeton Junction, NJ 08550-1030
T (609)275-8886 F (609)936-7247
kgrantdavis@njpca.org
www.njpca.org

New Mexico Primary Care Association
David Roddy, Executive Director
4206 Louisiana Blvd. NE
Albuquerque, NM 87109-1841
T (505) 880-8882 F (505) 880-8885
droddy@nmpca.org
www.nmpca.org

New York—Community Health Care Association of New York
Elizabeth Swain, CEO
254 W. 31st Street
9th Floor
New York, NY 10001
T (212)279-9686 F (212)279-3851
eswain@chcanys.org
www.chcanys.org

North Carolina Community Health Center Association
Sonya Bruton, Executive Director
2500 Gateway Center
Suite 100
Morrisville, NC 27560
T (919)469-5701 F (919)469-1263
brutons@ncchca.org
www.ncchca.org

North Dakota Office, Community HealthCare Association
Karen Larson, North Dakota Director/Deputy Director
1003 East Interstate Avenue
Suite 6
Bismarck, ND 58503
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Northwest Regional Primary Care Association
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Ohio Association of Community Health Centers
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Columbus, Ohio 43214
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Oklahoma Primary Care Association
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Oklahoma City, OK 73105
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Oregon Primary Care Association
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Portland, OR
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chostetler@northwest.com
www.orpca.org

Pacific Islands Primary Care Association
Clifford Chang, Executive Director
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Suite 601
Honolulu, HI 96813-4715
T (808)536-8442 F (808)524-0347
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Pennsylvania Forum for Primary Health Care
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Rhode Island Health Center Association
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kclark@rihca.org

South Carolina Primary Care Association
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Tennessee Primary Care Association
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Brentwood, TN 37027
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Texas Association of Community Health Centers
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Utah Association for Community Health
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Salt Lake City, UT 84107
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Virginia Community Healthcare Association
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Washington Association of Community & Migrant Health Centers
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2120 State Avenue NE, Suite 220
Olympia, WA 98506
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Email: skubid@wacmhc.org
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West Virginia Primary Care Association
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Charleston, WV 25301
T (304)346-0032 F (304)346-0033
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Wisconsin Primary Health Care Association
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Wyoming Primary Care Association
Pat Monahan, Executive Director
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Cheyenne, WY 82001
T 307/632-5743 F 307/638-6103
pat@wypca.org
www.wypca.org

Other Rural Resources

Walsh Center for Rural Health Analysis
www.cms.hhs.gov/center/rural.asp
Resource Center for Rural Behavioral Health
www.apa.org/rural
National Association for Rural Mental Health
http://narmh.org/
Rural Information Center
http://ric.nal.usda.gov/nal_display/index.php?tax_level=1&info_center=5
Rural Assistance Center
http://www.raconline.org/
Rural Health Resource Center
http://www.ruralcenter.org/
Federal Funding Sources for Rural Areas Database
http://ric.nal.usda.gov/nal_web/ric/ffd.php
Networking For Rural Health (Robert Wood Johnson Foundation)
www.academyhealth.org/ruralhealth
Rural Policy research Institute
www.rupri.org
Rural Community Assistance Corporation
http://www.rcac.org
BPHC Migrant Health Program
http://bphc.hrsa.gov/migrant/
Migrant Health
http://borderhealth.raconline.org/topics/topic.php?topic=Migrant%20health
Migrant Clinicians Network
http://www.migrantclinician.org/
Migrant Health Promotion
http://www.migranthealth.org/
National Center for Farmworker Health
http://www.ncfh.org/
Migrant Health Service, Inc.
http://www.migranthealthservice.org/
Rural Health Consultants, Inc.
www.ruralhealthconsultants.com

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Appendix A

Stakeholder Contact Listing

Stakeholder Contact Listing

Title	Name	Organization / Agency	Phone	Address
County Judge			XXX-XXX-XXXX	
Mayor				
City Council Members				
County Commissioners				
City/County Attorney				
Justices of the Peace				
Tribal Leaders				

Emergency Management Coordinator/Planner				
Local Health Director/Authority				
Other Healthcare Providers				
●Doctors				
●Nurses				
●Nurse Practitioner				
●Physician Assistant				
●Dentists				

●Mental Health Professionals				
Veterinarian(s)				
Pharmacist(s)				
Social Worker(s)				
Voluntary Organization				
Voluntary Organization				
Voluntary Organization				
Voluntary Organization				
Home Health Administrator				
Nursing Home Director				
Funeral Home Director				

EMS / Ambulance Service				
Law Enforcement				
●Police Chief				
●Sheriff				
Fire Chief (may be volunteer)				
Local Emergency Planning Committee (LEPC)				
Public Works and Utility Companies				
●Gas				
●Electric				
●Water				
●Sewer				
●Trash				
Public Schools				

●Superintendent				
●Principal				
●Nurses				
●Counselors				
●Teachers				
●PTA				
Cooperative Extension Agents				
Council of Government				
Community Resource Centers				
Community/Recreation Centers				
Faith Communities				
●Ministerial Alliance				

●Churches, Mosques, Synagogues, Temples				
Jail / Prison Administrator				
Border Patrol				
Chamber of Commerce				
Local Businesses				

Parks and Wildlife				
Community Volunteers				
●Community Emergency Response Team (CERT)				
●Medical Reserve Corp				
●Retired Senior Volunteer Program (RSVP)				
Computer/IT Support				
Media				
●Newspaper				
●Radio				
●Other				
Student Groups				
Vendor				

Vendor				
Vendor				
Vendor				
Vendor				

Appendix B

Memorandum of Understanding Template and Guidance

MEMORANDUM OF UNDERSTANDING (MOU)
Between

_____*[insert name of Party A]*

and

_____*[insert name of Party B]*

This is an agreement between "*Party A*", hereinafter called _____ and "Party B", hereinafter called _____.

I. PURPOSE & SCOPE

The purpose of this MOU is to clearly identify the roles and responsibilities of each party as they relate to [*...summary of activities, goals, etc.…*].

In particular, this MOU is intended to:
Examples:
- *Enhance*
- *Increase*
- *Reduce costs*
- *Establish*
- *Clarify*
- *Outline*

II. BACKGROUND

Brief description of agencies involved in the MOU

III. *[PARTY A]* RESPONSIBILITIES UNDER THIS MOU

[Party A] shall undertake the following activities:
Examples:
- *Develop*
- *Deliver*
- *Share*
- *Support*
- *Provide*
- *Promote*
- *Refer*

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- *Review*
- *Comply*
- *Train*
- *Maintain records*
- *Sponsor*
- *Evaluate*

IV. *[PARTY B]* RESPONSIBILITIES UNDER THIS MOU

[Party B] shall undertake the following activities:
Examples:
- *Develop*
- *Deliver*
- *Share*
- *Support*
- *Provide*
- *Promote*
- *Refer*
- *Review*
- *Comply*
- *Train*
- *Maintain records*
- *Sponsor*
- *Evaluate*

V. IT IS MUTUALLY UNDERSTOOD AND AGREED BY AND BETWEEN THE PARTIES THAT:

1. *Modification clause: how agreement can be modified*
2. *Termination clause: under what conditions agreement terminates automatically*

VI. EFFECTIVE DATE AND SIGNATURE

This MOU shall be in effect upon the signature of Party A's and Party B's authorized officials. It shall be in force from _____ to _____.
Parties A and B indicate agreement with this MOU by their signatures.

Signatures and dates

[*insert name of Party A*]	[*insert name of Party B*]
_____	_____
Date	Date

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Memorandum of Understanding (MOU) Guidance

MOUs provide the framework for effective linkages and are essential tools for successful partnerships. However, what works for one organization may not be effective for another. Some components may be essential for you, while others may be less useful in your particular situation. Create your MOU with your organization's individual needs in mind.

DIRECTIONS: Use the components below to generate a draft MOU between your organization and a potential partner. Think carefully about what components you want your MOU to contain.

INTRO. COMPONENT: WHAT IT IS: BE SURE TO INCLUDE:	**Names of parties entering agreement** List the agencies that are entering the agreement Your agency name Partner agency name
I. COMPONENT: WHAT IT IS: BE SURE TO INCLUDE:	**Overview of the project, activities, and goals** Summarize activities, authorization, goals, outcomes and target clientele Linkage activities What the MOU authorizes the agencies to do Goals of the linkage agreement Intended outcomes of the project Target clientele for linkages
II. COMPONENT: WHAT IT IS: BE SURE TO INCLUDE:	**Background and missions of parties entering agreement** Indicates backgrounds and missions of agencies involved in the MOU Your agency's background and mission Partner agency's background and mission
III. COMPONENT: WHAT IT IS: BE SURE TO INCLUDE:	**Responsibilities of your agency** Summarize responsibilities of your agency What your agency will do as part of the MOU (specific types of actions, activities, or information sharing; indicate whether ongoing or only when emergencies occur) (If appropriate: Statement that your agency will comply with all appropriate local, state, or federal laws and regulations)
IV. COMPONENT: WHAT IT IS: BE SURE TO INCLUDE:	**Responsibilities of your partner agency** Summarize responsibilities of your partner agency What the other agency will do as part of the MOU

	(specific types of actions, activities, or information sharing; indicate whether ongoing or only when emergencies occur) (If appropriate: Statement that your agency will comply with all appropriate local, state, or federal laws and regulations)
V. COMPONENT: WHAT IT IS: BE SURE TO INCLUDE:	**Modification and Termination** Conditions under which the MOU may be modified or terminated What conditions would modify MOU (usually by mutual agreement of both parties/amendment) What conditions would end MOU How modification or termination is conveyed to the other party
VI. COMPONENT: WHAT IT IS: BE SURE TO INCLUDE:	**Signature of executive from each agency** Indicates official authorization for the agreement Executive director, CEO, or relevant department head signing for your agency Executive director, CEO, or relevant department head signing for partner agency

Source: Community Health Care Association of New York State

Appendix C

Hazard Vulnerability Assessment

Hazard Surveillance Form

Structural and Nonstructural Hazard Mitigation Checklists

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Hazard Vulnerability Assessment Guidance and Tool

Using the HVA guidance and tool below, evaluate the potential for each event and response among the following categories using the hazard specific scale. Assume each incident occurs at the worst possible time (e.g. during peak patient loads). In the spreadsheet, use the equation **Risk = Probability x Severity** (see below).

Issues to consider for probability include, but are not limited to:

1 Known risk
2 Historical data
3 Manufacturer/vendor statistics

Issues to consider for response include, but are not limited to:

1 Time to marshal an on-scene response
2 Scope of response capability
3 Historical evaluation of response success

Issues to consider for human impact include, but are not limited to:

1 Potential for staff death or injury
2 Potential for patient death or injury

Issues to consider for property impact include, but are not limited to:

1 Cost to replace
2 Cost to set up temporary replacement
3 Cost to repair
4 Time to recover

Issues to consider for business impact include, but are not limited to:

1 Business interruption
2 Employees unable to report to work
3 Customers unable to reach facility
4 Company in violation of contractual agreements
5 Imposition of fines and penalties or legal costs
6 Interruption of critical supplies
7 Interruption of product distribution
8 Reputation and public image
9 Financial impact/burden

Issues to consider for preparedness include, but are not limited to:

1 Frequency of drills
2 Training status
3 Insurance
4 Availability of alternate sources for critical supplies/services

Issues to consider for internal resources include, but are not limited to:

1 Types of supplies on hand/will they meet need?
2 Volume of supplies on hand/will they meet need?
3 Staff availability
4 Coordination with MOBs
5 Availability of back-up systems
6 Internal resources' ability to withstand disasters/survivability

Issues to consider for external resources include, but are not limited to:

1 Types of agreements with local and state agencies.
2 Types of agreements with community agencies/drills?
3 Coordination with local and state agencies
4 Coordination with proximal health care facilities
5 Coordination with treatment specific facilities
6 Community resources

NATURALLY OCCURRING EVENTS	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur	*Possibility of death or injury*	*Physical losses and damages*	*Interruption of services*	*Preplanning*	*Time, effectiveness, resources*	*Community/ Mutual Aid staff and supplies*	*Relative threat**
SCORE	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 - 100%*
Hurricane								
Tornado								
Severe Thunderstorm								
Snow Fall								
Blizzard								
Ice Storm								
Earthquake								
Tidal Wave								
Temperature Extremes								
Drought								
Flood, External								
Wild Fire								
Landslide								
Dam Inundation								
Volcano								
Epidemic								
AVERAGE SCORE								

**Threat increases with percentage.*

RISK = PROBABILITY X SEVERITY

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TECHNOLOGICAL HAZARDS	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur	*Possibility of death or injury*	*Physical losses and damages*	*Interruption of services*	*Preplanning*	*Time, effectiveness, resources*	*Community/ Mutual Aid staff and supplies*	*Relative threat**
SCORE	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 - 100%*
Electrical Failure								
Generator Failure								
Transportation Failure								
Fuel Shortage								
Natural Gas Failure								
Water Failure								
Sewer Failure								
Steam Failure								
Fire Alarm Failure								
Communications Failure								
Medical Gas Failure								
Medical Vacuum Failure								
HVAC Failure								
Information Systems Failure								
Fire, Internal								
Flood, Internal								
Hazmat Exposure, Internal								
Supply Shortage								
Structural Damage								
AVERAGE SCORE								

**Threat increases with percentage.*

RISK = PROBABILITY X SEVERITY

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HUMAN HAZARDS	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur	*Possibility of death or injury*	*Physical losses and damages*	*Interruption of services*	*Preplanning*	*Time, effectiveness, resources*	*Community/ Mutual Aid staff and supplies*	*Relative threat**
SCORE	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 =Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 - 100%*
Mass Casualty Incident (trauma)								
Mass Casualty Incident (medical/infectious)								
Terrorism, Biological								
VIP Situation								
Infant Abduction								
Hostage Situation								
Civil Disturbance								
Labor Action								
Forensic Admission								
Bomb Threat								
AVERAGE								

**Threat increases with percentage.*

RISK = PROBABILITY X SEVERITY

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HAZARDOUS MATERIAL EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur	*Possibility of death or injury*	*Physical losses and damages*	*Interruption of services*	*Preplanning*	*Time, effectiveness, resources*	*Community/ Mutual Aid staff and supplies*	*Relative threat**
SCORE	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = Low 2 = Moderate 3 = High*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 = N/A 1 = High 2 = Moderate 3 = Low or none*	*0 - 100%*
Mass Casualty Hazmat Incident *(From historic events at your MC with >= 5 victims)*								
Small Casualty Hazmat Incident *(From historic events at your MC with < 5 victims)*								
Chemical Exposure, External								
Small-Medium Sized Internal Spill								
Large Internal Spill								
Terrorism, Chemical								
Radiologic Exposure, Internal								
Radiologic Exposure, External								
Terrorism, Radiologic								
AVERAGE								

**Threat increases with percentage.*

RISK = PROBABILITY X SEVERITY

Source: California Primary Care Association and the California Emergency Medical Services Authority

MANAGEMENT OF ENVIRONMENT
HAZARD SURVEILLANCE/RISK ASSESSMENT REPORT FORM

Date:_____ Building:_____

Program	Hazard Surveillance/Risk Assessment Item	1	2	3	4	5	Comments
Safety Management	1. Are grounds clean & free of hazards?						
	2. Are floors clean, dry, in good repair, & free of obstruction?						
	3. Are mechanisms for access (i.e. ramps, handrails, door opening mechanisms, etc.) operational?						
	4. Is the parking area free of potholes or other hazards?						
	SUBTOTALS						**PROGRAM TOTAL:**
Security Management	1. Are doors functioning & locked as appropriate?						
	2. Are medical records centrally located and accessible ONLY to authorized personnel?						
	3. Are alarms functioning, tested, and maintained in accordance with manufacturer's specifications?						
	4. Are systems/mechanisms in place to quickly notify officials or other staff quickly in the event of a security related problem?						
	SUBTOTALS						**PROGRAM TOTAL:**

Hazardous Materials & Waste Management	1. Are OSHA Hazard Communication and Exposure Control Documents Available?						
	2. Have all biohazard and toxic substances present been identified?						
	3. Are MSDS sheets quickly available for all identified toxic substances?						
	4. Are all waste contaminated with blood/body fluid considered and handled as infectious?						
	5. Are sharps containers puncture resistant and in accordance with require safety standards?						
	6. Are sharps and disposable syringes placed in approved Sharps containers?						
	7. Are all engineering, personal protective equipment & workplace controls in effect?						
	SUBTOTALS						**PROGRAM TOTAL:**
Emergency Preparedness Management	1. Is there an updated all-hazards disaster plan in the department?						
	2. Has a non-fire related emergency drill been performed in the past six months?						
	3. Is staff aware of at least three different types of potential non-fire emergencies and their role in eliminating or reducing the risk of patients, staff and property?						
	4. Is staff aware of the primary and secondary exits from the facility?						
	SUBTOTALS						**PROGRAM TOTAL:**

Life Safety Management	1. Is the evacuation plan posted and can staff demonstrate knowledge of the plan?						
	2. Are fire extinguishers located in accordance with NFPA standards?						
	3. Are fire extinguishers inspected monthly and documented on/near the extinguisher?						
	4. Are smoke/fire alarm systems functioning, tested, and maintained in accordance with manufacturers specifications?						
	5. Are exit hallways well lit & obstacle free?						
	6. Is emergency exit lighting operational and tested in accordance with NFPA standards?						
	7. Are fire/smoke doors operating effectively?						
	8. No smoking policies are in effect and signs are posted appropriately?						
	SUBTOTALS						**PROGRAM TOTAL:**
Medical Equipment Management	1. Is there a unique inventory of all medical equipment in the facility?						
	2. Are all equipment evaluated & prioritized 0 (Form EC 1.8) prior to use?						
	3. Has all equipment been tested/maintained according to manufacturer's specifications?						
	4. Are maintenance records complete, are they capable of tracking the maintenance history of a particular piece of equipment, and do they record the results of both electrical safety as well as calibration, as appropriate?						
	5. Are systems/mechanisms in place to respond appropriately to a medical equipment failure?						
	SUBTOTALS						**PROGRAM TOTAL:**

Utility Management	1. Are the lights, emergency lights, and power plugs operational and in working order?						
	2. Does the water/sewage system appear to be working properly and has the water quality been tested within the past year?						
	3. Is the telephone system operational?						
	4. Has the HVAC system been inspected in accordance with manufacturer's specifications and have the filters been checked quarterly?						
	5. Are fire suppression (sprinkler) systems checked at least once a year, or as appropriate by a qualified individual?						
	6. Are shut-offs for all utility systems clearly marked, & accessible for all staff in the event of an emergency?						
	7. Are systems/mechanisms in place to respond in the event of a failure of any utility system?						
	SUBTOTALS						**PROGRAM TOTAL:**
Infection Control Monitoring Issues	1. Is all staff utilizing Universal Precautions (i.e. utilizing appropriate PPE, handwashing, etc.) in the performance of their job duties?						
	2. Are cleaning solutions secured, mixed, and utilized appropriately throughout the facility?						
	3. Are potentially "infectious patients" aggressively identified and processed in a manner which would minimize the risk of infection of staff and other patients?						
	4. Can staff intelligently describe their role in infection control within the organization?						
	SUBTOTALS						**PROGRAM TOTAL:**

Other Key Safety Monitoring Issues	1. Are Utility Rooms locked, clean and clear of debris?						
	2. Are Storage Rooms secure, clean, and free of flammable?						
	3. Are Emergency Carts present, as appropriate, fully stocked, and checked per schedule?						
	4. Are all medications, including samples, secured and accounted for by lot number?						
	SUBTOTALS						**PROGRAM TOTAL:**
	OVERALL ASSESSMENT TOTALS						**TOTAL:**

SCORING LEGEND:
1 = Outstanding 2 = Good 3 = Satisfactory 4 = Marginal 5 = Unsatisfactory

Inspected Conducted By: _____

Reports Noted: _____ Date: _____
Safety Officer or Responsible Staff

Source: California Primary Care Association and the California Emergency Medical Services Authority

Structural Mitigation

Structural mitigation is reinforcing, bracing, anchoring, bolting, strengthening or replacing any portion of the building that may become damaged and cause injury such as:

- exterior walls – (e.g., use a wind resistant design for tornados or windstorms)
- exterior doors – (e.g., non-combustible materials for wildfires or urban fires)
- exterior windows – (e.g., use shutters on windows for tornados or windstorms)
- foundation – (e.g., brace, anchor or bolt the facility for earthquakes)
- exterior columns/pilasters/corbels – (e.g., steel or concrete columns)
- roof – (e.g., use non-combustible materials for wildfires or urban fires)

STRUCTURAL

_____ *Earthquakes* – anchor/brace (mobile home) or bolt the facility to its foundation and reinforce any portion of the exterior of the facility that may cause injury.

_____ *Floods and flashfloods* – elevate and reinforce the facility but ultimately avoid a floodplain location.

_____ *Landslide and mudflow* – build retaining walls on slopes. Build masonry walls to direct the mudflow around the facility. Bolt the foundation and reinforce the walls of the facility.

_____ *Tsunami* – elevate coastal facilities at risk. Although the strongest building can be damaged by a powerful tsunami.

_____ *Wildfire and urban fire* – use fire resistant materials (e.g., non-combustible roofing material) on the exterior of the facility.

_____ *Tornado* – follow local building codes to use a wind resistant design for your facility.

_____ *Dam failure* – reinforce and flood proof the facility.

Nonstructural Hazard Mitigation

Nonstructural mitigation reduces the threat to safety posed by the effects of earthquakes on such nonstructural elements as building contents, internal utility systems, interior glass and decorative architectural walls and ceilings. These actions involve identifying nonstructural fixtures and equipment, which are vulnerable to an earthquake and which are either essential to continued operations or a threat to public safety.

Nonstructural mitigation is:

- *Retrofit* – refers to various methods for securing nonstructural items. Retrofitting methods are bracing, securing, tying down (tethers or leashes), bolting, anchoring, and soon.
- *Replace* – replacing the item with a new one that is resistant to the hazard.
- *Relocate* – moving items from a hazardous location to a non-hazardous one.
- *Backup Plan* – if there is concern that an essential service will be disrupted, provide for backup service – *it is planning for the consequences of failure*.

Nonstructural mitigation includes all contents of the structure that do not contribute to its structural integrity such as:

- *Systems and elements* which are essential to the clinic operations
- Emergency power generating equipment - plumbing, HVAC
- Fire protection system - fire sprinklers and distribution lines, emergency water tank or reservoir
- Medical equipment - X-ray equipment, respirators and life support, refrigeration units to store pharmaceuticals and blood.
- Hazardous materials – restrain chemicals on shelves, containers stored on braced storage rack or tall stacks, gas tanks with flexible connections, gas tank legs anchored to a concrete footing or slab.
- *Non-essential elements* whose failure could compromise clinic operations, such as:
    - suspended lights and ceilings
    - partitions
    - interior doors
    - furniture and contents - book shelves, file cabinets, etc.

NONSTRUCTURAL

_____ Brace light fixtures and other items that could fall or shake loose.

_____ Secure top and bottom of compressed gas cylinders with a safety chain.

_____ Store containers of hazardous materials on braced storage rack or tall stacks and restrain the containers with a restraining device such as metal or wire guardrails.

_____ Secure any desktop equipment such as computers, TV monitors, typewriters, printers, etc.

_____ Install shatter resistant protective film or blinds on windows to prevent glass from shattering onto people or install safety glass.

_____ Ensure that any equipment with piping be a flexible connection (e.g., gas pipes, water tanks, sprinkler piping, water heaters,

_____ Anchor any tall, unsecured furniture to the wall and/or to each other.

_____ Ensure that cabinets have positive catching latches.

_____ Secure suspended ceilings with diagonal bracing wires.

_____ Hang heavy objects away from workstations.

_____ Secure any larger equipment such as copiers or heavy machinery to the floor or use tethers and attach to the wall.

_____ Cross brace tall storage racks in both directions or, for racks significantly taller than wide, secure with anchor bolts connected to the concrete slab.

_____ Ensure the main breaker or fuse box and the utility meters elevated above the anticipated flood level of your facility to prevent damage.

_____ Secure one-of-a-kind equipment of high value from overturning or sliding.

Source: California Primary Care Association and the California Emergency Medical Services Authority

Appendix D

Clinic Readiness Assessment

Summer 2007
USA Center for Rural Public Health Preparedness
Texas A&M Health Science Center School of Rural Public Health
http://centers.srph.tamhsc.edu/centers/osp/USACenter/index.htm

Clinic Readiness Assessment

A. Emergency Management Planning	**Yes**	**No**	**DK**	**NA**
A1. Does your center have written policies and/or procedures that address:				
• Fire Safety				
• Evacuation				
• Suspicious package				
• A natural infectious disease outbreak				
• Bioterrorism events				
A2. Does your center have an emergency management planning committee? If No, please go to Question A3.				
Name and title of person who chairs the committee:				
Phone Number:	E-mail:			
How often does the committee meet?				
A3. Does your center have a committee that meets to develop policies,/procedures for the center (e.g., infection control committee, quality assurance committee?				
Name and title of person who chairs the committee:				
Phone Number:	E-mail:			
How often does the committee meet?				
A4. Has your center conducted a Hazard Vulnerability Assessment (HVA)?				
A5. Does your center develop its own emergency response policies or do they come from a central office?				

B. Activations and Notification of the Plan	Yes	No	DK	NA
B1. Does your center have a contact list (other than phonebook) available of local emergency management agencies (e.g., Emergency Management, Police Department, Sheriff's Office, Fire Department, EMS, Public Health Department)?				
• Is this list readily available and easily accessible?				
• Is the list updated on a regular basis?				
B2. Is there a formalized notification system to alert staff that an emergency response is being activated?				

C. Disease Surveillance/Reporting	Yes	No	DK	NA
C1. Are the contact numbers for the NYC DOHMH posted in nurses' or doctors' stations for reporting diseases or unusual illnesses or clusters of illness?				
C2. Is a list of the reportable diseases posted in nurses' or doctors' stations?				
C3. Does your center have written triage protocols in place for patients who present with:				
• Fever/respiratory symptoms (e.g., SARS, influenza)				
• Fever/rash symptoms (e.g., measles, meningococcal meningitis)				
C4. Does the center have a digital camera onsite in case of the need for consultation on rash illness?				
• Are key staff (e.g., clinical providers) trained in the use of a digital camera?				
• Are key staff trained in sending digital photographs to the Public Health Department via HAN or electronically?				

D. Education and Training	Yes	No	DK	NA
D1. Does the center provide education and/or training to appropriate staff in:				
• Disease of public health importance (e.g., acute HIV seroconversion, TB, SARS, influenza, meningococcus, hepatitis)				
• Symptoms of/care for patients involved in biological attacks				
• Infection control issues				
– Standard/contact/droplet/airborne Precautions				
– Universal respiratory etiquette				

– Proper order for putting on/ taking off / disposing PPE(e.g., respirators, gloves, masks, gowns)				
• Reporting unusual symptoms or known reportable diseases to the Public Health Department				

E. Staff and Community Outreach	**Yes**	**No**	**DK**	**NA**
E1. Does the center maintain a database onsite of all staff that contains:				
• Up-to-date emergency contact information				
• Medical needs (e.g., insulin, asthma, seizure)				
• Languages (spoken or written)				
• Emergency response volunteer organizations that staff are involved with (e.g., Red Cross, Medical Reserve Corps)				
• Vaccination status (e.g., hepatitis B, smallpox, influenza)				
E2. Does your center provide information regarding emergency preparedness at home for staff, patients or community members?				
E3. Does the center have access to Language Line/AT&T or similar service?				
E4. Could your center offer any of the following in the event of an external (i.e., offsite) emergency:				
• Staff (e.g., surge capacity offsite)				
• Medical equipment or supplies				
• Patient or staff transportation				
• Mental health support/services				
• Triage services (e.g., for "worried well", non-event related medically ill, event-related but less severely ill)				

F. Communications	**Yes**	**No**	**DK**	**NA**
F1. Are key personnel (e.g., charge nurse, medical director, staff administrator) registered users of the State Health Department's Health Alert Network (HAN)? If Yes, please list below:				
Name and Title of Registered HAN users:				
Phone Number:	E-mail:			

F2. Which of the following communication equipment/methods does your center utilize during an emergency:				
• Two-way radios				
• One way receiving radios				
• Cell phones				
• Telephones/landlines				
• Satellite phones				
• PDA's				
• Citizen's band radio				
• Intercom system				
• Organized runner, messenger system				
• Other equipment or method (specify)				
F3. Does your center have a computer with internet service?				

G. Facility Capacity, Supplies and Equipment	**Yes**	**No**	**DK**	**NA**
G1. Please list the quantity of the following space and types of equipment that are available for use in the center:				
• Number of Examination Rooms				
• Number of Airborne Isolation Infection Rooms (AIIR)				
• Number of Isolation Rooms (i.e., a private room with door that can close to hallway)				
• Number of Stretchers				
• Number of Wheelchairs				
• Number of Flashlights with batteries				
G2. Does your center have:				
• Backup generators				
• Emergency lighting				
G3. Does your center have the following Personal Protective Equipment:				
• N95 (or higher) respirators				
– If Yes, are clinical staff fit-tested for N95 or higher respirators				
• Surgical masks				
• Goggles/Face shields				
• Protective Gowns				
• Gloves				
– Latex				
– Non-latex				

Source: Community Health Care Association of New York State

Appendix E

Listing: Nationally Notifiable Infectious Diseases (CDC)

Biological Agents

Summer 2007
USA Center for Rural Public Health Preparedness
Texas A&M Health Science Center School of Rural Public Health
http://centers.srph.tamhsc.edu/centers/osp/USACenter/index.htm

Listing: Nationally Notifiable Infectious Diseases (CDC)
United States 2007, Revised

The list of nationally notifiable diseases is revised periodically.

- Acquired Immunodeficiency Syndrome (AIDS)
- Anthrax
- Arboviral neuroinvasive and non-neuroinvasive diseases
    - California serogroup virus disease
    - Eastern equine encephalitis virus disease
    - Powassan virus disease
    - St. Louis encephalitis virus disease
    - West Nile virus disease
    - Western equine encephalitis virus disease
- Botulism
    - Botulism, foodborne
    - Botulism, infant
    - Botulism, other (wound & unspecified)
- Brucellosis
- Chancroid
- *Chlamydia trachomatis*, genital infections
- Cholera
- Coccidioidomycosis
- Cryptosporidiosis
- Cyclosporiasis
- Diphtheria
- Ehrlichiosis
    - Ehrlichiosis, human granulocytic
    - Ehrlichiosis, human monocytic
    - Ehrlichiosis, human, other or unspecified agent
- Giardiasis
- Gonorrhea
- *Haemophilus influenzae*, invasive disease
- Hansen disease (leprosy)
- Hantavirus pulmonary syndrome
- Hemolytic uremic syndrome, post-diarrheal
- Hepatitis, viral, acute
    - Hepatitis A, acute
    - Hepatitis B, acute
    - Hepatitis B virus, perinatal infection
    - Hepatitis, C, acute
- Hepatitis, viral, chronic
    - Chronic Hepatitis B
    - Hepatitis C Virus Infection (past or present)

- HIV infection
    - HIV infection, adult(> =13 years)
    - HIV infection, pediatric (<13 years)
- Influenza-associated pediatric mortality
- Legionellosis
- Listeriosis
- Lyme disease
- Malaria
- Measles
- Meningococcal disease
- Mumps
- Novel influenza A virus infections
- Pertussis
- Plague
- Poliomyelitis, paralytic
- Poliovirus infection, nonparalytic
- Psittacosis
- Q Fever
- Rabies
    - Rabies, animal
    - Rabies, human
- Rocky Mountain spotted fever
- Rubella
- Rubella, congenital syndrome
- Salmonellosis
- Severe Acute Respiratory Syndrome-associated Coronavirus (SARS-CoV) disease
- Shiga toxin-producing *Escherichia coli* (STEC)
- Shigellosis
- Smallpox
- Streptococcal disease, invasive, Group A
- Streptococcal toxic-shock syndrome
- *Streptococcus pneumoniae*, drug resistant, invasive disease
- *Streptococcus pneumoniae*, invasive in children <5 years
- Syphilis
    - Syphilis, primary
    - Syphilis, secondary
    - Syphilis, latent
    - Syphilis, early latent
    - Syphilis, late latent
    - Syphilis, latent, unknown duration
    - Neurosyphilis
    - Syphilis, late, non-neurological
    - Syphilitic Stillbirth
- Syphilis, congenital

- Tetanus
- Toxic-shock syndrome (other than Streptococcal)
- Trichinellosis (Trichinosis)
- Tuberculosis
- Tularemia
- Typhoid fever
- Vancomycin - intermediate *Staphylococcus aureus* (VISA)
- Vancomycin - resistant *Staphylococcus aureus* (VRSA)
- Varicella (morbidity)
- Varicella (deaths only)
- Vibriosis
- Yellow fever

BIOLOGICAL AGENTS

Some Potential Biological Warfare Agents

The information in this chart, from the *California Primary Care Association and the California Emergency Medical Services Authority,* is not meant to be complete but to be a quick guide; please consult other references and expert opinion, and check drug dosages particularly for pregnancy and children. **Check with your local, regional or state health department for biological agent treatment guidelines for clinicians.**

Disease	Incu-bation	Symptoms	Signs	Diagnostic tests	Transmission and Precautions	Treatment (Adult dosage)	Prophylaxis
Anthrax (inhaled and cutaneous)	2-6 days Range: 1 day to 8 weeks	**Inhalation**: Flu-like symptoms, nausea, vomiting, abdominal pain, fever, respiratory distress **Cutaneous**: initial itching papule; fever	**Inhalation**: fever, followed by abrupt onset of respiratory failure, confusion Widened mediastinum on chest X-ray (adenopathy), bloody pleural effusions, Atypical pneumonia **Cutaneous**: initial itching papule, 1-3 cm painless ulcer, then necrotic center; lymphadenopathy	Gram stain ("boxcar" shape) Gram positive bacilli in blood culture ELISA for toxin antibodies to help confirm Chest CT	Aerosol inhalation *No person-to-person transmission* Standard precautions	Mechanical ventilation Antibiotic therapy (inhalation) Ciprofloxacin 400 mg IV q 8-12 hr **OR** Doxycycline 200 mg IV initial, then 100 mg IV q 8-12 hr **PLUS** Rifampin 10 mg/kg/d po (up to 600 mg day) **OR** Clindamycin 1200-2400 mg/day IM or IV	Ciprofloxacin 500 mg or Doxycycline 100 mg po q 12 hr ~ 8 weeks Amoxicillin in pregnancy and children (if susceptible) Vaccine if available
Botulism	12-72 hours Range: 2 hrs – 8 days	Difficulty swallowing or speaking (symmetrical cranial neuropathies) Symmetric descending weakness Respiratory dysfunction No sensory dysfunction No fever	Dilated or un-reactive pupils Drooping eyelids (ptosis) Double vision (diplopia) Slurred speech (dysarthria) Descending flaccid paralysis Intact mental state	Mouse bioassay in public health laboratories (5 – 7 days to conduct) ELISA for toxin	Aerosol inhalation Food ingestion *No person-to-person transmission* Standard precautions	Mechanical ventilation Parenteral nutrition Trivalent botulinum antitoxin available from State Health Departments and CDC	Experimental vaccine has been used in laboratory workers

Disease	Incu-bation	Symptoms	Signs	Diagnostic tests	Transmission and Precautions	Treatment (Adult dosage)	Prophylaxis
Plague	1-3 days by inhalation	Sudden onset of fever, chills, headache, myalgia **Pneumonic:** cough, chest pain, dyspnea, fever **Bubonic**: painful lymph nodes	**Pneumonic:** Hemoptysis; radiographic pneumonia -- patchy, cavities, confluent consolidation, hemoptysis, cyanosis **Bubonic:** typically painful, enlarged lymph nodes in groin, axilla, and neck	Gram negative coccobacilli and bacilli in sputum, blood, CSF, or bubo aspirates (bipolar, closed "safety pin" shape on Wright, Wayson's stains) ELISA, DFA, PCR	*Person-to-person transmission in pneumonic forms* Droplet precautions until patient treated for at least three days	Streptomycin 30 mg/kg/day in two divided doses x 14 days Gentamicin 3-5 mg/kg/day IV/IM in q 8 hr dosage Tetracycline 2-4 g per day Ciprofloxacin 400 mg IV q 12 hr	Asymptomatic contacts or potentially exposed Doxycycline 100 mg po q 12 h Ciprofloxacin 500 mg po q 12 h Tetracycline 250 mg po q 6 hr **All x 7 days** Vaccine production discontinued
Tularemia "pneumonic"	3-5 days Range: 1-14 days	Fever, cough, chest tightness, pleuritic pain Hemoptysis rare	Community-acquired, atypical pneumonia Radiographic: bilateral patchy pneumonia with hilar adenopathy (pleural effusions like TB) Diffuse, varied skin rash May be rapidly fatal	Gram negative bacilli in blood culture on BYCE (Legionella) cysteine- or S-H-enhanced media Serologic testing to confirm: ELISA, microhemagglutination DFA for sputum or local discharge	Inhalation of agents *No person-to-person transmission but laboratory personnel at risk* Standard precautions	Streptomycin 30 mg/kg/day IM divided bid for 14 days Gentamicin 3-5 mg/kg/day IV in three equal divided doses x 10-14 days Ciprofloxacin possibly effective 400 mg IV q 12 hr (change to po after clinical improvement) x 10-14 day	Ciprofloxacin 500 mg po q 12 hr Doxycycline 100 mg po q 12 hr Tetracycline 250 mg po q 6 hr All x 2 wks Experimental live vaccine
Smallpox	12-14 days Range:7-17 days	High fever and myalgia; itching; abdominal pain; delirium Rash on face, extremities, hands, feet; confused with chickenpox which has less uniform rash	Maculopapular then vesicular rash -- first on extremities (face, arms, palms, soles, oral mucosa) Rash with hard, firm pustules ("intradermal blisters") Rash is synchronous on various segments of the body	Electron microscopy of pustule content PCR Public health lab for confirmation Rule out chicken pox with DFA	*Person-to-person transmission* Airborne precautions Negative pressure Clothing and surface decontamination	Supportive care Vaccinate care givers Experimental: cidofovir (useful in animal studies)	Vaccination (vaccine available from CDC)

Appendix F

Clinic Response Roles and Requirements

Emergency Response/Recovery Team Job Action Sheets

Summer 2007
USA Center for Rural Public Health Preparedness
Texas A&M Health Science Center School of Rural Public Health
http://centers.srph.tamhsc.edu/centers/osp/USACenter/index.htm

Clinic Response Roles and Requirements

Emergency Roles	Requirements
Internal Emergencies Protect patients and visitors, staff. Protect facilities, vital equipment and records	Generally requires planning, training and exercises. Also requires internal culture where safety and preparedness are given high priorities. Specific Requirements include • Emergency Plans • Training / Drills / Exercises • Emergency / Evacuation Signage • Business Continuity Plans • Security • Internal communications • Staff notification and recall • Emergency procedures distributed throughout the clinic
Mass Casualty Care	• Sufficient staff to manage patient surge • Triage capability • ALS capability • Holding • Agreements with receiving hospitals • Integration of clinic into operational area medical response system
Reception and triage During disasters, clinics may become points of convergence for injured, infected, worried, or dislocated community members. Depending on the emergency and availability of other medical resources, clinics may not be able to handle all of the presenting conditions. Minimum clinic role will likely be triage, reporting, stabilization, and holding until transport can be arranged.	• Response plan • Staff recall procedure • Procedures to obtain outside additional assistance – volunteers, assistance from county • Crowd management • Location of shelters • Reception area • Triage tags • Triage training • Medical supplies

Emergency Roles	Requirements
Reception of hospital overflow In disasters, hospitals may be overwhelmed with ill and injured requiring high levels of care, while at the same time facing convergence from patients with minor injuries or the worried well. Clinics may be requested to handle people with minor injuries of patients to relieve the pressure on the hospital.	Requirements above for mass casualty care. Prior agreement that defines: • Circumstances for implementation • Types of patients that will be accepted • Resource / staff support provided by hospital • Patient information / medical records • Liability releases
Maintaining Ongoing Routine Patient Care – Normal levels and extended surge The community's need for routine medical care may continue following a disaster.	Clinics should prepare to maintain their service capacity through protection of equipment, critical supplies and medications, and personnel. Requirements include: • Continuity of Operations Plan • Procedures to augment resources • In areas subject to frequent power outages, clinics should consider adding generators to ensure operational capacity.
Mental Health Services Clinics can expect the convergence of the "worried well" following a disaster.	• Disaster mental health training for clinicians / licensed mental health staff • Internal or external mental health team • External source of trained personnel to augment response
Bioterrorism Agent Initial Identification and Rapid Reporting Clinics may be the "early warning system" for a bio-terrorism outbreak. Clinicians should look for unusual symptoms or other signs of use of BT agents. Rapid reporting is critical. Unusual event may be a single case or multiple cases with the same symptoms.	• Infectious disease monitoring procedures and protocols • Zebra Pack - If an infection is suspected, the "Zebra Pack" provides information on precautions and initial treatment. • Procedures for reporting to county health department • Evidence Kits • Training

Emergency Roles	Requirements
Staff Protection Provide protection to staff in event of presence suspected Bioterrorism agent.	• Adherence to standard precautions • Level C PPE • Training • Infectious disease procedures • Reporting procedures
Mass Prophylaxis Clinics may be requested to participate in mass prophylaxis managed by the local health department. Clinic participation could include requesting clinic staff to support mass inoculations at other sites.	• Availability of staff who can volunteer. • Procedures for determining when clinic staff can volunteer.
Hazardous material response Clinics near major transportation routes, distant from hospitals, or with emergency medical capabilities may be called upon treat injured patients who have been contaminated by a hazardous material. Generally, in urban areas, clinics will not be required to be hazardous material responders.	• Protective equipment • Decontamination procedures / capability / equipment • Reporting procedures • Waste holding container
Risk Communications Clinics are often important conduits of health information for the communities they serve. Patients, staff and community members may look to the clinic for answers to their questions about a bioterrorist attack or other emergency.	• Communications link with Operational Area • Procedures for communicating with patients, staff and community (in languages spoken in the community).
Provide volunteer staff Clinics may be requested to provide staff to deliver health services at shelters, for mass prophylaxis or at other response sites.	• Back-up staff • Policy for receiving requests, polling staff, and releasing staff for non-clinic duties. • Policy on release of staff for volunteer duty
Receive volunteer providers / teams	• Reception procedures • Credential / background checks • Logistic support

Emergency Roles	Requirements
Community Preparedness	• Educational material in appropriate languages • Educators / volunteers • Ability to organize / sponsor Neighborhood Emergency Response Teams
Sheltering	• Holding area • Protection from weather • Bedding • Medical supplies • Pharmaceuticals for common conditions (insulin, etc.)

Source: California Primary Care Association and the California Emergency Medical Services Authority

Job Action Sheets

Day-to-Day Organization Chart

Include your healthcare organization's day-to-day organization chart to provide a starting point for selection of staff to fill Emergency Response Team (ERT) positions and to identify potential ERT backups and replacements.

Emergency Response Team Position Assignments

NAME	POSITION & LOCATION	DAY-TO-DAY ROLE	DISASTER ROLE

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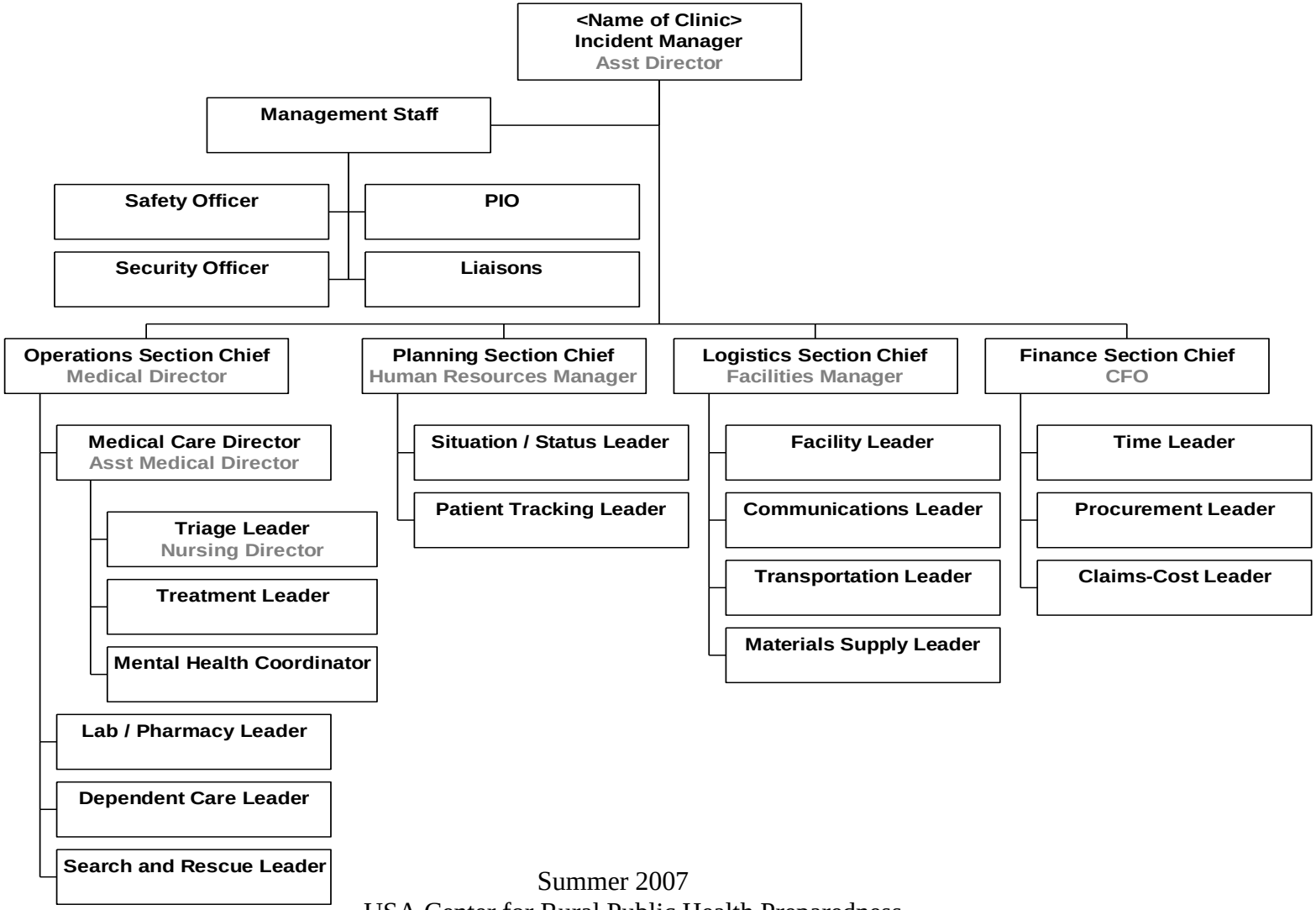
http://centers.srph.tamhsc.edu/centers/osp/USACenter/index.htm

Emergency Operations Organization

EXPANDED ICS ORGANIZATION w/ Possible Assignments



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Emergency Response/Recovery Team Job Action Sheets

LIST OF POSITIONS

Clinic Executive Director
Incident Manager
Public Information Officer
Legal Counsel
Liaisons
Safety Officer
Security Officer
Operations Section Chief
Planning and Intelligence Section Chief
Logistics Section
Finance and Administration Section

CLINIC EXECUTIVE DIRECTOR

Line of Authority

The line of authority flows from the Clinic Executive Director and then to the Incident Manager, and finally to the Section Chiefs in the EOC.

Responsibility and Duties

The Clinic Executive Director and the EOC Incident Manager should confer during major emergencies, providing overall guidance and policy direction for emergency response and recovery strategy assessment, including:

- Identifying the operations still at risk
- Establishing clinic operations restoration priorities
- Authorizing expenditure of funds for emergency acquisitions and for additional personnel expenditures, as needed

---

The Clinic Executive Director has three main roles to achieve during emergency response and recovery operations. The Executive Director:

- Acts as a bridge to the world outside of Clinic operations so that outside influences do not interrupt the recovery process
- Provides information to the external authorities when they ask about the status of Clinic emergency operations
- Acts as the spokesperson for Clinic when the PIO is asked to provide a management representative for Clinic at press briefings and for media announcements

The Clinic Executive Director (if not the Incident Manager) does not interfere or contradict the operations of the EOC, but rather supports and provides guidance as needed. In order to accomplish this, the Director will receive periodical updates, including provision of copies of the latest status reports and the operational period Action Plan.

CLINIC EXECUTIVE DIRECTOR (continued)

ACTIVATION DUTIES	
	Approve the activation of the EOP, the ERT, and the EOC.
	Have initial briefing with the EOC Incident Manager.
	Review the Executive Director's responsibilities and open a logbook.
	Determine where Executive Director will be during recovery, and set up that position.
	Meet with the PIO to: ■ Develop protocols and a schedule for news briefings ■ Establish schedule for delivery of Action Plan updates, status reports, and news releases ■ Establish a policy on visitor's access to Clinic during emergency response and recovery operations ■ Develop a policy on contacts with the operational area response actions during disasters while emergency response and recovery is in progress.
	Track the overall progress of recovery
	Review the needs for resources and staffing if the EOC goes on shift support for 24-7 operations. Ensure the overall budget for the clinic can support the effort.
	Attend any meeting as requested by the EOC Incident Manager.

OPERATIONAL PERIOD DUTIES	
	Continue to receive briefings on the latest status reports and Action Plan.
	Assist with outside agency coordination, when an upper-level management presence is required.
	If retiring for the day, ensure the EOC Incident Manager knows where you will be, and what number you can be reached at all hours. This should also be shared with the PIO and other key staff.

DEACTIVATION DUTIES	
	Evaluate the recovery progress. If it has been reduced to minor activities that can be handled by staff in their day-to-day functions, request the Incident Manager to start deactivation of resources, including staff.
	Request a timeline for deactivation.
	Close out your logbook.
	Determine what follow-ups staff addresses, in order to ensure closure is met.
	Ensure an event critique is scheduled, held, and well attended by EOC staff.
	Ensure that an After Action Report is prepared and filed.

EOC INCIDENT MANAGER

Line of Authority

The Incident Manager reports to the Clinic Executive Director. The five EOC Section Chiefs report directly to the Incident Manager—including sometimes through the EOC Incident Manager. The EOC provides additional recovery management functions through the Liaison, the PIO, the Safety Officer, and Security.

Duties

The Incident Manager is responsible for: activating the Clinic EOP, activating and deactivating the EOC, disseminating information to the EOC Incident Manager, management staff and Section Chiefs, directing specific actions as required, approving issuance of press releases, and providing liaison with other agencies. A summary list of overall responsibilities follows.

The Incident Manager is responsible for response and recovery activities including to:

- Develop and implement strategic decisions and approve the ordering and releasing of resources.
- Obtain situation briefing from prior shift Incident Manager (if running more than one shift.
- Assess situation regularly—using threat action checklists for basic actions to take
- Conduct initial briefing for all staff.
- Activate elements of ICS as needed.
- Brief management staff and section chiefs.
- Ensure planning meetings are conducted.
- Approve and authorize implementation of recovery Action Plan.
- Determine information needs and inform management personnel of needs.
- Coordinate staff activity.
- Manage overall operations.
- Approve requests for additional resources and requests for release of resources.
- Authorize release of information to news media.
- Approve plan for demobilization.

INCIDENT MANAGER (continued)

ACTIVATION DUTIES	
	Notify the Emergency Response/Recovery Team to activate and report to the EOC.
	Determine appropriate stage of EOC activation.
	Notify the staff needed to activate the EOC.
	Establish a sign in sheet for the operational period.
	Ensure the EOC is set up and ready for operations, including habitability.
	Brief the EOC staff after obtaining a situation report from the Section Chiefs and the PIO
	Review the Incident Manager's responsibilities
	Open a chronological logbook of your activities.
	Determine status of telephone and other communications: ■ Established ■ Tested ■ Assess linkage adequacy ■ Advise Logistics Section Chief to have IT address any communications problems
	Schedule an action-planning meeting for the first operational period with your staff and the Section Chiefs.
	Determine whether the EOC needs representation from other organizations.
	Estimate the emergency's duration.
	Plan for shift operations of no more than a 12-hour duration if the emergency is going to be more than one day in duration.
	Consider additional EOC support personnel for extended operations.

OPERATIONAL PERIOD DUTIES	
	Establish and maintain contacts with other Clinic facilities and with outside social services and disaster response agencies.
	Confer with your support staff and the EOC Section Chiefs. ■ Establish the goal for the first operational period. Recommendation: for an initial goal, determine the situation; cause, effects, impacts, projected impacts, countermeasures planned and begun. ■ Establish the steps needed to reach that goal, and ■ How long they should take. Use Action Planning and Intelligence forms attached to this Plan.
	Consider Clinic guidelines for information releases.
	Ensure the Clinic Executive Director is regularly informed.
	When information starts to flow, keep the Clinic Executive Director advised.
	■ Establish regular Action Planning and Intelligence meetings with the Section Chiefs. Consider inviting others with specialized technical expertise, as needed. ■ Get the staff and Section Chiefs' recommendations for the next operational period. ■ Use the Action Planning and Intelligence forms attached to this Plan.
	Prepare and brief relief at shift change. Use the Action Planning and Intelligence Form and Situation Status Reports.
	Sign out at change of shifts.

INCIDENT MANAGER (continued)

DEACTIVATION DUTIES	
	Downgrade EOC activation to reduce staffing when practicable, based on the situation reports and with the team's concurrence.
	Authorize deactivation of sections when they are no longer required. Ensure Section Chiefs debrief their teams and secure their logbooks.
	Notify the Operational Area Medical/Health Coordinator.
	Collect copies of logbooks and critical records from EOC personnel.
	Note incomplete actions to be cleared after deactivation.
	Deactivate the EOC and close out your own logs.
	Keep your notes for After Action Reports, reviews and analyses.
	Establish a time, date, and place for an Incident Critique.
	Ensure all EOC management positions and Section Chiefs attend the Critique.
	Ensure an After Action Report is completed.

HOW TO DETERMINE THINGS ARE RETURNING TO NORMAL

1. Conditions may persist, but are stable and no longer worsen.
2. Normal communications are restored and stable.
3. The Clinic Executive Director requests the deactivation of the ERT.

PUBLIC INFORMATION OFFICER (PIO)

Line of Authority

The Public Information Officer is a staff assistant to the Incident Manager, and is not in the direct line of authority.

Duties

The Public Information Officer (PIO) advises the Incident Manager on the potential effects of proposed actions on external and internal relations. The PIO serves as the dissemination point for all news releases from the Clinic. Other Clinic groups that want to release information to the public, employees, stakeholders, or regulators should coordinate through the PIO. The PIO reviews and coordinates all information releases from other Clinic sources. The PIO coordinates to ensure that: employees, their families, regulators, and other stakeholders receive timely and accurate information about the Clinic's situation. The PIO should follow the communications guidelines already established for the Clinic for emergencies. The PIO also prepares fact sheets about the Clinic with sidebars about the Clinic's business continuity program before interruptions occur.

The PIO, a member of the management staff, is responsible for the formulation and release of information about the response and recovery to the news media and other appropriate agencies and organizations, including the Clinic Director. During an emergency response and recovery the PIO should:

- Obtain briefing from the Incident Manager
- Contact other involved agencies to coordinate public information activities
- Establish single recovery information point of contact whenever possible
- Arrange for necessary workspace, materials, telephones, and staffing for PIO staff
- Prepare initial information summary as soon as possible after arrival
- Observe constraints on the release of information imposed by the Incident Manager.
- Obtain approval for release from the Incident Manager.
- Release information to news media and post information in EOC and other appropriate locations
- Attend meetings to update information releases
- Arrange for meetings between media and Clinic Executive Director
- Provide escort service to the media and VIP's
- Respond to special requests for information

PUBLIC INFORMATION OFFICER (PIO) (continued)

ACTIVATION DUTIES	
	Sign the attendance roster upon arrival at the EOC.
	Report to Incident Manager; obtain a briefing on the situation.
	Review the Public Information Officer's responsibilities and open a chronological logbook of your activities.
	Establish an electronic media monitoring position outside the EOC. Instruct the person monitoring what to look for and report to you (e.g., watch local TV or listen to local radio)
	Meet with the Logistics Section Chief; ■ Obtain briefing about on-site and external communications capabilities and restrictions; ■ Establish operating procedures for use of telephone and radio systems; ■ Determine established priorities and make any special requests for services you need; and ■ Assess the communications linkages provided for adequacy and advise the Logistics Section Chief.
	Track events of public information significance by the Incident Manager's briefings and the status boards in the EOC (or from Incident Manager). Record that information in your log.
	Get estimates of the time for recovery
	Consider adopting shifts for PIO staff.
	Attend and monitor the meetings by the Incident Manager with the other Section Chiefs.

OPERATIONAL PERIOD DUTIES	
	Confer with the Incident Manager about the information available and when it is appropriate for release.
	Confer with the Section Chiefs and other staff. Obtain and provide information the Clinic's stakeholders need to know. Stakeholders include: ■ Employees—through Personnel ■ Other key medical/health organizations—with the Executive Director ■ Clinic's customers – with Operations Section Chief ■ Media who may cover the event ■ Local / State government agencies other than regulators – with Liaison ■ Vendors ■ Insurers
	Determine if there are requirements to staff Public Information 24-7, if so, request the support required to: ■ Develop a media briefing schedule ■ Prepare briefing materials ■ Clear the releases with the Incident Manager
	Prepare final news releases and advise media representatives of points-of-contact for follow-up stories.
	Keep notes to brief your relief at change of shift.
	Sign out at the EOC attendance roster at change of shift.

PUBLIC INFORMATION OFFICER (PIO) (continued)

	OPERATIONAL PERIOD DUTIES
	Coordinate with the Incident Manager for concurrence that you can begin to close down Public Information's functions.
	Ensure that continuing media questions will be directed to Public Information.
	Leave forwarding phone number(s) where you can be reached.
	Periodically brief the ERT and the Clinic Executive Director about issues raised by reporters, and external situations the media are covering that are likely to affect the Clinic.
	The Incident Manager may call Section Chief meetings to determine the goals and objectives for subsequent operating periods. Attend and monitor those to determine potential impacts and requirements for Public Information.
	Use the information from broadcast media monitoring to develop follow-up news releases and rumor control. Be alert for the need to establish a rumor control branch.
	Provide copies of all releases to the Incident Manager; ensure file copies are maintained of all information released.
	Keep the Incident Manager advised of all unusual requests for information and all major critical or unfavorable media comments; provide an estimate of their impact and severity and consider / recommend actions.
	Conduct shift change briefings in detail; ensure in-progress activities are identified and that follow-up requirements are known.
	Sign out on the EOC attendance form.
	Ensure your comments and materials are made available to the Incident Manager for the After Action Report.
	Attend the event critique.

LEGAL COUNSEL

Line of Authority
The Legal Counsel advises the Emergency Response and Recovery Team (ERT) and the Emergency Operations Center (EOC) Director. The Legal Counsel is not in the direct line of authority, but reports directly to the Incident Manager.

Duties
The Legal Counsel is responsible for scanning situation information, guidelines, directives, and Action Plans for potential legal exposures including, but not limited to liability, compliance with existing contracts and statutory compliance. The Legal Counsel may or may not be situated in the physical EOC, but must be available for support as needed.

The Legal Counsel, a member of the management staff, is responsible for the review of policies that are adopted and adapted by the Incident Manager to ensure business continuity and emergency response and recovery. Legal Counsel can ensure that there is no specific act of malfeasance, non-feasance, or misfeasance. This may include review of mandates under law and regulation that must be completed even under crisis conditions. Legal Counsel may also be asked to review and approve agreements that are used or developed for the recovery effort. During an emergency response and recovery effort the Legal Counsel should:

- Sign in at the security check point, then tell the Logistics Section Chief you are present
- Obtain briefing from Incident Manager
- Establish a worksite location to support the EOC, without being in the EOC, unless necessary
- Attend key briefings and updates from the Incident Manager
- Prepare legal reviews for the Incident Manager and Section Chiefs as requested
- Assist the PIO, as requested, regarding news releases that may need legal impact considerations
- Attend media briefings to observe commitments or comments that may have legal impacts on Clinic operations
- Approve contract language, as requested
- Keep a log book during the event that reflects decisions and actions taken under Legal Counsel advice
- If deactivated, let the Incident Manager know where you will be, including a phone number
- Provide notes and materials to the Incident Manager
- Attend the event critique
- Assist with crafting the After Action Report

LEGAL COUNSEL (continued)

ACTIVATION DUTIES	
	Check in upon arrival at EOC.
	Report to Incident Manager; obtain a briefing on the situation.
	Review Legal Counsel's responsibilities.
	Determine your operating location in the EOC.
	Open a chronological logbook of your activities.
	Clarify any issues regarding your authority and assignment, and what others in the EOC are tasked with. Especially note your assignment from the Incident Manager for the first operational period.
	Meet with Logistics Section Chief: ■ Obtain briefing about on-site and external communications capabilities and restrictions; and ■ Establish operating procedures for your use of telephone and radio systems; determine established priorities and make any special requests for services you need. ■ Assess the communications linkages provided for adequacy and advise the Logistics Section Chief.
	Track emergencies for the potential legal significance in the EOC and note that information in your logs.
	Estimate the emergency's duration and consider adopting shifts for legal support.

OPERATIONAL PERIOD DUTIES	
	Attend action-planning meetings called by the Incident Manager.
	Coordinate with the Operations Section Chief to determine potential legal impacts in the developing situation.
	If there are problems in communicating, provide that information to the Logistics Section Chief.
	Keep notes to brief your relief at change of shift.
	Sign out at the EOC attendance roster at change of shift.

DEACTIVATION DUTIES	
	Coordinate with the Incident Manager to close down the Legal function.
	Ensure that remaining staff will complete any ongoing actions.
	Close out your logbook.
	Leave phone number(s) where you can be reached.
	Ensure your comments and materials are made available to the Incident Manager for the After Action Report.
	Attend the event critique.

LIAISON OFFICER

Line of Authority
The Liaison Officer is a staff assistant to the Clinic Executive Director, and is not in the direct line of authority.

Duties
The Liaison Officer provides direct support to the Executive Director. The Liaison Officer is responsible for: answering telephone calls and managing messages from other organizations in government and the private sector; coordinating with key stakeholders in government, including regulators and those with direct service agreements with Clinic; requesting assistance directly to other organizations when there is no formal emergency declaration; and keeping the Clinic Executive Director and Incident Manager informed about concerns and pressures from outside organizations.

The Liaison Officer is a member of the management staff, and is the point of contact for the assisting and cooperating agency representatives. This includes government agency representatives from other social services-related agencies, administrative agencies, law enforcement, regulators, colleges and universities, non-profit and private sector interests involved with Clinic operations. The Liaison Officer works very closely with the PIO.

- Obtain initial briefing from the Incident Manager or EOC Incident Manager.
- Provide point of contact for assisting/ cooperating agency representatives.
- Identify agency representatives from each agency including communications links and locations.
- Respond to requests from Clinic staff for inter-organizational contacts.
- Monitor recovery operations to identify current or potential inter-organizational problems.
- Assist the Incident Manager to craft strategies for coordinating with other organizations.

LIAISON OFFICER (continued)

	ACTIVATION DUTIES
	Sign the attendance roster upon arrival at the EOC.
	Report to Incident Manager and get a briefing on the situation.
	Review the Liaison Officer's responsibilities and open a chronological logbook of your activities.
	Establish a working position near the Director and Incident Manager so they can be reached immediately as outside requests and concerns come to the EOC.
	Meet with the Logistics Section Chief to: ■ Obtain briefing about on-site and external communications capabilities and restrictions; ■ Establish operating procedures for use of telephone and radio systems; ■ Determine established priorities and make any special requests for services you need; and ■ Assess the communications linkages provided for adequacy and advise the Logistics Section Chief, especially if key stakeholders cannot be contacted.
	Track events of inter-agency concern by attending the Incident Manager's briefings and by monitoring the status boards in the EOC. Record that information in your log.
	Get estimates of the time for recovery to share with concerned outside agencies.
	Consider adopting shifts for the Liaison Officer position.
	Attend and monitor the meetings by the Incident Manager with the other EOC Section Chiefs.
	OPERATIONAL PERIOD DUTIES
	Confer with the Incident Manager about the policies regarding other organization's roles.
	Establish contact names and numbers for all possible agencies that might call for information or be asked to assist with or adjust to the Clinic recovery operations.
	Confer with the Section Chiefs and other staff. Obtain and provide information that the external stakeholders need to know. Stakeholders to consider include: ■ Operational Area ■ Mental Health ■ Operational Area Medical/Health Coordinator ■ Emergency Medical Services
	■ Determine if there are requirements to staff the Liaison position 24-7.
	Prepare an operational strategy for managing external organization requests.
	Keep notes to brief your relief at change of shift.
	Sign out at the EOC attendance roster at change of shift.
	DEACTIVATION DUTIES
	Ensure all continuing coordination or questions from external organizations will be forwarded to the Public Information office.
	Sign out on the EOC attendance form and inform the Incident Manager you are deactivated.
	Ensure your comments and materials are made available to the Incident Manager for the After Action Report.
	Attend the event critique.
	Assist with the After Action Report.

SAFETY OFFICER

Line of Authority
The Safety Officer is a staff assistant to the Incident Manager, and is not in the direct line of authority.

Duties
The Safety Officer provides direct support to the Incident Manager. The Safety Officer is responsible for: developing the medical plan; continuously monitoring the work environment to ensure the health and safety of the Clinic personnel and visitors; developing safety strategies for the recovery along with the Incident Manager and the Logistics Section Chief; coordinating the provision of Critical Incident Stress management for staff; and providing direct medical attention to ill or injured personnel until professional medical help can arrive .

The Safety Officer is responsible for monitoring and assessing hazardous and unsafe situations and developing measures for assuring personnel safety. Although the Safety Officer may exercise emergency authority to stop or prevent unsafe acts when immediate action is required, the Safety Officer will generally correct unsafe acts or conditions through the regular line of authority. The Safety Officer maintains awareness of active and developing situations, approves the medical plan, and includes safety messages in each Action Plan.

- Obtain initial briefing from the Incident Manager or EOC Incident Manager.
- Identify hazardous situations associated with the response/recovery to ensure personnel avoid them or are prepared to manage operations in that environment without harm.
- Participate in all planning meetings.
- Develop the medical plan. (NOTE: Medical plan refers to treatment of injuries at the EOC or related to response and recovery actions).
- Review Action Plans.
- Identify potentially unsafe situations.
- For all reportable injuries conduct an initial investigation and write a report and submit it to appropriate officials within required timeframes.
- Exercise emergency authority to stop and prevent unsafe acts.
- Investigate accidents that have occurred within the response / recovery operations area, including arranging for investigation of accidents in field operations involving Clinic personnel.

SAFETY OFFICER (continued)

ACTIVATION DUTIES	
	Sign the attendance roster upon arrival at the EOC.
	Report to Incident Manager and get a briefing on the situation.
	Review the Safety Officer's responsibilities and open a chronological logbook of your activities.
	Establish a central worksite with access to phones for 911 calls and for a Clinic emergency first-aid kit and fire extinguisher.
	Meet with the Logistics Section Chief to: ■ Obtain briefing about on-site and external communications capabilities and restrictions ■ Establish operating procedures for use of telephone and radio systems ■ Determine established priorities and make any special requests for services you need ■ Assess the communications linkages provided for adequacy and advise the Logistics Section Chief, especially for connections to local medical response and Cal OSHA.
	Track events of safety significance by the Incident Manager's briefings and the status boards in the EOC (or from Incident Manager). Record that information in your log.
	Get estimates of the time for arrival of medical support if there are injuries, and ensure security is in place to direct arriving teams.
	Consider adopting shifts for the Security Officer position.
	Attend and monitor the meetings by the Incident Manager with the other EOC Section Chiefs.

OPERATIONAL PERIOD DUTIES	
	Confer with the Incident Manager about life safety issues that are found deficient or threatening during the recovery process.
	Confer with the Section Chiefs and other staff. Obtain and provide information the EOC staff and field staff needs to know to remain safe. Information can include: ■ Threatening weather and dangers from heat, cold, lightning, sunburn, etc. ■ Toxic chemical conditions and proper response to exposure ■ Recommendations to evacuate or shelter in place ■ Physical threats to avoid, such as after an earthquake, flood, or fire ■ Family preparedness guides to ensure the employees' families are also prepared ■ How to watch for and avoid tripping hazards and slipping hazards ■ How to avoid back strain by lifting correctly, even during emergencies
	■ Determine if there are requirements to staff the Safety Officer position for 24-7.
	Prepare safety reports, injury reports, and insurance application reports each operational period.
	Keep notes to brief your relief at change of shift.
	Sign out at the EOC attendance roster at change of shift.

SAFETY OFFICER (continued)

DEACTIVATION DUTIES	
	Coordinate with the Incident Manager for concurrence that you can begin to close down Safety Officer's position.
	Ensure that continuing safety questions will be directed to the Incident Manager.
	Provide copies of all safety actions, reports and assessments to the Incident Manager; ensure file copies are maintained for long-term issues of workers compensation and insurance.
	Sign out on the EOC attendance form.
	Leave a location and forwarding phone number(s) where you can be reached
	Ensure your comments and materials are made available to the Incident Manager for the After Action Report.
	Attend the event critique.
	Assist with the After Action Report.

SECURITY OFFICER

Line of Authority

Security reports directly to the Incident Manager, and is not in the direct line of authority. When Clinic site security is supplanted or enhanced by outside security (CHP, local law enforcement, FBI), then the line of authority will be a point of coordination between Clinic security and external agency security.

Duties

Security provides direct support to the Incident Manager. Security is responsible for: controlling ingress and egress into the area, including the maintenance of a sign-in and out log; controlling the location of parking and general traffic around the clinic HQ site after a major emergency; verifying identification and reason to enter the EOC or recovery area; preventing criminal acts upon Clinic staff or facilities; providing protection for the Executive Director, PIO and Incident Manager during public press briefings or general public briefings regarding recovery operations. Security is also responsible for preparing a security plan is coordination with the Logistics Section Chief.

Security must ensure that only authorized personnel are allowed access to Clinic during emergency operations. Their responsibilities include that they will:

- Receive initial briefing from Incident Manager
- Coordinate with Logistics Section Chief
- Establish and maintain a controlled entry area, including the use of a formal entry log
- Verify identification and entrance needs for all wishing to enter the EOC area
- Ensure staff wear ID badges. Provide badges for visitors and staff, as necessary.
- Deny entrance when there is reason to suspect the need for admittance is not warranted
- Coordinate with building security and/or law enforcement, if present
- Request external law enforcement assistance as needed
- Record staff entering for response / recovery activities in the entry log. This includes entrance and exit times.
- Provide a copy of the log to the Logistics Section Chief before the end of each operational period in order to track staffing.
- Provide a copy of the log to the Finance and Administration and Administration Section Chief so they can track time for possible reimbursement

SECURITY (continued)

ACTIVATION DUTIES	
	Set up and sign-in on the attendance roster upon arrival at the EOC.
	Report to Incident Manager to get a briefing on the situation.
	Review Security's responsibilities, the site safety plan, and then open a chronological logbook of your activities.
	Establish perimeter control, including the verification of locked doors and entries other than controlled entrances used by staff.
	Establish an electronic media monitoring position if security cameras are in place and allow for simultaneous control of ingress and egress (e.g., an entry kiosk with video display deck).
	Meet with the Logistics Section Chief; ■ Obtain briefing about on-site and external communications capabilities/restrictions; ■ Establish operating procedures for use of telephone and radio systems; ■ Determine established priorities and make any special requests for services; and ■ Assess the communications linkages provided for adequacy and advise the Logistics Section Chief, especially if 911 cannot be used, or law enforcement is not reachable.
	Get estimates of the time for recovery in order to plan staffing.
	Consider adopting shifts for Security staff.
	Attend meetings called by the Incident Manager only if specifically requested to attend.

OPERATIONAL PERIOD DUTIES	
	Confer with the Incident Manager about security information of concern including possibilities of bomb threats, nearby disorders, reports of hazmat spills, violence in the workplace, and intruder alerts.
	Confer with the Section Chiefs and other staff. Obtain and provide information the staff needs to know. Security information includes: ■ Sign In Log protocols ■ Identification protocols for entry, and then work within the EOC ■ Entry protocols for visitors, including vendors, government stakeholders, and the media ■ Violence control strategies, should staff or visitors be endangered ■ Conduct for working with outside law enforcement that may be involved ■ Coordination with arriving responders such as EMS, Fire, public health, and law enforcement ■ Personal effects search and seizure policies for entry during recovery operations
	Determine if there are requirements to staff Security 24-7, if so, request the support required to: ■ Protect all primary entrances ■ Control entry through a log ■ Support the Incident Manager's need for security status information
	Update the security plan, as needed, during the recovery process.
	Keep notes to brief your relief at change of shift.
	Sign out at the EOC attendance roster at change of shift.

SECURITY (continued)

DEACTIVATION DUTIES	
	Coordinate with the Incident Manager for concurrence that you can begin to close down Security support.
	Conduct shift change briefings in detail; ensure in-progress activities are identified and that follow-up requirements are known.
	Ensure that continuing security concerns will be directed to regular on scene security.
	Leave a location and forwarding phone number(s) where you can be reached.
	Sign out on the EOC attendance form.
	Ensure your comments and a copy of your log and the sign in log are made available to the Incident Manager for the After Action Report, and to the Finance and Administration and Administration Section Chief to verify staff support hours for reimbursement, when available.
	Attend the event critique.

OPERATIONS SECTION CHIEF

Line of Authority
The Operations Section Chief is in direct line of authority, reporting directly to the Emergency Operations Center (EOC) Incident Manager.

Duties
The Operations Section Chief oversees continuity of Operations, assesses response and recovery support situations, and oversees operational response and restoration throughout the Clinic's facilities, coordinating with the other Section Chiefs.

The Operations Section Chief should contact, inform, and coordinate with the other Clinic units. Initial contacts should be oriented on needs evaluations. Second priority should be to establish care and shelter operations.

The Operations Section Chief should consult with the Logistics Section Chief and the Planning and Intelligence Section Chief. Together they determine if full or partial closure of Clinic facilities is likely (both HQ and field sites). They then determine how to ensure effective response and recovery strategies and tactics.

The Operations Section Chief, a member of the general staff, is responsible for the management of all operations directly applicable to the primary response and recovery missions. The Operations Chief activates and supervises organization elements in accordance with the Action Plans and directs their execution. The Operations Chief also directs the preparation of Operations Section plans, requests or releases resources, makes expedient changes to the Action Plans as necessary and reports such to the Incident Manager.

- Obtain briefing from the Incident Manager.
- Develop operations portion of the Action Plans
- Brief and assign operations personnel in accordance with the Action Plan.
- Supervise Operations Section staff and activities to move the recovery forward.
- Determine response / recovery action needs and request additional support resources.
- Review the suggested list of resources to be used in response and recovery and initiate recommendations for when the resources will be used and for what purpose.
- Assemble and disassemble teams assigned to Operations Section.
- Report information about special activities, events, and occurrences to the EOC Incident Manager.

OPERATIONS SECTION CHIEF (continued)

ACTIVATION DUTIES	
	Check in upon arrival at the EOC by signing in and letting Logistics Section Chief know you are present.
	Report to the Incident Manager and obtain a briefing on the situation.
	Review your position's responsibilities and open your logbook.
	Ensure the Operations section is set up properly with needed equipment, and supplies in place -- including maps and status boards.
	Review the rest of the EOC organization and establish who has information or support you will need.
	Clarify any issues you may have regarding your authority and assignment, and those of others in the EOC, with the Incident Manager or EOC Incident Manager.
	Meet with the Logistics Section Chief: ■ Get briefed about on-site and external communications capabilities and restrictions. ■ Establish operating procedures for your section's use of telephone and radio systems; make any priorities or special requests known. ■ Assess communications adequacy for your section's needs and advise the Logistics Section Chief.

OPERATIONAL PERIOD DUTIES	
	Attend the Action Plan meeting with the Incident Manager to determine: ■ What the objectives are in the Action Plan ■ The steps needed to complete the objectives in the Action Plan ■ A timeline for completing the objectives (It may cover several operational periods.).
	Meet with Planning and Intelligence Section Chief to obtain and review major events, and to obtain additional operational information that can impact your section's operations.
	Track events throughout the Clinic by their event number assigned by Incident Manager, identifying: ■ Locations ■ Situation Status ■ Operational capabilities at risk from each event activity
	Estimate the response or the recovery process duration
	Consider adopting shifts for your section.

OPERATIONS SECTION CHIEF (continued)

OPERATIONAL PERIOD DUTIES	
	Make a list of key issues currently facing your section. Considerations: ■ Business functions impaired or lost ■ Continued operability of the EOC, including staffing ■ Relocation restrictions ■ Reestablishment of data ■ Communicating with critical stakeholders
	Set action items that match the current operational period's Action Plan's goal and objectives
	Ensure your logbook is maintained and key actions are recorded with time/date references.
	Determine if there is a need for representation or participation from outside organizations as part of Operations actions.
	Provide the Incident Manager, and the Planning and Intelligence Section Chief, with periodic reports about progress on the objectives.
	Think ahead to anticipate situations and problems before they occur using advanced planning information from the Planning and Intelligence Section. Examples: threat changes in respect to Clinic operations, shortages of resources critical to operations, heat/cold, darkness, weather changes, personnel burnout, next period's goal and objectives.
	Direct requests for resources, staffing, and facility support to the Logistics Section Chief.
	Refer media requests to the Public Information Officer.
	Attend and participate in Incident Manager's Action Planning and Intelligence meetings.
	Work with the Planning and Intelligence Section Chief to develop recommendations for the next operational period's Action Plans.
	Ensure all fiscal and administrative issues are attended to and discussed with the Finance and Administration and Administration Section Chief, including: ■ Extraordinary expenditures caused by this emergency ■ Time of hourly employees applied to this emergency ■ Other expenses that may be reimbursable by government or insurers.
	Brief the Incident Manager on major issues which require immediate resolutions or are foreseeable to occur in the near future when they may cause issues of health and safety, or major interruption of operations capabilities.
	Share received information with the other Section Chiefs. Confirm that their critical issues match yours.
	If there are problems in communicating, provide that information to the Logistics Section Chief.
	Keep notes to brief your relief at change of shift.
	Sign out at the EOC attendance roster at change of shift.

OPERATIONS SECTION CHIEF (continued)

DEACTIVATION DUTIES	
	Ensure any ongoing actions come to you for completion – or are transferred to another Section Chief or the Incident Manager.
	Close out your logbook.
	Leave phone number(s) where you can be reached.
	Ensure your comments and materials are made available to the Incident Manager for the After Action Report.
	Attend the event critique.

PLANNING AND INTELLIGENCE SECTION CHIEF

Line of Authority
The Planning and Intelligence Section Chief is in direct line of authority, and reports directly to the Incident Manager.

Duties
Responsibilities include: collecting, analyzing and displaying situation information; preparing periodic situation status reports with the Incident Manager, and the other Section Chiefs; and developing goals and objectives for the forthcoming operational period's Action Plan (please see the Action Planning and Intelligence forms attached to this plan and document the Action Plan on the Action Planning and Intelligence forms). During each operational period, begin advance planning for forthcoming periods. As the workload decreases, begin planning for deactivation and demobilization. Provide information management and related support to the other Section Chiefs and staff support positions in the EOC. Keep the Incident Manager updated on significant Planning and Intelligence findings (e.g., advance planning reports, serious changes in weather or safety issues, and projected reductions in resources or support, etc.).

The Planning and Intelligence Section Chief, a member of the ERT general staff, is responsible for the collection, evaluation, dissemination and use of information about the development of recovery and status of resources. Information is needed to: 1) understand the current situation; 2) predict probable course of recovery events; and, 3) prepare alternative strategies and control operations for the recovery. Raw data must be prepared and analyzed into meaningful information known as intelligence. The Planning and Intelligence Section Chief is responsible to:

- Obtain initial briefing from Incident Manager.
- Activate Planning and Intelligence Section.
- Establish information requirements and reporting schedules for all organizational elements for use in preparing the Action Plans.
- Post the names of the activated staff in the EOC, including names and locations of assigned personnel. The names should be available from the Logistics Section.
- Establish a weather data collection system, and other threat assessment techniques, as necessary. This could include traffic, fire, hazmat, and flood reports.
- Supervise preparation of Action Plans as facilitator for the action-planning meeting.
- Assemble information on alternative strategies for response and recovery.
- Identify need for use of specialized resource(s) for Logistics.
- Provide periodic predictions on recovery schedule status—evaluate milestones and % completion of objectives.
- Compile and display on status boards the response or recovery status summary information.
- Advise general staff of any significant changes in response or recovery status.

PLANNING AND INTELLIGENCE SECTION CHIEF (continued)

- Provide a traffic plan, including safe routes for evacuation to another site, or return to Headquarters, or the field station.
- Prepare and distribute the Action Plan and other written orders from the Director.
- Ensure that normal agency information/ reporting requirements are being met.
- Prepare recommendations for release of resources for the Director/Deputy.

ACTIVATION DUTIES	
	Sign the attendance roster on arrival at the EOC.
	Report to the Incident Manager and get a briefing on the situation.
	Review the Planning and Intelligence Chief's responsibilities and open your logbook.
	Determine where in the EOC you will be operating and set up.
	Review the EOC 's organization and who has the information or support you will need.
	Meet with the Logistics Section Chief to: ■ Obtain a briefing about on-site and external communications capabilities and restrictions ■ Establish operating procedures for use of telephone and radio systems ■ Determine established priorities and make any requests for services you need ■ Assess the communications linkages provided for adequacy and advise the Logistics Section Chief.
	Meet periodically with the Operations and Logistics Section Chiefs to exchange available situation information.
	Track events throughout the Clinic involving recovery and normal operations. Identify: ■ Event number (from Incident Manager) ■ Locations that are being used for mass care and shelter by facility name ■ Maps of the site locations, physical descriptions, and directions on safe routes to and from those facilities ■ Maps and details of other locations related to emergency response and recovery
	Estimate the emergency event's duration, and track objective status by % completion
	Consider adopting shifts for the Planning and Intelligence Section.
	Request additional personnel for your section if necessary to maintain a 24 hour-a-day operation.
	Attend and provide inputs to all Incident Manager meetings, especially for Action Planning and Intelligence. Take notes to add to your log, prepare the next situation status report, and the Action Plan.

PLANNING AND INTELLIGENCE SECTION CHIEF (continued)

OPERATIONAL PERIOD DUTIES	
	Anticipate situations and problems likely to occur, such as: interruptions of power, H/VAC failure, darkness, weather changes, personnel burnout, aftershocks, etc., that will impact the current and the next operational period's goal and objectives.
	Advise the Incident Manager about your section's status, including progress toward the operational period goals and objectives.
	Maintain current data displays, and ensure reports or displays you prepare are understandable.
	Ensure all contacts with the media are referred to the Public Information Officer.
	Share information received with the other Section Chiefs. Confirm that their information about critical issues matches your information.
	Make fiscal and administrative issues known to the Finance and Administration and Administration Section Chief. Examples: ■ Extraordinary expenditures this emergency causes. ■ Time of hourly employees applied to this emergency. ■ Other expenses that may be reimbursable by government or insurers.
	Prepare input to, and facilitate the Action Planning and Intelligence session. The goal of the meeting is to cover the following topics: ■ Time period the plan covers (operational period) ■ The mission priorities (health and safety always #1) ■ Listing of objectives to be accomplished (should address the priorities and be measurable in some way so Clinic knows when they are finished) ■ Statement of strategy to achieve the objectives (identify whether there is more than one way to accomplish the objective, and which way is preferred) ■ Assignments necessary to implement strategy ■ Organizational elements to be activated to support the assignments ■ Organizational elements that will be deactivated during or at the end of the period ■ Logistical or other technical support required, who will provide it, and time needed
	Attend the Incident Manager's Action Planning and Intelligence meetings for Section Chiefs and provide situation briefings with your section staff. Update the situation status report.
	Brief the Incident Manager on major problem areas (which now need or will require solutions), and then confer with the other Section Chiefs to develop recommendations.
	Keep notes and brief your relief at shift change time.
	Sign out on the EOC attendance roster.

PLANNING AND INTELLIGENCE SECTION CHIEF (continued)

DEACTIVATION DUTIES	
	After agreement by the Incident Manager to deactivate the Section, close out your logbook.
	Ensure any open actions are assigned to remaining EOC staff, and that the Incident Manager is informed.
	Sign out on the attendance roster.
	Advise the Incident Manager where you can be contacted and leave a phone number.
	Ensure your notes and materials are made available to the Incident Manager for the After Action Report.
	Attend the event critique and assist with the After Action Report.

LOGISTICS SECTION CHIEF

Line of Authority
The Logistics Section Chief is in direct line of authority, and reports directly to the Incident Manager.

Duties
Responsibilities include: transportation, coordination with security, and logistics resources to match the other Section Chiefs' needs.

The Logistics Section Chief, a member of the general staff, is responsible for providing facilities, services, and material in support of the emergency. The Section Chief participates in development and implementation of the Action Plans, and activates and supervises the work within the Logistics Section. During response and recovery the Section Chief should:

- Obtain a briefing from the Incident Manager.
- Plan the organization of the Logistics Section.
- Provide work locations for all ERT personnel, whether in or out of the EOC.
- Record and track the activated ERT members, including names and locations of assigned personnel.
- Participate in preparation of Action Plans for support and service elements.
- Identify service and support requirements for planned and expected operations.
- Provide input to and review communications plan, medical plan, and security plan.
- Coordinate and process requests for additional resources with other sections.
- Estimate all Section's needs for next operational period.
- Ensure Communications Plan is prepared.
- Assist Planning and Intelligence Section to develop an EOC Demobilization Plan.
- Recommend release of resources in conformity with the Demobilization Plan.
- Ensure general welfare and safety of all EOC personnel in coordination with the Safety Officer.
- Assist the Security Officer with any needs for establishing and maintaining security of the EOC and ERT staff, which could include escorts to and from personal vehicles.

LOGISTICS SECTION CHIEF (continued)

ACTIVATION DUTIES	
	Check in with the Incident Manager on arrival and establish the sign-in-sheet process with Security at all controlled entries to the EOC
	Report to the Incident Manager and get a briefing on the current situation.
	Review the Logistics Section Chief's position description and responsibilities; open your log.
	Set up maps, diagrams and status board for Planning and Intelligence Section.
	Order additional supplies and equipment as needed.
	Evaluate the current EOC organization for adequate staff and advise the Incident Manager of any shortfalls or special need, including 24-7 coverage, if required.
	Meet with the Incident Manager to clarify any issues you may have regarding your authority and assignment, and what others in the EOC do.
	Meet with the Planning and Intelligence Section Chief to obtain the most recent situation information and establish the Logistics Section's intelligence needs.
	Meet with all Section Chiefs to review their logistics needs
	Establish guidelines for coordination of logistics requests from the Sections.
	Attend and provide inputs to the Incident Manager Action Planning and Intelligence and briefing meetings. Take notes and use them to plan for upcoming resource requests, or for withdrawing resources no longer needed in order to control costs. This can include staffing reductions.
	Track events, requests, etc. that require action by Logistics Section. Identify: ■ Event number (from Incident Manager). ■ Time you received the request. ■ Location where the resource is needed, who will accept it, and who will use it. ■ Description of the resource: number, type, size, weight, etc. ■ Track when the resource Action was assigned, time, and to whom for completion ■ Track and report at Action Planning and Intelligence meetings about the status of the resources assigned.
	Have a habitability survey of the work site done. Consider: ■ Hazardous materials, including nearby sources ■ Air quality, including heating, cooling, and oxygen content ■ Structural integrity (As-built drawings available from the building owner) ■ Posted instructions for employees, to include escape routes, safe havens, and assembly points. ■ Disabled employees' issues ■ Utilities ■ Fire protection
	Meet with the Finance and Administration and Administration Section Chief regularly to review financial and administrative support needs and guidelines, including the purchasing authority and limits of the Logistics Section Chief.

LOGISTICS SECTION CHIEF (continued)

OPERATIONAL PERIOD DUTIES	
	Check with the Planning and Intelligence Section Chief to reinforce your plans; think ahead to anticipate situations and issues involving facilities and resources.
	Based on what's known and forecast, estimate probable logistics needs for: ■ Supplies ■ Equipment ■ People (skills and knowledge) ■ Services (vendors) ■ Transportation (for moving people, furnishings, supplies, and other resources)
	List the high priority issues for Logistics and provide to the Planning and Intelligence Section Chief for the Action Planning and Intelligence Meeting.
	Check with the Planning and Intelligence Section Chief to reinforce your proactive attitude; think ahead to anticipate situation, issues, and recommendations.
	Determine security requirements and advise the Security Officer if additional security is needed.
	Ensure your section's logbooks and all EOC files are being maintained.
	Determine needs for additional communications and inform staff responsible for providing additional capabilities.
	Ensure reports your section prepares are clear, accurate and concise.
	Ensure orders for additional logistics are coordinated with other sections and placed in time.
	Anticipate the need for evacuations--coordinate sealing off dangerous areas and consider access control.
	All contacts with the media should be directed to the PIO.
	Consider the need for executive security for the Clinic Executive Director and Incident Manager--provide security recommendations to Incident Manager when appropriate.
	Resolve issues with the other Section Chiefs; brief the Incident Manager on major issues, and coordinate with Section Chiefs to request the Incident Manager resolves unresolved issues.

DEACTIVATION DUTIES	
	Confer with Planning and Intelligence Section Chief to anticipate issues in order to prepare for likely logistics requests.
	Advise Incident Manager you plan to deactivate as workload permits.
	Prepare notes and logbooks so they can provide input to the After Action Report.
	Close out your logbook.
	Sign out with the Incident Manager, and provide a location and phone number where you can be reached.
	Ensure your notes and materials are made available to the Incident Manager.
	Attend the event critique and assist with the After Action Report.

FINANCE AND ADMINISTRATION SECTION CHIEF

Line of Authority

The Finance and Administration and Administration Section Chief is in direct line of authority, and reports directly to the Emergency Operations Center (EOC) Director.

Duties

The Finance and Administration and Administration Section Chief should: monitor incoming information and Action Planning and Intelligence in the Emergency Operations Center (EOC) in order to identify and assess potential impacts on the Clinic's financial status, including but not limited to: cash flow, extraordinary expenses, budget impacts, and needs for funding to meet the emergency's requirements. The Chief advises the Incident Manager about these impacts and recommends actions to mitigate them. The Chief assists the other Section Chiefs in developing means to identify potential impacts and ways to reduce them. The Chief works closely with the Logistics Section Chief to ensure that expenses related to the emergency are captured and recorded in the formats desired for governmental and insurance reimbursements. The Chief maintains contact with salvage and clean-up contractors to ensure they work effectively to minimize the Clinic's costs. The Finance and Administration and Administration Section Chief should also participate in Action Planning and Intelligence sessions and ensure the Finance and Administration and Administration Section Chief is supporting other elements consistent with priorities established in the Action Plans.

The Finance and Administration and Administration Section Chief is responsible for all financial and cost analysis aspects of the recovery and for supervising members of the Section. The other primary responsibilities include, but are not limited to:

- Obtain initial briefing from Incident Manager.
- Develop an operating plan for Finance and Administration and Administration Section for response and recovery.
- Ensure that personnel time records are tracked and processed according to policy.
- Processing purchase orders and contracts in coordination with Logistics Section Chief.
- Purchase/order needed food, lodging and transportation support for response and recovery.
- Processing Workers Compensation claims related to Clinic emergency response and recovery activities.
- Handle travel and expense claims.
- Attend planning meetings to gather information and to provide input on financial and cost analysis matters.
- Brief Section Chiefs on all response or recovery-related business management issues needing attention, and follow-up prior to closure of recovery.
- Ensure that all obligation documents initiated during response and recovery are properly prepared and completed.
- Participate in all demobilization planning.

FINANCE SECTION CHIEF (continued)

ACTIVATION DUTIES	
	Sign the attendance roster on arrival at the EOC.
	See the Incident Manager to get a briefing on the situation.
	Review the Finance and Administration and Administration Section Chief's responsibilities and open your logbook.
	Determine where in the EOC you will be operating and ensure the Finance and Administration and Administration Section is set up with your database and status board and telecommunications in place.
	Clarify any uncertainties about your authority and assignment. Clarify what others in the EOC are tasked with performing.
	Review the rest of the EOC's organization to determine who has the information and support you need.
	Track events with potential significance for Finance and Administration and Administration by their EOC event numbers (issued by Incident Manager). Record that information in your logbook.
	Estimate the emergency's duration to determine whether you need to adopt shifts for the Finance and Administration and Administration Section.
	Meet with the Logistics Section Chief to: ■ Get briefed on on-site and external communications capabilities and restrictions; and ■ Find out the operating procedures for using telephone and radio systems. ■ Determine the established priorities and make special requests for any services you need. ■ Assess the adequacy of the communications linkages provided and advise the Logistics Section Chief.
	Attend and provide input to the Incident Manager's Action Plan meeting and briefings.

FINANCE SECTION CHIEF (continued)

OPERATIONAL PERIOD DUTIES	
	Track events throughout the Clinic by Incident Manager-issued event numbers. Identify: ■ Contact names, addresses and phone numbers of critical vendors (via the Resources List) ■ Budget status to address needs being projected by the other Section Chiefs.
	Verify with the Logistics Section Chief whether there are personnel casualties. Then, ensure records exist to meet the needs for compensation claims and investigating agencies.
	List the key issues facing your section and set action items that match the operational period's goal and objectives. Considerations: ■ Records acceptable to auditors. ■ Records for regulatory agencies – with the Liaison ■ Cost accounting and tracking acceptable to insurance companies and other potential sources of reimbursement/funding.
	Keep the Incident Manager advised of your section's status with progress reports related to the operational period's goal. Brief the Incident Manager on major issues that require resolutions now or are foreseeable that might delay or disrupt response or recovery.
	Anticipate situations and problems likely to occur, such as: budget shortfalls, vendor inability to deliver/refuse to vend, lack of purchasing authority, lack of contracting authority, etc.
	Attend action-planning meetings called by the Incident Manager.
	Ensure these Finance and Administration and Administration issues are coming to your section from the other sections: ■ Extraordinary expenditures caused by this emergency. ■ Time of hourly employees applied to this emergency. ■ Other expenses that may be reimbursable.

DEACTIVATION DUTIES	
	Coordinate with the Incident Manager for concurrence that you can begin to close down the Finance and Administration and Administration Section's functions.
	Close out your logbook.
	Provide your notes and logbook to the Incident Manager for input to the After Action Report.
	Determine what follow-ups might be required and inform the Incident Manager before leaving to ensure that financial recovery processes continue and are completed.
	Sign out and advise the Incident Manager where you can be contacted, including phone and location.
	Attend the event critique.
	Assist with the After Action Report.

Source: California Primary Care Association and the California Emergency Medical Services Authority

Appendix G

Staff Call List

Summer 2007
USA Center for Rural Public Health Preparedness
Texas A&M Health Science Center School of Rural Public Health
http://centers.srph.tamhsc.edu/centers/osp/USACenter/index.htm

Hospital / Clinic – Staff Call-back/Alert Roster

Procedure:

1. In an emergency or disaster, contact the Executive Director
2. If unable to contact ED, call each person at the tope of the list until successful contact is achieved. The highest ranking manager will determine whether or not to activate a staff alert.
3. If an alert is activated, each person will call the next two people on the list. (Repeat/redundant calls are ok).
4. If unable to reach one of the individuals, leave a message and call the next person. Call again one hour later. If unsuccessful, repeat name to ED or Incident Manager.
5. Keep a list of persons contacted (and unreachable) and provide to ED or Incident Manager.

DATE OF LAST UPDATE: _____ UPDATED BY: _____

This List Contains Sensitive Information and Should Remain Confidential							
Name Position	**Prefer Home/Cell/Other**	**Home Phone**	**Cell Phone**	**Office Phone**	**Other (Pager, etc)**	**Email (work)**	**Email (home)**
Executive Director							
Medical Director							
Clinical Coordinator/Nursing Director							
Chief Operations Officer							
Office Manager							
HR Director							

Summer 2007
USA Center for Rural Public Health Preparedness
Texas A&M Health Science Center School of Rural Public Health
http://centers.srph.tamhsc.edu/centers/osp/USACenter/index.htm

This List Contains Sensitive Information and Should Remain Confidential							
Name Position	**Prefer Home/Cell/Other**	**Home Phone**	**Cell Phone**	**Office Phone**	**Other (Pager, ETC.)**	**Email (work)**	**Email (home)**
Finance Director							
Executive Assistant							
Health Education Director							
Administrative Assistant							
Administrative Assistant							
Staff Physician							
Staff Physician							
Staff Physician							
Staff Nurse							
Staff Nurse							
Staff Nurse							
Staff Nurse							
Staff Nurse							
Medical Assistant							

This List Contains Sensitive Information and Should Remain Confidential							
Name Position	**Prefer Home/Cell/Other**	**Home Phone**	**Cell Phone**	**Office Phone**	**Other (Pager, ETC.)**	**Email (work)**	**Email (home)**
Medical Assistant							
Medical Assistant							
Medical Assistant							
Dental Chief							
Dentist							
Dental Assistant							
Other Staff							
Other Staff							
Other Staff							

Appendix H

Family & Community Disaster Planning Resources (American Red Cross)

American Red Cross Home and Office Preparedness Guidelines
What You Can Do to Prepare
2004
http://www.redcross.org/static/file_cont36_lang0_23.pdf

Disaster can strike quickly and without warning. It can force you to evacuate your neighborhood or confine you to your home. What would you do if basic services--water, gas, electricity or telephones--were cut off? Local officials and relief workers will be on the scene after a disaster, but they cannot reach everyone right away.

Four Steps to Safety

1. Find Out What Could Happen to You

- Contact your local Red Cross chapter or emergency management office before a disaster occurs--be prepared to take notes.
- Ask what types of disasters are most likely to happen. Request information on how to prepare for each.
- Learn about your community's warning signals: what they sound like and what you should do when you hear them.
- Ask about animal care after a disaster. Animals are not allowed inside emergency shelters because of health regulations.
- Find out how to help elderly or disabled persons, if needed.
- Find out about the disaster plans at your workplace, your children's school or day care center, and other places where your family spends time.

2. Create a Disaster Plan

- Meet with your family and discuss why you need to prepare for disaster. Explain the dangers of fire, severe weather, and earthquakes to children. Plan to share responsibilities and work together as a team.
- Discuss the types of disasters that are most likely to happen. Explain what to do in each case.
- Pick two places to meet:
- Right outside your home in case of a sudden emergency, like a fire.
- Outside your neighborhood in case you can't return home. Everyone must know the address and phone number.
- Ask an out-of-state friend to be your "family contact." After a disaster, it's often easier to call long distance. Other family members should call this person and tell them where they are. Everyone must know your contact's phone number.
- Discuss what to do in an evacuation. Plan how to take care of your pets.

3. Complete This Checklist

- Post emergency telephone numbers by phones (fire, police, ambulance, etc.).
- Teach children how and when to call 9-1-1 or your local Emergency Medical Services number for emergency help.
- Show each family member how and when to turn off the utilities (water, gas, and electricity) at the main switches.
- Check if you have adequate insurance coverage.
- Get training from the fire department for each family member on how to use the fire extinguisher (ABC type), and show them where it's kept.
- Install smoke detectors on each level of your home, especially near bedrooms.
- Conduct a home hazard hunt.
- Stock emergency supplies and assemble a Disaster Supplies Kit.
- Take a Red Cross first aid and CPR class.
- Determine the best escape routes from your home. Find two ways out of each room.
- Find the safe places in your home for each type of disaster.

4. Practice and Maintain Your Plan

- Quiz your kids every six months or so.
- Conduct fire and emergency evacuations.
- Replace stored water and stored food every six months.
- Test and recharge your fire extinguisher(s) according to manufacturer's instructions.
- Test your smoke detectors monthly and change the batteries at least once a year.

If Disaster Strikes

- Remain calm and patient. Put your plan into action.
- Check for Injuries
- Give first aid and get help for seriously injured people.
- Listen to Your Battery-Powered Radio for News and Instructions
- Check for Damage in Your Home...
- Use flashlights. Do not light matches or turn on electrical switches, if you suspect damage.
- Sniff for gas leaks, starting at the water heater. If you smell gas or suspect a leak, turn off the main gas valve, open windows, and get everyone outside quickly.
- Shut off any other damaged utilities. (You will need a professional to turn gas back on.)
- Clean up spilled medicines, bleaches, gasoline, and other flammable liquids immediately.

Remember to...

- Confine or secure your pets.
- Call your family contact--do not use the telephone again unless it is a life threatening emergency.

- Check on your neighbors, especially elderly or disabled persons.
- Make sure you have an adequate water supply in case service is cut off.
- Stay away from downed power lines.

To get copies of American Red Cross community disaster education materials, contact your local Red Cross chapter.

Disaster Supply Kits

There are six basics you should stock for your home: water, food, first aid supplies, clothing and bedding, tools and emergency supplies, and special items. Keep the items that you would most likely need during an evacuation in an easy-to carry container--suggested items are marked with an asterisk(*). Possible containers include a large, covered trash container, a camping backpack, or a duffle bag.

Water

- Store water in plastic containers such as soft drink bottles. Avoid using containers that will decompose or break, such as milk cartons or glass bottles. A normally active person needs to drink at least two quarts of water each day. Hot environments and intense physical activity can double that amount. Children, nursing mothers, and ill people will need more.
- Store one gallon of water per person per day.
- Keep at least a three-day supply of water per person (two quarts for drinking, two quarts for each person in your household for food preparation/sanitation).*

Food

Store at least a three-day supply of non-perishable food. Select foods that require no refrigeration, preparation or cooking, and little or no water. If you must heat food, pack a can of sterno. Select food items that are compact and lightweight. Include a selection of the following foods in your Disaster Supplies Kit:

- Ready-to-eat canned meats, fruits, and vegetables
- Canned juices
- Staples (salt, sugar, pepper, spices, etc.)
- High energy foods
- Vitamins
- Food for infants
- Comfort/stress foods

First Aid Kit

Assemble a first aid kit for your home and one for each car.

- (20) adhesive bandages, various sizes.
- 5" x 9" sterile dressing.
- conforming roller gauze bandage.

- triangular bandages.
- 3 x 3 sterile gauze pads.
- 4 x 4 sterile gauze pads.
- roll 3" cohesive bandage.
- germicidal hand wipes or waterless alcohol-based hand sanitizer.
- (6) antiseptic wipes.
- pair large medical grade non-latex gloves.
- Adhesive tape, 2" width.
- Anti-bacterial ointment.
- Cold pack.
- Scissors (small, personal).
- Tweezers.
- CPR breathing barrier, such as a face shield.

Non-Prescription Drugs

- Aspirin or nonaspirin pain reliever
- Anti-diarrhea medication
- Antacid (for stomach upset)
- Syrup of Ipecac (use to induce vomiting if advised by the Poison Control Center)
- Laxative
- Activated charcoal (use if advised by the Poison Control Center)

Tools and Supplies

- Mess kits, or paper cups, plates, and
- plastic utensils*
- Emergency preparedness manual*
- Battery-operated radio and extra batteries*
- Flashlight and extra batteries*
- Cash or traveler's checks, change*
- Non-electric can opener, utility knife*
- Fire extinguisher: small canister ABC type
- Tube tent
- Pliers
- Tape
- Compass
- Matches in a waterproof container
- Aluminum foil
- Plastic storage containers
- Signal flare
- Paper, pencil
- Needles, thread
- Medicine dropper
- Shut-off wrench, to turn off household gas and water
- Whistle
- Plastic sheeting
- Map of the area

Sanitation

- Toilet paper, towelettes*
- Soap, liquid detergent*
- Feminine supplies*
- Personal hygiene items*
- Plastic garbage bags, ties (for personal sanitation uses)
- Plastic bucket with tight lid
- Disinfectant
- Household chlorine bleach

Clothing and Bedding

- Include at least one complete change of clothing and footwear per person*
- Sturdy shoes or work boots*
- Rain gear*
- Blankets or sleeping bags*
- Hat and gloves
- Thermal underwear
- Sunglasses

Special Items
Remember family members with special requirements, such as infants and elderly or disabled persons

For Baby*
- Formula
- Diapers
- Bottles
- Powdered milk
- Medications

For Adults*
- Heart and high blood pressure medication
- Insulin
- Prescription drugs
- Denture needs
- Contact lenses and supplies
- Extra eye glasses
- Entertainment
- Games and books

Important Family Documents
- Keep these records in a waterproof, portable container:
- Will, insurance policies, contracts deeds, stocks and bonds
- Passports, social security cards, immunization records
- Bank account numbers
- Credit card account numbers and companies
- Inventory of valuable household goods, important telephone numbers
- Family records (birth, marriage, death certificates)
- Store your kit in a convenient place known to all family members. Keep a smaller version of the supplies kit in the trunk of your car.
- Keep items in airtight plastic bags. Change your stored water supply every six months so it stays fresh. Replace your stored food every six months. Re-think your kit and family needs at least once a year. Replace batteries, update clothes, etc.
- Ask your physician or pharmacist about storing prescription medications.

Personal Workplace Disaster Supplies Kit

Flashlight with extra batteries
Use the flashlight to find your way if the power is out. Do not use candles or any other open flame for emergency lighting.

Battery-powered radio
News about the emergency may change rapidly as events unfold. You also will be concerned about family and friends in the area. Radio reports will give information about the areas most affected.

Food
Enough non-perishable food to sustain you for at least one day (three meals), is suggested. Select foods that require no refrigeration, preparation or cooking, and little or no water. The following items are suggested:
Ready-to-eat canned meals, meats, fruits, and vegetables.
Canned juices.
High-energy foods (granola bars, energy bars, etc.).

Water
Keep at least one gallon of water available, or more if you are on medications that require water or that increase thirst. Store water in plastic containers such as soft drink bottles. Avoid using containers that will decompose or break, such as milk cartons or glass bottles.

Medications
Include usual non-prescription medications that you take, including pain relievers, stomach remedies, etc. If you use prescription medications, keep at least three-day's supply of these medications at your workplace. Consult with your physician or pharmacist how these medications should be stored, and your employer about storage concerns.

First Aid Supplies
If your employer does not provide first aid supplies, have the following essentials:
(20) adhesive bandages, various sizes.
(1) 5" x 9" sterile dressing.
(1) conforming roller gauze bandage.
(2) triangular bandages.
(2) 3 x 3 sterile gauze pads.
(2) 4 x 4 sterile gauze pads.
(1) roll 3" cohesive bandage.
(2) germicidal hand wipes or waterless alcohol-based hand sanitizer.
(6) antiseptic wipes.
(2) pair large medical grade non-latex gloves.

Adhesive tape, 2" width.
Anti-bacterial ointment.
Cold pack.
Scissors (small, personal).
Tweezers.
CPR breathing barrier, such as a face shield.

Tools and Supplies
Emergency "space" blanket (mylar).
Paper plates and cups, plastic utensils
Non-electric can opener.
Personal hygiene items, including a toothbrush, toothpaste, comb, brush, soap, contact lens supplies, and feminine supplies.
Plastic garbage bags, ties (for personal sanitation uses) .
Include at least one complete change of clothing and footwear, including a long sleeved shirt and long pants, as well as closed-toed shoes or boots.
If you wear glasses, keep an extra pair with your workplace disaster supplies.

General Information
Your kit should be adjusted based on your own personal needs.
Do not include candles, weapons, toxic chemicals, or controlled drugs unless prescribed by a physician.

Resources for Kids:

General Disaster Preparedness Materials Children & Disasters
"Disaster Preparedness Coloring Book" (ARC 2200, English, or ARC 2200S, Spanish) Children & Disasters ages 3-10.
"Adventures of the Disaster Dudes" (ARC 5024) video and Presenter's Guide for use by an adult with children in grades 4-6.

Appendix I

At A Glance: Defining At-risk Populations (Appendix I)

At A Glance: Finding At-risk Populations

At a Glance: Reaching At-risk Populations

Through the Lens of the Categories: Finding At-risk Populations

Through the Lens of the Categories: Reaching At-Risk Populations

Sample Telephone Survey Template

Questionnaire Template/Phone Script

Memorandum of Understanding Template

Collaboration Agreement Letter Template

Focus Group, Interview, or Roundtable Discussion Template
Interview/Survey Template to
Learn from Other Agencies and Organizations

E-mail Test TEMPLATE

At A Glance: Defining At-risk Populations

Step 1 – Collect population information and data
Using U. S. Census Bureau and other national data as well as data developed just for your community (studies conducted by area agencies or quasi-governmental organizations, such as a Metropolitan Planning Organization [MPO]).
Step 2 – Estimate the number of people in special population groups who live in your jurisdiction.
Work with your health, emergency, and safety professionals, and other community partners to agree on the definitions you will use for at-risk populations in your community.
Step 3 – Identify key contacts at organizations and government agencies.
Collect phone numbers, e-mail addresses, and postal addresses.
Step 4 – Talk to key contacts
Topics can include:

- The issue and process of defining special populations
- Long-term goals and objectives
- Other people who should be part of the discussion and their contact information
- Information about the populations under discussion

Step 5 – Commit to regular contact with members of your network.
Build opportunities for them to give you feedback about their involvement.

How to Use the Information

Develop a database that includes:

- Broad categories of three to five at-risk populations
- Contact information for key representatives or trusted sources from overarching groups and government agencies that work with these populations

At A Glance: Finding At-risk Populations

Step 1 – Assess existing processes within your department or agency to find at-risk populations.

Step 2 – Choose digital mapping or alternate methods.

- If departmental resources are not available for mapping programs, consider working with a partner organization, such as a local Metropolitan Planning Organization (MPO) or regional council, department of transportation, fire departments, election offices, or others, many of which have access to such resources.
- If digital mapping is not available, consider using colored pins or dots placed on a map of your community to indicate the size and locations of defined at-risk population groups.
- Using Census and other data previously collected in the *Define* phase, map locations where there are significant numbers of people who are members of at-risk populations.

Step 3 – Find and map gathering places for the at-risk populations you have identified. Create a map that shows the locations of community centers, missions, churches, or grocery stores that might be used by at-risk populations in an emergency).

Step 4 – Identify and map trusted information sources. It is important to find contacts and service providers representing the at-risk population groups, and to know where they can be reached during an emergency.

Step 5 — Facilitate discussions. Talk with leaders and representatives from community organizations that are connected with at-risk populations. Meeting face-to-face, in person, the first time will do a lot to build trust and build a solid foundation for an ongoing successful working partnership.

- Arrange roundtable meetings or conference calls.
- Discuss goals, objectives, roles, and common issues surrounding the challenges in accurately finding at-risk populations.

Step 6 – Expand your COIN. Include service providers, businesses, faith-based organizations, community-based organizations and others who work with, represent, and belong to at-risk populations.

- Members of this network are your community collaborators and program partners.
- Maintain regular contact with the COIN members through a newsletter, conferences calls or meetings.

How to Use the Information

Expand your database by storing additional names and contact information for community collaborators and program partners. Also include gathering places in the database.

Update and maintain your database. Review the community organizations that helped you find at-risk populations and check to see if any of the contact information has changed.

Develop policies and procedures to manage the information you gather and to maintain the confidentiality of the individual COIN members' contact information. The success of your network is built upon trust. Define and address confidentiality issues when you begin your relationships.

At a Glance: Reaching At-risk Populations

Step 1 – **Survey people from agencies and organizations**.
Learn about their successes and failures other departments have faced in reaching at-risk populations.
Step 2 – **Conduct focus groups**.
Focus groups or community roundtables with members of different at-risk population groups can identify their needs and barriers to communication.
Step 3 – **Analyze data.**
Information gathered from the surveys, focus groups, and your previous research efforts will help you find at-risk populations.
Step 4 – **Collaborate with community organizations.**
Work together with your partners to develop messages and materials that reach at-risk populations.
Step 5 – **Identify appropriate, trusted messengers to deliver the messages.**

How to Use the Information

Update your database with information from your research on communication barriers for at-risk populations and preferred channels of communication.

Enhance your communication plan to reach at-risk populations using a variety of methods, messages, and messengers. This plan can be part of organization's existing crisis communication plan or a supplement.

Exercise your network with drills and preparedness exercises. Look for gaps in message delivery.

Revise your at-risk population outreach plans based upon the reports from your exercises.

Exercise the effectiveness of your network at least annually.

Expand your scope to include more at-risk population groups, enhance training of COIN members, or use the network for some day-to-day information dissemination activities

Through the Lens of the Categories: Finding At-risk Populations

Economic Disadvantage

Start with economic disadvantage to find people who are likely to need extra help in receiving or acting on health information in emergencies and in general. When you map the economically disadvantaged people living in poverty, you will also find many other populations from the categories of those who are at-risk because of limited language proficiency, disability, isolation (cultural, geographic or sensory), and age. For example, homeless people gather at shelters and food banks and in an emergency will turn to people at these places for information and guidance. Mapping this group will require identifying locations of shelters, soup kitchens, churches, and health clinics.

Limited Language Proficiency

People who share a common language and culture often live in the same communities. Community leaders may serve as excellent contacts for mapping language needs. In addition, public schools, community colleges, FBOs and multicultural community organizations often provide multilingual services, including classes in English as a Second Language (ESL). It can be very difficult to find information on the whereabouts and numbers of undocumented immigrants who can constitute a substantial population, and these resources can also help you map this group.

Disability (physical, mental, cognitive, or sensory)

People with disabilities who are not in an institutionalized setting don't usually live in clusters, making them isolated and difficult to find and reach. As a group, they are very difficult to map; some communities have tried self-registry, designed to aid fire and emergency personnel in identifying mobility-challenged and energy-dependent persons, but getting people with physical disabilities to register has proved difficult. Confidentiality, particularly for persons with a chronic disease or other medical condition, also inhibits registries. However, many are members of affinity groups, both national and local organizations, where they create an informational – and sometimes social – community with other people who have similar challenges.

Data you can use to find people with disabilities include information obtained from hospitals and other health service providers, rehabilitation organizations, veterans' organizations, schools for the deaf and blind, and CBOs and FBOs.

Isolation (cultural, geographic, or social)

Isolation presents perhaps the biggest challenge to reach people with special needs. People in remote rural areas and in dense urban areas are often outside the "mainstream" of contemporary American life, by choice, or by simple fact of life.

Both rural and urban populations in many locations can be mapped as part of the strategy that begins with economic disadvantage as a descriptor. Often simply finding the very poor in rural or urban areas is enough to assure that other aspects of special need will be reflected in the

mapping. For example, if a 10-block area in an urban core is mapped because of deep poverty, and health and emergency personnel recognize that there will be special attention required in emergencies, people there who have other special needs – because of age, disability, limited language proficiency, etc. – are likely to be helped appropriately.

To address both rural and urban isolation, collaborations may be the most important effort. Trusted information sources – persons who have credibility with others, regardless of title or official status – are critical to the work to find and reach people who are culturally, geographically or socially isolated.

In rural areas, residents within a certain distance usually know each other. It is vital, however, for state, local, county, and tribal health and emergency professionals to know where these people are located in order to create strategies to reach them in day-to-day communication and especially in an emergency, particularly if electric power is lost.

You can use information from CBOs, FBOs, volunteer organizations, neighborhood associations, public utilities, codes enforcement personnel, beat cops, and others to find people in your jurisdiction who are isolated.

Age

People who work with home-delivered meal programs as well as other elder care programs can be a good source of information to locate elderly persons. Schools can provide information to find children and family members in before- and after- school programs. You can also use data from group homes, senior centers, hospitals and daycare providers to find those who might be at-risk because of their age

Through the Lens of the Categories: Reaching At-Risk Populations

Economic Disadvantage

People who are economically disadvantaged can be reached through traditional communication channels, particularly television and radio. Messages should be simple, with easy to follow directions. The biggest barriers to receiving and acting on health information for this population are often the lack of resources to respond and a lack of awareness of possible threats to their health and well-being.

Brochures, refrigerator magnets, picture books, and posters can be distributed through trusted individuals in health clinics, hospital emergency rooms, schools, human service agencies, and neighborhood community centers. In an emergency, you may need to use recognized community leaders to broadcast messages on television and radio; in the event of power failure, outreach may require door-to-door contact and/or reaching people at venues where they may have gathered.

Limited Language Proficiency

Within this broad population category, you may identify common characteristics such as:

- Cultural differences in healthcare and medical practices vary significantly from group to group and from the mainstream population.
- Language is a major barrier for many populations.
- Certain populations can be easy to reach through close-knit community relationships and elders/leaders, but may have significant differences in health-related cultural beliefs and may tend to require tailored messages because of cultural practices.
- Specific cultural and linguistic identifiers are important in defining at-risk populations. Hispanics often define themselves according to national origin.
- They speak different dialects and have different cultural practices.

Individuals with limited English proficiency have difficulty understanding both written and verbal information in English. When possible, all written materials (brochures, posters, key directional signs, pocket guides) should be available in the languages that are common in your jurisdiction.

- When possible, keep all materials (even English materials) highly visual/pictorial, so that they will be useful to the various groups.
- Consider distributing language identification cards or posters ("I-speak" materials). These materials are prepared in advance and say "I speak" (language). I need an interpreter" in various languages, to allow an individual to carry a card or point to text in their language to request an interpreter.
- Materials can be prepared in advance of a crisis, distributed through multicultural community centers, ESLR classes, places of worship, and ethnic markets. They can also be available at emergency shelters.

- The importance of the ethnic media in reaching people who speak little or no
- English is still underestimated by most health and emergency planners.
- Consider having important messages translated into various languages and recorded in advance, for use in the event of an emergency. Record the messages in English for the visually impaired.

Disability (Physical, Mental, Cognitive, or Sensory)
People with disabilities can be reached through traditional means, such as television/radio, newspapers, brochures, and phone trees. The following considerations may be helpful:

- People who are blind can be alerted through sirens and radio announcements.
- People who are deaf can be reached by using closed captioning and in-screen ASL interpretation on television, e-mail alerts, and text messaging.
- People with mobility limitations are usually self-sufficient, but they might need help to access transportation.
- People with cognitive disabilities can be reached through family members and trusted caregivers. Keep messages simple and repeat them often in an emergency.
- People who have mobility, sensory, or mental disabilities cannot always use standard resources available in an emergency. This includes people using oxygen, those dependent on electricity or medicines, or those with service animals, such as guide dogs.
- Your collaborators can help people with almost any form of disability by helping them create a buddy system in which a neighbor or co-worker will check on their welfare and assist them in an emergency.

Isolation (Cultural, Geographic, or Social)
You may find that people who live in rural areas often believe they are at low risk for terrorism. However, they are at-risk because they live near farms and raw food supplies, many power facilities, and U.S. military facilities.

Other things to consider include:

- Sheriff's, deputies, and postal workers can be good sources of information about rural residents and tourists/campers. But, many times, emergency crews and sheriff's deputies cannot physically reach some areas during floods, blizzards, and other natural disasters.
- Rural residents also include migrant workers who may face additional barriers of language and culture.
- Faith-based organizations, inter-faith organizations and ministerial alliances in rural areas and urban centers are a common source of community information.
- Many remote rural areas have spotty or unreliable radio and television signals and little cell phone coverage.

- Factors that isolate people in dense urban areas – poverty, homelessness, low literacy, limited language proficiency, age – also come into play in overcoming barriers to receiving and responding to public health and emergency messages.
- As with other at-risk populations, messages should be brief, worded simply, and transmitted with pictures and other visual aids.
- People who work at shelters and food banks and police on patrol are most likely to know people who are homeless.
- Door-to-door outreach, calling trees, and recognized trusted neighborhood leaders can be effective in reaching isolated urban dwellers.
- Radio stations that appeal to specific urban audiences (e.g., young African Americans, Hispanic/Latino cultures) can be recruited as partners in outreach.

Age

Most people over the age of 65 and children ages 5 and older can be reached through television, radio, and printed materials. Some frail elderly, however, have hearing, sight, speech, physical, and cognitive impairments that can prevent them from understanding and responding to public health information and emergency directions.

- You may need to work through trusted caregivers, family members, and neighbors.
- A senior citizen phone tree, in which senior citizens volunteer to call other seniors in their community, can be an effective outreach tool for both ordinary and crisis communication.

Very young children and school aged children who are in daycare or school can be reached through their teachers, daycare providers and family members with messages that promote awareness of public health issues and family emergency planning.

Many families bring their children to focus groups, community roundtables, and other public involvement meetings. Simple coloring books can be created with pictures that illustrate good health habits, public health services, and emergency personnel who can be trusted.

Sample Telephone Survey Template

Hello, my name is _____NAME_____. I am with _____
_____ORGANIZATION_____.

We are conducting a brief survey to help us define our special or vulnerable populations. The survey should take about 15 minutes. Do you have time now or should I call you again at a later time? (If later, schedule a time to call).

We are collecting information to help us find and reach at-risk populations with healthcare and emergency preparedness information. Let's begin the survey.

- What distinguishes the community you live in from others in the nation or state?
- How would you define at-risk populations?
- Who are the at-risk populations in the community?
- What population trends are occurring in the community that might impact at-risk population groups?
- What is the primary language spoken in the community? What other languages are prevalent?
- What populations are served by your agency/organization?
- Who are the leaders, spokespersons, trusted sources, and key informants for at-risk populations in the community?
- What are non-traditional information sources in the community that need to be tapped to provide more insight into who is at risk, has barriers to communication, or is hard to reach?
- Which populations are easiest to reach?
- Which populations are the hardest to reach? Why?
- What is the biggest gap in communicating with at-risk populations?
- In the event of a public health emergency, which populations would be most at risk of not receiving critical information? Which would lack the means to act on the information?
- What are the most common methods of sharing information with members of the group (written materials, radio, in-person conversations, for example.)?
- On average, what is the highest level of education achieved by most members of the group?

Thank you for your time and answers. Goodbye.

Training interviewers so they collect accurate information is very important. Please refer to The Behavioral and Risk Factor Surveillance System (BRFSS) Operational and User's Guide[ftp://ftp.cdc.gov/pub/Data/Brfss/userguide.pdf] for more information about properly conducting a survey. The User's Guide is a manual covering all aspects of BRFSS survey operations and includes information on many aspects of the BRFSS survey, including the following: • Processes of the BRFSS • Survey protocol • Survey methodology • Quality assurance, funding • Staffing • Reference material • Data use and promotion • Tips and pointers from the states • Questionnaire development • Data collection and management

Questionnaire Template/Phone Script

Hello, my name is _____ with _____. We are currently working in the community to identify and reach at-risk populations to improve day-to-day communication and to be prepared to reach them in an emergency. I've done some research and I understand that your organization serves _____ in _____ .

We want to improve our ability to communicate with at-risk populations in the community. Would someone in your organization be willing to assist us by answering some questions about your organization, the populations it serves, and its communication capabilities?
Sample Questions:

- What populations does your organization serve?
- What are your organization's outreach capabilities?
- How many people do you serve?
- Where is your organization located?
- What geographic areas does your organization serve?
- How do your communicate with or reach the populations you serve?
- U.S. Mail address list
- Phone or fax list
- E-mail listserv
- Other
- Do you target messaging specifically for different populations?
- Would you consider your organization to be an overarching organization?
- Does your organization have member organizations?
- If so, who are they?
- If not, how does your organization fit in your community's communication chain?
- If the phone conversation goes well and the organization representative seems to fit with your goals and objectives:
    - Ask them for his/her contact information
    - Try to schedule a meeting to talk more in depth about future and ongoing formal or informal collaboration.

Memorandum of Understanding Template

Below is a template that can be used with community partner organizations to locate special, at-risk populations.

This document serves as a Memorandum of Understanding (MOU) between:
<Your Organization Name> AND <Community Organization Name>

General Purpose: To provide <Your Organization Name> with
_____

This collaboration supports improved communication with at-risk populations for emergency preparedness planning and information dissemination during emergencies.
Agreement:

<Community Organization Name> agrees to:
1.
2.
3.
<Your Organization Name> agrees to:
1.
2.
3.

If <Community Organization Name> staff have any questions that cannot be answered through <Community Organization Name>, they should contact <Your Organization Contact Person> at <Your Organization Name Contact Person> phone number.

This document is a statement of understanding and is not intended to create binding or legal obligations with either party.

Agreed to and accepted by:

Name_____Date _____
Title_____
Name of Your Organization
_____
Address_____
City _____ST___ ZIP _____
Telephone number_____

Name_____Date _____
Title_____
Name of Community Organization
_____
Address_____
City_____ST____ZIP_____
Telephone number _____

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Collaboration Agreement Letter Template

Date
Name, Title
Organization
Address
City, State Zip

Dear <Community Organization Name>,

I enjoyed meeting with you on <DATE> and talking more about how our organizations could collaborate. Our organizations could work well together on behalf of <At-risk Population> to improve daily communication as well as for emergency preparedness planning before an emergency and for information dissemination during an emergency.

In the meeting, we agreed that the purpose of our collaboration is to
_____
_____.

Our common goals and objectives were identified as:
Goals
1.
2.
3.
Objectives
1.
2.
3.

Your organization, <Community Organization Name>, will fulfill the following roles, and/ or provide the following services:

-
-
-

Name
Title
Phone
Fax
E-mail
Team members involved will be:

The <Your Organization Name> will fulfill the following roles, and/ or provide the following services:

-
-
-

Name
Title
Phone
Fax
E-mail
Team members involved will be:

The collaboration will begin on <DATE> and end on <DATE>, at which time the partnership goals and objectives will be reviewed and a new collaboration document will be created. The terms of the agreement will only be activated upon the <Your Organization Name> receiving a signed copy of the agreement letter from your organization.

<Your Organization Name> will be responsible for the following costs your organization may incur as a partner to this process:

-
-
-

<Community Organization Name> will be responsible for the following in-kind contributions:

-
-
-

This document is an agreed collaboration between two organizations – <Your Organization Name and Community Organization Name>. I submit that I am able to make decisions for my company and agree to fulfill the above conditions as stated.

Name_____Date _____
Title_____
Name of Your Organization
_____
Address_____
City _____ST___ ZIP _____
Telephone number_____

Name_____Date _____
Title_____
Name of Community Organization
_____
Address_____
City_____ST____ZIP_____
Telephone number _____

Please return a signed letter of this agreement at your earliest convenience or by the activation ate mentioned above. I look forward to working with you.

Sincerely,

<Your Name>
<Your Organization Name>

Focus Group, Interview, or Roundtable Discussion Template

The purpose of a focus group is to reveal the in-depth attitudes, perceptions, and behaviors of at-risk populations in your community. In-depth information can be obtained by asking leading questions such as:

- What sources do you usually use to get news and other information?
- Who gives you the most reliable information about healthcare and other health-related issues?
- What forms of communication are most effective (for example, door-to-door, face-to-face, or written materials)?
- When there is an emergency, how do you get information?
- If there were a public health emergency, where would you go for information?
- How do you prefer information to be communicated to you?
- In the past, what has kept you from receiving important information?

Interview/Survey Template to Learn from Other Agencies and Organizations

Conduct an interview or a survey with people in and outside your agency who routinely communicate with members of at-risk populations. Us this information to augment your existing emergency communication plan. A survey or interview list could include:

- Professionals such as first responders – fire, police, and emergency medical services
- People in charge of programs such as WIC or Meals on Wheels
- Instructors in ESL classes
- Healthcare practitioners
- Utility companies
- Church groups

You will be able to use this information to start planning appropriate ways to augment your existing communication plan to include at-risk population outreach.

- Do you have a list of at-risk populations your organization serves? Could it be made available to our organization?
- What are your organization's outreach capabilities?
- What type of community network do you have set up to reach the different populations you serve? Do you use U.S. Mail address or physical location (street address) lists, phone numbers, fax lists, e-mail listserv, or other means?
- How many people do you serve?
- What geographic regions does your organization serve?

E-mail Test TEMPLATE

How to conduct an e-mail test:

- Alert network members that you'll be conducting a test
- Give instructions for their response
- Plan a test message that is relevant and brief
- Send the message through your compiled listserv (or other e-mail list)
- Ask the network members to respond to the e-mail or get in touch with you to let you know whether or not they received the message to determine if the network works or does not work
- Record results

Appendix J

Alternate Care Site Selection Tool

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Alternate Healthcare Site – Decision Matrix

Alternative Healthcare Site Selection Matrix	Aircraft Hangers	Churches	Community/ Recreation Centers	Convalescent Care Facilities	Convention Facilities	Fairgrounds	Government Buildings	Hotels/Motels	Meeting Halls	Military Facilities	National Guard Armories	Clinics	Schools	Sports Facilities/ Stadiums	Trailers/Tents (Military/Other)	USAF	Other
Infrastructure																	
Door sizes adequate for gurneys																	
Floors																	
Loading Dock																	
Parking for staff and visitors																	
Roof																	
Toilet facilities/ showers (#)																	
Ventilation																	
Walls																	
Total Space and Layout																	
Auxiliary spaces (Rx, counselors, chapel)																	
Equipment/supply storage area																	
Family Area																	
Food supply and prep area																	
Lab specimen handling area																	

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Mortuary holding area																	
Patient decontamination areas																	
Pharmacy area																	
Staff areas																	
Utilities																	
Air Conditioning																	
Electrical power (backup?)																	
Heating																	
Lighting																	
Refrigeration																	
Water (hot?)																	
Communication																	
Communication (# phones, local/long distance, intercom)																	
Two-way radio capability to main facility																	
Wired for IT and Internet Access																	
Other Services																	
Ability to lock down facility																	
Geographic accessibility																	
Biohazard & other waste disposal																	

Laundry																	
Ownership/other uses during disaster																	
Oxygen delivery capability																	
Proximity to nearest hospital/clinic																	
Total Rating/Ranking (Largest # indicates best site)																	

Rating System

5 = Equal to or same as healthcare facility.

4 = Similar to that of a healthcare facility, but has SOME limitations (i.e., quantity/condition).

3 = Similar to that of a healthcare facility, but has some MAJOR limitations (I.e. quantity/condition).

2 = Not similar to that of a healthcare facility, would take modifications to provide.

1 = Not similar to that of a healthcare facility, would take MAJOR modifications to provide.

0 = Does not exist in this facility or is not applicable to this event.

Source: Denver Health, www.denverhealth.org/bioterror/matrix/page1.htm
Web Version: www.ahrq.gov/research/altsites/altmatrix1_final.htm
Excel File: www.ahrq.gov/downloads/pub/biotertools/alttool.xls

Appendix K

Volunteer Roster

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VOLUNTEER ROSTER
(completed by Logistics Section – copy to Human Resources)

Date Time	Last Name	First Name	Prof Degree	Phone Contact	Address	Prof License # Picture Id	Assigned To

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Appendix L

Mental Health Coordinator Checklist

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MENTAL HEALTH COORDINATOR CHECKLIST

Perform only those actions appropriate to the situation

	MENTAL HEALTH COORDINATOR RESPONSE ACTIONS ***TO DO FIRST***
1	Report to Incident Manager; receive briefing on status and priorities.
2	Inform Logistics Section of logistic support needs: phone, email access, space.
3	Set up mental health briefing station.
4	Activate Mental Health Team; Assemble Mental Health Team and Team supplies.
5	Assign roles and duties.
6	Designate a site for Mental Health Team operations.
7	Determine need for additional mental health personnel. Request recall of clinic mental health staff, activation of contract mental health providers or augmentation through Operational Area or clinic consortium.
8	Gather information and conduct assessment.
9	Identify most affected patients, staff – refer to therapists for assessment and intervention.
10	Assign staff or outside agency professionals to various roles.
11	Direct waiting room children to parents and separate clients served as needed.
12	Inform staff of time and place of mental health briefing and update meetings.
13	Delegate monitoring of phones / crisis calls.
14	Provide mental health emergency response guidelines to clinic staff.

	MENTAL HEALTH COORDINATOR RESPONSE ACTIONS *TO DO LATER OR AS A FOLLOW-UP*
1	Documentation and tracking
2	Draft announcements and updates for PIO to disseminate via e-mail messages or mailings / send letters to patients and staff.
3	Give info on grieving and other emotional issues.
4	Give info to staff on discussing the situation with patients.
5	Distribute counseling referral list.
6	Provide any other info necessary, as indicated by PIO.
7	Meet with patients / family / Staff.
8	Stand in for absent/affected staff.
9	Rumor Control – Monitor for rumors. Institute rumor control procedures.
10	Update staff on mental health situation status and services.
11	If there are staff fatalities, provide funeral information.
12	Identify clients/staff/patients requiring additional support
13	Debrief with site or operational area (county) and/or city Crisis Response Team
14	Provide informational material and resources
15	Amend Crisis Response procedures as necessary
16	Plan memorial
17	Monitor crisis anniversaries

Appendix M

Open / Close Decision Tool

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CLINIC DECISION TOOL FOR OPENING AND CLOSING

Indicate for each trigger item if it negatively impacts the ability of the clinic to remain open, if it encourages the clinic to remain open or if it is neutral or irrelevant. This tool is not meant to generate a score. Rather, it is intended to assist a clinic Executive Director to consider the full range of factors in making a decision to close or open the clinic for operations and the level of operations the clinic could support.

CLINIC DECISION TRIGGER POINTS FOR OPENING AND CLOSING	IMPACT ON CLINIC CAPABILITY				
	OPEN		NEUTRAL		CLOSE
FACILITY					
Permanent/Immediate loss of clinic facility					
Loss of clinic building for 1 day					
Loss of clinic for 1 hour or less					
Loss of clinic offices and patient care areas					
Loss of maintenance / building and grounds staff					
Earthquake – apparent structural damage					
Earthquake – suspected structural damage / unknown level of damage					
Earthquake – non-structural damage					
UTILITIES					
Loss of phones (landline and cellular)					
Loss of computer access for more than 1 day					

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CLINIC DECISION TRIGGER POINTS FOR OPENING AND CLOSING	IMPACT ON CLINIC CAPABILITY				
	OPEN		NEUTRAL		CLOSE
Loss of building heating/cooling for more than 1 day					
Loss of utilities/power shortage					
STAFF					
Loss of Clinic management					
Loss of Medical / Nursing Director					
ENVIRONMENTAL CONDITIONS					
Street flooding cuts off clinic					
Levee failure: general flooding					
Earthquake damages roadways					
WMD / Hazmat release near clinic					
Loss of clinic budget – financial constraints					
Wild-land fire or major flood in a critical habitat area					
Transportation accident requires evacuation					
Violent weather					
INTERNAL / EXTERNAL VIOLENCE OR THREAT					
Terrorism threat/bomb threat					

CLINIC DECISION TRIGGER POINTS FOR OPENING AND CLOSING	IMPACT ON CLINIC CAPABILITY				
	OPEN		NEUTRAL		CLOSE
Workplace violence					
Civil disorder nearby					
Security intrusion					
GOVERNMENT ACTIONS					
Operational Area (County) declares disaster					
Governor proclaims a State of Emergency in Operational Area					
President Declares a disaster in area served by clinic					
State of War Declaration					
NEED FOR CLINIC RESPONSE					
Operational Area (County) requests clinic remain open without MOU					
Operational Area (County) requests clinic remain open with MOU					
Community Residents / Clients request open clinic					
Mass casualties nearby					
Surge of injured and ill					
Board of Directors directive					

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Appendix N

Media Contact Information

Media Contact Form

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MEDIA CONTACT INFORMATION

WHO USES THIS GUIDE
The Incident Manager and the PIO.

WHEN IS THE GUIDE USED
This guide is used whenever there is information to be released to internal staff, external organizations, the media and the public

WHERE IS THE GUIDE TO BE USED
This guide is used in the EOC but also wherever the PIO is located (e.g., press briefings).

PURPOSE/OUTCOME

- To ensure that information released from the EOC is timely, concise and accurate.
- To ensure that the PIO gets full cooperation from EOC to gather intelligence.
- To ensure that the Incident Manager approves all official information prior to release.

STEPS TO ACHIEVE OUTCOME
Steps in this process are suggested in an order. Each situation is different, which may require skipping steps because of the impact of actual events. Check the box when completed.

	Perform an initial briefing of the PIO upon their arrival at the EOC.
	Ensure PIO provides regular briefings with Incident Manager on public information needs, and external information from the media of importance.
	Direct the Planning and Intelligence Section Chief to share information freely with the PIO, including Status Reports and the Action Plan.
	Direct other Section Chiefs to cooperate with the PIO.
	Coordinate press briefings with the Executive Director and the PIO.
	Ensure the PIO is following the Clinic public information policy.
	Approve all news releases prior to release.
	Ensure copies of all news releases are filed.
	Ensure radio, television, and print media are monitored by the PIO.
	Ensure all PIO materials are compiled for the critique and After Action Report.

Media Contact Form
(Submit completed form to PIO)

Date / Time	Initiated by Clinic	Media	Media Outlet	Reporter Name and contact information	Subject / Content	Follow-up Needed ? (Y/N)	Clinic Staff Interviewed

N3

Appendix O

Patient Tracking Form

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Patient Tracking Form
(completed form to Medical Director)

Date/ Time	Patient Name	Pt. or Tag Number	Sex	Age	Destination	Released To	Triage Leader Initials

Source: California Primary Care Association and California EMS Authority

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Appendix P

Association for Professionals Infection Control and Epidemiology: Decontamination of Patients and Environment

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Association for Professionals Infection Control and Epidemiology:
Decontamination of Patients and Environment

For practical purposes, the 1999 APIC document provides a good starting place to review options for decontamination. However, other groups such as EPA and CDC continue to offer additional guidelines and information in this important area and responders should continue to work with pertinent state and Federal organizations that are addressing these issues.

The APIC 1999 consensus paper suggests the following for decontamination:

- The need for decontamination depends on the suspected exposure and in most cases will not be necessary.
- The goal of decontamination after a potential exposure to a bioterrorism agent is to reduce the extent of external contamination of the patient and contain the contamination to prevent further spread.
- Decontamination should only be considered in instances of gross contamination.
- Decisions regarding the need for decontamination should be made in consultation with state and/or local health departments.
- Decontamination of exposed individuals prior to receiving them in the healthcare facility may be necessary to ensure the safety of patients and staff while providing care.
- When developing Bioterrorism Readiness Plans, facilities should consider available location and procedures for patient decontamination prior to facility entry.
- Depending on the agent the likelihood for re-aerosolization, or a risk associated with the cutaneous exposure, clothing of exposed person may need to be removed.
- After removal of contaminated clothing, patient should be instructed (or assisted as necessary) to immediately shower with soap and water. Potentially harmful practices, such as bathing patient with bleach solutions, are unnecessary and should be avoided.
- Clean water, saline solution, or commercial ophthalmic solutions are recommended for rinsing eyes.
- If indicated, after removal at the decontamination site, patient clothing should be handled only by personnel wearing appropriate personal protective equipment, and placed in an impervious bag to prevent further environmental contamination.

Patient Management Med-Air Negative Pressure Rooms are: Room without Med-Air: **IMPORTANT PHONE NUMBERS** Infectious Disease Service xxx-xxxx Infection Control xxx-xxxx Texas Department of Health xxx-xxx-xxxx	BACTERIAL AGENTS	Anthrax	Brucellosis	Cholera	Glanders	Bubonic Plague	Pneumonic Plague	Tularemia	Q Fever	VIRUSES	Smallpox	Venez. Equine Encephalitis	Viral Encephalitis	Viral Hemor. Fever	BIOLOGICAL TOXINS	Botulism	Ricin	T-2 Mycotoxins	Staph. Enterotoxin B
Isolation Precaution																			
Standard Precautions for all aspects of patient care		X	X	X	X	X	X	X	X		X	X	X	X		X	X	X	X
Contact Precautions			X								X			X					
Airborne Precautions					X						X			X					
Use of N95/HEPA mask by all individuals entering the room							X				X			X					
Droplet Precautions							X					X							
Wash hands with antimicrobial soap			X	X							X			X					
Patient Placement																			
No restrictions		X						X								X	X	X	X
Cohort 'like' patients when private room unavailable				X		X	X		X				X						
Private Room			X	X	X	X	X				X	X		X					
Negative Pressure											X			X					
Door closed at all times					X						X			X					

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Patient Transport																			
No restrictions		X						X	X				X			X	X	X	X
Limit movement to essential medical purposes only			X	X	X	X	X				X	X		X					
Place mask on patient to minimize dispersal of droplets					X		X				X	X		X					
Cleaning, Disinfection of Equipment																			
Routine terminal cleaning of room with clinic approved disinfectant upon discharge				X	X			X	X		X	X	X			X	X	X	X
Disinfect surfaces with clinic approved disinfectant		X	X			X	X							X					
Dedicated equipment that is disinfected prior to leaving room			X								X			X					
Linen management as with all other patients		X	X	X	X	X	X	X	X		X	X	X	X		X	X	X	X
Regulated Medical Waste handled per policy		X	X	X	X	X	X	X	X		X	X	X	X		X	X	X	X
Discharge Management																			
No special discharge instruction necessary		X		X	X			X	X			X	X			X	X	X	X
Home care providers need to be taught principles of Standard Precautions		X	X			X	X							X					
Not discharged from clinic until determined no longer infectious							X				X			X					
Patient usually not discharged until 72 hours of antibiotics completed							X												
Post-mortem Care																			
Follow principles of Standard Precautions		X	X	X	X	X	X	X	X		X	X	X	X		X	X	X	X
Droplet Precautions							X												
Airborne Precautions											X			X					
Use of N95/HEPA mask by all individuals entering the room											X			X					

Patient Transport																			
No restrictions		X						X	X				X			X	X	X	X
Limit movement to essential medical purposes only			X	X	X	X	X				X	X		X					
Place mask on patient to minimize dispersal of droplets					X		X				X	X		X					
Cleaning, Disinfection of Equipment																			
Routine terminal cleaning of room with clinic approved disinfectant upon discharge				X	X			X	X		X	X	X			X	X	X	X
Disinfect surfaces with clinic approved disinfectant		X	X			X	X							X					
Dedicated equipment that is disinfected prior to leaving room			X								X			X					
Linen management as with all other patients		X	X	X	X	X	X	X	X		X	X	X	X		X	X	X	X
Regulated Medical Waste handled per policy		X	X	X	X	X	X	X	X		X	X	X	X		X	X	X	X
Discharge Management																			
No special discharge instruction necessary		X		X	X			X	X			X	X			X	X	X	X
Home care providers need to be taught principles of Standard Precautions		X	X			X	X							X					
Not discharged from clinic until determined no longer infectious							X				X			X					
Patient usually not discharged until 72 hours of antibiotics completed							X												
Post-mortem Care																			
Follow principles of Standard Precautions		X	X	X	X	X	X	X	X		X	X	X	X		X	X	X	X
Droplet Precautions							X												
Airborne Precautions											X			X					
Use of N95/HEPA mask by all individuals entering the room											X			X					

Negative Pressure											X			X					
Contact Precautions											X			X					
Routine terminal cleaning of room with clinic approved disinfectant upon autopsy			X	X	X			X	X		X	X	X	X		X	X	X	X
Disinfect surfaces with clinic approved disinfectant		X				X	X							X					

STANDARD PRECAUTIONS - Standard Precautions prevent direct contact with all body fluids (including blood), secretions, excretions, non-intact skin (including rashes) and mucous membranes. Standard Precautions routinely practiced by health care providers include: **Hand washing, gloves** when in contact with above, **mask/eye protection/face shield** while performing procedures that cause splash/spray, and gowns to protect the skin and clothing during procedures.

Appendix Q

Donation Tracking Form

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DONATION TRACKING FORM
(completed form to Finance Section Chief)

Quantity	Item Description	Category	Donor	Donor Contact	Est Value	Disposition / Use

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Appendix R

Equipment Inventory List

Cost Tracking and Finance Forms

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Equipment Inventory List

Description of Item (include make and model number)	Serial Number	Date Acquired	Vendor or Lessor	Cost

R2

Cost Tracking and Finance Forms

Below are Finance Situation Report **Filled out by Finance Chief**

DATE:	**TIME:**	**REPORT NO.**	**RPTG PERIOD**	**8 12 24**
PREPARED BY:		**INCIDENT:**		
SECTION CHIEF SHIFT 1:		**SECTION CHIEF SHIFT 2:**		

PURCHASES DURING THIS TIME PERIOD [COST UNIT]

BEGINNING BALANCE $

	ITEM	QTY	UNIT COST	PURCHASED FROM	TOTAL COST
1					
2					
3					
4					
5					
6					
9					
10					
11					
12					
13					
14					
15					

TOTAL PURCHASED TO DATE $

CLAIMS [CLAIMS UNIT]

NAME	DEPT.	NATURE OF CLAIM	DISPOSITION	EST. COST

TOTAL CLAIMS ESTIMATE $

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FINANCE SECTION TASKS FOR THIS OPERATING PERIOD		DATE/TIME:
SECTION/UNIT	**TASK**	**ASSIGNED TO**
FINANCE SECTION CHIEF TASKS		
PRIORITY ISSUES:		
1.		
2.		
3.		
4.		

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SIGNIFICANT EVENT LOG

EVENT: _____ NAME: _____ DOC POSITION:_____

DATE	TIME	NOTES

Source: *California Primary Care Association and the California Emergency Medical Services Authority*

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Appendix S

After Action Report Form/Questionnaire

AFTER ACTION REPORT QUESTIONNAIRE

Use of After-Action Reports

After-Action Reports serve the following important functions:

- A source for documentation of response activities.
- Identification of problems/successes during emergency operations.
- Analysis of the effectiveness of the components of the response organization.
- Description and definition of a plan of action for implementation of improvements.

The ICS approach to the use of After-Action Reports emphasizes the improvement of emergency management at all levels. It is important for all clinic staff to be encouraged to contribute to the after-action report process. Even staff who continued their day-to-day functions can provide useful information. The After-Action Report provides a vehicle for not only documenting system improvements, but also can, if desired, provide a work plan for how these improvements can be implemented.

It may be useful to coordinate the After-Action Report process when multiple agencies/divisions are involved in the same emergency. For example, an operational area may take the lead in coordinating the development of an After-Action Report which involves multiple count response agencies.

_____ DUE BY: _____

(Disaster Name)

Section A.

THIS FORM IS FOR THE <Name of Clinic>

Completed by _____ _____

Name (print) Division

_____

Phone Number

Section B.

	QUESTION	YES	NO	N/A
1.	Were procedures established and in place for response to the disaster?			
2.	Were procedures used to organize initial and ongoing resources?			
3.	Was the ICS used to manage field response?			
4.	Were all ICS Sections used?			
6.	Was the EOC activated?			
7.	Was the EOC organized according to ICS?			
8.	Were sub-functions in the *EOC* assigned around the five *ICS* functions?			
9.	Were response personnel in the *EOC* trained?			
10.	Were action plans used in the *EOC*?			
11.	Was coordination performed with volunteer agencies (e.g., Red Cross)?			
12.	Was an Operational County EOC activated?			
13.	Was assistance requested and received?			
14.	Were the *EOC* assistance acquisition efforts coordinated?			
15.	Was communication established and maintained between operation centers?			
16.	Was public information disseminated according to procedure?			

Section C.

17. What response actions were taken by the clinic? Include such things as resource acquisition number of personnel, equipment and other resources.

18. As you responded, was there any part of *ICS* that did not work for your clinic? If so, how would/did you change the system to meet your needs?

19. As a result of your response to this incident, are any changes needed in your plans and procedures? If so, please explain.

Source: California Primary Care Association and the California Emergency Medical Services Authority