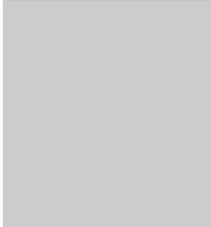
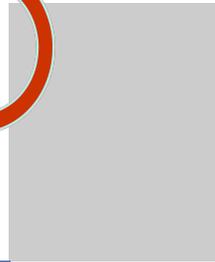
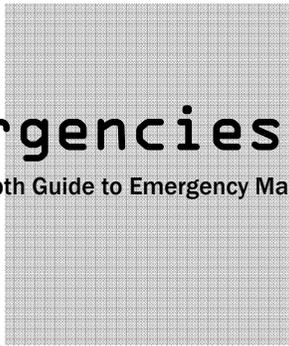




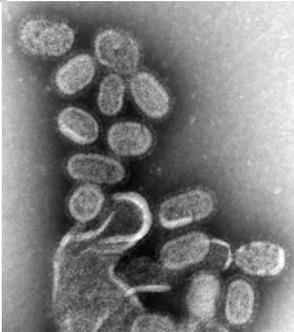
Emergencies Happen

An In-Depth Guide to Emergency Management for Health Centers



Tornado

Hurricane



PREPARE
NOW



Pandemic



Winter
Weather



Wildfire



Flood



Terrorism



NATIONAL ASSOCIATION OF
Community Health Centers

PREFACE

The intent of this health center resource guide is to provide health centers with detailed information and resources, including various approaches to assist health centers in developing and implementing an Emergency Management component to their established risk management program. This guide assumes an all-hazards approach for developing an emergency management plan (EMP) based on the phases of emergency management and disaster recovery, including planning, mitigation, preparedness, response, and recovery. This resource guide is a tool for all health centers, whether just starting the process of developing a comprehensive EMP, or for use in updating existing plans.

This guide **is not** regulatory, **does not** alter any existing regulations, and **does not** set standards for compliance. The models and examples included in the resource document are merely suggestions and are not to be viewed as the only methods. This guide is focused on health centers and is only one resource among many other emergency management planning resources, toolkits, and materials available for health centers to reference in preparing a comprehensive EMP.

We hope health centers will find this guide helpful in the development and implementation of a comprehensive EMP.

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INTRODUCTION

Emergencies happen – **all the time** – and even small ones can have a big impact on a health center. Although the word ‘emergency’ tends to conjure thoughts of September 11, Hurricane Katrina, and other catastrophic events, every day occurrences such as fires, floods, ice storms, and power outages can severely limit a health center’s ability to provide health care to its patients.

To help lessen the impact of disasters or emergencies and to help health centers get back to the business of providing health care as quickly as possible following an event, it is important to engage in emergency management activities. Here are just a few of the reasons why it is so important for health centers to get involved and **stay** involved in emergency management:

1. Emergencies happen whether people and health centers are prepared for them or not. Responding to and recovering from disasters is much easier when people and organizations are prepared for them. This is especially important for health centers which need to get back to the business of providing health care to their patients, keep revenue streams running, and payroll flowing.
2. People will go to your health center during a disaster. Studies have found that most people affected by a disaster transport themselves to healthcare facilities and will go to the most familiar source of health care for help. For many people in many communities, this means the health center – and history has shown this to be true.
3. Hospitals in your community will likely be overwhelmed during a large scale disaster and other healthcare facilities are needed to provide non-critical treatment of minimally injured or non-acutely ill patients, as well as maintain their own continuity of operations in order to prevent their own patients from adding to the hospital overload.
4. During and after an emergency, your patients will still have chronic diseases, babies being born, and other illnesses and conditions that need treatment – if you can’t provide primary health care services to them, where will they go?
5. Your health center is the link to vulnerable populations in your community – you speak their languages, understand their cultures, have developed a relationship with these folks based on trust, and know where they live and how to reach them. Because of the unique way that health centers provide health care, you have a link with hard to reach, vulnerable populations and can help to be sure that their needs are included in community wide planning and response by collaborating with vital partners such as the health department and hospitals in your area.

What is an Emergency?

To provide a solid foundation for using this guide, it is important to recognize that there are a number of formal definitions noted in this guide. The U.S. Congress enacted the *Robert T. Stafford Disaster Relief and Emergency Assistance Act* (P.L. 93-288, as amended) to support an organized response from the Federal Government to State and local governments to alleviate the suffering and damage which result from such disasters. **The Stafford Act** delineates the federal government disaster response in a “federally-declared” emergency and defines *emergency* and *major disaster* as follows:

Emergency is defined as any occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States.

Major Disaster is defined as any natural catastrophe (including any hurricane, tornado, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm or drought), or, regardless of cause, any fire, flood, or explosion, in any part of the United States, which in the determination of the President causes damage of sufficient severity and magnitude to warrant major disaster assistance under the Stafford Disaster Relief and Emergency Assistance Act to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused.

The **Federal Emergency Management Agency (FEMA)** defines an *emergency* as any unplanned event that can cause death or significant injuries to employees, customers, or the public, or that can shut down health center business, disrupt operations, cause physical or environmental damage, or threaten the facility's financial standing or public image.

In the **HRSA/Bureau of Primary Health Care Policy Information Notice 2007-15** titled 'Health Center Emergency Management Program Expectations', an emergency or disaster is defined as an event affecting the overall target population and/or the community at large, which precipitates the declaration of a state of emergency at a local, State, regional, or national level by an authorized public official such as a governor, the Secretary of the Department of Health and Human Services, or the President of the United States.

The **Joint Commission** defines an emergency as a natural or manmade event that:

- *Significantly disrupts the environment of care (for example, damage to the organization's building(s) and grounds due to severe winds, storms, or earthquakes)*
- *Significantly disrupts care and treatment (for example, loss of utilities such as power, water, or telephones due to floods, civil disturbances, accidents, or emergencies within the organization or in its community), or*
- *Results in sudden significantly changed or increased demands for the organization's services (for example, bioterrorist attack, building collapse, or plane crash in the organization's community).¹*

Many **states and communities** also have additional legislation around disasters. It is a good idea to check in with your PCA to see if there are state-based laws or definitions you should know about and use in your planning efforts.



Please note that throughout the resource guide, the terms *emergency* and *disaster* are used interchangeably to mean any type of emergency or disaster—manmade or natural.

¹ CAMAC, January 2007
National Association of Community Health Centers

THE PLANNING PROCESS

Emergencies will happen – whether you are ready for them or not. Health centers can greatly improve their ability to respond efficiently and recover more quickly by preparing for emergencies. Part of this process includes planning with your community and developing a comprehensive, all-hazards Emergency Management Plan (EMP) for your center. History has shown that organizations and agencies that have a coordinated, thorough, and well-exercised plan are better able to save lives, protect property, and recover more quickly.

An EMP will formalize and define your health center's role, both internally and externally, in an emergency. It is important that your patients, staff, and community partners are familiar with your plan so that they can help your health center during an emergency response. Benefits of sharing your plan with all your stakeholders include:

- Reducing reaction times, improving coordination, and minimizing confusion among staff and other response partners.
- Providing a tool for establishing formal coordination with other entities, which a health center may need in order to assist patients and support business operations during and after a disaster.
- Providing a valuable training tool for educating and preparing staff and patients for emergencies.
- Providing a framework for responding to any emergency situation whether anticipated by a hazard vulnerability analysis or not.

Successful all-hazards emergency and disaster planning is focused on preparing for a wide range of events. An EMP that clearly defines and describes policies, procedures, roles, responsibilities, tasks, and specific operational actions as they pertain to each emergency support function, before, during, and after an emergency, is invaluable. To ensure adequate planning for all applicable hazards, the contents of the plan should be responsive to the results of your health center's specific hazard vulnerability assessment (utilizing an all hazards approach), which is described in the Mitigation section of this resource document. There is no one-size-fits-all list of emergency management planning considerations that can be prescribed generically for all health centers. The primary goals are to ensure that the EMP is supported by your health centers capabilities and that it fully incorporates all activities determined to be important for the risks and hazards likely to impact your health center.

Critical Questions for Your Health Center in the Planning Process

- Has an Emergency Management Mission Statement been developed?
- Who will be on the Emergency Management Team?
- Have lines of authority been established for the emergency management planning process?
- What are the day-to-day health center operations that should be maintained during an emergency?
- Has an Asset Inventory been completed?
- What Emergency Support Functions are applicable to emergency operations?
- Has the EMP been endorsed and supported by the Board of Directors, Executive Director, and health center staff?

First Things First

Get buy-in

Preparing your health center for different types of emergencies is a long and ongoing process. It is important to build a strong foundation of support from the senior leadership and management in your health center, since that will be crucial if your center is to maintain its preparation efforts over time. Being prepared for emergencies and having plans in place to get back to business as quickly as possible is good business practice. Emergency management needs to be incorporated into your health center's risk management program and should have a budget attached to it, even if your center is not able to set aside much funding for these activities.

Assign responsibility

After getting the needed buy-in, it is important to appoint one person, an Emergency Management Coordinator, to coordinate all of the emergency management activities. Most Emergency Management Coordinators also have other roles within the health centers – it is common to see the Chief Operating Officer, Facility Manager, or Clinical/Nursing Director assume the additional title of Emergency Management Coordinator – although this may make it more difficult for that person to address both pre-existing and emergency management duties. Some of the duties assigned to the Emergency Management Coordinator include:

1. Chair the Emergency Management Committee.
2. Conduct a Hazard Vulnerability Analysis (HVA) and review/revise annually.
3. Coordinate the development of the Emergency Management Plan and review/revise at least annually and after any deficiencies identified through a drill/exercise or actual emergency.
4. Represent the health center in local, regional, and statewide emergency management meetings. There are many meetings in every state so be sure that the meetings your health center attends focus on medical and public health – they may be called Emergency Support Function 8 or ESF-8. The Primary Care Association in your state probably has a seat on the statewide Advisory Committee so you don't need to add that one to your calendar but be sure to participate in any PCA Emergency Management Committee meetings – you will learn a lot from the other centers in your state.
5. Work with local and regional partners to coordinate your plan with that of your city, town, or county. Key partners include your local health department, area hospitals, and nearby health centers.
6. Schedule staff training and drills and exercises.

Emergency management in health centers needs to be a group effort with many different perspectives to make it sustainable and responsive to the needs of all departments within the organization and this requires an Emergency Management Committee. Some health centers create a stand-alone Emergency Management Committee while others include emergency management to the list of responsibilities of existing committees such as Safety or Infection Control. Including a cross-section of staff provides a broader, more robust perspective on the health center's risks and response capabilities. Consider staff from senior and mid-level management, human resources, providers, support staff and medical records, enabling services (outreach, case management, transportation), finance and information technology, facility security and maintenance, and public relations/information.

However you decide to build your committee, it is important that the members have a clear understanding of the necessary activities as well as the need to report progress regularly to both senior management and the Board of Directors. Some of the emergency management duties of a committee include:

1. Support the Emergency Management Coordinator in the completion of an HVA and Emergency Management Plan. This might include dividing up the sections among the committee, researching existing emergency management structures in your community, developing recommendations about health center roles, and identifying resources.
2. Determine which roles are appropriate for the health center based on capacity and capability. These recommendations should be submitted to senior management and the Board of Directors for final approval.
3. Identify at least one member to serve as a back-up for the Emergency Management Coordinator, as needed.
4. Determine training needed by staff to fully implement the Emergency Management Plan.
5. Determine the areas of focus for drills and exercises. There are a number of resources to help guide the Emergency Management Committee through this process. Refer to Appendix N for websites and tools.

Components of an Emergency Management Plan

Once a committee is in place, it is really important to evaluate the potential for certain events and your health center's ability to respond to these events as part of the planning process. A good way to organize and prioritize all this information is to complete a Hazard Vulnerability Analysis (HVA). Detailed information about a HVA is found in the Mitigation section of this guide, beginning on page X. This will provide the framework for much of the development of your Emergency Management Plan – it is important to plan for all hazards but especially for the events identified in the HVA as being higher risk of happening or for which your center has greater vulnerability if it does happen.

Your health center's EMP should be a comprehensive, self-contained document that includes the components necessary to guide all emergency activities. Appendix A includes links to access sample Emergency Management Plans. These samples are provided to facilitate consideration of the appropriate components for the health center's EMP.

The following is a suggested list of elements for inclusion in your health center's EMP:

- **Certification of Plan Approval** - List plan developers (EM Coordinator and Team Members) and person(s) responsible for the plan approval, usually the Chief Executive Officer and the Board of Directors.
- **Record of Plan and Annex Revisions** - A page listing revisions to the plan and the date of the revision.
- **EMP Distribution List** - A list of all individuals and agencies who received a copy of the Emergency Management Plan including the date distributed.
- **Introduction** - A paragraph providing the health center's role and function within the community.
- **Phases of Emergency Management** – List the phases of emergency management, including planning, mitigation, preparedness, response, and recovery, along with the definitions for each for the health center.

- **Scope** - The specific health center facility or facilities the plan addresses.
- **Responsibility** - The line of authority for operation of the health center within the organization.
- **Hazard Vulnerability Assessment (HVA)** - A comprehensive analysis of the potential risks and hazards faced by the health center, which have a potential to adversely impact operations. The risk and hazard vulnerability assessment should utilize recommended models and an all-hazards approach, and be based on the specific risks and hazards within the communities served. Health centers should consult local and state emergency management agencies, city/county planning offices, and health department emergency planning offices for potential hazards already identified by these entities for consideration in the health center's EMP.
- **Schedule of Exercises** - Provide a list of scheduled exercises to be conducted yearly based on a recommended four-year planning cycle.
- **Corrective Action Plan** - Change is inevitable and the plan should be exercised annually to determine the plans viability in a changing environment. Any deficiencies should be addressed through a Corrective Action Plan. This section should describe the health center's process for developing Corrective Action Plans and how they are used to improve the EMP.
- **Operational Policies** - Define those responsible for activation of the EMP, accessing additional resources through mutual aid agreements, or through local, state, and federal partners, and the private sector. Operational policies should include a requirement for documentation of all assets expended and requested. These records should include work hours, equipment hours, supplies and materials consumed, injuries to personnel, and damage to facilities and equipment.
- **Legal Basis and References** - This section will provide the legal foundation for the plan and compliance requirements under law or contract.
- **Command and Control** - Provide a list of personnel with authoritative direction and control for emergency operations and the lines of succession. This should include an Incident Command Structure (ICS) Table of Organization.
- **Emergency Response Training** - Identify health center management staff who are aware and responsible for maintaining current policies and procedures, resource lists, and training programs for all personnel as required in the plan.
- **Continuity of Operations** - Describe the process for maintaining operations, lines of succession, safeguarding essential records and protection of personnel, resources, redundant capabilities, and facilities during and after an emergency or disaster. Explore the capability of mobile centers to augment or replace facilities, which may need to be abandoned for safety reasons.
- **Support** - List the contact information and names of agencies in the communities served by your health center who can provide support for the health center's operations during times of emergencies, including the procedures for requesting assistance. These agencies include local emergency managers, city, county, state, and federal agency partners, the health care community, faith-based groups, volunteers active in disasters such as the Red Cross, Salvation Army and other national disaster relief and recovery organizations, and private sector businesses and industry.

Incorporating Operational Policies and Procedures

Your health center's EMP should also include relevant policies and procedures covering the day-to-day operations of the health center as an annex, particularly when dealing with a severe weather event, building shelter and evacuation, hazardous material release, fire, bomb threat or suspicious activity, and any codes dealing with health care emergencies or other threats to the health center (i.e. Code Blue).

Completing an Asset Inventory

An asset inventory is a detailed record of an organization's assets, resources, and capabilities, which may be needed to continue operations and/or aid in the response to an emergency or other disaster. The asset inventory is an essential part of emergency management planning and will aid your health center in targeting emergency management strategies. The asset inventory process also helps in identifying gaps in resources and capabilities, as well as areas that need additional planning, mitigation, and preparation.

Conducting an asset inventory, coupled with the risk and hazard vulnerability assessment will assist the health center in determining the specific areas that need attention in order for your health center to be as prepared as possible in the event of an emergency. Gaps identified in the asset inventory will also assist in prioritizing efforts and resources to fill those voids.

Alignment of the Health Center EMP with Federal, State and Local EMPs

Your health center's EMP should not be developed in a vacuum – it should be integrated with existing federal, state and local EMPs to be most effective. The benefits of a well-developed and practiced EMP cannot be over emphasized. In the past, one of the hindrances in obtaining assistance for damaged health centers was a basic lack of knowledge about the health centers and the care they provide. In some cases, local emergency management coordinators and health officers were not even aware of the existence of the health center facilities or their emergency needs. This lack of knowledge brings to light the importance for health centers to get involved in the local community's emergency health care planning process, so that the needs of your health center can be considered by these officials, activities can be coordinated, and planning for a role as a critical community resource for medical needs in the event of a disaster. As part of a community's health care assets, health centers should be active participants in the community's emergency management planning team. This includes participation in planning and exercises, as well as providing staffing for community emergency medical operations centers. Health center should take proactive steps to become an active participant in the larger community planning process and to educate key players about the critical primary care services provided. This includes state and community emergency planning bodies, state primary care associations, health departments, hospitals, and other emergency responders. Collaboration with your PCA for outreach to those partners can help to develop a 'unified front' when seeking a seat at the planning table with our community and state emergency management partners.

Health centers should learn how the local and state planning process works, attend meetings, and make the necessary inquiries to become actively involved and recognized as an important player in the overall community response. Developing relationships, becoming an active participant, establishing lines of communication, and a chain of command that is coordinated with local emergency responders are important components of proper emergency management planning for the health center and the community as a whole. Health centers can work toward greater integration with state and local EMPs by doing the following:

- Obtain and thoroughly review the Federal Emergency Plan issued by FEMA and the National Response Framework (in draft form as of October 2007) issued by the Department of Homeland Security. Familiarize key health center staff with the different support functions and the responsible agencies including a contact list.

- Review and determine where in the state and local EMPs the health center can be an asset and determine the role of the health center in a community response.
- Develop a realistic assessment of both what assets the health center CAN provide, and those the health center can NOT provide. This will help avoid outside partners planning for assets that the health is not able to provide.
- Identify and meet with the state and local Emergency Management Coordinators.
- Provide a synopsis of the health care delivery capabilities and limitations of the health center.
- Assert that a health center representative should be a member of the emergency response planning committee.
- Volunteer health center personnel as part of the first responder group and staffing for the emergency medical operation centers when activated and encourage staff to register in the State ESAR-VHP System.
- Actively participate in state and local community disaster exercises.

Informing the community and emergency officials about the health center's mission and role is a critical part of coordinating with local EMPs. Possible strategies include:

- Conduct public information campaigns for the health center.
- Speak before civic groups, community boards, the private sector, and with local and state elected officials, which can include the health center management, staff and board members.
- Distribute monthly newsletters to the community highlighting the health center activities and the positive impact the health center has on the health and well being of the patients and community as a whole.
- Invite local, regional, and state emergency management agencies to the health center's emergency management planning meetings, drills and exercises, and to special events sponsored by the health center, such as health fairs. Ask to be included in upcoming state and local emergency management exercises to the degree possible for the health center.
- Attend conferences and seminars sponsored by local/state emergency management agencies.
- Ask to attend some of the local/state emergency management planning sessions with the knowledge the health center may be asked, "What can the health center bring to the table?" and be prepared to answer.

When the health center accomplishes some of these goals, the health center will gain an understanding of the health center's role and responsibility to the community and in kind the local/state emergency management officials will understand the health center's contribution, thereby developing a working relationship. This relationship may be integral to ensuring that the needs of your target population will be integrated and addressed as part of the community wide planning process.

Funding for Emergency Management

For fiscal year 2007, there are three main federal programs that fund emergency management efforts for public health and medical facilities. The Hospital Preparedness Program (HPP) and the Public Health Emergency

Preparedness Program (PHEPP) both go to the state health department and which then usually sub-contracts out with hospitals, health care facilities, and local health departments. The third program, Healthcare Facilities Partnership Program (HFPP), may go to the state but may also be awarded directly to the partnership.

Health centers and Primary Care Associations have been included in this funding in many states, but not all. Contact your PCA to find out how these funds are distributed in your state and if there are any funds available to your center. If not, you may be able to access these resources through your local health department.

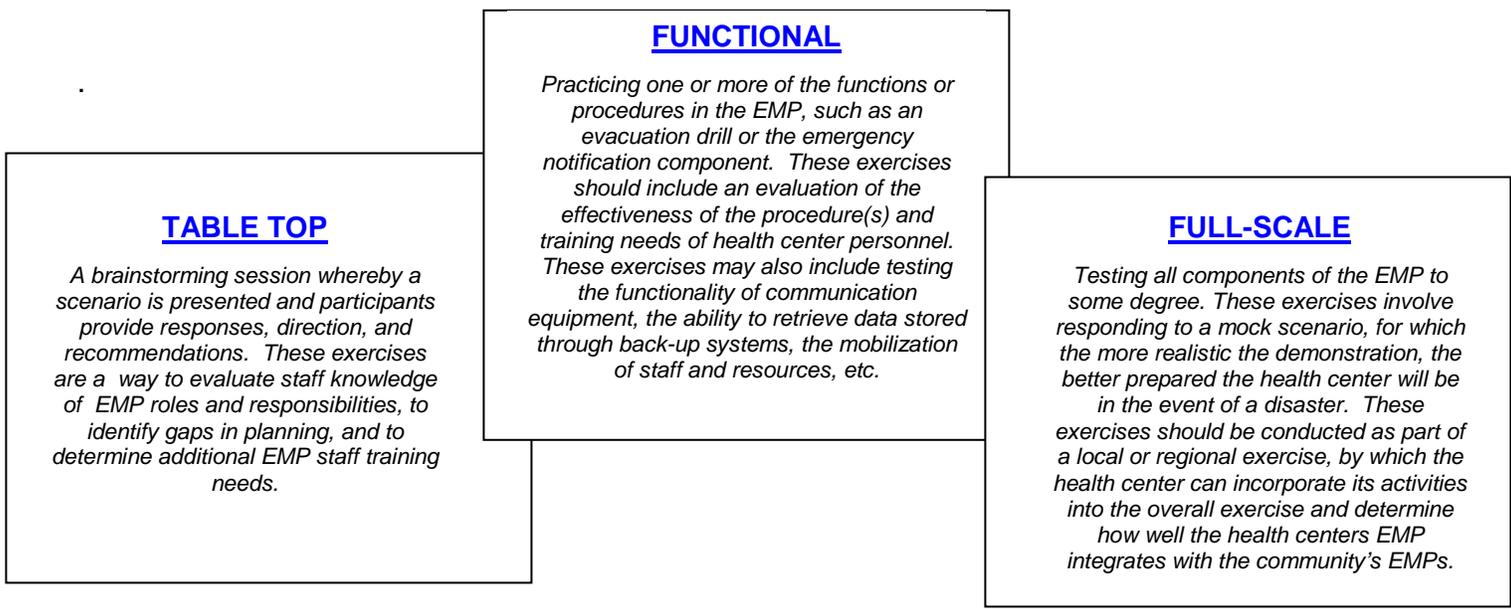
Board of Directors Approval of the Emergency Management Plan

Your health center’s EMP needs to have the endorsement of the senior leadership and staff, as well as the review and approval of the Board of Directors for the plan to be successful. The Board may prefer to review and approve the EMP as a whole, or form a special committee for this purpose.

Your health center may want to hold a special board meeting to assure a thorough review and discussion of the EMP. It is important to remember the Board of Director’s role throughout the emergency management process. The Board may need to be called into an emergency session to handle Board actions required during the course of a disaster or emergency. The health center’s policies and procedures may require Board approval for certain types of expenditures and purchases exceeding dollar thresholds. In addition, the health center’s EMP and corporate by-laws should contain Board procedures during an emergency.

Practice, Evaluation, and Revision

After a health center completes the EMP and the Board approves it, exercises are needed to test it. Testing consists of evaluating the EMP by practicing and conducting drills and exercises. The purpose of testing is to evaluate the system and plan in place, not individuals and their performance. It is only through honest evaluation of mistakes made that effective corrective actions can be developed and implemented. It is important to recognize the health center may never experience a disaster to the same degree others have experienced similar events. Nonetheless, health centers should be prepared in the event similar disasters occur, and the only proven method for effective preparation is to exercise, practice, evaluate, revise, and utilize lessons learned from the drills, as well as from those who have had actual experiences in responding to major emergencies and disasters. Exercises and drills come in many forms, including tabletop, functional, and full-scale exercises and evaluations. Your health center should consider conducting each type of exercise annually, with the results documented and recorded in the EMP.



As part of completing any of these exercises, a 'hotwash' (a discussion about the exercise that takes place immediately afterwards while the event is fresh in participants' minds) and an after-action report (AAR) should be prepared to establish what went well and what went wrong. The AAR should also include a corrective action plan to eliminate deficiencies in the future. It is important to include specific recommendations, responsible parties, and a realistic timeline in the corrective action plan. If all phases and components of the exercise went well, your health center may not have sufficiently challenged the emergency management response team. Exercises build strong relationships within an organization, the community served, and the greater emergency preparedness family. Revisions to the EMP based on exercise evaluation and the changing environment should be documented, approved, dated, and exercised again.

Training

No plan can be considered effective unless participants understand what is required of them and take part in regular emergency management exercises. The training of staff in general, as well as the coordination of training with local emergency management teams, is an essential component of an effective planning process. Things to consider include:

- Does the staff receive adequate and appropriate emergency management training?
- Does staff participate in tabletop exercises conducted by response partners, such as the local health department, hospitals, or other health centers?
- Does staff understand cultural competence needs during emergencies?
- Has your health center conducted emergency drills and periodic briefings for all key staff and new personnel, and is regular confirmation of in-place contracts completed? These activities will often result in the identification of deficiencies in the EMP. Deficiencies should be addressed and any changes to procedures should be highlighted for health center staff and other participants.
- Has your health center conducted training on a regular basis for everyone who works at the health center? Individuals should be familiar with the emergency management plan including their roles and responsibilities and procedures for such things as notification and evacuation. The following are basic considerations for developing a training program:
 - Determine how frequently the training should be conducted. It is recommended that health centers conduct formal training for all new employees and at least every 12 months for other employees.
 - Identify who will conduct the training and where the training will take place. There are many training resources available at low or no cost. Contact your PCA or NACHC to get a listing of these resources.
 - Build training costs and lowered productivity as a result of training into your annual budget. Although many trainings are available at no cost, you may be able to maximize staff time by providing training materials and food.
 - Identify what types of training activities will be used. Consider utilizing classroom or online instruction for orientation and educational sessions, walk-through drills to test performance of roles and functions, tabletop exercises to highlight response to mock scenarios, and functional exercises to test specific functions.

- Determine how the health center will document and evaluate the effectiveness of the training. Ideally this should include pre and post evaluation of staff knowledge of emergency management procedures, roles, and principles.
- Invite community emergency responders such as the local police and fire departments, to assist in developing, conducting and evaluating the health center's training program. Also, consider inviting other partners who may be specifically related to training you are conducting. For example, invite local medical to a public information training session.
- Fulfilling additional training commitments is difficult at best for most health centers, but a basic foundation and understanding is needed of the systems utilized by governments and the private sector. Not everyone should be certified or trained to the highest level, but basic levels are important.

FEMA has a wealth of training opportunities that can be accessed through the FEMA website at www.fema.gov. Some are on-line courses and train-the-trainer opportunities. Training programs are also available through local or state homeland security/ emergency management offices. There are many other resources available for emergency management training, including the Centers for Public Health Preparedness at www.bt.cdc.gov/training/cphp/centers.asp. Health centers may also be able to participate in local emergency management training programs and exercises. Additional training sources can be found in Appendix N.

MITIGATION

Mitigation is defined as any sustained action taken to reduce or eliminate the risks to life and property from a hazard or other catastrophic event. Mitigation planning is the systematic process of learning about the hazards and vulnerabilities that can affect your health center, target population and community at large and then setting clear goals, identifying appropriate actions, and following through with an effective strategy to reduce the likely impact of such events. Mitigation encourages a long-term reduction of hazards and vulnerabilities, serves to reduce the enormous cost of disasters to property and operational capacity, increases the protection of critical facilities and equipment, reduces exposure to liability, and helps to minimize health center business disruption and overall community impact.

Hazard Vulnerability Assessment

All health center facilities are vulnerable to any number of natural or manmade hazards. An analysis of your health center's vulnerability to particular hazards provides the foundation for building a practical and workable EMP. The analysis provides specific information for use in developing mitigation strategies, standard operating procedures in the event of an emergency, and in the development of the overall EMP.

The hazard vulnerability assessment identifies the hazards and/or vulnerabilities that need special attention, the actions that might be taken to reduce the impact of those hazards, and what resources are likely to be needed. The analysis should incorporate an all-hazards approach to include natural disasters, infrastructure disruptions, human-caused events and hazards, and terrorist incidents. Health centers should recognize facility-specific vulnerabilities for particular hazards based on the unique location(s) and operation(s) of each facility. Examples of each are provided below:

Critical Questions for Mitigation Activities at Your Health Center

- Has your health center conducted a Hazard Vulnerability Assessment (HVA) using an all hazards approach to identify specific risks that may impact your health center and target population?
- What risks and hazards are specific to or historically prevalent near your health center?
- Has the Chief Financial Officer contacted the health center's insurance agent to determine if the current insurance coverage(s) is adequate to cover your health center in the event of a disaster, including considering business interruption insurance coverage?
- Does your health center maintain a physical plant inventory and is it updated every year?
- Are appraisals for buildings and other key assets up to date and are the updated values included in your health

Natural Disasters

- Severe weather
- Hurricanes
- Tornadoes
- Fires
- Flooding
- Earthquakes
- Mud slides
- Widespread life-threatening infectious disease outbreaks, such as an influenza pandemic

Technological Events

- Utility and power failures
- Water supply failures
- Critical resource shortages

Human Caused Events

- Urban fires
- Chemical spills
- Civil disorder
- Industrial plant accidents
- Nuclear plant malfunctions causing radiation release
- Transportation accidents, such as a plane crash or passenger train derailment

Terrorist Incidents

- Bomb threats
- Sabotage
- Hijacking
- Armed insurrection, which threaten life or property
- CBRNE (Biological/Chemical/Radiological/Nuclear/Explosive agents)

For each of these categories, consider the following questions:

- How likely is the event to occur based the known risk and historical data?
- Could people die or be injured if it happened?
- Would our health center and/or the equipment inside be damaged if it happened?
- Would we have to close our health center? If so, for how long?
- How prepared are we currently to respond if it happened?
- Have we met with our community partners to develop a response?
- Do we have what we would need to respond? Do we have a plan? Have we tested the plan?
- Is there someone that can help us if it happened? Do we have any agreements for supplies or resources if it happened?

Many of the templates that are available will ask for a numeric response to each of the above questions (1 = low, 2 = moderate, and so on) and will take these numbers to calculate the relative threat for each event. This will help to focus your priorities and guide your plan development.

As part of working with outside agencies in the planning process, it is important to contact city and county planning commissions, state and local health departments, and federal, state, and local emergency management offices to assist in identifying specific hazards that could affect your health center's facilities and business operation. These agencies may have already determined potential vulnerabilities for the community and specific locales. Your health center should also seek to coordinate and share information with your partners, and work collaboratively in the risk assessment and mitigation process.

Appendix C of this resource document includes a hazard vulnerability assessment. Additional examples of risk and hazard vulnerability assessments can be located on the Federal Emergency Management Agency website at www.fema.gov. The National Association of Community Health Centers (NACHC), www.nachc.com, offers additional examples in their Risk Management Series.

Insurance Coverage

An important part of mitigation is the identification of insurance needs for your center. All health centers should review insurance coverage(s) at least annually, including consultation with insurance agent(s) to determine if the current coverage(s) are adequate to protect your center for risk of loss, as a result of any potential occurrence, including business interruption losses. Inadequate insurance coverage can have devastating financial consequences on a health center's business operations. Unfortunately, most organizations discover insurance coverage is inadequate only **after** suffering a major loss.

In evaluating insurance needs, consider all types of coverage including property, liability, business interruption, and income/revenue losses due to a disaster or other emergency. The following are some of the important issues that you should discuss with your insurance carrier(s):

- Types of insurance coverage needed including property, professional liability, general liability, automobile(s), mobile medical/dental unit(s), equipment operation, directors and officers liability; and business interruption/loss of revenue, etc.;
- Property value for buildings, contents, and major equipment - be sure to maintain an up to date physical plant inventory, supply inventory, and appraisal of these assets;
- Amount of insurance required in order to be adequately covered and avoid the possibility of being under-insured and becoming a co-insurer;
- List of assets that are and are not covered;

- How coverage for assets will be determined (i.e. replacement value); If so, what is the current replacement value of covered equipment and assets;
- Causes of loss covered by the policy(s), factors that may affect coverage levels, and how to avoid/mitigate losses for events/causes not covered;
- Deductibles, including the amount(s);
- Insurance policy requirements of the health center in the event of a loss;
- Timeframe for reporting losses, types of records and documentation required by the insurance company, and safe storage of key records;
- Extent of coverage for lost income/revenue and supplies due to power interruption that occurs both on and off the health center's premises, the period of time before coverage begins, the duration of coverage, data required to document the loss, and any other limitations on the amount of losses covered;
- Extent of coverage for lost income/revenue due to business interruption, types of interruptions covered, the period of time before coverage begins, the duration of coverage, and any other limitations on the amount of losses covered;
- Extent of coverage for reduced income/revenue due to the loss of business resulting from displacement of the customary population served due to a disaster/emergency, the period of time before coverage begins, the duration of coverage, and any other limitations on the amount of losses covered;
- How business interruption income/revenue losses will be calculated and the historical and post event data required for validating the value of losses;
- How the health center's emergency management program will affect insurance rates; and
- Timeframe for when receipt of insurance payment(s) can be expected.

PREPAREDNESS

While it is not possible to eliminate or mitigate all potential disasters or other emergencies, your center can take proactive steps to be prepared in the event of an emergency. This includes planning, training, and conducting drills and exercises to determine the effectiveness of your health center's EMP. In preparing for a potential disaster or other emergency, all employees of your center should know their role, responsibilities, and task assignments during an emergency. Specifically, be sure that everyone in your center knows what to do, where to report and who (or which ICS position) to report to, assigned duties, persons in charge of various aspects of the response, and who and how to report critical emergency information.

All staff should receive training on the EMP and participate in annual drills and exercises to reinforce training and improve results of the response to a disaster or other emergency. Smaller scale drills and exercises can also be conducted on quarterly or semi-annual schedules, and can address specific, focused elements of an EMP (i.e. donning/doffing PPE and communication plans). Everyone should be encouraged to report any area of operational concern, which could adversely affect your health center's ability to effectively respond to an emergency and/or recover from the impact of a disaster. This includes ideas on how to mitigate potential losses.

Roles and Responsibilities

In all organizational activities, it is important to define the roles and responsibilities of the person(s) who will be tasked with carrying out the activities and the chain of command for decision-making and obtaining critical resources to carry out the activities. Federal, state, and local government emergency management offices utilize the National Incident Management System (NIMS) and Incident Command System (ICS) to define roles and responsibilities in the event of an emergency.

The ICS is a way of uniformly managing resources, such as facilities, equipment, supplies, and personnel from different organizational units during times of emergencies. The NIMS is a system that provides an integrated approach for federal, state, local, and tribal governments, nonprofit, and private organizations to work effectively together to prepare for, respond to, and recover from disasters. There are numerous online training courses that provide an overview of ICS and its relationship to the NIMS. See Appendix N for more information.

Critical Questions to Ask Your Health Center for Preparedness Activities

- Are there defined the roles and responsibilities for all employees in the event of an emergency, identifying who is responsible, standard operating procedures for each functional role, and how to respond?
- Has an Emergency Management Coordinator been designated?
- Is there a communications plan, including back-up communication methods if the primary systems fail, or there are community-wide communication failures?
- Is there a comprehensive plan for continuity of operations, handling a surge in patient demand, and communicating with staff, the public, and the media?
- Are there emergency supplies and temporary sources for medications, medical supplies, and other emergency needs been identified?
- Have any exercises been conducted to test the plan or are any planned?
- Is there a financial management plan in the event of a disaster?
- Are the facilities and equipment adequately safeguarded against physical disasters and are these assets properly insured?
- What losses are covered by FEMA?
- Is there a backup and recovery plan for IT systems?
- Is there coordination with federal, state and local authorities?
- Are all health center staff trained on the EMP policies and procedures, as well as their likely roles?
- Are all relevant government regulations and standards associated with emergency management planning identified and incorporated?

To organize and coordinate activities in your health center during a response, it is important to establish an emergency response team (ERT). This team may or may not be the Emergency Management Committee. The members of **the ERT will serve as the leaders in an Incident Command System Structure**. There are five categories in the ICS structure and include Administration, Operations, Finance, Logistics, and Planning. In determining the make-up of the team and the roles and responsibilities that it will cover, you should consider the following:

1. The team should consist of members of the disciplines represented by the health center and include factors and credentials, which constitute being part of an emergency response team.

EMERGENCY RESPONSE TEAM	
Administration	<i>Chief Executive Officer/Executive Director or designee responsible for facility, policies, and regulations</i>
Operations	<i>Chief Operating Officer, managers and supervisors responsible for daily operations, health care service providers, resource management, patient enabling, medical records, personnel safety, and operating procedures</i>
Finance	<i>Chief Financial Officer and finance staff responsible for billing, payroll, purchasing, tracking expenditures, and managing IT systems</i>
Logistics	<i>Employees responsible for facility maintenance, mechanical and communications systems, security, and medical supply inventories</i>
Planning	<i>Employees or board members responsible for community outreach and coordination with outside agencies including governmental entities</i>

2. Identify the roles and responsibilities of each team member and entity.

The roles and responsibilities of each team member should be specified including position assignment, scope of command, line of authority, description of duties, and detailed duty checklists in priority order. Within the ICS/NIMS model, these are commonly referred to as Job Action Sheets (JAS). JAS templates for each position within the EMT should be prepared ahead of time, included in the EMP, and made readily available to whoever takes on the assignment to any of the EMT positions. The authority for an internal emergency should reside with your health center's CEO or designee(s). In order to maintain lines of authority to initiate a state of emergency, it is important to plan 'three deep' and designate a primary, secondary, and tertiary individual with the responsibility and authority in the absence of the primary individual.

In the case of an external state of emergency being issued, the same procedure for notification of health center personnel should apply, but the action(s) taken by your health center may differ dramatically. Your health center may be placed on an alert or stand-by level in support of an actual or impending event as directed by local, state, or federal authorities.

3. Identify the flow of leadership and authority for your health center, including who determines a state of emergency, and who initiates the plan.

Depending on your health center's size and emergency management capabilities, this section, which defines the individuals and system for the health center's emergency management operations, may vary greatly. The following are elements, which should go into this section of the EMP:

a. Designation of an Incident Commander

The Incident Commander (IC) is in charge of command and control for all aspects of an emergency. It is essential to identify a clear chain of command to eliminate employee confusion regarding who has authority for making decisions during an emergency. The IC is responsible for the "big picture" and controls all incident related activities.

b. Personnel Management

As indicated previously, when selecting personnel to fill emergency roles, consider individuals with decision-making authority who have expertise in the following areas: security, safety and health, clinical operations, human resources, finance, environmental, maintenance, public relations, planning, and logistics. The following procedures should be implemented:

- Assign personnel to specific emergency preparedness and response roles based on areas of expertise
- Develop Job Action Sheets for each position and prepare checklists that summarize the procedures in priority order to be used as quick references
- Remember the 'three deep' philosophy and identify backup personnel for all personnel with emergency responsibilities. There should also be a clear line of succession identified for key positions
- Ensure all personnel, including backup personnel, are adequately trained for/able to execute emergency management assignments
- Ensure all personnel are familiar with how to recognize and report an emergency, warn co-workers, adhere to facility security and safety measures, and health center evacuation procedures

Your Health Center is Getting Prepared – Is Your Staff?

The plan developed for your health center could be the best on the face of the earth but if your staff is not prepared to stay at or return to work, the plan is virtually worthless. Remember to incorporate personal and family preparedness support for your staff as you prepare your health center for emergencies. People are more likely to stay at or come in to work if they know that their families are safe and cared for.

Start with providing some basic information about personal preparedness and offer some easy to use templates for making family plans. Most family plans are basically a contact list and arrangements made with family, friends, and neighbors to pick up children, care for children if schools or daycares are closed, feed the pets, and so on if the staff member can't be home to do these things.

Some health centers have guided their staff in building small caches of food, water, and supplies in their homes. It is recommended that everyone have at least 3 days of food and water (minimum one gallon of water per person per day is the standard recommendation) plus any health sustaining medication on hand in case a disaster strikes and grocery stores and pharmacies are closed. Purchasing items in bulk may facilitate the collection of home emergency supplies for large numbers of staff members, as well as reduce the financial burden borne by individuals when purchasing relatively large stores of food, water, and supplies.

Communication and Notification Considerations

Communication systems and plans for disseminating information are critical elements in preparing for potential disasters and other emergencies. Determining who needs to be notified, what events require notification, and the priority rank of those notifications should all be considered during the planning process. This includes communicating with everyone affected by a disaster or other emergency, such as family members, government officials, staff and board members, patients both onsite and offsite, the public at-large, other health care and social service providers, key suppliers and vendors, and emergency management response partners.

The ways that you inform your constituents can range from government-based early warning systems to your health center's internal and external communication networks, and include various types of communication equipment for both voice and data communications. In establishing communication dissemination systems, it is important to consider the potential failure of communications equipment (telephones, telephone lines, wireless services, internet service, cell phones, pagers, walkie-talkies, ham radios, etc.) during an emergency. Other potential communication failures include the loss of power to run the communications equipment and failures with other linkages in the communications network, such as high call volume overwhelming a cellular phone company's system. This includes temporary/short-term disruptions and/or total failure. As such, planning for alternative means for communications and restoring communications capability is a critical aspect of the EMP. A list of communication system options is included in Appendix G of this resource document.

Emergency communication plans should consider:

- Everyday functions performed by your health center and the communication systems, both voice and data, used to support them.
- Impact on your center's business operations if communication systems are rendered inoperable, as well as how failure of communications equipment will impact emergency operations.
- Prioritizing all communication systems, and determining which should be restored first in an emergency, as well as establishing procedures for restoring communication systems.
- Contacting the communication vendor(s) about their emergency response capabilities.
- Determining the need for backup communications. Options include messengers, cellular telephones, portable microwave radios, amateur radios, point-to-point private lines, satellite, basic wired telephones that are connected directly to a land line (in other words, not cordless, part of a larger phone system, or requiring electricity to work), etc.

Communications will be needed for staff, officials, patients, and the general public throughout the response to the emergency. These will include communications relevant to:

- Activating the ICS structure.
- Ensuring safety of staff and patients during an emergency.
- Activating plans for resuming health center business operations.
- Disseminating information about continuity of services or any other arrangements made for temporary service locations for patients and the community at large.
- Activating plans for responding to a community-wide need for emergency health care.

- Coordinating with local, state, and federal officials in response to an emergency.
- Coordinating your center’s response with the State Primary Care Association and other entities.
- Coordinating with HRSA, Project Officer(s), and funding agencies.
- Collaborating with the local health care provider network.

Systems should be in place to immediately alert the ERT in the event of an accident involving hazardous substances, or an imminent threat of an accident, which would require the ERT’s involvement. This notification to emergency management personnel should trigger the implementation of the Emergency Management Plan.

The designated health center spokesperson is referred to as the Public Information Officer (PIO) in the ICS structure and should have the necessary knowledge, skills, authority, and credibility to effectively communicate with the media and the public at-large. The PIO should be as open as possible in providing information during and after an accident. The PIO should be timely in presenting information, admit when information is not available, avoid making promises which cannot be fulfilled, and ensure the messages provided are consistent with actions taken. Depending on the scale of the incident it may be necessary to coordinate these messages with the local health authorities. In the case of a large scale event, coordination of messages with the Joint Information Center (JIC) organized by the lead emergency management agency in your area to conduct crisis communications where multiple organizations must collaborate to provide timely and accurate information to the public and other stakeholders may be required.

Continuity of Operations

Planning for the continuity of business operations is an essential component of the EMP. There are many different events that could disrupt the operations of your center, which may last for only a short period of time, or potentially cause long-term closure and the need for more complex recovery steps. Developing plans for resuming health center operations as quickly as possible are critical to both the health care needs of your community and the health center’s financial wellbeing.

Your health center should develop operational policies for emergency response periods, including policies for the acquisition of emergency resources for employees, patients, to meet surge needs, and/or to resume operations. This may include temporary or volunteer staff, medical supplies, medications, food, water, fuel for generators and other consumable items. It can also include modified hours of operation; temporary site locations; use of mobile units, tents, and vans; and obtaining necessary medical equipment to meet a surge in patient health care needs.

Seven Principles for Continuity of Operations

- 1. Succession***
- 2. Pre-delegation of authority***
- 3. Emergency action steps***
- 4. Designated health center emergency operations facilities***
- 5. Alternate emergency operations facilities***
- 6. Safeguarding of vital records***
- 7. Protection of facilities and personnel***

Succession: Identify and designate emergency management interim personnel with the authority to implement emergency management response provisions in the absence of the normal and established hierarchy. The identified chain of successors should be sufficient for each critical position to allow for absence, injury, or inability to act. The identification of successors should be by job title, not by name.

Pre-Delegation of Authority: A Board of Director's approved statement specifying the authority and chain of command for the health center's emergency management team members and/or successors to direct the emergency management response for your health center.

Emergency Action Steps: A list of actions to be taken when disaster strikes or an emergency arises including notification of authorized personnel, steps to activate portions of the emergency management plan, and to acquire resources (e.g., medical supplies, equipment, food, water, etc.). This can be accomplished through the establishment of MOUs with volunteer organizations and contractual agreements with key vendors and suppliers. Preparation of action steps ensures essential considerations in personnel and facility protection will be addressed during times of system stress. Action steps should be validated during training exercises and amended when deficiencies are identified.

Health Center Emergency Operations Center (EOC): The pre-designated location(s) from which health center emergency management and/or continued business operations can be directed and controlled. A variety of circumstances may require the use of temporary sites, due to issues such as debris build up, high water levels, toxic fumes, power failures, damage to roofs and structures, etc. Preplanning the use of temporary facilities is essential to ensure a rapid transition during an emergency, including consideration of access, power, communications, personnel protection, and security as well as for ensuring the location has not been identified for some other purpose. Provisions for alternate EOCs should be considered and preparations made before a disaster strikes.

Safeguarding of Vital Records: Part of the emergency management planning process includes the identification of essential records, documents, and forms required to initiate and sustain emergency business operations. Policies and procedures need to be in place to assure electronic records are routinely backed up and maintained in a secure off-site storage system, along with plans for required software, hardware, and supplies to resume utilization of Information Technology (IT) systems in the event of a total loss of these systems in a disaster. It is vital to eliminate reliance on personal computer drives and private data storage for all critical segments of the health center's operations. It is also very important to note that two IT/EHR systems running on the same line, or maintained in the same location and/or by the same service providers are NOT redundant IT/EHR; they are simply two systems running parallel to one another. It is likely that if one fails, the other one may be at increased risk of failing as well. Agreements with key vendors and suppliers for IT systems should be in place before a disaster occurs. It is also important to consider ways to mitigate the loss of patient medical records. Implementation of electronic medical records is one of the best methods to avoid a total loss of patient medical records during a disaster that destroys a health center's facility(s).

Protection of Facilities and Personnel: Emergency management operations will rely on many 'business as usual' activities, such as billing and placing supply orders, and the personnel who perform them. Protection of these assets is essential. In most cases, vital records will be a major resource, which has been addressed above. Plans should address the protection of employees, patients, and visitors. Facility evacuations should be planned in advance of an emergency or disaster and accountability for employees is a key consideration in evacuation planning. The best way to test and improve these plans is through the execution of exercises such as fire drills. In some cases, evacuation may not be feasible, and the EMP should consider alternatives to evacuation, such as sheltering-in-place, to ensure safety based on the emergency circumstances. Designated officials should have the authority to initiate any personnel protection plan. The EMP should also provide for the authority to waive the evacuation plan, if a determination is made that safety would be more threatened by leaving the facility.

Other Key Business Continuity Planning Considerations

Memorandums and Agreements

It is important to develop memorandums of understanding (MOU) with volunteer organizations, mutual aid agreements (MAA) with local government, other health centers in your area, and health care emergency response offices, and contractual agreements with key vendors and suppliers to help support your response during an emergency. The content of MOUs, MAAs, and contractual agreements will depend on the vulnerabilities and identified needs of your center in an emergency, the nature of activities covered by the agreement(s), the capacity of the entities to fulfill the agreements, and other considerations specific to your center and partnering organization(s) in the event of an emergency or other disaster. There is a sample MOU for your reference in Appendix E.

MOUs, MAAs, and contractual agreements for emergency situations will generally include the following considerations:

- Purpose of the MOU, MAA, or contractual agreement;
- Events which invoke agreement activities;
- Notification requirements;
- Responsibilities of each party;
- Effective period, terms, and other considerations;
- Modification and amendment procedures;
- Responsibility for compliance with applicable laws and standards;
- Indemnification; and
- Renewal and termination procedures.

MOUs may be entered into between your health center and volunteer organizations, to fulfill resource needs and coordinate emergency management response and disaster recovery activities. These agreements should also be coordinated through local public health departments and local emergency management planners as part of the larger emergency management plan. These types of agreements may be entered into before and/or following an emergency or other disaster. An example may include a MOU with a volunteer organization, which may agree to supply a mobile medical unit, so the health center can continue to provide health care services in the event that the health center's facilities are rendered temporarily or permanently unusable as a result of a disaster.

MAAs may be entered into between the health center, local government emergency response offices, and emergency health care coordinating agencies, in order to provide mutual assistance in responding to a surge in health care demand due to injuries and other medical needs of the community as a result of a disaster. An example may include an agreement to provide physicians, nurses, and clinical support personnel to staff emergency medical operations located in tents, shelters, temporary emergency operation sites, and/or at your health center's facilities. The limitations of Federal Tort Claims Act (FTCA) and other malpractice liability coverage must be considered when entering into these types of arrangements. Be sure to review Policy Information Notice 2007-16, 'Federal Tort Claims Act (FTCA) Coverage for Health Center Program Grantees Responding to Emergencies.'

Contractual agreements with key vendors and suppliers may include clauses for assistance in providing emergency equipment, restocking of critical supplies, and other considerations to assure the continuity of business operations. An example may include assistance from software and computer hardware vendor(s) to reestablish information management systems, including practice management systems, electronic medical records, billing and collections systems, accounting and payroll processing systems, and other business management applications.

Clinical Patient Surge Preparedness

The aftermath of a disaster is often involves a surge in demand for medical services, including immediate attention for injuries, treatment of acute infectious diseases due to contamination of water supplies, and treatment for chronic illnesses such as asthma, diabetes, heart disease, etc. exacerbated by an emergency event. A disaster may result in the relocation and/or dislocation of a significant portion of the affected population to other geographic areas outside of the disaster area. The degree of relocation and/or dislocation of the affected population can be minor, as seen in certain localized incidents, or massive in the event of a major catastrophic disaster. Health centers may be affected by either situation, experiencing a significant surge in demand, a significant decrease in operational capacity, or a significant decrease in demand due to the relocation and/or dislocation of the population served.

Health centers should have a clear understanding of surge capacity, which is the ability to respond to a sharp increase in demand for medical services. This includes identifying ways to handle patient surge based on existing clinical capacity. This planning may require that health centers work closely with local healthcare providers, such as hospital emergency departments, in order to develop a cohesive and manageable community response in the event of patient surge during or after a disaster. Health centers should assess the likely medical needs for various potential emergency events, along with the corresponding medical supplies, diagnostic test, and medications required to effectively respond to the expected emergency medical needs. This assessment may find that your health center can NOT adequately handle a surge, and therefore must work in concert with other healthcare providers to maximize the overall surge capacity in your community. Appendix D of this resource document includes a sample model for expanding clinic operations – surge plans. The considerations for clinical patient surge preparedness include:

- Procedures for securing additional clinical personnel
- Sources for supplemental medical supplies, vaccines, and pharmaceuticals
- Changes in operations, including expanded hours, temporary locations, and/or mobile units or vans

Sources for Supplemental Medical Supplies, Vaccines, and Pharmaceuticals

In response to a major disaster, there often is an influx of medical supplies, vaccines, and pharmaceuticals from a variety of public and private sector sources. These resources are important since the demand for services can outstrip the availability of these non-durable medical supplies on hand at health centers. While there are many logistical tasks to be accomplished, access to these supplies is crucial to the provision of health care services to the affected population. As such, your center's EMP should:

- Identify potential sources for medical supplies, pharmaceuticals, and vaccines along with contact names and numbers in advance of an emergency or disaster. This includes coordination with federal, state, and local emergency response offices, supply vendors, and volunteer disaster assistance organizations.
- Develop a system of warehousing and distribution for supplies and donated goods. Identify the location(s) where supplies will be stored, the inventory management procedures, and the system for distribution.

Changes in Operations including Expanded Hours, Temporary Structures, and/or Mobile Units and Vans

After a disaster an initial damage assessment should be conducted of the facilities and operating capacity to determine where, and the extent to which, existing service sites can be utilized to provide health care services to handle a surge in patient demand following an emergency and to reestablish routine business operations. In situations where existing facilities are not useable, establishing plans for temporary structures and locations is a

potential alternative in order to meet surge needs and to resume services. The Agency for Healthcare Research and Quality (AHRQ) has a tool to help state and local officials quickly locate alternate health care sites if hospitals are overwhelmed by patients due to a bioterrorism attack or other public health emergency. This may be helpful if faced with the need to temporarily relocate. The tool can be accessed at www.ahrq.gov/research/altsites.htm.

Expansion of hours is an alternative at facilities that are intact and functional, to accommodate a surge in demand, to increase capacity in the event of the loss of other operating locations, and to provide the broadest possible availability of services to the affected population. In addition, mobile medical units and vans can play a dual role of establishing a temporary health care delivery point, as well as, providing the capability to reach affected areas of the community, particularly when damage to transportation systems, roadways, and bridges hinders patient access to services after a disaster occurs. Such mobile outreach capabilities may also better enable health centers to reach out to rural migrant populations or other populations that may be reluctant to go to hospital emergency rooms or other temporary healthcare treatment centers. EMPs should include:

- Procedures for the assessment of damage to the facilities and evaluation of your center's ability to continue operations. This includes a profile of normal operations and determination of the circumstances under which the center may need to temporarily discontinue non-emergency services, and/or cease all operations.
- Plans and procedures for alternative site locations and mobile units, to assure continuity of operations and to accommodate a surge in demand for services during an emergency.
- Plans to alert your patients and community to the changes in location, hours, and services provided.
- Procedures for expanding hours of operations during an emergency, when possible, should include appropriate employee considerations and alternate staffing plans.
- Plans and procedures for securing and utilizing mobile medical and dental units and vans, including staffing, equipment, expendable supplies, waste management, and liability protection. This includes provisions for replacing mobile medical and/or dental units damaged or destroyed in the disaster.
- Procedures for informing the HRSA Project Officer of emergency activities, operational status, changes in patient demand, surge activities, and the impact on the health center's scope of services. It is also important to work with the PCA in your state to develop procedures to communicate with them and other health centers in your state during an emergency.

Financial Management Considerations

In preparing for potential emergencies, it is important to include financial management considerations, including the financial resources necessary to respond to various emergencies, as well as financial management processes relevant to assuring continuity of business operations. Financial management considerations include:

- Establishing strategies and business planning models to assure sound financial results from operations at all times, to be in the best possible financial position in the event of a disaster or other emergency.
- Establishing an emergency management budget and process for estimating additional costs for responding to a variety of potential emergencies and disasters based on the hazard vulnerability assessment.
- Conducting a thorough risk management assessment to assure adequate insurance coverage is in place to mitigate losses sustained during a disaster including property and equipment losses and business interruption losses.

- Establishing a cash reserve to support payroll, essential vendor payments, and purchase of goods and services necessary for response and recovery activities.
- Establishing procedures and strategies to safeguard information management systems from loss of data and loss of operational capacity. This includes safeguarding electronic medical records, practice management, billing and collections, accounting and payroll, pharmacy, lab, key administrative files and other information management systems used in business operations, including hardware and software. This may also include consideration of methods by which paper health records can be protected, preserved, and accessed either during or after an emergency.
- Arranging for continuation of key supplies, services, and equipment to maintain business operations through contractual agreements and MOUs. This includes medical supplies and equipment, medications and pharmaceutical supplies, contractual services, and replacement or temporary equipment during the response or immediately following an emergency, including IT and communications equipment.
- Arranging for temporary facilities to continue business operations. This includes mobile units, modular units, rental, and donated space.
- Establishing strategies for handling the loss of utility and telecommunication services, including power, water, sewage, telephone, Internet, and disposal of debris, trash, and hazardous medical waste or other materials.
- Establishing procedures and strategies to minimize the loss of revenues. This includes procedures for tracking services provided during the response to an emergency for billing and reporting purposes, including manual record keeping methods should electronic systems be disabled or fail. Informing the Medicare Fiscal Intermediary and State Medicaid Office of any temporary locations within the Bureau of Primary Health Care approved scope of service. Credentialing of temporary and volunteer provider staff for billing purposes. The State Medicaid Program may issue a waiver and special criteria for program eligibility during a significant disaster for uncompensated care. Plans should factor in maintaining sufficient records to qualify for these funds.
- Establishing procedures and strategies to maintain cash flow, financial reporting capability, issuing of payrolls, reporting to funding agencies, and other day-to-day aspects of financial management. This includes establishing operating reserves and lines of credit, manual methods for tracking financial transactions in the event that all electronic systems fail, obtaining emergency check supplies and other business forms, and working with the bank and key funding agencies to maintain financial transaction capabilities.
- Maintaining financial data and other information necessary for filing insurance claims for reimbursement of covered losses and FEMA applications for covered losses and the costs specific to an emergency response during a declared national disaster.
- Arranging for temporary staff to augment the health center's needs in response to a major event or to continue business operations. The EMP should plan for potential surges in patient demand due to evacuation from an impacted area or region. A number of solutions should be explored to assist in dealing with increased patient demand. These include:
 - In the short-term, regional planning can be beneficial in determining the potential staff available across health centers within a given region and the willingness of other regional or state health centers to share staff on a temporary basis. These arrangements between health centers will require a letter of agreement or MOU between the organizations and can work well in the short term. The State Primary Care Association may be able to assist in facilitating these efforts.

Health centers should consider malpractice insurance coverage issues, as FTCA will not cover volunteers.

- Long-term personnel support may be available from a variety of resources within the local, state, and federal emergency management community. State health departments and homeland security/emergency management offices have access and knowledge of this process and would be a good starting point for health center planning.
- Housing of temporary staff should be coordinated with the health center's emergency management partners. When sharing personnel within the region or state, housing options for the short term could be with other staff of the health center or local emergency management agencies.
- Establishing procedures and strategies for securing the health center's facilities, equipment, and supplies, including securing medication and pharmacy supplies. These may be damaged or destroyed due to natural elements or theft from intruders. In the event of a major emergency, reliance on external security and law enforcement may not be realistic.
- Assuring adequate supplies and protective equipment for use in response to a disaster or other emergency.

Equipment and Facilities

Assuring adequate equipment and facilities are essential elements for all business operations before, during, and after a disaster has occurred. Establishing practices to safeguard these essential assets is a fundamental component of financial management, including maintenance, repair, security, and insurance coverage. Preparing for equipment and facility disruptions during a disaster or other emergency are critical components for maintaining health center business operations. Health centers should also consider the differences relevant to facilities and equipment that are leased versus owned in preparing for continuation of health center business operations.

Questions to consider regarding facilities and equipment include:

- Are facilities and equipment adequately maintained, repaired, and updated to avoid losses due to neglect or untimely repair? Failure to maintain and repair equipment and facilities may pose a risk for a disaster, and/or exacerbate the impact of a disaster; such as, a roof collapse, out of date software and equipment for key business operations malfunctioning or no longer being supported.
- Are facilities structurally sound and/or can steps be taken to improve the structural integrity of the facility(s)? Is the roof and foundation sound? Are drainage systems functioning properly? Can the facility withstand expected wind levels for commonly occurring weather conditions? Is the facility located in a flood plane or can it sustain significant damage due to earthquakes, tornados, hurricanes, or flooding from storm surges? Can any steps be taken to mitigate these occurrences?
- Are contractual agreements and/or MOUs in place to provide temporary and/or replacement equipment in the event of loss due to a disaster or other emergency? What is the timeframe for receipt of the temporary/replacement equipment? What is the vendor/supplier's capability to fulfill the agreement in the event of various types of disasters or other emergencies?
- If the facility(s) is leased, is the landlord insured? How can the landlord be contacted in the case of an emergency? Does the lease provide for timely repair of damages in order to minimize the disruption of the health center's operations? If the building requires significant and lengthy repairs, does the lease allow the center to cancel and relocate elsewhere without penalty?

- What alternatives are there for establishing temporary facilities? What are the costs of various alternatives? Are there volunteer or other organizations that will donate temporary mobile or modular facilities? Health centers may receive numerous potential offers for assistance during a disaster, which may or may not come to realization. As such, health centers should keep many different avenues open, in the event that preferred options do not pan out.
- If there is a surge in demand for services, is the current facility space and equipment adequate to handle the increased volume? How will additional space and equipment be obtained to meet demand for services in an emergency? What alternatives can be identified in advance of an emergency to expedite facility and equipment needs in order to relocate and/or meet surge demand? How will expanded hours increase the health center's capacity to provide services during a surge in demand or to accommodate the loss of other site locations?

Develop Back-Up Information Technology Systems

Information management systems and the health center's data in general are critical components of business operations, which should be safeguarded before, during, and after an emergency. Equipment lost during a disaster can be replaced, but the health center's business data can be irretrievably lost if proper steps are not taken to ensure adequate retention and backup of critical data, as well as the ability to retrieve stored data in the event of an emergency.

Health centers utilize a variety of electronic information management systems, which are critical to the financial management of the organization, including practice management software, billing and collections software, accounting systems software, and more recently electronic medical records.

Lessons learned during major disasters indicate traditional procedures for backing-up data and off-site storage of backup are not adequate to safeguard data and ensure the data is retrievable. If all data storage locations can be severely damaged or destroyed during an event, then the health center's data is not adequately secured. Health centers need to employ new methods and strategies that are cost effective and proven in order to properly safe guard important and mission critical health center business data.

Off-site storage of electronic information generated by the health center can be costly over time, but should be addressed for continuity of operations planning. Generally, cost savings may be achieved when centers unite within a region or state to share in the expense of data storage. Selecting a vendor for out of state storage or in another region of the country is a good practice.

Businesses and industries located in the neighborhood may have already developed data storage strategies to secure and backup business data and as part of continuity of business operations planning. Health centers should consider contacting local businesses and industries to learn about possible alternatives and to determine if these are options available to the health center. This inquiry may open other opportunities for collaboration in the future.

The health center's capability to immediately access patient data can be hindered by equipment, backup, software, or other system failures, including the ability to restore data from backup media and/or retrieving stored electronic medical records. Health centers should factor in restoration and access issues in preparing for a disaster or other emergency, including emergency equipment and software needs.

Questions to consider in developing back-up information technology systems include:

- Are current back-up procedures and storage of backed up data adequate to properly safeguard the health center's business data? If not, what back-up technology system is appropriate and does this system take into consideration the health center's risk and hazard vulnerability assessment?

- How to acquire an appropriate back-up technology system? What are the costs? How does the system work, including how to complete the back-up procedures and how to restore data from back-up media or remote systems?
- If using a data storage vendor, does the vendor have adequate redundancy built into its systems? Where is the data actually stored? Is the data secured from unauthorized access? What format is the data stored? How is the data retrieved? How will the equipment and software needed to retrieve data be supplied, if the health center's systems are destroyed (software and hardware vendor agreements)? Can the data be retrieved without the relevant software? Is the storage vendor financially sound? What are the potential threats to the storage vendor that could adversely affect retrieval of data? How will the storage vendor support the health center during the response to an emergency? How will the storage vendor support the health center in retrieval and restoration of data after a disaster?
- Has the data back-up and retrieval system been tested to assure functionality? How often is it tested? Are internal procedures in place to assure data is properly up-loaded to the back-up storage site in a timely manner?
- What are the procedures for back-up and immediate access of financial and medical records in an emergency? Who is responsible for back-up procedures? Who has authorization to access stored data? How are financial and medical records retrieved during an emergency? Does the health center have agreements with software and hardware vendors for key business system for temporary emergency equipment or to rebuild systems in the event of an emergency? What are the notification requirements for these agreements? What is the timeframe for temporary equipment or rebuilding systems?

Industry Standards and Government Regulations

Knowledge of industry standards and government regulations is part of routine day-to-day management for any organization and health centers should have corporate compliance plans in place. Standards and regulations also exist for emergency management, and health centers should be aware of these requirements and standards and take steps to ensure compliance. This includes fire codes, building codes, and other local, state, and federal statutes that define emergency management responsibilities and activities, such as requirements for fire escapes, alarms, and sprinkler systems. Also included are standards for incident command, emergency management plan development, and conducting exercises and drills, to name a few.

Industry standards also need to be considered. An example of an industry standard is The Joint Commission standards for emergency management. Health centers accredited by the Joint Commission are required to meet the Environment of Care Standard - 4.10. When the Joint Commission conducts a survey to ensure compliance with these standards, the team will assess, at a minimum, the following:

- How the health center plans, designs, implements, and improves the EMP.
- How the health center has engaged in community emergency management efforts.
- Whether the health center employees at all levels have been trained in their roles and responsibilities in the EMP.
- Whether the EMP addresses all key aspects of emergency management.
- Whether the EMP applies to a variety of disasters on various scales.

Health centers should keep up to date on new or revised requirements and standards. As more information and experience with different types of emergencies are obtained, gaps not previously identified may emerge, which

will result in new procedures, requirements, and standards. Compliance should be an on-going activity and the Emergency Management Coordinator should be tasked with staying on top of the latest emergency management requirements and standards, informing the Emergency Management Committee, ERT, updating the EMP accordingly, and assuring compliance.

RESPONSE

Once an emergency situation has occurred, the immediate priority is life safety. Protecting the health and safety of health center staff, patients, and the public requires a strong Emergency Management Plan, including routes for evacuation, assembly areas out of harms way, and sheltering in-place. Once life safety considerations are handled, attention can be focused toward assessment of damage and resumption of services. It may be necessary to establish temporary operating sites quickly in the response phase of an emergency.

Medical Care

Health centers may play any of several potential roles during a disaster. In a slowly evolving bioterrorism event, for example, the health center may be the initial site of recognition and referral. Later, the health center may function as a Point of Distribution (POD) for a large-scale medication distribution or as an Alternate Care Site (ACS) in coordination with other medical efforts in the area. During an acute mass casualty scenario, the health center may serve as a surge capacity or triage site for larger healthcare facilities. Provisions should be made in advance to delineate and strengthen medical care capabilities in response to a wide range of disasters. Health centers must also plan to provide ongoing primary care to their patients – chronic diseases, acute illnesses, and other medical conditions will continue even in the midst of a disaster. By maintaining the ability to treat your patients, you will help to alleviate some of the congestion of patients seeking treatment elsewhere, such as the local hospital emergency room.

Before a disaster, be sure that your health center has:

Signed up for health alerts: Communications regarding both routine updates and breaking health alerts are available through state and local health departments. Health centers are encouraged to have as many clinical personnel receive these alerts as possible. There also needs to be procedures about the distribution of this information within the health center to be sure that the decision makers get this information in a timely manner. Contact the local health authorities for sign-up information.

Developed an adequate supply of medications and other resources: Shortages should be anticipated during widespread medical emergencies. Therefore, health centers should stockpile a pre-determined amount of medications appropriate for your patient population and basic supplies, which would be needed in such a disaster.

Critical Questions to Ask Your Health Center about Response Activities

- What medical capabilities does your health center have in the presence of different types of disasters?
- What response activities does your health center know it CAN NOT perform?
- Is the health center familiar with the clinical guidelines and protocols as they related to specific hazard plans?
- What internal and external resources are available when responding to an emergency?
- Are there internal procedures for obtaining equipment and supplies that are in high demand after an emergency?
- Is there a detailed evacuation plan that also includes transportation options for persons with disabilities and considerations for persons with limited proficiency in English?
- What procedures are in place for primary and backup communications with the media, government authorities, community, etc.?
- Is there a physical security plan in the event the health center facility(s) is damaged?
- Is there a plan to manage volunteers and donations from the public?
- If applicable, how will the health center respond to the need for decontamination?
- Is there a plan to coordinate mental health support for patients and staff?
- How will the health center address special needs populations?

During a disaster, your health center should:

Maintain communications with public health authorities: Novel infectious diseases and unusual presentation of various conditions require constant updating of treatment protocols and procedures during a disaster. Health centers should be in regular communication with local and regional health authorities to receive current recommendations and provide feedback on the nature of illness presenting in the community. Early and frequent communication with other regional healthcare providers and statewide associations is recommended.

Screen staff for fitness to work: Healthcare providers are often so dedicated to their work and patients, they resist taking time off even when ill. This may be especially true during a healthcare disaster when altruistic pressure to serve is even greater. Nevertheless, sick and potentially infectious providers and staff can do more harm in such a situation simply due to the close proximity of their patients and the numbers of people they are in contact with during an emergency. Therefore, it is crucial for health centers to establish and adhere to “fitness to work” protocols for medical emergencies.

Clearly communicate the health center’s treatment priorities: In an emergency, health centers may take on a role different from normal operations. In fact, the role may vary during the course of the event. Patients will probably not know in advance what services a health center is assuming during a disaster and may become confused or angry when they learn normal procedures have changed. Health centers should clearly identify to patients any changes in medical “mission” or procedures to help facilitate the ongoing provision of care.

Critical Resources Needed during a Disaster

In responding to a disaster, health centers should plan for the resources needed to effectively meet the response needs. It is important to provide for a variety of resources within budget constraints, while other resources may be available from governmental and other sources. Some of the key considerations are:

Generators to restore power in order to facilitate resumption of health center operations. Generators can be the difference between being able to resume operations or not, so obtaining a generator(s) sufficient to meet the health center’s needs is an important part of emergency management planning. If possible, health centers should factor the costs of obtaining and maintaining generators within the emergency management budget. If this is beyond the financial capacity of your health center, explore funding for outfitting your facilities to accept a donated generator during an emergency. Support may be available through the local health or emergency management agency or hospital. Information on obtaining generators during an emergency is contained in Appendix I of this resource document.

Supplies and medical equipment to assure critical supplies and medical equipment are available to support health center provision of emergency health care services. The immediate material needs after an emergency are often related to restoration of heating and air conditioning systems, potable water, etc. It is important to consider the amount and type of supplies and basic medical equipment needed based on the demand at each site and the presenting medical problems, as well as how the supplies and equipment will be delivered to the various locations. Health centers should include plans for quickly re-stocking supplies, coordinating supply needs with local Emergency Operations Centers (EOC), and working with vendors for emergency re-supply orders. Information on medical re-supply assistance during an emergency is contained in Appendix J of this resource document.

Another consideration is the need for personal protective equipment (PPE) and supplies for health center staff to provide protection from exposure to various emergency related hazards. This may include exposure to chemicals, contaminants, biological agents, and infectious materials. Sound medical practices to protect health care staff apply equally in times of an emergency as in routine times. It is strongly recommended that ALL staff, not only medical staff, get fit-tested for N95 or equivalent respirator use and receive hands-on training in the proper use of all PPE (gowns, gloves, N95 masks, and eye/face protection).

In the event of a federally declared emergency, supplies may be available to health centers from the Strategic National Stockpile (SNS). The SNS is the national repository of antibiotics, chemical antidotes, antitoxins, vaccines, life-support medications, IV administration supplies, airway maintenance supplies and medical/surgical items. The SNS is designed to supplement and re-supply state and local public health agencies in the event of a national emergency, especially bioterrorism, anywhere and at anytime within the United States or its territories. Be sure to work with your PCA, local, and state health departments to understand how these supplies would be distributed within your state. Further information on the SNS is available at the CDC's website at <http://www.bt.cdc.gov/stockpile>.

Evacuation and Transportation

The development and implementation of an evacuation plan is a primary action step in the life safety protection of staff and patients. A comprehensive evacuation plan includes the following:

- Determine the conditions or triggers for initiating an evacuation.
- Establish a clear chain of command identifying who within the health center has the authority to order an evacuation. Designate other staff to assist in an evacuation and to account for staff, patients, and visitors after the evacuation is complete (i.e. evacuation wardens).
- Designate specific health center staff to facilitate the shutdown of operations while an evacuation is underway (e.g. shut down servers, HVAC systems, etc.), as well as, the parameters for the conditions, which will require the immediate evacuation of shutdown personnel
- Designate primary and secondary evacuation routes and exits, which should be clearly marked and lighted. Evacuation routes and emergency exits should be wide enough to accommodate the number of evacuating personnel and be clear and unobstructed at all times.
- Establish transportation plans for patients and staff and the circumstances for initiating these plans. This may entail use of vehicles owned by the health center, ambulance services, public transportation, taxis, or other transportation plans and systems initiated by state and local emergency management authorities to facilitate an evacuation.
- Establish specific evacuation procedures for assisting persons with disabilities and those with limited English proficiency, including identifying transportation methods.
- Designate an assembly area outside of the health center where staff, patients, and visitors should gather after evacuation. Establish procedures for further evacuation away from the health center, should the conditions warrant. This may consist of sending staff and patients home by normal means or arranging transportation to an off-site location.

Post evacuation, an accurate count is needed of health center staff, as well as any patients and visitors that were at the health center during the emergency. There will be confusion at the assembly area. It is important everyone remains until a count is completed. The names and last location of any for individuals not accounted for should be referred to the appropriate local emergency response manager. To support effective and efficient evacuation during emergencies, staff should receive training in evacuation and other safety procedures at least annually and upon hire at the health center.

Security

When a disaster or other emergency damages the health center's facilities to the point of rendering the structures open and unsecured, it is important for the emergency response team to take swift action to secure the sites. The EMP should factor in the potential for a security breach, particularly when operating a pharmacy or managing a large supply of medications, including controlled substances, as well as to secure critical equipment, such as computers, printers, etc.

It may be necessary for health centers to post 24-hour security and or move equipment and supplies to temporary storage facilities. The EMP should incorporate procedures and strategies for securing the health center's facilities, equipment, and supplies, from further destruction or loss due to natural elements or theft from intruders.

Crowd control is an important aspect of planning for security in your plan. Large numbers of people seeking health care services or medication may present at your health center and cause considerable disruption. Keeping crowds calm and controlled will greatly reduce the chaos during an emergency. Front line and security staff should complete basic crowd control and risk communication training to support the health centers ability to provide services during emergencies.

Decontamination for Health Centers

Certain disasters may require the need for decontamination, and health centers should consider the potential for decontamination activities in the EMP. It is important to note that specialized equipment and training is necessary for certain types of decontamination. Determine if you can collaborate with your local fire department or emergency management agency to meet this need. Even if you are able to sign a mutual aid agreement with another agency to provide decontamination services at your health center, your staff should still be able to recognize when a person may be contaminated and take appropriate actions to protect the safety and wellbeing of patients and staff. Additional resources include CDC decontamination protocols on hazard specific plans and Occupational Safety and Health Administration (OSHA) guidance regarding biological agent response. This information can be accessed at www.osha.gov/SLTC/biologicalagents/index.html. Detailed information to guide the development of a decontamination plan is presented in Appendix H.

Mental Health Needs for Patients and Staff

The majority of the immediate health concerns after an emergency are concentrated in preventing infectious disease outbreaks, addressing injuries, and ensuring that individuals with chronic diseases have the necessary medications. However, many plans continue to underestimate the importance of addressing mental health concerns associated with disasters. It is important for health centers to systematically plan for the mental health effects on patients *and* staff. The website for the Substance Abuse and Mental Health Services Administration (SAMHSA) Disaster Technical Assistance Center provides a wealth of information on mental health assistance at times of emergencies and is located at www.mentalhealth.samhsa.gov/dtac. See Appendix F for detailed information.

Special Needs Populations, Including Homeless, Migrant, and Residents of Public Housing

Communities are not a homogeneous collection of people. Any particular emergency or disaster may disproportionately affect a segment of the population. It is important to address the needs of the community as a whole by ensuring that special populations receive sufficient attention. This may require more intense outreach to interact with the homeless population, engage migratory and seasonal agricultural workers, attend to residents of public housing, or make necessary accommodations for individuals with disabilities or language barriers.

Since disasters affect a cross-section of citizens within a community, a disaster may result in individual, as well as, collective trauma, which affects the basic social fabric of life that bonds people together. Therefore, cultural

and socioeconomic factors contribute to both individual and community responses to the trauma caused by a disaster.

The culture of the community provides the lens through which its members view and interpret the disaster, and the community's degree of cohesion helps determine the level of social support available to those affected. In other words, a community that is disrupted and fragmented will be unable to provide as much support as a cohesive community.

Cultural competence is a set of values, behaviors, attitudes, and practices within a system, organization, program, or among individuals, which helps people to work effectively across cultures. It refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time.

Culturally competent disaster response services proactively respond to the culturally defined needs of the community. Disruption of many aspects of life and the need for individuals to adapt in difficult circumstances can cause stress and anxiety. Effective emergency response requires familiarity with help-seeking behaviors; customs and traditions related to trauma, loss, and eventual healing; and use of natural support networks of various cultural groups.

Of particular importance is language since it can be a major barrier to service delivery. Affected individuals with limited English proficiency, or those that are hearing impaired may be at a particular disadvantage. State and local emergency response programs generally have few or no staff trained to work with such populations. As a result, many may not receive needed food, medical care, supplies, or disaster mental health assistance information.

It is important to address the needs of the community as a whole by ensuring that special populations receive sufficient attention. This should be a community wide effort involving the health department, other human service organizations, the emergency management agency, health centers, and other stakeholders. This may require more intense outreach to interact with the homeless and elderly population, engage with agricultural workers, attend to residents of public housing, or make necessary accommodations for individuals with disabilities. Health centers should systematically undertake the following steps as part of developing an EMP:

- Assess and understand the community's composition. Identify special population groups within the area potentially affected by a disaster located within the service area of the health center.
- Ensure accurate communication of information in languages other than English by the use of trained bi or multi-lingual and bi or multi-cultural staff, translations of educational materials and documents, sign language, and language interpretation services.
- Be knowledgeable about the formal and informal community institutions that help to meet the diverse need of the community.
- Assess the ability of the health center to interface and address the emergency medical response needs of the special populations, including collaborating with local and state emergency management officials and the health care delivery network.
- Establish procedures and mechanisms to meet the identified medical response needs of the special population groups, including developing transportation and/or mobile medical units, providing interpreters and materials in other languages, identifying other cultural issues, training staff in cultural competency, and working collaboratively with other health and social services organizations to meet the larger needs of special populations in the event of a disaster.

Different racial and ethnic groups affected by a disaster represent specific challenges to the response capacity of the community. The importance of effective communication and cultural understanding is heightened during these times. Proactive steps prior to a disaster can help mitigate some of these issues, such as, involving representatives from the particular group in the planning and training activities.

Individuals with low socioeconomic resources are often faced with an immediate financial crisis after a disaster. It is important to be familiar with federal, state, and local resources for all types of assistance, including who to call and how to refer patients to such services.

Migratory and seasonal agricultural workers may have a relatively transient nature in regard to physical location within a potential disaster area. Extension of services to migrant camps via temporary structures or mobile vans may help to provide healthcare services to this population. Moreover, the importance of linguistic competence through bi or multi-lingual staff or interpreter services cannot be understated.

The elderly are often severely affected when a disaster strikes. A lack of mobility, chronic medical conditions, and relatively diminished resources result in a greater vulnerability. This may require an enhancement of outreach to ensure that the needs of the elderly are understood and met. While this is not the sole domain of the health center, its position and influence within the community creates an opportunity to have a positive impact.

Homeless individuals are probably the most vulnerable population at the time of a disaster due to the lack of protective structures as well as the increased potential for existing mental health problems. Furthermore, the number of homeless swells after a disaster due to the destruction of housing, which can easily overwhelm the community institutions that would normally provide services to this population. Health centers should, if possible, expand services to areas associated with the homeless, as well as assist these patients in interactions with other social service organizations.

Limited financial resources, as well as, transportation difficulties often challenge the residents of public housing. Connection with federal, state, and local resources for all types of assistance will help provide residents of public housing some additional resiliency in the face of a disaster. In addition, providing services to the residents of the housing complexes by mobile van or shuttle service to and from the health center is extremely valuable.

Individuals with disabilities, which involve difficulty with mobility, hearing or vision impairments, and dependence on special equipment or procedures, can feel vulnerable and helpless during emergencies and disasters. Being unable to hear warnings, or to be physically unable to leave one's home, needing to rely on strangers to be evacuated, are often deeply distressing. People with disabilities may be especially anxious about future disasters and may benefit from problem-solving discussions about disaster preparedness prior to an event.

RECOVERY

In the aftermath of a disaster, once the principle threat has passed and the primary concern for protection of citizens from harm has been addressed, it becomes critical to public safety to ensure the speedy yet orderly recovery of the community. Recovery functions include continued, potentially long-term response operations (such as debris removal and disposal, infrastructure repair, etc.), liaison with state and federal response and recovery agencies, damage assessment, and response to the basic needs of the population whom may have lost their homes, possessions, businesses, or jobs. Emergency management plans should address the long-term operations needed to return the health center to 'business as usual'.

Documentation

Health center plans should include detailed steps to assure proper documentation is maintained during a disaster so that the process of filing of insurance claims and applying for assistance and reimbursable emergency activities is more easily completed. Additionally, health centers should establish protocols and methods for tracking business activities for financial management purposes to mitigate revenue losses. This includes tracking encounters for billing purposes and emergency response expenses for potential reimbursement.

Inventory Damage and/or Loss

Once the emergency phase of the response has ended, damage assessments are needed to provide documentation, such as, insurance claims and evaluation of facilities for safety and suitability of re-occupancy. Damage assessment should begin prior to the removal of any debris or the beginning of the recovery phase, and should be well documented. It is also a good idea to take pictures or video of the damage.

Loss of Revenue through Disruption of Services

There are many issues a health center can face as a result of a disaster or another emergency that may place the organization's revenue at risk. This includes the loss of income/revenue due to disruption of facilities, such as short-term closures, movement to temporary locations, reduced facility capacity due to damage, or complete loss of space to serve patients. Revenue losses can also occur due to population shifts as a result of a disaster causing a decrease in patient demand, which can be short-term displacements, or much longer-term displacements, such as occurred in major hurricane disasters.

Income/revenue losses can also happen due to equipment and system failures that result in data losses or the inability to maintain billing and collection functions. Another concern for income/revenue losses is the failure to adequately document activities to properly file insurance claims or apply for emergency response costs from FEMA or other entities. Additionally, data losses may hinder the health center's ability to file required reports, such as the Uniform Data System (UDS), grant reports, and other reports required by funding agencies.

Another issue can be a change in the patient mix, whereby the health center may have greater numbers of homeless and uninsured requiring services due to the impact of the disaster on homes and the local economy. These shifts can alter the health center's revenue streams, resulting in lower revenue collections from patient

Critical Questions to Ask Your Health Center About Recovery Activities

- What procedures for documentation and audit trails have been established to track operations in a disaster and to facilitate filing insurance and other assistance claims?
- What are the procedures for damage assessment and reporting?
- Is there a financial recovery plan in the event business operation disruption occurs due to a disaster that results in the loss of revenue?
- What is the recovery plan for restoring services, especially in the face of physical relocation or limited staff availability and lack of financial resources?

sources. In some cases, the State Medicaid Program may provide for special uncompensated care provisions. Health centers should monitor State Medicaid decisions and follow-through on applying for uncompensated care funds.

As part of the EMP, health centers should fully examine revenue loss risks and develop detailed procedures and protocols for responding to emergencies that will minimize revenue losses. This includes full evaluation of business interruption insurance coverage.

Some of the key considerations for health centers are:

- Develop of processes for tracking uncompensated care and identify responsible personnel and action steps to follow through on applying for special reimbursement should the State Medicaid Office make special provisions (waivers) during an emergency.
- Develop systems to track patients served and other required data elements, including manual systems, should electronic systems for billing and reporting purposes fail.
- Identify back-up billing systems for obtaining timely reimbursement.
- Keep up to date on grants administration issues and changes during an emergency. Recognize that emergencies may not warrant any changes in grant policies. For example, cost accounting policies are usually not changed regardless of a declared or undeclared state of emergency.

In some circumstances, the impact of a disaster or other emergency may result in such a complete destruction of a health center's operating facilities, or so significantly change the local community, that continued operations as they existed pre-disaster are not feasible. In these instances, it may be necessary to re-evaluate the mission and services provided by the health center and the related service area. Health centers may need to scale back services, increase services, change the mix of services offered, or change service delivery methods, depending on the situation.

The potential for marketplace changes should be anticipated in emergency management planning. Lessons learned from the impact of major hurricanes on health centers located on the Gulf Coast indicate recovery from such a tremendous disaster can take a considerable amount of time and resources. Loss of facilities, staff, and the patient base can be devastating to a health center. Additionally, a health center that is not financially sound at the time of a major disaster may face additional threats during the recovery phase, which may jeopardize the survival of the organization.

Needs of Patients and Staff

In recovering from a disaster or other emergency, health centers should take into consideration the potential needs of patients and staff during and after the emergency. There may be increased transportation needs for patients to receive services and for staff to make it into work, or for mobile units to reach patients in isolated locations.

Staff may no longer have homes and may need help with temporary shelter in order to remain ready and available to work. There may be shortages of food and water and other basic needs, such as clothing. Additionally, staff may need some flexibility during work hours to handle personal recovery efforts for their homes and families. Establishing protocols for providing assistance and remaining flexible are important during the recovery phase.

Restoration of Services

Restoration of services is one of the final steps in emergency response management. However, there may be limitations due to damage, relocation of the population, or continuing risks that may require mitigation. In addition to assessment of the physical plant, health centers may be constrained by the availability of human resources. Previous natural disasters have resulted in changes in the availability of health professionals within the affected areas. This can have a ripple effect on the health center's operations since it can affect hours of operations, services provided, and costs to provide such services.

In restoring services within the health center, the following are important questions to explore:

- What services are priorities for the health center?
- What physical locations are important to provide services to the community?
- What are the personnel staffing needs, as well as the means to secure to appropriate staffing for the provision of services?
- What is a reasonable timetable for bringing services back to the community?

After-Action Report

The after-action report provides an account of significant occurrences during the emergency. There are many lessons that can be learned from an after-action report to inform your health center and others about what went well and what didn't go well during a response. An after-action report should be prepared immediately after resolution of the event. A formal debriefing of the event should occur with key management personnel. Topics covered in the after-action report should include:

- Staffing requirements, including a list of individuals who were working during the emergency and their titles and roles.
- Support received by the health center, including any federal, state, or local agency, organization(s), or other entities that rendered assistance, along with the capacity provided and length of time the support was provided.
- Obstacles and problems encountered during the emergency, including the reason(s) they were viewed as such. Also describe efforts that were made, or will be made, to counter them.
- Successes encountered during the emergency, including the reason(s) they were viewed as successes.
- Recommended improvements to the EMP that will make emergency management operations run more efficiently and effectively in the future, along with actions that will be taken to assure implementation.

APPENDIX A

Emergency Management Plan Templates

There are a number of very good templates for Emergency Management Plans specifically for health centers available. To help keep the information in this resource as up to date as possible and to keep the size of this document manageable, website information is provided for these templates. Follow the links below for the most recent version of Emergency Management Plan templates.

California Primary Care Association (CPCA)

CPCA and the California Emergency Medical Services Authority (EMSA) developed the Community Clinic and Health Center (CCHC) Emergency Operations Plan (EOP) Template in 2004. Members of the Clinic Emergency Preparedness Project (CEPP) Working Group also contributed to this publication.

<http://www.cPCA.org/resources/cepp/>

Community Health Center Association of New York State (CHCANYS)

The purpose of this template is to aid Community Health Centers (CHCs) in developing an emergency management plan that guides their response to all hazards. Included are policies, procedures and forms that create a comprehensive plan. These templates may be used to both initiate and maintain emergency management programs.

http://www.chcanys.org/index.php?src=gendocs&link=ep_forcenters&category=Main

Community Health Center, Inc.

The Community Health Center, Inc. (CHC, Inc.), a federally qualified health center in Middletown, Connecticut participated in the 2005 TOPOFF drill. In preparation for their participation in this international emergency management exercise, CHC, Inc. expanded their emergency management plan. A copy of their plan and a video of their experience are available for download off their website.

<http://www.chc1.com>

There are undoubtedly other great examples of emergency management plans developed specifically for community health centers. If you have additional templates that you would like to share, please contact Mollie Melbourne at mmelbourne@NACHC.com.

APPENDIX B

Health Center Readiness Assessments

An assessment of the preparedness level of your health center will provide you with a solid baseline against which you can measure your progress. There are numerous templates available – here are just a few from California and New York that are specific to health centers.

California Primary Care Association

<http://www.cpcpa.org/resources/cepp/>

Community Health Center Association of New York State

http://www.chcanys.org/index.php?src=gendocs&link=ep_forcenters&category=Main

APPENDIX C

Hazard Vulnerability Assessment (HVA)

Here is an example of a Hazard Vulnerability Assessment from Kaiser Permanente. If used as an Excel Spreadsheet, it will calculate the risk for you and create graphs and comparisons that may be helpful in prioritizing your emergency management efforts. You can find this template in Excel at this website: http://www.calhealth.org/public/press/Article%5C103%5CHazard%20&%20Vulnerability%20Analysis_kaiser_model.xls



Medical Center Hazard and Vulnerability Analysis

This document is a sample Hazard Vulnerability Analysis tool. It is not a substitute for a comprehensive emergency preparedness program. Individuals or organizations using this tool are solely responsible for any hazard assessment and compliance with applicable laws and regulations.

INSTRUCTIONS:

Evaluate potential for event and response among the following categories using the hazard specific scale. Assume each event incident occurs at the worst possible time (e.g. during peak patient loads).

Please note specific score criteria on each work sheet to ensure accurate recording.

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



Medical Center Hazard and Vulnerability Analysis

Issues to consider for **preparedness** include, but are not limited to:

- 1 Status of current plans
- 2 Frequency of drills
- 3 Training status
- 4 Insurance
- 5 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 MOB's
- 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 community agencies/drills?
- 2 Coordination with local and state agencies
- 3 Coordination with proximal health care facilities
- 4 Coordination with treatment specific facilities
- 5 Community resources

Complete all worksheets including Natural, Technological, Human and Hazmat.
The summary section will automatically provide your specific and overall relative threat.

HAZARD AND VULNERABILITY ASSESSMENT TOOL NATURALLY OCCURRING EVENTS



EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	<i>Likelihood this will occur</i>	<i>Possibility of death or injury</i>	<i>Physical losses and damages</i>	<i>Interruption of services</i>	<i>Preplanning</i>	<i>Time, effectiveness, resources</i>	<i>Community/ Mutual Aid staff and supplies</i>	<i>Relative threat*</i>
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								0%
Tornado								0%
Severe Thunderstorm								0%
Snow Fall								0%
Blizzard								0%
Ice Storm								0%
Earthquake								0%
Tidal Wave								0%
Temperature Extremes								0%
Drought								0%
Flood, External								0%
Wild Fire								0%
Landslide								0%
Dam Inundation								0%
Volcano								0%
Epidemic								0%
AVERAGE SCORE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0%

*Threat increases with percentage.

RISK = PROBABILITY * SEVERITY		
0.00	0.00	0.00

HAZARD AND VULNERABILITY ASSESSMENT TOOL TECHNOLOGIC EVENTS



EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
		<i>Possibility of death or injury</i>	<i>Physical losses and damages</i>	<i>Interruption of services</i>	<i>Preplanning</i>	<i>Time, effectiveness, resources</i>	<i>Community/ Mutual Aid staff and supplies</i>	
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								0%
Generator Failure								0%
Transportation Failure								0%
Fuel Shortage								0%
Natural Gas Failure								0%
Water Failure								0%
Sewer Failure								0%
Steam Failure								0%
Fire Alarm Failure								0%
Communications Failure								0%
Medical Gas Failure								0%
Medical Vacuum Failure								0%
HVAC Failure								0%
Information Systems Failure								0%
Fire, Internal								0%
Flood, Internal								0%
Hazmat Exposure, Internal								0%
Supply Shortage								0%
Structural Damage								0%
AVERAGE SCORE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0%

*Threat increases with percentage.

RISK = PROBABILITY * SEVERITY
0.00 0.00 0.00

HAZARD AND VULNERABILITY ASSESSMENT TOOL HUMAN RELATED EVENTS



EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	<i>Likelihood this will occur</i>	<i>Possibility of death or injury</i>	<i>Physical losses and damages</i>	<i>Interruption of services</i>	<i>Preplanning</i>	<i>Time, effectiveness, resources</i>	<i>Community/ Mutual Aid staff and supplies</i>	<i>Relative threat*</i>
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)								0%
Mass Casualty Incident (medical/infectious)								0%
Terrorism, Biological								0%
VIP Situation								0%
Infant Abduction								0%
Hostage Situation								0%
Civil Disturbance								0%
Labor Action								0%
Forensic Admission								0%
Bomb Threat								0%
AVERAGE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0%

*Threat increases with percentage.

RISK = PROBABILITY * SEVERITY
0.00 0.00 0.00

HAZARD AND VULNERABILITY ASSESSMENT TOOL EVENTS INVOLVING HAZARDOUS MATERIALS



EVENT	PROBABILITY <i>Likelihood this will occur</i>	SEVERITY = (MAGNITUDE - MITIGATION)						RISK <i>Relative threat*</i>
		HUMAN IMPACT <i>Possibility of death or injury</i>	PROPERTY IMPACT <i>Physical losses and damages</i>	BUSINESS IMPACT <i>Interruption of services</i>	PREPARED-NESS <i>Preplanning</i>	INTERNAL RESPONSE <i>Time, effectiveness, resources</i>	EXTERNAL RESPONSE <i>Community/ Mutual Aid staff and supplies</i>	
		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	
Mass Casualty Hazmat Incident <i>(From historic events at your MC with >= 5 victims)</i>								0%
Small Casualty Hazmat Incident <i>(From historic events at your MC with < 5 victims)</i>								0%
Chemical Exposure, External								0%
Small-Medium Sized Internal Spill								0%
Large Internal Spill								0%
Terrorism, Chemical								0%
Radiologic Exposure, Internal								0%
Radiologic Exposure, External								0%
Terrorism, Radiologic								0%
AVERAGE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0%

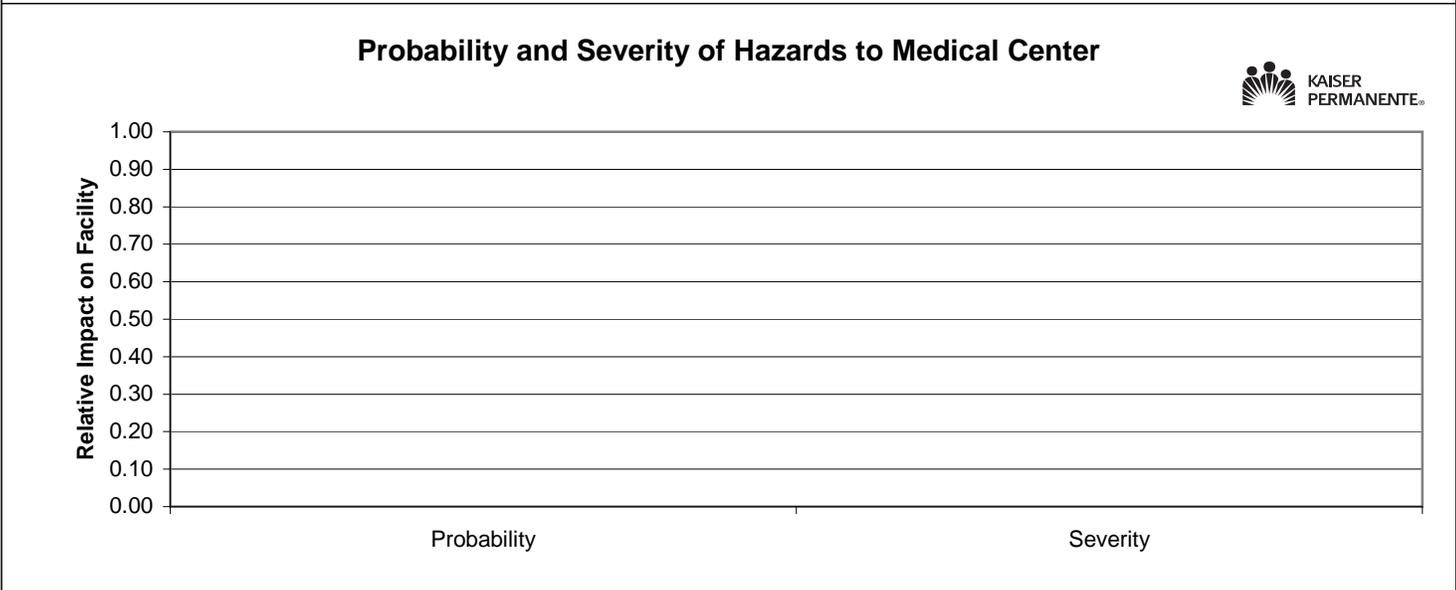
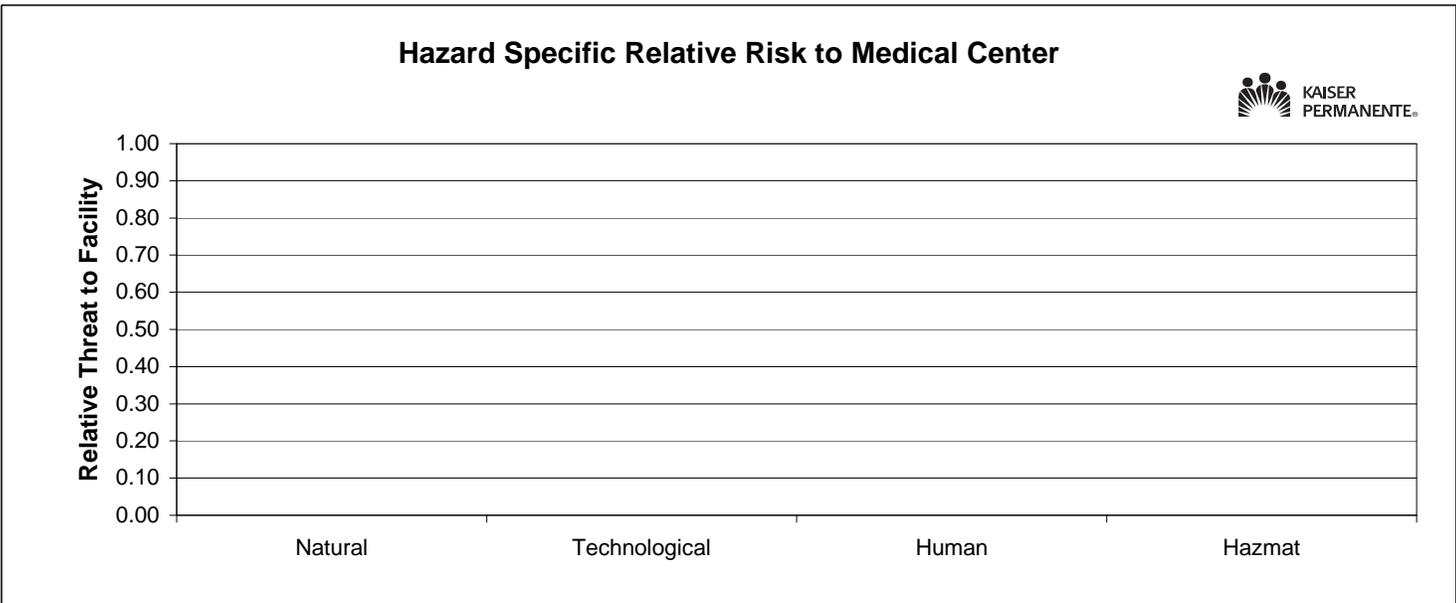
*Threat increases with percentage.

RISK = PROBABILITY * SEVERITY		
0.00	0.00	0.00



SUMMARY OF MEDICAL CENTER HAZARDS ANALYSIS

	Natural	Technological	Human	Hazmat	Total for Facility
Probability	0.00	0.00	0.00	0.00	0.00
Severity	0.00	0.00	0.00	0.00	0.00
Hazard Specific Relative Risk:	0.00	0.00	0.00	0.00	0.00



This document is a sample Hazard Vulnerability Analysis tool. It is not a substitute for a comprehensive emergency preparedness program. Individuals or organizations using this tool are solely responsible for any hazard assessment and compliance with applicable laws and regulations.

APPENDIX D

Surge Capacity Plan Template



Expanded Clinic Operations Model

April 2006

The clinic emergency plan will be activated in an emergency affecting the clinic area, whether or not expanded clinic operations are required. The purpose of this model is to describe key features of expanded operations.

Response Area	Expanded Disaster Operations
Staffing	<ul style="list-style-type: none"> ➤ Assign response teams to cover extended clinic hours. ➤ Close non-medical sites (such as Women, Infant and Child [WIC] sites) and mobilize staff to clinical sites as needed. ➤ Borrow staff from other clinics if feasible.
<ul style="list-style-type: none"> • Clinical 	<ul style="list-style-type: none"> ➤ Acquire additional needed staffing from other clinics for extended hours coverage. ➤ Request clinical Disaster Service Workers (DSWs) as needed. ➤ Implement policies (when available) to credential clinicians on site if the disaster is severe enough to warrant it.
<ul style="list-style-type: none"> • Mental Health 	<ul style="list-style-type: none"> ➤ Monitor the need for additional mental health staff. ➤ If needed, request staff from other clinics or County Mental Health.
Security	<ul style="list-style-type: none"> ➤ Request additional security if needed from the clinic security service if available. ➤ Use non-medical staff to provide additional security. ➤ Contact local law enforcement. ➤ Control building entry and exit.
Internal Communications	<ul style="list-style-type: none"> ➤ Inform the staff about report-to-work requirements and regular or extended hours. ➤ Utilize the phone tree as needed to contact individuals away from the office; communicate with staff about the disaster and their roles. ➤ Communicate with staff throughout during regular hours and after hours as needed regarding the emergency utilizing a variety of communication tools as needed such as e-mail, cell phones, pay phones, amateur radio, or runners.

Response Area	Expanded Disaster Operations
External Communications	<ul style="list-style-type: none"> ➤ Utilize the external communications phone list to contact the appropriate individuals or agencies such as County Community Epidemiology, the Council of Community Clinics, the CCC representative in the County DOC, the local hospitals, and nearby clinics to assess resources and needs. ➤ Monitor television and radio for information about the disaster; monitor e-mail for EMAN communications. ➤ Provide risk communication to patients and community.
Triage	<ul style="list-style-type: none"> ➤ Establish a triage team; determine whether to treat each patient or request transport to the appropriate level of care. ➤ If the service needed is outside of the clinic scope, refer the patient to a hospital, Red Cross, or other setting with the appropriate level of care as needed.
Treatment	<ul style="list-style-type: none"> ➤ Establish additional treatment areas as needed such as conference rooms, storage areas and other areas. ➤ Cancel previously scheduled non-essential medical appointments. ➤ Provide the level of care that is within clinic capabilities.
Pharmaceuticals	<ul style="list-style-type: none"> ➤ Assess and monitor quantity of pharmaceuticals available at the clinic. ➤ Request emergency supplies from EOC or DOC. ➤ Receive information from the County regarding distribution of the Strategic National Stockpile and direct patients to the appropriate location.
Mass Prophylaxis	<ul style="list-style-type: none"> ➤ Contact the CCC Emergency Preparedness Coordinator at the County DOC to determine the County plan for mass prophylaxis and need for clinic involvement. ➤ If needed by the County, assess the feasibility of providing mass prophylaxis at the clinic site, and report status to DOC. <ul style="list-style-type: none"> • If clinic can provide the service, prepare the facility for mass prophylaxis in coordination with County. ➤ If clinical volunteers are needed by the County to report to another mass prophylaxis site, assess the feasibility of releasing clinical staff, and follow up as appropriate. <ul style="list-style-type: none"> • If clinic can provide volunteers, send them to the County-designated site.

Contact: Emergency Preparedness Coordinator

APPENDIX E

Memorandum of Understanding Template

Developed by Ozark Tri-County Health Center Consortium, Inc. Neosha, Missouri

(Health Center Name)
(City, State)

Memorandum of Understanding In Public Health Emergency

Between the following health agencies (Health Centers Name)

1. **Purpose:** This Memorandum of Understanding (MOU) is entered this XXth day of XXXX, 20XX between the following: (Health Centers Names).
2. **Authority:** This MOU is voluntarily entered into by the agencies with the approval of the Board of Trustees.
3. **General:**
 - a. **Scope:**

This MOU provide guidance and documents agreements between each party to provide assistance to one another in the event of a public health emergency that overwhelms the capabilities of any party. This agreement covers response to all emergency situations to include natural disasters, technological accidents and terrorist attacks involving weapons of mass destruction and communicable disease outbreaks.
 - b. **Assumptions:**
 - Any major public health emergency may affect all parties in this agreement. Each party will prioritize its needs, capabilities and the utilization of available resources. The level of assistance provided to each party will be determined by resources available and to the extent which the supplier is affected by the disaster.
 - The parties may commit to providing maximum assistance to the other but each party's primary mission may take precedence over the other.
 - When any party responds to a request for assistance, the party of whom assistance is requested may petition reimbursement for funds expended.
 - c. **Types of Aid or Support:**

The following types of aid may be exchanged between parties, depending upon the conditions of need and availability and shall include but not be limited to:

- Provide health care and administrative staff
- Provide emergency supplies
- Dispensing of pharmaceuticals
- Decontamination Assistance
- Environmental Sampling
- Epidemiological Investigations

4. Responsibilities:

- a. Each party will provide assistance within existing capabilities in accordance with current guidance and directives
- b. Parties agree to seek indemnification from each other from any settlement, verdict or judgment resulting from any claim or lawsuit arising out of each other's performance under this MOU.
- c. Parties will maintain records of all expenditures for reimbursement purpose in accordance with current applicable directives.

5. Requesting Support:

When requesting assistance, the following information will be provided:

- Name, title, agency and phone number of requestor
- Brief assessment of the situation
- Description of the type and amount of aid needed
- Name, title, location and phone number of the person from your agency that assisting personnel will report to.
- Initial request for mutual aid may be by telephone, in person or fax but must be followed by a written request.

6. Accounting and Reimbursement:

- a. The responding agency will be entitled to reimbursement of expenses incurred as a result of their response and participation.
- b. Billing:
 1. Each agency will keep detailed records of all expenditures incurred.

7. Period of Agreement: This agreement is effective upon date of signature and will remain in effect until all parties agree to amend with mutual consent.

a. Review and Revision:

This agreement will be reviewed every three (3) years or sooner if requested by a participating agency and revised as needed. Amendments may be submitted for consideration at any time. All changes to this agreement will be circulated among the agencies for review. Agreed changes will be in writing

and will then be incorporated into the document and circulated for approval/implementation by obtaining signatures of all participating agencies.

b. Cancellation:

This agreement may be rescinded by mutual consent between the parties. Any party may cancel their part of the agreement by giving at least ninety (90) days written notice.

(Name)

Date

(Name)

Date

APPENDIX F

Mental Health Support

Mental Health Preparedness Phase

The following are some suggested action steps that may help staff and patients cope with the stress of a disaster in a more effective manner:

- Establish clear lines of authority and responsibility to minimize stress by eliminating confusion about who reports to whom.
- Provide regular training on stress management techniques for staff and patients.
- Create a facility evacuation plan and practice drills regularly.
- Provide ongoing training to ensure health center employees are thoroughly familiar with safety procedures and policies.
- Develop guidelines to help staff prepare for deployment into disaster areas or to staff temporary sites or work extended hours.
- Maintain an updated list of family members' contact information for each health center employee.
- Have a pre-established plan for how staff will check on their families if disaster strikes during work hours.
- Develop plans to inform patients about changes in services during a major disaster or emergency.
- Encourage staff and patients to develop family emergency management plans, including consideration of medication needs.

Mental Health Response Phase

At the disaster scene, health centers can provide certain support for staff to mitigate stress and help them effectively perform the tasks at hand:

- Clearly define the roles of personnel and reevaluate if the situation changes.
- Institute regular briefings to cover the current status of the work environment and next steps.
- Partner inexperienced staff with experienced veterans. The buddy system is an effective method to provide support, monitor stress, and reinforce safety procedures. Require outreach personnel to enter the community in pairs.
- During lengthy disasters, implement days off and curtail weekend work as soon as possible.

- Implement flexible schedules for workers who are directly impacted by an event. This can help workers balance home and job responsibilities.
- Provide security for staff at facilities or sites in dangerous areas.

Mental Health Recovery Phase

The conclusion of a disaster assignment, whether it involves immediate response or long-term recovery work, can be a period of mixed emotions for health center staff. While there may be some relief that the disaster operation is ending, there is often a sense of loss and letdown, with some difficulty making the transition back into a normal family life and regular job.

The following are some action steps that can help ease the disengagement and transition process:

- Allow time off for staff experiencing personal trauma or loss. Transition these individuals back into the operations of the health center at a pace that is comfortable.
- Develop protocols to provide health center staff with stigma-free counseling so that they can address the emotional aspects of their experience
- Institute interviews and/or seminars to help staff put their experiences in perspective and to validate what they have seen, done, thought, and felt.
- Provide educational workshops around stress management and self-care.

APPENDIX G

Communications Equipment and Systems

COMMUNICATION OPTIONS

Communication Option	Description	Advantages	Disadvantages	Cost Range
Pagers <ul style="list-style-type: none"> • Two-Way • Alpha Numeric • Numeric 	<ul style="list-style-type: none"> • Dedicated radio frequency device that allows user to receive messages broadcast on a specific frequency 	<ul style="list-style-type: none"> • Provides additional coverage where cellular carrier may not • Inexpensive • Low monthly fees 	<ul style="list-style-type: none"> • Similar issues of coverage as cell phones 	\$40-\$400
Cellular Telephones	<ul style="list-style-type: none"> • Variety of options and coverage • Direct connect features 	<ul style="list-style-type: none"> • Providers expanding coverage • Group plans available • Shared minutes 	<ul style="list-style-type: none"> • Still gaps in coverage • Frequent technology changes 	\$50-\$600
Satellite Telephones	<ul style="list-style-type: none"> • Mobile phone that uses orbiting satellites instead of cell towers to connect with main phone lines 	<ul style="list-style-type: none"> • Cost becoming more reasonable. • Greater availability • Optimal coverage • Short-term rental plans available 	<ul style="list-style-type: none"> • Weather conditions can impact operability • Per minute charge expensive when used • Monthly charges higher than cell phones 	\$650-\$1500 <ul style="list-style-type: none"> • Rentals also available for \$40/wk and up
NOAA Weather Radio	<ul style="list-style-type: none"> • National Oceanic and Atmospheric Administration provides up to the minute emergency weather and all-hazard information across the nation 	<ul style="list-style-type: none"> • Inexpensive - available at local stores 		\$60 and up

AMATEUR RADIO OPERATORS (HAM RADIO)

Amateur radio operators possess a very robust communications system worldwide. Many operators have formed emergency teams within cities, counties and states and support government communications operations during exercises and disasters. These organizations provide a variety of services from both mobile and fixed communications capability. Additional information related to amateur radio operators in your community may be obtained by contacting your public safety and emergency management personnel.

NATIONAL COMMUNICATIONS SYSTEM (NCS): The National Communication System (NCS) offers a wide range of National Security and Emergency Preparedness (NS-EP) communications services, which support qualifying federal, state, local and tribal government, industry and non-profit organizations in the performance of their missions during emergencies.

NCS Program	Description
Government Emergency Telecommunications Service (GETS)	GETS - provides emergency access in the local and long distance segments of the public switched wire line network.
Telecommunications Service Priority (TSP)	TPS - provides service vendors with a FCC mandate for prioritizing service requests critical to telecommunications.
Wireless Priority Services (WPS)	WPS - provides priority cellular network access.
Shared Resources High Frequency Radio Program (SHARES)	SHARES - provides a single interagency Emergency message handling system through existing HF resources when normal communications are destroyed or unavailable.

* Information regarding the National Communication System programs of GETS, TSP, WPS, and SHARES can be accessed at www.ncs.gov

APPENDIX H

Decontamination Procedures for Health Centers

Decontamination Procedures for Health Centers

Definition: Decontamination is the reduction or removal of chemical, radiological or biological agents so they are no longer hazards. In treating patients with chemical exposures, decontamination is of primary importance provided the patient does not require immediate life-saving interventions. Therefore, decontamination takes precedence over non-life-threatening injuries. Decontamination of skin is the primary concern, but decontamination of eyes and wounds must also be done when necessary.

The most important and most effective technique after any exposure is that decontamination done within the first minute or two after exposure. What decontamination method is used is not as important as how and when it is used. Agents should be removed as quickly and completely as possible by the best means available.

Goals: Decontamination has 2 primary goals:

1. Decontamination helps prevent further harm to the patient from the exposure.
2. Decontamination helps protect healthcare providers and maintains the viability of the facility as a treatment center. Mismanagement may result in illness in healthcare providers and contamination of the site; severe contamination of the site may necessitate closure.

Recognition: Before decontamination can occur, contamination must be recognized. Recognition of biological and radiological contamination may be difficult, if not impossible in the primary care setting. For chemical contamination, however, the most important tool for assessing a patient is a careful history. Continue to consider chemical exposures in the differential diagnosis for any incident in which multiple ill persons with similar clinical complaints (point-source exposure) seek treatment at about the same time or in persons who are exposed to common ventilation systems or unusual patterns of death or illness.

Potential for Secondary Contamination: The route and extent of exposure are important in determining the potential for secondary contamination. Victims who were exposed only to gas or vapor and have no gross deposition of the material on their clothing or skin are not likely to carry significant amounts of contaminant on themselves. They are therefore not likely to pose risks of secondary contamination to clinic personnel. However, victims whose skin or clothing are covered with liquid or solid chemical or victims who have condensation of chemical vapor on their clothes or skin may contaminate others and the facility by direct contact or by off-gassing vapor. If the victim has ingested a chemical, toxic vomitus may also pose a danger through direct contact or off-gassing vapor.

All patients should be evaluated who that have been exposed to the contaminant. If decontamination at the Primary Care site is not possible, transportation should be arranged for evaluation at a secondary facility. Asymptomatic patients who have not had direct chemical exposure can be discharged from the scene after their names, addresses, and telephone numbers are recorded. Those discharged should be advised to seek medical care

promptly if symptoms develop. Consultation with the regional poison control center (1-800-222-1222) is recommended for advice regarding chemical decontamination.

Evacuation: Evacuation of the facility rarely is indicated. In most situations, isolation of the contamination is all that is required. Consider evacuation of the Center in the following situations:

- Toxic material spills in the facility
- Nearby hazardous materials are threatening the facility
- The patient is contaminated with a volatile toxic or flammable chemical and is decontaminated insufficiently prior to entering the facility

Basic Decontamination recommendations: Patients who are able and cooperative may assist with their own decontamination. This reduces the potential for cross-contamination. Remove contaminated clothing and personal belongings and place them in a double-bag, if possible.

Physical Removal: In situations with large amounts of contaminant, physical removal may be initiated by scraping with a wooden stick, (e.g. a tongue depressor or popsicle stick) or by blotting with adsorbent materials (e.g. 2x2 gauze).

Inhalation Exposure: Administer supplemental oxygen by mask to patients who have respiratory complaints. Treat patients who have bronchospasm with aerosolized bronchodilators; use these with caution because of the potential or possible enhanced risk of cardiac dysrhythmias.

Skin Exposure: If chemical burns are present, treat as thermal burns. Flush exposed or irritated skin and hair with plain water. For oily or otherwise adherent chemicals, use mild soap on the skin and hair. Further skin decontamination is achieved as follows:

- Wash the patient thoroughly from head to toe. Avoid vigorous scrubbing to prevent skin breakdown.
- Flush exposed areas with soap and water for 10-15 minutes with gentle sponging.
- Decontaminate open wounds by irrigation with saline or water for an additional 5-10 minutes.
- Try to avoid contaminating unexposed skin on the patient. Use surgical drapes if necessary.
- Clean under fingernails with a scrub brush.
- Ideally, collect runoff water in containers, if possible.

Eye Exposure: Flush exposed or irritated eyes with plain water or saline for 10-15 minutes, except in alkali exposures, which require 30-60 minutes of irrigation. Remove contact lenses if present and easily removable without additional trauma to the eye. If a corrosive material is suspected or if pain or injury is evident, continue irrigation and refer the patient for further ophthalmologic attention.

Ensure that adequate eye irrigation has been completed. Test visual acuity. Examine the eyes for corneal damage using a magnifying device or a slit lamp and fluorescein stain, if available. For small corneal defects, use ophthalmic ointment or drops, analgesic

medication, and an eye patch. Immediately consult an ophthalmologist for patients who have severe corneal injuries. Continue irrigating exposed skin and eyes, as appropriate.

Ingestion Exposure: In cases of ingestion, do not induce emesis. Administer 4 to 8 ounces of water to dilute stomach contents if the patient is conscious and able to swallow. Obtain advanced medical care immediately. Consultation with your regional Poison Control Center (1-800-222-1222) is recommended.

Location: If possible, the ideal location for decontamination is outdoors. If indoor decontamination is necessary, an isolated location or “decontamination room” is the next ideal location. Indoor decontamination only should occur in cases in which a controlled indoor environment may be maintained safely.

If such a room is not available, try to isolate the patient in a single large room after removing nonessential and non-disposable equipment. Ideally, this room should be away from other patient care areas. Maintain ventilation to the area in which the patient is located, but be wary of further contaminating the facility with recycled ventilation.

Establish a “secure zone” with yellow tape or other visible barrier and permit only appropriately protected individuals to enter as needed. Include in the secure zone any area the patient may contaminate while entering/leaving the facility. Upon arrival of the patient, determine whether the patient requires any immediate life-saving interventions. If these are required, stabilize the patient before or during decontamination.

Laundry: Textiles and Bedding: Textiles and fabrics (e.g., protective clothing, linens, clothing) from patients and their immediate contacts should be handled with minimum agitation to avoid contamination of air, surfaces, and persons. This prevents the dispersion of potentially contaminants into the air. Textiles and clothing should be bagged or contained at the point of use in accordance with Occupational Safety and Health Administration (OSHA) regulations.

Reusable Medical Equipment: For biologic contaminants, the surfaces of reusable medical equipment should be cleaned and then subjected to either low- or intermediate-level disinfection with an EPA-registered chemical germicide in accordance with label instructions. Current protocols and procedures for cleaning and disinfection need not be changed.

Environmental Surfaces: For biologic contaminants, environmental surfaces that are touched frequently by hand can be cleaned and subjected to low- to intermediate-level disinfection with EPA-registered chemical germicides according to label instructions. Large housekeeping surfaces such as floors and tabletops can be cleaned using an EPA-registered detergent disinfectant according to manufacturer’s instructions.

Current procedures and schedules can be used for management of floors and furniture. Use a vacuum cleaner equipped with a high efficiency particulate air (HEPA) filter for cleaning carpeted floors or upholstered furniture. Disinfection of the vacuum cleaner is not required when a HEPA filter is properly installed and remains intact during use. Full vacuum cleaner bags can be placed in another closable container and discarded as a routine solid waste. If carpets and upholstered furniture require cleaning to remove visible soil, commercially available products for this purpose are acceptable for use as per usual.

Regulated Medical Waste: Regulated medical waste should be placed in containment, subjected to a decontamination treatment, and discarded in accordance with medical waste

regulations of the state or other appropriate jurisdiction. This includes the use of offsite medical waste treatment services.

References include:

1. ATSDR – Medical Management Guidelines for Unidentified Chemical
2. CDC – Chemical Agents: Facts About Personal Cleaning and Disposal of Contaminated Clothing
3. CDC – Smallpox Response Plan and Guidelines (Version 3.0)
4. eMedicine – CBRNE - Chemical Decontamination
5. Columbia University-Mailman School of Public Health-National Center for Disaster Preparedness.

APPENDIX I

Generators from FEMA

**Guidance for Health Centers
Who Need Generator Support to Operate**

When HRSA project officers contact health centers to ascertain their operating status during a disaster, if the only impediment to opening to provide services is lack of power from the local power grid, project officers should advise the health centers as follows:

- If able, contact your county/parish emergency management agency (EMA) to request a generator through the FEMA disaster assistance process.
- Health centers should explain their role in providing services in the community and their ability to provide medical services during the disaster in an effort to obtain priority status for generator support.
 - Project officers can assist their grantees who may not have computer access by providing them verbally with the phone number of their county/parish EMA.
 - County/parish EMA contact info can be found on the respective State EMA websites are as follows (Provide State information as appropriate):
 - Other States <http://www.fema.gov/fema/statedr.shtm>
- In their requests, health centers should also specify the need for fuel re-supply to keep the generator running.
- County/parish EMAs, if operational (they typically are), will funnel such requests to the State EMA.
- The State EMA will generate an action request form (ARF) which will be provided to FEMA to prioritize and hopefully fill the request during disaster operations.
- Health centers that have telephone service but are unable to contact their county/parish EMA directly because the EMA's lines are down or for some other reason should contact the State EMA directly.
- Health centers that are unable to secure assistance through their local mechanisms should advise their HRSA project officer. Project officers should in turn notify the HRSA EOC.
- If the health center receives a FEMA supplied generator, they should ascertain contact information from those delivering the generator, to report problems with the generator, to request fuel re-supply, and to notify when power from the grid is restored and the generator is no longer needed.
- When contacting their county/parish EMA, health centers should inquire when the FEMA Public Assistance meeting will be held for their area and be sure to send a representative.

APPENDIX J

Re-Supply Guidance

Guidance for Health Centers
Medical Re-supply Issues

When HRSA project officers contact health centers to ascertain their operating status during a disaster, if the only impediment to providing continuity of services is lack of medical supplies, equipment and pharmaceuticals, project officers should advise their grantees as follows:

- If able, contact your county/parish Emergency Operations Centers (EOC) or state EOC to request the needed medical supplies, equipment or pharmaceuticals through the ESF - 8 disaster assistance process.
- Health centers should explain their role in providing services in the community and their ability to provide medical services during the disaster in an effort to obtain priority status for re-supply from the county/parish EOC or state EOC.
 - Project officers can assist their health centers who may not have computer access by providing them verbally with the phone number of their county/parish Emergency Management Agency (EMA) who can direct them to the proper EOC.
 - County/parish EMA contact info can be found on the respective State EMA websites as follows (Provide State information as appropriate):
 - Other States <http://www.fema.gov/fema/statedr.shtm>
- In their requests, health centers should specify the specific quantity and type of supplies, equipment and pharmaceuticals needed as they would for any other routine re-supply order
- County/parish EOCs, if operational (they typically are), will funnel such requests to the State EOC.
- The State EOC will generate an action request form (ARF) which will be provided to State or Local Health and Human Services (HHS) to prioritize and fill the request during disaster operations.
- Health centers that have telephone service but are unable to contact their county/parish EOC directly because the EMA's lines are down or for some other reason should contact the State EOC directly.
- Health centers that are unable to secure assistance through their local mechanisms should advise their HRSA project officer. Project officers should in turn notify the HRSA EOC. The HRSA EOC will raise the issue with its Federal and state contacts in an effort to have the matter addressed. Health centers should continue to work through its local and state contacts to get assistance even after notifying the project officer.
- When contacting their county/parish EOC, health centers should inquire when the FEMA Public Assistance meeting will be held for their area and be sure to send a representative.

APPENDIX K

PIN 2007-15: Emergency Management Expectations

POLICY INFORMATION NOTICE

DOCUMENT NUMBER: 2007-15

DATE: August 22, 2007

DOCUMENT TITLE: Health Center
Emergency Management Program
Expectations

TO: Health Center Program Grantees
Federally Qualified Health Center Look-Alikes
Primary Care Associations
Primary Care Offices
National Cooperative Agreements

Health centers are a vital component of our Nation's health care safety net. As such, health centers are positioned to 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 including having a plan in place to prevent, prepare for, respond to, and recover from emergencies.

This Policy Information Notice (PIN) provides guidance on emergency management expectations for health centers to assist them in planning and preparing for future emergencies. This document is not intended to be all inclusive but rather to provide guidance so that health centers can develop and maintain an effective and appropriate emergency management strategy—including developing and implementing an emergency management plan, building existing and growing new relationships, enhancing effective and efficient communications, and ensuring that the health center can effectively operate after an emergency. The expectations set forth in this notice are intended to be an extension of PIN 98-23, "Health Center Program Expectations."

If you have any questions or require further guidance, please contact the Office of Policy and Program Development at 301-594-4300.



James Macrae
Associate Administrator

Attachment

Health Center Emergency Management Program Expectations

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Health Center Emergency Management Program Expectations

I. PURPOSE

This Policy Information Notice (PIN) provides guidance to health centers (i.e., section 330 funded grantees and Federally Qualified Health Center (FQHC) Look-Alikes) on emergency management expectations related to planning and preparing for future emergencies. For purposes of this document, an “emergency” or “disaster” is defined as an event affecting the overall target population and/or the community at large, which precipitates the declaration of a state of emergency at a local, State, regional, or national level by an authorized public official such as a governor, the Secretary of the Department of Health and Human Services, or the President of the United States. Examples include, but are not limited to: hurricanes, floods, earthquakes, tornadoes, wide-spread fires, and other natural/environmental disasters; civil disturbances; terrorist attacks, collapses of significant structures within the community (e.g., buildings, bridges); and infectious disease outbreaks and other public health threats.

At the core of emergency management planning and preparation are three key elements: safeguarding human resources, protecting physical resources, and ensuring business continuity. For health centers, this translates to protecting health center staff and patients as well as safeguarding its ability to deliver health care. Emergencies can disrupt the environment of care or change the demand for the health center’s services making it essential for health centers to ensure that emergency management is integrated into its daily functions and values.

The expectations outlined in this guidance are intended to be broad to ensure applicability to the diverse range of health centers and ease in integrating them into what health centers are already doing related to emergency and risk management.¹ They are not intended to be an all inclusive guide but rather to provide guidance so that health centers can develop and maintain an effective and appropriate emergency management strategy. For health centers, building on existing relationships with natural partners at the local level, such as hospitals and health departments, is critical for engaging in emergency management. At the State level, health centers are strongly encouraged to work with their Primary Care Association (PCA). PCAs are expected to provide State level leadership, where appropriate, for the (a) integration of health centers into Statewide and community preparedness and response plans and (b) direct assistance in the area of emergency preparedness planning to health centers. At the national level, health centers can also seek technical assistance on emergency management from the HRSA’s Bureau of Primary Health Care (BPHC) as well as from BPHC’s national technical assistance partners.

II. APPLICABILITY

This PIN applies to FQHC Look-Alikes and all health centers funded under the Health Center Program authorized in section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b), as amended, specifically:

- Community Health Center (CHC) Programs, funded under section 330(e);

¹ This PIN is not intended to address issues associated with the applications of the Federal Tort Claims Act to health centers’ activities during emergencies or disasters. Please refer to the BPHC PIN 98-23, Health Center Program Expectations and PIN 2007-16, Federal Tort Claims Act (FTCA) Coverage for Health Center Program Grantees Responding to Emergencies.

- Migrant Health Center (MHC) Programs, funded under section 330(g);
- Health Care for the Homeless (HCH) Programs, funded under section 330(h); and
- Public Housing Primary Care (PHPC) Programs, funded under section 330(i).

For the purposes of this document, the term “health center” refers to the diverse types of health centers that are supported under section 330 of the PHS Act (i.e., CHC, MHC, HCH, and PHPC) and FQHC Look-Alikes.

III. BACKGROUND

The Federal government has established a Federal emergency management plan, referred to as the National Response Plan or the NRP. The NRP is a national, all-discipline, all-hazards plan that provides the framework and mechanisms to coordinate Federal, State, local, Tribal, private sector, and non-governmental entities during national emergencies. The NRP establishes a single, comprehensive approach to prevent, prepare for, respond to, and recover from major events, including natural disasters, terrorist attacks, and other public health emergencies. It applies to all incidents requiring a coordinated Federal response as part of an appropriate combination of Federal, State, local, Tribal, and community entities.

The NRP is constructed on the framework established by the National Incident Management System (NIMS). At the request of the President of the United States, the Department of Homeland Security developed NIMS to provide a consistent, comprehensive, and nationally recognized framework for incident management. NIMS is designed to help emergency managers and responders from different jurisdictions and disciplines work together more effectively in the management of domestic incidents at all jurisdictional levels regardless of the cause, size, or complexity of the incident. NIMS provides an integrated process towards incident management, standard command and management structures, and emphasis on preparedness, mutual aid, and resource management. National capabilities are strengthened to prevent, prepare for, respond to, and recover from any incident through the adoption and implementation of NIMS across all jurisdictions—Federal, State, local, Tribal, private sector, and non-governmental entities.

The NIMS standard incident command structures are based on preparedness through implementation of a general chain of command, efficient personnel and resource management, and effective communications and information management. The Incident Command System or ICS is a component of the NIMS. ICS is scalable to address large and small incidents; it is also interdisciplinary and organizationally flexible. ICS includes a unified approach for controlling personnel, facilities, equipment, and communications. In general, health centers are strongly encouraged to use ICS in context of their emergency management strategy, understand the NIMS and NRP framework, and move toward full NIMS compliance. Since October 1, 2005, all 56 States and Territories were required to meet NIMS implementation requirements to be eligible to receive Federal preparedness assistance in the form of grants, cooperative agreements and direct contracts. While it is not a requirement for health centers at this time, compliance with NIMS is strongly encouraged. Health centers should visit the Department of Homeland Security’s web site training.fema.gov for NIMS training information and resources.

The NRP and NIMS are companion strategies designed to improve the Nation's incident management capabilities and overall efficiencies—integrating the capabilities and resources of various governmental jurisdictions, incident management and emergency response disciplines, non-governmental organizations, and the private sector into a cohesive, coordinated, and seamless national framework for domestic incident management. An underlying tenet of the NRP is that, in general, most emergencies are limited in scope and range and, therefore, the response to such events is managed at the local level. The NRP also recognizes that private sector entities have a key role related to critical infrastructure protection and restoration as well as contributing necessary resources and services in an emergency event. In this context, health centers are a vital part of an effective emergency response in the communities they serve.

Health centers can support the NRP by being prepared to handle emergencies—whether man made or natural. This means having a plan in place to prevent, prepare for, respond to, and recover from emergencies. Health centers can also support the NRP by working collaboratively at the State, local, and community levels in identifying risks, performing vulnerability assessments, maximizing effective use of available resources, and enhancing overall readiness. For additional information on NRP, see the Department of Homeland Security's website, www.dhs.gov/xprepresp/committees/editorial_0566.shtm.

IV. EXPECTATIONS

Health centers must have risk management policies and procedures in place that proactively and continually identify and plan for potential and actual risks to the health center in terms of its facilities, staff, clients/patients, financial, clinical, and organizational well-being. Plans and procedures for emergency management must be integrated into a health center's risk management approach to assure that suitable guidelines are established and followed so that it can respond effectively and appropriately to an emergency. Health centers should also be aware that other entities (i.e., accrediting organizations, State and/or local health departments) may also have requirements related to emergency management activities.

Health centers are diverse organizations. Therefore, each health center will require an emergency management approach that considers the center's size, location, resources, as well as current State, local, or community/regional plans. Location and size of the facility, the number of staff, and the type of operations are key factors to consider in developing an appropriate emergency management strategy. Small health centers might have relatively basic emergency management strategies whereas centers with multiple sites, greater variability in operations, or large numbers of staff may develop more complex approaches.

The emergency management expectations for health centers addressed in this guidance are as follows:

- A. Emergency management planning—health centers should be engaged in an ongoing, continuous process to ensure that emergency management plans (EMP) are appropriate.
- B. Linkages and collaborations—health centers should maximize their linkages and collaborations.
- C. Communications and information sharing—health centers should have policies and procedures for communicating and sharing information with internal and external stakeholders.

D. Maintaining financial and operational stability—health centers’ business plans should address financial viability in the event of an emergency.

A. Emergency Management Planning

Emergencies can disrupt care provided to health center patients by significantly increasing demand for services or severely impacting current operations. An emergency management plan or EMP (also known as an emergency operations plan or disaster plan) is essential to minimize the disruption of services for patients, assure the health center’s ongoing financial and organizational well-being, and link the health center to the local community response.

The purpose of the EMP is to ensure predictable staff behavior during a crisis, provide specific guidelines and procedures to follow, and define specific roles and responsibilities. The EMP should address the four phases of emergency management—mitigation, preparedness, response, and recovery:

- Mitigation activities lessen the severity and impact a potential disaster or emergency might have on a health center’s operation;
- Preparedness activities build capacity and identify resources that may be used should a disaster or emergency occur;
- Response refers to the actual emergency and controls the negative effects of emergency situations; and
- Recovery actions begin almost concurrently with response activities and are directed at restoring essential services and resuming normal operations. Recovery planning is a critical aspect to sustaining the long-term viability of the health center.

It is essential that the EMP be developed with an interdisciplinary approach involving all departments within the organization as the entire organization will be affected and play a role in an emergency. The Governing Board, senior management, and the clinical staff should have a lead role in the development of the EMP, and the Governing Board should approve the final EMP and any revisions to it.

Health centers should initiate emergency management planning by conducting a risk assessment such as a Hazard Vulnerability Analysis. The risk assessment should identify potential emergencies and the direct and indirect effects these emergencies may have on the health center’s operations and the demand for services. The risks identified in the risk assessment should be prioritized based on the likelihood of occurrence and severity and addressed in the EMP. There are many risk assessment tools available and health centers are encouraged to use the tools that best meets their specific needs.

Health centers are encouraged to participate in community level risk assessments and integrate their own risk assessment with the local community. Many States and communities may have already completed a risk assessment for their area, and health centers are encouraged to use these assessments as a starting point for their own assessment.

In developing the EMP, health centers should describe their approach to responding to emergencies that would suddenly and significantly affect the demand for the organization's services or its ability to provide those services. The EMP should take an all-hazards approach—meaning that the health center has considered and has developed an EMP that is simple and flexible enough to respond to all of the identified emergencies. These could include a sudden and abrupt event such as an explosion or a sustained event over a longer period of time such as pandemic influenza.

Many State and/or local EMPs are already in place and, to the extent possible, a health center's EMP should be aligned and integrated with these emergency plans. The role of the health center in these plans should be clearly established and reflected in both the health center's internal EMP as well as in the State and/or local EMPs. To maximize integration, health centers are encouraged to connect with any ongoing efforts in these areas before developing and implementing their EMP. Health centers may also want to explore developing mutual aid agreements with other community health care providers such as other health centers, hospitals, and rural health clinics for resources such as personnel, equipment, and supplies. To find out if there is an established community and/or regional EMP, health centers should contact their local county government.

The EMP is necessary to ensure the continuity of patient care in the event of an emergency. It should describe under what circumstances and how, when, and by whom the EMP is activated, procedures for notifying staff when it has been initiated, and the roles and responsibilities of all personnel responding to the emergency. Health centers should appropriately include components in their plan that reflect the unique characteristics of the health center—size, location, resources, environment, populations served, and the role it plays within its community. For many health centers, the EMP can be a basic plan; for others, the EMP will need to reflect the complex nature of its operations and capacities. A health center's EMP should address the following components **as appropriate**, considering the role of the health center in the local and/or State plans and what is most appropriate and necessary for the health center to respond to an emergency:

- Continuity of operations;
- Command and control;
- Staffing;
- Surge patients;
- Medical and non-medical supplies;
- Pharmaceuticals;
- Security;
- Evacuation;
- Decontamination;
- Isolation;
- Power supply;
- Transportation;
- Water/Sanitation;
- Communications; and
- Medical records security and access.

Individuals impacted by emergencies often experience significant emotional stress. The health center's EMP should address the behavioral needs of both patients and staff and identify additional resources for providing those services. The plan should also help staff prepare their families for emergencies—if staff are prepared at home, they are more likely to carry out vital responsibilities and duties at work in the health center. For

additional information on personal preparedness, visit the Department of Homeland Security's www.Ready.gov website.

The EMP should describe if and how health centers will continue to provide primary health care services to current and surge patients to the extent possible during an emergency, including consideration for continuity of services for contracted services as well as those services that are directly provided by the health center. The EMP should evaluate a health center's ability to maintain normal operations and describe the circumstances that must be met for the health center to discontinue non-emergency primary care services or cease operations for a period of time, especially if staffing levels decrease. **Provision of primary health care services should be consistent and aligned with the health center's role, as determined in consultation with the local community.** If applicable, the EMP should also address how the health center will utilize mobile vans during an emergency and how services to patients served by the van will be continued should access be impeded, or if it were damaged or destroyed.

Health centers should plan for assuring access for special populations, such as migrant and seasonal farmworkers, homeless people, and residents of public housing. Many times these populations need additional assistance and communication (such as culturally and linguistically appropriate messages and outreach). In developing the EMP, health centers are encouraged to also consider other populations such as non-English speaking individuals, children including those with special needs and those served at school-based health centers, individuals living with HIV disease, and disabled and elderly individuals.

Health centers should provide ongoing training on emergency management and the implementation of the EMP to employees at all levels of the organization. Health center employees may be eligible to participate in State and local trainings on emergency management and health centers are encouraged to use these available resources. Appropriate planning and adequate education and training are critical to ensure staff are prepared to deal with an emergency when confronted with one.

Health centers should continually test and evaluate the effectiveness of their EMP and make adjustments as necessary. Exercises reveal what works, what does not, and what is needed to enhance the effectiveness of the EMP. The objectives of testing EMPs through exercises are to minimize confusion and mistakes that may occur during an actual emergency. The frequency and methods of testing and evaluation (table top drills, functional exercises, etc.) should be determined by the organization, but should be at least on an annual basis. Health centers are also encouraged to test their plan in a community-wide and regional setting by participating in local, regional, or national disaster drills or exercises, if possible and as appropriate. Health centers' EMPs should be updated and revised based on any lessons learned from participation in drills, exercises, or actual emergencies.

B. Linkages and Collaborations

Normal operations can become overwhelmed during an emergency, and health centers may have to rely on other community organizations for assistance and, possibly, for

assuming some aspects of patient care. Established linkages and collaborations are critical for an effective EMP. Coordinated efforts are necessary to provide comprehensive care during this time and integration into the local community response can increase the health center's ability to obtain needed resources for continuing care.

In developing their EMP, health centers should integrate with the emergency management system at the State, local, and community levels. Health centers should collaborate with State 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, national organizations, PCAs, and Primary Care Organizations (PCO). Health centers should also be prepared to work with organizations that may not be part of their usual primary health care delivery network. These may include local businesses, law enforcement, fire services, local military installations, schools, and faith-based organizations.

Health centers should define their role within their local community prior to an emergency and be proactive in engaging community leaders, identifying key organizations, and developing ongoing relationships. Well in advance of an emergency, health centers should establish relationships with key decision makers to assist in effectively navigating State and local systems to obtain needed resources before, during and after an emergency. Participating in State, local, and community emergency/disaster exercises will aid in initiating and developing linkages with these individuals and organizations.

C. Communications and Information Sharing

During an emergency, standard communication systems are often overwhelmed or destroyed and health centers will likely have difficulty accessing critical information. A well-defined communications plan is an important component of an effective EMP. The EMP should identify the health center's policies and procedures for communicating with internal (staff, patients, special populations, Governing Board) and external (appropriate Federal, State, local, and Tribal agencies) stakeholders as well as with the public during emergencies.

Health centers should also develop policies and procedures that describe who will be responsible for communicating important information and which agencies or groups should receive communication, the process for how the communication will take place, and what general information should be communicated.

As part of the EMP, the health center should develop strategies for communicating with patients during an emergency including procedures to make patients aware of any alternative primary care service arrangements that may be available in the event the health center is closed. Health centers are encouraged to work with their State and/or local public health department in developing appropriate communication messages for patients. Local radio and television may be useful for communicating such messages. All educational materials and other emergency information should be culturally and linguistically appropriate and developed at reading levels appropriate for the population being served.

The health center's EMP should identify backup (also referred to as redundant) communication systems in the event that standard communication systems are unavailable and include these in its EMP. Example of redundant communication systems include: two-way radios, mobile/cell phones, and wireless messaging. The health center's communication policies, procedures, command structure, and backup communication systems should be tested in conjunction with the EMP at least on an annual basis or more frequently, as appropriate. Health centers' communications systems should be integrated into the local health care and community systems and be tested in conjunction with these systems.

Health centers should have an all-hazards command structure within the organization, such as a standard ICS, that links with the community's command structure for emergencies. As a component of the NIMS, many communities have established an ICS for use during an emergency—the ICS provides a unified, organized, and structured method for cooperation and coordination as well as to facilitate decision making and response. The health center's ICS should also include procedures for communicating with staff and other key stakeholders during an emergency. These policies and procedures should be integrated with the health center's EMP.

The quality of key decisions made during emergencies is critically dependent on the availability of current, accessible, accurate, and relevant information. Data reporting assists decision makers in assessing the current situation and identifies critical needs, such as supplies and staffing, that are essential to continuing the provision of care prior to, during and after an emergency. Data reporting can assist local communities in positioning resources and facilitate access to these resources for health centers.

To maximize access to resources, health centers are encouraged to have systems in place which accurately collect and organize data for anticipated requested/required reporting. Health centers should collaborate with State and local agencies, such as PCAs, PCOs, and local public health departments to develop standard reporting protocols. The reporting protocols should be integrated into the communication section of the health center's EMP.

In the event of an emergency, health centers (both Health Center Program grantees and FQHC Look-Alikes) will be required to submit data to their HRSA Project Officer (PO). Depending on the circumstances, HRSA may initiate procedures before, during and after emergency events that include asking for information from each affected health center such as the status of health center operations, patient capacity and/or staffing/resource/infrastructure needs.

D. Maintaining Financial and Operational Stability

Health centers can face significant obstacles in regaining financial stability after an emergency and may spend several months or even years in the recovery phase. Physical or property losses sustained from emergencies can cause interruption or discontinuation of services for patients and disrupt the community health care infrastructure. Adequate planning for recovery in the assessment, planning, and response process will shorten the time it takes a health center to become fully operational.

The ability to adequately respond to an emergency can help preserve the financial viability of the health center. Health centers' business plans should address the financial response to an emergency including goals for maintaining cash reserves and plans related to managing and insuring against business interruptions, equipment, facilities, and property loss. The purpose of incorporating emergency management considerations in the business plan is to reduce and/or minimize potential adverse impacts brought about by an emergency. As part of these plans, health centers should annually review their insurance coverage to ensure that it is current and that the coverage is adequate.

Preserving vital operational records and documents is critical to a quick resumption of operations. Health centers should have backup information technology systems to ensure that electronic financial and medical records² are available during and after an emergency. Consideration should be given to the feasibility of obtaining off-site storage for these electronic records with emphasis on electronic access and retrieval during or after an emergency. In advance of an anticipated event, health centers are encouraged to secure facilities to the extent possible, and may want to consider off-site or safe storage for their equipment and data.

Business plans should address strategies for resuming key functions that would enable health centers to fully conduct operations, such as ensuring that billing systems are in place for obtaining payment and reimbursement as soon as possible. Health centers are encouraged to have a backup billing system in place to track charges and sustain the flow of reimbursement needed to maintain the financial viability of the health center during any response and recovery. They should have 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.

In the event of an emergency, Health Center Program grantees can use grant funds to provide services consistent with their approved scope of project and the terms of their grant award. Generally, all costs charged to Federal grant awards must be consistent with Federal cost policy guidelines, program regulations, and the terms of the award. Health centers should contact their Grants Management Specialist if they have grants administration questions related to emergencies. Both Health Center Program grantees and FQHC Look-Alikes should make every attempt to collect reimbursement for services from appropriate public and private coverage.

V. CONCLUSION

Health centers have demonstrated exceptional expertise in delivering comprehensive, culturally competent, quality primary health care services to vulnerable and underserved populations. This may prove even more crucial in the event of an emergency. A successful emergency response may largely depend on the ability of health centers to communicate with appropriate stakeholders, whether staff, patients, or other entities. Health centers are

² For information on HIPAA privacy and disclosures in the event of an emergency, please visit the following website: www.hhs.gov/ocr/hipaa/emergencyPPR.html.

encouraged to be proactive in engaging community leaders, identifying key partner organizations, and developing ongoing relationships. The ability to adequately respond to an emergency can help safeguard the operational and financial viability of the health center.

The expectations outlined in this guidance are intended to be broad to ensure applicability to the diverse range of health centers and ease in integrating them into what health centers are already doing related to emergency and risk management. In addition to developing, implementing, and maintaining an EMP, health centers should continually look for opportunities to enhance awareness, educate and train boards and staff, evaluate and test procedures, and integrate emergency management into what the health center does on a daily basis. A well-developed and appropriate emergency management strategy which reflects the unique characteristics, circumstances, and environment for the health center, will assure that it will be able to recover quickly and continue to provide essential services in their community.

VI. KEY DEFINITIONS

Emergency Management: The process of planning, developing, implementing, and executing a comprehensive system of principles, policies, procedures, methods, and activities designed to ensure an organization's effective response to natural and manmade disasters affecting its environment and business operations. Emergency management is a comprehensive system, which includes planning, mitigation, preparedness, response, and recovery activities. Health center emergency management entails developing a plan based on the hazard vulnerabilities likely to affect the health center, conducting exercises and drills to assure sound response and recovery activities, and includes annual reassessments and updates to recognize any new threats or vulnerabilities to improve on emergency management procedures and activities.

Emergency Management Plan (EMP): A document describing the comprehensive system of principles, policies, procedures, methods, and activities to be applied in response to natural and manmade disasters to ensure patient and employee safety, to mobilize resources, to maintain health center business operations, and to assist in providing mutual aid in a community-wide response requiring medical services.

Homeland Security Presidential Directives: Homeland Security Presidential Directives (HSPDs) are issued by the President of the United States on matters pertaining to Homeland Security. Two key HSPDs were created to establish national initiatives that develop a common approach to domestic incident management and include the National Response Plan (NRP), the National Preparedness Goal, the National Incident Management System (NIMS), the Universal Task List (UTL), and the Targeted Capability List (TCL). These are HPSD-5: Management of Domestic Incidents and HSDP-8: National Preparedness.

Incident Command System (ICS): A system for managing resources from other organizations during an emergency. The ICS is a standardized on-the-scene emergency management system that is used nationwide. It is specifically designed for an integrated multi-organizational structure and is scalable to handle the complexity and demands of a single or multiple incidents without being hindered by jurisdictional boundaries. The ICS manages and coordinates facilities, equipment, supplies, procedures, and communications

within a common and defined organizational structure, to effectively accomplish stated objectives pertinent to an incident.

Jurisdiction: A range or sphere of authority. Public agencies have jurisdiction at an incident related to their legal responsibilities and authority. Jurisdictional authority at an incident can be political or geographical (e.g., city, county, tribal, State, or Federal boundary lines) or functional (e.g., law enforcement, public health).

National Incident Management System (NIMS): A system mandated by HSPD-5 that provides a consistent nationwide approach for Federal, State, local, and tribal governments; the private-sector, and nongovernmental organizations to work effectively and efficiently together to prepare for, respond to, and recover from domestic incidents, regardless of cause, size, or complexity. To provide for interoperability and compatibility among Federal, State, local, and tribal capabilities, the NIMS includes a core set of concepts, principles, and terminology. HSPD-5 identifies these as the ICS; multiagency coordination systems; training; identification and management of resources (including systems for classifying types of resources); qualification and certification; and the collection, tracking, and reporting of incident information and incident resources.

National Preparedness Goal (NPG): The NPG will guide Federal departments and agencies, State, territorial, local and tribal officials, the private sector, non-government organizations and the public in determining how to most effectively and efficiently strengthen preparedness for terrorist attacks, major disasters, and other emergencies. The NPG also includes seven *national priorities*. The national priorities are: Implement the National Incident Management System (NIMS) and the National Response Plan (NRP), Expanded Regional Collaboration, Implement the Interim National Infrastructure Protection Plan, Strengthen Information Sharing and Collaboration Capabilities, Strengthen Interoperable Communications Capabilities, Strengthen Chemical/Biological/Radiological/Nuclear/Explosives Detection, Response and Decontamination Capabilities, and Strengthen Medical Surge and Mass Prophylaxis Capabilities. Focusing on these priorities will ensure adequate infrastructure that is prepared—at the Federal, State, local, and regional levels—through shared priorities, goals, and objectives.

National Response Plan (NRP): A plan mandated by HSPD-5 that integrates Federal domestic prevention, preparedness, response, and recovery plans into one all-discipline, all-hazards plan.

Targeted Capability List (TCL): The identification of target levels of capabilities that Federal, State, local, and tribal entities must achieve to perform critical tasks for homeland security missions. Capabilities are combinations of resources that provide the means to achieve a measurable outcome resulting from performance of one or more critical tasks, under specified conditions and performance standards. The TCL identifies 37 capabilities integral to nationwide all-hazards preparedness, including terrorism. The full documentation for the TCL can be viewed at www.llis.gov.

Universal Task List (UTL): The UTL was developed in close consultation with Federal, State, local, and Tribal entities and national associations to help the homeland security community implement the capabilities-based planning process established under HSPD-8. The UTL is a "living" document that will continue to be refined and expanded as it is put into practice.

VII. RESOURCES

There are a wide range of resources available to assist health centers in support of emergency management activities. Technical assistance related to emergency management also may be available from PCAs that have been engaged in emergency management planning activities in their State and health centers that have already developed EMPs. Listed below are a number of Federal references health centers may find helpful.

Department of Health and Human Services

⇒ www.hhs.gov/disasters/index.html

Health Resources and Services Administration

⇒ www.hrsa.gov/healthconcerns/

Centers for Medicare and Medicaid Services

⇒ www.cms.hhs.gov/Emergency/

Centers for Disease Control and Prevention—Emergency Preparedness & Response

⇒ www.bt.cdc.gov/

Food and Drug Administration—Bioterrorism/Counterterrorism

⇒ www.fda.gov/oc/opacom/hottopics/bioterrorism.html

Substance Abuse and Mental Health Services Administration—Disaster Readiness and Response

⇒ www.samhsa.gov/Matrix/matrix_disaster.aspx

National Institute for Occupational Safety and Health—Business Emergency Management Planning

⇒ www.cdc.gov/niosh/topics/prepared/

Department of Labor, Occupational Safety and Health Administration—Emergency Preparedness and Response

⇒ www.osha.gov/SLTC/emergencypreparedness

State Offices and Agencies of Emergency Management—Contact Information

⇒ www.fema.gov/about/contact/

Department of Homeland Security

⇒ www.ready.gov/business/index.html

APPENDIX L

PIN 2007-16: FTCA Coverage in Emergencies

POLICY INFORMATION NOTICE

DOCUMENT NUMBER: 2007-16

DATE: August 22, 2007

DOCUMENT TITLE: Federal Tort Claims Act (FTCA) Coverage for Health Center Program Grantees Responding to Emergencies

TO: Health Center Program Grantees
Primary Care Associations
Primary Care Offices
National Cooperative Agreements

The purpose of this Policy Information Notice (PIN) is to clarify the circumstances under which Federal Tort Claims Act (FTCA)-deemed Health Center Program grantees (section 330(e), (g), (h) and (i) grantees) are covered under the FTCA as they respond to emergencies and to address frequently asked FTCA questions. PIN 2005-19, "Federal Tort Claims Act Coverage for Deemed Health Center Program Grantees Responding to Hurricane Katrina," applied only to the emergency response after Hurricanes Katrina and Rita. This PIN describes a broader, prospective policy that applies to future emergencies.

If you have questions regarding this PIN, please contact the Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BPHC), Office of Policy and Program Development at (301) 594-4300. If you have questions regarding the FTCA Program, please contact BPHC's Office of Quality and Data at 301-594-0818.



James Macrae
Associate Administrator

Attachment

**Federal Tort Claims Act (FTCA) Coverage for Health Center
Program Grantees Responding to Emergencies**

I. PURPOSE

The purpose of this Policy Information Notice (PIN) is to clarify the scope of Federal Tort Claims Act (FTCA) coverage for FTCA-deemed Health Center Program grantees during an emergency. This PIN does not address a health center's scope of project for purposes of Medicaid/Medicare reimbursement during an emergency or eligibility for the 340B Drug Pricing Program during an emergency. PIN 2002-07, "Scope of Project Policy," and PIN 2007-14, "Technical Revisions to PIN 2002-07," provide general guidance on these subjects.

II. OVERVIEW

A. Legislative Background

FTCA coverage for eligible Health Resources and Services Administration (HRSA) grantees was initially legislated through the Federally Supported Health Centers Assistance Act of 1992 (FSHCAA) (Public Law 102-501) by amending section 224 of the Public Health Service (PHS) Act. The eligible entities are Health Center Program grantees (section 330(e), (g), (h) and (i) of the PHS Act). The FSHCAA of 1995, signed into law on December 26, 1995, clarified the 1992 Act and eliminated its sunset provision, making the program permanent.

The intent of FSHCAA is to increase the availability of funds for the provision of primary health care services by reducing the expenditure of Health Center Program funds for medical malpractice insurance premiums. The FSHCAA accomplishes this by making deemed health centers (and their officers, directors, employees, and certain contractors) Federal employees for the purpose of medical malpractice protection. As Federal employees, these organizations and individuals are immune from medical malpractice suits for actions within the scope of their project and health center employment. In the event that a medical malpractice lawsuit is filed against a deemed entity or covered provider acting within the scope of his/her employment in grant-related activities, the United States is substituted for the deemed entity and the covered employee. The health center and the covered employee will be dismissed from the case, with the case continuing against the United States as the sole defendant.

B. Applicability

This PIN applies to all health centers funded under the Health Center Program authorized in section 330 of the PHS Act (42 U.S.C. 254b), as amended, specifically:

- Community Health Center (CHC) Programs, funded under section 330(e);
- Migrant Health Center (MHC) Programs, funded under section 330(g);
- Health Care for the Homeless (HCH) Programs, funded under section 330(h); and
- Public Housing Primary Care (PHPC) Programs, funded under section 330(i).

For the purposes of this document, the term “health center” refers to the diverse types of health centers (i.e., CHC, MHC, HCH, and PHPC) that are supported under section 330 of the PHS Act and that have been deemed to be employees of the Public Health Service pursuant to section 224(g) of the PHS Act.

III. WHAT IS AN “EMERGENCY”?

For the purposes of this PIN, an “emergency” or “disaster” is defined as an event affecting the overall health center target population and/or the health center’s community at large, which precipitates the declaration of a state of emergency at a local, State, regional, or national level by an authorized public official such as a governor, the Secretary of the U.S. Department of Health and Human Services, or the President of the United States. Examples include, but are not limited to: hurricanes, floods, earthquakes, tornadoes, widespread fires, and other natural/environmental disasters; civil disturbances; terrorist attacks, collapses of significant structures within the community (e.g., buildings, bridges); and infectious disease outbreaks and other public health threats.

In situations where an emergency has not been officially declared, HRSA will evaluate on a case-by-case basis whether extraordinary circumstances justify a determination that the situation faced by the health center constitutes an “emergency” for purposes of extending FTCA coverage to services provided at temporary locations.

IV. SCOPE OF PROJECT AND FTCA COVERAGE

Health center employees and certain contractors are eligible for FTCA coverage only while providing services within the approved section 330-grant supported scope of project. This PIN describes the two mechanisms by which, during an emergency, FTCA-deemed health centers may include the provision of FQHC services at a temporary location within the scope of project. The choice of which mechanism to use depends on whether the proposed activity is located (1) inside the health center’s service area and within areas adjacent to the health center’s service area (i.e., neighboring counties, parishes, or other political subdivisions) or (2) outside the health center’s service area and beyond neighboring counties, parishes, or other political subdivisions. If a health center needs to continue operating the temporary site beyond 90 days from the onset of the emergency, the health center must submit a change in scope request through the HRSA Electronic Handbooks. The request must be consistent with the requirements described in PIN 2002-07 and PIN 2007-14.

A. FTCA Coverage within the Service Area

The scope of project is a description of the health center’s project, categorized by five core elements (sites, services, providers, target population, and service area) for which grant funds have been approved. The FTCA statute and regulations do not permit FTCA coverage to follow health center providers providing care outside of the health center’s approved scope of project, which includes a defined target population and service area, nor outside of the scope of their employment.

HRSA recognizes that, during an emergency, FTCA-deemed health centers are likely to participate in an organized State or local response and may be called upon to provide primary health care services at temporary locations. Temporary locations include any place that provides shelter to evacuees and victims of an emergency. It also includes those locations where mass immunizations or medical care is provided as part of a coordinated effort to provide temporary medical infrastructure where it is most needed. These temporary locations will be considered part of a health center's scope of project if all of the following conditions are met:

1. Services are provided on a temporary basis.
2. Temporary locations are within the health center's service area or neighboring counties, parishes, or other political subdivisions adjacent to the health center's service area.
3. Services provided by health center staff¹ are within the approved scope of project.
4. All activities of health center staff are conducted on behalf of the health center. (Health center providers who volunteer in their individual capacity to respond will not be protected under the health center's FTCA coverage.)

To assure that the emergency response at temporary locations is considered part of the health center's scope of project and that it will be covered by the FTCA, the health center must provide the following information to its HRSA Project Officer by phone, e-mail, or fax: (1) health center name; (2) the name of a health center representative and that person's contact information; and (3) a brief description of the emergency response activities. Health centers must submit this information as soon as practicable but no later than 15 days after initiating emergency response activities. HRSA will determine on a case-by-case basis whether extraordinary circumstances justify an exception to this 15-day requirement. If the HRSA Project Officer is not available, the health center should contact (1) the Bureau of Primary Health Care's main phone line at: 301-594-4110 or (2) the FTCA Hotline at: 1-866-FTCA-Help (382-2435).

For purposes of FTCA coverage, patients served by FTCA-deemed providers at temporary locations included in the scope of project (following the process above) will be considered health center patients. As such, the health center and its providers will be covered by the FTCA for these services.

As stated above, if a health center needs to continue operating the temporary site beyond 90 days from the onset of the emergency, the health center must submit a change in scope request as described in PIN 2002-07 and PIN 2007-14. The request must be submitted through the HRSA Electronic Handbooks.

¹ Including contractors eligible under section 224(g)(5) of the PHS Act.

B. FTCA Coverage Outside the Service Area

In rare cases, an emergency may impact an entire region or State, causing widespread devastation and evacuation of the population served by the health center to another area of the State or region. In those unique situations, a health center may be called upon to fulfill its requirements under the Health Center Program by continuing to provide care to its target population, which has been displaced by the emergency to a distant part of the State or region. In these instances, if the site of a deemed health center in the impacted area is destroyed or unable to operate, the health center may submit a request for prior approval to temporarily change its scope of project to include operation of a temporary site within the health center's general geographic region, in an area outside the health center's regular service area and beyond areas adjacent to the health center's service area. The purpose of this scope change should be to provide medical care primarily to the health center's target population and to other medically underserved populations that may have been displaced by the disaster. The following conditions must be met in order for the temporary site outside of the service area and in an area that is not in a neighboring county, parish, or political subdivision to be eligible for inclusion within the scope of project:

1. The health center must demonstrate that the purpose of the temporary site is to provide services primarily to its original health center target population (as defined in the most recent application for section 330 grant support), which has been displaced by the emergency, and to other medically underserved populations that may have been displaced by the disaster.
2. Services provided are on a temporary basis.
3. Services are provided by health center staff² and are within the approved scope of project.
4. All activities of health center staff are conducted on behalf of the health center. (Health center providers who volunteer in their individual capacity to respond will not be protected under the health center's FTCA coverage.)

Please note that State licensure requirements apply in all instances.

To ensure that the temporary site is considered part of the center's scope of project and that FTCA coverage will apply, grantees must contact their HRSA Project Officer by telephone, e-mail or fax and submit a request for prior approval to add the new site. The request must include a summary of the requested change in scope of project, including verification that the four conditions above will be met. HRSA will expedite the review of these requests with the goal of notifying the grantee of HRSA's decision (i.e., approval or disapproval) by telephone or via e-mail within 48 hours of receipt of the request. Again, if a health center needs to continue operating an approved temporary

² Including contractors eligible under section 224(g)(5) of the PHS Act.

site beyond 90 days from the onset of the emergency, the health center must submit, through the HRSA Electronic Handbooks, a change in scope request as described in PIN 2002-07 and PIN 2007-14.

C. FTCA Coverage for Non-Impacted Health Centers

In emergency situations, health centers that are not impacted by the emergency may (1) assist at temporary sites within the same service area and within neighboring counties, parishes, or political subdivisions or (2) operate temporary sites within the service area and within neighboring counties, parishes, or political subdivisions by including the temporary locations within the scope of project using the process described in Section IV.A., above. The processes described in this PIN are not applicable to situations where employees of non-impacted health centers seek FTCA coverage to provide care during emergencies outside their service area and beyond neighboring counties, parishes, or political subdivisions.

V. VOLUNTEERS ARE NOT ELIGIBLE FOR FTCA COVERAGE UNDER THE HEALTH CENTER FTCA PROGRAM

The law that authorizes the Health Center FTCA Program does not extend FTCA coverage to volunteers at health centers. The current statute specifically limits FTCA coverage to health center employees, governing board members, officers, and certain contractors.³ While it can be anticipated that health centers will receive numerous offers of and requests for volunteer assistance during emergencies, those volunteers will not be covered by the FTCA under the Health Center FTCA Program.

However, it is possible that the volunteer would qualify for immunity or limited liability under State or Federal charitable immunity/limited liability statutes (such as the Federal Volunteer Protection Act of 1997⁴) or under Federal provisions related to the National Disaster Medical System (section 2811 of the PHS Act).⁵

VI. FREQUENTLY ASKED QUESTIONS

1. Is the FTCA Katrina PIN (2005-19) policy applicable to future emergencies?

A: No. PIN 2005-19, "Federal Tort Claims Act Coverage for Deemed Consolidated Health Center Program Grantees Responding to Hurricane Katrina," applied only to the emergency response after Hurricanes Katrina and Rita. This PIN (PIN 2007-16) describes a broader, prospective policy that applies to future emergencies.

³ PHS section 224(g)(1)(A).

⁴ Public Law 105-19.

⁵ For more information on the National Disaster Medical System, see: <http://www.hhs.gov/aspr/opeo/ndms/join/index.html>

2. Does FTCA coverage apply if a health center provider crosses State lines?

- A: The key question is not whether the provider has crossed State lines, but whether the provider is providing services within the approved scope of project. If the health center's clinicians are providing care outside of the approved scope of project, the center and clinicians will NOT be covered by the FTCA.

In certain border area cases, the health center's service area or neighboring counties may cross State lines. In this instance, if the health center's clinicians are providing care within the health center's approved scope of project, the health center and clinicians will be covered by the FTCA. In situations of regional emergencies, it may be possible for a health center to request prior approval to temporarily change its scope of project to include operation of a temporary site outside the State, as described in Section IV.B. of this PIN. Please note that State licensure requirements apply in all instances.

3. When should a health center submit a formal change in scope of project request?

- A: Health centers expecting to operate at a temporary location beyond 90 days from the onset of the emergency must submit a formal change in scope of project request. Health centers are encouraged to submit the formal request well in advance of the 90-day limitation for a temporary site to allow for processing time and to ensure FTCA coverage beyond the 90 days.

4. Do health centers have to submit a formal change in scope of project request to provide services at temporary sites during an emergency?

- A: No. HRSA will consider these temporary sites part of the center's scope of project if the criteria described in Section IV.A. or IV.B. are met and the health center follows the process described in the applicable section. Note that prior approval is necessary for changes in scope described in Section IV.B. Health centers expecting to operate at a temporary location beyond 90 days from the onset of the emergency must submit a formal change in scope of project request.

5. As the result of an emergency, a deemed health center provides services at a site within its scope of project to evacuees who have traveled from another service area where medical facilities have been destroyed. Are the health center and its providers covered by the FTCA for services to evacuees?

- A: For purposes of FTCA coverage, anyone seeking care at a deemed facility, including at temporary sites within the scope of project, is a "health center patient." It does not matter whether the person is a permanent resident of the community or is there temporarily. Therefore, in the example above, FTCA coverage applies to the health center and its providers who provide services to the evacuees at its regular facility and at temporary sites.

6. A deemed health center is destroyed as a result of a disaster. In order to continue providing services, the destroyed health center sets up and operates a temporary site

within the service area or within neighboring counties, parishes, or political subdivisions. Are medical services provided by the health center's staff at this temporary site covered under the FTCA?

A: Yes, HRSA will consider a temporary site part of the center's scope of project if the criteria described in Section IV.A. are met and the health center follows the process prescribed in that section. If a health center needs to continue operating a temporary site beyond 90 days from the onset of the emergency, the health center must submit a change in scope request as described in PIN 2002-07 and PIN 2007-14.

7. A deemed health center is destroyed as a result of a disaster. In order to continue providing services, the destroyed health center sets up and operates a temporary site OUTSIDE the service area, in an area that is NOT in a neighboring county, parish, or political subdivision. Are medical services provided by the health center's staff at this temporary site covered under the FTCA?

A: In this situation, the process described in section IV.A. is not applicable because the health center is providing services outside its service area and beyond neighboring counties, parishes, or political subdivisions. Instead, the health center should follow the process described in section IV.B. of the PIN, which applies to requests to temporarily change the scope of project to include operation of a temporary site outside the service area and beyond neighboring counties, parishes, or political subdivisions.

8. In order to assist with the medical response after an emergency, staff from a deemed health center go to work at a temporary location such as a shelter for evacuees within its service area or within neighboring counties, parishes or other political subdivisions adjacent to its service area. Are medical services provided by the health center's staff at this temporary location covered under the FTCA?

A: If temporary locations are included within the approved scope of project following the prescribed process in Section IV.A., the evacuees treated by those clinicians are considered health center patients. Therefore, the health center staff would be covered under the FTCA for medical services provided to the evacuees.

9. A health center employee is providing care at a local hospital as part of a community-wide emergency response. Are these services covered under FTCA?

A: Yes, as long as the employee is providing services within the health center's approved scope of project, at the direction of the health center (not volunteering on his/her own), and the health center has followed the process described in Section IV.A.

10. If grantees use volunteers to provide services during an emergency, are these volunteers eligible for coverage under the Health Center FTCA program?

A: No. The relevant statute does not allow for FTCA coverage of health center volunteers. It is possible that the volunteer, if he/she has been deployed by the Federal Government

as an intermittent Federal employee under a Federal Emergency Mission Act (FEMA) Mission Assignment, would be covered under another FTCA authority. It is also possible that the volunteer would qualify for immunity or limited liability under State or Federal charitable immunity/limited liability statutes (such as the Federal Volunteer Protection Act of 1997) or under Federal provisions related to the National Disaster Medical System (section 2811 of the PHS Act).

APPENDIX M

Emergency Management Resources

General Information

California Primary Care Association (CPCA)

<http://www.cPCA.org>

The CPCA website has many tools and resources for emergency management available for free download. Tools and templates include an Emergency Operations Plan, needs Assessments tools, and training presentations.

Community Health Care Association of New York State (CHCANYS)

http://www.chcanys.org/index.php?src=gendocs&link=ep_forcenters&category=Main

This website provides many resources for health centers, including a patient brochure on role of CHC in emergency, guide to working with comm. Organizations, a manual template, and sample policies/procedures related to emergency management.

Community Health Center Association of Connecticut (CHCACT)

<http://www.chcact.org>

This website offers free download of a CD that provides information for all types of emergencies, planning tools, and many resources. The CD is called ‘Emergencies Happen (so read this now!’.

Homeland Security Presidential Directives

http://www.dhs.gov/xabout/laws/editorial_0607.shtm

National Preparedness Goal

<http://www.ojp.usdoj.gov/odp/assessments/hspd8.htm>

National Response Plan (Homeland Security)

http://www.dhs.gov/dhspublic/interapp/editorial/editorial_0566.xml

National Incident Management System

<http://www.fema.gov/emergency/nims/index.shtm>

Advanced Practice Centers

<http://www.naccho.org/topics/emergency/APC.cfm>

These centers funded by the National Association of City and County Health Officials (NACCHO) and the Centers for Disease Control and Prevention are local public health agencies that are developing cutting-edge tools and resources that will help other public health agencies prepare for, respond to, and recover from major emergencies.

American College of Physicians Bioterrorism Information

http://www.acponline.org/bioterro/self_assessment.htm

This is a self-assessment program for clinicians to recognize common bioterrorism weapons.

Centers for Disease Control Emergency Preparedness Response

<http://www.bt.cdc.gov>

This is CDC’s emergency preparedness and response page with information about terrorist threats such as agents, diseases, chemical, and radiation emergencies.

Community Preparedness

<http://www.counterterrorismtraining.gov/comm/index.html#4>

This has a list of resources for community-level planning.

Department of Health and Human Services

<http://www.dhhs.gov/emergency/index.shtml>

This webpage provides information on many areas of emergency management, including biological, chemical and radiological weapons, disaster and emergency preparedness, environmental disasters, and mental health and traumatic events.

Disaster Preparedness and Response (NACHC)

<http://www.nachc.com/disaster/default.asp>

NACHC's emergency preparedness main page contains a resource list of various websites and articles specifically geared towards community health centers.

Ready.gov

<http://www.ready.gov/>

The Department of Homeland Security developed this site to provide hands on information for individuals, businesses, and kids to prepare for emergencies. Information is available in both English and Spanish.

Disaster Preparing Your Small Business for a Disaster

www.bomasf.org/pdf/news/smallbizdisaster.pdf

Created for small businesses by the San Francisco Small Business Commission, this tool contains checklists for Emergency Planning and Emergency Preparedness

Disaster Services (American Red Cross)

http://www.redcross.org/services/disaster/0,1082,0_500_00.html

These resources are geared towards personal preparations and can be beneficial to health centers for informing staff and patients about what they can personally do to prepare for an emergency.

Emergency Preparedness and Response: Preparation and Planning (CDC)

<http://www.bt.cdc.gov/planning/>

The CDC emergency preparedness website includes a wide-range of materials from legal and planning issues surrounding emergency preparedness to personal preparedness. This is a good starting point for health centers to explore in getting familiar with the aspects emergency preparedness.

Emergency Preparedness, Response & Recovery Checklist: Beyond the Emergency Management Plan

http://www.healthlawyers.org/Template.cfm?Section=Public_Information_Series&Template=/ContentManagement/ContentDisplay.cfm&ContentID=43074

Developed by the American Health Lawyers Associations, this tool identifies the key legal and operational issues that arise during emergency situations.

Emergency Preparedness Resource Inventory (AHRQ)

<http://www.ahrq.gov/research/epri/index.html>

A web-based tool to help local, regional, and state public health planners compile customized inventories of health care and emergency resources. In addition, it allows communities to assess their regional supply of critical resources, prepare for incident response, estimate gaps and support future resource investment decisions.

Evacuation Plans and Procedures (OSHA)

<http://www.osha.gov/SLTC/etools/evacuation/index.html>

This e-tool is designed to assist small, low-hazard service or retail businesses implement an emergency action plan, and comply with OSHA's emergency standards.

Federal Emergency Management Agency (FEMA)

<http://www.fema.gov>

This website gives information about FEMA and the resources they provide to disaster response personnel and victims of a disaster.

Incident Command System and Unified Command (ICS/UC).

<http://www.osha.gov/SLTC/etools/ics/index.html>

This e-tool is designed to provide basic information about the Incident Command System and Unified Command, specifically as it relates to the National Contingency Plan 40 CFR.300.

Model Operational Guidelines for Disease Exposure Control (CSIS Homeland Security Program)

http://www.csis.org/index.php?option=com_csis_pubs&task=view&id=2504

This report provides recommendations and strategies on how communities can prevent or minimize exposure to contagious diseases when medical countermeasures are unavailable.

National Health Care for the Homeless Council

<http://www.nhchc.org/shelterhealth.html>

This document provides detailed information on maintaining health in shelters.

NYC Healthcare PREPARES (NYC Department of Health and Mental Hygiene)

<http://www.nyc.gov/html/doh/html/bhpp/bhpp.shtml>

This public website has been created to share many of the protocols, templates, and emergency preparedness drill scenarios that have been created in New York City over the past 4 years of the BHPP program.

Present at the Table, Absent from the Plans II: Update on the Involvement of Health Centers in State Bioterrorism Preparedness Planning (NACHC)

http://www.nachc.com/pubmgr/Files/IB/specialtopics1_dp.pdf

This document outlines the extent of PCAs' involvement in their respective states on emergency preparedness planning.

Public Health Emergency Response Guide for State, Local and Tribal Public Health Directors (CDC)

<http://www.bt.cdc.gov/planning/responseguide.asp>

This document is an all-hazards template in assisting state, local and tribal health leaders in establishing priorities and undertaking necessary actions during the response to an emergency or disaster. It also has a template for assessing readiness of a facility and leadership roles and responsibilities during preparation and response. For a Spanish version of this document, go to:

www.bt.cdc.gov/planning/espanol/responseguide.asp

Public Health Preparedness (ASTHO)

<http://www.astho.org/?template=preparedness.html>

ASTHO's main page about emergency preparedness contains a wide-range of resources about emergencies and disasters, food safety and security, measuring preparedness, mutual aids, public health security, Strategic National Stockpile, Assessment tools and much more.

Public Health Preparedness Database (RAND Corporation)

<http://www.rand.org/health/projects/php/>

This website contains a searchable database of exercises used to evaluate public health preparedness.

What to Do in an Emergency (National Oceanic and Atmospheric Administration)

http://www.nws.noaa.gov/om/all-haz/what_to_do.htm

This is a health education tool (poster) that health centers can use in their facilities.

Personal Protective Equipment

Personal Protective Equipment (PPE)

<http://www.osha.gov/SLTC/personalprotectiveequipment/index.html>

This website contains a wide-range of information (i.e. tools, OSHA standards, PPE evaluation, etc.) about personal protective equipment in a workplace. This is a starting point for health centers in identifying the appropriate protective equipment they need for their facility.

Training/Competencies

Bioterrorism Preparedness: Education and Training Resources (PHF, 2003)

http://www.phf.org/BT_Workforce_Prep_Resources101703.pdf

This is a compilation of resources aiming to help states and communities strengthen workforce capacity and establish core public health competencies around emergency preparedness and response.

Centers for Public Health Preparedness Resource Center (CDC and Association of Schools of Public Health)

<http://www.asph.org/acphp/>

This site contains a listing of the Centers of Public Health Preparedness and is a source for the public health workforce in establishing partnerships and collaborative efforts in the academic field.

Center for Emergency Preparedness and Disaster Response (CEPDR)

<http://yalenewhavenhealth.org/emergency/>

This website provides many online courses designed for health care workers. Some are specifically tailored for the needs of community health centers. There are also a couple of courses that will help you meet NIMS training requirements.

Emergency Management Institute (FEMA)

<http://training.fema.gov/emiweb/IS/crslist.asp>

This website lists various classes, both independent study and off-site courses. A listing of all courses can be viewed in this site and is a good starting point in identifying which courses are appropriate for health centers.

Illinois Public Health Preparedness Center (IPHPC)

<http://www.publichealthlearning.com/Public/default.aspx>

This website offers more than 60 competency-based, online courses that are continuously available at no cost and offered in a unique self-directed, instructor-led format. These courses enhance basic, crosscutting and advanced competency needs for public health workers in areas that include emergency preparedness and response, and infectious disease preparedness.

Clinical Surge Capacity

Community-Based Mass Prophylaxis: A Planning Guide for Public Health Preparedness

<http://www.ahrq.gov/downloads/pub/biotertools/cbmprophyl.pdf>

The guide includes the *Bioterrorism and Epidemic Outbreak Response Model* (AHRQ Pub. No. 04-0044) which is a web-based interactive tool to help health system leaders calculate staffing needs for vaccination and antibiotic dispensing. This tool can be accessed at: <http://www.ahrq.gov/research/biomodel3/>

Modular Emergency Medical System (MEMS): Expanding Local Healthcare Structure in Mass Casualty Terrorism Incident

http://accem.org/pdf/mems_copper_book.pdf

This document illustrates the MEMS model, giving insight to health centers as to how to maximize the utility and capacity of local medical system assets.

Optimizing Surge Capacity: Regional Efforts in Bioterrorism Readiness (AHRQ)

<http://www.ahrq.gov/news/ulp/btbriefs/btbrief4.pdf>

This document gives an overview of surge capacity in a hospital setting. However, this document identifies the factors that needs to be considered in a surge event and therefore could be helpful to health centers

Strategic National Stockpile

Emergency Dispensing Site Management and Operations (Commonwealth of Massachusetts Department of Public Health)

http://www.mass.gov/dph/bioterrorism/advisorygrps/pdfs/emergency_dispensing_site_3_05.pdf

This document provides guidance to communities distributing, transferring and allocating medical assets in a biological emergency event by establishing community-based emergency dispensing sites (EDS). Although this document is a draft in progress, it provides information about essential components that are involved in embarking on this type of system.

Strategic National Stockpile (CDC)

(<http://www.bt.cdc.gov/stockpile/#er>)

This gives a basic overview of how SNS works and operates.

The Strategic National Stockpile (SNS): A Reference for Local Planners (NACCHO)

<http://archive.naccho.org/documents/NACCHO-NPS-Guide.pdf>

Provides a step-by step guide on SNS function and coordination with other entities

Pandemic Influenza

Avian Influenza (CDC)

<http://www.cdc.gov/flu/avian/>

This website focuses primarily on Avian flu and has various resources.

Avian Influenza, including Influenza A (H5N1), in Humans: WHO Interim Infection Control Guideline for Health Care Facilities (WHO)

<http://www.wpro.who.int/NR/rdonlyres/EA6D9DF3-688D-4316-91DF-5553E7B1DBCD/0/InfectionControlAlinHumansWHOInterimGuidelinesfor.pdf>

This guideline provides infection control guidance for health workers in health care facilities involved in managing patients with suspected or confirmed avian influenza infection.

Business Pandemic Influenza Checklist (CDC)

<http://www.cdc.gov/flu/pandemic/pdf/businessChecklist.pdf>

This checklist is geared towards businesses; however it can be a useful tool for health centers in providing guidance about pandemic influenza planning.

Department of Health and Human Services Official Pandemic Flu site

(www.PandemicFlu.gov)

This website contains information about planning, response and recovery of pandemic and Avian influenza for various audiences and settings. There is also a checklist for medical offices and clinics on pandemic influenza planning.

(<http://www.pandemicflu.gov/plan/medical.html>).

HHS Pandemic Influenza Plan

<http://www.hhs.gov/pandemicflu/plan/>

This website contains a wide-range of pandemic influenza resources.

Influenza (National City and County Health Officials)

<http://www.naccho.org/topics/infectious/influenza.cfm>

This website contains information, updates and tools pertaining to avian flu.

National Strategy for Pandemic Influenza (Homeland Security Council, November 2005)

<http://www.whitehouse.gov/homeland/pandemic-influenza.html>

The entire national Strategy for Pandemic Influenza document can be downloaded from this site.

Pandemic Influenza (ASTHO)

http://www.astho.org/templates/display_pub.php?pub_id=1383&admin=1

This resource provides access to state pandemic influenza plan.

Pandemic Influenza for Health Professionals (CDC)

<http://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 the spread of this agent to the United States.

State and Local Pandemic Influenza Planning Checklist (CDC)

<http://www.cdc.gov/flu/pandemic/pdf/PandemicFluChecklist.pdf>

This checklist is based on the HHS Pandemic Influenza Plan, Public Health Guidance for State and Local Partners, which identifies specific activities that state and local officials can do to prepare. It addresses the various steps necessary in developing a pandemic influenza plan.

Communication

Communication in Risk Situations: Responding to the Communication Challenges Posed by Bioterrorism and Emerging Infectious Diseases (ASTHO)

<http://www.astho.org/pubs/ASTHO%20Risk%20Communication%20e-Workbook.htm>

It is a guideline for the communication of health risk information to diverse audiences in response to the risks posed by bioterrorism and emerging infectious diseases.

Disaster Communications and Alert Systems (National Oceanic and Atmospheric Administration)

<http://www.disastercenter.com/commun.htm>

This website has a list of resources about state radio frequencies, types of radio to use and various resources pertaining to disaster communication systems.

Environmental Health

Emergency and Terrorism preparedness for Environmental Health Practitioners

<http://www.cdc.gov/NCEH/EHS/etp/DEFAULT.HTM>

This website serves as a clearinghouse of information resources related to emergency and terrorism preparedness for environmental health practitioners. Although this resource list is created for environmental health practitioners, it includes a comprehensive list of emergency preparedness materials from various public health agencies.

Continuity of Operations

Business and Industry Guide (American Red Cross)

http://www.redcross.org/services/disaster/0,1082,0_606_00.html

This website is a great resource for health centers in identifying various elements to consider in an emergency situation.

Prepare Financially (American Red Cross)

http://www.redcross.org/services/disaster/0,1082,0_605_00.html

This website outlines financial preparations needed for a disaster. The information on this website is geared more towards personal property, which can be useful for health centers in educating their clients about emergency financial preparations.

Mental Health

Disasters and Emergencies (HHS)

<http://www.hhs.gov/disasters/>

A repository of resources on how to deal with mental health issues in an emergency targeted for parents and families, adults, teachers, emergency and response workers and clinicians. This is also an excellent patient education tool for health centers to use.

Disaster Mental Health Resources (CDC)

<http://www.bt.cdc.gov/mentalhealth/>

This page includes information on general strategies for promoting mental health and resilience that have been developed by various organizations based on experiences in prior disasters.

Emergency Mental Health and Traumatic Stress (SAMHSA)

<http://www.mentalhealth.samhsa.gov/cmhs/EmergencyServices/default.asp>

This website has resources on immediate, short-term crisis counseling, as well as ongoing support for emotional recovery in emergencies. It also has a direct link to SAMHSA's Disaster Training Assistance Center, which assists states and territories with behavioral health "all-hazards" disaster planning, that allows them to prepare for and respond to both natural and man made disasters. SAMHSA Disaster Training Assistance Center provides consultation to review disaster plans and compiles research on "new" threats and planning methodologies.

Mental Health in Emergencies (WHO)

http://www.who.int/mental_health/emergencies/en/

This website features a global perspective on mental health during emergencies. It has a checklist of mental health needs planning during an emergency and toolkits that provide the key elements of mental health issues in an emergency.

National Center for Post-Traumatic Stress Disorder

http://www.ncptsd.va.gov/pfa/PFA_9_6_05_Final.pdf

The Psychological First Aid Field Operations Guide is an evidence-informed modular approach for assisting people in the immediate aftermath of disaster and terrorism: to reduce initial distress, and to foster short and long-term adaptive functioning.

Training Manual for Mental Health and Human Service Workers in Major Disasters

<http://www.mentalhealth.samhsa.gov/publications/allpubs/ADM90-538/Default.asp>

This manual presents an overview of essential information including: how disasters affect children, adults and older adults, the importance of tailoring the program to fit the community, descriptions of effective disaster mental health interventions, and strategies for preventing and managing worker stress.

Best Practices

Best Practices (FEMA)

<http://www.fema.gov/emergency/practices.shtm>

This has a list of resources of best practices in disaster management.

Best Practices and Case Studies (FEMA)

<http://www.fema.gov/plan/prevent/bestpractices/index.shtm>

This website has a compilation of best practices in disaster mitigation.

California Fires Coordinating Group: A Report to the Secretary of Homeland Security (February 13, 2004) (FEMA)

http://www.fema.gov/pdf/library/draft_cfcg_report_0204.pdf

This report provides an overview of the shared success of federal, state and local governments, as they worked with voluntary agencies to conduct joint response and recovery operations in the aftermath of the California Wildfires of 2003.

Cultural Competency

An ADA Guide for Local Governments: Making Community Emergency Preparedness and Response Programs Accessible to People with Disabilities (Department of Justice)

<http://www.usdoj.gov/crt/ada/emergencyprep.htm>

This guide includes elements and action steps that should be considered in supporting and providing services for people with disabilities in an emergency.

Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations (SAMHSA)

<http://www.mentalhealth.samhsa.gov/publications/allpubs/SMA03-3828/default.asp>

The purpose of this guide is to assist states and communities in planning, designing, and implementing culturally competent disaster mental health services for survivors of natural and human-caused disasters of all scales.

Disaster Medical Resources

Citizen Corps

<http://www.citizencorps.gov/>

This website provides information about the Citizen Corps whose goal is to help communities prevent, prepare for, and respond to crime, natural disasters, and other emergencies.

Community Emergency Response Teams

<http://www.citizencorps.gov/cert/>

The Community Emergency Response Team (CERT) is a concept that was developed and by the Los Angeles City Fire Department (LAFD) in 1985 with a charge of training civilians to better prepare for emergencies. This website has training materials and a directory of state Community Emergency Response Teams.

Medical Reserve Corps (Office of the U.S. Surgeon General)

<http://www.medicalreservecorps.gov/HomePage>

This website provides information about the Medical Reserve Corps (MRC) whose mission is to establish 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.

APPENDIX N

Glossary

Other Key Definitions

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

Damage Assessment: The process of assessing damage to campus facilities, infrastructure, computer hardware, vital records, etc. following an emergency, and determining what can be salvaged or restored and what should be replaced.

Emergency Operations Center: A centralized location from which emergency operations can be directed and coordinated.

Emergency Management: The process of planning, developing, implementing, and executing a comprehensive system of principles, policies, procedures, methods, and activities designed to ensure an organization's effective response to natural and manmade disasters affecting its environment and business operations. Emergency management is a comprehensive system, which includes planning, mitigation, preparedness, response, and recovery activities. Health center emergency management entails developing a plan based on the hazard vulnerabilities likely to affect the health center, conducting exercises and drills to assure sound response and recovery activities, and includes annual reassessments and updates to recognize any new threats or vulnerabilities to improve on emergency management procedures and activities.

Emergency Management Plan (EMP): A document describing the comprehensive system of principles, policies, procedures, methods, and activities to be applied in response to natural and manmade disasters to ensure patient and employee safety, to mobilize resources, to maintain health center business operations, and to assist in providing mutual aid in a community-wide response requiring medical services.

Emergency Support Functions (ESF): This is a way to organize the roles, responsibilities, and activities in emergency response used in many governmental emergency management plans. A specified agency leads each function and supporting agencies are coordinated under that lead. For example, the State Department of Transportation would likely take the lead for ESF 1 and bus companies and trucking vendors would be supporting agencies to help move people and resources as part of the larger emergency response. The emergency support functions recognized by federal, state, and local government emergency responders are as follows:

EMERGENCY SUPPORT FUNCTIONS (ESF)		
ESF 1: Transportation	ESF 6: Mass Care, Housing, and Human Services	ESF 11: Agriculture and Natural Resources
ESF 2: Communication	ESF 7: Resource Support	ESF 12: Energy
ESF 3: Public Works/Engineering	ESF 8: Health and Medical Services	ESF 13: Public Safety and Security
ESF 4: Firefighting	ESF 9: Urban Search and Rescue	ESF 14: Long-term Community Recovery/Mitigation
ESF 5: Emergency Management	ESF 10: Oil and Other Hazardous Materials Response	ESF 15: External Affairs

Although **ESFs** are considered to be the responsibility of government, many of these functions are important to the daily operation of a health center, with the significance of these functions being more evident during

major events or times of disaster. Health centers should establish the emergency support functions and corresponding roles and responsibilities relevant to each health center's specific emergency management needs, which may be similar but not necessarily the same as a typical local government ESF.

Federal Emergency Declaration: Any disaster or other event for which the President of the United States has determined the available resources of the affected State(s) and local government(s), disaster relief organizations, and any applicable insurance coverage are inadequate to meet the needs of the emergency situation. A federally declared emergency initiates the federal response, which is guided, in part, by the Stafford Disaster Relief and Emergency Assistance Act (P.L. 93-288, as amended). The Stafford Act provides for an orderly and continuing means of assistance by the federal government to State and local governments in carrying out their responsibilities to alleviate the suffering and damage which result from such disasters including supplementing efforts and capabilities to save lives, protect property, and ensure public health and safety. The request for a federal emergency declaration is initiated by the Governor of the State, via memorandum to the President through the Director of FEMA.

Federal Emergency Management Agency (FEMA): The federal agency responsible for national emergency planning, response, and recovery, including mitigation activities, training first responders, and managing the National Flood Insurance Program.

Hazard Vulnerability Analysis (HVA): The process of identifying the risks that may pose a threat to an organization so that plans can be developed to avoid or minimize the impact if incident occurs.

Incident Command System (ICS): A system for managing resources from other organizations during an emergency. The ICS is a standardized emergency management system that is used nationwide. It was developed in the 1970's as a method of coordinating the response from many fire departments to wildfires in California and has been proven to work over the past 3 decades. It is specifically designed to support numerous organizations working together for incidents of all sizes. There are specific positions with defined job roles that support the entire response. Only the positions needed are 'activated' for the response so if it is small, there may be only a few people involved. If it is big, the entire structure may be activated.

The Joint Commission: A national independent, not-for-profit organization, which serves as a "standards setting" and accrediting body for health care organizations. The Joint Commission focuses on improving the quality and safety of care provided by health care organizations. The Joint Commission utilizes a comprehensive accreditation process to evaluate an organization's compliance with these standards and other accreditation requirements. The Joint Commission evaluates and accredits more than 15,000 health care organizations and programs in the United States.

National Incident Management System (NIMS): Provides a national approach for Federal, State, local, and tribal governments, and private organizations to work effectively together to prepare for, respond to, and recover from disasters. There is an online training course that provides an overview of the ICS and its relationship to the NIMS and can be found at <http://training.fema.gov/EMIWeb/IS/is100.asp>.

Recovery Plan: The part of the Emergency Management Plan, which defines the resources, actions, and tasks needed to restore facilities and business operations, based on defined recovery goals, after a disaster occurs.

Strategic National Stockpile (SNS): The national cache for antibiotics, chemical antidotes, [antitoxins](#), [vaccines](#), life-support medications, [IV](#) administration supplies, airway maintenance supplies, and medical/surgical items. The SNS is designed to supplement and re-supply State and local [public health](#) agencies in the event of a national emergency, anywhere and at anytime within the United States or its territories. The SNS is part of the Centers for Disease Control and Prevention (CDC), Coordinating Office of Terrorism Preparedness and Emergency Response.

Surveillance: The systematic ongoing collection, analysis, and reporting of data to those who need to know so that action can be taken. Surveillance is the essential component of identifying disease outbreaks before they spread throughout the community.

Surge Capacity: The ability of institutions, such as health centers, hospitals, pharmacies, or public health laboratories, to respond to a substantial increase in demand for services during a public emergency.

APPENDIX 0

Commonly Used Acronyms

Commonly Used Acronyms

ADA	Americans with Disabilities Act
AHRQ	Agency for Healthcare Research and Quality
ASPR	Assistant Secretary of Preparedness and Response
ASTHO	Association of State and Territorial Health Officials
BPHC	Bureau of Primary Health Care
CDC	Centers for Disease Control
CERT	Community Emergency Response Teams
CFLOP	Command, Finance, Logistics, Operations, and Planning
CMHS	Center for Mental Health Services
CSIS	Center for Strategic and International Studies
DHHS	Department of Health and Human Services
DHS	Department of Homeland Security
DMAT	Disaster Medical Assistance Teams
DMORT	Disaster Morticians
EDS	Emergency Dispensing Sites
EMAC	Emergency Management Assistance Compact
EMC	Emergency Management Coordinator
EMP	Emergency Management Plan
EMRD	Emergency Management Resource Document
EMT	Emergency Management Team
EOC	Emergency Operations Centers
ESAR-VHP	Emergency System for Advance Registration of Volunteer Health Professionals
ESF	Emergency Support Functions
FAQ	Frequently Asked Questions
FEMA	Federal Emergency Management Agency
FTCA	Federal Tort Claims Act
FQHC	Federally Qualified Health Center
GETS	Government Emergency Telecommunication Service
HASP	Health and Safety Plans
HRSA	Health Resources and Services Administration
HVAC	Heating/Ventilation/Air Conditioning
ICS	Incident Command System
ICS/UC	Incident Command System and Unified Command
JAMA	Journal of the American Medical Association
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MAA	Mutual Aid Agreements
MEMS	Modular Emergency Medical System
MOU	Memorandums of Understanding
MRC	Medical Reserve Corp
NACHC	National Association of Community Health Centers
NEMA	National Emergency Management Association
NHSC	National Health Service Corp
NIMS	National Incident Management System
NOAA	National Oceanic and Atmospheric Administration
NS/EP	National Security and Emergency Preparedness
OSHA	Occupational Safety and Health Administration
PCA	Primary Care Association
PCO	Primary Care Officer
PHS	Public Health Service

PIN	Program Information Notice
POD	Point of Distribution
PPE	Personal Protective Equipment
SAMHSA	Substance Abuse and Mental Health Services Administration
SARS	Severe Acute Respiratory Syndrome
SNS	Strategic National Stockpile
SOP	Standard Operating Procedures
TSP	Telecommunications Service Program
UDS	Uniform Data System
VIPS	Volunteers in Police Service
VMI	Vendor Managed Inventory
VOAD	Volunteer Organizations Active in Disasters
WHO	World Health Organization
WMD	Weapons of Mass Destruction
WPS	Wireless Priority Service