



**<Insert Name of Facility>
Hospital
Emergency Operations Plan**

<Insert Date Template is Completed/Revised>
Supersedes Previous Version
This plan covers license year <insert year>
<License Number>

Facility Profile

Facility Name: _____

Address: _____

County: _____

Phone: _____ **Fax:** _____

Emergency Phone: _____

Email Address: _____

Owner/Corporation: _____

Address: _____

Phone: _____ **Secondary Phone:** _____

Emergency Phone: _____

Facility Administrator: _____

Address: _____

Phone: _____ **Secondary Phone:** _____

Emergency Phone: _____

Emergency Operations Plan Coordinator: _____

Address: _____

Phone: _____ **Secondary Phone:** _____

Emergency Phone: _____

Licensed Facility Bed Capacity: _____

Average Daily Census: _____

Specialty Services or Units: _____

Patients in Care

Provide the **average** number of individuals within the facility's care who have the following disabilities and/or dependencies:

Disability or Other Challenges	
Alzheimer's, dementia or cognitive impairment: _____	Confined to bed: _____
Blind or low vision: _____	Require 24-hour constant care: _____
Deaf or hearing impaired: _____	Chronic condition (please specify): _____
Speech impaired: _____	Other (please specify): _____
Limited mobility or difficulty walking: _____	
Primary language other than English	

Dependency	
Dialysis: _____ Insulin: _____	Walker/cane/scooter/wheelchair: _____
Ventilator: _____ Oxygen: _____	Other (please specify): _____
Service animal: _____	_____
Bariatric Bed	
Other machine dependent: _____	

**Table 1
Primary and Affiliate/Sister Facilities (See Attachment E)**

Primary Facility			
Facility Name	Address (Street, City, State, Zip)	County	Contact Number
Affiliate/Sister Facilities (Include specific information in Attachment E.)			
Facility Name	Address (Street, City, State, Zip)	County	Contact Number

Signature Page

<Insert Facility Name>

Name, Title

Date

Name, Title

Date

Mississippi State Department of Health, Office of Emergency Planning and Response

District Level

Emergency Planner

Date

Emergency Response Coordinator

Date

Emergency Preparedness Nurse

Date

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1. INTRODUCTION

A. Purpose

The *Minimum Standards of Operation for Mississippi Hospitals, Subchapter 43, Rule 41.43* states:

The licensed entity shall develop and maintain a written preparedness plan utilizing the “All Hazards” approach to emergency and disaster planning. The plan must include procedures to be followed in the event of any act of terrorism or man-made or natural disaster. The Emergency Operations Plan (EOP) will be reviewed by the Mississippi State Department of Health (MSDH) Office of Emergency Planning and Response (OEPR), or their designees, for conformance with the “All Hazards Emergency Preparedness and Response Plan.” Particular attention shall be given to critical areas of concern which may arise during any “all hazards” emergency whether required to evacuate or to sustain in place. Additional plan criteria or a specified EOP format may be required as deemed necessary by OEPR. The six (6) critical areas of consideration are:

- Communications - Facility status reports shall be submitted in a format and a frequency as required by the OEPR.
- Resources and assets
- Safety and security
- Staffing
- Utilities
- Clinical Activities

EOPs must be exercised and reviewed annually or as directed by OEPR. Written evidence of current approval or review of provider EOPs, by OEPR, shall accompany all applications for facility license renewals.

Regulatory and Center for Medicare and Medicaid Services require the following supporting plan documents:

- Alternate care sites (on and off campus)
- Transportation contracts with designated patient transporters
- Communications plan
- Continuity of operations
- Evacuation maps and floor plans
- Mutual aid agreements
- Organizational charts
- Policies and procedures
- Fire safety plan
- Hazard Vulnerability Analysis
- Training and exercise plans

- Incident specific appendices

B. Scope

The Emergency Operations Plan (EOP) is designed to guide planning and response to a variety of hazards that could threaten the environment of the hospital or the safety of patients, staff and visitors, or adversely impact the ability of the hospital to provide healthcare services to the community. The plan is also designed to meet state and local planning requirements.

Authority for activating the plan will rest with the **<Insert position title>**. Activation of the plan will be conducted in conjunction with agency command staff as well as local emergency management and public health personnel.

C. Planning Assumptions

The following assumptions delineate what is assumed to be true when the EOP was developed. The assumptions statement shows the limits of the EOP, thereby limiting liability.

- Identify top five hazards
- Identified hazards will occur.
- Healthcare personnel are familiar with the EOP.
- Healthcare personnel will execute their assigned responsibilities.
- Executing the EOP will save lives and reduce damage.

2. ADMINISTRATION

A. Executive Summary

The **<Insert name of facility>** Emergency Operations Plan (EOP) is an all-hazards plan that outlines policies and procedures for preparing for, responding to, and recovering from possible hazards faced by the organization. Coordination of planning and response with other healthcare organizations, public health, and local emergency management are emphasized in the plan. The plan also addresses proper plan maintenance, communications, resource and asset management, patient care, continuity of operations, management of staff, evacuation, and contingency planning for utilities failure.

The plan will undergo an annual review process to ensure any plan deficiencies are identified and addressed. An improvement plan will be instituted and maintained in the plan to ensure lessons learned and action items identified from exercises and real events are properly addressed and documented.

All response activities will follow the National Incident Management System (NIMS) guidelines. In addition, the agency will follow the Incident Command System organizational structure in response to emergency events and in exercises. In the event of a communitywide emergency, the agency's incident command structure will be integrated into and be consistent with the community command structure. Staff is encouraged to receive training in the ICS system and in assigned roles and responsibilities to ensure they are prepared to meet the needs of patients in an emergency.

B. Plan Review and Maintenance

Plan Review

The EOP will be reviewed and updated annually incorporating: the latest NIMS elements, data collected during actual and exercise plan activations, changes in the hazard vulnerability assessment, changes in emergency equipment, changes in external agency participation, etc.

Plan review should also consider changes in contact information, new communications with the local Emergency Management Agency, review of evacuation routes and alternate care sites, and staff and departmental assignments. The review will be conducted by **<Insert position title or group>**. Plan updates will be the responsibility of **<Insert position title>**.

Exercises

The <Insert name of facility> must test its plan and operational readiness at least annually. The hospital must participate in a community mock disaster drill at least annually. Also the hospital must conduct a paper-based, tabletop exercise at least annually (42 CFR 482.15) and CAH (42 CFR 485.625). This is accomplished through exercises in which many planned disaster functions are performed as realistically as possible under simulated disaster conditions.

An After-Action Report/Improvement Plan will be completed within 60 days. This improvement plan will be incorporated into the plan as soon as it is feasible. The <Insert position title> will be responsible for coordinating the exercises, AARs, and improvement planning.

All exercises will incorporate elements of the National Incident Management System, Hospital Incident Command System, and are Homeland Security Exercise and Evaluation Program compatible. Information on the Homeland Security Exercise and Evaluation Program can be found at <https://www.preptoolkit.org/web/hseep-resources>.

Future exercises should be planned and conducted according to improvement action items identified during previous exercises.

Table 2
Exercises Conducted

Type of Exercise	Hazard Exercised	Date of Exercise	AAR Completed

C. Authorities and References

<Insert title and date of local city and/or county Emergency Operations Plan >

<Insert titles of other organizational plans or policies that have a connection to the Emergency Operations Plan>

Mississippi Emergency Management Agency (MEMA)

<http://www.msema.org/>

Minimum Standards of Operations for Hospitals

Mississippi State Department of Health

Title 15, Part III, Subpart 01, Chapter 41

[MSDH Minimum Standards of Operations for Hospitals PDF](#)

Regulations of Hospitals, Hospital Records

Mississippi Code Annotated

41-9-1 through 41-9-35

National Incident Management System (NIMS)

Federal Emergency Management Agency (FEMA)

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

Incident Command System (ICS)

FEMA

<https://www.fema.gov/incident-command-system-resources>

The Joint Commission

www.jointcommission.org

Det Norske Veritas

www.dnv.com

Strategic National Stockpile

Centers for Disease Control and Prevention

<http://www.bt.cdc.gov/stockpile/index.asp>

Mississippi Responder Management System

Mississippi State Department of Health

www.signupms.org

State Medical Asset and Resource Tracking Tool

EMS Emergency Performance Improvement Center

<http://www.emspic.org>

Centers for Medicare & Medicaid Services (CMS)

<http://www.cms.gov>

Disaster Resiliency and NFPA Codes and Standards

Refer to the National Fire Protection Association (NFPA) Standards in NFPA 101

Life Safety Code, and NFPA 1600, Disaster/Emergency Management and Business

Continuity Programs

Mississippi Emergency Access Program (MEAP)

<http://www.dps.state.ms.us/divisions/office-of-emergency-operations/mississippi-statewide-credentialing-access-program/>

CDC Emergency Water Supply Planning Guide Table 6-4.1

<http://www.cdc.gov/healthywater/pdf/emergency/emergency-water-supply-planning-guide.pdf>

3. SITUATION

Risk Assessment

A hazard vulnerability analysis (HVA) conducted by **<Insert name of entity>** provides details on local hazards including type, effects, impacts, risk, capabilities, and other related data.

Facility and MSDH County Medical HVAs are located in Attachment 1 and 2 of the Continuity of Operations Annex and are provided by the District Planner.

<Insert the top five hazards from facility HVA>

- 1.
- 2.
- 3.
- 4.
- 5.

4. CONCEPT OF OPERATIONS

A. Incident Management

Incident management activities are divided into four phases: mitigation, preparedness, response, and recovery. These four phases are described below:

- **Mitigation:** Mitigation activities are those that eliminate or reduce the possibility of a disaster occurring. For healthcare operations, this may include installing generators for backup power, installing hurricane shutters and raising electrical panels to protect them from possible flood damage. **<Insert Facility’s strategies for mitigation>**
- **Preparedness:** Preparedness activities develop the response capabilities that are needed in the event an emergency occurs. These activities may include developing emergency operations plans and procedures, conducting training for personnel in those procedures, and conducting exercises with staff to ensure they are capable of implementing response procedures when necessary. **<Insert Facility’s strategies for preparedness>**
- **Response:** Response includes those actions that are taken when a disruption or emergency occurs. It encompasses the activities that address the short-term, direct effects of an incident. Response activities in the healthcare setting can include activating emergency plans and triaging and treating patients who have been affected by an incident. **<Insert Facility’s strategies for response>**
- **Recovery:** Recovery focuses on restoring operations to a normal or improved state of affairs. It occurs after the stabilization and recovery of essential functions. Examples of recovery activities include: the restoration of non-vital functions, replacement of damaged equipment, facility repairs, organized return of patients into the facility, and reconstitution of patient records and other vital information systems. Another key consideration in the recovery and response phases of an incident is the tracking of staff hours, expenses, and damages incurred as a result of the emergency. Detailed records will need to be maintained throughout an emergency to document expenses and damages for possible reimbursement or to properly file insurance claims. **<Insert Facility’s strategies for recovery>**

B. Plan Activation

The Emergency Operations Plan will be activated in response to internal or external threats to the facility. Internal threats could include fire, bomb threat, loss of power or other utility, or other incidents that threaten the well-being of patients, staff, and/or the facility itself. External threats include events that may not affect the facility directly but have the potential to overwhelm hospital resources or put the hospital on alert.

Persons Responsible for Plan Activation

Once a threat has been confirmed, the employee obtaining the information must notify their supervisor immediately. If the employee cannot contact their supervisor, they must immediately contact the **<Insert position title>** directly.

The supervisor should in turn contact the **<Insert position title>**. The **<Insert position title>** will assess the situation and initiate the plan if necessary.

The following individuals have the authority to activate the Emergency Operations Plan:

Table 3
Individuals Responsible for Emergency Operations Plan Activation

Name	Contact Number
Primary:	
Backup 1:	
Backup 2:	

Alerting Staff (On and Off Duty)

To notify staff that the Emergency Operations Plan has been activated, those within the facility will be contacted first through the **<Insert internal communication system (e.g., overhead paging system, radio)>**.

Staff away from the facility at the time of activation will be contacted by **<Insert external communication system (e.g., phone tree, radio, media)>**. The individuals responsible for contacting staff include the **<Insert position title (e.g., dispatcher, supervisors)>**.

Alerting Response Partners

The facility works closely with several external partners (**See Annex A: Communications**). The **<Insert position title>** will be the individual responsible for contacting these external agencies to notify them that the Emergency Operations Plan has been activated.

5. ROLES AND RESPONSIBILITIES

During an event, specific roles and responsibilities will be assigned to individual positions/titles as well as facility departments.

A. Essential Services

The table below identifies the departmental roles and responsibilities during plan activation.

Table 4
Roles and Responsibilities

Essential Services	Roles and Responsibilities	Point of Contact	Secondary Point of Contact
Administration			
Dietary			
Housekeeping			
Maintenance			
Nursing			
Pharmacy			
Safety & Security			
(Add additional essential services if needed)			

B. Positions

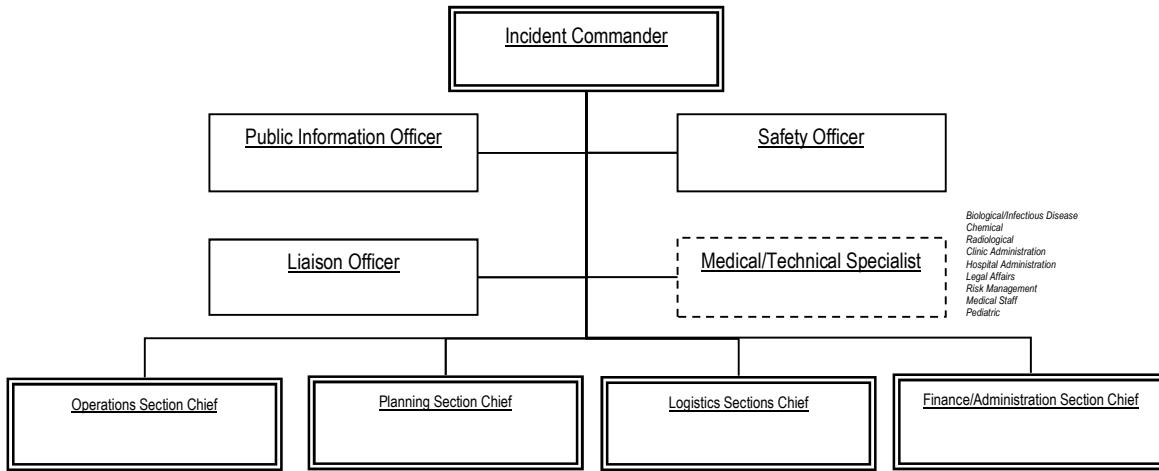
Identifying and assigning personnel in the Hospital Incident Command System (HICS) depends a great deal on the size and complexity of the incident. The HICS is designed to be flexible enough so that the number of staff needed to respond to an incident can be easily expanded or contracted. HICS Form 203 is used to document and assign staff to HICS specific positions. See sample HICS forms in Attachment D.

6. COMMAND AND COORDINATION

A. Command Structure

Command will be organized according to the Hospital Incident Command System (HICS). The chart on the next page illustrates the structure of response activities under the HICS. The chart shows the chain of command and the span of control under each level of management. It also illustrates the flexibility of HICS to expand or contract response activities based on the type and size of the event.

Organizational Chart



Biological/Infectious Disease
 Chemical
 Radiological
 Clinic Administration
 Hospital Administration
 Legal Affairs
 Risk Management
 Medical Staff
 Pediatric

- **Staging Manager**
 Personnel
 Vehicle
 Equipment/Supply
 Medication
- **Medical Care Branch Director**
 Inpatient
 Outpatient
 Casualty Care
 Clinical Support Services
 Patient Registration
- **Infrastructure Branch Director**
 Power/Lighting
 Water/Sewer
 HVAC
 Building/Grounds Damage
 Medical Gases
 Medical Devices
 Environmental Services
 Food Services
- **HazMat Branch Director**
 Detection and Monitoring
 Spill Response
 Victim Decontamination
 Facility/Equipment Interface
- **Security Branch Director**
 Access Control
 Crowd Control
 Traffic Control
 Search
 Law Enforcement Interface
- **Business Continuity Branch Director**
 Information Technology
 Service Continuity
 Records Preservation
 Business Function Relocation

- **Resource Unit Leader**
 Personnel Tracking
 Material Tracking
- **Situation Unit Leader**
 Patient Tracking
 Bed Tracking
- **Documentation Unit Leader**
- **Demobilization Unit Leader**

- **Service Branch Director**
 Communications Unit
 IT/IS Unit
 Staff Food & Water Unit
- **Support Branch Director**
 Employee Health & Well-being Unit
 Family Care Unit
 Supply Unit
 Facilities Unit
 Transportation Unit
 Labor Pool & Credentialing Unit

- **Time Unit Leader**
- **Procurement Unit Leader**
- **Compensation/Claims Unit Leader**
- **Cost Unit Leader**

Orders of Succession

Orders of succession ensure leadership is maintained throughout the facility during an event when key personnel are unavailable. Succession will follow facility policies for the key facility personnel and leadership.

**Table 5
Key Personnel and Orders of Succession**

Command and Control	Primary	Successor 1	Successor 2
Shift 1			
Hospital Representative			
Incident Commander			
Public Information Officer			
Safety Officer			
Liaison			
Operations Section Chief			
Planning Section Chief			
Logistics Section Chief			
Finance/Administration Section Chief			
Shift 2			
Hospital Representative			
Incident Commander			
Public Information Officer			
Safety Officer			
Liaison			
Operations Section Chief			
Planning Section Chief			
Logistics Section Chief			
Finance/Administration Section Chief			

Delegation of Authority

Delegations of authority specify who is authorized to make decisions or act on behalf of facility leadership and personnel if they are away or unavailable during an emergency. Delegation of authority planning involves the following:

- Identifying which authorities can and should be delegated
- Describing the circumstances under which the delegation would be exercised and including when it would become effective and terminate
- Identifying limitations of the delegation
- Documenting to whom authority should be delegated
- Ensuring designees are trained to perform the emergency duties

**Table 6
Delegation of Authority**

Authority	Type of Authority	Position Holding Authority	Triggering Conditions
Close facility	Emergency Authority	Senior Leadership	When conditions make coming to or remaining in the facility unsafe
Represent facility when engaging Govt. Officials	Administrative Authority	Senior Leadership	When the pre-identified is not available
Activate facility memorandum of understanding/mutual aid agreements	Administrative Authority	Senior Leadership	When the pre-identified leadership is not available
Add additional authorities as needed			

B. Local Emergency Operations Center Coordination

This organization will coordinate fully with the **<Insert name of local Emergency Management Agency>**, follow the prescribed Incident Command System, and integrate fully with community agencies in activation for a disaster event or during exercises. In addition, the hospital will provide the following information: hospital occupancies, hospital needs, and a list of essential services the hospital can provide. The facility will participate in any district/county coalition/local emergency planning committee.

C. Public Health Coordination

The **<Insert position title>** will coordinate planning and response activities with public health. Activities may include:

- Following disease reporting requirements at [MSDH List of Reportable Diseases and Conditions PDF](#).
- In the event the Emergency Operation Plan is activated by the facility, the MSDH Emergency Response Coordinator shall be notified along with the local Emergency Management Agency. Reference District Public Health Emergency Preparedness Map in Annex A: Communications.
- Providing regular updates to the Statewide Medical Asset and Resource Tracking Tool as required (See Annex E).
- Participating in and providing support for the Mississippi Responder Management System (See Annex F).
- Participating in public health planning initiatives.
- Receiving guidance and health alerts through the Health Alert Network.
- Participating in any after-action planning as requested from public health officials.

<Describe/outline below how the facility will coordinate planning and response activities with public health>

7. RESOURCES AND ASSETS

A. Acquiring and Replenishing Medications and Supplies

The amounts and locations of current pharmaceuticals and medical and non-medical supplies are evaluated to determine how many hours the facility can sustain itself before needing re-supply. This gives the facility a par value on supplies and aids in the projection of sustainability before terminating services or evacuating if needed supplies are unable to reach the facility.

Supplying the hospital in an emergency will be initially satisfied by pulling from local resources. As replenishment becomes necessary, resources will be requested from vendors. A list containing the names and contact information of the vendors that deliver and/or manufacture supplies and provide critical services can be found in Annex A: Communications Plan.

If the hospital is unable to acquire sufficient resources through outside vendors and pre-positioned arrangements to meet the healthcare needs of the community, the **<Insert position title>** will communicate this need to the **<Insert name of local emergency management agency>** to help locate resources and replenishments. If sufficient supplies cannot be acquired, the local emergency management agency will also provide assistance coordinating the transfer of patients to other facilities upon request.

B. Sharing Resources with Other Healthcare Organizations

Include procedure for sharing or borrowing supplies within the hospital network, if applicable.

If the healthcare organizations sharing the resources are within **<Insert name of jurisdiction>**, a Resource Accounting Record form (HICS Form 257) should be used to document the borrowed or loaned products. See sample HICS forms in Attachment D. The equipment should then be returned after use. Any consumable supplies that are used should be billed via invoice and paid by the organization using the supplies. Any unused consumables should be returned.

Include other procedures, if applicable.

If the items shared or borrowed come from outside **<Insert name of jurisdiction>**, the request should be coordinated through the **<Insert name of emergency management agency>**. The facility should document the final location of the supplies and the quantity and type of items transported. The need must be demonstrated to exceed that of the local jurisdiction prior to disbursement of supplies or equipment.

Include other procedures, if applicable.

C. Monitoring Quantities of Resources and Assets

The **<Insert position title>** is responsible for monitoring quantities of assets and resources during an emergency. A Resource Accounting Record form (HICS Form 257) should be used when resources and assets are tracked during an emergency. See sample HICS forms in Attachment D.

Available services and resources can also be tracked daily using the State Medical Asset Resource Tracking Tool (SMARTT) System. For additional information on the SMARTT System, see Annex E.

List other inventory tracking systems, if applicable.

D. Resource Sustainability

Establishing the sustainability of resources is crucial to determining if services can be rendered during a disaster for three total days, based on the facility's assessment of their hazard vulnerabilities. Resource inventory is currently maintained to provide for approximately **<Insert number of hours/days>**. If this cannot be sustained through current inventory, agreements are in place with suppliers and vendors for the remaining days. If supplies cannot be obtained, policies and procedures are in place in the event the facility may need to evacuate or temporarily close.

Agreements can be found in Attachment B: Mutual Aid Agreements/Memorandum of Understanding Table 16.

8. MANAGEMENT OF STAFF

A. Assignment of Staff

In a disaster, personnel may not necessarily be assigned to their regular duties or their normal supervisor. They may be asked to perform various jobs that are vital to the operation but may not be their normal day to day duties. The designated reporting location for staff and volunteers will be **<Insert reporting location>**. The **<Insert position title>** will delegate assignments based on communication with the Hospital Command Center. Staff will be assigned as needed and provided information outlining their job responsibilities and who they report to.

<Insert Facility Policy/Reference>

B. Managing Staff Support Needs

In some circumstances, it may be necessary to provide housing and/or transportation for staff that might not otherwise be able to perform their critical functions for the hospital. These staff support functions will be coordinated through the **<Insert position title>**.

Housing for staff and staff family will be located at:

<Insert housing options and include addresses for staff and staff family>

Identified resources for transportation of staff and staff family include:

<Insert transportation resources and include addresses for staff and staff family>

Disasters can create considerable stress for those providing medical care. The **<Insert position title>** will coordinate the provision of mental health support including incident stress debriefings for staff with:

<Insert name of department(s) and/or organizations (e.g., social workers, chaplains, community mental health service organizations)>

<Insert contact information for each department/organization listed>

C. Volunteer Needs

<Insert or reference facility's policy for credentialing, assigning to tasks, Just in Time Training, feeding, and housing volunteers>

Volunteer contact list can be found in Annex A: Communications, Attachment 1, Table 3.

9. PATIENT MANAGEMENT IN AN EMERGENCY

A. Patient Scheduling, Triage/Assessment, Treatment, Transfer, and Discharge

In the event of an emergency affecting the facility, the **<Insert position title and/or department(s)>** will assess staffing and hospital capacity. Additional staff may be called upon to assist in managing the anticipated number of cases. The medical staff will immediately evaluate all current hospital inpatients and decide who can be safely discharged or moved out of intensive care units. The **<Insert position title and/or department(s)>** will facilitate patient discharges, notify the **<Insert position title and/or department(s)>** of all available beds, and update the State Medical Asset Resource Tracking Tool as needed for patient tracking. The **<Insert location>** will serve as the holding area for discharged patients awaiting transportation from family or friends. Hospital admissions and scheduling for elective procedures may be curtailed until the emergency situation has subsided.

All personnel will report to their assigned area. The **<Insert position title and/or department(s)>** will take stretchers, wheelchairs and blankets to the Triage area. As the victims arrive, assigned nurses will assist physicians in evaluating patients and direct them to the appropriate treatment area with treatment orders. Victims requiring immediate life-saving procedures will be taken directly to the **<Insert location (e.g., emergency room)>**. The **<Insert position title and/or department(s)>** will tag the victims as they arrive in the treatment area. See Appendix P: Surge Capacity.

B. Vulnerable Populations

Vulnerable populations are patients who are pediatric, geriatric, disabled, or have serious chronic conditions or addictions. As these patients are identified in the triage process, they will be linked with needed hospital services. For those services the hospital cannot provide, social service personnel will assist the patient by linking them with healthcare or social service agencies that can provide the assistance the patient requires.

C. Management of Behavioral Health Patients

The management of patients receiving behavioral health services will be coordinated with the **<Insert position title and/or department(s)>** and security as necessary. Patient medications and medical records should accompany the patient in a bag around the patient's neck in the event they are being transferred or evacuated to another facility. Coordination should be made with the receiving facility so it can adequately accommodate the patient.

D. Behavioral Health Services to Patients

Prior to an emergency, the **<Insert position title and/or department(s)>** will establish links with local community mental health centers and community service organizations to identify community resources that can respond to the mental health needs of patients in an emergency. Current contact information will be maintained for these organizations so patients, their families, and others can be referred to those resources if needed. The **<Insert position title and/or department(s)>** will also ensure that appropriate hospital personnel have been trained in psychological first aid or other psychosocial interventions to ensure the hospital can provide support to patients needing such care.

During and after an emergency, the **<Insert position title and/or department(s)>** will coordinate hospital and community mental health resources to provide support for patients, family members and staff.

E. Patient Tracking

<Insert Facility's Tracking Policy, if no policy in place describe below>

The Emergency Department and other departments receiving patients will have a patient tracker assigned to track the patients entering and leaving the patient care areas. In the Emergency Department, the **<Insert position title and/or department(s)>** will perform this task in conjunction with the triage areas and charge nurse or designee. The **<Insert position title and/or department(s)>** staff will use the HICS 254 - Disaster Victim Patient Tracking Form (See sample HICS forms provided by District Planner located in Attachment D), using the triage tracking number to log in patients at the point of triage. The location of these patients in the continuum of care will be logged in using this form until disposition status is determined.

In the event that the computer system is down, the registration staff will coordinate the use of the Disaster Victim Patient Tracking Form with the **<Insert hospital patient tracking system>**.

Ensure that all patient identification wristbands (or equivalent identification) must be intact on all patients.

If patients are evacuated, the HICS 260 - Patient Evacuation Tracking Form will be used. When more than two patients are being evacuated, the HICS 255 - Master Patient Evacuation Tracking Form (See sample HICS forms in Attachment D) should be used to gain a master copy of all those that were evacuated. Form should include, but is not limited to: resident name, date of birth, Medicare/Medicaid number, evacuation site location, date of evacuation, arrival time at evacuation site, date of return to facility (if known), and comments/notes.

Each patient unit, in conjunction with the **<Insert position title (e.g., Patient Tracking Manager)>**, shall designate a team member responsible for this task. The information for each patient must be completed when the receiving hospital is contacted and a report given regarding the patient's status. The **<Insert position title (e.g., Patient Tracking Manager)>** or designee shall assist the evacuating unit as necessary to assure that appropriate tracking information is completed for each nursing unit.

In addition, **<Insert name of facility>** will utilize third-party information such as **<Insert other patient tracking system that may be used (e.g., MPaTS, American Red Cross database or fax tracking information)>** as appropriate to assist families in locating patients.

10. UTILITIES AND SUPPLIES

A. Power

In the event of an outage, the emergency generator will provide power to the facility. The **<Insert position title and/or department(s)>** will call the power company to report the outage and get an estimated time that the power will be restored. The **<Insert position title and/or department(s)>** will notify all departments of the power failure and the status of repair. In the event a power failure happens after normal business hours, the **<Insert position title (e.g., Dispatcher) and/or department(s)>** will immediately notify the **<Insert position title and/or department(s)>** to report the outage.

**Table 7
Generator Details**

Generator Details	Generator 1	Generator 2	Generator 3
Generator make/model			
Watt rating			
Type of fuel required			
Tank capacity			
Number of hours of power can be generated using full fuel supply			
What triggers refueling of tanks for generators?			
Essential services supported by the generator			
Minimum kW needed for essential services			
Date of last full load test performed			
Type of external hook up needed for generator			
Person Responsible for:	Primary	Backup 1	Backup 2
Obtaining fuel			
Fuels generator			
Oversees maintenance contract			
Company/Agency Name	Type Fuel Provided	Contact Name	Phone
Primary:			
Backup 1:			
Backup 2:			

Generator Failures

In the event of a generator failure, the problem is immediately assessed by the **<Insert position title and/or department(s)>**, who will make needed repairs or contact the **<Insert name and contact information of generator maintenance company>**.

If the hospital's power distribution system fails and cannot be repaired in a reasonable time-period, the **<Insert name of local Emergency Management Agency>** and **<Insert name of District MSDH ERC>** should be notified. The Emergency Response Coordinator or Emergency Management Agency will assess if resources are available to provide assistance or if evacuation is necessary.

B. Water

Water for Drinking, Cooking, and Sanitation

If there is an interruption in water service, the problem will be immediately assessed by **<Insert position title and/or department(s)>**, who will make needed repairs or contact **<Insert name and contact information for water supplier>** to report the outage and get an estimated time that water service will be restored. The **<Insert position title and/or department(s)>** will notify all departments of the water service interruption and anticipated time of restoration. If a water service interruption happens after normal business hours, the **<Insert position title (e.g., Dispatcher)>** will immediately notify the **<Insert position title and/or department(s)>** to report the situation. The **<Insert position title>** will determine if water use restrictions should be implemented (e.g., bathing, cooking, etc.), or if patient relocations, discharges, or transfers are necessary.

Water Usage

Estimate water usage under normal operating conditions to determine water needs during a water restriction situation. **<Insert estimated 3 day water usage for facility>**. Reference Table 6-4.1 from CDC Emergency Water Supply Planning Guide.

Amount On Hand

Identify quantities of potable and non-potable water on-site and identify vendors for acquiring additional potable and non-potable water.

**Table 8
Quantities of Potable and Non-Potable Water**

Type	Quantity
Potable Water	
Bottled Water (units)	
Storage Tank (gallons)	
Water Well (gallons)	
Other	
Non-Potable Water	
Fire Department	
Other	

Acquiring Additional Water

Potable water can be supplied through:

- **List supplier name/contact information**

Non-potable water can be supplied through:

- **List supplier name/contact information**

Water Rationing

If an emergency situation is anticipated that could affect water supplies, certain measures can be initiated to ensure the hospital has enough potable and non-potable water to supply the facility until water service is restored. The facility can stockpile bottled water for drinking and cooking. If the event allows, containers capable of holding water can be filled prior to the event including pots, buckets, and bath tubs.

If an event occurs that limits water supplies to the facility, water rationing measures may be initiated to conserve water until water supplies have been restored. Patient sanitary needs will be addressed by the use of bedside toilets or bedpans. Waste from bedside toilets or bedpans will be red-bagged and disposed of as hazardous waste. Another method is the use of cat litter in red bags. If using this method, the red bags and cat litter will be placed in toilets. When deemed necessary by Infection Control or when water service is restored, the red bags will be removed from the toilets and disposed of as biohazard waste.

Water used for bathing and cleaning may have to be restricted. Hand washing will require soap and water, if in sufficient quantity. If water is unavailable, the use of hand sanitizers will be encouraged. Fruit juices and broth, which should normally be discarded in preparing meals, could be set aside for use in preparing meals that may call for adding water. <Insert Facility Policy>

Water Decontamination

EPA Guideline Document for decontamination of drinking water:

- Use bottled water that has not been exposed to contamination if available.
- If bottled water is not available, water may be boiled to make it safe. Boiling water will kill most types of disease-causing organisms that may be present. If the water is cloudy, filter it through clean cloths or allow it to settle, and draw off the clear water for boiling. Boil the water for one minute, let it cool, and store it in clean containers with covers.
- If unable to boil water, water may be disinfected using household bleach. Bleach will kill some, but not all, types of disease-causing organisms that may be in the water. If the water is cloudy, filter it through clean cloths or allow it to settle, and draw off the clear water for disinfection. Add 1/8 teaspoon (or 8 drops) of regular, unscented, liquid household bleach for each gallon of water, stir it well and let it stand for 30 minutes before you use it. Store disinfected water in clean containers with covers.
 - Non-chlorine bleach should not be utilized to disinfect water.
 - Typically, household chlorine bleaches will be 5.25% available chlorine. Follow the procedure written on the label. When the necessary procedure is not given, find the percentage of available chlorine on the label and use the information in the following table as a guide. (1/8 teaspoon and 8 drops is about the same quantity.)

**Table 9
Water Disinfection**

Available Chlorine	Drops per Quart/Gallon of Clear Water	Drops per Liter of Clear Water
1%	10 per Quart - 40 per Gallon	10 per Liter
4-6%	2 per Quart - 8 per Gallon (1/8 teaspoon)	2 per Liter
7-10%	1 per Quart - 4 per Gallon	1 per Liter

C. Medical Gas/Vacuum Systems

In the event of a loss of the vacuum system, the **<Insert position title and/or department(s) and facility administration>** must be notified immediately. They will determine if repairs can be made in an expeditious manner or whether portable suction equipment beyond reserve units in the hospital must be procured. In any event, nursing personnel in affected areas must ensure that patients with artificial airways and those in need of tracheal suction receive priority attention until the patient is relocated to an unaffected area or the primary vacuum system is restored.

In the event of a loss of medical gases, the **<Insert position title and/or department(s) and facility administration>** must be notified immediately. The responsible individual will determine if repairs can be made in an expeditious manner or if emergency medical gas supplies must be procured.

The hospital maintains **<Identify the amount of medical gas available and the location>**. Additional cylinders can be procured through **<Insert name and contact information of supplier>**.

11. OTHER CRITICAL UTILITIES

Maintenance Activities

The following table lists other utilities critical to the comfort and care of residents and daily operations that should be addressed for maintenance.

Table 10
Maintenance Activities

System	Primary Personnel	24/7 Contact Information	Outside of Facility	24/7 Contact Information
Generators/Electric				
Heating, ventilation, and air conditioning				
Water/Sewer Systems				
Medical Gases/Vacuum Systems				
Information Technology				
List others that apply				

12. EVACUATION

A. Decision Making: Evacuate or Shelter-in-Place

The decision whether to evacuate the facility or shelter-in-place will rest with the **<Insert position title(s)>**, who will be responsible for deciding which action to take and when evacuation or shelter-in-place activities should commence. The decision will be made in consultation with facility staff and external stakeholders such as emergency management, fire department, or public health personnel. Both internal and external factors will be considered in deciding whether to evacuate or shelter-in-place.

Internal factors could include the physical structure of the facility, patient acuity, staffing, accessibility to critical supplies, availability of transportation assets for evacuation (not including ambulances), and accessibility of possible evacuation destinations. External factors to be considered in making the decision to evacuate or shelter-in-place include the nature and timing of the event, the location or projected path of the threat such as in the case of a flooding incident, ice storm or hurricane, and the vulnerability of the facility to the threat.

The chart below identifies hazards **(Include the top five hazards from the internal county medical hazard vulnerability analysis (HVA) provided by the district planner or the facility’s own HVA)** that could necessitate the need for the evacuation or shelter-in-place of patients and staff, who is responsible for making the decision, who is to be consulted, the timeline of activities, and factors that should be considered in deciding whether to evacuate or shelter-in-place.

Complete the chart below based on the top five hazards from the internal county medical or facility HVA and additional threats faced by the facility that could necessitate either evacuation or shelter-in-place response activities.

**Table 11
Evacuation or Shelter-in-Place Decision Making Chart**

Hazard	Decision Authority	Alternate	Consulting Parties	Timeline	Triggers for Evacuation
Fire*	Administrator	Director of Nursing	Facilities Manager, City Fire Chief	Immediately	Location and intensity of fire
Hurricane*	Administrator	Director of Nursing	Emergency Management	48 hours prior to arrival of tropical force winds	Category, track, and speed of storm

*Examples

B. Transportation Resources

The <Insert name of facility> will identify appropriate resources to transport the patient population, staff, supplies and necessary equipment in the event evacuation of the facility is necessary. The hospital will seek to identify primary and back-up transportation providers with suitable vehicles and personnel to ensure adequate resources are available in an emergency.

Ensure that the vendors or volunteers who will help transport patients and those who receive them at shelters and other facilities are trained on the needs of the chronic, cognitively impaired, and frail population and are knowledgeable on the methods to help minimize transfer trauma.

The following transportation facilities (not including county 911 EMS Services) have agreed to provide transportation to the <Insert name of facility> in the event evacuation of all or part of the facility is necessary. If these facilities are not able to provide transportation resources, the <Insert position title> will request resources through the <Insert name of local Emergency Management Agency>.

Table 12
Transportation Resources

Name of Agency/Company	Types of Transportation Equipment Available	Contact Name	Contact Number	Alternate Contact Information

C. Patient Records and Maintenance

In the event of an evacuation, patient records should be moved with the patient to the receiving facility.

Describe the procedure for ensuring patient records are transported with the patient and identify who is responsible.

The <Insert position title> is responsible for maintaining and transferring patient records during an event. Facility patient records may be stored digitally on a computer's hard drive, on CDs, and/or maintained in hard copy files. Computers will be unplugged, moved to a higher location in the building, or moved offsite. Digital records will be saved

to a removable storage medium (e.g., CD, DVD, USB flash drive, thumb drive) and carried offsite. Assessing the backup of the electronic data retrieval system will be a function of the annual review of the emergency preparedness system.

Hard copies of records will be stored in such a way that the critical records can be gathered and transported. The **<Insert name of facility>** has implemented/ is considering scanning critical data/documents. Critical data includes:

- Patient information (e.g., face sheets, clinical data, physician orders, care plans)
 - Name
 - Social Security Number
 - Photograph
 - Medicaid or other health insurance number
 - Date of Birth
 - Diagnosis
 - Current drug/prescriptions and dietary regimens
 - Name and contact of next of kin/responsible person/Power of Attorney
- Family information (e.g., contact information)
- Reference Hospital Health Insurance Portability and Accountability Act Policy

D. Patient Provisions/Personal Effects

In an evacuation, provisions for patient care will also be moved with the patient to ensure adequate medical care is maintained throughout the evacuation and care at the receiving facility. This will include necessary medications, medical equipment, supplies, staff, and psychological first aid to care for patients. Procedures are in place to ensure patient's personal effects are also transferred with the patient.

Describe procedures for ensuring provisions for patient care, including food, one gallon/person of water, and medications, and transport of personal effects are addressed in an evacuation and identify the staff and/or responsible departments.

E. Evacuation Locations

If the facility is damaged to the extent that patient care cannot be rendered, or it is determined that evacuation is warranted due to fire, an approaching hurricane, or other hazard, patients may be transported to a receiving facility for temporary care. The terms "close", "within area", and "outside of area" represent the concept that healthcare facility patients need to move as short a distance as possible. The farther frail patients must travel, the less safe the evacuation becomes for them. Therefore, the distance traveled must be balanced with the possible harm extended travel may cause.

Close Proximity

Close proximity locations are within a short distance (within 10 miles) from the facility and will be utilized when unplanned or immediate evacuations are necessary.

Table 13
Close Proximity Evacuation Locations

Location	Facility Name	Address	Phone Number	Alternate Contact
Primary				
Backup 1				
Backup 2				

Within Area

Within area locations are those within a reasonable distance (within 10 - 50 miles) from the facility and will be utilized for unplanned or planned evacuations relative to the type of hazard or threat to the facility.

Table 14
Within Area Evacuation Locations

Location	Facility Name	Address	Phone Number	Alternate Contact
Primary				
Backup 1				
Backup 2				

Out of Area

Out of area locations are a significant distance (over fifty miles) from the facility and will be utilized for planned evacuations.

**Table 15
Out of Area Evacuation Locations**

Location	Facility Name	Address	Phone Number	Alternate Contact
Primary				
Backup 1				
Backup 2				

F. Evacuation Routes

Floor plans with evacuation routes and maps to evacuation locations are located in Attachment C: Alternate Care Sites Evacuation Routes and Facility Floor Plans.

G. Evacuation Priorities

<Insert description of order of patient evacuation>

H. Securing Equipment

The <Insert position title> will be responsible for ensuring hospital equipment is secure or is safely moved in the event of an evacuation of the facility. The facility should be mindful that some medical and diagnostic equipment must be re-calibrated after being moved or disconnected from a power source. Mutual aid agreements with other healthcare facilities should be sought and maintained for the sharing of equipment and/or resources in an emergency.

Include mutual aid agreements located in Attachment B.

I. Securing Vital Records

The <Insert position title> will be responsible for ensuring vital departmental records are secure or are safely moved in the event of an evacuation of the facility. The <Insert position title> will be responsible for coordinating with the <Insert name of departments (e.g., medical records, information technology, accounting, human resources)> to ensure proper procedures are followed in moving and/or securing these records.

13. RECOVERY

A. Initiation and Recovery

The decision to enter into the recovery stage of an event is made by the **<Insert position title>**. In this stage, the **<Insert name of facility>** will undertake recovery procedures to return the hospital to normal operations.

B. Protocol

In order to efficiently recover from an event, protocols must be followed. Listed below are protocols important to recovery operations.

Recovery protocols:

- Prioritize health care service, delivery, and recovery objectives by organizational essential functions.
- Maintain, modify, and demobilize healthcare workforce according to the needs of the facility.
- Work with local emergency management, service providers, and contractors to ensure priority restoration and reconstruction of critical building systems.
- Maintain and replenish pre-incident levels of medical and non-medical supplies.
- Work with local, regional, and state emergency medical system providers, patient transportation providers, and non-medical transportation providers to restore pre-incident transportation capability and capacity.
- Work with local emergency management, service providers, and contractors to restore information technology and communication systems.
- Prepare after-action reports, corrective action reports, and improvement plans.

C. Restoration of Services

The **<Insert position title>** will coordinate the restoration of services after an emergency situation affecting the hospital.

List responsibilities in restoring services (e.g., restoration of utilities, repair or replacement of critical systems, and overseeing of facility repairs).

D. Utility Restoration

Describe procedures for restoration of critical systems not already identified in the plan or identify where these procedures can be located.

E. Staff/Patient Re-Entry

The **<Insert position title>** will work with the Bureau of Health Facilities Licensure and Certification to give approval for the return of staff and patients to the facility. The coordination of the return of staff and patients to the facility will be the responsibility of the **<Insert position title>**.

List preparations and procedures for returning residents after an emergency (e.g., transport of patients back to the facility and related activities).

F. Staff Debriefing

A debriefing will be conducted within **<Insert number of hours>** of the incident to collect lessons learned from the incident or exercise. These lessons learned will be used to revise and update the plan. The **<Insert position title>** will be responsible for coordinating the debriefing.

G. After-Action Report/Improvement Plan

After any real incident or exercise where the emergency operations plan is activated, an after-action report and an improvement plan will be developed. The purpose of the after-action report is to document the overall performance of the organization during the exercise or real event. It will contain a summary of the scenario or events, staff actions, strengths, issues, opportunities for improvement, and best practices.

The purpose of the after-action report/improvement plan is to ensure issues and opportunities for improvement are adequately addressed to improve response capabilities to future events. The improvement plan will include a list of issues to be addressed, tasks that will be performed to address them, individuals responsible for completing the tasks, and a timeline for completion.

The **<Insert position title>** will be responsible for coordinating the development of the after-action report and improvement plan and will ensure identified improvements are completed within the targeted timeframes.

14. GLOSSARY

Activation - When all or a portion of the plan has been put into motion.

After-Action Report (AAR) - A report that includes observations of an exercise or real event and that makes recommendations for improvements. The purpose of the after-action report is to document the overall performance of the organization during the exercise or real event. It will contain a summary of the scenario or events, staff actions, strengths, issues, opportunities for improvement, and best practices.

Communications Redundancy - A communications system wherein alternative modes of communication are present in case a component fails.

Continuity of Operations (COOP) Plan (Business Continuity) - Planning designed to facilitate the continuance of mission essential functions and the protection of vital information in the event that the organization is faced with a situation that could disrupt operations.

Corrective Action Plan (CAP) - The concrete, actionable steps outlined in the Improvement Plan (IP) that are intended to resolve preparedness gaps and shortcomings experienced in exercises or real-world events.

Decontamination - The process of making safe by eliminating poisonous or otherwise harmful substances, such as noxious chemicals or radioactive material.

Delegations of Authority - Specifies who is authorized to make decisions or act on behalf of facility leadership and personnel if they are away or unavailable during an emergency.

Devolution Site - Alternate site designated for Continuity of Operations if original site is compromised.

Emergency Operations Center (EOC) - A specially equipped facility from which emergency leaders exercise direction and control, and coordinate necessary resources in an emergency situation.

Hazard Vulnerability Analysis (HVA) - Identifies possible hazards, including their probability, severity, frequency, magnitude, and locations/areas affected.

Health Alert Network (HAN) - A nationwide program to establish the communications, information, distance-learning, and organizational infrastructure used to defend against health threats, including the possibility of bioterrorism.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) - U.S. government legislation that ensures a person's right to buy health insurance after losing a job, establishes standards for electronic medical records, and protects the privacy of a patient's health information.

Homeland Security Exercise and Evaluation Program (HSEEP) - Developed by the Department of Homeland Security (DHS) as a threat and performance-based exercise program that provides doctrine and policy for planning, conducting, and evaluating exercises. HSEEP was developed to enhance and assess terrorism prevention, response, and recovery capabilities at the federal, state, and local levels. HSEEP training courses are free and available online.

Human-Caused Events - An event that is a result of human intent, negligence, or error, or involving a failure of a man-made system. Includes terrorism, criminal events, biological events, hazardous material and chemical spills, extended power outages, fires, or any event for which a human is responsible.

Improvement Plan (IP) - Identifies specific corrective actions, assigns to responsible parties, and establishes targets for completion.

Incident Command System (ICS) - A standardized, on-scene, all-hazards incident management approach that allows for the integration of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure; enables a coordinated response among various jurisdictions and functional agencies, both public and private; and establishes common processes for planning and managing resources.

Isolation - The separation of an ill patient from others to prevent the spread of an infection or to protect the patient from irritating or infectious environmental factors.

Key Personnel - Personnel designated by their department, organization, or agency as critical to the resumption of mission-essential functions and services.

Long Term Care Facility - A facility that provides rehabilitative, restorative, and/or ongoing skilled nursing care to patients and residents in need of assistance with activities of daily living. Long term care facilities include nursing homes, rehabilitation facilities, inpatient behavioral health facilities, and long-term chronic care hospitals.

Mission Essential Functions (Essential Functions) - Activities, processes, or functions that could not be interrupted or unavailable for several days without significantly jeopardizing the operation of the department, organization, or agency.

Mississippi Responder Management System (MRMS) - A secure registration system and database for health professional volunteers willing to respond to public health emergencies.

Mitigation - The stage of emergency management where activities are conducted that eliminate or reduce the possibility of a disaster occurring. For healthcare operations, this might include the installation of generators for backup power, the installation of hurricane shutters, or the raising of electrical panels to protect from possible flood damage.

Mutual Aid Agreements (MAA) - Arrangements made between governments or organizations, either public or private, for reciprocal aid and assistance during emergency situations where the resources of a single jurisdiction or organization are insufficient or inappropriate for the tasks that must be performed to control the situation. These are also referred to as inter-local agreements or Memorandum of Understanding (MOU).

National Incident Management System (NIMS) - A systematic, proactive approach to guide departments and agencies at all levels of government, nongovernmental organizations, and the private sector to work seamlessly to prevent, protect against, respond to, recover from, and mitigate the effects of incidents, regardless of cause, size, location, or complexity, in order to reduce the loss of life and property and harm to the environment.

Natural Disasters - The effect of a natural hazard that affects the environment and leads to financial, environmental, and/or human losses. Includes severe weather events such as hurricanes, tropical storms, thunderstorms, snow and ice storms, mudslides, floods, and wildfire events.

Orders of Succession - Ensures leadership is maintained throughout the facility during an event when key personnel are unavailable.

Personal Protective Equipment (PPE) - Specialized clothing or equipment worn by an employee for protection against infectious materials.

Preparedness - The stage of emergency management where activities are conducted to develop the response capabilities needed in the event an emergency occurs. These activities may include developing emergency operations plans and procedures, conducting training for personnel in those procedures, and conducting exercises with staff to ensure they are capable of implementing response procedures when necessary.

Public Health - The science and practice of protecting and improving the health of a community, as by preventive medicine, health education, control of communicable diseases, application of sanitary measures, and monitoring of environmental hazards.

Public Information - Information that is disseminated to the public via the news media before, during, and/or after an emergency or disaster.

Recovery - The stage of emergency management that focuses on restoring operations to a normal or improved state of affairs. This stage occurs after the stabilization and recovery of essential functions. Examples of recovery activities might include the restoration of non-vital functions, replacement of damaged equipment, and facility repairs.

Response - The stage of emergency management that includes those actions that are taken when a disruption or emergency occurs. It encompasses the activities that address the short-term, direct effects of an incident. Response activities in the healthcare setting can include activating emergency plans, triaging, and treating patients that have been affected by an incident.

Standard Operating Guidelines (SOG) - A set of approved methods for accomplishing a task or set of tasks. SOGs are typically prepared at the department or agency level. They may also be referred to as Standard Operating Procedures (SOPs).

State Medical Asset and Resource Tracking Tool (SMARTT) - A web-based tool capable of monitoring hospitals, Emergency Medical Services (EMS) systems, and health center resources on a regular basis. SMARTT also serves as a sophisticated communications tool that allows information to be disseminated throughout a state's healthcare system. SMARTT is a multi-state system in use in the states of Mississippi, North Carolina, South Carolina, and West Virginia.

Strategic National Stockpile (SNS) - A federal resource to provide medicine and medical supplies to protect the public in the event of a public health emergency as a result of an act of terrorism or a large scale natural or human-caused disaster that is so severe local and state resources are inadequate or become overwhelmed.

Vital Records, Files and Databases - Records, files, documents, or databases, which if damaged or destroyed, would cause considerable inconvenience and/or require replacement or re-creation at considerable expense. For legal, regulatory, or operational reasons, these records cannot be irretrievably lost or damaged without materially impairing the organization's ability to conduct business.

Vulnerable Populations - Vulnerable populations are patients who are pediatric, geriatric, disabled, or have serious chronic conditions or addictions.

15. ACRONYMS

AAR	After-Action Report
AHRQ	Agency for Healthcare Research and Quality
CAP	Corrective Action Plan
CD	Compact Disc
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid Services
COOP	Continuity of Operations Plan
DHS	Department of Homeland Security
DPHEP	District Public Health Emergency Preparedness
EMC	Emergency Management Coordinator
EMS	Emergency Medical Services
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
EP	Emergency Planner
EPA	Environmental Protection Agency
EPN	Emergency Preparedness Nurse
ERC	Emergency Response Coordinator
ESAR-VHP	Emergency System for Advance Registration of Volunteer Health Professionals
ESF	Emergency Support Function
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Agency
HAN	Health Alert Network
HC	Healthcare
HCF	Healthcare Facility
HICS	Hospital Incident Command System
HIPAA	Health Insurance Portability and Accountability Act
HPP/WMD	Hospital Preparedness Program/Weapons of Mass Destruction
HSEEP	Homeland Security Exercise and Evaluation Program
HVA	Hazard and Vulnerability Analysis
HVAC	Heating, Ventilation and Air Conditioning
IC	Incident Command
ICS	Incident Command System
IP	Improvement Plan
IS	Independent Study
JAS	Job Action Sheets
JIC	Joint Information Center
JIS	Joint Information System
MAA	Mutual Aid Agreement
MEAP	Mississippi Emergency Access Program
MEMA	Mississippi Emergency Management Agency
MERCs	Mortuary Enhanced Remains Cooling System

MOU	Memorandum of Understanding
MPaTS	Mississippi Patient Tracking System
MRMS	Mississippi Responder Management System
MSDH	Mississippi State Department of Health
MUL	Mortuary Unit Leader
NFPA	National Fire Protection Association
NIMS	National Incident Management System
NOAA	National Oceanic and Atmospheric Administration
NWS	National Weather Service
OEPR	Office of Emergency Planning and Response
PIO	Public Information Officer
POC	Point of Contact
POD	Point of Distribution
PPE	Personal Protective Equipment
SMARTT	State Medical Asset Resource Tracking Tool
SNS	Strategic National Stockpile
SOG	Standard Operating Guidelines
SOP	Standard Operating Procedures

16. ATTACHMENTS

Attachment A: Training Plan

Attachment B: Mutual Aid Agreements/Memorandum of Understanding in Place

Attachment C: Alternate Care Site Evacuation Routes and Facility Floor Plans

Attachment D: Sample Hospital Incident Command System Forms

Attachment E: Affiliated Facilities Specific Information

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A. Training Plan

<Insert Facility Staff Training Requirements and Tracking> and include the following:

It is recommended all employees receive specific training during new employee orientation and at least annually on:

- Emergency Preparedness Policies and Procedures
- IS-100.HC, IS-200.HC, IS-700 and IS-800:
 - Personnel who will have a direct role in response to an incident will be trained in ICS-100 (Incident Command System, An Introduction) and ICS-200 (Incident Command System)
- IS-300 and IS-400:
 - Personnel who will assume Incident Command positions and/or supervisory roles will be trained in IS-300 Intermediate ICS for Expanding Incidents and IS-400 Advanced ICS
- HPP/WMD Centers of Excellence that have a MSDH Decontamination Trailer will train annually and will provide documentation of exercising/training. The MSDH DPHEP Team shall be notified of these trainings/exercises.
- Chempack Training
- Psychological First Aid Training for identified staff
- Public Information Officer (PIO) Training

The hospital should be able to provide documentation of completion of all trainings.

National Incident Management System (NIMS)

Federal Emergency Management Agency (FEMA)

<http://www.training.fema.gov/is/>

National Incident Management System (NIMS)

Federal Emergency Management Agency (FEMA)

Implementation for Healthcare Organizations Guidance

<http://www.phe.gov/Preparedness/planning/hpp/reports/Documents/nims-implementation-guide-jan2015.pdf>

B. Mutual Aid Agreements/Memorandum of Understanding

List existing Mutual Aid Agreements (MAA) and/or Memorandum of Understanding (MOU). MAAs/MOUs are stored <Insert Location>.

**Table 16
Mutual Aid Agreements/Memorandum Of Understanding**

Facilities/Agencies in Agreement	Nature of Agreement	Expiration Date (if applicable)	Date Verified/POC
Sysco*	Emergency Food Supply	None	
XYZ Hospital*	Shelter		
Transportation service*	Transport		
Additional MOUs			

*Examples

C. Alternate Care Site Evacuation Routes and Facility Floor Plans

<Insert evacuation routes, floor plans, maps, and written directions to evacuation sites>

D. Sample Hospital Incident Command System Forms

Hospital Incident Command System (HICS) forms are provided by the District Planner.

HICS 203 – Organization Assignment List

HICS 207 – Hospital Incident Management Team Chart

HICS 254 – Disaster Victim / Patient Tracking

HICS 255 – Master Patient Evacuation Tracking

HICS 257 – Resource Accounting Record

HICS 260 – Patient Evacuation Tracking Form

E: Affiliated Facilities Specific Information

This attachment should include the following location specific information:

- Table 2: Exercises Conducted
- Table 3: Individuals Responsible for Emergency Operations Plan Activation
- Table 4: Roles and Responsibilities
- Table 6: Delegations of Authority
- List of Top Five Hazards from Facility Hazard Vulnerability Analysis
- Facility Floor Plan
- Table 17: External Contacts
- Attachment 2: Table 1: Employee Emergency Call Back Roster
- Attachment 2: Table 6: Critical Infrastructure Contact Information
- Facility Hazard Vulnerability Analysis
- MSDH County Medical Hazard Vulnerability Analysis

17. ANNEXES

Annex A: Communications

Annex B: Safety and Security

Annex C: Strategic National Stockpile

Annex D: Continuity of Operations

Annex E: State Medical Asset and Resource Tracking Tool

Annex F: Mississippi Responder Management System and Volunteer Information

Annex G: Mass Fatality

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Annex A: Communications

<Reference/Insert Communications Policy>

Internal Communication

To ensure personnel are adequately informed throughout the course of emergency response activities, the facility will provide updates and general information to staff through regularly scheduled briefings, facility internal website, e-mail, etc. This flow of information regarding the incident will continue throughout the emergency until the all-clear signal is given.

Communication with External Response Partners

The **<Insert name of Facility’s Liaison>** will provide updates to external organizations within **<Indicate time interval>**. To communicate with external agencies, the hospital will use **<Insert external communication system (e.g., phone tree, radio, media)>**.

**Table 17
External Contacts**

Agency	Purpose for Contact	Contact Name/Title	Phone	Alternate Contact Info
Fire				
EMS				
EMA				
Police Department				
Sheriff				
Coroner				
Other such as EP, ERC				
Other Healthcare facilities with MOU’s				
EPI (hotline number)				
Surrounding Hospitals				
Sister Facilities				
Ombudsman				

**Attachment 1: Mississippi State Department of Health District Public Health
Emergency Preparedness Map**

**<Insert current Mississippi State Department of Health District Public Health
Emergency Preparedness Map provided by District Planner>**

Public Information

The **<Insert position title (e.g., Public Information Officer)>** will have the responsibility for coordinating media and public information. All media inquiries should be directed to the **<Insert position title (e.g., Public Information Officer)>**. No other staff member should interact directly with the media unless they have approval from the **<Insert position title (e.g., Public Information Officer)>**. It is recommended that staff who may serve in this capacity have Public Information Officer training.

Coordination of Public Information with Response Partners

If several agencies are involved in response, the **<Insert position title (e.g., Public Information Officer)>** will coordinate with them to form a Joint Information Center (JIC). The information that will go out to the community will come from the JIC as a single, consistent, and unified message from all of the affected agencies.

Communication with Patients and Families

Policies and protocols have been established for communication activities prior to and during an emergency. The **<Insert position title>** will communicate updates every **<Insert time interval>** in the **<Insert location>**.

Planning Activities

Facility's plan should include the following communication planning activities the facility is or will be conducting: safety information upon admission of the patient, collaboration with other healthcare facilities and/or community service organizations for patient tracking, and psychological first aid, etc. To ensure communication with patients and their families is consistent and timely during an emergency, this facility has established and will continue to develop family contact lists for patients and working relationships with local, state, and federal partners to ensure patients' safety, physical, and psychological needs are met during a disaster. Facility should ensure that families are aware of and knowledgeable about the facility plan, including: how and when they will be notified about evacuation plans, how they can be helpful in an emergency (e.g., coming to the facility to assist), and how/where they can plan to meet their loved ones. Out-of-town family members should be given a number they can call for information. Residents who are able to participate in their own evacuation should be informed and aware of their roles and responsibilities in the event of a disaster.

Response Activities

<Insert Facility's plan for establishing a family support center>

This facility has pre-designated points for families to meet during an emergency where they will be given updates during the event on the patients and how the incident is being

mitigated. At the time of the incident, families will be directed to this location upon arrival at the facility. These locations are subject to change due to the unknown nature of the incident.

Communication with Vendors of Essential Supplies, Services and Equipment

The **<Insert name of facility>** has developed a list of vendors, contractors, and consultants that can provide specific services before, during, and after an emergency event. The **<Insert position title>** is responsible for maintaining the list. This list will be updated periodically but no less than annually. The list includes the name of the vendor and the supplies, services, or equipment provided to the hospital, a phone number, and alternate contact information.

Communication with Other Healthcare Organizations

The **<Insert Facility Liaison>** will be responsible for providing key information to other healthcare organizations. Key information to be shared with other healthcare organizations in the community during a disaster includes:

- Command structures, including names and contact information for the command center
- Essential elements of the hospital's command center
- Resources and assets that can be shared
- Process for the dissemination of the names of patients and the deceased for tracking purposes

Communication with the Long-Term Care Ombudsman Program

Prior to any disaster, discuss the facility's emergency plan with a representative of the Long Term Care Ombudsman Program serving the area where the facility is located and provide a copy of the plan to the Long Term Care Ombudsman Program. When responding to an emergency, notify the local Long Term Care Ombudsman Program of how, when, and where residents will be sheltered, so the program can assign representatives to visit and provide assistance to residents and their families.

Communication about Patients to Third Parties

<Reference Hospital HIPAA Plan/Policy>

Backup Communications Redundancy and Equipment

List backup communications equipment and systems to be used in the event of telephone failure (must include communication plan e.g., radios, runners).

**Table 18
Communication Methods**

Internal/External	Primary	Alternate	Testing
Internal*	PBX*	Runner*	
Internal*	Phone*	Vocera*	
External*	Telephone*	Satellite Radio, Ham Radio*	

*Examples

Use of Plain Text by Staff in Emergencies

To launch an effective response to an emergency event, it is critical that communications between responding agencies and personnel are clear and understandable. To ensure communication is understood in an emergency, staff will use plain text and avoid the use of acronyms, radio ten codes, and other terminology that may lead to confusion in the midst of emergency response activities.

**Table 19
Internal Hospital Emergency Intercom Codes**

Code	Emergency/Threat

Attachment 2: Emergency Call Lists

Table 1: Employee Emergency Call Back Roster

Table 2: Patient Physicians Emergency Call Back Roster

Table 3: Volunteers Emergency Call Back Roster

Table 4: Contractors Emergency Call Back Roster

Table 5: Vendor Contact Information

Table 6: Critical Infrastructure Contact Information

**Attachment 2: Table 1
Employee Emergency Call Back Roster
<Insert Date> (Indicate Location)**

Name	Department	Phone	E-mail Address	Emergency Staffing Role

**Attachment 2: Table 3
Volunteers Emergency Call Back Roster
<Insert Date> (Indicate Location)**

Name	Department	Phone	E-mail Address	Emergency Staffing Role

**Attachment 2: Table 5
Vendor Contact Information
<Insert Date> (Indicate Location)**

Vendor	Contact	Phone	Supply/Resource	MEAP: Yes or No

**Attachment 2: Table 6
Critical Infrastructure Contact Information
<Insert Date> (Indicate Location)**

Supply/Resource	Vendor	Contact	Phone	E-mail Address
Electricity				
Employee Assistance Program				
Gas				
Internet				
Mental Health				
Telephone				
Transportation				
VOIP Vendor				
Water				

Annex B: Safety and Security

Internal Security Measures

<Insert Lockdown Plan/Policy including Mutual Aid Agreements/Memoranda of Understanding with external agencies>

- Entrances and Exits (North, East, etc.)
- Reception

Table 20
Internal Security Assignments

Area to Secure	Assigned Staff	Department	Contact Information

Controlling Access

The <Insert position title> will be tasked with maintaining external security along with restricted movement of persons in and out of the hospital parking lot and entryways. Security will be coordinated with security officers and/or staff members from <Insert name of department(s) or available staff from the labor pool>.

Only families of disaster victims, families picking up discharged patients, physicians and individuals assisting in the treatment of victims will be allowed to enter hospital property. Employees will park in their regular parking spaces and must present hospital ID at designated entrances. Physicians will enter through <Insert location of designated entry area(s)> and will be given identifying badges. All others seeking entrance to the hospital shall be directed to <Insert location of designated entry area(s)> for directions or other information. Staff from <Insert name of applicable departments and/or labor pool> may be used to escort families to appropriate areas as needed.

Controlling Movement within the Facility

Movement of people will be restricted based on consultation with the Hospital Command Center and the exact nature of the emergency. Those individuals with hospital ID badges and temporary identification (volunteers, etc.) will be allowed access throughout the hospital to perform their duties. Any visitors, patients, and family members will be restricted to their units unless treatment is required. If this is the case,

a hospital staff member will escort the patient to their destination. The Incident Commander, in conjunction with the Operations Section Chief and Security Branch Manager, can alter the flow of non-staff traffic as deemed necessary throughout the event.

Controlling Vehicle Traffic

The **<Insert position title>** will assign staff members to control traffic at all unsecured entrances. No one without specific hospital business is to be permitted beyond that point unless requested by someone with such authority. All visitors, families, etc., will be directed to the appropriate area.

The **<Insert position title>** will ensure that a security officer or staff person controls the following areas: **<Insert external areas, entrances and exits that will require security personnel>**. The **<Insert position title>** will monitor traffic patterns and close off any areas deemed necessary in consultation with the Security Branch Director and the Hospital Command Center.

Coordination with Local Law Enforcement Agencies

In the event of an internal or external incident the **<Insert name of local law enforcement agency>** can be called to assist. They will assist with security of the perimeter and manage traffic flow in the event of patient relocation. Any request for additional resources must be coordinated through the **<Insert name of local Emergency Management Agency>**.

Annex C: Strategic National Stockpile

Purpose

The Strategic National Stockpile (SNS) is a federal resource used to provide medicine and medical supplies to protect the public in the event of a public health emergency as a result of an act of terrorism or a large-scale natural or human-caused disaster that is so severe that local and state resources are inadequate or become overwhelmed. If such an event should affect this community, **<Insert name of facility>** may need to utilize SNS resources to treat patients and/or to provide prophylaxis to both patients and facility staff. The purpose of this annex is to outline procedures for coordinating with public health to obtain medications and needed medical supplies from the SNS during a public health emergency.

Definition of Strategic National Stockpile

The SNS consists of antibiotics, chemical antidotes, anti-toxins, life-support medications, IV administration, airway maintenance supplies, and medical/surgical items. Medications and medical supplies are intended to support treatment of ill patients and mass prophylaxis for those exposed but not yet symptomatic. Once local, state, and federal authorities agree that local and state resources have or will soon become overwhelmed, SNS supplies can be delivered to the state. Once the SNS supplies arrive in Mississippi, the Mississippi State Department of Health (MSDH) is responsible for managing the supplies and distributing them to affected communities and facilities across the state. Local governments will play a vital role in providing support to state SNS operations such as the use of facilities, resources, staff, and volunteers to help with the distribution of medications and/or medical supplies to target populations. Healthcare facilities play a major role by treating those who are ill and providing medications to medical staff and their families to prevent them from becoming ill.

Coordination of Planning with Public Health

Planning for the SNS must be coordinated with MSDH.

Planning for mass prophylaxis of hospital staff:

The first step in coordinating this planning is to register with the state by completing the Strategic National Stockpile (SNS) and Pandemic Influenza Programs Provider Enrollment MSDH Form No. 255E. This form will be submitted to the MSDH District Emergency Preparedness Nurse **<Insert the date of submission>**. If not, this form can be obtained on the MSDH website at www.healthyMS.com or from any district health office.

The MSDH coordinates with registered facilities in planning for receiving the SNS. The MSDH will also provide training, including how the treatment algorithms and standing

orders contained in the MSDH SNS Plan (plan is located on the MSDH website at www.healthyMS.com) are to be used by healthcare personnel in the distribution of medications from the SNS. The **<Insert position title>** will work with MSDH to coordinate planning and training of staff for possible SNS activation. The MSDH point of contact for **<Insert name of facility>** SNS planning is the MSDH District Emergency Preparedness Nurse, **<Insert contact phone number>**.

MSDH also requires a coordinating physician be identified from the facility to oversee the dispensing of medications and/or administration of vaccine(s). The physician is not required to be on-site, but staff will be required to work under his or her direction. The Coordinating Physician for **<Insert name of facility>** is **<Insert name of coordinating physician>**.

Planning for receiving assets for treatment of ill patients:

MSDH does not require completion of the Provider Enrollment Form for healthcare facilities to receive SNS assets for the treatment of ill persons.

- MSDH will need case count, epidemiologic, intelligence and inventory information from treatment centers to support strategic decisions.
- MSDH will need contact information for people at the treatment center responsible for providing periodic case counts.

Acquiring the Strategic National Stockpile

If the situation necessitates the need for the SNS, the **<Insert position title>** of the healthcare facility will coordinate with MSDH for the receipt of SNS supplies. To some extent, circumstances will drive the response and dictate how supplies will be received. A representative from the **<Insert name of facility>** might be asked to pick up SNS supplies from a health department point-of-dispensing (POD) site or another drop site in the county/city. If so, the **<Insert name of facility>** will need to provide MSDH with the name of the healthcare representative designated to pick up the medications and/or medical supplies prior to pick up. Upon arrival at the designated location, the representative will be asked to present two forms of identification; one form of identification issued by the **<Insert name of facility>** and one form of photo identification issued by the state (e.g., driver license). The representative will sign for all medications and/or medical supplies received. If there is a discrepancy between the order and what was received, the **<Insert position title>** of the healthcare facility must notify the MSDH Public Health Command/Coordination Center by phone at (601) 576-8085, as instructed in the packet of information received with the shipment.

Two methods for acquiring/receiving SNS assets include:

- 1) Direct shipment to facility:
 - With over 5,000 regimens of medication
 - Plan for receiving SNS assets to include:
 - Day and night point of contact (in triplicate) who has authority to order and receive materials and sign for controlled substances
 - Identification for receipt of SNS delivery (e.g., building A, rear loading dock, south entrance, etc.)
 - Adequate material handling equipment required to off-load and stage large pallets; if a loading dock is not available, the facility should ensure plans include how to off-load by hand
- 2) Healthcare representative pick-up from a predetermined health department POD or other drop site in the county/city.

Distribution of Strategic National Stockpile Medications

Distribution of medications and/or administration of vaccinations from the Strategic National Stockpile (SNS) must follow the same algorithms for prophylaxis and standing orders contained in the MSDH SNS Plan or provided by MSDH with the vaccine. These algorithms will be provided to the **<Insert name of facility>** with the SNS supplies received and through MSDH guidance issued to healthcare facilities and medical providers. The **<Insert position title>** providing coordination at the healthcare facility will oversee the distribution of SNS medications to patients. The **<Insert position title>** of the healthcare facility will coordinate the distribution of the SNS medications to staff and their families.

Health information forms provided by MSDH (either hard copy or electronic copy) must be completed to receive medications and/or vaccines from the SNS. These forms must be returned to MSDH within 48 hours for patient tracking. The **<Insert position title>** of the healthcare facility will coordinate the collection of these documents and ensure they are received by MSDH within the proper timeframe.

The **<Insert name of facility>** may not charge patients, staff, and/or their families for medications, vaccines, or any supplies received from the SNS.

A copy of the standing orders, algorithms, and health information forms can be found in the MSDH SNS Plan. The Standing orders and algorithms can be found in Section IV: Clinical Policies and Procedures and the health information forms can be found in Section V: Forms.

Utilization of medications for the treatment of ill persons, although accompanied by medical guidance from MSDH and interim guidance from federal partners, is ultimately up to the attending physician. There are no treatment algorithms. Information about treatment regimen(s) should be captured as part of the healthcare facility's standard Medical Administration Record (MAR), which is standard medical practice, not a stipulation of distribution of the Strategic National Stockpile (SNS).

Healthcare facilities:

- Must have a plan to store SNS assets under appropriate medical and pharmaceutical laws and regulations
- Must have an inventory plan
- Must not charge for SNS assets
- Must have a dispensing plan

A copy of the standing orders, algorithms and health information forms can be found in the [MSDH SNS Plan](#). The standing orders and algorithms can be found in Section IV: Clinical Policies and Procedures, and the health information forms can be found in Section V: Forms.

Requesting the Strategic National Stockpile

The SNS is a federal resource. As with all federal resources, it cannot be requested unless response to the incident is anticipated to exceed local and state resources. If **<Insert name of facility>** encounters a situation where patient demand is anticipated to exceed available resources, the **<Insert position title>** of the healthcare facility should communicate this to **<Insert name of local Emergency Management Agency>**. If local and regional resources are not sufficient to supply the increased demand, the request will be forwarded to the state Emergency Operations Center (EOC) at the Mississippi Emergency Management Agency, which will assess the situation. If indicated by the event, MSDH will request the SNS assets from the Centers for Disease Control and Prevention.

The healthcare facility will need a plan to request resupply of SNS assets. This plan should include:

- Communications plan that staff assigned to request resupply, contact information for the county emergency management office and local and state public health offices, and any additional numbers that would be provided during an incident,
- Provision to MSDH of up-to-date information on case count, epidemiologic intelligence, and inventory information from treatment centers to support strategic decisions,

- Provision to MSDH of number of staff and/or staff family members for whom there has been insufficient distribution of prophylactic regimens, and
- Detailed information for product description and quantities related to specific requests.

Security

Heightened security measures may be needed as a result of the events leading up to activation of SNS plans. Circumstances may lead some individuals to take unlawful measures to try to secure SNS assets for themselves and/or others. Adequate security measures must be in place to ensure SNS assets received by **<Insert name of facility>** are secure and to reduce any unnecessary risk to staff transporting or dispensing the medications. **<Insert name of facility>** will take appropriate measures to coordinate security at the facility.

Include a specific security plan identifying who will provide security. Please note, county and city police may not be able to provide security officers in the case of a community wide event, so an alternate plan is necessary.

Public Information

During SNS activation, MSDH will activate its risk communication plan. Guidance will be communicated to the general public including the nature of the public health threat, where state operated point-of-dispensing (POD) sites will be located and who should go there. In addition, information will be provided regarding symptoms of infection and/or contamination and who should seek medical attention. Any public information messages released to the media from the **<Insert name of facility>** should be consistent with the message issued by the state to avoid confusion and panic in the general public. The **<Insert name of facility>** should coordinate any information released to the public with the local Emergency Management Agency, Emergency Operations Center, and Joint Information Center.

Demobilization

As SNS operations conclude, MSDH will provide specific instructions to healthcare facilities regarding what to do with unused supplies. The **<Insert position title>** of the healthcare facility will coordinate with MSDH in the final disposition of these supplies.

Within a week of demobilization of SNS operations, the **<Insert name of facility>** staff will conduct a debriefing to discuss lessons learned from the incident. The lessons learned identified in the debriefing will be used to update and improve the facility's SNS Annex. The **<Insert position title>** of the healthcare facility will update and revise plans accordingly and cooperate with MSDH in any after-action planning discussions or meetings.

References

Mississippi State Department of Health, Plan for Receiving, Distributing, and Dispensing the Strategic National Stockpile Assets:

www.msdh.state.ms.us/msdhsite/index.cfm/44,1136,122,154,pdf/SNSPlan2008%2Epdf

*This link may change when the new plan is uploaded.

Centers for Disease Control and Prevention, Strategic National Stockpile website:

www.bt.cdc.gov/stockpile/

SNS Planning Checklist for Hospitals

SNS Planning Checklist for Hospitals
Primary Point of Contact (POC) (24/7) Name and contact information:
Secondary POC (24/7) Name and contact information:
Ship to Address (Do not ship to P.O. Boxes):
Describe the facility's plan to receive shipments after normal work hours (after 8 a.m. to 5 p.m.):
Describe the facility's plan to receive/unload materials if shipped directly to the facility:
Describe the facility's plan if materials must be picked up and transported from a staged location in the county/city:
Describe the facility's plan to store SNS materials at appropriate temperature/storage requirements:

SNS Planning Checklist for Hospitals

*****If shipments are requested, facilities could be responsible for costs of returning shipments to MSDH. A documentation of understanding that persons cannot be charged or billed for supplies received from SNS (state or federal) must be completed at the time of receiving SNS materials.*****

Describe the facility's security plan:

Describe/insert facility's dispensing plan.

The SNS is a voluntary program-please note that at any time, a facility may elect to participate.

Ensure **<Insert name of responsible individual>** documents dispensing activity in the Administration Section in Table 2.

Attachment 1: Closed Point of Distribution Form

<Insert Closed Point of Distribution Form provided by District Planner>

Annex D: Continuity of Operations

Purpose

Whether due to natural forces such as a hurricane, a technological event such as an electrical fire, or an event caused by humans such as an act of terrorism, a disaster can have a serious impact on the organization's ability to provide the healthcare functions that patients and the community depend on. Therefore, it is vitally important to have plans in place to be able to continue to perform mission-essential functions and protect vital information in the event that the organization is faced with a situation that could disrupt operations. Continuity of Operations (COOP) planning addresses three possible types of disruption to an organization:

- Denial of access to a facility (e.g., damage to a building)
- Denial of service due to a reduced workforce (e.g., pandemic influenza)
- Denial of service due to equipment or systems failure (e.g., information technology systems failure)

COOP planning seeks to minimize the potential impact of these events on employees, operations, and facilities.

Phases of Continuity of Operations Planning

There are three phases to the COOP process:

- Normal Operations (mitigation and preparedness)
- COOP Execution (emergency operations period)
- Reconstitution (return to normal operations)

Normal Operations

Normal operations are those periods without a declared state of emergency or the period directly following the conclusion of an event. Mitigation and planning activities can be conducted during normal operations to protect systems and prepare for an emergency affecting information systems.

Mitigation activities are those that eliminate or reduce the possibility of a disaster occurring. For IT systems, this would include measures to protect equipment and critical information such as backup power, firewalls, virus protection, password protection of files, and data redundancy.

Preparedness activities develop the response capabilities that are needed in the event that an emergency occurs. These activities may include developing response procedures for the backup and restoration of data, training personnel in those procedures, conducting system(s) tests, executing regular backups of data, developing

manual interim process to ensure continuous service of essential functions, and conducting exercises with staff to ensure they are capable of implementing response procedures when necessary.

COOP Execution

The COOP execution phase includes the actions that are taken when an emergency occurs. This includes activating emergency procedures and staff to protect or restore information systems and data for essential functions of the **<Insert name of facility>**.

Reconstitution

Recovery focuses on restoring the essential functions to a normal or improved state of affairs. It occurs after the stabilization and recovery of essential functions. Examples of recovery activities might include the restoration of non-vital functions, replacement of damaged equipment and facility repairs.

Continuity Elements

During an emergency, continuing operation of essential functions is imperative. In order to more efficiently continue operation of essential functions, the following continuity elements have been listed:

- Orders of Succession: Located in **Command and Coordination Section**.
- Delegations of Authority: Located in **Command and Coordination Section**.
- Risk Assessments and Hazard Vulnerability Analysis: Located in **Attachment 1 and 2 of this Annex**.

Continuity Facilities

The **<Insert name of facility>** has identified continuity facilities to conduct business and/or provide clinical care to maintain essential functions when the original property, host facility, or contracted arrangement where the facility conducts operations is unavailable for the duration of the continuity event. The table below lists the pre-arranged alternate sites, devolution sites, and telework options.

**Table 21
Continuity Facilities**

Continuity Facility	Type of Facility	Location of Facility	Accommodations
ABC Hospital*	Alternate/Devolution Site	1234 Medical Center Drive, Niceville, MS	Identified meeting rooms with telephones, internet access, ham radio access, satellite radio access, 2 desktop computers, laptop connectivity
County EOC*	Alternate/Devolution Site	7000 Disaster Way, My Town, Gotham City	Possible meeting room with telephones, internet access, shared ham radio capability, shared satellite phone capability, no desktop computers, laptop connectivity
Home Telework*	Alternate/Devolution Site	Home of Record Facility Leadership	Telephones, internet access, no ham radio, no satellite phone, desktop computers, laptop connectivity

*Examples

**Table 22
Alternative Care/Surge Site Locations**

Facility Name	Admin Facility	Emergency Care	Acute Care beds available	Low Acuity	Skilled Nursing Care
HCC Headquarters*	St. Joseph's Training Room	N/A	N/A	N/A	N/A
Hospital A*	Contracted Hot site	Deployable Shelter	Sister Facility	Reopen Closed Wards	Affiliated LTC
Hospital B*	No Admin Location	Mobile Trailer	No Acute Care Capability	College Gymnasium	No Long Term Capability
Nursing Home*	Affiliated System	Affiliated System	Affiliated System	Affiliated System	Affiliated System
Dialysis Center*	No Admin Location	Closest ER	Closest Hospital	Closest Hospital	Closest LTC

*Examples

Continuity Communications

The **<Insert name of facility>** maintains a robust and effective communications system to provide connectivity to internal response players, key leadership, and state and federal response and recovery partners. The facility has established communication requirements that address the following factors:

- Facilities possess, operate and maintain, or have dedicated access to communication capabilities at their primary facilities, off-sites and pre-identified alternate care/devolution sites
- Facility leadership and members possess mobile, in-transit communications capabilities to ensure continuation of incident specific communications between leadership and partner emergency response points of contact
- Facilities have signed agreements with other pre-identified alternate care sites to ensure adequate access to communication resources
- Facilities possess interoperable redundant communications that are maintained and operational as soon as possible following a continuity activation, and are readily available for a period of sustained usage for up to 30 days following the event

**Table 23
Interoperable Communications Capabilities**

Healthcare Facility	Primary Contact	Secondary Contact	700/800 MHZ	Satellite Phone	Ham Radio
Hospital A*	Bob Smith 1-800-000-777 Email:	Jane Johnson 1-555-222-0005	Yes MSWIN Channel 6	8816-763-27031	Joe Thatcher General Class

*Example

Essential Records Management

The **<Insert name of facility >** keeps all essential hardcopy records in a mobile container that can be relocated to alternate sites. In addition, electronic records, plans, and contact lists are maintained by the organization’s leadership and can be accessed online and retrieved on system hard drives when applicable and appropriate. Access to

and use of these records and systems enables the performance of essential functions and reconstitution to normal operations.

Delegation of Authority

The **<Insert name of facility >** devolution option requires the transition of roles and responsibilities for performance of facility essential functions through pre-authorized delegations of authority and responsibility. The authorities are delegated from facility leadership to other representatives in order to sustain essential functions for an extended period. The devolution option will be triggered when one or more facility leaders are unable to perform the required duties of the position. The responsibilities of the position will be immediately transferred to designated personnel in the delegation of authority matrix. Personnel delegated to conduct facility activities will do so until termination of devolution option.

Mission Essential Functions

The **<Insert name of facility>** has established the following list as sample essential functions during a continuity of operations activation. The sample essential functions identified are:

- Emergency Services
- Surgical Services
- Laboratory Services
- Health Information Technology
- Patient Care Unit
- Central Supply
- Human Resources
- Obstetrics
- Pharmacy Services
- Public Relations
- Food Services
- Security
- Laundry
- Health Information Management
- Infusion Chemotherapy

Roles and Responsibilities for Information Technology Continuity of Operations

The positions responsible for overseeing Information Technology Continuity of Operations are:

Primary	
Name	
Contact	
Alternate Contact	
Roles and Responsibilities	
Backup 1	
Name	
Contact	
Alternate Contact	
Roles and Responsibilities	
Limitations	
Backup 2	
Name	
Contact	
Alternate Contact	
Roles and Responsibilities	
Limitations	
Backup 3	
Name	
Contact	
Alternate Contact	
Roles and Responsibilities	
Limitations	

Plans and Procedures for Information Technology Continuity of Operations

Describe the organization's plan/procedures for backing up vital data:

Describe how personnel are trained on the plans/procedures for backing up vital data:

Does the organization have an emergency service plan? If so, explain:

Describe how the organization plans to minimize service interruptions as a result of necessary scheduled downtime:

Describe the contingency plans that are in place for managing unscheduled operational interruptions:

Describe how end-users are trained in executing downtime plans/procedures:

Describe how data will be retrieved (whether stored on external hardware, the operating system, or as backed up data) in the event of an operational interruption:

Describe the process by which data will be entered into the system as soon as it is restored following an outage or disruption:

Critical Information Technology, Systems, Equipment, and Databases

The chart below identifies critical information technology (IT) systems, equipment and databases that are used by the organization and describes what function the system serves, where it is located, who manages the IT needs of the system, equipment or database, and what those responsibilities are.

IT Functions	Name of Critical System/Equipment/Database	Location	Managed By	Responsibilities
Communications Systems				
Food/Dining Services				
Heating, Ventilation, and Air Conditioning				
Inventory Management				
Other				
Patient Management				
Security Systems				

Attachment 1: Facility Hazard Vulnerability Analysis

<Insert facility hazard vulnerability analysis provided by District Planner>

Attachment 2: MSDH County Medical Hazard Vulnerability Analysis

<Insert MSDH County Medical Hazard Vulnerability Analysis provided by District Planner>

Annex E: State Medical Asset and Resource Tracking Tool System

Purpose

In a disaster, it is vital that healthcare facilities, local and state emergency management agencies, and public health have a clear understanding of the medical resources that are readily available in the affected and surrounding communities. Such information can make a tremendous impact on how quickly victims of a disaster receive needed medical services. The purpose of this annex is to introduce the State Medical Asset Resource Tracking Tool (SMARTT) System and outline procedures for its use by the **<Insert name of facility>** to meet state requirements in reporting bed and transportation availability, service capabilities, and disaster resources.

Background

The SMARTT System is a web-based tool capable of monitoring hospitals, emergency medical services (EMS) systems, long term care facilities, and dialysis centers on a regular basis. The SMARTT System also serves as a sophisticated communications tool that allows information to be disseminated throughout a state's healthcare system. The SMARTT System is a multi-state system in use in the states of Mississippi, North Carolina, South Carolina, and West Virginia.

Reporting Requirements

As required by state licensure statute, hospitals are required to input information into the SMARTT System daily. Required information includes bed availability, specialty service capabilities and disaster resources. Specialty service capabilities that the system tracks include burn centers, cardiology centers, obstetrics and gynecology (OB/GYN) centers, emergency departments and transport capabilities. Resource capabilities that the system tracks include isolation, decontamination, available personal protective equipment (PPE), surge capacity, and pharmacologic caches that the organization maintains. During a disaster or an exercise, the MSDH may require more frequent and specific reporting.

Monthly compliance reports are sent to the Bureau of Health Facilities Licensure and Certification, which cites the facility for non-compliance and requests a plan of improvement.

Roles and Responsibilities

The **<Insert position title(s)>** will be responsible for the daily entry of required information into the SMARTT System and will be the main contact for the state for the SMARTT System issues. If more frequent reporting is required by the state, such as in a disaster situation or during system testing, the **<Insert position title(s)>** will be responsible for ensuring updates are entered into the system as required.

The **<Insert position title(s)>** will be responsible for ensuring primary personnel and adequate numbers of backup personnel are trained in the use of the system and for updating requirement information in the SMARTT System. All healthcare organizations must have a minimum of three personnel trained in the use of the SMARTT System. Names of staff currently trained and familiar in the use of the SMARTT System include:

**Table 24
Roles and Responsibilities**

	Name	Position	Department	Contact Information
Shift 1				
Primary				
Backup 1				
Backup 2				
Shift 2				
Primary				
Backup 1				
Backup 2				

Training

Training on the SMARTT System is available online at www.emspic.org. Newly hired staff with responsibilities for entering data into the SMARTT System will be trained on the use of the system within **<Insert number of days>** of hire. All staff will receive semi-annual re-orientation training on the system. The MSDH will train on site if requested.

References and Authorities

General information and training on the use of the SMARTT System: www.emspic.org

Annex F: Mississippi Responder Management System and Volunteer Information

Purpose

The purpose of this annex is to familiarize healthcare staff and administrators with the Mississippi Responder Management System (MRMS) and encourage participation and support of the program. This is not a credentialing program for volunteers.

Background

After the attacks on the World Trade Center and Pentagon building on September 11, 2001, complications arose from the many well-intentioned medical volunteers who traveled to New York and Washington D.C. to provide assistance. Because a system was not in place to quickly credential medical volunteers, many of these individuals were either sent away or assigned menial tasks that did not require a medical license to perform. In response, Congress authorized funding for states to develop Emergency Systems for the Advance Registration of Volunteer Health Professionals.

In Mississippi, MRMS is the online registration system for medical, health, and non-medical responders for the state. It is a secure database of pre-credentialed healthcare professionals and pre-registered non-medical volunteers who are trained to provide a coordinated response to emergencies in support of established public health and emergency response systems. The volunteer registry improves the efficiency of volunteer deployment and utilization by verifying the credentials of volunteer healthcare professionals in advance. Pre-registration and pre-verification of potential volunteers enhances the state's ability to quickly and efficiently dispatch qualified health professionals to assist in emergency response activities.

MRMS Operations

Health professionals and others interested in participating in the program should visit the Mississippi State Department of Health Responder Management System website at <https://signupms.org>.

On the website, volunteers can register for the program, list contact information, professional licensure information, and indicate where and how they would like to volunteer in the event of a disaster. Licensure information is verified through the appropriate state licensing boards. The information volunteers supply to the website is confidential and will only be made available to government emergency planners if a disaster is declared. In addition, signing up for the program does not in any way obligate members to respond during a particular crisis.

In the event of a disaster or mass casualty event, potential volunteers will be provided with information regarding volunteer opportunities and given the option to accept or decline. Volunteers are expected to maintain current contact information on the

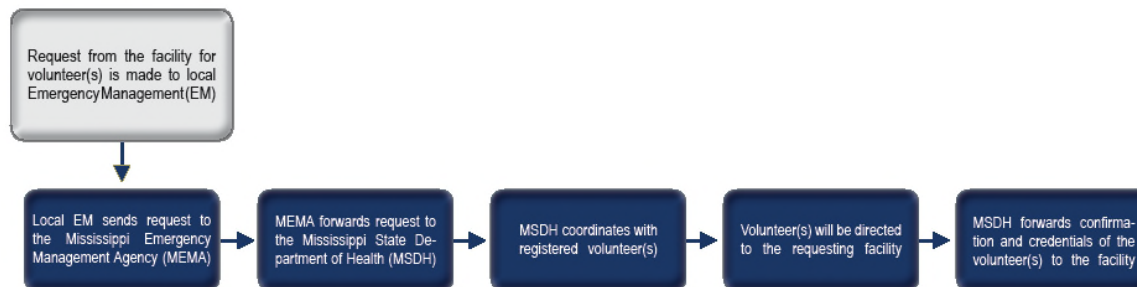
Mississippi Responder Management System. The Mississippi Responder Management System is supported by federal funding from the National Healthcare Preparedness Program.

Benefits to the Volunteer

First and foremost, individuals who volunteer under the Mississippi Responder Management System (MRMS) will have the opportunity to use their experience and training in providing critical services to fellow Mississippians in a disaster situation. Training for members is provided across the state on topics such as Disaster Mental Health, State Medical Needs Shelter Operations, Strategic National Stockpile Operations, Cardiopulmonary Resuscitation, Personal Preparedness, the National Incident Management System and more. Continuing Education Units are available at no cost to many licensed professionals for much of the training offered under the program.

Requesting Volunteers

- If the facility experiences staffing shortages and/or patient surge conditions due to a disaster situation, a representative of the healthcare facility should first submit the request for staffing assistance to the local Emergency Management Agency.
- The request should be specific, indicating the number of staff needed, specific expertise needed, and the estimated number of days the assistance will be required.
- From the local Emergency Management Agency, the request will be channeled to the Mississippi Emergency Management Agency where public health officials will use the MRMS system to generate a list of qualified and credentialed volunteers.
- Those individuals listed will be contacted by the state through the MRMS and provided with the opportunity to volunteer for deployment. The individuals will be provided with information regarding the event (including where to report) and will be given the opportunity to accept or decline service as a volunteer.
- The requesting healthcare facility will be provided with an update from the state regarding the status of the request, including the number of volunteers responding and estimated date and time of arrival.



Liability Protections for Volunteers

Volunteer immunity is available for good faith acts associated with volunteer services. However, there is no immunity for acts or omissions that are intentional, willful, wanton, reckless, or grossly negligent (Miss. Code Ann. § 95-9-1).

An unpaid volunteer acting on behalf of MSDH is afforded coverage under the Tort Claims Act. Op.Atty.Gen. No. 2002-0144, Conerly, March 29, 2002.

State/political subdivision employees/agents receive some liability protections during a declared emergency (Miss. Code Ann. § 35-15-21).

References

The Mississippi State Department of Health Responder Management System website:

<https://signupms.org>

“Emergency Systems for Advance Registration of Volunteer Health Professionals (ESAR-VHP) – Legal and Regulatory Issues”, The Center for Law and the Public’s Health at Georgetown and Johns Hopkins Universities, 2008

“Hurricane Katrina Response – Legal Protections for VHPs in Alabama, Louisiana and Mississippi”, The Center for Law and the Public’s Health at Georgetown and Johns Hopkins Universities, 2008

Annex G: Mass Fatality

During an event, a surge in human mortality may occur. This surge may be caused by a natural disaster, disease outbreak or a manmade event. A mass fatality event is defined as an event where there are more fatalities than can be managed by the normal system.

In this type of event, the Incident Commander (IC) should name a Mortuary Unit Leader (MUL). The MUL will be responsible for:

- The collection and protection of deceased patients.
- Coordinate with the Medical Care Branch Director and Staging Manager to establish a morgue area and Family Assistance Center, as needed.
- Ensure all transporting devices are removed from under deceased patients and returned to the transportation area.
- Maintain master list of deceased patients.
- Ensure all deceased patients in morgue areas are covered, tagged, and identified where possible.
- Keep the Public Information Officer and IC informed of the number of deceased.
- Arrange for frequent rest and recovery periods for staff away from the morgue.
- Observe and assist staff members who exhibit signs of stress, fatigue, and inappropriate behavior and provide psychological support.
- Coordinate contact of next of kin.

The facility's morgue is located in **<Insert location>**. The MUL must maintain the facility's current morgue capacity **<Insert capacity number>**. If this capacity is expected to be exceeded, the MUL shall contact the local coroner/medical examiner to assist in obtaining storage space of the additional decedents. This may include the use of local funeral homes, refrigerated trailers, or activation of the state mortuary response team's Mortuary Emergency Response Cooling System units.

Security

Decedents and their personal effects must be secured and safeguarded at all times until the arrival of the county coroner/medical examiner, a mortuary-authorized representative or law enforcement (if evidentiary). Security of decedents and their property will be coordinated by the **<Insert position title>**.

18. Incident Specific Appendices

Appendix A: Active Shooter

Appendix B: Biological Event

Appendix C: Bomb Threat

Appendix D: Chemical Event

Appendix E: Cyber Attack

Appendix F: Earthquake

Appendix G: Explosive Event

Appendix H: Extended Power Outages

Appendix I: Fire

Appendix J: Floods

Appendix K: Hazardous Materials and Decontamination

Appendix L: Hurricanes

Appendix M: Nuclear/Radioactive Event

Appendix N: Pandemic Influenza/Infection Control/Isolation

Appendix O: Severe Weather/Extreme Temperatures/Winter Storms

Appendix P: Surge Capacity

Appendix Q: Wildfire

Appendix A: Active Shooter

An active shooter is an individual actively engaged in killing or attempting to kill people in a confined and/or populated area; in most cases, active shooters use firearms(s) and there is no pattern or method to their selection of victims. Active shooter situations are unpredictable and evolve quickly. Typically, the immediate deployment of law enforcement is required to stop the shooting and mitigate harm to victims. Because active shooter situations are often over within ten to fifteen minutes, before law enforcement arrives on the scene, individuals must be prepared both mentally and physically to deal with an active shooter situation. This annex is designed to minimize the negative impacts and to provide an appropriate response in the event of an incident involving a person with a weapon within the facility.

Include the organizational plan for an active shooter event.

Planning considerations:

- Contact response partners
- Intercom codes
- Facility Lockdown Policy
- Facility “Go Box” (map of facility, keys, etc.)

Links:

<http://www.dhs.gov/publication/active-shooter-how-to-respond>

<http://training.fema.gov/is/courseoverview.aspx?code=IS-907>

Appendix B: Biological Event

A biological event is the deliberate release of viruses, bacteria, or other germs (agents) used to cause illness or death in people, animals, or plants. These agents are typically found in nature, but it is possible that they could be changed to increase their ability to cause disease, make them resistant to current medicines, or to increase their ability to be spread into the environment. Biological agents can be spread through the air, through water, or in food.

Terrorists may use biological agents because they can be extremely difficult to detect and do not cause illness for several hours to several days. Some bioterrorism agents, such as the smallpox virus, can be spread from person to person and some, such as anthrax, cannot.

Include the organizational plan for a biological event.

Planning efforts need to be made for these specific biological attacks: Aerosol Anthrax, Plague, Food Contamination, and Foreign Animal Disease.

Planning considerations:

- Contact response partners
- Shut down heating, ventilation, and air conditioning
- Personal Protection Equipment Plan/training
- Infection Control Plan
- Isolation/Quarantine Plan
- Food Safety Plan
- Treatment Plan
- Decontamination procedures
- Negative pressure room
- Closed Point Of Distribution Enrollment form
- Reference Strategic National Stockpile Annex

Links:

http://www.fema.gov/pdf/emergency/nrf/nrf_BiologicalIncidentAnnex.pdf

<http://www.ready.gov/sites/default/files/documents/files/biological.pdf>

<http://www.dhs.gov/topic/biological-security>

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4904a1.htm>

[MSDH SNS Plan](#)

Appendix C: Bomb Threat

A bomb threat can be delivered as either a written or verbal notification of intent to detonate an explosive or incendiary device with the intent of causing harm to individuals or of causing damage to or the destruction of physical property. Such a device may or may not exist. While a good number of bomb threats are pranks, bomb threats made in connection with other crimes such as extortion, hijacking, and robbery are quite serious.

Include the organizational plan for a bomb threat.

Planning considerations:

- Contact response partners
- Intercom codes
- Bomb Threat Call Checklist
- Facility Lockdown Policy
- Evacuation Decision Maker(s) with contact information
- Evacuation with meeting locations identified
- Search procedures for each department
- Train staff on awareness of suspicious packages

Link:

https://emilms.fema.gov/is906/assets/ocso-bomb_threat_samepage-brochure.pdf

Annex D: Chemical Event

A chemical event is the intentional use of toxic chemicals to inflict mass casualties and mayhem on an unsuspecting civilian population.

Chemical terrorism often refers to the use of military chemical weapons that have been illicitly obtained or manufactured *de novo*. However, a chemical event could also be an accidental release such as the unintentional explosion of an industrial chemical factory, a tanker car, or a transport truck in proximity to a civilian residential community, school, or worksite.

Include the organizational plan for a chemical event.

Planning efforts need to be made for these specific chemical attacks: Blister Agent, Toxic Industrial Chemicals, Nerve Agent, and Chlorine Tank Explosion.

Planning considerations:

- Contact response partners
- Intercom codes
- Shut down heating, ventilation, and air conditioning
- Decontamination procedures

Links:

[http://www.mhanet.org/Images/aWebDocuments/PDFs/Emergency%20Prep/CHEM PACK%20Training%202015.2 M1s.pdf](http://www.mhanet.org/Images/aWebDocuments/PDFs/Emergency%20Prep/CHEM%20PACK%20Training%202015.2%20M1s.pdf)

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4904a1.htm>

Annex E: Cyber Attack

Cyber security involves protecting an infrastructure by preventing, detecting, and responding to cyber incidents. Unlike physical threats that prompt immediate action, such as stop, drop, and roll in the event of a fire, cyber threats are often difficult to identify and comprehend. Among these dangers are viruses erasing entire systems, intruders breaking into systems and altering files, intruders using your computer or device to attack others, or intruders stealing confidential information. The spectrum of cyber risks is limitless. Threats, some more serious and sophisticated than others, can have wide-ranging effects on the individual, community, organizational, and national level.

Include the organizational plan for a cyber attack.

Planning considerations:

- Policies and procedures for employee use of your organization's information technologies
- Procedures for securing all computer equipment and servers with specific individual access permissions
- Procedures to report lost items for employees
- Procedures to prevent unauthorized data transfer via USB drives (flash drives or thumb drives) and other portable devices
- Policies and procedures to disable inactive accounts, including those of transferred or terminated employees, after a set time period
- Procedures on how to address potential cyber security vulnerabilities with medical devices

Links:

<http://www.ready.gov/cyber-attack>

http://www.fema.gov/pdf/government/grant/hsqp/fy09_hsqp_cyber.pdf

<http://www.ready.gov/document/common-sense-guide-cyber-security-small-businesses>

<http://www.phe.gov/Preparedness/planning/cip/Documents/cybersecurity-checklist.pdf>

Appendix F: Earthquake

Earthquakes are among the most unpredictable and devastating of natural disasters. An earthquake can be defined as a sudden movement of the earth as the result of the abrupt release of pressure. This release of pressure can result at fault lines where two tectonic plates collide or separate; it can occur as the ground lifts or sinks due to underlying pressures, or pressure can be released in thrust faults or folded rock. An earthquake is also referred to as a “shaking hazard.”

Include the organizational plan for an earthquake.

Planning considerations:

- Contact response partners
- Evacuation with meeting locations identified
- Procedures for utility shut down
- Medical surge (if applicable)
- Mass fatality and casualty

Links:

http://www.fema.gov/pdf/plan/prevent/rms/396/fema396_a.pdf

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

Appendix G: Explosive Event

An unintentional explosion can result from a gas leak in the presence of an ignition source. These leaks/explosions can occur in building lines, infrastructure pipelines, or transportation. The principal explosive gases are natural gas, methane, propane, and butane, because they are widely used for heating purposes. However, many other gases, like hydrogen and acetylene, are combustible and have caused explosions in the past. Gas explosions can be prevented with the use of intrinsic safety procedures to prevent ignition.

Improvised Explosive Devices, commonly referred to as IEDs, have become common tools of domestic and international terrorists. According to the Agency for Healthcare Research and Quality (AHRQ), due to the public accessibility of explosive materials and bomb-making knowledge, a domestic terrorist attack would probably take the form of a conventional explosive munitions attack. An explosive device may consist of explosives alone or may be combined with biological, chemical, or radiological materials. The AHRQ states that a “lack of knowledge about primary blast injuries and failure to recognize a blast’s effect on certain organs can result in additional morbidity and mortality.”

Include the organizational plan for an explosive event.

Planning efforts need to be made for these specific explosive attacks: Gas Leak/Explosion, and IEDs.

Planning considerations:

- Contact response partners
- Intercom codes
- Mass fatality and casualty
- Medical surge
- Blast injuries
- Secondary devices
- Shut down heating, ventilation, air conditioning, power, oxygen, and gas to affected area(s)
- Close doors and windows
- Evacuation with meeting locations identified
- Fire extinguishers (types, location, and training)
- Smoke detector locations
- Sprinkler systems
- Disaster Resiliency and National Fire Protection Association (NFPA) Codes and Standards
 - Refer to the NFPA Standards in NFPA 101 Life Safety Code, and NFPA 1600, Disaster/Emergency Management and Business Continuity Programs

Links:

<http://www.dhs.gov/topic/explosives>

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

<http://m.fema.gov/explosions>

<https://www.osha.gov/SLTC/etools/hospital/hazards/fire/fire.html>

<http://www.nfpa.org/safety-information/for-consumers/escape-planning/basic-fire-escape-planning>

Appendix H: Extended Power Outages

Extended loss of electrical services can be fatal for a frail and compromised population in a healthcare facility. While the occasional interruption of the electrical utility grid is part of life, steps need to be taken to protect vulnerable patients during times of any loss of power. Utility service can be interrupted by natural disasters, industrial accidents at power generation facilities, or damage to power transmission systems.

Include the organizational plan for extended power outages.

Planning considerations:

- Contact response partners
- Section 10: Utilities and Supplies: A: Power
- External Contacts (Power Company, electrical contractors, etc.)
- Evaluation of patients for hypothermia/hyperthermia

Links:

<http://www.phe.gov/Preparedness/planning/cip/Documents/healthcare-energy.pdf>

http://www.acphd.org/media/269431/electical%20power%20outage_loss%20response%20plan.wv.pdf

<http://www.ready.gov/power-outage>

Appendix I: Fire

Fire is a rapid oxidation process that releases energy in varying intensities in the form of heat and often light, and generally creates and releases toxic vapors. Fire does not have to be in immediate proximity to be fatal. The reduced oxygen and production of smoke and fumes can replace breathable air, creating an anaerobic environment that leads to asphyxiation. Not all fires create visible smoke. Inside a building where airflow is restricted, the risk of dying from oxygen starvation is greatly increased.

Include the organizational plan for fire.

Planning considerations:

- Contact response partners
- Intercom codes
- Shut down heating, ventilation, air conditioning, power, oxygen, and gas to affected area(s)
- Close doors and windows
- Evacuation with meeting locations identified
- Fire extinguishers (types, location and training)
- Smoke detector locations
- Sprinkler systems
- Disaster Resiliency and National Fire Protection Association (NFPA) Codes and Standards
 - Refer to the NFPA Standards in NFPA 101 Life Safety Code, and NFPA 1600, Disaster/Emergency Management and Business Continuity Programs

Links:

<https://www.osha.gov/SLTC/etools/hospital/hazards/fire/fire.html>

<http://www.nfpa.org/safety-information/for-consumers/escape-planning/basic-fire-escape-planning>

Appendix J: Floods

Floods are one of the most common hazards in the United States. A flood is the inundation of a normally dry area caused by an increased water level in an established watercourse. Flood effects can be local, impacting a neighborhood or community, or very large, affecting entire basins and multiple states. Flooding can also occur along coastal areas as a result of abnormally high tides, storms, and high winds.

Include the organizational plan for floods.

Planning considerations:

- Contact response partners
- Intercom codes
- Internal and external flooding
- Shut down power to affected area(s)
- Evacuation with meeting locations identified
- Monitor weather radio and media outlets

Links:

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

<https://www.osha.gov/dts/weather/flood/index.html>

Appendix K: Hazardous Materials and Decontamination

Hazardous Materials incidents occur when a hazardous substance has been dispersed into the environment in a manner that has the potential to harm people. These emergencies can result from the release of toxic substances in any quantity, the release of large quantities of a substance that is not problematic when used in smaller and controlled amounts, or from the results of combining two otherwise non-hazardous substances. Release can be in vapor, aerosol, liquid, or solid form.

Include the organizational plan for hazardous materials and decontamination.

Planning considerations:

- Contact response partners
- Intercom codes
- Identify sources of hazardous materials/waste
- Decontamination Plan
- Runoff of contaminated water during decontamination
- Identify necessary emergency actions to save lives and protect the staff and the environment
- Evacuation with meeting locations identified
- Identify exposure procedures
- Infection Control Plan

Links:

<http://www.ready.gov/hazardous-materials-incidents>

<https://www.osha.gov/SLTC/hazardouswaste/training/decon.html>

Appendix L: Hurricanes

A tropical cyclone, also called a hurricane depending on its location and strength, is a storm system characterized by winds reaching a constant speed of at least 74 miles per hour and possibly exceeding 200 miles per hour. On average, a hurricane's spiral clouds cover an area several hundred miles in diameter. The spirals are heavy cloud bands from which torrential rains fall. Tornado activity may also be generated from these spiral cloud bands. Hurricanes are unique in that the vortex or eye of the storm is deceptively calm and almost free of clouds with very light winds and warm temperatures. Outside the eye, a hurricane's counter-clockwise winds bring destruction and death to coastlands and islands in its erratic path. High winds and heavy rains from hurricanes impact inland regions many miles from the coast.

Include the organizational plan for tropical cyclones.

Planning considerations:

- Contact response partners
- Storm surge zones
- Hurricane evacuation routes
- Evaluation of patients for discharge/transfer
- Evacuation Plan
- Transfer agreements and transportation
- Staffing needs
- Section 7 Resources and Assets
- Section 10 Utilities and Supplies
- Shelter in Place Plan (if applicable)
- Monitor weather radio and media outlets
- Influx of patients
- Reference Severe Weather Plan

Links:

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

<http://emergency.cdc.gov/disasters/hurricanes/index.asp>

<http://www.nws.noaa.gov/om/hurricane/index.shtml>

Appendix M: Nuclear/Radioactive Event

While nuclear power facilities have multiple mechanical, technological, and procedural redundancies to minimize technological failure and human error, it is prudent to have a plan for dealing with the possibility of a catastrophic failure at a nuclear facility or threat of an act of terrorism. Likewise, radiological events occur without warning and will require rapid responses to decontaminate and treat those who may have been exposed.

Include the organizational plan for nuclear and radiological events.

Planning efforts need to be made for these specific nuclear and radiological events: Radiological Dispersal Device, Nuclear Detonation, and Nuclear Accident.

Planning considerations:

- Contact response partners
- Intercom codes
- Proximity to nuclear facility (plume projections)
- Evacuation with meeting locations identified
- Identify exposure procedures
- Decontamination Plan
- Identify necessary emergency actions to save lives and protect the staff
- Nuclear medicine

Links:

<http://www.ready.gov/nuclear-power-plants>

<http://www.ready.gov/nuclear-blast>

<http://www.ready.gov/radiological-dispersion-device-rdd>

<http://www.remm.nlm.gov/>

Appendix N: Pandemic Influenza/Infection Control/Isolation

A pandemic is a global disease outbreak. An influenza pandemic occurs when a new influenza virus emerges for which people have little or no immunity and for which there is no vaccine. The disease spreads easily from person to person, causes serious illness, and can sweep across the country and around the world in a very short time. It is expected that such an event could overwhelm local healthcare systems as an increased number of sick individuals seek healthcare services. In addition, the number of healthcare workers available to respond to these increased demands will be reduced by illness rates similar to pandemic influenza attack rates affecting the rest of the population.

Include the organizational plan for pandemic influenza/infection control/isolation.

Planning considerations:

- Contact response partners
- Infection Control Plan
- Isolation Plan
- Immunization Policy
- Preventative measures (e.g., personal protective equipment, hand sanitizer)
- Staff absenteeism due to illness

Links:

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

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

<http://www.cdc.gov/flu/pandemic-resources/index.htm>

http://msdh.ms.gov/msdhsite/_static/44,0,122,278.html

[MSDH SNS Plan](#)

[MSDH List of Reportable Diseases and Conditions PDF](#)

Appendix O: Severe Weather/Extreme Temperatures/Winter Storms

Severe Weather

Severe weather is any atmospheric phenomenon that can cause property damage or physical harm.

Extreme Temperatures

The loss of the heating, ventilation, and air conditioning (HVAC) system in a healthcare facility is a serious technological failure, under certain conditions. During times of extreme weather, such as a frigid cold winter or unusually hot summer, the failure of these systems can create harmful and fatal conditions for patients.

Winter Storms

Snow and accompanying ice can immobilize a region and paralyze a city. Ice can bring down trees and break utility poles, disrupting communications and utility service. It can also immobilize ground and air transportation. The healthcare facility may find itself completely on its own for several days.

Include the organizational plan for severe weather/extreme temperatures/winter storms.

Planning considerations:

- Contact response partners
- Intercom codes
- Section 10: Utilities and Supplies
- Loss of HVAC
- Identify necessary emergency actions to save lives and protect the staff
- Evaluation of patients for hypothermia/hyperthermia
- Monitor weather radio and media outlets
- Severe Weather
 - Hail
 - Intense cloud to ground lightning
 - Torrential rain
 - Strong winds (micro-bursts, straight line winds)
 - Tornadoes
 - Extreme cold and heat
 - Ice and snow

Links:

<http://www.ready.gov/severe-weather>

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

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

<http://www.ready.gov/winter-weather>

Appendix P: Surge Capacity

Surge capacity is a measurable representation of a healthcare system's ability to manage a sudden or rapidly progressive influx of patients within the currently available resources at a given point in time. Healthcare systems must develop and maintain surge capacity throughout the system in anticipation of the need to care for patients presenting from infectious disease outbreaks, public health emergencies, and mass casualty incidents.

Include the organizational plan for surge capacity including alternate on-site triage and treatment locations.

Planning considerations:

- Contact response partners
- Intercom codes
- Alternate triage options during a mass casualty event
- Variations of casualty events
- Staffing needs
- Equipment and supplies
- Evaluation of patients for discharge/transfer

Links:

<http://archive.ahrq.gov/news/ulp/btbriefs/btbrief3.htm>

<http://www.phe.gov/Preparedness/planning/mscc/handbook/Documents/mscc080626.pdf>

Appendix Q: Wildfire

Each year, thousands of acres of land and dozens of structures are destroyed by fires that can start at any time of the year. Wildfires have a variety of causes including arson, lightning, debris burning, and carelessly discarded cigarette butts. Adding to the fire hazard is the growing number of people living in new communities built in areas that were once open land.

Include the organizational plan for wildfire.

Planning considerations:

- Contact response partners
- Intercom codes
- Shut down heating, ventilation, and air conditioning
- Close doors and windows
- Smoke (inhalation, visibility)
- Evacuation with meeting locations identified

Links:

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

<https://www.osha.gov/dts/wildfires/index.html>

http://www.readyforwildfire.org/wildfire_action_plan