Reasonable accommodations can be made for persons with disabilities planning to attend the EMCC Meeting by contacting EMS Staff at least 24 hours in advance at (925) 646-4690.

Any disclosable public records related to an item on a regular meeting agenda and distributed by the County to a majority of members of the Emergency Medical Care Committee less than 96 hours prior to that meeting are available for public inspection at 1340 Arnold Drive, Suite 126, Martinez, during normal business hours.
## Emergency Medical Care Committee
### Contra Costa County

### Informal Discussion Session
September 14, 2016

<table>
<thead>
<tr>
<th>Members Present Representing</th>
<th>STAFF PRESENT</th>
</tr>
</thead>
</table>
| **Chair:** Kacey Hansen *Trauma Center (CC Contract)*  
**Executive Committee:**  
Ross Fay *Air Medical Transportation Provider*  
Ellen Leng *Alameda-Contra Costa Medical Association*  
Gale Bowen *Contra Costa Sheriff-Coroner*  
Derek Krause *Contra Costa Fire Chiefs’ Association*  
Jon Michaelson *Public Provider Field Paramedic*  
Florence Raskin *Hospital Council East Bay*  
John Speakman *District II*  
Kelley Stieler *District I*  
Allan Tobias *District IV*  
Ross Wilson *Private Provider Field Paramedic*  | Jesse Allured *Contra Costa EMS Agency*  
Leticia Andreas *Contra Costa EMS Agency*  |

<table>
<thead>
<tr>
<th>Members Absent Representing</th>
<th>Others Present</th>
</tr>
</thead>
</table>
| Deborah Campbell *District V*  
Pat Frost *EMS Agency Director (ex-officio)*  
David Goldstein *EMS Agency Medical Director (ex-officio)*  
Gerard Heidkamp *Communications Center Managers’ Association*  
Gary Napper *Public Managers’ Association*  
Steve Perea *California Highway Patrol*  
Elaina Petrucci Gunn *American Heart Association*  
David Samuelson *Emergency Nurses Assoc. East Bay*  
Albert Sebilia *American Red Cross*  
Steve Simpkins *Contra Costa Police Chiefs’ Association*  
Alvin Tang *Emergency Dept. Physicians (CCC Receiving Hospital)*  | Terence Carey *Contra Costa County Fire Protection District*  
Olga Crowe *American Red Cross*  
Douglas Dunn *Mental Health Commission, NAMI Contra Costa*  
David English *Alameda-Contra Costa Medical Association*  
Summer Galer *Concord PD MHET*  
Gary Giusti *Mt. Diablo Adult Education*  
Joe Greaves *Alameda Contra Costa Medical Association*  
Brian Hubbell *Falck Ambulance*  
Jennifer LaRault *Falck Ambulance*  
Marcelle Indelicato *Contra Costa County Office of the Sheriff*  
Vic Montoya *Contra Costa Regional Medical Center*  
Jill Ray *District II*  
Anthony Rodigin *Sutter Delta Medical Center*  
David Seidner *Contra Costa Behavioral Health*  
Timothy Thompson *Cook Contra Costa Regional Medical Center*  
Jason Vorhauer *Contra Costa County Fire Protection District*  
Elisa Washington *Hospital Council*  
Donald Waters *Alameda-Contra Costa Medical Association*  |

#### 1. Introduction of Members and Guests

#### 2. Approval of June 15, 2016 Meeting Minutes

A quorum was not achieved; minutes could not be approved at this meeting.

#### 3. Comments from the Public

None.

#### 4. Chair’s Report - Kacey Hansen, EMCC Chair

Staff Andreas reported on the status of the new membership term nominations. Slightly more than half of the seats have received nominations; reminder emails will be sent out to the remaining nominating parties.

#### 5. Fire Chiefs’ Report - Derek Krause, Deputy Chief, EMS/Logistics, San Ramon Valley Fire Protection District

Member Krause reported that the renewal agreements to host Fire Service EMS Medical Director as well as Zoll program are in process in collaboration with Contra Costa Health Services and the EMS Agency. Both programs work well for Fire EMS agencies; finalization is upcoming.

#### 6. Members’ Reports

Member Fay: As of September 1st, 2016, CalStar and Reach are part of the same organization, with headquarters in Louisville, Texas. There will be no change in service to the community; emphasized is an amalgamate dispatch.

#### 7. POLST Program - Donald Waters, Executive Director, Alameda-Contra Costa Medical Association, and David English, MD

Now a well-established and developed program for twenty-five (25) years, physicians are required to fulfill patients’ wishes.
Guest English referred to the distributed pink POLST form, which is signed by patient and physician for end of life treatment. Nurse practitioners may be co-signees. Anyone in California may have one of these forms filled out by their doctor. Contra Costa EMS Agency’s Dr. Joe Barger was instrumental in implementing this form in California in 2008. POLST is recognized by national organizations as one of three (3) mature programs, and EMS plays a vital role in its successful utilization. As availability of the POLST form continues to be a challenge, Oregon maintains an online POLST registry which will be coming to Contra Costa County.

Guest Waters reported that the California Healthcare Foundation allocated 3 Million Dollars towards the POLST program, and approached the Alameda-Contra Costa Medical Association (ACCMA) to pilot this program. Grants and Request for Proposals (RFPs) already exist, yet there is a need to engage everyone for public knowledge of the POLST form. The website provider in Oregon is also working with California. EMS is trying to establish connectivity with the hospitals on an EPIC platform regarding POLST, and will be implementing this process over the next six (6) months leading to a pilot program.

8. **Six (6) Month Program Update for Assisted Outpatient Treatment (AOT) Program - David Seidner, Program Manager, Contra Costa County Behavioral Health**

- The program launched on February 1st, 2016, and so far has received approx. 140 requests for investigations. The unintended consequence of this program is the interface with the justice system. The idea of legislation is LPS diversion, a variative and expensive program coming from the Mental Health Service Act.
- During the three-year pilot, medical providers are not qualified as qualified requesters. This year, twenty (20) persons signed up voluntarily, ten (10) were signed up through court; many did not qualify; just being symptomatic does not meet the standard. Every family that contacts Behavioral Health still receives service in form of connections to a provider.
- The evaluation plan is biannual: two (2) reports are sent to Behavioral Health supervisors. Three (3) years of data are needed to observe trends.
- Court cases would go to civil court which is confidential and non-adversarial. A public defender civilly defends the consumer.
- In three (3) years the board has to make another decision whether to further provide the funds, as the investment is rather large for a relatively small number of individuals. The mental health system is the contract provider.
- Patients calling 911 should be referred to PES (Psychiatric Emergency Services); the three (3) parties that EMS touches are family, PES, and law enforcement.

9. **5150 Summit Update Discussion - Derek Krause, Deputy Chief, EMS/Logistics, San Ramon Valley Fire Protection District; Pat Frost, Contra Costa EMS Agency; EMCC Membership**

John Muir Walnut Creek will be hosting the summit in February 2017, (refer to draft plan in packet). Member Frost is collecting data for baseline benchmark success or failure prior to the summit. It was suggested from Guest Dunn to contact the National Association for Mental Illness (NAMI) Contra Costa. Guest Seidner noted that Behavioral Health is not mentioned on the draft plan for the summit yet. Mental evaluation teams and law enforcement should also participate in the summit.

10. **EMS Medical Director’s Report - David Goldstein, MD, Contra Costa EMS Medical Director**

None.

11. **EMS Director’s Report - Jesse Allured, Program Coordinator, Contra Costa EMS (for Pat Frost, Contra Costa EMS Director)**

- On September 13th, EMS convened their second half day Quarterly Systems of Care meeting, presenting data.
- On November 9th, EMS is hosting the 1st annual Survivor’s Luncheon to show tangible continuum of care, and where survivors meet their rescuers.
- Treatment guidelines and policies are updated once a year at this time, and are mostly finished for sending out for public comment. Implementation is January 1st, 2017.
- Fourth quarter training is developing a standardized presentation.
- Welcomed EMS Chief Terry Carey from Contra Costa County Fire Protection District.
- Acknowledged retiring Member Gale Bowen from the Sheriff’s Office regarding Multi-Casualty Incidents (MCIs) and Reddinet. Complimented the strong work surrounding.

12. **Proposed agenda items for December 7, 2016 meeting: Approval of June and September draft minutes; Developments on the protest of the Alliance filed with state EMSA by the CAA.**

Note: The December EMCC meeting will take place in the Ball Auditorium at John Muir Health Center in Walnut Creek.
Vice Chair Napper called the meeting to order at 4:03 p.m.

1. Introduction of Members and Guests

2. Approval of March 9, 2016 Meeting Minutes
   Member Napper motioned to approve minutes, seconded by Member Leng. None opposed. Motion passed. Minutes approved.

3. Comments from the Public
   None.

4. Chair’s Report - Kacey Hansen, EMCC Chair
   - Chair Hansen shared that the John Muir Trauma Center celebrated its 30th anniversary, and passed out T-shirts.
   - Staff Andreas mentioned that memberships are expiring this year on September 30th, and nomination requests will be mailed out soon.

5. Fire Chiefs’ Report
   None.

6. Members’ Reports
   Member Samuelson: The Emergency Nurses Association (ENA) has been active in government affairs and monitoring legislation, specific to the EMCC. The FDA is moving to ban the use of standing orders regarding controlled substances in EMS, ENA on national level has been actively advocating for new bill 48365. Members will be travelling to Washington, D.C. to campaign for it. Member Frost requested that a link regarding this legislation be sent to the committee.
   Member Fay: Calstar has signed an agreement with Sutter Health to be their primary helicopter provider. Member Frost suggested to make legislative issues a standing item at the EMCC.

7. Quarterly Update on Alliance Ambulance Services - Bob Atlas, Assistant Fire Chief, Contra Costa County Fire Protection District
   - Communications have been fully integrated, and all ambulances are now dispatched through the CCFPD communications center and no longer through Sacramento. The communications center is staffed with a minimum total of 8 staff on duty.
   - The Alliance is meeting response time compliance at an average of 93-97%.
   - Ambulance branding continues; white ambulances are being cycled out.
The mutual aid agreement between CCCFPD-EMS, Moraga-Orinda Fire Protection District, and San Ramon Valley Fire Protection District is now at county counsel for review. Member Frost requested for a draft be sent to EMS for review.
- CCCFPD is in beginning development the ALS inter-facility transport, non-emergency ambulance services as part of the ambulance service contract.
- Guest Atlas elaborated that the CCCFPD is recurring EMS and Training System Chief as a permanent position as of July 1st, and in the hiring process at this time. The current interim battalion chief position held by Chief Sonsteng will also transition into a full-time EMS Chief position.

8. **Overview of Assisted Outpatient Treatment (AOT)** - David Seidner, Program Manager, Contra Costa County Behavioral Health, and Crystal Luna-Yarnell, Program Manager, MHS Contra Costa ACTION Team

   - An overview of the new AOT program was presented to the EMCC. Begins with a request for a civil investigation. The program is a joint project facilitated by Mental Health Systems and Contra Costa County Behavioral Health Division.
   - Once a referral is made by a qualified party to AOT a review is conducted and a care team will deploy once called, and the client may join the program voluntary or with court order. Should the client be court-ordered to AOT, they will do so through the Contra Costa ACTION Team.
   - Goal is based on a full-service, high fidelity, asserted community treatment model, based on shared case load, with a capacity of up to 75 clients. Different disciplines are represented on any one care team, and each team discusses every patient daily.
   - Program is being conducted as a 3-year pilot program and in the first 12 months of implementation. Funding consists of $2.25 million through the Mental Health Service Act (MHSA) for 75 6-month treatment slots in a 12-month period. The county is in control of regional funding. $400,000 have been set aside for evaluations.
   - Law enforcement receives 32 hours of training in crisis intervention, which includes behavioral health.

9. **5150 Summit Proposal Discussion** - Derek Krause, Operations Chief San Ramon Valley FPD; Pat Frost, Contra Costa EMS; EMCC Members

   - A draft of the proposal was shared by Chief Krause. Involvement: Law enforcement; public and private ambulance providers; private hospitals and Contra Costa Regional Medical Center; various public and private insurance providers; others.
   - The goal is to develop and approve to understand each stakeholders perspective and role in the psychiatric emergency process; identify issues; collaborate on solutions and recommendations; establish benchmarks; formalize the outcomes of the summit.
   - Discussion starting points: Ambulance has no legal basis to detain a patient; no common understanding between police and ambulance services exists. Member Samuelson quoted California Bill 1300 which allows to transport and detain the mentally ill.
   - Member Frost has scheduled a meeting Anna Roth and Cynthia Belon to discuss the summit at a meeting in July. This summit is intended to be a multi-system collaboration to support information sharing across all parties involved.
   - Chair Hansen offered that John Muir Health would be happy to host such a summit.
   - Member Frost recommended that after the discussion with Roth and Belon, she would provide information to the executive committee and Member Krause to be able to draft a plan.

10. **EMS Medical Director's Report** - David Goldstein, MD, Contra Costa EMS Medical Director

   - In Member Goldstein’s absence, Member Frost brought attention to the End-of-Life Directive authored by Member Goldstein which was recently distributed to stakeholders.

11. **Ambulance Ordinance Update** - Pat Frost, Contra Costa EMS Director

   - The ordinance is still at county counsel, and likely to come out prior to the EMCC September meeting.
   - Suggested a special EMCC session in July or August to provide information and receive comments and feedback when the draft ordinance is available.
   - Most updates in the ordinance is focused on non-emergency ambulances services and to improve medical transportation and establish a more coordinated system between emergency and non-emergency.
   - EMS plans to provide an informational workshop to the EMCC and community to solicit feedback from the community. Staff Kenagy elaborated that the board is the sole authority to conduct the official public comment process.
   - The executive committee requested for a letter to be drafted by Member Frost to the board stating the EMCC’s expectations, and to be able to provide input. Vice Chair Napper reminded the EMCC that it functions as an advisory committee to the board.
   - Chair Hansen motioned for the letter to be drafted; Member Leng proposed the motion; seconded by Member Tobias; none opposed; motion passed.

12. **CAAS / EMSA Complaint** - Pat Frost, Contra Costa EMS Director

   - EMS became aware of the action in February when both Contra Costa Fire Protection District and Contra Costa EMS Agency received a request for public information associated with EMS’ procurement process. In May Member Frost became aware that letter had been sent to the EMSA had requested this letter from the EMS Authority (EMSA) as part of a public records request. EMSA has not responded to the complaint yet. Member Frost advised that EMSA was fully aware of the Alliance model prior to procurement and had approved the emergency ambulance RFP. Any response to EMSA will be in conjunction
with County Counsel. EMS is confident in the EMSA approved the LEMSA procurement process. Member Fay mentioned that the specifics of the complaint for the committee and a copy of letter was made available to those present.

13. **EMS Director’s Report - Pat Frost, Contra Costa EMS Director**
- For 3 years in row, Contra Costa EMS has received the Mission Lifeline Bronze Award for our STEMI system.
- Congratulated Kaiser Foundation Hospital in Antioch who received the 2016 Get-With-The-Guidelines Stroke Gold Award.
- April and May patient transfer of care times: EMS had a successful meeting with Sutter Delta, which is now down to 26 minutes for transfer of care 90% of the time, prior to over 40 minutes. EMS is focusing on delays of greater than 60 minutes, standard in community is 20 minutes 90% of the time, which has been accepted as the statewide standard. Member Frost will send out the May reports by next week.
- EMS is doing massive restructuring and upgrade of our data systems focusing on interfaces and readiness for bi-directional exchange of patient information with hospitals.
- Opportunities to connect prehospital records with patient records in the hospital using EPIC Care Everywhere and EDIE (Pre-manage ED) is being explored.
- EMS is upgrading its FirstWatch system to include enhanced analytics.
- EMSA has just released a publication for strategy and data collection evaluation and quality:
  Recent legislation requires EMS will be a conduit for registries, POLST, Stroke registry and others in terms of providing information to the state.
- West County transports: Consistent distribution of patient post DMC closure. Pattern of distribution has not changed, only the volume. Kaiser Richmond is seeing on a routine basis over 200 patients; Kaiser Richmond ED bed capacity was increased in January from 15 to 25.

14. **Proposed agenda items for September 14, 2016 meeting: Legislative EMS Issues and Updates; 5150 Summit**

15. **Adjournment at 5:34pm**
Advisory Body Name: Emergency Medical Care Committee (EMCC)
Advisory Body Meeting Time/Location: 4:00 p.m. - 5:30 p.m. on the second Wednesday of March, June, September, and December, unless otherwise noted. Meetings are held at various locations in Contra Costa County.
Chair: Kacey Hansen (December 2015 – present)
Staff Person: Leticia Andreas (September 2013 – present), Health Services, Emergency Medical Services
Reporting Period: January 1, 2016 – December 31, 2016

I. Activities:
The EMCC, over four (4) regular meetings in the past year, was involved in or kept its membership informed about the following EMS System issues:
- Proposed 5150 psychological emergency summit in February of 2017 to involve multiple stakeholders: County Health, Contra Costa Regional Medical Center, other hospitals, public and private transport providers, transport staff.
- Guest Patricia Tanquary, CEO of Contra Costa Health Plan, reported on CCHS health plan efforts to support West County after the closure of Doctors Medical Center.
- New ambulance provider “Alliance” successfully transition to assume responsibilities for 92% of county emergency ambulance services effective January 1, 2016.
- Alliance leadership reporting to EMCC on implementation and system improvements established.
- EMS Agency piloting consolidation of Systems of Care and MAC meetings to improve hospital and stakeholder engagement into periodic half day meetings. The first half day meeting convened in March 2016.
- EMS Agency implements mobile treatment and policy application for field providers.
- EMS treatment protocols transitioned to visual algorithm format with full implementation effective 2017.
- EMS establishes first responder BLS protocols as part of their optional scope for epinephrine and narcan. Once established, the new protocols will create an opportunity for all BLS Fire first responder agencies to use.
- EMCC informed on need to update the ambulance ordinance. After County Counsel approval of draft the ordinance will be made available to stakeholders and go to the Board of Supervisors for approval. Updates in ordinance are focused on non-emergency ambulances services and to improve EMS Agency ability to assure public safety and improvements in coordination of medical transportation services throughout the EMS system between emergency and non-emergency transport providers.
- The CCHS Public Health Department issued a health advisory regarding opioids.
- ImageTrend online certification and licensing renewal platform implemented in September 2016.
- EMS System stakeholders advised of new EMSA ePCR (electronic patient care record) and HIE (health information exchange) to support bi-directional exchange between EMS and hospitals by January 2018.
- Official Alliance response time reports posted on EMS website as of September 2016 due to technology delays.
- LAFCO conducted and completed 2016 Fire EMS Municipal Service Review focusing on mutual aid issues and making recommendations for consolidation.
- LAFCO conducting special report on West County Health Care District to be finalized in December 2016.
- County Ambulance Patient Transfer of Care reports for Sutter Delta demonstrate significant improvement for East County EMS Services.
- BOS recognized May 16-20th 2016 was National EMS Week and May 18th as EMS for Children Day.
- An overview of the new AOT (Assisted Outpatient Treatment) program was presented at the EMCC. The program is a joint project facilitated by Mental Health Systems and Contra Costa County Behavioral Health Division, and its 3-year pilot launched on February 1st, 2016.
- Kaiser Foundation Hospital in Antioch received the 2016 Get-With-The-Guidelines Stroke Gold Award.
- EMCC advised of marked reductions in Hospital Preparedness Program Grant funding and continued unfunded state regulations and mandates.
- EMCC informed of potential closure of Alta Bates Hospital announcement and concerns of impact to West County.
- EMS service in West county remains stable with Lifelong urgent care filling the gap for non-emergency care with support of CCHS nurse call lines and Kaiser Richmond ED high walk in volume.
- EMS System stakeholders participated in Statewide Tabletop exercise on October 12, 2016 and Functional Drill on
November 17, 2016.

- EMCC informed of complaint to EMS Authority from the California Ambulance Association regarding Alliance award. Alliance award was conducted in compliance with EMSA approved RFP process.
- EMS Agency HIE and EPIC workgroups and strategies to connect prehospital care records with emergency department patient records in the hospital using EPIC Care Everywhere. EMS implementing upgrades of FirstWatch data platform - to include enhanced analytics to improve medical oversight and utilization reporting.
- EMSA released a publication for strategy and data collection evaluation and quality: recent legislation requires EMS will be a conduit for registries, POLST, Stroke registry and others in terms of providing information to the state.
- West County transports consistent distribution of patients post DMC closure. Kaiser Richmond is seeing on a routine basis over 200 patients. ED bed capacity at Kaiser Richmond was increased in January from 15 to 25.
- As of September 1st, 2016, CalStar and Reach are one organization, with headquarters in Louisville, Texas.
- POLST Program: Contra Costa EMS to pilot EMSA POLST registry with implementation in 2017 in collaboration with ACCMA.
- Contra Costa EMS System selected to pilot improvements in California Stroke Registry and Stroke system improvements as part of CMS grant with Stanford Health Services.
- On September 13th, EMS convened their second half day Quarterly Systems of Care meeting, presenting data.
- On November 9th, EMS hosted the 1st annual Contra Costa County Survivor’s Luncheon to show tangible continuum of care, and where survivors meet their rescuers.
- Treatment guidelines and policies updated towards the end of a year are mostly finished for sending out for public comment. Implementation is January 1st, 2017.
- EMS Agency Measure H funding supporting Fire Service EMS Medical Director and ePCR server support to assure compliance with EMSA data requirements.

II. Accomplishments
- Approval of EMCC 2015 Annual Report
  - On February 22, 2016, the EMCC Executive Committee and Staff distributed an official letter to its membership informing them of the new Bylaws, eliminating all alternate seats. Previously alternate members were invited to state their interest should they wish to remain on the EMCC.
  - Implementation of new Bylaws: Adjustments to membership are effective as of the March meeting with alternate seats removed. EMS staff worked with stakeholder groups to submit recommendations to fill vacant seats.
  - EMCC to co-host with support of John Muir Medical Center a 5150 Summit on February 22, 2017.
  - On July 6, 2016, the EMCC Executive Committee sent a letter to the Board of Supervisors regarding providing further input to the Board to assist them in evaluating the proposed updates to the ambulance ordinance.
  - 2015 EMS System Plan has met all standards and criteria required by state EMS Authority as of September 7, 2016.
  - Contra Costa EMS has received the Mission Lifeline Bronze Award for their STEMI system 3rd year in a row.

III. Attendance/Representation
The EMCC is a multidisciplinary committee with membership consisting of representation of specific EMS stakeholder groups and organizations plus one (1) consumer member and one (1) alternate nominated by each Board of Supervisor member. There are twenty (20) filled member seats on the EMCC. Four (4) seats are unfilled. A quorum was achieved at three (3) of the four (4) EMCC meetings in 2016.

IV. Training/Certification
Each EMCC representative was given a copy of the Advisory Body Handbook and copies of the “The Brown Act and Better Government Ordinance - What you Need to Know as a Commission, Board or Committee Member” and “Ethics Orientation for County Officials” videotapes during their two (2) year term. Responsibilities of County Boards were discussed including the responsibility to view the videotapes and submit signed certifications. Certification forms have been received from thirteen (13) of the twenty (20) representatives. The certificates received for two (2) of the new members in 2016 are attached.

V. Proposed Work Plan/Objectives for Next Year
Report to the local EMS Agency and to the Board of Supervisors as appropriate its observations and recommendations relative to its review of:
• Alliance/EMS partnerships to implement efficiencies and workflows supporting EMS System improvement
• Efforts to procure grant funding for EMS System data infrastructure enhancements to support bi-directional data exchange
• Promote and sustain Medical Health Disaster Coalition preparedness and engagement throughout EMS System.
• Enhancements Medical Reserve Corps’ capability for children and special needs populations.
• Update of County EMS for Children (EMSC) program and system of care enhancements.
• Continue to work with county counsel and stakeholders to update the county ambulance ordinance.
• Manage, update and submit to the State EMS Authority the 2016 EMS System Plan, Quality, Trauma, Stroke, STEMI and EMS for Children programs.
• Monitor and report on EMS System impacts due to changing economics and health care reform.
• Receive 2016 Annual EMS System performance report.
• Innovative models of EMS service delivery with hospital community.
• Update the County Multi-Casualty Incident (MCI) Plan in partnership with EMS System stakeholders.
• Support emergency ambulance provider and community hospitals efforts to reduce patient transfer of care extended delays that impact the availability of ambulances for the next 9-1-1 call.
• Support EMS System program (STEMI, Stroke, Cardiac Arrest, EMSC, Quality/Patient Safety and Trauma) initiatives.
• Continue to support and sustain community education and outreach, e.g. HeartSafe, Child Injury Prevention.
• Support appropriate use of 9-1-1, CPR Anytime, and Automatic External Defibrillator (AED) programs through partnerships with law enforcement, CERT, fire first responders and community coalitions.
• Update of county ambulance ordinance.
• Hold 2nd Annual Contra Costa Survivors Reunion in 2017
• Conduct 5150 Summit February 22, 2016
• Continue to monitor West County EMS System associated with closure of Doctor’s Hospital and pending closure of Alta Bates Summit
DATE: November 30, 2016

TO: Contra Costa EMS System Stakeholders

FROM: Patricia Frost, RN, MS, PNP Contra Costa EMS Director

SUBJECT: A Special Save the Date: Contra Costa EMS System 5150 Summit: Supporting a Greater Collective Awareness

February 22, 2017, 8:00am-4:30pm John Muir Medical Center Walnut Creek Conference Center

On behalf of the Emergency Medical Services Care Committee and Contra Costa Emergency Medical Services we invite you to join us for a day of discussion, reflection and dialogue associated with responding to the needs of behavioral health patients in our community who require emergency services and psychiatric holds.

The event will be held at John Muir Medical Center (JMMC) Walnut Creek Conference Center from 8-4:30pm. Continuing Education will be available for nurses and EMS personnel. Refreshments and lunch will be provided.

Objectives: By the end of the summit participants will be able to:
1. Understand the countywide frequency and impact of use of 5150 holds on the community.
2. State the legal requirements and responsibilities associated with voluntary and involuntary holds
3. Recognize the special challenges associated with 5150 of individuals with substance abuse, dementia or when youth are involved.
4. Explore how inter-disciplinary collaboration across the EMS and Health Care System can reduce the impact of 5150 in your community

The purpose of this special Summit is to promote shared understanding of concerns associated with the population across disciplines. Please contact us with your email and contact information if you are interested in attending this special event by calling our office at 925 646-4690 or emailing Leticia.Andres@hsd.cccounty.us
# 2016 Emergency Medical Services (EMS) System Plan

**SYSTEM PLAN SMART\(^2\) OBJECTIVES**

Progress from Last Reporting Period

<table>
<thead>
<tr>
<th>No.</th>
<th>Standard</th>
<th>Meets State Standard</th>
<th>FY 2015-2016 Objectives</th>
<th>Progress to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.06</td>
<td>Annual system Plan Update</td>
<td>Yes</td>
<td>Annual EMS System Update to State EMS Authority (EMSA)</td>
<td><strong>Progress to Date:</strong> In Progress to be submitted EMSA July 2017</td>
</tr>
<tr>
<td>1.07</td>
<td>Trauma Planning</td>
<td>Yes</td>
<td>Annual Trauma System Status Report.</td>
<td><strong>Progress to Date:</strong> In Progress Update due by January 2017.</td>
</tr>
<tr>
<td>1.08</td>
<td>ALS Planning</td>
<td>Yes</td>
<td>EMS System Review and Modernization study integration into emergency ambulance Request for Proposal (RFP) procurement and selection complete by November 2015.</td>
<td><strong>Progress to Date:</strong> Met New ambulance provider competitively procured and new contract started January 1, 2016</td>
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<td>1.10</td>
<td>Special Populations</td>
<td>Yes</td>
<td>Exploration of alternative delivery models to match patient need to resource.</td>
<td><strong>Progress to Date:</strong> In Progress 1-5 years. Engaged with local Health System partners to explore opportunities.</td>
</tr>
<tr>
<td>1.11</td>
<td>System Participants</td>
<td>Yes</td>
<td>Stakeholder participation in update, approval and implementation of new ambulance ordinance</td>
<td><strong>Progress to Date:</strong> In Progress 12months Draft updated ordinance in review with County Counsel.</td>
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<tr>
<td>1.13</td>
<td>Coordination</td>
<td>Yes</td>
<td>Exploration of coordination of EMS Dispatch Centers with Nurse Call centers to support appropriate use of 9-1-1 or specialty dispatch and triage call centers</td>
<td><strong>Progress to Date:</strong> Not Started Engage stakeholders within 1-5 years</td>
</tr>
<tr>
<td>1.14</td>
<td>Policy and Procedure Manual</td>
<td>Yes</td>
<td>Annually update of prehospital care policies and procedures based on evidence-based care.</td>
<td><strong>Progress to Date:</strong> Ongoing Updated policies and protocols posted on EMS website at <a href="http://www.cccems.org">www.cccems.org</a>.</td>
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**No.** | **Standard** | **Meets State** | **FY 2015-2016 Objectives** | **Progress to Date** |
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<td>System Participants</td>
<td>Yes</td>
<td>Stakeholder participation in update, approval and implementation of new ambulance ordinance</td>
<td><strong>Progress to Date:</strong> In Progress 12months Draft updated ordinance in review with County Counsel.</td>
</tr>
<tr>
<td>1.13</td>
<td>Coordination</td>
<td>Yes</td>
<td>Exploration of coordination of EMS Dispatch Centers with Nurse Call centers to support appropriate use of 9-1-1 or specialty dispatch and triage call centers</td>
<td><strong>Progress to Date:</strong> Not Started Engage stakeholders within 1-5 years</td>
</tr>
<tr>
<td>1.14</td>
<td>Policy and Procedure Manual</td>
<td>Yes</td>
<td>Annually update of prehospital care policies and procedures based on evidence-based care.</td>
<td><strong>Progress to Date:</strong> Ongoing Updated policies and protocols posted on EMS website at <a href="http://www.cccems.org">www.cccems.org</a>.</td>
</tr>
</tbody>
</table>

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1 Approved by the EMCC on XXXX

2 SMART: Specific, Measurable, Achievable, Realistic and Timely
<table>
<thead>
<tr>
<th>No.</th>
<th>Standard</th>
<th>Meets State Standard</th>
<th>FY 2015-2016 Objectives</th>
<th>Progress to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.16</td>
<td>System Finances</td>
<td>Yes</td>
<td>Annually review of costs and fees to support sustainable EMS System and EMS Agency oversight and operations.</td>
<td>Progress to Date: Ongoing</td>
</tr>
<tr>
<td>1.20</td>
<td>DNR (Do Not Resuscitate)</td>
<td>Yes</td>
<td>Participating on the Steering Committee for Physicians Orders for Life Sustaining Treatment (POLST) with EMS System Stakeholders supporting the conversation project over 12-24 months.</td>
<td>Progress to date: Ongoing</td>
</tr>
<tr>
<td>1.27</td>
<td>Pediatric Emergency Medical and Critical Care System</td>
<td>Yes</td>
<td>Pediatric EMS for Children (EMSC) System Program Plan update and regulation implementation within 1-5 years.</td>
<td>Progress to date: In progress</td>
</tr>
<tr>
<td>1.28</td>
<td>Exclusive Operating Area (EOA)</td>
<td>Yes</td>
<td>Update of county ambulance ordinance within 12-18 months. Update of EOA I, II and V completed as part of system redesign and ambulance procurement.</td>
<td>Progress to date: In progress</td>
</tr>
<tr>
<td>2.01</td>
<td>Local EMS Agency Staffing and Assessment of Needs</td>
<td>Yes</td>
<td>EMS System Study and Modernization Project review of EMS staffing needs and workflows to support statutory requirements within 1-2 years.</td>
<td>Progress to date: In progress</td>
</tr>
<tr>
<td>2.04</td>
<td>Dispatch Training</td>
<td>Yes</td>
<td>Promote support high quality Emergency Medical Dispatch (EMD) dispatcher training and performance consistent for Center of Excellence Accreditation within 3-5 years.</td>
<td>Progress to date: In progress</td>
</tr>
<tr>
<td>2.06</td>
<td>Response</td>
<td>Yes</td>
<td>Contra Costa EMS (CCEMS) continues ongoing evaluation of sustainability of EMS System partners based on safety, funding and opportunities for health care reimbursement.</td>
<td>Progress to date: Ongoing</td>
</tr>
<tr>
<td>2.12</td>
<td>Early Defibrillation</td>
<td>Yes</td>
<td>Continued expansion of public access Automated External Defibrillation (AED) and Law AED programs with integration into dispatch.</td>
<td>Progress to Date: Ongoing</td>
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<td>------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>5.06</td>
<td>Hospital Evacuation Plan</td>
<td>Yes</td>
<td>Update medical surge and transportation plans for hospitals incorporating standardized training with HICS for all hospital facilities with opportunities for integration of first responders with hospital leadership and incident commanders.</td>
<td>Progress to date: In progress Plan updates within 1-3 years. Update of MCI plan and Pediatric Surge Toolkit.</td>
</tr>
<tr>
<td>5.10</td>
<td>Pediatric Emergency and Critical Care System</td>
<td>Yes</td>
<td>Continued networking with pediatric emergency care advocates throughout the local, regional and state EMS systems supporting pediatric emergency care best practices.</td>
<td>Progress to date: Ongoing CCEMS and Alameda County (ALCO) EMS have collaborative program of active advocacy for emergency preparedness for children.</td>
</tr>
<tr>
<td>5.13</td>
<td>Specialty System Design</td>
<td>Yes</td>
<td>Annual Stroke, STEMI, Trauma and Cardiac Arrest System Evaluation.</td>
<td>Progress to date: Ongoing Continuous CQI program &amp; participation in California Stroke Registry, Cardiac Arrest Registry for Enhanced Survival (CARES), Trauma Registry and California EMS Information System (CEMSIS).</td>
</tr>
<tr>
<td>5.14</td>
<td>Public Input</td>
<td>Yes</td>
<td>Active program of engagement with public including quarterly Emergency Medical Care Committee (EMCC) meetings. EMCC bylaw update.</td>
<td>Progress to date: Ongoing. Public and EMCC comment to be included as part of ambulance ordinance review and update process.</td>
</tr>
<tr>
<td>6.01</td>
<td>QA/QI Program</td>
<td>Yes</td>
<td>Bi-annual public reporting EMS Hospital transfer of care never event monitoring. Implementation of Quality Review Team (QRT) for review of event reports concerning clinical care concerns.</td>
<td>Progress to date: Ongoing Hospitals public reporting continues. QRT implemented and reviewing cases for trends.</td>
</tr>
<tr>
<td>7.01</td>
<td>Public Education</td>
<td>Yes</td>
<td>Expansion of HeartSafe Communities to include support for CPR, Public Access Defibrillation (PAD), Heart Attack, Stroke and Healthy Lifestyle.</td>
<td>Progress to date: Ongoing continue countywide expansion of outreach in progress.</td>
</tr>
<tr>
<td>7.03</td>
<td>Disaster Preparedness Promotion</td>
<td>Yes</td>
<td>Annual advocacy and implementation of regional pediatric medical surge planning. Develop policies and work with stakeholders for implementation and use of BLS providers to backup 911 system in surge.</td>
<td>Progress to date: Ongoing CCEMS participating in National, regional and statewide efforts supporting Med/Health Preparedness. Evaluation and update of MCI plan in progress.</td>
</tr>
<tr>
<td>8.13</td>
<td>Disaster Medical Response</td>
<td>Yes</td>
<td>Sustain Contra Costa Medical Reserve Corp and demonstrate effective deployment Medical Reserve Corps</td>
<td>Progress to date: Met MRC coordinator in place to support training to enable effective deployment of MRC.</td>
</tr>
<tr>
<td>8.15</td>
<td>Interhospital Communications</td>
<td>Yes</td>
<td>Address ongoing gaps in emergency communications e.g. ReddiNet, evaluate emergency communication tools and apps. Identify and address gaps in East Bay Regional Communications System (EBRCS) hospital radio system.</td>
<td>Progress to date: Ongoing. Annually monitor, exercise support and upgrade as fiscally able inter-hospital communications</td>
</tr>
<tr>
<td>8.18</td>
<td>Enhanced Level: Specialty Care Systems</td>
<td>Yes</td>
<td>Update of new state regulations for specialty care systems e.g. Trauma, ST Elevation Myocardial Infarction (STEMI), Stroke, EMSC.</td>
<td>Progress to date: Ongoing. Annually involved in the development through EMSAAC</td>
</tr>
</tbody>
</table>

**2017 TIMELINE & ACTIONS TO BE ADDRESSED**

All State standards have been met. We plan to address or reassess the following SMART objectives.
<table>
<thead>
<tr>
<th>No.</th>
<th>Standard</th>
<th>Meets State Standard</th>
<th>2017 Objectives</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.06</td>
<td>Annual System Plan Update</td>
<td>Yes</td>
<td>Update Annually.</td>
<td>July 2017</td>
</tr>
<tr>
<td>1.08</td>
<td>ALS Planning</td>
<td>Yes</td>
<td>Support successful ambulance provider transition and monitor for system gaps</td>
<td>July 2017</td>
</tr>
<tr>
<td>1.10</td>
<td>Special Populations</td>
<td>Yes</td>
<td>Exploration of alternative delivery models to match patient need to resource.</td>
<td>1-5 years</td>
</tr>
<tr>
<td>1.11</td>
<td>System Participants</td>
<td>Yes</td>
<td>Stakeholder participation in update of ambulance ordinance.</td>
<td>1-2 years</td>
</tr>
<tr>
<td>1.13</td>
<td>Coordination</td>
<td>Yes</td>
<td>Exploration of EMS dispatch services, exploration of coordination with Nurse Call centers to support appropriate utilization of 9-1-1 services.</td>
<td>1-5 years</td>
</tr>
<tr>
<td>1.14</td>
<td>Policy and Procedure Manual</td>
<td>Yes</td>
<td>Update of prehospital care policies and procedures based on prehospital evidence-based care. Implementation of new American Heart Association Guidelines for ALS.</td>
<td>Annually</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Continue to evaluate policies and standard operating procedures for patient benefit, delay in definite care and patient safety. Revise protocols to control cost while prioritizing patient safety.</td>
<td>Annually</td>
</tr>
<tr>
<td>1.16</td>
<td>System Finances</td>
<td>Yes</td>
<td>Review of fees and costs to support sustainable delivery of EMS services.</td>
<td>Annually</td>
</tr>
<tr>
<td>1.20</td>
<td>Do Not Resuscitate (DNR)</td>
<td>Yes</td>
<td>Participation with “Conversation Project” in Bay Area.</td>
<td>Annually</td>
</tr>
<tr>
<td>1.27</td>
<td>Pediatric Emergency Medical and Critical Care System</td>
<td>Yes</td>
<td>Update of Pediatric EMSC plan and future implementation of State Pediatric EMSC System of Care regulations.</td>
<td>3 years</td>
</tr>
<tr>
<td>1.28</td>
<td>Exclusive Operating Area</td>
<td>Yes</td>
<td>Complete county ambulance ordinance.</td>
<td>1-2 years</td>
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<tr>
<td>2.01</td>
<td>Local EMS Agency Staffing and Assessment of Needs</td>
<td>Yes</td>
<td>Annual review of EMS Staffing needs and workflows to support statutory requirements.</td>
<td>1-2 years</td>
</tr>
<tr>
<td>2.04</td>
<td>Dispatch Training</td>
<td>Yes</td>
<td>Support high quality EMD and dispatcher training for Center of Excellence Accreditation.</td>
<td>1-5 years</td>
</tr>
<tr>
<td>2.12</td>
<td>Early Defibrillation</td>
<td>Yes</td>
<td>Expand and enhance Public Access AED and Law AED programs within fiscal resources</td>
<td>Annually</td>
</tr>
<tr>
<td>5.06</td>
<td>Hospital Evacuation Plan</td>
<td>Yes</td>
<td>Update of medical surge and transportation plans for hospitals.</td>
<td>1-3 years</td>
</tr>
<tr>
<td>5.08</td>
<td>Trauma Planning</td>
<td>Yes</td>
<td>Update of trauma plan.</td>
<td>January 2017</td>
</tr>
<tr>
<td>5.10</td>
<td>Pediatric Emergency and Critical Care System</td>
<td>Yes</td>
<td>Continued networking with pediatric emergency care advocates throughout the local, regional and state EMS systems supporting pediatric emergency care best practices.</td>
<td>Annually</td>
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<tr>
<td>5.13</td>
<td>Specialty System Design</td>
<td>Yes</td>
<td>Stroke, STEMI, Cardiac Arrest, Trauma, EMS for Children System Program Evaluation.</td>
<td>Annually</td>
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<tr>
<td>5.14</td>
<td>Public Input</td>
<td>Yes</td>
<td>Support EMCC engagement on EMS issues including public input of Ambulance Ordinance</td>
<td>1 year</td>
</tr>
<tr>
<td>6.01</td>
<td>Quality Assurance (QA)</td>
<td>Yes</td>
<td>Evaluate EMS-Hospital data system integration supporting patient safety and prehospital care.</td>
<td>1-4 years</td>
</tr>
<tr>
<td>Quality Improvement (QI) Program</td>
<td>Development Details</td>
<td>Frequency</td>
<td></td>
<td></td>
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<td>7.01 Public Education</td>
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<td>Annually</td>
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<tr>
<td>7.03 Disaster Preparedness Promotion</td>
<td>Yes</td>
<td>Continued advocacy and implementation of regional pediatric medical surge planning.</td>
<td>Annually</td>
<td></td>
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<tr>
<td>8.13 Disaster Medical Response</td>
<td>Yes</td>
<td>Sustain development and recruitment of Contra Costa Medical Reserve Corp volunteers. Effective MRC capability for medical health deployment as needed.</td>
<td>Annually</td>
<td></td>
</tr>
<tr>
<td>8.15 Interhospital Communications</td>
<td>Yes</td>
<td>Address ongoing gaps and improvement opportunities for ReddiNet platform to support reliable use by hospitals. Support redesign emergency communications system to support sustainability.</td>
<td>Annually</td>
<td></td>
</tr>
<tr>
<td>8.18 Enhanced Level: Specialty Care Systems</td>
<td>Yes</td>
<td>Evaluate new regulations for specialty care system implementation when complete. e.g. STEMI, Stroke, EMS for Children.</td>
<td>1-2 years</td>
<td></td>
</tr>
</tbody>
</table>
NAEMT THANKS THE MEMBERS OF THE EMS WORKFORCE COMMITTEE FOR CONTRIBUTING THEIR INSIGHTS AND EXPERTISE TO THE SURVEY AND REPORT.

Garrett Hedeen (Chair), Paramedic, Indianapolis EMS

Sean Britton, Director of Public Health, Broome County, New York

Terry L. David, Chief, Reno Co. EMS, Hutchinson Regional Medical Center

Craig Dunham, Director of Risk Management Programming, RiskWatch Systems

R. Mark Heath, Chief Fire & EMS Officer, Memphis Fire Department

Kris Kaull, Co-founder, EMS1

Jim Slattery, EMT, American Medical Response

Mike Szczygiel, Senior Loss Control Specialist, Markel Specialty Commercial

Jason White, EMS Consultant, Mid-America Regional Council

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4 INTRODUCTION
EMS practitioners face significant work-related stress.

6 EMS MENTAL HEALTH SERVICES
A majority of EMS practitioners are not satisfied with the mental health services provided.

7 WHAT IS AN EAP?
And why are so many EMS practitioners hesitant to use them?

8 GENERAL HEALTH AND WELLNESS SERVICES
Less than half of EMS agencies offer any health or wellness services.

10 IS MENTAL HEALTH A PRIORITY FOR EMS AGENCIES?
EMS practitioners share their thoughts and perceptions.

11 SETTING BENCHMARKS AND MEASURING THE EFFECTIVENESS OF MENTAL HEALTH SERVICES
Few EMS agencies measure the effectiveness of services provided.

12 WORD ON THE STREET
What EMS practitioners say about mental health.

14 CONCLUSION
Encourage EMS practitioners to speak up and seek help.

15 RESOURCES
Information about suicide prevention, mental health first aid and building emotional resiliency.

NAEMT 2016 EMS Mental Health Services Survey
INTRODUCTION

EMS is an inherently stressful job. On any given shift, EMTs and paramedics may be called on to render care to people in horrific circumstances. Many EMS practitioners can tell stories of answering calls involving violence, death, or abuse that continue to haunt them.

Even on more routine calls, EMS practitioners face the risks of being exposed to infectious disease, bloodborne pathogens, or other hazardous substances. And then there is the stress of being subjected to threats or violence from a would-be patient who is under the influence of drugs or alcohol, suffering from a mental health disorder, or has criminal intent.

Combine all of that with sleep deprivation, shift work, time pressures and work overload, and it’s no wonder the world of EMS is rife with anecdotes about the toll that working in these unpredictable, emotionally charged conditions can take on practitioners. Recently, the Code Green Campaign, a grassroots effort to raise awareness about mental health issues, struck a nerve when it launched a website inviting EMS practitioners to share their struggles. Day after day, EMTs and paramedics post raw, painful messages about struggling with panic attacks, flashbacks, anxiety, depression and suicidal thoughts. Their stories are interwoven with memories of calls that left them feeling hopeless or deeply disturbed by what they had seen or experienced.

Some of that anguish is ending in tragedy. Many EMS practitioners know of a colleague who has attempted, or committed, suicide. A 2015 survey by Fitch & Associates’ Ambulance Service Manager Program suggested that mental health struggles and depression among fire and EMS professionals are widespread. In the survey, 37 percent reported contemplating suicide, nearly 10 times the rate of American adults, while 6.6 percent reported having attempted suicide. That’s compared to just 0.5 percent of all adults.

STUDIES LIMITED

Despite important work like the Fitch survey and at the grassroots level to provide information and support, gauging the depth and extent of the problem remains difficult. Multiple studies indicate that healthcare workers are exposed to high levels of occupational stress, which contributes to higher levels of substance abuse, depression and anxiety. But there have been few published studies looking at the long-term mental health of U.S.-based EMS practitioners, outside of the impact of specific, high profile events such as Hurricane Katrina or the 9/11 attacks.

Nor are official suicide statistics readily available. In July 2016, the CDC published a report analyzing suicide rate by occupation.1 Using data on 12,000 suicides that occurred in 17 states in 2012, the analysis found that among females, the highest suicide rate was among women who work in the “protective services,” including law enforcement officers and firefighters. That was followed by women in the legal profession, with healthcare practitioners/technical occupations third. (EMTs and paramedics are included in the healthcare practitioner/technical occupations category). Among men, the suicide rate for those working as police officers or firefighters ranked fifth, behind farming, fishing, forestry, construction and multiple other professions, while the rate for those working in healthcare professions was 12th. Yet males accounted for more suicides than females, with men making up 77% of the total.

Thus far, the granular tracking of suicides in EMS has been up to the grassroots. The Firefighter Behavioral Health Alliance, run by retired firefighter and counselor Jeff Dill, has a team of volunteers who collect and confirm reports of EMS suicides. In 2014, Dill’s group verified 104 suicides by fire and EMS professionals – more than the 87 firefighters who were killed in the line of duty.1

“Mental health continues to be a topic that people would rather ignore, especially management. Emergency services still generally has the attitude, ‘suck it up’.”

–Survey respondent

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1 Morbidity and Mortality Weekly Report, Centers for Disease Control and Prevention, July 1, 2016, Suicide Rates by Occupational Group – 17 States, 2012. (http://www.cdc.gov/mmwr/volumes/65/wr/mm6525a1.htm#T2_down)
AWARENESS GROWING

A common sentiment heard from EMS practitioners is that mental health issues aren’t something people want to talk about, for fear of being seen as weak or soft, or at worse, unfit to do their jobs. There is little question that a reluctance to talk about mental health issues remains in EMS.

Yet awareness about mental health issues in EMS is growing, thanks to the efforts by groups such as the Firefighter Behavioral Health Alliance, the Code Green Campaign, and other individuals who have suffered from PTSD or depression, and had the courage to speak out.

To assist the EMS profession in determining how best to address mental health issues, NAEMT is pleased to present the results of our 2016 national survey on EMS mental health services. The results provide a snapshot of the resources, programs and services EMS agencies provide to EMS practitioners to help them cope with the stress of the job, to maintain their mental health and wellbeing, and to seek help when they need it.

ABOUT THE SURVEY

The survey, developed by the experts on NAEMT’s EMS Workforce Committee, was distributed electronically to more than 40,000 EMTs, paramedics, EMS managers and medical directors in March 2016. We received nearly 2,200 responses from all 50 states.

Some of the most revealing responses were to an open-ended (qualitative) question asking for comments about the services provided by their EMS agency and about the issue of EMS mental health generally. More than 500 respondents provided their thoughts. Many indicated EMS mental health is an urgent issue, and that far more needs to be done to address it. Others shared personal stories of struggling with PTSD, depression and other mental health issues. Their comments are summarized beginning on page 12.

We also asked EMS practitioners about their perceptions of the importance their agency places on mental health issues, whether they know where to get help, and if they are satisfied with the services available to them.

The survey revealed that the EMS profession has significant work to do in demonstrating to the EMS workforce that their struggles and concerns matter, and in ensuring that EMS professionals know where to turn when they are struggling.

“...The culture of EMS must change... The stigma of mental health issues is very prominent. ”

-Survey respondent

RESPONDENTS

- Paramedic: 50%
- EMT: 27%
- EMS Training Coordinator: 5%
- Medical Director: 0.4%
- EMS Director: 8%
- EMS Manager: 5%
- Other: 4.6%
58% of respondents disagreed or strongly disagreed when asked if they are satisfied with the EMS mental health services provided by their agency.

**EMS MENTAL HEALTH SERVICES**

Mental health services is a broad term encompassing any number of services intended to foster the mental health and wellbeing of the workforce, and provide assistance when an employee is struggling. Examples of services include employee assistance programs (EAP), critical incident stress counseling, chaplaincy programs, conflict resolution programs and peer support programs.

Despite the well-known stress and demands of working in EMS, less than half of respondents said their agencies provide any sort of mental health support.

**DOES YOUR EMS AGENCY PROVIDE MENTAL HEALTH SERVICES?**

- 46% Yes
- 37% No
- 15% Unsure
- 2% Being Developed

Although 92% of respondents reported their EMS agency has a written policy regarding alcohol and drug use, only 26% provide a substance abuse program to help those struggling with dependence or addiction.

Multiple respondents referenced substance abuse policies from their agency, which often involve punishment rather than treatment.

- Even if we fess up to it, substance abuse is grounds for dismissal rather than assistance or treatment.
- A coworker who was off due to a substance abuse issue that he self-reported and sought help for was disciplined and given unfair benchmarks to return to work as a condition of employment.
- The link between PTSD and substance abuse has been disregarded for a long time.

**TYPES OF MENTAL HEALTH SERVICES PROVIDED**

By a wide margin, the most common type of mental health service provided by EMS agencies are employee assistance programs (EAP).

- 86% of those whose EMS agency provides mental health services report having an EAP.
- EAP was followed by critical incident stress counseling (59%) as the most common form of mental health service provided.

- Employee Assistance Program
- Critical incident stress counseling
- Peer support program
- Chaplaincy program
- Substance abuse program
- Crisis hotline access
- Mental health awareness training
- Social worker or therapist on staff
- Screening, brief intervention, and referral to treatment
- Conflict resolution program
- Resiliency training
RELUCTANCE TO USE EAP

EAP services are supposed to be confidential, but the survey reveals that not everyone trusts those assurances, and many are reluctant to reveal their struggles with any counselor associated with their workplace.

“Initiating mental health services through the EAP is an invitation for mandatory competency evaluation, grounds for dismissal.”

—Survey respondent

“Most of the people in my organization do not feel comfortable using any service provided by the organization for fear that the information will come back and be used against them in the future.”

—Survey respondent

Others are unsure about the types and availability of EAP services offered by their employer or human resources professionals. Additionally, due to a lack of knowledge about how the program works, some employees might avoid seeking help from the EAP because they fear that they might somehow be demoted or even fired by showing the need for assistance.

“We can pursue mental healthcare through the EAP, but not really sure how to access it confidentially.”

—Survey respondent

Even among those willing to use the EAP, the short-term nature of the counseling may be viewed as inadequate.

“EAP provided for 3 sessions per incident. I do not believe that to be adequate for someone seeking help.”

—Survey respondent

In addition, counselors are unlikely to have ever worked in EMS, and may not know much about what it’s like to work in EMS, leading some to feel that EAP-provided psychologists or therapists aren’t really able to understand their stress.

“I have used the EAP and was not impressed with the counselor’s understanding of the job I do and the difficulty I was facing.”

—Survey respondent
When an employee is struggling or in crisis, counseling and other mental health services can help provide care, support and treatment to overcome the issues.

But are there steps EMS practitioners could take to prevent depression or other mental health issues from arising, despite work-related stress and other challenges?

Though no one suggests that mental health issues can be fully prevented, advice often given by medical professionals (and backed up by research) is that there are some things people can do to protect their mental health. Those include getting regular medical care to maintain overall health, seeking help for feelings of depression or anxiety early on if symptoms emerge, getting sufficient sleep, eating a nutritious diet and getting regular physical activity.

Night shifts, irregular schedules, and long hours on the road can all conspire against EMS practitioners in heeding that advice.

The question for EMS agencies is: Are there resources agencies can provide to help EMS practitioners maintain their overall health and wellbeing, so that they have the resiliency to recover from trauma they experience on the job?

The extent to which any employer can help employees live a healthy, balanced lifestyle is difficult to measure. But many employers try, by offering health and wellness services such as access to fitness centers, tobacco cessation programs, stress management classes, dietary and nutrition counseling, or access to a health clinic on premises.

These services are not a common feature at many EMS agencies. According to the survey, less than half (47%) of respondents said their EMS agency offered any health or wellness services.

Of those that did, the most common resource was a fitness center on the agency’s premises (52%).

### Types of General Health/Wellness Services Offered

- **52%** Fitness center on premises
- **41%** Tobacco cessation program
- **33%** Dietary/nutrition counseling
- **28%** Substance abuse counseling
- **25%** Membership to a local fitness center
- **21%** Stress management classes
- **16%** Health clinic on the agency’s premises
- **15%** Free access to a local health clinic
- **10%** Group exercise class
59% of survey respondents agreed or strongly agreed that they know where to go for help within their agency if they need it, while 41% disagreed or strongly disagreed.

**AVAILABILITY OF MENTAL HEALTH AND WELLBEING SERVICES WHILE ON DUTY**

Being able to access mental health or general health and wellbeing services while on duty may make it more feasible for EMS practitioners to actually make use of them. This is not a common practice in EMS, however.

**Mental health services**
- About one-third (34%) of respondents reported their EMS agency permits them to access mental health services on duty.
- About one-third (35%) are not allowed to access mental health services while on-duty.
- Another one-third (32%) didn’t know.

**General health and wellbeing services**
- 37% reported their EMS agency permits them to access general health and well-being services on duty.
- 45% are not allowed.
- 18% didn’t know.

In the comments, several respondents expressed their frustration with what they perceive as worker’s comp limitations related to mental health claims.

“Currently, acute emotional injuries and mental health are not considered to be work-related by worker’s comp.”

–Survey respondent

“I was seeing a mental health professional for PTSD after an ambulance accident that resulted in the death of the driver in the other car... Worker’s comp denied my claim...leaving me stuck with the bills.”

–Survey respondent

**WORKER’S COMP FOR MENTAL HEALTH CRises**

Workers’ compensation insurance is a type of insurance purchased by employers for the coverage of employment-related injuries and illnesses. Nearly all states require employers with five or more employees to provide coverage. But the specifics vary state to state. States determine what injuries are covered, how impairments are to be evaluated and how medical care is to be delivered, and the level of coverage, according to the Insurance Information Institute.

Mental health conditions may be eligible for workers’ compensation, including psychiatric injuries from singular events, such as post-traumatic stress disorder (PTSD), and conditions arising over time, such as depression and severe anxiety.

Many respondents (58%) were not sure if their EMS agency provided worker’s compensation for mental health claims. Only 15% said their agency did provide compensation, while 27% said no.
IS MENTAL HEALTH A PRIORITY FOR EMS AGENCIES? PERCEPTIONS OF EMS PRACTITIONERS

In the comments section of the survey, dozens of EMS practitioners expressed a high degree of dismay, and even disgust, with management and co-workers’ attitudes toward mental health services.

“ The agency I work for sees mental health as a weakness. If you ask for help you become verbally abused by co-workers, supervisors and station managers. I needed help and was told, ‘that’s why women don’t belong in EMS. They’re overly emotional.’ ”

“ There is absolutely no concern for the mental or physical health of employees at my agency. ”

“ Field personnel are suffering mentally and physically and morale is low. We keep coming back because we got in it to help people and we love the job. However, we have no support when it comes to taking care of our sick employees. ”

“ I find it sad that my service doesn’t seem to care or just makes jokes about the employees if they are having a hard time with something. ”

To be sure, not every comment was negative. Some praised the efforts of management to be there for employees on a personal level, as well as the resources provided by the agency. Peer support, critical incident stress management were mentioned fairly often, as were sessions with trained counselors.

“My company takes mental health seriously…I am proud of my agency. ”

“I had to use mental health resources after a pediatric trauma code. It took a few months for me to fully deal with it, but the services provided helped greatly. ”

“We have an established EAP program that can be used by all employees and their immediate families for six free sessions. They can access it for any issue, not just work related. We found that it is used more frequently now that it isn’t just for job-related issues. We believe if an employee has issues in their personal life it can affect them in their work life. ”

But even those who had a more positive view about the availability of services and the compassion and concern showed by managers and co-workers, a common theme was that the available resources weren’t enough.

“I work in a poor area. Management is extremely supportive and willing to provide any support they can. We just don’t have the funds to provide any extra. ”
While providing resources to help EMS practitioners maintain their mental health and wellbeing certainly sounds like a good idea, in deciding what to offer, employers would like to know that their investment in providing these services is having an impact. But with many variables, trying to figure out what actually works, for whom, and in what circumstances, isn’t easy.

For example, critical incident stress debriefings gained popularity in the ‘80s and ‘90s as a way to help responders process and overcome trauma from harrowing calls. But eventually, questions were raised about the helpfulness of those interactions – as it turned out, not everyone benefitted from talking about what had happened. In addition, the way in which the debriefing was conducted and the qualifications of the facilitator could significantly impact how participants felt about it.

So how can an employer measure the effectiveness of EAPs or other mental health services?

Measuring utilization is one strategy, which can help employers determine if they’re doing enough to get the word out about the services offered. Another strategy is surveys. Employers may anonymously survey employees about their satisfaction with the services provided by an EAP or other service. But this method has limitations – liking or appreciating a service doesn’t necessarily mean it’s effective. Employees may also not want to answer truthfully because they fear their responses will be shared. And if too few answer the survey, the results may not reflect what’s really going on.

A second surveying strategy is periodically gauging employees’ feelings related to broad measures of mental health. For example, employees could be asked to indicate how strongly they agree or disagree with a set of statements (like the ones listed below) covering a specified period of time, then measuring aggregate changes over time, suggests the Employee Assistance Society of America.

1. I had a hard time doing my work because of my personal problems.
2. My personal problems kept me from concentrating on my work.
3. Because of my personal problems I was not able to enjoy my work.
4. My personal problems made me worry about completing my tasks.
5. I could not do my job well because of my personal problems.

Learn more about these strategies in “Selecting and Strengthening Employee Assistance Programs: A Purchaser’s Guide,” published by the Employee Assistance Society of America. Free copies are available at easna.org.

A total of 50 respondents said their agency measures the effectiveness of mental health services. The most common strategy was measuring number of sick days used (57%), followed by attrition rates (49%), number of post-employment positive drug tests (26%) and number of DUI arrests (10%).

Very few EMS agencies have set benchmarks or measure outcomes related to the effectiveness of mental health services.

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Very few EMS agencies have set benchmarks or measure outcomes related to the effectiveness of mental health services.

Does your EMS agency measure the effectiveness of mental health services?

76% NO
19% DON’T KNOW
2% YES
2% BEING DEVELOPED
Some of the most revealing responses were to a question asking respondents for comments about the services provided by their EMS agency, or about the issue of EMS mental health generally. More than 500 respondents provided their thoughts.

Some told personal stories about struggling with depression and PTSD, or of having difficulty accessing help when they needed it. Many expressed frustration that mental health continues to be stigmatized. In reviewing all of the comments, several themes emerged.


Some, particularly those working for government or hospital-based systems, wrote about having access to a comprehensive EAP that includes an array of services. Others had far more limited resources, such as peer counseling only, free sessions with a counselor from a local church, or grief counselors when necessary.


“Mental health is a joke to management. They still operate on the philosophy that if you can’t handle it, you’re in the wrong line of work.”

“Attitude at our department is, if you can’t handle it, get out, sissy.”

“I strongly believe that in the workplace mental health is viewed as taboo, not to be talked about and if found out, viewed as weakness.”

“In seeking help you are shamed, made fun of by superiors, and told to suck it up. It’s part of the job.”


“Just talking with a counselor doesn’t fix anyone’s problem but that is all our EAP provides. When we are referred to someone else… it comes out of the employee’s pocket.”

“We are a small volunteer agency… We have mental health counselors we can recommend, but we cannot pay for this service. They will have to access it using their own insurance.”

“Rural agencies that operate off monies strictly derived by billing simply cannot afford to offer these types of services to their employees.”


“The biggest factor affecting mental health is EMS practitioners are paid so little in my state that they have to work multiple jobs to make ends meet, which means no family or personal time, no opportunity to exercise, eat right or get any sleep.”

“I’ve been in EMS almost 13 years and struggle daily with what may be PTSD… With long hours and little rest, the situation can be exacerbated and exhausting.”

“Throwing money at something isn’t always the answer but I feel that if we made a more respectable wage we wouldn’t have to kill ourselves working major OT and second jobs to get by, which in my opinion is a large contributor to the issue of mental health and burnout.”
CRITICAL INCIDENT STRESS MANAGEMENT OR DEBRIEFINGS MAY HAVE A ROLE IN HELPING EMS PRACTITIONERS COPE, BUT IT IS NOT ENOUGH, AND THEY MUST BE CAREFULLY CONDUCTED. WHILE SOME VALUE CRITICAL INCIDENT STRESS MANAGEMENT OR DEBRIEFINGS, OTHERS DESCRIBED VERY NEGATIVE EXPERIENCES.

“In my other job I had a debriefing. It was horrible and I would never do it again.”

“We have a critical incident management person. But when she debriefs people... she jokes about the issue and has once offered the solution... to drink.”

“The few debriefings I have attended over 22 years, they all bring back up what we are desperately trying to let go of or bury.”

EMS PRACTITIONERS WANT COUNSELORS WHO UNDERSTAND THE JOB OF EMS. GENERAL COUNSELORS, THERAPISTS OR PSYCHOLOGISTS WHO ARE UNINFORMED ABOUT EMS ARE SEEN AS OFFERING LITTLE USEFUL HELP.

“We have an EAP program accessible to all city employees. I believe there should be a separate and more specialized program geared toward first responders...This would include counselors that have a background dealing with first responders.”

“We self-debrief and help each other when the need arises.”

“We are a volunteer company... and a very close-knit family. Any issues that may arise we are comfortable talking to each other about.”

“As a senior member of my organization, I speak openly (formally and informally) with co-workers about my experiences to lessen the stigma and encourage self-identification to seek help.”

EMS PRACTITIONERS WANT HELP.

“We see death and trauma daily and our sleep is interrupted on average 2 or 3 times after midnight every shift. Please help.”

“If someone has a problem they may be seen as soft by their peers. We need the tools and resources easily available to get the help we need.”

“If I can’t take care of myself, I am unable to take care of others. I have found ways of coping with the stress that I acquire on the job but many of my coworkers have not. Let’s face it, we don’t get called because someone is having a great day. It would be extremely beneficial to have a functioning, non-biased mental health service within our EMS system to help lighten the load and help us take care of ourselves first.”

THERE IS WIDE AGREEMENT THAT TOO LITTLE IS BEING DONE TO HELP EMS PRACTITIONERS WITH MENTAL HEALTH ISSUES, AND THAT MORE SHOULD BE DONE, INCLUDING EDUCATING NEW PRACTITIONERS ABOUT MENTAL HEALTH ISSUES.

Mental health should be a fundamental part of the EMS training curriculum so that EMTs, paramedics, first responders all know what it is, how to identify it, how to deal with stress and where to get help.

“This is a silent epidemic. I have seen people depart the profession and have seen profound damage done to others... You can’t hand somebody an EAP card and expect a result.”

IN THE ABSENCE OF ADEQUATE RESOURCES, MANY EMS PRACTITIONERS HELP ONE ANOTHER, WHETHER IT’S CHECKING IN ON COLLEAGUES AFTER A BAD CALL OR TRYING TO BE THERE TO PROVIDE SUPPORT TO COLLEAGUES WHO ARE STRUGGLING.

“We cope by talking to coworkers. There are a few unofficial people that always check in with people who have had bad calls. It’s not nearly adequate.”

“We are a volunteer company... and a very close-knit family. Any issues that may arise we are comfortable talking to each other about.”

“As a senior member of my organization, I speak openly (formally and informally) with co-workers about my experiences to lessen the stigma and encourage self-identification to seek help.”

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CONCLUSION

From difficult calls involving injured children, to horrifying calls involving violence or abuse, to working in conditions where practitioners themselves face the risk of violence, the job of an EMS practitioner can be extraordinarily stressful.

At the same time, EMS practitioners also have to cope with challenges outside of work. Stressors faced by many Americans include marital and family problems, financial strain, legal issues, conflicts among co-workers and managers, depression, preexisting psychological or health conditions, substance abuse, child and elder care pressures — all of which can compromise a person’s mental health and overall wellbeing.

Traditionally, EMS practitioners have felt that they are expected to simply deal with their stress, showing no signs of “weakness” or struggle — an attitude that the survey results indicate are a continuing barrier to seeking help.

Yet the large number of anecdotal reports about the stress and mental health struggles of many practitioners, combined with these survey responses, illustrate that the culture of EMS related to mental health is in urgent need of change.

EMS practitioners expressed a strong desire for additional mental health and general health and wellbeing resources to help them recover from critical incidents. They also expressed a desire for resources to “proactively” help them maintain their mental and physical health, so that they are better able to cope with stress and less likely to develop conditions such as PTSD, depression and anxiety.

EMS agency management and stakeholders must listen to EMS practitioners, and take action to address mental health issues. That includes conducting research to determine the true extent of mental health issues, risk factors that contribute and interventions that are effective. The EMS profession must also identify resources that will help the EMS workforce maintain their mental health and wellbeing, build emotional resiliency, and provide for the early detection and treatment of mental health problems.

Educating the EMS workforce about healthy ways to handle stress, staying safe on the job and other topics related to mental health and safety should begin in initial training and be incorporated into continuing education.

EMS management must also make it a priority to offer mental health resources to the extent budgets allow, and to measure whether those services are having a positive impact on their staff.

There is no doubt that budget restrictions will limit the ability of many EMS agencies to provide a full array of services. But there is one thing that all EMS agencies can do, regardless of finances, and that’s letting go of the idea that mental health issues are shameful or a sign of weakness. Managers should encourage EMS practitioners to speak up and seek help without fear of reprisal, and support them in their efforts to care for themselves, so that they can continue to take care of our patients and our nation’s communities.

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– Survey respondent
RESOURCES

NAEMT Mental Health Resource Library – To assist EMS practitioners in recognizing, managing and seeking assistance for mental health issues, NAEMT has compiled a resource library of articles, tips and other information about suicide prevention, mental health first aid, and building emotional resiliency.

Find the resources at naemt.org, under the EMS Health & Safety tab. We urge you to use these resources to learn more about mental health issues, and to share them widely with your colleagues.

Code Green Campaign – Visit codegreencampaign.org to read about others’ experiences with mental health issues, and for a list of mental health resources.

If you are struggling, seek help.

Safe Call Now – (206) 459-3020 A 24/7 hotline and referral service for first responders and their family members to speak confidentially with other first responders who are trained in mental health crisis counseling. They can assist with treatment options for responders who are suffering from mental health, substance abuse and other personal issues. Visit safecallnow.org.

National Suicide Prevention Lifeline – (800) 273-8255 Available 24/7, the national suicide hotline will connect you with a trained, experienced crisis counselor who is ready to listen and connect you with mental health services in your area. Visit suicidepreventionlifeline.org.

PROTECT YOUR PRACTITIONERS
with EMS Safety training that also saves your agency money!

NAEMT’s EMS Safety program teaches:
• Situational awareness
• Personal protection
• Individual resilience
• Injury-free workplace practices
• Safe emergency vehicle operation

COST-SAVING TIP: Become an NAEMT training center and train your entire agency as well as other agencies in your community!
ABOUT NAEMT

Formed in 1975 and more than 55,000 members strong, the National Association of Emergency Medical Technicians (NAEMT) is the only national association representing the professional interests of all emergency and mobile healthcare practitioners, including emergency medical technicians, advanced emergency medical technicians, emergency medical responders, paramedics, advanced practice paramedics, critical care paramedics, flight paramedics, community paramedics, and mobile integrated healthcare practitioners. NAEMT members work in all sectors of EMS, including government agencies, fire departments, hospital-based ambulance services, private companies, industrial and special operations settings, and in the military.
2017-2022 Health Care Preparedness and Response Capabilities

Office of the Assistant Secretary for Preparedness and Response

November 2016
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Introduction

The U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR) leads the country in preparing for, responding to, and recovering from the adverse health effects of emergencies and disasters. This is accomplished by supporting the nation’s ability to withstand adversity, strengthening health and emergency response systems, and enhancing national health security. ASPR’s Hospital Preparedness Program (HPP) enables the health care delivery system to save lives during emergencies and disaster events that exceed the day-to-day capacity and capability of existing health and emergency response systems. HPP is the only source of federal funding for health care delivery system readiness, intended to improve patient outcomes, minimize the need for federal and supplemental state resources during emergencies, and enable rapid recovery. HPP prepares the health care delivery system to save lives through the development of health care coalitions (HCCs) that incentivize diverse and often competitive health care organizations with differing priorities and objectives to work together.

ASPR developed the 2017-2022 Health Care Preparedness and Response Capabilities guidance to describe what the health care delivery system, including HCCs, hospitals, and emergency medical services (EMS), have to do to effectively prepare for and respond to emergencies that impact the public’s health. Each jurisdiction, including emergency management organizations and public health agencies, provides key support to the health care delivery system.

Individual health care organizations, HCCs, jurisdictions, and other stakeholders that develop the capabilities outlined in the 2017-2022 Health Care Preparedness and Response Capabilities document will:

- Help patients receive the care they need at the right place, at the right time, and with the right resources, during emergencies
- Decrease deaths, injuries, and illnesses resulting from emergencies
- Promote health care delivery system resilience in the aftermath of emergencies

The intended audience for this document is any health care delivery system organization, HCC, or state or local agency that supports the provision of care during emergencies, including but not limited to:

- Behavioral health services and organizations
- Child care providers (e.g., daycare centers)
- Community Emergency Response Teams (CERT)1 and Medical Reserve Corps (MRC)2
- Dialysis centers and regional Centers for Medicare & Medicaid Services (CMS)-funded end-stage renal disease (ESRD) networks3
- EMS (including inter-facility and other non-EMS patient transport systems)
- Emergency management organizations
- Faith-based organizations
- Federal facilities (e.g., U.S. Department of Veterans Affairs (VA) Medical Centers, Indian Health Service facilities, military treatment facilities)
- Home health agencies, including home and community-based services

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Hospitals (e.g., acute care hospitals, trauma centers, burn centers, children's hospitals, rehabilitation hospitals)

Infrastructure companies (e.g., utility and communication companies)

Cities, counties, parishes, townships, and tribes

Local chapters of health care professional organizations (e.g., medical societies, professional societies, hospital associations)

Local public safety agencies (e.g., law enforcement and fire services)

Medical equipment and supply manufacturers and distributors

Non-governmental organizations (e.g., American Red Cross, voluntary organizations active in disasters, amateur radio operators, etc.)

Outpatient health care delivery (e.g., ambulatory care, clinics, community and tribal health centers, Federally Qualified Health Centers (FQHCs), urgent care centers, freestanding emergency rooms, stand-alone surgery centers)

Primary care providers, including pediatric and women’s health care providers

Public health agencies

Schools and universities, including academic medical centers

Skilled nursing, nursing, and long-term care facilities

Social work services

Support service providers (e.g., clinical laboratories, pharmacies, radiology, blood banks, poison control centers)

Planning for and responding to emergencies varies depending on a number of factors, including existing resources, geography (e.g., urban, suburban, rural, or frontier settings), type of health care delivery system (e.g., private sector, government), types of threats and hazards, and demographics. While the goals and objectives of these capabilities are intended for all communities across the nation, ASPR recognizes that the pathways to achieve them will differ based on the factors noted above and acknowledges the importance of flexibility and scalability.

Purpose of the 2017-2022 Health Care Preparedness and Response Capabilities

The 2017-2022 Health Care Preparedness and Response Capabilities document outlines the high-level objectives that the nation’s health care delivery system, including HCCs and individual health care organizations, should undertake to prepare for, respond to, and recover from emergencies. These capabilities illustrate the range of preparedness and response activities that, if conducted, represent the ideal state of readiness in the United States. ASPR recognizes that there is shared authority and accountability for the health care delivery system’s readiness that rests with private organizations, government agencies, and Emergency Support Function-8 (ESF-8, Public Health and Medical Services) lead agencies. Given the many public and private entities that must come together to ensure community preparedness, HCCs serve an important communication and coordination role within their respective jurisdiction(s).

These capabilities may not be achieved solely with the funding provided to HPP awardees and sub-awardees (including HCCs and health care organizations) through the HPP Cooperative Agreement. ASPR will present clear expectations and priorities, as well as performance measures for assessing HPP

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awardees’ and sub-awardees’ progress toward building the capabilities, in the HPP funding opportunity announcement for the five-year project period that begins in July 2017.

The Four Capabilities

The four Health Care Preparedness and Response Capabilities are:

**Capability 1: Foundation for Health Care and Medical Readiness**

Goal of Capability 1: The community’s health care organizations and other stakeholders—coordinated through a sustainable HCC—have strong relationships, identify hazards and risks, and prioritize and address gaps through planning, training, exercising, and managing resources.

**Capability 2: Health Care and Medical Response Coordination**

Goal of Capability 2: Health care organizations, the HCC, their jurisdiction(s), and the ESF-8 lead agency plan and collaborate to share and analyze information, manage and share resources, and coordinate strategies to deliver medical care to all populations during emergencies and planned events.

**Capability 3: Continuity of Health Care Service Delivery**

Goal of Capability 3: Health care organizations, with support from the HCC and the ESF-8 lead agency, provide uninterrupted, optimal medical care to all populations in the face of damaged or disabled health care infrastructure. Health care workers are well-trained, well-educated, and well-equipped to care for patients during emergencies. Simultaneous response and recovery operations result in a return to normal or, ideally, improved operations.

**Capability 4: Medical Surge**

Goal of Capability 4: Health care organizations—including hospitals, EMS, and out-of-hospital providers—deliver timely and efficient care to their patients even when the demand for health care services exceeds available supply. The HCC, in collaboration with the ESF-8 lead agency, coordinates information and available resources for its members to maintain conventional surge response. When an emergency overwhelms the HCC’s collective resources, the HCC supports the health care delivery system’s transition to contingency and crisis surge response and promotes a timely return to conventional standards of care as soon as possible.

These four capabilities were developed based on guidance provided in the 2012 Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness document. They support and cascade from guidance documented in the National Response Framework, National Preparedness Goal, and the National Health Security Strategy to build community health resilience and

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5 As the HCC defines in Capability 1, Objective 1, Activity 1 – Define HCC Boundaries
integrate health care organizations, emergency management organizations, and public health agencies. See Appendix 1 for more details on the process ASPR followed to revise the capabilities.

The Value of Health Care Coalitions in Preparedness and Response

HCCs—groups of individual health care and response organizations (e.g., hospitals, EMS, emergency management organizations, public health agencies, etc.) in a defined geographic location—play a critical role in developing health care delivery system preparedness and response capabilities. HCCs serve as multiagency coordination groups that support and integrate with ESF-8 activities in the context of incident command system (ICS) responsibilities. HCCs coordinate activities among health care organizations and other stakeholders in their communities; these entities comprise HCC members that actively contribute to HCC strategic planning, operational planning and response, information sharing, and resource coordination and management. As a result, HCCs collaborate to ensure each member has what it needs to respond to emergencies and planned events, including medical equipment and supplies, real-time information, communication systems, and educated and trained health care personnel.

The value of participating in an HCC is not limited to emergency preparedness and response. Day-to-day benefits¹⁰ may include:

- Meeting regulatory and accreditation requirements
- Enhancing purchasing power (e.g., bulk purchasing agreements)
- Accessing clinical and non-clinical expertise
- Networking among peers
- Sharing leading practices
- Developing interdependent relationships
- Reducing risk
- Addressing other community needs, including meeting requirements for tax exemption through community benefit¹¹

Using the Capabilities Document

The 2017-2022 Health Care Preparedness and Response Capabilities document is organized into four sections—one for each capability. Each capability has a goal and a set of objectives with associated activities. Definitions of capability goal, objective, and activity are defined below.

- Goal: The outcome of developing the capability
- Objective: Overarching component of the capability that, when completed, helps achieve the goal
- Activity: A task critical for achieving an objective

The capabilities are a high-level overview of the objectives and activities that the nation’s health care delivery system, including HCCs and individual health care organizations, should undertake to prepare for, respond to, and recover from emergencies. ASPR encourages HCCs, health care organizations, and

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other stakeholders supporting the provision of care during emergencies to use ASPR’s Technical Resources, Assistance Center, and Information Exchange (TRACIE)\textsuperscript{12} to receive assistance and resources for developing the capabilities.

Capability 1. Foundation for Health Care and Medical Readiness

The foundation for health care and medical readiness enables the health care delivery system and other organizations that contribute to responses to coordinate efforts before, during, and after emergencies; continue operations; and appropriately surge as necessary. This is primarily accomplished through health care coalitions (HCCs) that incentivize diverse and often competitive health care organizations with differing priorities and objectives to work together. HCCs should collaborate with a variety of stakeholders to ensure the community has the necessary medical equipment and supplies, real-time information, communication systems, and trained and educated health care personnel to respond to an emergency. These stakeholders include core HCC members—hospitals, emergency medical services (EMS), emergency management organizations, and public health agencies—additional HCC members, and the Emergency Support Function-8 (ESF-8, Public Health and Medical Services) lead agency. (For more information, see Capability 1, Objective 1, Activity 2 – Identify Health Care Coalition Members.)

Goal for Capability 1: Foundation for Health Care and Medical Readiness

The community’s health care organizations and other stakeholders—coordinated through a sustainable HCC—have strong relationships, identify hazards and risks, and prioritize and address gaps through planning, training, exercising, and managing resources.

Objective 1: Establish and Operationalize a Health Care Coalition

HCCs should coordinate with their members to facilitate:

- Strategic planning
- Identification of gaps and mitigation strategies
- Operational planning and response
- Information sharing for improved situational awareness
- Resource coordination and management

HCCs serve as multiagency coordination groups that support and integrate with other ESF-8 activities. Coordination between the HCC and the ESF-8 lead agency can occur in a number of ways. Some HCCs serve as the ESF-8 lead agency for their jurisdiction(s). Others integrate with their ESF-8 lead agency through an identified designee at the jurisdiction’s Emergency Operations Center (EOC) who represents HCC issues and needs and provides timely, efficient, and bi-directional information flow to support situational awareness. (See Capability 2 – Health Care and Medical Response Coordination for details on ESF-8 and situational awareness.)

HCCs serve as a public-private partnership. As stated in the National Response Framework:

“...private sector organizations contribute to response efforts through partnerships with each level of government....During an incident, key private sector partners should have a direct link to...
emergency managers and, in some cases, be involved in the decision making process....Private sector entities can assist in delivering the response core capabilities by collaborating with emergency management personnel before an incident occurs to determine what assistance may be necessary and how they can support local emergency management organizations during response operations....”

Activity 1. Define Health Care Coalition Boundaries

The HCC should define its boundaries based on daily health care delivery patterns—including those established by corporate health systems—and organizations within a defined geographic region, such as independent organizations and federal health care facilities. Additionally, the HCC may consider boundaries based on defined catchment areas, such as regional EMS councils, trauma regions, accountable care organizations, emergency management regions, etc. Defined boundaries should encompass more than one of each member type (e.g., hospitals, EMS) to enable coordination and enhance the HCC’s ability to share the load during an emergency. HCC boundaries may span several jurisdictional or political boundaries, and the HCC should coordinate with all ESF-8 lead agencies within its defined boundaries.

The HCC should:

- Include enough members to ensure adequate resources; however, at the same time, having too many members may make the HCC unmanageable
- Consider existing regional service areas, as they define common and known health care delivery patterns and emergency response activities
- Consider HCC boundaries that cross state borders where appropriate
- Engage the jurisdiction’s public health agency to ensure all health care facilities, including independent facilities, belong to an HCC and that there are no geographic gaps in HCC coverage

Activity 2. Identify Health Care Coalition Members

An HCC member is defined as an entity within the HCC’s defined boundaries that actively contributes to HCC strategic planning, identification of gaps and mitigation strategies, operational planning and response, information sharing, and resource coordination and management. In cases where there are multiple entities of an HCC member type, there may be a subcommittee structure that establishes a lead entity to communicate common interests to the HCC (e.g., multiple dialysis centers forming a subcommittee). HCC membership does not begin or end with attending meetings.

The HCC should include a diverse membership to ensure a successful whole community response. If segments of the community are unprepared or not engaged, there is greater risk that the health care delivery system will be overwhelmed. As such, the HCC should liaise with the broader response community on a regular basis (see Introduction for a list of stakeholders). The list is recreated below, delineating core and additional HCC members.

- Core HCC members should include, at a minimum, the following:
  - Hospitals
  - EMS (including inter-facility and other non-EMS patient transport systems)

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- Emergency management organizations
- Public health agencies

- Additional HCC members may include but are not limited to the following:
  - Behavioral health services and organizations
  - Community Emergency Response Team (CERT)\(^{15}\) and Medical Reserve Corps (MRC)\(^{16}\)
  - Dialysis centers and regional Centers for Medicare & Medicaid Services (CMS)-funded end-stage renal disease (ESRD) networks\(^{17}\)
  - Federal facilities (e.g., U.S. Department of Veterans Affairs (VA) Medical Centers, Indian Health Service facilities, military treatment facilities)
  - Home health agencies (including home and community-based services)
  - Infrastructure companies (e.g., utility and communication companies)
  - Jurisdictional partners, including cities, counties, and tribes
  - Local chapters of health care professional organizations (e.g., medical society, professional society, hospital association)
  - Local public safety agencies (e.g., law enforcement and fire services)
  - Medical and device manufacturers and distributors
  - Non-governmental organizations (e.g., American Red Cross, voluntary organizations active in disasters, amateur radio operators, etc.)
  - Outpatient health care delivery (e.g., ambulatory care, clinics, community and tribal health centers, Federally Qualified Health Centers (FQHCs)\(^ {18}\), urgent care centers, freestanding emergency rooms, stand-alone surgery centers)
  - Primary care providers, including pediatric and women’s health care providers
  - Schools and universities, including academic medical centers
  - Skilled nursing, nursing, and long-term care facilities
  - Support service providers (e.g., clinical laboratories, pharmacies, radiology, blood banks, poison control centers)
  - Other (e.g., child care services, dental clinics, social work services, faith-based organizations)

Specialty patient referral centers (e.g., pediatric, burn, trauma, and psychiatric centers) should ideally be HCC members within their geographic boundaries. They may also serve as referral centers to other HCCs where that specialty care does not exist. In such cases, referral centers’ support of HCC planning, exercises, and response activities can be mutually beneficial.

Urban and rural HCCs may have different membership compositions based on population characteristics, geography, and types of hazards. For example, in rural and frontier areas—where the distance between hospitals may exceed 50 miles and where the next closest hospitals are also critical access hospitals with limited services—tribal health centers, referral centers, or support services may play a more prominent role in the HCC.


Activity 3. Establish Health Care Coalition Governance

The HCC should define and implement a structure and processes to execute activities related to health care delivery system readiness and coordination. The elements of governance include organizational structures, roles and responsibilities, mechanisms to provide guidance and direction, and processes to ensure integration with the ESF-8 lead agency. The HCC should specify how structure, processes, and policies may shift during a response, as opposed to a steady state. HCC members should adopt these elements and be part of regular reviews.

The HCC should document the following information related to its governance:

- HCC membership
- An organizational structure to support HCC activities, including executive and general committees, election or appointment processes, and any necessary administrative rules and operational functions (e.g., bylaws)
- Member guidelines for participation and engagement that consider each member and region’s geography, resources, and other factors
- Policies and procedures, including processes for making changes, orders of succession, and delegations of authority
- HCC integration within existing state, local, and member-specific incident management structures and specified roles—such as a primary point of contact who serves as the liaison to the ESF-8 lead agency and EOCs during an emergency

Objective 2: Identify Risk and Needs

The HCC should identify and plan for risks, in collaboration with the ESF-8 lead agency, by conducting assessments or using and modifying data from existing assessments for health care readiness purposes. These assessments can determine resource needs and gaps, identify individuals who may require additional assistance before, during, and after an emergency, and highlight applicable regulatory and compliance issues. The HCC and its members may use the information about these risks and needs to inform training and exercises and prioritize strategies to address preparedness and response gaps in the region.

Activity 1. Assess Hazard Vulnerabilities and Risks

A hazard vulnerability analysis (HVA) is a systematic approach to identifying hazards or risks that are most likely to have an impact on the demand for health care services or the health care delivery system’s ability to provide these services. This assessment may also include estimates of potential injured or ill survivors, fatalities, and post-emergency community needs based on the identified risks.

General principles for the HVA process include but are not limited to the following:

- HCC members should participate in the HVA process, using a variety of HVA tools
- The HVA process should be coordinated with state and local emergency management organization assessments (e.g., Threat and Hazard Identification and Risk Assessment [THIRA])

and any public health hazard assessments (e.g., jurisdictional risk assessment). The intent is to ensure completion, share risk assessment results, and minimize duplication of effort.

- Health care facilities, EMS, and other health care organizations should provide input into the development of the regional HVA based on their facilities’ or organizations’ HVAs.
- The assessment components should include regional characteristics, such as risks for natural or man-made disasters, geography, and critical infrastructure.
- The assessment components should address population characteristics (including demographics), and consider those individuals who might require additional help in an emergency, such as children; pregnant women; seniors; individuals with access and functional needs, including people with disabilities; and others with unique needs.
- The HCC should regularly review and share the HVA with all members.

Activity 2. Assess Regional Health Care Resources

HCC members should perform an assessment to identify the health care resources and services that are vital for continuity of health care delivery during and after an emergency. The HCC should then use this information to identify resources that could be coordinated and shared. This information is critical to uncovering resource vulnerabilities relative to the HVA that could impede the delivery of medical care and health care services during an emergency.

The resource assessment will be different for various HCC member types, but should address resources required to care for all populations during an emergency. The resource assessment should include but is not limited to the following:

- Clinical services – inpatient hospitals, outpatient clinics, emergency departments, private practices, skilled nursing facilities, long-term care facilities, behavioral health services, and support services (see Capability 4 – Medical Surge)
- Critical infrastructure supporting health care (e.g., utilities, water, power, fuel, information technology [IT] services, communications, transportation networks)
- Caches (e.g., pharmaceuticals and durable medical equipment)
- Hospital building integrity
- Health care facility, EMS, corporate health system, and HCC information and communications systems and platforms (e.g., electronic health records [EHRs], bed and patient tracking systems) and communication modalities (e.g., telephone, 800 MHz radio, satellite telephone)
- Alternate care sites
- Home health agencies (including home and community-based services)
- Health care workforce
- Health care supply chain
- Food supply
- Medical and non-medical transportation system
- Private sector assets that can support emergency operations

Activity 3. Prioritize Resource Gaps and Mitigation Strategies

A comparison between available resources and current HVA(s) will identify gaps and help prioritize HCC and HCC member activities. Gaps may include a lack of, or inadequate, plans or procedures, staff, equipment and supplies, skills and expertise, services, or any other resources required to respond to an emergency. Just as the resource assessment will be different for different member types, so will efforts to prioritize identified gaps. HCC members should prioritize gaps based on consensus and determine
mitigation strategies based on the time, materials, and resources necessary to address and close gaps. Gaps may be addressed through coordination, planning, training, or resource acquisition. Ultimately, the HCC should focus its time and resource investments on closing those gaps that affect the care of acutely ill and injured patients.

Certain response activities may require external support or intervention, as emergencies may exceed the preparedness thresholds the HCC, its members, and the community have deemed reasonable. Thus, during the prioritization process, planning to access and integrate external partners and resources (i.e., federal, state, and/or local) is a key part of gap closure.


Certain individuals may require additional assistance before, during, and after an emergency. The HCC and its members should conduct inclusive planning for the whole community, including children; pregnant women; seniors; individuals with access and functional needs, such as people with disabilities; individuals with pre-existing, serious behavioral health conditions; and others with unique needs.21

The HCC should:

- Support public health agencies with situational awareness and IT tools already in use that can help identify children; pregnant women; seniors; and individuals with access and functional needs, including people with disabilities; and others with unique needs (e.g., the U.S. Department of Health and Human Services emPOWER map,22 which provides information on Medicare beneficiaries who rely on electricity-dependent medical and assistive equipment, such as ventilators, at-home dialysis machines, and wheelchairs)
- Support public health agencies in developing or augmenting existing response plans for these populations, including mechanisms for family reunification
- Identify potential health care delivery system support for these populations (pre- and post-event) that can reduce stress on hospitals during an emergency
- Assess needs and contribute to medical planning that may enable individuals to remain in their residences. When that is not possible, coordinate with the ESF-8 lead agency to support the ESF-6 (Mass Care, Emergency Assistance, Housing, and Human Services) lead agency with inclusion of medical care at shelter sites
- Coordinate with the ESF-8 lead agency to assess medical transport needs for these populations
- Assess specific treatment and access to care needs; incorporate how to address needs into individual HCC member Emergency Operations Plans (EOPs) and the HCC response plan (see Capability 2, Objective 1 – Develop and Coordinate Health Care Organization and Health Care Coalition Response Plans)
- Coordinate with the U.S. Department of Veterans Affairs (VA) Medical Center to identify veterans in the HCC’s coverage area (if applicable)

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Activity 5. Assess and Identify Regulatory Compliance Requirements

The HCC, in collaboration with the ESF-8 lead agency and state authorities, should assess and identify regulatory compliance requirements that are applicable to day-to-day operations and may play a role in planning for, responding to, and recovering from emergencies.

The HCC should:

- Understand federal statutory, regulatory, or national accreditation requirements that impact emergency medical care, including:
  - Centers for Medicare & Medicaid Services (CMS) conditions of participation, (including CMS-3178-F Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers)\(^{23}\)
  - Clinical Laboratory Improvement Amendments (CLIA)\(^{24}\)
  - **Health Insurance Portability and Accountability Act (HIPAA)** Privacy Rule requirements\(^{25}\) and circumstances when covered entities can disclose protected health information (PHI) without individual authorization including to public health authorities and as directed by laws (e.g., state law)\(^{26}\)
  - Emergency Medical Treatment & Labor Act (EMTALA) requirements\(^{27}\)
  - Licensing and accrediting agencies for hospitals, clinics, laboratories, and blood banks (e.g., Joint Commission,\(^{28}\) DNV GL – Healthcare\(^{29}\)
  - Federal disaster declaration processes\(^{30,31}\) and public health authorities
  - Available federal liability protections for responders (e.g., Public Readiness and Emergency Preparedness (PREP) Act\(^{32}\))
  - Environmental Protection Agency (EPA) requirements\(^{33}\)
  - Occupational Safety and Health Administration (OSHA) requirements\(^{34}\) (e.g., general duty clause, blood-borne pathogen standard)

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• Understand state or local regulations or programs that impact emergency medical care, including:
  ▪ Scope and breadth of emergency declarations
  ▪ Regulations for health care practitioner licensure, practice standards, reciprocity, scope of practice limitations, and staff-to-patient ratios
  ▪ Legal authorization to allocate personnel, resources, equipment, and supplies among health care organizations
  ▪ Laws governing the conditions under which an individual can be isolated or quarantined
  ▪ Available state liability protections for responders

• Understand the process and information required to request necessary waivers and suspension of regulations, including:
  ▪ Processes for emergency resource acquisition (this may require coordination with the federal, state, and/or local government)
  ▪ Special waiver processes (e.g., section 1135 of the Social Security Act waivers\(^\text{35}\)) of key regulatory requirements pursuant to emergency declarations
  ▪ Process and implications for Food and Drug Administration (FDA) issuance of emergency use authorizations for use of non-approved drugs or devices or use of approved drugs or devices for unapproved uses
  ▪ Legal resources\(^\text{36}\) related to hospital legal preparedness, such as the deployment and use of volunteer health practitioners
  ▪ Legal and regulatory issues related to alternate care sites and practices
  ▪ Legal issues regarding population-based interventions, such as mass prophylaxis and vaccination
  ▪ Processes for emergency decision making from state or local legislature

• Support crisis standards of care planning,\(^\text{37}\) including the identification of appropriate legal authorities and protections necessary when crisis standards of care are implemented (see Capability 4 – Medical Surge)
• Maintain awareness of standing contracts for resource support during emergencies

Objective 3: Develop a Health Care Coalition Preparedness Plan

The HCC preparedness plan enhances preparedness and risk mitigation through cooperative activities based on common priorities and objectives. In collaboration with the ESF-8 lead agency, the HCC should develop a preparedness plan that includes information collected on hazard vulnerabilities and risks, resources, gaps, needs, and legal and regulatory considerations (as collected in Capability 1, Objective 2, Activities 1-5 above). The HCC preparedness plan should emphasize strategies and tactics that promote communications, information sharing, resource coordination, and operational response planning with HCC members and other stakeholders. The HCC should develop its preparedness plan to include core HCC members and additional HCC members so that, at a minimum, hospitals, EMS, emergency

management organizations, and public health agencies are represented. The plan can be presented in various formats (e.g., a subset of strategic documents, annexes, or a portion of the HCC’s concept of operations plans [CONOPS]).

The HCC preparedness plan should:

- Incorporate the HCC’s and its members’ priorities for planning and coordination based on regional needs and gaps
  - Priorities will depend on multiple factors, including perceived risk, emergencies occurring in the region, available funds, applicable laws and regulations, supporting personnel, HCC member facilities and organizations involved, and time constraints
- Draw from and address gaps identified in HCC members’ existing preparedness plans as required by CMS-3178-F Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers
- Be developed by HCC leadership with broad input from HCC members and other stakeholders
- Outline strategic and operational objectives for the HCC as a whole and for each HCC member
- Include short-term (e.g., within the year) and longer-term (e.g., three- to five-year) objectives
- Include a recurring objective to develop and review the HCC response plan, which details the responsibilities and roles of the HCC and its members, including how they share information, coordinate activities and resources during an emergency, and plan for recovery (see Capability 2 – Health Care and Medical Response Coordination)
- Include and inform training, exercise, and resource and supply management activities during the year
- Include a checklist of each HCC member’s proposed activities, methods for members to report progress to the HCC, and processes to promote accountability and completion

HCC members should approve the initial plan and maintain involvement in regular reviews. Following reviews, the HCC should update the plan as necessary after exercises and real-world events. The review should include identifying gaps in the preparedness plan and working with HCC members to define strategies to address the gaps.

The HCC should also develop a complementary HCC response plan in collaboration with the ESF-8 lead agency (see Capability 2 – Health Care and Medical Response Coordination).

Objective 4: Train and Prepare the Health Care and Medical Workforce

Training, drills, and exercises help identify and assess how well a health care delivery system or region is prepared to respond to an emergency. These activities also develop the necessary knowledge, skills, and abilities of an HCC member’s workforce. Trainings can cover a wide range of topics including clinical subject matter, incident management, safety and protective equipment, workplace violence, psychological first aid, or planning workshops. The HCC should promote these activities and participate in training and exercises with its members, and in coordination with the ESF-8 lead agency, emphasizing consistency, engagement, and demonstration of regional coordination.
Activity 1. Promote Role-Appropriate National Incident Management System Implementation

The HCC should assist its health care organization members and other HCC members with National Incident Management System (NIMS) implementation.

The HCC should:
- Ensure HCC leadership receives NIMS training
- Promote NIMS implementation, including training and exercises, among HCC members to facilitate operational coordination with public safety and emergency management organizations during an emergency using an incident command system (ICS)
- Assist HCC members with incorporating NIMS components into their EOPs
- For those members not bound by NIMS implementation, the HCC should consider training on response planning techniques, organizational structure, and other incident management practices that will prepare members for their roles during a response

Activity 2. Educate and Train on Identified Preparedness and Response Gaps

HCC members should support education and training to address health care preparedness and response gaps identified through strategic planning, development of the HCC preparedness and response plans, or other assessments. Whenever possible, training should be standardized at the HCC level to ensure efficiency and consistency.

The HCC should:
- Promote understanding of every HCC member’s specific roles and responsibilities in the health care delivery system’s emergency response
- Base training on specific gaps and needs identified by HCC members
- Promote and support training for health care providers, laboratorians, non-clinical staff, and ancillary workforce in:
  - Clinical management (e.g., chemical, biological, radiological, nuclear and explosives [CBRNE], burn, trauma, and other recognized hazards) for all populations
  - Responder safety and health requirements (see Capability 3, Objective 5 – Protect Responders’ Safety and Health)
  - Management of patients in a resource-scarce environment, including the implementation of crisis standards of care
- Ensure health care organization leadership is aware of and engaged in HCC activities (see Capability 1, Objective 5, Activity 2 – Engage Health Care Executives below)

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• Develop and implement training plans, including those that support appropriate health care providers and first responders. Training plans may include but are not limited to, initial education, continuing education, appropriate certifications, and just-in-time training
• Employ a variety of modalities (e.g., online, classroom, etc.)

Activity 3. Plan and Conduct Coordinated Exercises with Health Care Coalition Members and Other Response Organizations

The HCC, in collaboration with its members, should plan and conduct coordinated exercises to assess the health care delivery system’s readiness. The HCC should focus exercises on the outcomes of HVAs and other assessments that identify resource needs and gaps, identify individuals who may require additional assistance before, during, and after an emergency, and highlight applicable regulatory and compliance issues.

The HCC should:

• Plan and conduct health care delivery system-wide exercises that incorporate hospitals, EMS, emergency management organizations, public health agencies, and additional HCC member participation
• Base exercises on specific gaps and needs identified by HCC members, including emerging infectious diseases and CBRNE threats
• Update an exercise schedule annually or in accordance with jurisdictional needs
• Provide opportunities for clinical laboratory participation
• Assess readiness to support emergencies involving children across the age and developmental trajectory; children represent nearly 25 percent of the population and have unique response needs during emergencies, including special medical equipment and treatment needs and family reunification considerations
• Assess readiness to support other individuals who have special health needs and may require additional assistance before, during, and after an emergency (e.g., pregnant women, seniors, individuals who depend on electricity-dependent medical and assistive equipment, etc.)
• Exercise medical surge capacity and capability, including decisions leading to the implementation of crisis standards of care (see Capability 4 – Medical Surge)
  • Assess the mobilization of beds, personnel, and key resources, including equipment, supplies, and pharmaceuticals
• Coordinate exercises with other response organizations (e.g., Federal Emergency Management Agency [FEMA], National Guard, etc.)
• When appropriate, include federal, state, and local response resources in exercises (e.g., National Disaster Medical System [NDMS] Disaster Medical Assistance Teams [DMAT], NDMS

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Federal Coordinating Centers [FCCs], Emergency System for Advance Registration of Volunteer Health Professionals [ESAR-VHP], state medical teams, MRC, and other federal, state, local, and tribal assets

- Collect information about HCC member operating status and resource availability during exercises and disseminate the information to other members
- Develop an after-action report (AAR) and improvement plan (IP) that incorporates lessons learned from exercises and a follow-up process, including steps to overcome the identified gaps in the AAR/IP (see Capability 1, Objective 4, Activity 5 – Evaluate Exercises and Responses to Emergencies below)

Activity 4. Align Exercises with Federal Standards and Facility Regulatory and Accreditation Requirements

The HCC should consider the following when developing and executing exercises:

- Apply Homeland Security Exercise and Evaluation Program (HSEEP) fundamentals to both the exercise program and the execution of individual exercises
- Integrate current health care accreditation requirements such as the Joint Commission Emergency Management Standards, and health care regulatory requirements such as CMS-3178-F Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers
- Use a stepwise progression of exercise complexity for a variety of emergency response scenarios (e.g., workshop to tabletop to functional to full-scale exercises)

Activity 5. Evaluate Exercises and Responses to Emergencies

The HCC should coordinate with its members and other response organizations to complete an AAR and an IP after exercises and real-world events. The same exercise or response may generate facility, member type, HCC, and community AAR/IPs – each with a somewhat different focus and level of detail.

The AAR should document gaps in HCC member composition, planning, resources, or skills revealed during the exercise and response evaluation processes. The IP should detail a plan for addressing the identified gaps, including responsible entities and the required time and resources to address the gaps. The IP should also recommend processes to retest the revised plans and capabilities. Facility and organization evaluations should follow a similar process. AARs may also reveal leading practices that can be shared with HCC members and other HCCs.

Successful HCC maturation depends on integrating AAR/IP findings into the next planning, training, exercise, and resource allocation cycle.

Activity 6. Share Leading Practices and Lessons Learned

The HCC should coordinate with its members, government partners, and other HCCs to share leading practices and lessons learned. Sharing information between HCCs will improve cross-HCC coordination during an emergency and will help further improve coordination efforts.

The HCC should employ the following principles when sharing leading practices and lessons learned:

- Ensure information is shared among HCCs after real-world events and exercises to identify gaps, leading practices, and lessons learned
- Incorporate lessons learned from real-world events and exercises into HCC plans, training, and exercises
- Utilize mechanisms to rapidly acquire and share new clinical knowledge for a wide range of hazards and threats during exercise scenarios and real-world events. Examples include:
  - Utilizing the Office of the Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE)\(^{48}\)
  - Sharing hazardous material (HAZMAT) information from poison control centers
  - Using virtual telemedicine platforms (e.g., Project ECHO\(^{49}\))
  - Obtaining information from federal alert systems (e.g., Centers for Disease Control and Prevention [CDC], FDA, FEMA)
  - Coordinating clinical treatment information on conference calls or webinars (e.g., CDC Clinician Outreach and Communication Activity [COCA]\(^{50}\))

Objective 5: Ensure Preparedness is Sustainable

Sustainability planning is a critical component to HCC development. Strong governance mechanisms, constant regional stakeholder engagement, and sound financial planning help form the foundation to continue HCC activities well into the future. Sustainability should emphasize HCC processes and activities that support member needs and regulatory requirements (e.g., exercises and evacuation planning).

Activity 1. Promote the Value of Health Care and Medical Readiness

The HCC, with support from its health care organization members, should be able to articulate its mission, including its role in community preparedness and how that provides benefit (both direct and indirect) to the region. The HCC has a duty to plan for a full range of emergencies and both planned and unplanned events that could affect its community. It is essential that the HCC has leaders who can serve as primary points of contact to promote preparedness and response needs to community leaders. Additionally, members have a shared responsibility to ensure the HCC has visibility into their activities in the region.

The HCC should:


\(^{49}\) “Project ECHO.” UNM School of Medicine, 2016. Web. 19 Jul. 2016. echo.unm.edu/.

• Develop materials that identify and articulate the benefits of HCC activities to its members and additional stakeholders
• Engage champions among its members and other response organizations to promote HCC preparedness efforts to health care executives, clinicians, community leaders, and other key audiences

Activity 2. Engage Health Care Executives

The HCC should communicate the direct and indirect benefits of HCC membership to health care executives to advance their engagement in preparedness and response. Executives can promote buy-in across all facility and organization types, clinical departments, and non-clinical support services. The benefits of HCC participation are not limited to emergency preparedness and response.

Day-to-day benefits may include:

• Meeting regulatory and accreditation requirements
• Enhancing purchasing power (e.g., bulk purchasing agreements)
• Accessing clinical and non-clinical expertise
• Networking among peers
• Sharing leading practices
• Developing interdependent relationships
• Reducing risk
• Addressing other community needs, including meeting requirements for tax exemption through community benefit

Health care executives should formally endorse their organization’s participation in an HCC. This can take the form of letters of support, memoranda of understanding, or other agreements. Health care executives should be engaged in their facilities’ response plans and provide input, acknowledgement, and approval regarding HCC strategic and operational planning.

The HCC should regularly inform health care executives of HCC activities and initiatives through reports and invitation to participate in meetings, training, and exercises. The HCC should engage health care executives in debriefs (“hotwashes”) related to exercises, planned events, and real-world events.

Activity 3. Engage Clinicians

The HCC should engage health care delivery system clinical leaders to provide input, acknowledgement, and approval regarding strategic and operational planning. Clinicians from a wide range of specialties should be included in HCC activities on a regular basis to validate medical surge plans and to provide subject matter expertise to ensure realistic training and exercises. Clinicians with relevant expertise should lead health care provider training for assessing and treating various types of illnesses and injuries. Clinicians should be engaged in strategic and operational planning, contribute to committees and advisory boards, and participate in training and education sessions. Additional engagement can include active participation in planning, exercise, and response activities.

Activity 4. Engage Community Leaders

Consistent with a whole community approach to preparedness, the HCC should actively work with and engage community leaders outside of its members. The HCC should identify and engage community members, businesses, charitable organizations, and the media in health care preparedness planning and exercises to promote the resilience of the entire community. Community engagement creates greater awareness of the HCC’s role and emergency preparedness activities, promotes community resilience, and speeds the recovery process following emergencies.

Activity 5. Promote Sustainability of Health Care Coalitions

There are a variety of ways to promote greater community effectiveness and organizational and financial sustainability. Full investment in readiness includes in-kind donation of time, resources, support, and continued engagement with HCC members and the community. Financial strategies, including cost-sharing techniques and other funding options, enhance stability and sustainment.

The HCC should:

- Offer HCC members technical assistance or consultative services in meeting CMS-3178-F Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers
- Explore ways to meet individual member’s requirements for tax exemption through community benefit
- Analyze critical functions to preserve, and identify financial opportunities beyond federal funding (e.g., foundation, and private funding, dues, and training fees) to support or expand HCC functions
- Develop a financing structure, and document the funding models that support HCC activities
- Determine ways to cost share (e.g., required exercises may be coordinated with public health agencies, emergency management organizations, and other organizations with similar requirements)
- Incorporate leadership succession planning into the HCC governance and structure
- Leverage group buying power to obtain consistent equipment across a region and allow for sharing or emergency allocation of equipment

HCC members should be aware of the HCC’s sustainability activities, including any requirements established by HCC leadership, so they can plan their future investments accordingly.

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Capability 2. Health Care and Medical Response Coordination

Health care and medical response coordination enables the health care delivery system and other organizations to share information, manage and share resources, and integrate their activities with their jurisdictions’ Emergency Support Function-8 (ESF-8, Public Health and Medical Services) lead agency and ESF-6 (Mass Care, Emergency Assistance, Housing, and Human Services) lead agency at both the federal and state levels.

Private health care organizations and government agencies, including those serving as ESF-8 lead agencies, have shared authority and accountability for health care delivery system readiness, along with specific roles. In this context, health care coalitions (HCCs) serve a communication and coordination role within their respective jurisdiction(s). This coordination ensures the integration of health care delivery into the broader community’s incident planning objectives and strategy development. It also ensures that resource needs that cannot be managed within the HCC itself are rapidly communicated to the ESF-8 lead agency. HCC coordination may occur at its own coordination center, the local Emergency Operations Center (EOC), or by virtual means – all of which are intended to interface with the ESF-8 lead agency.

Coordination between the HCC and the ESF-8 lead agency can occur in a number of ways. Some HCCs serve as the ESF-8 lead agency for their jurisdiction(s). Others integrate with their ESF-8 lead agency through an identified designee at the jurisdiction’s EOC who represents HCC issues and needs and provides timely, efficient, and bi-directional information flow to support situational awareness. Regardless, HCCs connect the elements of medical response and provide the coordination mechanism among health care organizations—including hospitals and emergency medical services (EMS)—emergency management organizations, and public health agencies.

Goal for Capability 2: Health Care and Medical Response Coordination

Health care organizations, the HCC, their jurisdiction(s), and the ESF-8 lead agency plan and collaborate to share and analyze information, manage and share resources, and coordinate strategies to deliver medical care to all populations during emergencies and planned events.

Objective 1: Develop and Coordinate Health Care Organization and Health Care Coalition Response Plans

Health care organizations respond to emergent patient care needs every day. During an emergency response, health care organizations and other HCC members contribute to the coordination of information exchange and resource sharing to ensure the best patient care outcomes possible. HCCs and their members can best achieve enhanced coordination and improved situational awareness when there is active participation from hospitals, EMS, emergency management organizations, and public health agencies and by documenting roles, responsibilities, and authorities before, during, and immediately after an emergency.
Every individual health care organization must have an Emergency Operations Plan (EOP) per federal and state regulations and multiple accreditation standards. The HCC, in collaboration with the ESF-8 lead agency, should have a collective response plan that is informed by its members’ individual EOPs. In cases where the HCC serves as the ESF-8 lead agency, the HCC response plan may be the same as the ESF-8 response plan. The purpose of coordinating response plans is not to supplant existing ESF-8 structures, but to enhance effective response in accordance with the wide array of existing federal, state, and municipal legal authorities in which HCC members operate (e.g., Emergency Medical Treatment & Labor Act [EMTALA] 53, communicable disease reporting, and the Health Insurance Portability and Accountability Act [HIPAA] Privacy Rule).

Activity 1. Develop a Health Care Organization Emergency Operations Plan

Each health care organization should have an EOP to address a wide range of emergencies. The EOP should detail the use of incident management—including specific indicators for plan activation, alert, and notification processes, response procedures, and resource acquisition and sharing—and a process that delineates the thresholds to demobilize and begin the transition to recovery and the restoration of normal operations (see Capability 3, Objective 7 – Coordinate Health Care Delivery System Recovery). The plan should define the internal and external sources of information that will be necessary to assess the impact of the emergency on the health care organization. The plan should also address how the individual HCC member communicates this information to the HCC and to key health care organization leadership.

Critical elements of the health care organization’s EOP include:

- Identification of triggers to activate the plan
- Communications (internal and external)
- Information management
- Access to resources and supplies
- Safety and security measures
- Delineation of staff roles and responsibilities within the incident command system (ICS)
- Utility readiness (e.g., back-up generator, water supplies)
- Provision of clinical care
- Support activities

The EOP should summarize the actions required to initiate and sustain a response to an emergency. Health care organizations’ departmental plans should provide specific information for each unit or area. Employees should have a clear understanding of their actions and how to communicate with the facility or organization’s EOC during a response. The EOP should include plans for caring for employees and their dependents during and after an emergency in an effort to promote their return to work 54 (see Capability 3, Objective 5 – Protect Responders’ Safety and Health).

During an emergency, the EOP should inform the HCC’s expectations related to sharing information, attaining situational awareness, and managing and sharing resources, at a minimum. The HCC may help

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health care organizations facilitate patient and resource distribution (or re-distribution) during a surge emergency (see Capability 4 – Medical Surge).

The EOP may contain annexes that document specific planning actions for various types of medical responses (e.g., evacuation and relocation, hazardous material (HAZMAT), burn mass casualty, pediatric mass casualty). Additionally, the EOP may contain provisions, including an annex, regarding actions required by the health care organization if it is a member of the National Disaster Medical System (NDMS) in a Federal Coordinating Center’s (FCC) patient receiving area.

In coordination with their HCC, health care organizations should review and update their EOPs regularly, and after exercises and real-world events. The review should involve identifying gaps in the health care organization’s response plan. Health care organization leadership, supported by the HCC, should take steps to define strategies and tactics that address those gaps to ensure a more robust response in the next emergency. The HCC should continuously monitor the health care organization’s progress toward gap closure and offer assistance to help close the gaps as appropriate.

Activity 2. Develop a Health Care Coalition Response Plan

The HCC, in collaboration with the ESF-8 lead agency, should have a collective response plan that is informed by its members’ individual plans. In cases where the HCC serves as the ESF-8 lead agency, the HCC response plan may be the same as the ESF-8 response plan. Regardless of the HCC structure, the HCC response plan should describe HCC operations that support strategic planning, information sharing, and resource management. The plan should also describe the integration of these functions with the ESF-8 lead agency to ensure information is provided to local officials and to effectively communicate and address resource and other needs requiring ESF-8 assistance.

The HCC should develop a response plan that clearly outlines:

- Individual HCC member organization and HCC contact information
- Locations that may be used for multiagency coordination
- Brief summary of each individual member’s resources and responsibilities
- Integration with appropriate ESF-8 lead agencies
- Emergency activation thresholds and processes
- Alert and notification procedures
- Essential Elements of Information (EEIs) agreed to be shared, including information format (e.g., bed reporting, resource requests and allocation, patient distribution and tracking procedures, processes for keeping track of unidentified [John Doe/Jane Doe] patients)
- Communication and information technology (IT) platforms and redundancies for information sharing
- Support and mutual aid agreements
- Evacuation and relocation processes
- Policies and processes for the allocation of scarce resources and crisis standards of care, including steps to prevent crisis standards of care without compromising quality of care (e.g., conserve supplies, substitute for available resources, adapt practices, etc.) (See Capability 4, Objective 1, Activity 1 – Incorporate Medical Surge into the HCC Response Plan)

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• Additional HCC roles and responsibilities as determined by state and/or local plans and agreements (e.g., staff sharing, alternate care site support, shelter support)

The HCC should coordinate the development of its response plan by involving core members and other HCC members so that, at a minimum, hospitals, EMS, emergency management organizations, and public health agencies are represented. While the interests of all members and stakeholders should be considered in the plan, those of hospitals and EMS are paramount given these entities’ roles in patient distribution across the HCC’s geographic area during an emergency.

In coordination with its members, the HCC should review and update its response plan regularly, and after exercises and real-world events. The review should include identifying gaps in the response plan and working with HCC members to define strategies and tactics to address the gaps. In addition, the HCC should review and recommend updates to the state and/or local ESF-8 response plan regularly.

The HCC response plan can be presented in various formats, including the placement of information described above in a supporting annex.

Objective 2: Utilize Information Sharing Procedures and Platforms

Effective response coordination relies on information sharing to establish a common operating picture. Information sharing is the ability to share real-time information related to the emergency, the current-state of the health care delivery system, and situational awareness across the various response organizations and levels of government (federal, state, local). The HCC’s development of information sharing procedures and use of interoperable and redundant platforms is critical to successful response.

Activity 1. Develop Information Sharing Procedures

Individual HCC members should be able to easily access and collect timely, relevant, and actionable information about their own organizations and share it with the HCC, other members, and additional stakeholders according to established procedures and predefined triggers and in accordance with applicable laws and regulations.

HCC information sharing procedures, as documented in the HCC response plan, should:

• Define communication methods, frequency of information sharing, and the communication systems and platforms available to share information during an emergency response and steady state
• Identify triggers that activate alert and notification processes
• Define the EEIs that HCC members should report to the HCC, and coordinate with other HCC members and with federal, state, local, and tribal response partners during an emergency (e.g., number of patients, severity and types of illnesses or injuries, operating status, resource needs and requests, bed availability)
• Identify the platform and format for sharing each EEI
• Describe a process to validate health care organization status and requests during an emergency, including in situations where reports are received outside of HCC communications systems and platforms (e.g., media reports, no report when expected, rumors of distress, etc.)
• Define processes for functioning without electronic health records (EHRs) and document issues related to interoperability
Activity 2. Identify Information Access and Data Protection Procedures

The HCC may coordinate with state and local authorities to identify information access and data protection procedures, including:

- Access to public or private systems
- Authorization to receive and share data
- Types of information that can and will be shared (e.g., EEIs)
- Data use and re-release parameters for sensitive information
- Data protections
- Legal, statutory, privacy, and intellectual property issues, as appropriate

Activity 3. Utilize Communications Systems and Platforms

The HCC should utilize existing primary and redundant communications systems and platforms—often provided by state government agencies—capable of sending EEIs to maintain situational awareness. The HCC should:

- Identify reliable, resilient, interoperable, and redundant information and communication systems and platforms (e.g., incident management software; bed and patient tracking systems and naming conventions; EMS information systems; municipal, hospital, and amateur radio systems; satellite telephones; etc.), and provide access to HCC members and other stakeholders
- Use these systems to effectively coordinate information during emergencies and planned events, as well as on a regular basis to ensure familiarity with these tools
- Maintain ability to communicate among all HCC members, health care organizations, and the public (e.g., among hospitals, EMS, public safety answering points, emergency managers, public health agencies, skilled nursing facilities, and long-term care facilities)
- Restore emergency communications quickly during disruptions through alternate communications methods
- Leverage communications abilities of health information exchanges (HIEs) and capabilities of EHR vendors where they exist

Objective 3: Coordinate Response Strategy, Resources, and Communications

The HCC should coordinate its response strategies, track its members’ resource availability and needs, and clearly communicate this information to all HCC members, other stakeholders, and the ESF-8 lead agency. In addition, the HCC, in collaboration with its members, should provide coordinated, accurate, and timely information to health care providers and the public in order to ensure a successful emergency response.

Activity 1. Identify and Coordinate Resource Needs during an Emergency

The HCC and all of its members—particularly emergency management organizations and public health agencies—should have visibility into member resources and resource needs (e.g., personnel, teams, facilities, equipment, and supplies) to meet the community’s clinical care needs during an emergency.

Outlined below are the general principles when coordinating resource needs during emergencies:
• HCC members should inform the HCC of their operational status, actions taken, and resource needs. The HCC should relay this information to the jurisdiction’s EOC and the ESF-8 lead agency
• Resource management should include logging, tracking, and vetting resource requests across the HCC and in coordination with the ESF-8 lead agency
• Ideally, systems should track beds available by bed type57 (ideally, common bed types are defined across the jurisdiction), resource requests, and resources shared between HCC members, from HCC-controlled or other resource caches
• The HCC should work with distributors to understand and communicate which health care organizations and facilities should receive prioritized deliveries of supplies and equipment (e.g., personal protective equipment [PPE]) depending on their role in the emergency. HCC members should collectively determine the prioritization of limited resources provided by distributors, reflecting needs at the time of the emergency (see Capability 3, Objective 3, Activity 1 – Assess Supply Chain Integrity)

Activity 2. Coordinate Incident Action Planning During an Emergency

During an emergency or planned event, each health care organization should develop an Incident Action Plan (IAP)58 and utilize incident action planning cycles to identify and modify objectives and strategies. The HCC should develop an IAP based on its individual HCC members’ plans, with its own focus on planning cycles, objectives, and strategies. Ultimately, the HCC’s IAP should be integrated into the jurisdiction’s IAP, via the ESF-8 lead agency. This will enable a consistent, transparent, and scalable approach to establishing strategies and tactics that will govern the response to an emergency or planned event. Keeping response strategies (e.g., implementing alternate care sites, allocating resources, and developing policies on visitors during infectious disease outbreaks) consistent across HCC members requires coordinated discussion and joint decision making. The IAP can address both response and recovery or a separate recovery plan may be developed in accordance with existing plans at the state or local level (see Capability 3, Objective 7 – Coordinate Health Care Delivery System Recovery).

Activity 3. Communicate with Health Care Providers, Non-Clinical Staff, Patients, and Visitors during an Emergency

Sharing accurate and timely information is critical during an emergency. Health care organizations should have the ability to rapidly alert and notify their employees, patients, and visitors to update them on the situation, protect their health and safety (see Capability 3, Objective 5 – Protect Responders’ Safety and Health), and facilitate provider-to-provider communication.

The HCC, in coordination with its public health agency members, should develop processes and procedures to rapidly acquire and share clinical knowledge among health care providers and among health care organizations during responses to a variety of emergencies (e.g., chemical, biological, radiological, nuclear or explosive [CBRNE], trauma, burn, pediatrics, or highly infectious disease) in order to improve patient management, particularly at facilities that may not care for these patients regularly.

57 Bed types include but are not limited to: adult ICU, adult medical/surgical, burn, pediatric ICU, pediatric medical/surgical, psychiatric, airborne infection isolation, operating rooms
Activity 4. Communicate with the Public during an Emergency

HCC members should coordinate relevant health care information with the community’s Joint Information System (JIS) to ensure information is accurate, consistent, linguistically and culturally appropriate, and disseminated to the community using one voice.

Coordinated health care information that could be shared with the JIS includes but is not limited to:

- Current health care facility operating status
- When and where to seek care
- Alternate care site locations
- Screening or intervention sites
- Expected health and behavioral health effects related to the emergency
- Information to facilitate reunification of families
- Other relevant health care guidance, including preventive strategies for the public’s health

The HCC and its members should agree upon the type of information that will be disseminated by either the HCC or individual members.

The HCC should provide Public Information Officer (PIO) training (including health risk communication training) to those designated to act in that capacity during an emergency.
Capability 3. Continuity of Health Care Service Delivery

Optimal emergency medical care relies on intact infrastructure, functioning communications and information systems, and support services. The ability to deliver health care services is likely to be interrupted when internal or external systems such as utilities, electronic health records (EHRs), and supply chains are compromised. Disruptions may occur during a sudden or slow-onset emergency or in the context of daily operations. Historically, continuity of operations planning has focused on business continuity and ensuring information technology (IT) redundancies. However, health care organizations and health care coalitions (HCCs) should take a broader view and address all risks that could compromise continuity of health care service delivery. Continuity disruptions may range from an isolated cyberattack on a single hospital's IT system to a long-term, widespread infrastructure disruption impacting the entire community and all of its health care organizations.

A safe, prepared, and healthy workforce and comprehensive recovery plans will bolster the health care delivery system's ability to continue services during an emergency and return to normal operations more rapidly.

Goal for Capability 3: Continuity of Health Care Service Delivery

Health care organizations, with support from the HCC and the Emergency Support Function-8 (ESF-8) lead agency, provide uninterrupted, optimal medical care to all populations in the face of damaged or disabled health care infrastructure. Health care workers are well-trained, well-educated, and well-equipped to care for patients during emergencies. Simultaneous response and recovery result in a return to normal or, ideally, improved operations.

Objective 1: Identify Essential Functions for Health Care Delivery

There are key health care functions (e.g., Mission Essential Functions [MEFs]) that should be continued after a disruption of normal activities and are a priority for restoration should any be compromised. Health care organizations should first determine its key functions when planning for continuity of health care service delivery. The HCC may play an important role in assessing and supporting the maintenance of these functions.

These key health care functions include clinical services and infrastructure:

- Pre-hospital care
- Inpatient services
- Outpatient care
- Skilled nursing facilities and long-term care facilities
- Home care
- Laboratory
- Radiology

Continuity of Health Care Service Delivery

- Pharmacy
- Supply chain management (leasing, purchasing, and delivery of critical equipment and supplies such as medical devices, blood products, personal protective equipment (PPE), and pharmaceuticals)
- Facility infrastructure
- Utilities (water, electricity, gas, sewer, and fuel)
- Medical gases
- Air handling systems (heating, ventilation, and air conditioning [HVAC])
- Telecommunications and internet services
- Information technology (e.g., software and hardware for EHRs and patient billing)
- Central supply
- Transportation services
- Nutrition and dietary services
- Security
- Laundry
- Human resources

Health care and administrative personnel are a critical component of continuity. More information is included in Capability 3, Objective 5 – Protect Responders’ Safety and Health.

Objective 2: Plan for Continuity of Operations

The foundation for safe medical care delivery includes a robust, redundant infrastructure and availability of essential resources. Health care organizations should determine their priorities for ensuring key functions are maintained during an emergency, including the provision of care to existing and new patients. Facilities should determine those services that are critical to patient care and those that could be suspended (e.g., closing a hospital’s outpatient clinics to preserve staff to manage an elevated inpatient census). In addition, the HCC should have a plan to maintain its own operations.

During continuity preparedness activities, health care organizations and the HCC should consider what disaster risk reduction strategies should be implemented in order to lessen the likelihood of complete and total failure. The HCC should facilitate each individual member’s approach to risk reduction to promote a regional approach to addressing critical infrastructure (e.g., utilities, telecommunications, and supply chain).

Activity 1. Develop a Health Care Organization Continuity of Operations Plan

Continuity of Operations (COOP) planning ensures the ability to continue essential business operations, patient care services, and ancillary support functions across a wide range of potential emergencies. The health care organization’s COOP plan may be an annex to the organization’s Emergency Operations Plan (EOP) and during a response should be addressed under the incident command system (ICS).

Regardless of the format, the COOP plan should include the following:

- Activation and response functions
- Supervisor and managerial points of contact for each department
- Orders of succession and delegations of authority
- Immediate actions and assessments to be performed in case of disruptions
- Safety assessment and resource inventory to determine whether the health care organization can continue to operate
Multiple employees from each HCC member organization should understand and have access to the HCC’s information sharing platforms to ensure the continuity of information flow and coordination activities.

The HCC and governmental partners (including the ESF-8 lead agency) should be engaged when one or more health care organizations has lost capacity or ability to provide patient care or when a disruption to a health care organization requires evacuation.

The HCC and its members should incorporate COOP into their routine exercises (see Capability 1, Objective 4, Activity 3 – Plan and Conduct Coordinated Exercises with HCC Members and Other Response Organizations).

Activity 2. Develop a Health Care Coalition Continuity of Operations Plan

HCC COOP plans may be an annex to the HCC’s response plan or may take another form. In addition to the topics covered in Capability 3, Objective 2, Activity 1 – Develop a Health Care Organization Continuity of Operations Plan, the HCC COOP plan should include strategies for communications and leadership continuity.

The HCC, in coordination with the ESF-8 lead agency, should ensure that communication and coordination systems that are used for incident management are adequately secured, backed up, and have redundant power and server protections. In addition, redundant or backup systems should be identified in case the usual means of coordination (e.g., internet software platform) is unavailable. Backup plans for communications should be understood prior to an emergency and documented in the HCC response plan.

HCC leadership may not be available to assist with coordination during an emergency due to illness, injury, or commitments external to the HCC. The HCC COOP plan should detail orders of succession and delegations of authority, and a suitable number of personnel (ideally not from the same organization) should be trained to carry out HCC coordination activities.

Activity 3. Continue Administrative and Finance Functions

Health care organizations and the HCC should maintain administrative and financial functions during and after an emergency even if these functions need to continue at an off-site location. This includes essential business processes used to maintain financial security (e.g., registration, billing, access to health records, payroll, and human resource systems).

Activity 4. Plan for Health Care Organization Sheltering-in-Place

The decision to shelter-in-place is based on the nature and timing of the emergency (e.g., tornado, flooding, active shooter, or improvised nuclear device detonation), the potential effects on patient care delivery, and the status of critical infrastructure in the surrounding community.60

Health care organizations should consider the following when developing their shelter-in-place plans:

• Decision-making criteria and authorities
• Identification of patient and non-patient care locations to provide protection from the external environment
• Operational procedures for shutting down HVAC, lock-down, and access control
• Assessment of internal capabilities and needs
• Acquisition of supplies, equipment, pharmaceuticals, and other necessary resources for sustainment (e.g., water and food), as well as materials that may be important for children and others during extended sheltering (e.g., books and games)
• Internal and external communications plans, including plans for communicating with patients’ and workforce’s families
• Triggers for lifting shelter-in-place orders

Objective 3: Maintain Access to Non-Personnel Resources during an Emergency

Critical equipment and supplies for all populations should be available to ensure the ongoing delivery of patient care services. HCC members should assess equipment and supply needs that will likely be in demand during an emergency and develop strategies to address potential shortfalls.

Activity 1. Assess Supply Chain Integrity

Each individual HCC member should examine its supply chain vulnerabilities by collaborating with manufacturers and distributors to determine access to critical supplies, amounts available in regional systems, and potential alternate delivery options in the case that access or infrastructure is compromised. The HCC should then collect and use this information to coordinate effectively within the region, in collaboration with the ESF-8 lead agency.

The supply chain integrity assessment should include the following:

• Blood banks
• Medical gas suppliers
• Fuel suppliers
• Nutritional suppliers and food vendors
• Pharmaceutical vendors
• Leasing entities for biomedical (monitors, ventilators, etc.) and other durable medical equipment and beds
• Manufacturers and distributors for disposable supplies
• Manufacturers and distributors for PPE
• Hazardous waste removal services

The HCC should collaborate with health care organization members and other stakeholders to develop joint understanding and strategies to address supply chain vulnerabilities.

These vulnerabilities may be addressed at a health care organization and/or HCC level by decisions and mitigation strategies including but not limited to:

• Accessing stockpile (or maintain and rotate higher stock levels)
• Accessing vendor- and/or distributor-managed inventory/stockpile
• Establishing secondary vendors
• Developing ‘push’ or pre-event disaster supply procedures and triggers for activation

Continuity of Health Care Service Delivery
• Identifying alternate modes of delivery
• Using bulk purchasing to benefit from advantages in pricing and availability across HCC members

Health care organizations will need to determine whether additional new contracts or other agreements are needed prior to an emergency. In many cases, there is little redundancy in available vendors and little available inventory, which may contribute to rapid exhaustion of supplies in a major emergency. HCC agreements to share supplies may provide a critical resource during emergencies. These agreements should be developed and documented prior to an emergency (see Capability 1, Objective 2, Activity 2 – Assess Regional Health Care Resources). The HCC and its members should also be aware of the need for redundancies in backup planning (e.g., in events affecting all HCC members, individual facilities may plan for the same vendors to provide backup supplies or utilities).

When these strategies fail, health care organizations and the HCC should consider implementing contingency plans, which may include conservation, substitution, adaptation, reuse, or reallocation. Additional strategies may include transferring resources from other HCCs and/or coordinating with the ESF-8 lead agency to request assets from the Strategic National Stockpile (SNS).

Activity 2. Assess and Address Equipment, Supply, and Pharmaceutical Requirements

Pharmaceuticals and medical materiel are needed for both emergency treatment and to maintain the health of patients, health care providers, and first responders. Health care organizations should maintain awareness of critical medications and materiel they have on hand and how to obtain additional supplies through their established procurement processes, their HCC, and any state/local stockpiles.

Certain categories of pharmaceuticals and medical materiel are more likely to be required during a patient surge, such as:

• Pharmaceuticals
  ▪ Analgesia and sedation medications (including oral and injectable)
  ▪ Anesthesia medications (e.g., paralytics)
  ▪ Antibiotics (including oral and injectable)
  ▪ Antivirals (e.g., oseltamivir)
  ▪ Tetanus vaccine
  ▪ Pressor medications
  ▪ Antiemetics
  ▪ Respiratory medications (e.g., albuterol)
  ▪ Anticonvulsant drugs
  ▪ Antidotes (e.g., atropine, hydroxocobalamin) – based on community risks and resources
  ▪ Psychotropic medications

• Medical supplies and equipment
  ▪ Blood products
  ▪ Intravenous fluids and infusion pumps

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- Ventilators
- Bedside monitors
- Airway suction for all populations, including children
- Surgical equipment and supplies
- Supplies needed to administer pharmaceuticals, blood products, and intravenous fluids (e.g., needles, syringes, etc.)

Health care organizations should ensure access to formulations appropriate for dosing all patient types, including children and other special populations.

For most health care organizations, small increases above baseline levels of common, inexpensive medications will provide a buffer, particularly when organizations can share resources with HCC members during an emergency. Decisions to stockpile medications are complex and rely on a risk assessment and resource commitments by health care organizations, the HCC, and other stakeholders. Acquisition, storage, rotation, activation, use, and disposal decisions should all be considered and documented.

All health care organizations and the HCC should understand the SNS distribution plan for their jurisdiction(s). Health care organizations and HCCs in jurisdictions participating in the CHEMPACK program, the Cities Readiness Initiative (CRI), and local and state-based plans that maintain treatment or prophylaxis caches should be engaged in the development, training, and exercising of those distribution plans.

**Objective 4: Develop Strategies to Protect Health Care Information Systems and Networks**

Cyberattacks on health care organizations have had significant effects on every aspect of patient care and organizational continuity. With increasing reliance on information systems, including EHRs, administrative and payment systems, mobile technology, communication systems, and networked medical devices, there is a potential risk to their integrity and safety. To combat these risks, health care organizations should implement cybersecurity leading practices and conduct robust planning and exercising for cyber incident response and consequence management. As the number of cyberattacks on the health care sector increases, health care practitioners, executives, IT professionals, legal and risk management professionals, and emergency managers should remain current on the ever-changing nature and type of threats to their organizations, systems, patients, and staff.

Health care organizations, assisted by the HCC, should explore industry cybersecurity standards, guidelines, and leading practices necessary to protect these systems (e.g., National Institute of Standards and Technology Cybersecurity Framework - *Framework for Improving Critical Infrastructure Cybersecurity*), and have a plan in place for response and recovery should they be compromised.

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Some industry-recognized leading practices\textsuperscript{67} for protecting health care information systems and networks include but are not limited to:

- Conducting a computer network assessment to obtain the information necessary to develop a cybersecurity plan to reduce cyberattacks and reduce breaches
- Encrypting all computers and mobile devices
- Pre-approving the use of any devices not issued by the organization
- Implementing role-based access to any systems to ensure employees only have access to programs and applications necessary to perform functions of their jobs
- Configuring any EHR system or database to require specific access permissions to each user; inquiring with the EHR vendor to determine how they provide updates and technical support
- Developing security policies for the use of virtual private network (VPN) or private connections
- Implementing staff cybersecurity training and enforcement policies
- Including cybersecurity and continuity of information systems considerations in the organization’s hazard vulnerability analysis (HVA)
- Including appropriate IT personnel and considerations in EOPs, training, and exercises
- Engaging outside partners (e.g., law enforcement, regulatory agencies, and IT security providers/vendors) for assistance with cybersecurity incidents
- Developing mechanisms for IT personnel to obtain needed cybersecurity information through law enforcement partnerships
- Becoming a member in information sharing and analysis organizations (ISAOs)\textsuperscript{68} or other means

**Objective 5: Protect Responders’ Safety and Health**

The safety and health of clinical and non-clinical personnel are high priorities for preparedness and continuity as effective care cannot be delivered without available staff. Health care organizations, in coordination with the HCC, should develop processes to protect responders’ safety and health and align with various requirements, certifications, and standards (e.g., Occupational Safety and Health Administration [OSHA],\textsuperscript{69} Joint Commission, etc.). Those processes should be implemented to equip, train, and provide resources necessary to protect responders, employees, and their families from hazards during response and recovery operations. PPE, medical countermeasures (MCMs), workplace violence training, psychological first aid training, and other interventions specific to an emergency are all necessary to protect health care workers from illness or injury and should be readily available to the health care workforce. This section addresses selected aspects of workforce safety and protection relevant to emergencies, but does not include the much broader spectrum of health care worker safety during routine operations.

**Activity 1. Distribute Resources Required to Protect the Health Care Workforce**

It is important to keep patients, responders, employees, and their families safe during emergencies. The health care organization should be prepared to distribute MCMs, using a closed point of dispensing.


(POD) or other model, when there is potential or confirmed exposure to any chemical, biological, radiological, nuclear, and explosives (CBRNE) hazard for which MCMs exist. Access to such MCMs should be coordinated and planned for with the local public health department. This approach allows for organized and timely MCM distribution.

In addition, PPE (e.g., respirators, protective clothing, gloves, face shields, etc.) should be available to response personnel across varying job functions to offer protection from a wide range of threats such as infectious diseases, radiation, chemical exposure, and various physical hazards. In certain situations, staff exposures may warrant pharmaceutical prophylaxis, which should be managed according to the health care organization’s infection control policies. Exposures may result from PPE failure, emerging infectious disease outbreaks, industrial accidents, natural disasters, or terrorist attacks. Providing access to food and sleeping arrangements is also key to protecting responders’ safety and health, increasing their ability and willingness to work during an emergency.

The HCC should promote regional PPE procurement that could offer significant advantages in pricing and consistency for staff, especially when PPE is shared across health care organizations in an emergency. In circumstances where HCC members are part of a larger corporate health system, a balance between corporate procurement and regional procurement could be considered (see Capability 3, Objective 3, Activity 1 – Assess Supply Chain Integrity).

Activity 2. Train and Exercise to Promote Responders’ Safety and Health

Training, drills, and exercises develop the knowledge, skills, and abilities of an HCC members’ workforce to effectively respond to emergencies (see Capability 1, Objective 4 – Train and Prepare the Health Care and Medical Workforce).

Health care organizations, in collaboration with other HCC members, should:

- Integrate responder safety and health policy development, training, and program implementation with existing occupational health and infection control programs (e.g., PPE including respiratory protection, MCMs, workplace violence, psychological first aid)
- Plan for pre-hospital decontamination, and ensure coordination among fire, emergency medical services (EMS), and other health care organizations
- Create hazardous material (HAZMAT) plans that include appropriate staff training requirements and PPE to perform decontamination per OSHA guidance for first receivers\(^{70}\) (see Capability 4 – Medical Surge for more information on HAZMAT response)
- Provide training for health care providers, laboratorians, and support staff for contact, droplet, airborne infectious diseases, including those that may be classified as highly pathogenic and transmissible
- Work with human resources departments and health care unions, as applicable, to develop policies and procedures to ensure health care worker readiness and safety associated with caring for patients
- Maintain PPE in a state of readiness, and ensure inventory is updated and adequate for staffing demands and needs

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Activity 3. Develop Health Care Worker Resilience

A resilient workforce is critical to successful emergency response and recovery. The HCC and its members should consider the following:

- Pre-emergency resilience building, such as encouraging healthy lifestyles; developing family emergency plans; conducting staff training for active shooter events and psychological first aid; and instituting workplace violence reduction strategies
- Emergency resilience support, such as rotating staff to limit fatigue; providing support to staff and families (e.g., child care); providing accurate and timely updates during an emergency; providing opportunities for interacting with health care organization leadership; and providing just-in-time training relative to the emergency
- Post-emergency support, such as providing psychological first aid; distributing information on expected stress responses; conducting self- and peer-assessment and monitoring activities; providing access to employee assistance programs, including professional behavioral health services; and modifying duty assignments. Post-emergency activities may continue for months and even years beyond the emergency
- Ongoing health and safety monitoring activities, such as determining which groups of responders should be included in a health care or disease registry program to monitor their long-term physical and behavioral health; establishing and implementing long-term tracking of responder health, and where appropriate, community health; and providing technical assistance to help determine the appropriate duration and content of long-term health tracking

The HCC can disseminate information and promote these programs and initiatives to all HCC members.

Objective 6: Plan for and Coordinate Health Care Evacuation and Relocation

Health care organizations should evacuate or relocate when continuity planning efforts cannot sustain a safe working environment or when a government entity orders a health care organization to evacuate. The HCC should ensure all members and other stakeholders are included in evacuation and relocation planning including but not limited to, skilled nursing facilities and long-term care facilities. The HCC plays a critical role in coordinating the various elements of patient evacuation and relocation.

Activity 1: Develop and Implement Evacuation and Relocation Plans

The HCC and its members should prepare for evacuation or relocation with little or no warning. Evacuation and relocation plans assist health care organizations with the safe and effective care of patients, use of equipment, and utilization of staff when relocating to another part of the facility or when evacuating patients to another facility. Health care organizations may rely on the HCC and their affiliated corporate health systems to assist in planning, evacuation, and relocation processes.

The HCC and its members, in coordination with the ESF-8 lead agency, should consider the following when planning and coordinating patient evacuation and relocation:

- Planning considerations:

Establish authorities for decision-making processes, including triggers for evacuation

Ensure internal and external communications

Identify appropriate relocation and evacuation staging areas within the facility

Integrate health care organization evacuation planning with local and regional patient movement plans

Identify situations for early discharge

Identify available destination facilities and their ability to expand existing services to receive patients from evacuating facilities

Establish processes for when patients cannot be moved (see Capability 3, Objective 2, Activity 4 – Plan for Health Care Organization Sheltering-in-Place)

Establish procedures for facility closure

- Evacuation and relocation considerations:
  - Prioritize the order and category of patients chosen for evacuation and relocation
  - Obtain section 1135 of the Social Security Act waivers, these waivers can be obtained retroactively in certain emergency situations
  - Match patient needs with available transport resources (including non-EMS transportation assets)
  - Move and track patients and their belongings, staff, and medical records; ensure vital patient medications and equipment (e.g., mechanical ventilators, monitors, intravenous [IV] poles, etc.) are brought with the patient during patient transport and are returned to the facility of origin
  - Notify families, and initiate reunification

Planning, training, and exercising these activities are critical to the success of evacuation and relocation. High risk patients should be given special consideration during evacuation and relocation. These patients include adults, children, and neonates in critical care units, current operative cases, psychiatric (including memory/dementia care) patients, and other patients who may need specialized care during evacuation and relocation.

Activity 2. Develop and Implement Evacuation Transportation Plans

The HCC and its members, in collaboration with the ESF-8 lead agency, should develop and implement transportation plans for evacuating patients from one health care facility to another.

The plans should:

- Articulate the HCC’s role in coordinating EMS assistance
- Include a process to appoint a transport manager or similar position under the ICS operations section
- Identify a coordinating entity for public and private EMS agencies, including both ground and air medical services
- Identify transportation assets including non-medical transportation partners, such as commercial bus companies
- Identify processes to access specialized transportation assets through emergency management organizations (e.g., National Guard [State Active Duty], tractors, boats)

• Consider age- and size-related transportation equipment needs
• Develop processes to track patients and staff during transport
• Establish processes for transport partners to communicate with sending and receiving facilities
• Establish processes to communicate with patients’ families when transferring patients to the next health care provider

Objective 7: Coordinate Health Care Delivery System Recovery

Effective recovery and reconstitution of the health care delivery system includes pre-incident planning and implementation of recovery processes that begin at the outset of a response. The HCC can play an important role in monitoring and facilitating the recovery processes of the health care delivery system disrupted by an emergency. These efforts are intended to promote an effective and efficient return to normal or, ideally, improved operations for the provision of and access to health care in the community.

Activity 1. Plan for Health Care Delivery System Recovery

Recovery processes can be integrated into existing plans (e.g., annex to EOPs) or be developed as a separate stand-alone plan. The HCC and its members should participate in state and local pre-emergency recovery planning activities as described in the National Disaster Recovery Framework73 in order to leverage existing recovery resources, programs, projects, and activities. Response, continuity operations, and recovery are overlapping, interdependent, and often conducted concurrently. Therefore, identifying connected functions, tasks, or activities in the post-emergency environment will facilitate a coordinated transition from response to recovery.

Key considerations to recovery planning include:

• Goals and strategic priorities for the continued delivery of essential health care services, including behavioral health, and opportunities for improvement after an emergency
• Flexible operational objectives and tactics to accommodate different recovery approaches
• Integration with pre-incident assessments and plans (e.g., community health needs assessments, community health improvement plans, organizational capital improvement plans)
• Critical infrastructure dependencies (e.g., public utilities, IT, transportation, etc.)
• Workforce retention issues essential to operations (e.g., access to child or adult dependent care)

Activity 2. Assess Health Care Delivery System Recovery after an Emergency

The HCC may assist its members’ assessment of emergency-related structural, functional, and operational impacts.

The HCC can assist its members with the following activities:

• Data collection and analysis to identify priorities in the reconstitution and delivery of community health care services at the outset of an emergency

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• Collaboration with federal infrastructure assessment teams74 to enhance knowledge of disaster impacts on physical infrastructure and inform future risk mitigation strategies
• Implementation of emergency management organizations’ disaster impact assessments to assess post-disaster community health concerns

Activity 3. Facilitate Recovery Assistance and Implementation

The HCC, in coordination with its government partners, supports its members in the post-emergency recovery process by facilitating patient repatriation and system operations restoration. The HCC should:

• Assist HCC members with government processes for reimbursement, reconstitution, and resupply in concert with its emergency management organizations and ESF partners
• Convene a platform to identify long-term health care and community health recovery gaps, and develop potential strategies to address them
• Develop and communicate short- and long-term priorities to the jurisdiction’s government and emergency management functions (e.g., ESF-6 [Mass Care, Emergency Assistance, Housing, and Human Services], ESF-8, and the Health and Social Services Recovery Support Function)
• Collaborate with emergency management organizations and government officials to identify opportunities for future mitigation strategies or initiatives to enhance the resilience of the physical health care infrastructure

Health care organizations should ensure that their ICS prepares for a return to normal operations by:

• Identifying and preparing documentation necessary for government assistance
• Assessing damaged infrastructure and impacted patient care services to restore functionality
• Supporting the physical and behavioral health needs of affected patients, staff, and families
• Connecting patients and staff with case management and financial services75
• Planning the after-action learning and improvement processes

Successful reconstitution and recovery should be guided by efforts to build back better.

Capability 4. Medical Surge

Medical surge is the ability to evaluate and care for a markedly increased volume of patients that exceeds normal operating capacity. Providing an effective medical surge response is dependent on the planning and response capabilities developed in Capability 1 – Foundation for Health Care and Medical Readiness, Capability 2 – Health Care and Medical Response Coordination, and Capability 3 – Continuity of Health Care Service Delivery. Developing health care coalitions (HCCs) is especially important to support the coordination of the medical response across health care organizations.

Medical surge requires building capacity and capability:

- Surge capacity is the ability to manage a sudden influx of patients. It is dependent on a well-functioning incident command system (ICS) and the variables of space, supplies, and staff. The surge requirements may extend beyond placing patients into beds, and should include all aspects related to clinical services (e.g., laboratory studies, radiology exams, operating rooms).

- Surge capability is the ability to manage patients requiring very specialized medical care. Surge requirements span a range of medical and health care services (e.g., expertise, information, procedures, or personnel) that are not normally available at the location where they are needed (e.g., pediatric care provided at non-pediatric facilities or burn care services at a non-burn center). Surge capability also includes special interventions in response to uncommon and resource intensive patient diagnoses (e.g., Ebola, radiation sickness) to protect medical providers, other patients, and the integrity of the medical care facility.

Although these terms are not mutually exclusive (e.g., an emergency with large numbers of burn patients results in a need for both capacity and capability), they provide context for medical surge planning and can assist the HCC in developing regional approaches to providing care to patients with specific illnesses or injuries resulting from a wide variety of emergencies (e.g., regional viral hemorrhagic fever plan, regional mass burn plan, and regional mass pediatric plan).

HCCs and their members that coordinate during a medical surge response are more likely to be able to manage the emergency without state or federal assets or employing crisis care strategies. However, it is not possible to plan for all worst case scenarios, and there may be times when the health care delivery system is stressed beyond its maximum surge capacity. For those scenarios, crisis care strategies may be employed and planned well in advance. Planning for medical surge should follow the Medical Surge

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78 Ibid.


80 Ibid.
Goal for Capability 4: Medical Surge

Health care organizations—including hospitals, emergency medical services (EMS), and out-of-hospital providers—deliver timely and efficient care to their patients even when the demand for health care services exceeds available supply. The HCC, in collaboration with the Emergency Support Function-8 (ESF-8) lead agency, coordinates information and available resources for its members to maintain conventional surge response. When an emergency overwhelms the HCC’s collective resources, the HCC supports the health care delivery system’s transition to contingency and crisis surge response and promotes a timely return to conventional standards of care as soon as possible.

Objective 1: Plan for a Medical Surge

Health care organizations can most effectively implement and manage medical surge when appropriate information sharing systems and procedures have been established, appropriate plans for all levels of care and populations have been developed, and personnel have been trained in their use.

Activity 1. Incorporate Medical Surge Planning into a Health Care Organization Emergency Operations Plan

An emergency event will require the HCC and its members to share information, attain and maintain situational awareness, and manage and share resources, at a minimum. The HCC may help facilitate patient and resource distribution (or re-distribution) during a surge emergency. The health care organization’s Emergency Operations Plan (EOP) will help inform these efforts.

The health care organization EOP should summarize the actions to initiate a response to a medical surge. The EOP should include individual departmental sections that provide specific surge strategies for each unit or service line. Further, employees should clearly know how to communicate with the organization’s Emergency Operations Center (EOC). The EOP should include a process for the health care organization to request waivers and emergency use authorizations. As the response evolves and situational awareness is enhanced, the health care organization can refine its response strategies according to the scope of the emergency.

For more information on the health care organization’s EOP, see Capability 2 – Health Care and Medical Response Coordination.

Activity 2. Incorporate Medical Surge into an Emergency Medical Services Emergency Operations Plan

EMS organizations, the HCC, and its members support each other during medical surge. The EMS EOP should incorporate information on dispatch, response, pre-hospital triage and treatment, transportation, supplies, and equipment. Like the health care organization EOP, the EMS EOP will help inform the overarching HCC response.

The EMS EOP should detail the implementation of a stepwise approach to medical surge, including the use of conventional, contingency, and crisis care strategies, as well as state (e.g., request for National Guard) and interstate (e.g., Emergency Management Assistance Compact [EMAC]) resources to address potential shortfalls. Ultimately, EMS organizations should strive to return to normal operations as quickly as possible. EMS providers should develop and consistently implement common strategies within the HCC. EMS medical directors and managers should develop and activate surge procedures appropriate for the emergency that enable their employees to make informed decisions in the field so they can provide the best care possible, given limited resources and staff. Table 1 below outlines key elements to incorporate into an EMS EOP.

Table 1 Medical Surge Elements to Incorporate into an EMS Emergency Operations Plan

<table>
<thead>
<tr>
<th>Category</th>
<th>Elements to incorporate into an EMS EOP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dispatch</td>
<td>• Identify procedures to:</td>
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<tr>
<td></td>
<td>▪ Alert hospitals of an emergency</td>
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<tr>
<td></td>
<td>▪ Communicate hospital capacity and capability to EMS providers</td>
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<tr>
<td></td>
<td>▪ Track patient distribution (or redistribution)</td>
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<tr>
<td></td>
<td>▪ Change emergency dispatch processes (e.g., not dispatching EMS to motor vehicle crashes until police or fire report significant injuries)</td>
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<tr>
<td></td>
<td>▪ Assign low priority calls to other resources or alternative forms of transport</td>
</tr>
<tr>
<td>Response</td>
<td>• Match appropriate specialized providers and equipment with the nature of the emergency (e.g., hazardous materials [HAZMAT] trained crews during a chemical spill)</td>
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<tr>
<td></td>
<td>• Consider surge strategies such as changing shift lengths or crew configurations, using alternate vehicles, using community paramedicine, or other non-ambulance responses in coordination with dispatch priorities</td>
</tr>
</tbody>
</table>

### Category Elements to incorporate into an EMS EOP

<table>
<thead>
<tr>
<th>Category</th>
<th>Elements</th>
</tr>
</thead>
</table>
| Pre-hospital triage and treatment             | • Implement disaster triage procedures and other standard operating procedures (e.g., eliminate requirement for verbal orders)  
                                                • Consider processes that allow for expanded scope of practice  
                                                • Plan for specialty responses, such as HAZMAT, highly infectious disease, mass burn, mass trauma, and mass pediatric emergencies |
| Transportation                                | • Identify procedures to surge the numbers of patients transported per vehicle or aircraft  
                                                • Identify procedures for changing preferred destination facilities (e.g., trauma center, pediatric hospital) or not using the closest hospital  
                                                • Identify procedures for type and level of pre-hospital care delivery and mode of transport (ground and air medical)  
                                                • Develop and implement EMS patient distribution strategies to avoid overloading any single hospital  
                                                • Identify procedures for transporting patients to alternate care sites |
| Supplies and equipment                        | • Utilize physical resources including supplies, equipment, and cached materials to support a medical surge |

**Activity 3. Incorporate Medical Surge into a Health Care Coalition Response Plan**

The HCC response plan as described in Capability 2 – Health Care and Medical Response Coordination should detail the activation and notification processes for initiating medical surge response coordination among HCC members, including ESF-8 partners. The HCC response plan should include the following elements related to medical surge:

- Strategies to implement if the emergency overwhelms regional capacity or specialty care (e.g., trauma, burn, pediatric) capability, including the execution of crisis standards of care plans; plans should also address steps to prevent crisis standards of care without compromising quality of care (e.g., conserve supplies, substitute for available resources, adapt practices, etc.)
- Strategies for patient tracking, including a process for keeping track of unidentified (John Doe/Jane Doe) patients
- Strategies for initial patient distribution (or re-distribution) in the event a facility becomes overwhelmed (e.g., across proximal geographic region among local hospitals)
- Strategies for definitive patient movement out of the affected region coordinated with U.S. Department of Defense (DoD) or U.S. Department of Veterans Affairs (VA) Federal Coordinating Centers (FCCs), including the establishment of aerial ports of embarkation and debarkation for patient movement (e.g., deployable U.S. Department of Health and Human Services [HHS] response teams, definitive medical care in National Disaster Medical System [NDMS] civilian hospitals)

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Objective 2: Respond to a Medical Surge

Health care organizations and the HCC will need to respond to a surge in demand for health care services as a result of an emergency. This will require a coordinated approach to share information and resources, including staff, and ensure the stewardship of beds, medical equipment, supplies, pharmaceuticals, and other key items to provide the best possible care under such conditions.

Certain emergencies require a specialized response, either because of the type of event or specific vulnerabilities of different patient populations. The HCC facilitates these responses through timely information and resource sharing (e.g., Essential Elements of Information (EEIs), expertise that exists within the HCC, etc.).

Activity 1. Implement Emergency Department and Inpatient Medical Surge Response

Hospitals should activate their EOP to rapidly develop a medical surge response proportionate to the emergency. While the goal of immediate bed availability (IBA) is to create capacity within hospitals, other health care organization partners (e.g., home care, skilled nursing facilities, long-term care facilities, clinics, and community and tribal health centers) can meet the needs of patients who are discharged early as part of the surge response. DoD military treatment facilities and VA Medical Centers should be included in surge planning and response. Hospitals should engage HCC members with the end goal of returning to normal operations as quickly as possible by either acquiring additional resources or sharing the patient load. Hospitals should develop medical surge capacity and capability for all populations across a number of areas (as described in Table 2 below).

Table 2 Areas to Develop Emergency Department and Inpatient Medical Surge Capacity and Capability

<table>
<thead>
<tr>
<th>Area</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department</td>
<td>• Make beds and surge spaces rapidly available for initial triage and stabilization, and obtain additional staff, equipment, and supplies</td>
</tr>
<tr>
<td>General medical, general surgical, and monitored beds</td>
<td>• Ensure IBA (at least 20 percent additional acute hospital inpatient capacity within the first four hours following an emergency) by rapidly prioritizing patients for discharge, maximizing the use of staffed beds, and using non-traditional spaces (e.g., observation areas)</td>
</tr>
</tbody>
</table>


85 DoD military treatment facilities and VA Medical Centers provide medical care for active duty service members, other military health care beneficiaries, and their families. In an emergency, DoD military treatment facilities may provide lifesaving (e.g., emergency department) care for non-military health care beneficiaries and transfer them at the appropriate time (e.g., patient is stable) to a civilian hospital for inpatient care.
<table>
<thead>
<tr>
<th>Area</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical care</td>
<td>• Rapidly expand capacity (for those facilities that provide it) by adapting procedural, pre- and post-operative, and other areas for critical care</td>
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<td></td>
<td>• Assess staff, equipment, and supply needs for these spaces to facilitate requests</td>
</tr>
<tr>
<td>Surgical intervention</td>
<td>• Secure resources, such as operating rooms, surgeons, anesthesiologists, operating room nurses, and surgical equipment and supplies to provide time-sensitive, immediate surgical interventions to patients with life threatening injuries</td>
</tr>
<tr>
<td>Clinical laboratory and radiology</td>
<td>• Rapidly expand basic laboratory services (e.g., hematology, chemistries, Gram stain, blood cultures), including mechanisms for staff augmentation and rapid reporting</td>
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<tr>
<td></td>
<td>• Consider use of point-of-care testing</td>
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<tr>
<td></td>
<td>• Rapidly expand radiology services (e.g., diagnostic radiology, ultrasound, computed tomography [CT]), including mechanisms for staff augmentation and rapid reporting</td>
</tr>
<tr>
<td>Staffing</td>
<td>• Call back clinical and non-clinical staff; utilize staff in non-traditional roles</td>
</tr>
<tr>
<td></td>
<td>• Adjust staffing ratios and shifts as required, and implement HCC member staff sharing plans</td>
</tr>
<tr>
<td>Health care volunteer management</td>
<td>• Identify situations that would necessitate the need for volunteers in hospitals</td>
</tr>
<tr>
<td></td>
<td>• Identify processes to assist with volunteer coordination</td>
</tr>
<tr>
<td></td>
<td>• Estimate the anticipated number of volunteers and health professional roles based on identified situations and resource needs of the facility</td>
</tr>
<tr>
<td></td>
<td>• Identify and address volunteer liability issues, scope of practice issues, and third party reimbursement issues that may deter volunteer use</td>
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<tr>
<td></td>
<td>• Leverage existing government and non-governmental volunteer registration programs (e.g., Emergency System for Advance Registration of Volunteer Health Professional [ESAR-VHP] and Medical Reserve Corps [MRC])</td>
</tr>
<tr>
<td></td>
<td>• Develop rapid credential verification processes to facilitate emergency response</td>
</tr>
<tr>
<td>Equipment and supplies</td>
<td>• Implement emergency equipment, supplies and stocking strategies, and HCC resource sharing agreements</td>
</tr>
</tbody>
</table>

Activity 2. Implement Out-of-Hospital Medical Surge Response

Patient care settings outside of hospitals may be impacted during an emergency. For example, structural impacts from natural disasters or increased demand during epidemics may compromise an outpatient

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clinic’s ability to provide care. If not adequately addressed, the demand for out-of-hospital care will usually fall on hospitals and EMS, further overloading an already burdened system. Safe, continued operations of a community’s out-of-hospital care resources are critical to an effective medical surge response. Therefore, HCC out-of-hospital members should share staff and resources and fully integrate with the region’s surge response activities. Out-of-hospital members include but are not limited to, ambulatory care (including primary care providers), Federally Qualified Health Centers (FQHCs),88 community and tribal health centers, stand-alone surgical and specialty centers, skilled nursing facilities, long-term care facilities, clinics, private practitioners, and home care.

Activity 3. Develop an Alternate Care System

An alternate care system—the utilization of non-traditional settings and modalities for health care delivery—may be required when demand overwhelms a region or the nation’s health care delivery system for a prolonged period, or an emergency has significantly damaged infrastructure and limited access to health care. In these situations, the ESF-8 lead agency, in collaboration with health care organizations and the HCC, should work together to meet patient care needs. Public health agencies and emergency management organizations have leadership roles in selecting, establishing, and operating the sites, though the health care delivery system may provide support, including personnel and supplies.

Initial efforts for staffing an alternate care system should not disrupt health care delivery services (see Capability 3 – Continuity of Health Care Service Delivery). Communities should utilize MRCs and other staffing augmentation efforts (e.g., nursing and medical students) to staff an alternate care system whenever possible. When these resources are no longer available, request for additional assistance (e.g., federal and state assistance, etc.) may be required. Table 3 below outlines key elements to consider when developing an alternate care system.

Table 3 Key Considerations to Develop an Alternate Care System

<table>
<thead>
<tr>
<th>Category</th>
<th>Key considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telemedicine/virtual medicine</td>
<td>• Use telephone, internet, telemedicine consultations, or other virtual platforms to provide consultation between providers</td>
</tr>
<tr>
<td></td>
<td>• Provide access to specialty care expertise where it does not exist within the HCC to allow for remote triage and initial patient stabilization</td>
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<tr>
<td></td>
<td>• Establish call centers to offer scripted patient support</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Key considerations</th>
</tr>
</thead>
</table>
| Screening/early treatment | • Ensure that a section 1135 of the Social Security Act waiver\(^{89}\) is in place if required  
• Establish assessment and screening centers that allow the health care delivery system to respond to increased demand for screening and early treatment (e.g., during a pandemic)  
• Preferentially manage patients with minor symptoms and those who might require limited medical intervention as these patients might otherwise overwhelm emergency departments |
| Medical care at shelters | • Provide medical care support at community-established shelters (may involve ESAR-VHP, MRC, state disaster medical teams, nursing home staff, or a variety of ambulatory care providers) |
| Disaster alternate care facilities selection and operation | • Be able to provide non-ambulatory care for patients when hospital beds are not available  
• Select sites for out-of-hospital patient care management based on recommended guidance\(^{90}\)  
• Identify the process to assist with multiagency volunteer coordination to organize, assemble, dispatch, and properly out-process volunteers (e.g., Volunteer Reception Center)  
• Integrate with Federal Medical Stations (FMS) |

**Activity 4. Provide Pediatric Care during a Medical Surge Response**

All hospitals should be prepared to receive, stabilize, and manage pediatric patients. However, given the limited number of pediatric specialty hospitals, an emergency affecting large numbers of children may require HCC and ESF-8 lead agency involvement to ensure those children who can most benefit from pediatric specialty services receive priority for transfer. Additionally, pediatric practitioners may be able to help identify patients who are appropriate for transfer to non-pediatric facilities. EMS resources, including providers with appropriate training and equipment, should be prepared to transport pediatric patients.

The HCC should promote its members’ planning for pediatric medical emergencies and foster relationships and initiatives with emergency departments that are able to stabilize and/or manage pediatric medical emergencies.

**Activity 5. Provide Surge Management during a Chemical or Radiation Emergency Event**

Communities should be prepared to manage exposed or potentially exposed patients during a chemical or radiation emergency. During such events, individuals may go to various health care facilities, police and fire stations, and other locations for assistance.

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archive.ahrq.gov/prep/acfselection/dacfreport.pdf.
To ensure successful surge management, HCC members should be prepared to do the following:

- Provide wet and dry decontamination by personnel trained and equipped according to the Occupational Safety and Health Administration (OSHA) guidance for first receivers\(^91\) and the *Patient Decontamination in a Mass Chemical Exposure Incident: National Planning Guidance for Communities*\(^92\)
- Ensure involvement and coordination with regional HAZMAT resources (where available), including EMS, fire service, health care organizations, and public health agencies (for public messaging)
- Distribute and administer available antidotes, including mobilization of CHEMPACKs\(^93\) when necessary
- Screen to differentiate exposed from unexposed patients, especially in radiation emergency events
- Develop a process for radiation triage, treatment, and transport (RTR response)\(^94\)
- Manage behavioral health consequences for these types of emergency events (see Capability 4 Objective 2, Activity 8 – Respond to Behavioral Health Needs during a Medical Surge Response below)

**Activity 6. Provide Burn Care during a Medical Surge Response**

All hospitals should be prepared to receive, stabilize, and manage burn patients. However, given the limited number of burn specialty hospitals, an emergency resulting in large numbers of burn patients may require HCC and ESF-8 lead agency involvement to ensure those patients who can most benefit from burn specialty services receive priority for transfer. Additionally, burn surgeons may be able to help identify patients who do not require burn center care and who are appropriate for transfer to other health care facilities.

**Activity 7. Provide Trauma Care during a Medical Surge Response**

The HCC and its members should coordinate a response to large-scale trauma emergencies with all trauma system partners. All hospitals should be prepared to receive, stabilize, and manage trauma patients. However, given the limited number of trauma centers, an emergency resulting in large numbers of trauma patients may require HCC and ESF-8 lead agency involvement to ensure those patients who can most benefit from trauma services receive priority for transfer. Health care facilities should ensure sufficient availability of operating rooms, surgeons, anesthesiologists, operating room nurses, and surgical equipment and supplies to provide immediate surgical interventions to patients with life threatening injuries.

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Activity 8. Respond to Behavioral Health Needs during a Medical Surge Response

Emergencies may have severe emotional impact on survivors, their families, and responders and also cause substantial destabilization of patients with existing behavioral health issues. Hospitals and outpatient care providers, including behavioral health professionals, should identify a regional approach to assess and address the needs of the community. Behavioral health organizations are valuable HCC members and can provide needed support to survivors, responders, and people with pre-existing behavioral health concerns.

HCC members should promote a robust behavioral health response that include the following elements:

- A proportional behavioral health response, addressing the unique behavioral health needs of children, implemented according to the impact of emergencies on the community
- The development and use of behavioral health support and strike teams to support the affected population
- Ongoing support for inpatient and outpatient care of psychiatric patients
- Widespread information dissemination to help providers, patients, family, and the community understand the symptoms and signs of acute stress responses and when and where to seek treatment
- Behavioral health professionals increasing contact with clients
- Provision of psychological first aid to those impacted (including health care workers)

Activity 9. Enhance Infectious Disease Preparedness and Surge Response

Both health care organizations and the HCC have roles in planning for and responding to infectious disease outbreaks that stress either the capacity and/or capability of the health care delivery system.

Health care organizations should:

- Screen patients for signs, symptoms, and relevant travel and exposure history
- Support treatment protocol and algorithm use in clinical care by deploying clinical decision support (CDS) where electronic health records (EHRs) are in use
- Document exposure information in EHRs, and ensure it is communicated to the entire care team and state and local health departments (by electronic means, if available)
- Rapidly isolate patients
- Provide personal protective equipment (PPE) and prophylaxis to their employees and visitors while awaiting either comprehensive evaluation, definitive diagnosis, or transfer
- Utilize tertiary care facilities, when possible, or designated facilities to assess, manage, and treat patients with suspected highly pathogenic transmissible infections (e.g., severe acute respiratory syndrome [SARS]/Middle East respiratory syndrome [MERS]) or non-transmissible infections (e.g., anthrax)
- Define and implement visitor policies for infectious disease emergencies, in collaboration with the HCC, to ensure uniformity

The HCC, in collaboration with the ESF-8 lead agency, should:

- Expand existing Ebola concept of operations plans (CONOPs) to enhance preparedness and response for all infectious disease emergencies that stress the health care delivery system
- Ensure jurisdictional public health infection control and prevention programs (including healthcare-associated infections [HAI] programs) participate in developing infectious disease
response plans, and include HCC members for management of individual cases and larger emerging infectious disease outbreaks

- Develop HCC and regional trainings and strategies for the consistent use of PPE
- Manage PPE resources, including stockpiling considerations, vendor managed inventory, and the potential reuse of equipment. This includes consistent policies regarding the type of PPE necessary for various infectious pathogens and sharing information about PPE supplies across HCCs, EMS, public health agencies, and other HCC members
- Include HAI coordinators and quality improvement professionals at the facility and jurisdiction levels in HCC activities, including planning, training, and exercises/drills; include HCC leaders in state HAI coordination work groups
- Develop and/or integrate a uniform process of continuous screening, integrated with EHRs where possible, throughout HCC member facilities and organizations
- Coordinate patient distribution for highly pathogenic respiratory viruses and other highly transmissible infections when tertiary care facilities or designated facilities are not available
- Provide real-time information through coordinated HCC and jurisdictional public health information sharing systems (see Capability 2, Objective 3, Activity 4 – Communicate with the Public during an Emergency)
- Partner with relevant public health and health care delivery system informatics initiatives, including electronic laboratory reporting, electronic test ordering, electronic death reporting, and syndromic surveillance as it relates to the submission of emergency department visit data to the public health agency
- Identify, utilize, and share leading practices to optimize infectious disease preparedness and response; support the use of these practices with CDS in EHRs whenever possible

Activity 10. Distribute Medical Countermeasures during Medical Surge Response

In coordination with public health agencies, the HCC and its member organizations should be prepared to receive and dispense medical countermeasures (MCMs) to patients, responders, and employees and their household members during a medical surge emergency (e.g., radiation, botulism, anthrax, and other category A bioterrorism agents95).

Where possible, health care organizations should coordinate with local public health agencies prior to an emergency to establish a closed point of dispensing (POD) in their facility. In the event of a public health emergency requiring mass dispensing of MCMs to local populations, available MCMs may exist in HCC or individual HCC member’s caches or be provided by local public health agencies to established closed PODs. Establishing closed PODs prior to an emergency allows for organized and timely distribution of medication or vaccines to hospital patients, employees, and their families.

Activity 11. Manage Mass Fatalities

Mass fatality management may involve emergency management organizations, public health agencies, coroners, medical examiners, and other stakeholders depending on the nature of the emergency. Hospitals should be able to manage an increase in decedents at their facilities. Hospitals should be aware of community plans and authorities for an emergency resulting in mass fatalities.

Health care organizations, in collaboration with public health agencies and other stakeholders, should:

- Prepare for a surge in initial storage of decedents, including those who will not become medical examiner cases (e.g., pandemic)
- Manage large numbers of family members and friends of decedents who may come to the hospital
- Facilitate the identification of temporary, ad hoc mass fatality storage sites in the community (e.g., parking decks, ice rinks) when refrigerated trailers and other conventional storage means are not immediately available
- Manage contagious, chemically, or radiologically contaminated remains
### Glossary

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<th>Term</th>
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| Access and functional needs               | Access-based needs: All people must have access to certain resources, such as social services, accommodations, information, transportation, medications to maintain health, and so on.  
Function-based needs: Function-based needs refer to restrictions or limitations an individual may have that requires assistance before, during, and/or after a disaster or public health emergency. |
| Alternate care sites                      | Substitute non-medical physical locations converted to provide health care services when existing health care facilities are compromised by a hazard impact, or the volume of patients exceeds the capacity and/or capabilities of everyday health care facilities. They may be managed by private health care or public agencies.  
In some instances, these sites may be located on hospital campuses or other health care facilities. |
| Alternate care system                     | Encompasses a full array of organizations outside the hospital in which health care can be delivered in a health care emergency, including nursing homes, home care, skilled nursing facilities, and long-term care facilities, etc. |
| Category A bioterrorism agents            | Category A bioterrorism agents (pathogens) are those organisms/biological agents that pose the highest risk to national security and public health because they:  
• Can be easily disseminated or transmitted from person to person  
• Result in high mortality rates and have the potential for major public health impact  
• Might cause public panic and social disruption  
• Require special action for public health preparedness |

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<tr>
<td>CHEMPACK</td>
<td>The CHEMPACK program is an ongoing initiative of the Centers for Disease Control and Prevention’s (CDC) Division of Strategic National Stockpile (SNS) launched in 2003, which provides antidotes (three countermeasures used concomitantly) to nerve agents for pre-positioning by state, local, and/or tribal officials throughout the U.S. The CHEMPACK program is envisioned as a comprehensive capability for the effective use of medical countermeasures in the event of an attack on civilians with nerve agents.(^{100})</td>
</tr>
<tr>
<td>Cities Readiness Initiative (CRI)</td>
<td>A federally funded program designed to enhance preparedness in the nation’s largest population centers where more than 50% of the U.S. population resides. Using CRI funding, state and large metropolitan public health departments develop, test, and maintain plans to quickly receive and distribute life-saving medicine and medical supplies from the nation’s Strategic National Stockpile (SNS) to local communities following a large-scale public health emergency.(^{101})</td>
</tr>
<tr>
<td>Clinical decision support (CDS)</td>
<td>A process for enhancing health-related decisions and actions with pertinent, organized clinical knowledge and patient information to improve health and health care delivery.(^{102})</td>
</tr>
<tr>
<td>Closed point of dispensing (POD)</td>
<td>A specific business or organization that has the ability to dispense medical countermeasures to a defined population, as opposed to the general public (e.g., private sector workplace, hospital, etc.)(^{103})</td>
</tr>
<tr>
<td>Community Emergency Response Teams (CERT)</td>
<td>An organization of volunteer emergency workers who have received specific training in basic disaster response skills and who agree to supplement existing emergency responders in the event of an emergency or disaster.(^{104})</td>
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<tr>
<td>Community paramedicine</td>
<td>An organized system of services, based on local need, which are provided by emergency medical technicians and paramedics integrated into the local or regional health care delivery system and overseen by emergency and primary care physicians. This not only addresses gaps in primary care services, but enables the presence of emergency medical services (EMS) personnel for emergency response in low call-volume areas by providing routine use of their clinical skills and additional financial support from these non-EMS activities.</td>
</tr>
<tr>
<td>Corporate health system</td>
<td>An organized, coordinated, and collaborative network that (1) links various health care providers, via common ownership or contract, across three domains of integration – economic, noneconomic, and clinical – to provide a coordinated, vertical continuum of services to a particular patient population or community, and (2) is accountable both clinically and fiscally for the clinical outcomes and health status of the population or community served, and has systems in place to manage and improve them.</td>
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<tr>
<td>Critical care</td>
<td>Critical care helps people with life-threatening injuries and illnesses. It might treat problems such as complications from surgery, accidents, infections, and severe breathing problems. It involves close, constant attention by a team of specially-trained health care providers. Critical care usually takes place in an intensive care unit (ICU) or trauma center.</td>
</tr>
<tr>
<td>Disaster</td>
<td>A hazard impact causing adverse physical, social, psychological, economic or political effects that challenges the ability to respond rapidly and effectively. Despite a stepped-up capacity and capability (call-back procedures, mutual aid, etc.) and change from routine management methods to an incident command/management process, the outcome is lower than expected compared with a smaller scale or lower magnitude impact (see “emergency” for important contrast between the two terms).</td>
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<tr>
<td>Disaster Medical Assistance Team (DMAT)</td>
<td>A component of the National Disaster Medical System (NDMS) Response Teams. A DMAT is a group of professional and para-professional medical personnel (supported by a cadre of logistical and administrative staff) designed to provide medical care during a disaster or other event. NDMS recruits personnel for specific vacancies, plans for training opportunities, and coordinates the deployment of the teams.</td>
</tr>
<tr>
<td>Emergency</td>
<td>A hazard impact causing adverse physical, social, psychological, economic or political effects that challenges the ability to respond rapidly and effectively. It requires a stepped-up capacity and capability (call-back procedures, mutual aid, etc.) to meet the expected outcome, and commonly requires change from routine management methods to an incident command process to achieve the expected outcome (see “disaster” for important contrast between the two terms).</td>
</tr>
<tr>
<td>Emergency Management Assistance Compact (EMAC)</td>
<td>A congressionally ratified organization that provides form and structure to interstate mutual aid. Through EMAC, a disaster impacted state can request and receive assistance from other member states quickly and efficiently, resolving two key issues upfront: liability and reimbursement.</td>
</tr>
<tr>
<td>Emergency Operations Center (EOC)</td>
<td>The physical location at which the coordination of information and resources to support incident management (on-scene operations) activities normally takes place. An EOC may be a temporary facility or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. EOCs may be organized by major functional disciplines (e.g., fire, law enforcement, medical services), by jurisdiction (e.g., federal, state, regional, tribal, city, county), or by some combination thereof.</td>
</tr>
<tr>
<td>Emergency Operations Plan (EOP)</td>
<td>The “response plan” that an entity (organization, jurisdiction, state, etc.) maintains that describes intended response to any emergency situation. It provides action guidance for management and emergency response personnel during the response phase.</td>
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111 Ibid., 33.
112 Ibid., 34.
113 Ibid., 34.
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| Emergency Support Function-6 (ESF-6) – Mass Care, Emergency Assistance, Temporary Housing, and Human Services Annex | ESF-6 (Mass Care, Emergency Assistance, Housing, and Human Services) coordinates the delivery of federal mass care, emergency assistance, housing, and human services when local, tribal, and state response and recovery needs exceed their capabilities.  
| Emergency Support Function-8 (ESF-8) – Public Health and Medical Services Annex | ESF-8 (Public Health and Medical Services) provides the mechanism for coordinated federal assistance to supplement state, tribal, and local resources in response to the following:  
- Public health and medical care needs  
- Veterinary and/or animal health issues in coordination with the U.S. Department of Agriculture (USDA)  
- Potential or actual incidents of national significance  
- A developing potential health and medical situation  
| Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) | ESAR-VHP is a federal program created to support states and territories in establishing standardized volunteer registration programs for disasters and public health and medical emergencies. The program, administered on the state level, verifies health professionals' identification and credentials so that they can respond more quickly when disaster strikes.  
| Emergency use authorization | This authority allows U.S. Food and Drug Administration (FDA) to help strengthen the nation’s public health protections against chemical, biological, radiological, nuclear or explosive (CBRNE) threats by facilitating the availability and use of medical countermeasures (MCMs) needed during public health emergencies. Under section 564 of the Federal Food, Drug, and Cosmetic Act, the FDA Commissioner may allow unapproved medical products or unapproved uses of approved medical products to be used in an emergency to diagnose, treat, or prevent serious or life-threatening diseases or conditions caused by CBRNE threat agents when there are no adequate, approved, and available alternatives.  
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<tr>
<td>ESF-8 lead agency</td>
<td>ESF-8 language distinguishes between lead and supporting agencies to conduct an emergency response. Within the context of Emergency Support Functions (ESF), primary agencies have significant authorities, roles, resources, and capabilities for a particular function within an ESF.</td>
</tr>
<tr>
<td>Essential Elements of Information (EEI)</td>
<td>Important and standard information items needed to make timely and informed decisions. EEIs also provide context and contribute to analysis. EEIs are also included in situation reports.</td>
</tr>
<tr>
<td>Federal Coordinating Center (FCC)</td>
<td>A federal facility (U.S. Department of Defense or U.S. Department of Veterans Affairs) located in a metropolitan area of the United States, responsible for day-to-day coordination of planning, training, and operations in one or more assigned geographic National Disaster Medical System (NDMS) Patient Reception Areas (PRA). NDMS participating medical treatment facilities (MTF) should be within 5 miles of the managing FCC.</td>
</tr>
<tr>
<td>Federal Medical Station (FMS)</td>
<td>A U.S. Department of Health and Human Services (HHS)- deployable health care facility that can provide surge beds to support health care systems anywhere in the U.S. that are impacted by disasters or public health emergencies. FMS are not mobile and cannot be relocated once established.</td>
</tr>
<tr>
<td>Hazard vulnerability analysis (HVA)</td>
<td>A systematic approach to identifying all hazards that may affect an organization and/or its community, assessing the risk (probability of hazard occurrence and the consequence for the organization) associated with each hazard, and analyzing the findings to create a prioritized comparison of hazard vulnerabilities. The consequence, or “vulnerability,” is related to both the impact on organizational function and the likely service demands created by the hazard impact.</td>
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<tr>
<td>Hazardous material (HAZMAT)</td>
<td>Any material that is explosive, flammable, poisonous, corrosive, reactive, or radioactive (or any combination) and requires special care in handling because of the hazards posed to public health, safety, and/or the environment. 123</td>
</tr>
<tr>
<td>Health and Social Services Recovery Support Function</td>
<td>Assists locally-led recovery efforts in the restoration of the public health, health care and social services networks to promote the resilience, health and well-being of affected individuals and communities. 124</td>
</tr>
<tr>
<td>Healthcare-associated infections (HAI)</td>
<td>Healthcare-associated infections (HAIs) are infections people get while they are receiving health care for another condition. HAIs can happen in any health care facility, including hospitals, ambulatory surgical centers, end-stage renal disease facilities, and long-term care facilities. HAIs can be caused by bacteria, fungi, viruses, or other less common pathogens. 125</td>
</tr>
<tr>
<td>Health care coalition (HCC)</td>
<td>A group of individual health care and response organizations (e.g., hospitals, emergency medical services (EMS), emergency management organizations, public health agencies, etc.) in a defined geographic location. HCCs play a critical role in developing health care delivery system preparedness and response capabilities. HCCs serve as multiagency coordinating groups that support and integrate with ESF-8 activities in the context of incident command system (ICS) responsibilities.</td>
</tr>
<tr>
<td>Health care coalition (HCC) member</td>
<td>An HCC member is defined as an entity within the HCC’s defined boundaries that actively contributes to HCC strategic planning, operational planning and response, information sharing, and resource coordination and management.</td>
</tr>
<tr>
<td>Health care executive</td>
<td>Health care organization senior executives with institutional decision-making authority. Titles of health care executives may include but are not limited to, President, Chief Executive Officer, Chief Operating Officer, Chief Medical Officer, Chief Nursing Officer, and Medical Director.</td>
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<tr>
<td>Health care facility</td>
<td>Any asset where point-of-service medical care is regularly provided or provided during an incident. It includes hospitals, integrated health care systems, private physician offices, outpatient clinics, nursing homes, and other medical care configurations. During an emergency response, alternative medical care facilities and sites where definitive medical care is provided by emergency medical services (EMS) and other field personnel would be included in this definition.</td>
</tr>
<tr>
<td>Health Insurance Portability and Accountability Act (HIPAA)</td>
<td>Public Law 104-191 (August 21, 1996) addresses many aspects of health care practice and medical records. This federal act most notably addresses the privacy of protected health information (PHI), and directs the development of specific parameters as to how PHI may be shared.</td>
</tr>
<tr>
<td>Homeland Security Exercise and Evaluation Program (HSEEP)</td>
<td>Doctrine and policy provided by the U.S. Department of Homeland Security for design, development, conduct, and evaluation of preparedness exercises. The terminology and descriptions related to exercise in this document is a Homeland Security industry application of emergency management concepts and principles.</td>
</tr>
<tr>
<td>Immediate bed availability (IBA)</td>
<td>[The ability of a hospital] to provide no less than 20 percent bed availability of staffed beds within four hours of a disaster. It is built on three pillars: continuous monitoring across the health system; off-loading of patients who are at low risk for untoward events through reverse triage; and on-loading of patients from the disaster.</td>
</tr>
<tr>
<td>Incident Action Plan (IAP)</td>
<td>An oral or written plan containing general objectives reflecting the overall strategy for managing an incident. It may include the identification of operational resources and assignments. It may also include attachments that provide direction and important information for management of the incident during one or more operational periods.</td>
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127 Ibid., 49.
128 Ibid., 49.
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<tr>
<td>Incident action planning cycles</td>
<td>The flux in incident and response conditions is best managed using a deliberate planning process that is based on regular, cyclical reevaluation of the incident objectives. Commonly known in the incident command system (ICS) as the planning cycle, this iterative process enhances the integration of public health and medical assets with other response agencies that operate planning cycles.(^{131})</td>
</tr>
<tr>
<td>Incident command system (ICS)</td>
<td>The combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations.(^{132})</td>
</tr>
<tr>
<td>Joint Commission</td>
<td>The Joint Commission is an independent, not-for-profit organization that accredits and certifies health care organizations and programs in the United States. Joint Commission accreditation and certification standards are the basis of an objective evaluation process designed to help health care organizations measure, assess, and improve performance.(^{133})</td>
</tr>
<tr>
<td>Joint Information System (JIS)</td>
<td>A structure that integrates incident information and public affairs into a cohesive organization designed to provide consistent, coordinated, accurate, accessible, timely, and complete information during crisis or incident operations. The mission of the JIS is to provide a structure and system for developing and delivering coordinated interagency messages; developing, recommending, and executing public information plans and strategies on behalf of the Incident Commander (IC); advising the IC concerning public affairs issues that could affect a response effort; and controlling rumors and inaccurate information that could undermine public confidence in the emergency response effort.(^{134})</td>
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<td>Medical countermeasures (MCMs)</td>
<td>Medical countermeasures, or MCMs, are Food and Drug Administration (FDA)-regulated products (biologics, drugs, devices) that may be used in the event of a potential public health emergency stemming from a terrorist attack with a biological, chemical, or radiological/nuclear material, a naturally occurring emerging disease, or a natural disaster. MCMs can be used to diagnose, prevent, protect from, or treat conditions associated with chemical, biological, radiological, nuclear, and explosives (CBRNE) threats, or emerging infectious diseases.</td>
</tr>
<tr>
<td>Medical Reserve Corps (MRC)</td>
<td>A national network of local groups of volunteers engaging local communities to strengthen public health, reduce vulnerability, build resilience, and improve preparedness, response, and recovery capabilities.</td>
</tr>
<tr>
<td>Medical Surge Capacity and Capability (MSCC)</td>
<td>A management methodology based on valid principles of emergency management and the incident command system (ICS). Medical and public health disciplines may apply these principles to coordinate effectively with one another and to integrate with other response organizations that have established ICS and emergency management systems (fire service, law enforcement, etc.). This promotes a common management system for all response entities—public and private—that may be brought to bear in an emergency. In addition, the MSCC Management System guides the development of public health and medical response that is consistent with the National Incident Management System (NIMS).</td>
</tr>
<tr>
<td>Member type</td>
<td>A category of health care coalition (HCC) members that represents a type of facility or organization (e.g., all nursing facilities, all hospitals, or all emergency medical services [EMS] agencies within one HCC).</td>
</tr>
<tr>
<td>Mission Essential Functions (MEFs)</td>
<td>Functions that are required to be performed by statute, Executive Order, or otherwise deemed essential by the heads of principal organizational elements to meet mission requirements.</td>
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<tr>
<td>Multiagency coordination group</td>
<td>A multiagency coordination group functions within a broader multiagency coordination system. It may establish the priorities among incidents and associated resource allocations, deconflict procedures, and provide strategic guidance and direction to support incident management activities.</td>
</tr>
<tr>
<td>National Disaster Medical System (NDMS)</td>
<td>The National Disaster Medical System (NDMS) is a federally coordinated health care system and partnership of the U.S. Departments of Health and Human Services, Homeland Security, Defense, and Veterans Affairs. The purpose of the NDMS is to support state, local, tribal, and territorial authorities following disasters and emergencies by supplementing health and medical systems and response capabilities. The NDMS hospital network also supports the military and U.S. Department of Veterans Affairs (VA) Medical Centers in a military health emergency.</td>
</tr>
<tr>
<td>National Incident Management System (NIMS)</td>
<td>A systematic, proactive approach to guide departments and agencies at all levels of government, nongovernmental organizations, and the private sector to work together seamlessly and manage incidents involving all threats and hazards—regardless of cause, size, location, or complexity—in order to reduce loss of life, property, and harm to the environment.</td>
</tr>
<tr>
<td>Personal protective equipment (PPE)</td>
<td>Equipment worn to minimize exposure to a variety of hazards. Examples of PPE include such items as gloves, masks, foot and eye protection, protective hearing devices (earplugs, muffs) hard hats, respirators, and full body suits.</td>
</tr>
<tr>
<td>Psychological first aid</td>
<td>An evidence-informed modular approach for assisting people in the immediate aftermath of disaster and terrorism to reduce initial distress and to foster short- and long-term adaptive functioning.</td>
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<td>Public Information Officer (PIO)</td>
<td>As part of the incident response team, responsible for communicating with the public, media, and/or coordinating with other agencies, as necessary, with incident-related information requirements. The PIO is responsible for developing and releasing information about the incident to the news media, incident personnel, and other appropriate agencies and organizations.</td>
</tr>
<tr>
<td>Section 1135 of the Social Security Act waivers</td>
<td>When the President declares a major disaster or an emergency under the Stafford Act or an emergency under the National Emergencies Act, and the HHS Secretary declares a public health emergency, the Secretary is authorized to take certain actions in addition to his/her regular authorities under section 1135 of the Social Security Act. [The Secretary] may waive or modify certain Medicare, Medicaid, Children’s Health Insurance Program (CHIP) and Health Insurance Portability and Accountability Act (HIPAA) requirements as necessary to ensure to the maximum extent feasible that, in an emergency area during an emergency period, sufficient health care items and services are available to meet the needs of individuals enrolled in Social Security Act (SSA) programs and that providers of such services in good faith who are unable to comply with certain statutory requirements are reimbursed and exempted from sanctions for noncompliance other than fraud or abuse. 146</td>
</tr>
<tr>
<td>Strategic National Stockpile (SNS)</td>
<td>Strategic National Stockpile (SNS) has large quantities of medicine and medical supplies to protect the American public if there is a public health emergency (e.g., terrorist attack, flu outbreak, earthquake) severe enough to cause local supplies to run out. Once federal and local authorities agree that the SNS is needed, medicines will be delivered to any state in the U.S. in time for them to be effective. 147</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threat and Hazard Identification and Risk Assessment (THIRA)</td>
<td>A four-step common risk assessment process that helps the whole community—including individuals, businesses, faith-based organizations, nonprofit groups, schools, and academia and all levels of government—understand its risks and estimate capability requirements.(^{148})</td>
</tr>
<tr>
<td>Whole community</td>
<td>A means by which residents, emergency management practitioners, organizational and community leaders, and government officials can collectively understand and assess the needs of their respective communities and determine the best ways to organize and strengthen their assets, capacities, and interests.(^{149})</td>
</tr>
</tbody>
</table>


Appendix 1: The 2017-2022 Health Care Preparedness and Response Capabilities Revision Process

The 2017-2022 Health Care Preparedness and Response Capabilities document improves upon the 2012 version titled Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness. The Office of the Assistant Secretary for Preparedness and Response (ASPR) incorporated lessons learned from previous responses to emergencies and extensive stakeholder engagement into the revised capabilities. Stakeholder feedback included a Capability Needs Assessment in 2015, which involved surveys and facilitated discussions with awardees, health care coalitions (HCCs), and other stakeholders, to obtain their reactions to the capability content, structure, and level of detail in the 2012 version, and suggested areas for revision. ASPR also solicited and considered input from more than 50 national associations whose members have an interest in emergency preparedness and response. Finally, ASPR facilitated discussions at emergency preparedness and response conferences, solicited public feedback on ASPR’s Technical Resources, Assistance Center, and Information Exchange (TRACIE) website, and consulted preparedness and response and health care subject matter experts. ASPR also conducted a thorough review of relevant preparedness and response literature and researched recent past events to inform the revision process.

Based on process described above, ASPR streamlined the eight capabilities in the 2012 version into four capabilities. While the number of capabilities have decreased, the concepts from all of the capabilities in the 2012 version can be found within the new set of four capabilities. As seen in Figure 1 below, the 2017 capabilities were informed by the content found in the 2012 capabilities. Foundation for Health Care and Medical Readiness aligns with the 2012 capability 1 (Healthcare System Preparedness). Health Care and Medical Response Coordination aligns with the 2012 capabilities 3 (Emergency Operations Coordination) and 6 (Information Sharing). Continuity of Health Care Service Delivery aligns with the 2012 capabilities 2 (Healthcare System Recovery) and 14 (Responder Safety and Health). Finally, Medical Surge aligns with the 2012 capabilities 10 (Medical Surge), 15 (Volunteer Management) and 5 (Fatality Management).

Figure 1: Crosswalk of the 2012 and 2017-2022 Capabilities

<table>
<thead>
<tr>
<th>Proposed Capabilities</th>
<th>2012 Capabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundation for Health Care and Medical Readiness</td>
<td>C1: Healthcare System Preparedness</td>
</tr>
<tr>
<td>Health Care and Medical Response Coordination</td>
<td>C3: Emergency Operations Coordination</td>
</tr>
<tr>
<td>Continuity of Health Care Service Delivery</td>
<td>C2: Healthcare System Recovery</td>
</tr>
<tr>
<td>Medical Surge</td>
<td>C6: Information Sharing</td>
</tr>
<tr>
<td></td>
<td>C14: Responder Safety and Health</td>
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<td></td>
<td>C10: Medical Surge</td>
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<tr>
<td></td>
<td>C15: Volunteer Management</td>
</tr>
<tr>
<td></td>
<td>C5: Fatality Management</td>
</tr>
</tbody>
</table>
Appendix 2: Health Care Preparedness and Response Capabilities and Public Health Preparedness Capabilities Areas for Alignment

This appendix will be developed upon the completion of the Public Health Preparedness Capabilities in 2017. The appendix will include a crosswalk of 2017-2022 Health Care Preparedness and Response Capabilities, the 2017-2022 Public Health Preparedness Capabilities, and National Preparedness Goal core capabilities.
Meeting Date: 11/14/2016
Subject: Safe Drug Disposal Ordinance Proposal
Submitted For: FAMILY & HUMAN SERVICES COMMITTEE,
Department: County Administrator
Referral No.: N/A
Referral Name: N/A
Presenter: Daniel Peddycord, Public Health Director
Contact: Enid Mendoza, (925) 335-1039

Referral History:
On April 27, 2010 the Contra Costa Board of Supervisors adopted a resolution supporting Extended Producer Responsibility. It was noted that local governments do not have the resources to adequately address the rising volume of discarded products and that there are significant environmental and health impacts associated with improper management of Universal Wastes, sharps and other products.

In March of 2012, Supervisor Mary Piepho brought forward a resolution to the Board of Supervisors declaring March as “Prescription Drug Abuse Awareness Month”. Comment was made regarding the importance of safely storing and disposing of medications. Subsequently, at an April 28, 2012 Prescription Drug Take Back event, Supervisor Piepho noted that her office was working with County departments to review and evaluate a “Safe Medication Disposal” Ordinance for Contra Costa County.

On March 3, 2015, the Contra Costa County Board of Supervisors issued a resolution recognizing March as Prescription Drug Awareness month to bring attention to the seriousness and significance of deaths associated with the misuse of prescription drugs. Supervisor Candace Andersen referenced the importance of disposing unwanted medications when they are no longer needed and Supervisor Mary Piepho indicated that she hoped the County would soon be able to adopt a safe drug disposal ordinance, following Alameda County's lead in adopting a similar ordinance.

Over the past year staff has worked with the Office of Supervisor Piepho to develop a draft ordinance for safe drug disposal. These efforts have focused on modeling an ordinance that would require the producers of covered drugs to create and pay for a system for the safe and convenient disposal of unwanted prescription drugs, similar to those adopted by other Bay Area counties.

Although this item is not a Family and Human Services (F&HS) referral, it is being presented to F&HS for discussion and further direction prior to presenting the topic to the full Board of
Supervisors.

**Referral Update:**
Please see the attached staff report and draft ordinance.

**Recommendation(s)/Next Step(s):**
CONSIDER receiving the report from the Health Services Department regarding current issues with drug misuse and abuse and the proposed Safe Drug Disposal Ordinance, and recommending to the Board of Supervisors approval of a Safe Drug Disposal Ordinance.

**Fiscal Impact (if any):**
Inspections and audits, including review of plans and annual reports, will be covered by fees paid to the County by participating producers. There is no anticipated impact to the County general fund.

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**Attachments**

Report on Safe Drug Ordinance Proposal
DRAFT Safe Drug Disposal Ordinance
Date: November 14, 2016

To: Family and Human Services Committee, Contra Costa Board of Supervisors

From: William B. Walker, M.D., Health Services Director
By: Daniel Peddycord, Public Health Director

Re: Safe Drug Disposal Ordinance

Recommendations:

1. Receive report by the Public Health Director on a draft Safe Drug Disposal Ordinance ("Ordinance").

2. Consider referring and recommending approval of the Ordinance to the Board of Supervisors.

Background:

On April 27, 2010, the Contra Costa Board of Supervisors adopted a resolution supporting Extended Producer Responsibility. It was noted that local governments do not have the resources to adequately address the rising volume of discarded products and that there are significant environmental and health impacts associated with improper management of Universal Wastes, sharps and other products.

In March of 2012, Supervisor Mary Piepho brought forward a resolution to the Board of Supervisors declaring March as “Prescription Drug Abuse Awareness Month”. Comment was made regarding the importance of safely storing and disposing of medications. Subsequently, at an April 28th, 2012 Prescription Drug Take Back event, Supervisor Piepho noted that her office was working with County departments to review and evaluate a “Safe Medication Disposal” Ordinance for Contra Costa County.
On March 3, 2015, the Contra Costa County Board of Supervisors, again, issued a Proclamation recognizing March as Prescription Drug Awareness month to bring attention to the seriousness and significance of deaths associated with the misuse of prescription drugs. Supervisor Candace Andersen referenced the importance of disposing of unwanted medications when they are no longer needed and Supervisor Mary Piepho indicated that she hoped the County would soon be able to adopt a safe drug disposal ordinance, following Alameda County’s lead in adopting a similar ordinance.

Extended producer responsibility (EPR) laws, sometimes referred to as product stewardship laws, assign responsibility for end-of-product life management of consumer products on the manufacturers of those products. Given the parallel increase in the number of prescription drug related overdose deaths, with the dramatic increase in sales of prescription controlled substances, product stewardship is a relevant and essential strategy to protect the public’s health. However, there is currently no mandatory statewide drug stewardship program for unwanted household drugs in California.

Over the past year staff has worked with the Office of Supervisor Piepho to develop a draft ordinance for safe drug disposal. These efforts have focused on modeling an ordinance that would require the producers of covered drugs to create and pay for a system for the safe and convenient disposal of unwanted prescription drugs, similar to those adopted by other Bay Area counties.

Scope of the Problem:

The United States is in the midst of an epidemic of drug overdose deaths. From 2000 to 2014 nearly 500,000 people in the US died from drug overdose. In 2013 alone, 16,000 people died from overdose related to opioid pain relievers, a four hundred percent increase as compared to 1999. The significant increase in number of overdose deaths is largely attributed to the misuse of prescription opioids and sedatives. In 2014, 47,055 drug overdose deaths occurred nationally, more than during any previous year on record and opioids, including prescription painkillers and heroin, were involved in 28,647 deaths, or 61 percent of all drug overdose deaths. Overdose deaths involving opioid pain relievers (OPR) are now associated with more deaths than heroin and cocaine combined. The increase in deaths associated with drug overdose has now replaced motor vehicle crashes as the leading cause of accidental death for persons age 25-64.
Drug misuse and abuse resulted in approximately 2.5 million emergency department (ED) visits nationally in 2011. More than 1.4 million of these were related to prescription drugs.

Misuse and diversion of prescription medication is a significant issue. According to the 2014 National Survey on Drug Use and Health administered by the US Department of Health and Human Services, about 15 million people age 12 or older used prescription drugs non-medically in the previous year.

In the United States, prescription opioid abuse costs were about $55.7 billion in 2007. Of this amount, 46 percent was attributable to workplace costs (e.g., lost productivity), 45 percent to healthcare costs (e.g., abuse treatment) and 9 percent to criminal justice costs.

Contra Costa County:

On March 1, 2016, the Contra Costa Public Health Division issued a Health Advisory warning of the misuse and abuse of prescription opioids. The advisory was issued to bring attention to a national epidemic of misuse and abuse of prescription opioids and sedatives. The advisory called attention to the need for health care professionals to be aware of the scope of this epidemic and new guidelines for prescribing.

Data from the California Department of Public Health reveal that there were 53 accidental drug overdose deaths in 2003 in Contra Costa County. The number of accidental drug overdose deaths increased to 84 in 2008 and 113 in 2013. In 2014, the majority (72 of the 96) of drug-related accidental deaths reported to the Contra Costa Coroner’s Office in 2014 involved prescription drugs.

What we are experiencing in our County is mirrored across the Nation. Information from the Centers for Disease Control and Prevention (CDC) reveals that the death rate from drug overdose has more than doubled since 2000. On a national level, drug overdoses have claimed the lives of nearly 500,000 individuals since 1999. [http://www.cdc.gov/mmwr/pdf/wk/mm6450.pdf](http://www.cdc.gov/mmwr/pdf/wk/mm6450.pdf)

It is no coincidence that the number of drug overdose deaths reported in the U.S. during 2014 was 140 percent higher than in 2000 (CDC statistic). The increase in deaths parallels a decade long increase in medical prescriptions for opioid pain medication.

According to the CDC, prescription opioid sales in the United States increased by 300 percent between 1999 and 2010. (CDC Vital Signs MMWR 2011:60(43); 1487-1492.) Between 1999 and
2013, the number of deaths attributed to opioid pain relievers increased by 400%.
http://www.cdc.gov/nchs/deaths.htm

Nationally each year, prescription narcotics result in more fatal overdoses than heroin and cocaine combined. The second leading cause of fatal overdoses are prescription sedatives — medicines like Xanax and Ativan.

Counties, health systems and community partners across the greater bay area are addressing this epidemic. The Alameda-Contra Costa Medical Association, working together with local public health agencies, health insurers, community partners and health care provider organizations have helped local Emergency Departments, Urgent Care Centers and Primary Care clinicians adopt a set of guidelines for prescribing opioids. These guidelines are intended to help balance the need for the treatment of pain with the risk of drug dependency, abuse and addiction. In addition, health systems are expanding the availability of drug treatment programs, medication assisted treatment and drug counseling services.

Safer disposal of prescription medication is also a strategy that aids in reducing the risk of diversion and misuse of prescription drugs. Having ease of access to appropriate methods to dispose of these medications helps to reduce the chance that unwanted medications will be taken by individuals who misuse or are addicted to prescription medications.

In 2010, Congress passed the “Secure and Responsible Drug Disposal Act of 2010” (Public Law No. 111-273), which authorized the Attorney General to increase methods, formerly restricted to law enforcement, by which controlled substances may be collected, including collection at pharmacies. On October 9, 2014, the Drug Enforcement Administration (DEA) promulgated regulations implementing the bill. These regulations, among other things, authorize retail pharmacies to maintain secure collections bins for controlled substances. However, these policies and regulations are permissive, not mandatory. On August 29, 2016, Governor Jerry Brown signed Senate Bill 1229, which protects pharmacies that properly secure drug disposal bins from civil damages.

Only two pharmacies in Contra Costa County have yet to establish drug disposal kiosks for the collection of controlled and uncontrolled medication. One is located in El Cerrito and the other in Walnut Creek. Both are part of a large retail chain, Walgreens, which has expressed interest in supporting safe drug disposal. However, to date, this voluntary model has yet to yield a common or widely available means of disposing of unused prescription medications.

The current solid waste collection system run by the three regional entities, West Contra Costa Integrated Waste Management, Central Costa Sanitation District and Delta Diablo Sanitation District, Central San and Delta Diablo) is also insufficient to dispose of unused prescription pain medication. These entities are focused on the collection of non-controlled pharmaceutical
substances, and according to regulations from the Drug Enforcement Administration (DEA) they cannot legally accept controlled substances, such as prescription opioids or sedatives.

To date, there are only two local law enforcement agencies in the County that accept controlled substances for disposal on a regular basis, those being in Antioch and Pittsburg.

In addition, the DEA host periodic prescription drug take back events. These are often supported by and located at local police or Sherriff stations but are infrequent in nature. Hence, they create an environment where members of the public might hoard their medication vs. disposing of it readily.

To test the interest and need for a more convenient means of safe drug disposal, from the perspective of consumers, the Public Health Division conducted a survey in September of 2016, modeled after a similar one done in Los Angeles County. More than 1,600 individuals responded. Below is a summary:

- 73 percent of respondents reported having unused or left-over prescription medications in their home.

- 94 percent of respondents said that they believe it is inappropriate to dispose of medications in the toilet and 84 percent said the same thing about disposing of medication in the trash.

- 37 percent of respondents said one reason they keep unwanted medications around the home is that there is no convenient means to properly dispose of them. Less than 10 percent said they were saving the medications for a drug take-back event.

- 83 percent of respondents said they would be likely or very likely to dispose of unwanted medications at a pharmacy, while 55 percent said they would be likely or very likely to use a prepaid return envelope.

- 58 percent of respondents selected “take back to pharmacy” as their most preferred option, more than three times the number who preferred dropping them off at a police or sheriff’s office.

- As to why respondents were unlikely to use certain methods to dispose of their unwanted medications, nearly 78 percent said drug take-back events are inconvenient and more than 83 percent said the same thing about household hazardous waste collection facilities.

- 66 percent of respondents indicated that a benefit of removing unused or left-over medications from the home was less chance of misuse of the medication. Less chance of theft
and less chance that children or pets might inadvertently get into them were also selected as reasons to remove unused prescription medication from the home.

The survey results and significance of this public health issue indicate that the currently available disposal measures in Contra Costa County are not sufficient to alleviate the risk of misuse, addiction and death, nor to curb the tide of this national epidemic. It is the view of staff that a similar ordinance is needed here in Contra Costa County.

The counties of Alameda, Marin, San Mateo, Santa Clara, Santa Cruz and Santa Barbara and the City and County of San Francisco have adopted product stewardship ordinances to promote safe drug disposal. So too have King County (Seattle), Washington, and most recently Cook County, Illinois. In addition, Mexico, Brazil, Columbia, a number of Canadian provinces, including British Columbia and Manitoba as well as number of European nations, including France, Spain, Portugal and Belgium have adopted safe drug disposal programs, which are paid for by drug manufactures and operated under product stewardship programs on their behalf.

Features of the draft Safe Drug Disposal Ordinance:

The proposed ordinance would require producers of covered prescription medications to establish and pay for a collection system consisting of the following:

- A minimum of 3 drop-off sites in each of the five supervisorial districts in locations that allow for convenient and equitable access by residents of the unincorporated areas of those districts. If achievement of this standard is not feasible in a supervisorial district, the stewardships program must provide for both of the following additional methods of collection of unwanted covered drugs.
  - A mail-back service
  - Periodic take-back events that are at least 6 hours in length, held a least once per quarter and located in at least three locations in the district.
- Preference is given to having retail pharmacies and law enforcement agencies serve as collectors.
- In addition, mail-back services must be made available to individuals who are disabled or homebound.

If adopted, the Ordinance would require the producer(s) (manufacturer) of a covered drug to submit a product stewardship plan, to the Public Health Officer, describing how they would provide for the disposal options noted above. The proposed ordinance allows for producers to satisfy their stewardship obligation either individually or jointly with other producers, in the form of a stewardship organization. As drafted, the ordinance would require that producers provide notice to
all retail pharmacies and all law enforcement agencies located in the County of the opportunity to participate as collectors.

Covered drugs include prescription drugs but do not include vitamins, herbal-based remedies, cosmetics, non-prescription drugs or personal care items.

Producers would have six months after the effective date of the ordinance to provide the Health Officer with written notice of their intent to participate in a stewardship program. Within 90 days after the Health Officer’s approval, the producer shall implement the plan by commending operations of the approved product stewardship program. In addition to meeting the requirements for number and convenience, the stewardship program will need to describe how the mail-back components of the program are to be administered. Public notice will also be required at the collection sites and advertised in the local media.

The Operators of the Stewardship program(s) are required to submit an annual report noting, among other things, the weight of total drugs collected, a description of public education and promotional activities, the number of mailers provided to county residents, details on transportation of drugs to be disposed and total expenditures of the stewardship program.

The administrative and operational cost of the stewardship program will be the sole responsibility of the participating producers. However, the proposed ordinance does not require a producer to pay for staff time provided by collectors who agree to participate in an approved stewardship program. Revenue from fees paid may only be used to cover the cost of the Health Officer in the performance of investigations, inspections, audits, and administrative enforcement and adjudication.

The drug stewardship program described in the draft ordinance would benefit the public by significantly increasing timely and convenient disposal options for county residents, enabling collection of larger quantities of unwanted drugs and reducing the above risk to public health.

In Summary:

Reflecting on the strong themes from the survey together with the significance of this public health issue, the available disposal measures noted above are not sufficient to alleviate the risk of misuse, addiction and death, or to curb the tide of this national epidemic. There is a glaring lack of (legal) disposal options for controlled substances, which are a contributor to the epidemic of drug overdose deaths in our County. While many nations and multiple counties in California, particularly in and around the Bay Area have adopted Extended Producer Responsibility ordinances for the safe disposals of prescription drugs, to date, the State has not yet provided similar policy. The current environment for safe drug disposal is inadequate, in some examples inappropriate, and is better
Family and Human Services Committee
November 14, 2016

described as a patchwork system vs. a consumer friendly and convenient system of safe drug disposal. For all of these reasons staff recommends consideration of the Safe Drug Disposal Ordinance.

Attachment:

Draft Safe Drug Disposal Ordinance

cc: Randy Sawyer, Director Contra Costa Hazardous Materials
    Marilyn Underwood, Director Contra Costa Environment Health
    Michael Kent, Hazardous Materials Ombudsman
ORDINANCE NO. 2016-_______

(Safe Drug Disposal)

The Contra Costa County Board of Supervisors ordains as follows:

SECTION I. SUMMARY. This ordinance adds Chapter 418-16 to the Contra Costa County Ordinance Code to establish a stewardship program for the collection and disposal of unwanted prescription drugs.

SECTION II. AUTHORITY. This ordinance is adopted pursuant to Health and Safety Code section 101025 and article XI, section 7 of the California Constitution.

SECTION III. FINDINGS.
(a) Prescription drugs allow people to live longer, healthier and more productive lives.
(b) There is a lack of sufficient safe and convenient disposal locations for unwanted prescription drugs in this county.
(c) As a result, unwanted prescription drugs are often left in homes, where they can be accidentally ingested by children, adults and the elderly, thus increasing their risk of poisoning and death.
(d) The improper or careless disposal of unwanted prescription drugs can also lead to illegal resales of drugs and drug addiction.
(e) Nationwide, the drug overdose death rate increased by 137 percent from 2000 to 2014. Nearly 500,000 people died from drug overdoses in that time period. More than 50 percent of those deaths were related to overdoses of prescription drugs, primarily opioids.
(f) The sales of, and overdose-related deaths from, prescription opioids quadrupled nationwide from 1999 to 2010. From 1999 to 2014, more than 165,000 people died from prescription opioid-related overdoses.
(g) In Contra Costa County, 75 percent of the 96 accidental drug overdose deaths reported to the Contra Costa County Coroner’s Office in 2014 involved prescription drugs.
(h) Opioid prescription guidelines have been developed and implemented at emergency rooms throughout Contra Costa County to limit the potential for opioid abuse. However, prescription limitations alone are not enough.
(i) A survey conducted by the Contra Costa Health Services Public Health Division in 2016 revealed that 73 percent of 1,653 respondents reported having unused or leftover prescription drugs in their homes. Of 1,204 respondents, 43 percent said they hadn’t gotten around to disposing of them, 38 percent said there was no convenient means of proper disposal and 18 percent were uncertain how to properly dispose of them.
(j) These accumulated drugs pose a serious risk of misuse, abuse and death of residents of Contra Costa County.
(k) There is currently no mandatory statewide drug stewardship program for unwanted household drugs in California.
(l) The West Contra Costa Integrated Waste Management Authority, Central Contra Costa Sanitary District and Delta Diablo Sanitation District currently provide collection bins at
locations such as the County hospital, police stations and waste disposal facilities, but only for unwanted drugs that are not controlled substances.

(m) Unused prescription opioids and other controlled drugs, however, may be lawfully collected only by law enforcement and pharmacists, and to date collection options for these types of drugs are very limited. Only two police stations and two pharmacies in Contra Costa County collect unused controlled drugs, and none is located in the unincorporated area. The U.S. Drug Enforcement Administration sponsors take-back events where controlled drugs may be dropped off, but these events are held only a few times each year.

(n) Due to the limitations of these collection options, the above measures do not go far enough to address the risks of misuse, addiction and death from prescription drugs, particularly those drugs that are controlled substances.

(o) Because existing programs to take back unused and unwanted prescription drugs are either too limited or not convenient, establishing the drug stewardship program described in this ordinance is necessary to preserve and protect the health of residents of Contra Costa County.

(p) The drug stewardship program described in this ordinance will benefit the public by significantly increasing convenient disposal options for county residents, enabling collection of larger quantities of unwanted prescription drugs and reducing the above risks to public health.

SECTION IV. Chapter 418-16 is added to the County Ordinance Code, to read:

Chapter 418-16 Safe Drug Disposal

For purposes of this chapter, the following words and phrases have the following meanings:

(a) “Approved stewardship plan” means a stewardship plan approved by the health officer.

(b) “Approved stewardship program” means a stewardship program that is described in and operates in accordance with an approved stewardship plan.

(c) “Collector” means a person or government entity that collects unwanted covered drugs in an approved stewardship program.

(d) “County residents” means human beings who reside in the unincorporated area of the county.

(e) “Covered drug” means a prescription drug as defined in subsection 418-16.202(l).

(f) “Drug” means a drug defined in section 321(g)(1) of title 21 of the United States Code, but does not include any of the following:

(1) Vitamins or supplements;

(2) Herbal-based remedies and homeopathic drugs, products or remedies;

(3) Cosmetics, shampoos, sunscreens, toothpaste, lip balm, antiperspirants, or other personal care products that are regulated as both cosmetics and nonprescription drugs under the federal Food, Drug, and Cosmetic Act (21 U.S.C. § 301 et seq.);

(4) Drugs for which producers provide a pharmaceutical product stewardship or take-back program as part of a federal Food and Drug Administration-managed risk evaluation and mitigation strategy under section 355-1 of title 21 of the United States Code;
(5) Biological products as defined by 21 Code of Federal Regulations part 600.3(h) (2015) for which a producer provides a pharmaceutical product stewardship or take-back program; and

(6) Medical devices or their component parts or accessories.

(g) "Drug wholesaler" means a person who engages in the sale or distribution of covered drugs to retailers or other entities located in the unincorporated area of the county but not individual consumers.

(h) "Mail-back service" means a collection method for the return of unwanted covered drugs that utilizes prepaid and preaddressed mailing envelopes.

(i) "Manufacturing" means the production, preparation or compounding of a drug, but does not include the repackaging or relabelling of a drug or the preparation, compounding, packaging, labeling, dispensing or distribution of a drug by a practitioner in the course of his or her professional practice.

(j) "Manufacturer" means a person engaged in manufacturing.

(k) "Pharmacy" means a place licensed by the State of California Board of Pharmacy where the practice of pharmacy is conducted.

(l) "Prescription drug" means a drug as defined in subsection 418-16.202(f) that is required by federal or state law or regulation to be dispensed by prescription only or is restricted to use by practitioners only.

(m) "Producer" means the manufacturer of a covered drug that is sold or distributed in any form in the unincorporated area of the county.

(n) "Retail pharmacy" means a pharmacy licensed by the State of California Board of Pharmacy for the retail sale and dispensing of drugs.

(o) "Stewardship plan" means a written document that describes a stewardship program.

(p) "Stewardship program" means a program operated by or on behalf of a producer that provides for the collection, transportation and disposal of unwanted covered drugs generated by county residents.

(q) "Stewardship organization" means a person designated by a producer to develop or implement a stewardship plan or operate a stewardship program on behalf of the producer.

(r) "Unwanted covered drug" means any covered drug that a county resident has obtained and intends to discard, or has discarded, or has abandoned. (Ord. 2016-___ § 4).

418-16.204 Drug wholesalers.

Within 60 days after the effective date of this chapter, and no later than April 1 of every year thereafter, a drug wholesaler shall submit written notification to the health officer of the names and manufacturers of all covered drugs that the drug wholesaler sells or distributes in the unincorporated area of the county. (Ord. 2016-___ § 4).

418-16.206 Producers.

A producer shall satisfy all of the obligations set forth in this section, either individually, jointly with other producers, or by and through a stewardship organization:

(a) Notice of intent.

(1) Within six months after the effective date of this chapter, a producer shall provide written notice to the health officer of the producer’s intent to participate in a stewardship program.

ORDINANCE NO. 2016-___
(2) Within six months after the commencement of sale or distribution in the unincorporated area of the county of a covered drug manufactured by the producer, a producer that has not submitted the notice described in subsection 418-16.206(a)(1) shall submit that notice to the health officer.

(b) Identification of operator.

(1) Within nine months of the effective date of this chapter, a producer shall provide written notice to the health officer of the name of, and contact information for, a person who operates or will operate a stewardship program in which the producer intends to participate.

(2) Within nine months of commencement of sale or distribution in the unincorporated area of the county of a covered drug manufactured by the producer, a producer who has not submitted the notice described in subsection 418-16.206(b)(1) shall submit that notice to the health officer.

(c) Notification to retail pharmacies and law enforcement.

(1) Within nine months after the effective date of this chapter, a producer shall provide written notices to all retail pharmacies located in the county and all law enforcement agencies with jurisdiction in the county of the opportunity to participate as collectors. The notice must explain the process for entering into an agreement to participate in the stewardship program.

(2) Within nine months of commencement of sale in the unincorporated area of the county of a covered drug manufactured by the producer, a producer who has not provided the notices described in subsection 418-16.206(c)(1) shall provide those notices to the designated recipients.

(3) Annually after providing the notices required under subsections 418-16.206(c)(1) or 418-16.206(c)(2), a producer shall provide the same notices to all nonparticipating or new retail pharmacies located in the county.

(d) Plan submission; fee.

(1) Within one year after the effective date of this chapter, a producer shall submit to the health officer a stewardship plan that conforms to the requirements set forth in section 418-16.208, together with payment of a fee established by the board by resolution.

(2) Within one year after commencement of sale in the unincorporated area of the county of a covered drug manufactured by the producer, a producer who has not submitted a stewardship plan under subsection 418-16.206(d)(1) shall submit to the health officer a stewardship plan that conforms to the requirements set forth in section 418-16.208, together with payment of a fee established by the board by resolution. If a producer seeks to participate in an existing approved stewardship program in lieu of commencing a new stewardship program, the plan required by this subsection must be an amended stewardship plan, and the amended stewardship plan must be submitted by all of the producers identified in the amended plan.

(e) Plan implementation.

(1) Except as set forth in subsection 418-16.206(e)(2), within 90 days after the health officer’s approval of a stewardship plan under subsection 418-16.210(b), a producer shall implement the plan by commencing operation of the stewardship program described in the plan. Commencement of operations of an approved stewardship program must include:

(A) Establishment of the drop-off sites and mail-back services identified in the approved stewardship plan.

(B) Public notice of the availability of unwanted covered drug collection services through postings at collection sites and advertising in local media.

ORDINANCE NO. 2016____
(2) Changes to an approved stewardship program that are set forth in an amended stewardship plan that has been approved by the health officer under subsection 418-16.212(a)(1) must be implemented by the participating producer(s) within 10 business days after the approval.

(f) Program participation. A producer shall participate in an approved stewardship program by providing for the continued operation of an approved stewardship program in accordance with an approved stewardship plan. (Ord. 2016-___ § 4).

418-16.208 Content of stewardship plans.
A stewardship plan must fully describe a stewardship program. The plan must include all of the following:

(a) Identification of and contact information for each participating producer.
(b) Identification of and contact information for the person who will operate the stewardship program.
(c) Description of a collection system that conforms to Section 418-16.214(a), including a list of all collection methods and collectors, a list of drop-off sites, a description of how any periodic take-back events will be scheduled and located, a description of how mail-back services will be provided and an example of the prepaid, preaddressed mailers that may be used.
(d) Description of a system for transporting and disposing of the collected unwanted covered drugs that conforms to section 418-16.216, including identification of, and contact information for, transporters and disposal facilities to be used.
(e) Description of the policies and procedures to be followed by persons handling collected unwanted covered drugs, including a description of (1) how the collected unwanted covered drugs will be safely and securely tracked from collection through final disposal; (2) how all persons participating in the stewardship plan will comply with all applicable federal and state laws, rules and guidelines, including but not limited to those of the U.S. Drug Enforcement Administration and State of California Board of Pharmacy.
(f) Description of measures reasonably calculated to result in the use by county residents of the collection services to be offered under the stewardship program, such as public education and promotional materials, signage, standardized instructions and establishment of a toll-free number and website where collection options may be publicized.
(g) The short-term and long-term goals of the stewardship program in terms of collection amounts, education, and promotion.
(h) Description of how the stewardship program will consider:
   (1) Use of existing providers of pharmaceutical waste services;
   (2) Separation of covered drugs from packaging to the extent feasible to reduce transportation and disposal costs; and
   (3) Recycling of drug packaging to the extent feasible. (Ord. 2016-___ § 4).

418-16.210 Inspection, approval and rejection of stewardship plans.
(a) Upon submission of a stewardship plan, the health officer will inspect it for the purpose of determining whether it satisfies the requirements set forth in section 418-16.208.
(b) Within 90 calendar days after submission of a stewardship plan, the health officer will either approve or reject the plan. If the plan conforms to the requirements set forth in section 418-16.208, the health officer will approve the plan and provide written notice to the producer of the approval.

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(c) If the health officer rejects a stewardship plan, the health officer will provide to the producer written notice of the rejection that includes the reasons for the rejection.

(d) Within 60 calendar days after the date of the written notice of rejection of a stewardship plan for a new stewardship program, the producer shall submit to the health officer a revised stewardship plan that conforms to the requirements set forth in section 418-16.208, together with payment of a fee established by the board by resolution.

(e) If the health officer rejects a revised stewardship plan, each producer identified in the plan is in violation of this chapter and will remain in violation of this chapter until the producer commences participation in an approved stewardship program. (Ord. 2016-____ § 4).

418-16.212 Changes to existing stewardship programs; new programs.

(a) Changes.

(1) Substantive changes may be made to an existing approved stewardship program only with the prior written approval of the health officer. Substantive changes include changes in the location, number or operating hours of drop-off sites or periodic take-back events; changes in collection methods; changes in mail-back service procedures; changes in the policies or procedures to be followed by persons handling collected unwanted covered drugs; changes required in response to federal, state or local laws or regulations; and changes in stewardship program operators or participating producers. Except as set forth in subsection 418-16.206(d)(2), the participating producers identified in the approved stewardship plan shall submit any proposed substantive changes to the health officer in the form of an amended stewardship plan, along with a written explanation of the change(s) and payment of a fee established by the board by resolution. The health officer will approve an amended stewardship plan if it conforms to applicable requirements set forth in section 418-16.208. If an amended stewardship plan submitted to the health officer under this section is rejected by the health officer for non-conformance with the applicable requirements set forth in section 418-16.208, the approved stewardship program may continue to operate in accordance with the approved stewardship plan.

(2) The following non-substantive changes to an approved stewardship program may be made only with 20 days advance written notification by the program operator to the health officer: Changes in location of a collection kiosk within a retail pharmacy; changes in methods of distribution of prepaid, preaddressed mailers used for the mail-back of unwanted covered drugs; changes in contact information for the program operator and participating producers; and changes in the system described in Subsection 418-16.208(d).

(3) Other than the changes described in subsections 418-16.212(a)(1) and 418-16.212(a)(2), changes may be made to an approved stewardship program without the prior approval of or notification to the health officer.

(4) An approved stewardship plan that is changed in accordance with this section will be deemed an approved stewardship plan. An approved stewardship program that is changed in accordance with this section will be deemed an approved stewardship program.

(b) New programs. After implementation of an approved stewardship program, a participating producer may propose the formation of a new stewardship program by submitting to the health officer a stewardship plan that conforms to the requirements set forth in section 418-16.208, together with payment of a fee established by the board by resolution. (Ord. 2016-____ § 4).

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418-16.214 Collection of unwanted covered drugs.
(a) Collection system requirements. A stewardship program's collection system must meet all of the following requirements:

1. Provide safe and secure collection services within the unincorporated area.
2. Provide for the operation of at least three drop-off sites in each supervisorial district for the collection of unwanted covered drugs, in locations that allow for convenient and equitable access by residents of the unincorporated areas of those districts, to the greatest extent feasible. If providing for the operation of at least three drop-off sites is not feasible in a supervisorial district, a stewardship program's collection system must provide for the operation of as many drop-off sites in the district as is feasible, in addition to both of the following methods of collection of unwanted covered drugs:
   (A) A free mail-back service that allows for convenient and equitable access by all county residents in the district.
   (B) Periodic take-back events that are at least six hours in length and held once per quarter of each calendar year in at least three locations in the district.
3. Give preference to having retail pharmacies and law enforcement agencies serve as collectors.
4. Include, as collectors, any retail pharmacy or any law enforcement agency that offers to serve as a collector of unwanted covered drugs and is able to meet the requirements of this chapter within three months of the offer.
5. Make available free mail-back services to county residents who are disabled or homebound, in a manner that allows for convenient and equitable access to these services by these persons.

(b) Collector requirements.

1. A collector shall operate a drop-off site in accordance with this chapter and all applicable state and federal laws and regulations applicable to the handling of covered drugs.
2. A collector shall accept all unwanted covered drugs from county residents during all hours that the collector is normally open for business.
3. A collector that is not a law enforcement agency shall utilize secure collection bins in compliance with all applicable legal requirements.

(c) Commencement. The collection of unwanted covered drugs under a stewardship program under this chapter may commence only after the stewardship plan under which the program will operate has been approved by the health officer.

(d) Nothing in this chapter shall be construed to require any person or government entity to serve as a collector under a stewardship plan. (Ord. 2016-___ § 4).

418-16.216 Transport and disposal.
(a) All unwanted covered drugs that are collected under an approved stewardship program must be transported only by a person who operates under all required permits and licenses.

(b) All unwanted covered drugs that are collected under an approved stewardship program must be disposed of only at a medical waste facility or hazardous waste facility that operates under all required permits and licenses. (Ord. 2016-___ § 4).
418-16.218 Reporting.
Within six months after the end of the first 12-month period of operation of an approved stewardship program, and annually thereafter, the program operator shall submit a report to the health officer that details the following information about program operations during the reporting period:
(a) A list of all participating producers.
(b) The weight of all unwanted covered drugs collected, including the weight of unwanted covered drugs collected using each collection method utilized in the program.
(d) A list of all drop-off sites.
(e) The number of mailers provided to county residents.
(f) The locations where mailers were provided, if applicable.
(g) The dates and locations of collection events held, if applicable.
(h) A list of all transporters used.
(i) A list of all facilities to which the collected unwanted covered drugs were transported.
(j) Any safety or security problems that occurred during collection, transportation or disposal of unwanted covered drugs, and changes made or proposed to alleviate those problems.
(k) A description of all public education and promotion activities.
(l) A description of how collected packaging was recycled to the extent feasible; including identification of the recycling facilities used.
(m) A discussion of the degree of success in meeting the short- and long-term goals of the approved stewardship program, and to the extent goals were not met, plans to achieve those goals in the next reporting period.
(n) Total expenditures of the approved stewardship program. (Ord. 2016-___ § 4).

418-16.220 Costs and fees.
(a) The administrative and operational costs of an approved stewardship program will be the sole responsibility of the participating producer(s), except as set forth in subsection 418-16.220(c).
(b) No person may charge a point-of-sale fee or point-of-collection fee to recoup any costs of an approved stewardship program.
(c) Nothing in this chapter shall be construed to require a producer to pay for staff time provided by collectors who agree to participate in an approved stewardship program.
(d) Revenues from fees paid under this chapter may be used only to pay for the costs incurred by the health officer in the performance of investigations, inspections and audits under this chapter and the administrative enforcement and adjudication thereof. (Ord. 2016-___ § 4).

418-16.222 Audits, inspections and investigations.
(a) Audits. The health officer may audit the records of stewardship program for the purpose of enforcing the provisions of this chapter. Upon request of the health officer, the operator of the program shall provide the health officer with access to perform audits of the program’s records at reasonable times.
(b) Inspections and investigations. Whenever it is necessary to inspect a drop-off site or other property to enforce the provisions of this chapter, or whenever the health officer has cause to believe that there exists on any property any violation of this chapter, the health officer may enter the property to inspect and gather evidence or perform the duties imposed on the health

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officer by this chapter. Entry may be made at any reasonable time upon advance notice to the owner or occupant of the property. If entry is refused, the health officer is authorized to proceed pursuant to Code of Civil Procedure section 1822.50 and following, and pursue any and all other remedies provided by law, to secure entry. (Ord. 2016-____ § 4).

418-16.224 Enforcement.
(a) The health officer will enforce the provisions of this chapter.
(b) If the health officer determines that any person has violated any provision of this chapter, the health officer shall provide written notice of the violation to the person who violated it and provide an opportunity to the person to cure the violation before the health officer takes any other enforcement action authorized by this code. The person shall have 30 calendar days after receipt of the notice, or other time agreed to in writing by the person and the health officer, to correct the violation. (Ord. 2016-____ § 4).

418-16.226 Regulations.
The health officer may propose regulations to make more detailed or specific the provisions of this chapter. The regulations are not effective unless adopted by the board by resolution. Effective regulations will be deemed incorporated into this chapter by this reference. (Ord. 2016-____ § 4).

SECTION V. EFFECTIVE DATE. This ordinance becomes effective 30 days after passage, and within 15 days after passage shall be published in the East Bay Times, a newspaper published in this County. This ordinance shall be published in a manner satisfying the requirements of Government Code section 25124, with the names of the supervisors voting for and against it.

PASSED on _________________, by the following vote:

AYES:
NOES:
ABSENT:
ABSTAIN:

ATTEST: David J. Twa, Clerk of the Board of Supervisors and County Administrator

By: ____________________________________________  __________________________
     Deputy  Board Chair

[seal]

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ORDINANCE NO. 2016-____
Killer CMS Preparedness Timeline

Time is Ticking

Healthcare providers and suppliers are now required to meet the new CMS preparedness regulation; they have one year to implement the rule. For some providers, such as hospitals who have participated in emergency preparedness activities through professional accreditation and grant participation this new regulation implementation period is not as daunting. Many hospitals have engaged in comprehensive emergency management planning, performing risk assessments, training personnel and exercising their response plans for years.

But if your facility is one of the 17 provider types that have not been historically required to engage in preparedness activity through grant programs or professional accreditation, this new regulation presents a formidable challenge to your organization; you must develop a comprehensive emergency management program in one year- not an easy task.

Consequences for Non-Compliance
From the CMS Preparedness Rule FAQ:

Providers/suppliers have one year to implement the emergency preparedness requirements. Surveying for compliance to these requirements will begin in November 15, 2017. There will be no exceptions for the requirements and non-compliance will follow the same process noncompliance with any other Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) for the facility at hand.

Looks clear to me that there will be no exceptions to adopting the new preparedness regulation. So now is the time to take action. The first step in developing a comprehensive emergency management program is to organize this task into a project timeline so you can work from a progress driven roadmap that will get you into compliance before your destination deadline of November 16th 2017.

**Build Your Project Timeline**

I have used this effective and easy to implement step by step process for building new emergency preparedness programs for years. It’s a time sensitive, aggressive, outcome focused building block approach designed to quickly create an emergency preparedness and response system in a short amount of time. It will take deliberate, committed action to progress through the milestones established in the project timeline to get your program up and running by the deadline.

Although this timeline is linear in nature, there is always room for modification and redirection if moments of opportunity present themselves that will assist you in meeting the specific core elements of the regulation. For instance, my standard process for building the foundation of an emergency management program is Assess-Plan-Train-Test.

This model is reflected in chronological order in the timeline. I recommend that you should develop a plan before you train on the plan. But if your facility has an opportunity to participate in training and/or testing-exercising your plans without them being fully developed, go to the training or disaster exercise and get the experience of learning emergency response through those activities. If you feel the experience resulted in adequate attainment of skills and best practices, document such experiences for validation and verification in meeting CMS Preparedness Rule requirements.
Assemble an Implementation Team- Nov. 16th 2016

Depending on your organization’s current preparedness posture there are three possible strategies to employ when assembling an implementation team.

1. If this is your first rodeo at the preparedness ranch and you have little experience in developing an emergency management program, you should take the approach of totally leaning on best practices, preparedness systems and communities already in place. Seek wisdom beyond the four walls of your institution and get mentors to help you put together your program.

2. If your healthcare facility has been engaging in meaningful preparedness activity throughout the last several years, the focus should be on making sure all your satellite business occupancy providers are now included in the integrated healthcare system’s plan. I would utilize current emergency management committee members and influencers to develop new processes to integrate the four core elements of the CMS Preparedness Rule into existing plans.

3. A hybrid model considers using outside partners, vendors, state and local response officials coupled with organizational human capital to usher the project to completion. This model may make sense for both small and large institutions with both foundational and more experienced teams that are charged with this tasking.

The bottom line is, work with whom you have. If you are a small independent Home Health Agency or a sparsely staffed Religious Non-Medical Institution you may be the sole person responsible for getting your facility up to speed with meeting the new regulations. Don’t be discouraged, you can do this thing!

Start Documentation Review- November 16th 2016

The Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers regulation is 651 grueling pages. The
beginning is essentially pages of responses to suggestions and inquiries that were captured during the public comment period. The middle section details estimated costs associated with implementing the rule within provider sectors. The last 50 pages is dedicated to the breakdown of the individual rule requirements for each provider type. Find your provider type and read the requirements carefully. The core elements are essentially the same but there is distinction regarding conducting testing and some variance in infrastructure mitigation and preparation.

The following links serve as a good starting point for documentation review:

- 17 Facility- Provider Supplier Types Impacted [PDF, 89KB]
- EP Rule - Table Requirements by Provider Type [PDF, 126KB]
- Frequently Asked Questions (FAQs) Round One [PDF, 312KB]
- Frequently Asked Questions (FAQs) Round Two [PDF, 32KB]
- CMS Preparedness Rule Page
- ASPR TRACIE CMS Rule Page

**Start Assessment- December 16th 2016**

After you have reviewed all the essential documentation it’s time to conduct an initial assessment to capture critical information about your organization, the environment in which it operates and what is required to provide uninterrupted patient care, protect property and support the health, welfare and resilience of your staff during disasters and emergencies.

There is existing hazard vulnerability and risk assessment data available through your county emergency management agency, state health department and regional healthcare preparedness coalitions.

The following links serve as a good starting point when initiating preparedness assessments:

- TRACIE Topic Collection: Hazard Vulnerability & Risk Assessment
- Organizational Resilience: Security, Preparedness & Continuity Management Systems
- California Hospital Association: Hazard Vulnerability Analysis Tool
Start Emergency Plan/Policy/Procedures/Communications Plan
Development- January 16th 2017

CMS is directing providers to develop a plan based on a risk assessment using an “all hazards” approach, which is an integrated approach focusing on capacities and capabilities critical to preparedness for a full spectrum of emergencies and disasters. The plan must be updated annually.

CMS is also directing providers to develop and implement policies and procedures based on the emergency plan, risk assessment, and communication plan which must be reviewed and updated at least annually.

In addition to emergency plans, policies and procedures, CMS is directing providers to develop and maintain an emergency preparedness communication plan that complies with both federal and state laws. Patient care must be well coordinated within the facility, across health care providers and with state and local public health departments and emergency systems. The plan must include contact information for other facilities and a method for sharing information and medical documentation for patients.

The following links serve as a good starting point for emergency planning:

- TRACIE Topic Collection: Communication Systems

Start Training- March 16th 2017

It’s time to start training your team. Trainings can cover a wide range of topics including clinical subject matter, communicating during a disaster, patient evacuation and employee safety. There are free training opportunities available in your community and online. Contact your regional healthcare coalition and/or your state health department to find out more information about available training opportunities.
The CMS Preparedness Rule outlines the following requirements for preparedness training:

- Provide initial training in preparedness policies and procedures to all new and existing staff.
- Provide initial training to individuals providing services under arrangement and volunteers consistent with their expected roles.
- Make sure you capture and maintain documentation of all emergency preparedness training.

The following links serve as a good starting point for training resources:

- TRACIE Topic Collection Incident Management Training
- FEMA Independent Study Program

**CMS Preparedness Rule Interpretive Guidance Release- April 16th 2017 (Estimated)**

The interpretive guidance to support this rule and the associated state operations manual will be released in the Spring of 2017. I recommend not to wait for the interpretive guidance to be released before you start developing your program. You may have to modify some of your plans or reconsider a few planning processes but I do not anticipate the release of the interpretive guidance will cause any major course correction to the work you have already accomplished.

**Start Testing/Exercise Development- May 16th 2017**

CMS is requiring all 17 provider types to develop and maintain testing programs. Types of exercises will vary among some providers. Most providers will need to conduct one full-scale exercise that is community based at least annually. Most providers must conduct either an additional facility based full-scale exercise or a facilitated table-top exercise. Refer to this table to see what specific testing requirements your provider type needs to accomplish.

The following links serve as a good starting point for researching testing and exercising:

- TRACIE Topic Collection Exercise Program Design, Evaluation & Facilitation
- HSEEP Preparedness Toolkit

**1st Facilitated Table-Top Exercise (TTX)- June 16th 2017**
If your organization is new to preparedness you may want to conduct a facilitated paper-based table-top exercise (TTX) first. A tabletop exercise involves key personnel discussing simulated scenarios in an informal setting. TTXs can be used to assess your newly created emergency plans, communication plans and policies, and procedures.

Providers who are Religious Non-Healthcare Institution’s (RNHCI) and Organ Procurement Organization’s (OPO) only need to conduct a paper based table-top exercise annually. All other providers must conduct an annual community based full-scale exercise plus either an additional facility based full-scale exercise or a facilitated table-top exercise.

1st Full-Scale Exercise (FSE) with After-Action Report (AAR)-September 16th 2017

Unless you are a RNHCI or an OPO, you must conduct at least one community based full-scale exercise. The goal of the “community” provision is to ensure that healthcare providers collaborate with other entities within a given community to promote an integrated response.

A health care full-scale exercise is a multi-discipline exercise involving many functional areas operating at your healthcare facility. It’s a “soup to nuts” type of exercise where your facility is testing every aspect of its operation from patient care and medical transport to communicating with outside partners and officials and maintaining resiliency of building systems.

Develop an after-action report (AAR) and improvement plan (IP) that incorporates lessons learned from the exercises and a follow-up process too, including steps to take to improve your plans, policies and procedures.

Refer to the links in the exercise development section of this article to get more information on how to develop and conduct a full-scale exercise.
Final Plans Concurrence- October 16th 2017

By this time, you have conducted assessments, developed plans, policies and procedures. Exercise development has taken place, you conducted both a TTX and a FSE, you are in the homestretch for your first year of preparedness activity!

Now it’s time to ready your preparedness program for certification and survey. The State Survey Agencies (SA), Accreditation Organizations (AOs), and CMS Regional Offices (ROs) will be involved in monitoring for compliance as is the case with all other requirements for participation in Medicare. Facilities may choose to work with local health and emergency management officials to review the facility's plan to meet local requirements. The facility has the option of choosing to seek approval of its plan from state/local emergency preparedness officials. Facilities may also utilize the services of contractors to review their final plans. Your regional health care coalition may be able to assist in concurring final plans and procedures.

You Can Do This!

In my 26 years in emergency management and business continuity, this is the most exciting time to be a preparedness professional. We have never had far reaching regulatory authority to mandate healthcare preparedness activity for providers. Although there may be a significant burden and challenge bestowed on some of our provider types to meet these new requirements, we can expect an increase in patient care and staff safety as a direct outcome of these new regulations.

If you follow this building block approach to comprehensive emergency management and implement this step-by-step method to create a robust healthcare disaster response system, your organization will meet the new CMS Preparedness Rule requirements way beyond the scope of compliance.

I guarantee it!