



REGION VII

DISASTER HEALTH
RESPONSE ECOSYSTEM

End-of-Year Report

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Executive Summary

The ongoing COVID-19 pandemic continues to highlight the vulnerability of our communities in the face of large-scale health emergencies. Creating a resilient society begins with more flexible, scalable, and sustainable health systems at the local and regional level. During its third year of existence, the Region 7 Disaster Health Response Ecosystem (RDHRE) remained on the front lines of the battle against COVID-19, improving information sharing, coordination, and best practice implementation for state and regional response and assessing lessons learned. At the same time, R7DHRE continued to develop the concept of its health preparedness matrix of Themes and Enablers, designed to create innovative approaches for a whole-of-community approach for a sustainable preparedness ecosystem. This annual report details Year 3 achievements and sets the course for continued progress in Year 4 and beyond.

In the current pandemic emergency, R7DHRE's primary focus has remained to improve coordination, expand information sharing, and provide novel system solutions for health system and community response to COVID-19. Several accomplishments in this space warrant particular highlighting. R7DHRE efforts to establish, maintain, and evolve a medical emergency operations center (MEOC) dramatically improved information sharing and coordination for COVID-19 response in Nebraska and provided a model for effective implementation across the region. Combined with twice-weekly information-leveling calls, these efforts routinely bring 250-300 stakeholders to share real-time updates, troubleshoot impending problems, and develop best practices for response. In orchestrating the formation of Region 7 Pediatric COVID-19 Surge Group, R7DHRE brought together regional pediatric care specialty hospitals and subject matter experts (SMEs) to address pediatric referral and transport issues affecting rural hospitals facing surging pediatric COVID-19 cases. As the coordinating hub for a collaborative pilot project with the Office of the Assistant Secretary for Preparedness and Response (ASPR), R7DHRE was able to facilitate expanded access to COVID-19 monoclonal antibody (mAb) therapeutics in long-term care residents and other high-risk communities in the state of Nebraska. As a result, Nebraska had one of the highest mAb utilization rates in the country and had a significantly reduced rate of hospital admission and death compared to baseline. The R7DHRE team also led the development of the first crisis standards of care (CSC) for the state of Nebraska. Finally, the project continued to build on its success with the Knowledge Center information sharing platform enabling COVID-19 response, expanding reach and focusing on evolution to a more integrated regional capability that will begin to interface more with additional data from health information exchanges and other sources.

While principally focused on pandemic response, R7DHRE continued to take major strides forward in developing the Themes and Enablers that constitute the center of its long-term approach to preparedness. A strong partnership with Region 1 DHRS explored new ground in forming actionable metrics and assessment for health system and community preparedness and response. R7DHRE expanded regional engagement with specialty care resources and advanced development of response teams. The team enlarged its scope of engagement with community and volunteer organizations active in disaster response. Additional tools were brought to bear for regional information leveling and coordination across sectors. The Economic Incentives Working Group formulated a comprehensive set of white papers to outline a roadmap to regional and national sustainable funding models. Finally, R7DHRE partnered with the Region 1 and

Region 8 teams to provide generalized guidance and models to expand regional systems disaster health preparedness and response.

As R7DHRE moves into its fourth year, we will continue to address regional needs for pandemic response while developing long-term solutions for sustainable and adaptive readiness for health emergencies. More than ever, the nation needs novel solutions and systems to reduce morbidity and mortality and sustain economic and societal function in the face of large-scale health emergencies. R7DHRE will continue to work with its sister RDHRS programs to define the future of health security for the nation.

Introduction

The Nebraska Regional Disaster Health Response Ecosystem (NRDHRE) project was launched in October of 2018 to address recognized gaps in health system ability to respond to large-scale public health emergencies and disasters. The long-term goal of this project is to develop a self-sustaining ecosystem for regional healthcare preparedness, capable of leveraging public and private resources both inside and outside of traditional healthcare delivery organizations in response to disasters and public health emergencies. In Year 2 of the grant, the project broadened scope beyond the borders of Nebraska to advance regional expansion and has thereafter been called the Region VII Disaster Health Response Ecosystem (R7DHRE).

This report conveys progress made in the third year of the grant. Efforts were organized around a set of Themes and Enablers established to provide pathways toward a sustainable ecosystem of preparedness that leverages a whole-of-community response. The R7DHRE envisions a journey to a sustainable ecosystem of healthcare preparedness that reengineers health system actions and coordination during response, taps into the vast human capital and logistical resources of non-traditional responders, and provides economic incentives to weave preparedness into the fabric of community. In combination, the Themes and Enablers that drive R7DHRE efforts address the capabilities and objectives outlined in the project's funding opportunity announcement by the Assistant Secretary for Preparedness and Response (ASPR) within the U.S. Department of Health and Human Services.

R7DHRE successes during COVID-19 response demonstrate how a regional health system network, centered on a hub with extensive expertise and resources, can enhance the capability of communities to manage health emergencies. Year 3 efforts built upon lessons learned during the first 9 months of COVID-19 and additional progress made in Year 2, expanding regional capacity and capability for managing the pandemic while renewing focus on strategies to advance all-hazards emergency preparedness and response. Increased collaboration with other RDHRS sites in Region 1 and Region 8 offered sharing of best practices and lessons learned to continue the development of a robust, coordinated network of RDHRS sites across the U.S.

Continued Pandemic Focus

Continued COVID-19 Response Efforts

The R7DHRE project moved into Year 3 with a continued focus on COVID-19 mitigation and response while renewing focus on the program's original Year 3 strategies to advance regional all-hazards preparedness and response.

The R7DHRE Medical Emergency Operations Center (MEOC) continued to serve as a primary convener to organize COVID-19 response efforts across the Nebraska's healthcare sector and as a coordinating function with public health. The MEOC organized working groups focused on targeted issues including integration of Nebraska Hospital Transfer Center data, movement of long-term care patients boarding in acute care hospitals, development of crisis standards of care, tracking of COVID-19, and overall hospital census and load-balancing strategies as the fall/winter surge in late 2020 and early 2021 occurred in the state.

In several regional webinars and meetings, R7DHRE leadership shared the model of the Nebraska MEOC and lessons learned from implementation to foster enhanced regional capability. The National Association of County & City Health Officials (NACCHO) Prep Summit and the ASPR Project Echo Rounds offered additional opportunities for R7DHRE team members to share information on the Nebraska MEOC. The R7DHRE presentation centered on MEOC structure and the roles and responsibilities of the organizations contributing to the MEOC.

Multi-state and Regional Partnership for Disaster Health Responses

R7DHRE convened a broader regional congregation of hospital associations, healthcare coalition (HCC) leaders, and public health state leaders and federal response personnel to share best practices and challenges related to COVID-19 medical surge response. R7DHRE's successes in the COVID-19 response have demonstrated how a regional health system network with extensive expertise and resources can enhance the capability of communities to manage health emergencies.

As regional stakeholders continue to find new ways to collaborate and coordinate, lessons learned have contributed towards continued advancement in all-hazard emergency preparedness and response. For example, a group representing 11 pediatric facilities in Region 7 (Figure 1) was formed to address issues specific to this population.

Region VII Pediatric Teams

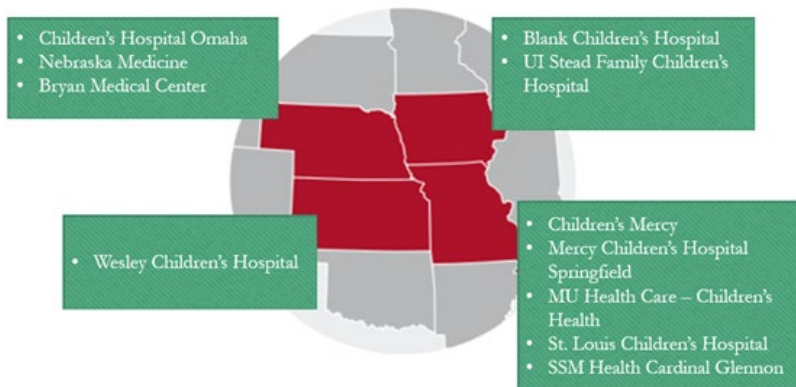


Figure 1. Pediatric facilities in Region 7

Pediatric-specific response aids were compiled and posted on the R7DHRE website to provide just-in-time resources for facilities that traditionally do not take pediatric patients. Likewise, resources were collected, organized, and added to the website to assist in a multitude of scenarios related to disaster response (Figure 2). Moreover, as COVID-19 cases surged in Fall 2020, working groups were organized to connect transfer centers in the region. A transport team working group met (and continues to meet) twice per month to identify best practices and share staffing and education strategies. In Year 4, this working group plans to outline a long-term plan of action to build pediatric regional capabilities and capacity.

Welcome to the Region VII Disaster Health Response Ecosystem

Quick Links



Figure 2. Homepage of the R7DHRE website <https://regionviidhre.com/>

Long Term Care Monoclonal Antibody Pilot

Long-term care facility (LTCF) residents are at increased risk of severe COVID-19. The BLAZE-1 trial found lower hospitalization rates in high-risk patients receiving monoclonal antibody (mAb) vs placebo (4.2% vs 14.6%) for mild to moderate infections,¹ indicating a

¹ Chen P, Nirula A, Heller B, et al. SARS-CoV-2 Neutralizing Antibody LY-CoV555 in Outpatients with Covid-19. *N Engl J Med.* 2021;384(3):229-237. doi:10.1056/NEJMoa2029849

promising treatment option for LTCF residents; however, many LTCFs lack staff to prepare and administer mAb therapy. To address this need, R7DHRE coordinated an ASPR pilot project via the Nebraska MEOC to facilitate infusion of COVID-19 mAb therapeutics for LTCF residents in the state.

R7DHRE collaborated with Great Plains Health, Nebraska Department of Health and Human Services (DHHS), Nebraska Antimicrobial Stewardship Assessment and Promotion Program (ASAP), and Infection Control Assessment and Promotion Program (ICAP) to surveil cases in the state, establish distribution/administration pathways, and educate providers on mAb therapeutics. A multi-hub-and-spoke model was created to allow LTCFs to work with regional hospitals or pharmacy services to administer drug in their facilities, reducing time to therapy and transmission risk associated with patient transport. A centralized request process was created using a REDCap platform and verification of patient eligibility by ASAP. The request link, informational documents, fact sheets, and custom-built order form templates were hosted on a dedicated ASAP webpage, and details were shared during weekly ICAP LTCF webinars.

Outcomes data, including 14 and 28-day COVID-related hospitalizations and mortality, were collected using databases from Nebraska Health Information Initiative and Nebraska DHHS. Through this program, 513 doses were administered to LTCF residents. Average time from symptom onset to infusion was 2.6 days. COVID-related hospitalization and mortality rates were lower than previously reported for LTCF residents (Table 1). By utilizing existing relationships with LTCFs in the region, we established a program to promptly distribute, prepare, and administer monoclonal antibody therapy to LTCF residents in need, preventing COVID-related hospitalizations and deaths. See Figure 3 for a poster from the pilot presented at ID week.

Table 1. Demographics and outcomes of monoclonal antibody infusions to Nebraska long-term care facility residents

	mAb Therapy (n=513)
Demographics	
Age, years, mean (median)	81.8 (84)
Male, n (%)	179 (34.9)
Process Measures	
Average time from symptom onset to infusion, days	2.6
Average time from positive test to infusion, days	2.6
Outcome Measures	
Hospitalizations†, all-cause, n (%)	
14-day	26 (5)
28-day	34 (6.6)
Hospitalizations†, COVID-related, n (%)	
14-day	17 (3.3)
28-day	22 (4.3)
Mortality, n (%)	
14-day	15 (2.9)
28-day	24 (4.7)
Adverse reactions reported, n (%)	4 (0.8)

† Hospitalizations include inpatient admissions and ED visits

Implementation and Outcomes of a Program to Coordinate and Administer Monoclonal Antibody Therapy to Long-Term Care Facility Residents with COVID-19

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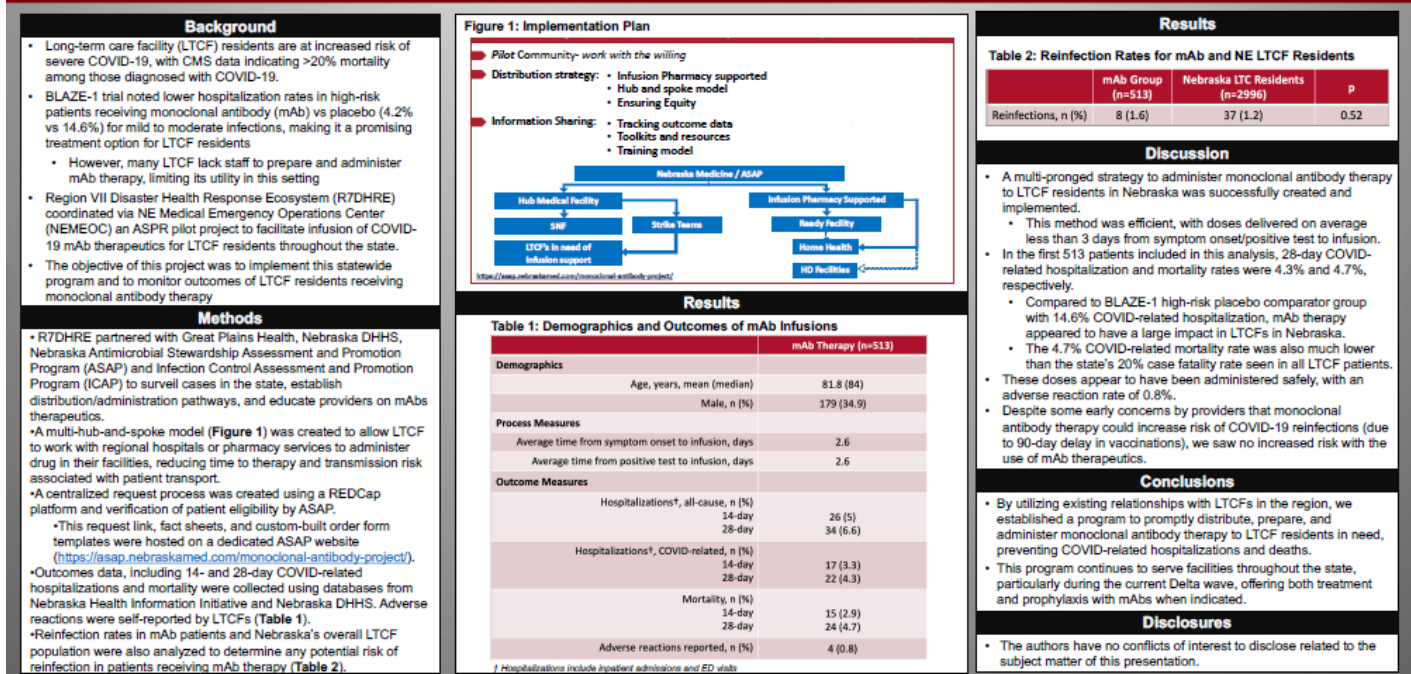


Figure 3. Poster developed with Dr. Andrew Watkins for ID Week 2021.

Medical Emergency Operations Center (MEOC)

In Year 2, in response to the COVID-19 pandemic, the R7HDRE team implemented a Medical Emergency Operations Center (MEOC) response structure to facilitate local, state, and regional information sharing, resource management, and response strategies (Figure 4). The MEOC convened Region 7 federal partners and state hospital associations, policymakers, and public health and healthcare leaders across the region. Initially established to coordinate support for the federal missions for repatriated Americans from Wuhan, China, and the Diamond Princess cruise ship in February 2020, the MEOC expanded to provide regular real-time technical expert information and updates to coalitions and public health jurisdictions throughout the first year of the pandemic.

The MEOC continued to serve as a primary convener to coordinate the COVID-19 healthcare response in the state of Nebraska and as a platform for healthcare coalition and hospital leaders to discuss issues in their regions during the first half of Year 3. The MEOC organized working groups that focused on targeted issues, including integrating Nebraska Hospital Transfer Center data, tracking of COVID-19 and overall hospital census, load-balancing strategies during the state's fall/winter surge (late 2020 and early 2021), surge staffing, and crisis standards of care guidance. As part of MEOC, the R7DHRE team conducted regular briefings to provide updates and share data and trends to healthcare and public health leaders and stakeholders across the region.

In July 2021, following a decline of COVID-19 cases in Nebraska and after the coronavirus state of emergency was rescinded, the R7DHRE MEOC stood down after eight months of serving as the primary convener and coordinator of COVID-19 healthcare response in the state. The MEOC was transitioned to the Nebraska State Public Health department under ESF8 for future needs/implementation. However, in response to increasing COVID-19 cases during the summer of 2021, the MEOC was reinstated in the final months of Year 3. The MEOC continues to meet weekly to share information regarding bed and hospital data trends, transfer center data, vaccine deployment, supply chain issues, and other urgent topics. To advance regional capability, the R7DHRE leadership has shared Nebraska's MEOC model and lessons learned in its implementation through regional webinars and meetings.



Nebraska Healthcare Surge Structure

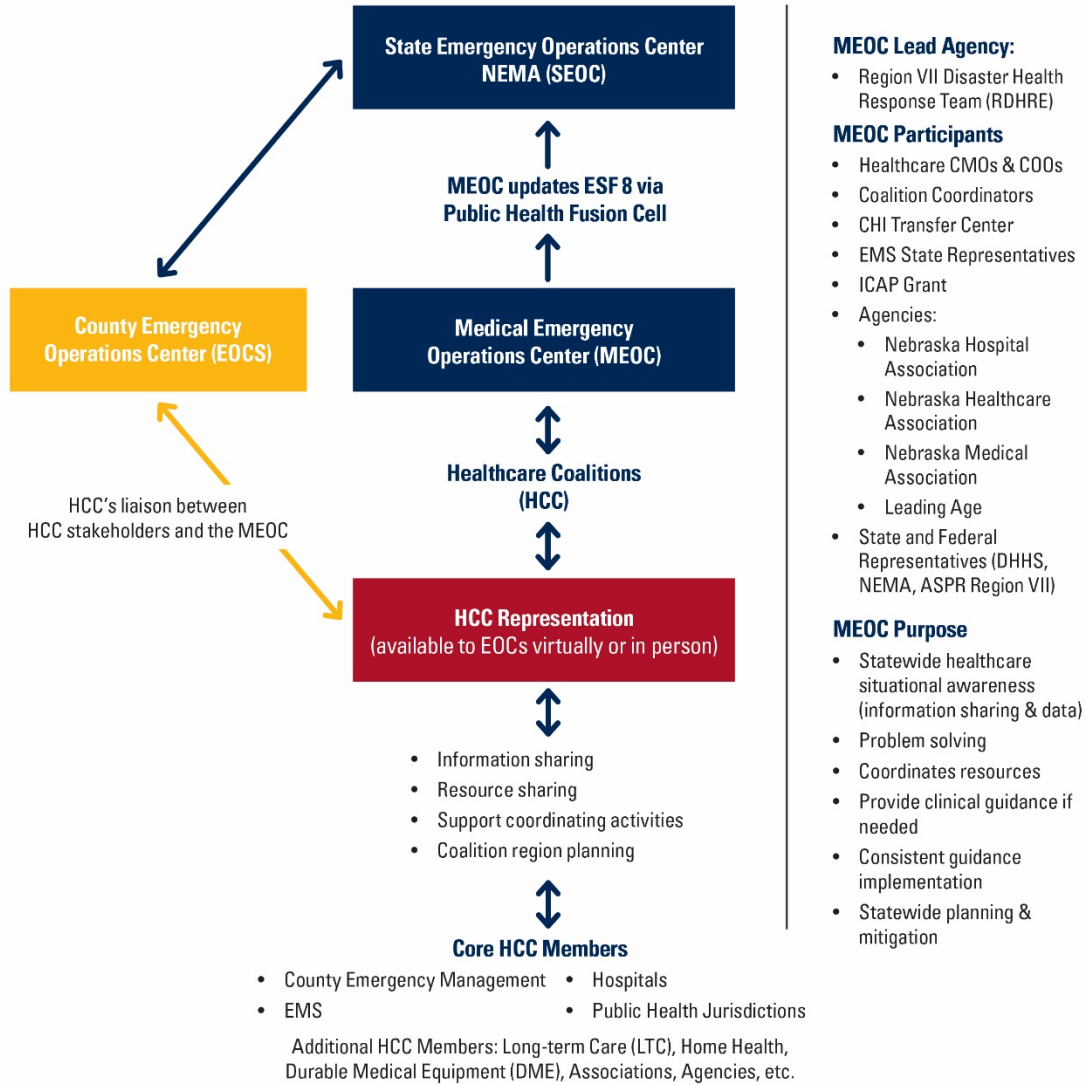


Figure 4. Nebraska Medical Emergency Operations Center (MEOC) structure and function. The MEOC concept was developed in R7DHRE Year 1 activities and was refined and implemented in response to the COVID-19 pandemic.

R7DHRE Implementation-Year 3

The focus for Year 3 centered on continued development of metrics and assessment tools, improved situational awareness through platforms to integrate primary hospital and electronic medical records, advanced concepts of economic incentives for preparedness, integrated community training and education strategies, and pilot community implementation of concepts.

The work plan objectives and activities continued to build upon the previous year's R7DHRE capabilities. The team continued to establish the Themes and Enablers (T&E) concept for a regional response ecosystem. The R7DHRE cross-jurisdictional efforts utilized successes and lessons learned from the first two years of the grant.

Matrix: Themes and Enablers Framework

R7DHRE activities in Year 3 were organized around the Themes and Enablers Framework (Figure 5). **Themes** represent goals that, when realized, create a robust regional system capable of managing large-scale and dynamic disasters and public health emergencies. **Enablers** are functional areas in which meaningful progress will increase the ability of communities and regions to implement the identified themes.

Themes:

Self-organizing Medical Response – Community-based, self-actuating disaster response systems.

Tiered Casualty Management – Adaptable system designed to expand and contract depending on the scope and nature of an incident; provides escalating levels of care while conserving resources as response dictates.

Health System Expansion – Community-focused response that expands the boundaries of traditional healthcare delivery systems, expanding first responder care and infrastructure for more definitive care.

Specialty Care Penetrance – Flexible and deployable specialty team development and other real-time information resources to meet a specialty needs incident.

Enablers:

Metrics and Assessment – A comprehensive set of foundational metrics that addresses all aspects of disaster health response and provides accurate prediction of community response.

Economic Incentives – A system of tools and resources to translate financial rewards of improved community preparedness into funding for preparedness activities; mechanisms for reimbursement, funding, or discounts as incentive for efficient and prepared community disaster response.

Local/Regional Adaptive Planning – Real-time capability to address the planning gaps and inconsistencies that could hinder or complicate a coordinated regional response.

Education, Training Standards, and Exercises – A coordinated system of trainings offered to healthcare professionals and laypersons in the community to build capacity and resiliency, supported by a robust curriculum of exercise demonstration.

Information Sharing Platforms – Multiple platforms enabled throughout the community that allow effective and widely available situational awareness during a response.

R7DHRE		THEMES			
		Self-organizing Medical Response	Tiered Casualty Management	Health System Expansion	Specialty Care Penetrance
ENABLERS	Metrics and Assessment	Community survey tools	Full-scale exercises, Local/regional plan review	Table-top exercises	Credentialing and licensing mutual agreements
		Community exercises		Site visits	Virtual consult metrics
		Real-world health response event planning			Telemedicine cost reimbursement schemes
	Economic Incentives	Business/community preparedness funds	State reimbursement mechanisms for disaster	Insurance and underwriting discounts	Telemedicine cost reimbursement schemes
			National (CMS) reimbursement proposals	Community funds	
				Novel market instruments	
	Local/Regional Adaptive Planning	Designated aid and transport stations	Hub and spoke system	Outpatient asset integration	Strike team training deployment plans
		Community/business response teams	Crisis standards of care	User managed inventor	
	Education and Training Standards	Disaster life support training requirements	Mobile training (HEROES)	HCW cross training requirements	Simulation and virtual reality training
	Information Sharing Platforms	Amateur radio teams	Knowledge Center/Juvare	Online decision support tools	Telemedicine platforms
Apps and social media tools		ASPR Med Maps integration	EMR data integration (CyncHealth)		

Figure 5. The R7DHRE matrix of themes and enablers forms the central theme of the project’s activities. Included at the intersections are representative efforts demonstrating or enhancing the concepts.

Self-Organizing Medical Response

A focus for Year 3 was to build models for enhancing individual volunteers and community volunteer organizations effectiveness in responding to large-scale disasters. At the same time, formal response structures need to be able to coordinate and create synergistic effort with spontaneous and semi-spontaneous community response. Examples of effective self-organizing response include the Cajun Navy along the US gulf coast and faith-based medical response teams in various recent hurricane and flooding disasters. Unlike traditional healthcare teams, self-organizing teams are not bound by the rigidity of a pre-defined management structure and legal framework, and individuals and teams can adapt based on the needs of the emergency. While creating a pre-defined framework for self-organizing teams would remove autonomy and defeat the foundational purpose of such teams, key elements can be explored to facilitate their development, ongoing effectiveness, and ability to augment in a traditional response environment.

Year 3 Major Accomplishments

- Background literature reviews were conducted to assess the foundational principles of self-organizing teams.
- An overview of “Distributed Network Operations” concept was prepared. Key facets of the concept include centralized command and control with decentralized operational execution; design of simple communication systems that coordinate collective behavior; and creation of simple collective behavior that responds to complex situations.
- A survey and semi-structured interview guide were developed to assess key elements and best practices of effective self-organizing teams. Both tools are pending approval by the Institutional Review Board.
- Potential interviewees were identified at the regional and national levels.

Year 4

The survey and interview guide, which have been submitted to and are under review by the UNMC Institutional Review Board, will be implemented in Year 4. Findings from the survey and semi-structured interviews will be used to identify key capabilities, commonalities, and high-risk areas that impact the effectiveness of these teams in a response; define the foundational elements of an effective, well-functioning self-organized team; and inform a guidebook for self-organizing teams in a response.

Tiered Casualty Management

The primary goal for Year 3 for Tiered Casualty Management was to understand the regional landscape through a more robust partnership with regional hospital associations, public health, and federal partners. Regular meetings were held with regional stakeholders to further define issues and solutions related to the current state of transfer centers and opportunities to improve regional load balancing efforts. A flexible model was envisioned that could coordinate patient movement from a vantage point that includes all health assets available within a geographical region.

Year 4

- Expand community preparedness efforts in partnership with Health System Expansion initiatives to ensure casualty management is built into plans and training.
- Build the framework around a flexible multilayered system that can address the needs of a healthcare system that is stressed
- Explore the concept of a regional transfer center model and data sharing requirements associated with its operation
- Support Medical Response & Surge Exercise (MRSE) planning within the region

Health System Expansion

The primary goal of the Health System Expansion (HSE) theme is to increase capability to respond to all hazards through education and training of community members and through improved coordination and incorporation of community resources. Conceptually, Health System Expansion focuses on building resilient communities and incorporating an overlooked resource of community members as part of the response body during and after a local disaster. To augment first responder capability, community member participants receive comprehensive basic education and training.

Year 3 Major Accomplishments

There were three focus areas for Health System Expansion in Year 3, each detailed below:

1. Develop a guidance document to enhance community preparedness
2. Explore community-based emergency response programs that currently exist across Nebraska and collaboration opportunities with R7DHRE
3. Expand previous trainings to include a plan of instruction for a comprehensive, tiered approach to education and training offered to community members

Guidance Document for Small Communities

A guidance document was developed to enhance community preparedness programs. Reviewed by pilot communities for its use as a “handbook” for community preparedness, it includes steps to support resiliency and a whole-of-community approach to disaster response and offers templates for a connection point between public health, healthcare, emergency management and local leadership. Figure 6 illustrates communities as the foundation of emergency preparedness

and response; however, this structure is in direct opposition to the current hierarchal structure of response. This captures the impactful change desired through the whole-of-community approach.



Figure 6. The Emergency Pyramid (Source: <http://www.readyoc.org/prepare/why-prep.html#tab-3>)

Community-Based Emergency Response Program Collaboration

To determine what programs currently exist and explore collaboration opportunities, the R7DHRE team met with the following organizations in Year 3:

- Omaha Rapid Response (ORR), a faith-based, volunteer organization of health care workers, construction workers, and emotional support volunteers that respond locally, regionally, and internationally
- New View Training, an organization that provides a full complement of medical training resources to better protect communities by training medical professionals and the general public on the skills needed to save lives
- Talacko Solutions, an organization that focuses on helping businesses, schools, places of worship, and large public facilities prepare for adverse events
- Heartland Workforce Solutions, dedicated to strengthening the Nebraska workforce and connecting people to opportunities

R7DHRE Education and Training Evolution

In disasters, outside help can take hours to days to arrive; as such, novel models of community-based response should be explored to augment the current EMS-based system which is limited in capacity. Understanding that all disasters are local, adding community members to the response capability in a community can both increase capacity to respond to a surge and save the lives of those impacted.

At the beginning of Year 3, the team engaged with emergency managers and Health Care Coalition leaders from the pilot communities to identify training gaps in their communities to

inform the development of training and education curriculum. A tiered training approach targeting community members, the healthcare sector, and organization leadership was developed, with plans to implement in Year 4. The vision for the training and education model is to be readily replicated by regional partners and easily adaptable to diverse local contexts.

A key activity in Year 3 was the development of psychological first aid training that was shared on Nebraska Medicine social media platforms, produced in collaboration with the Nebraska Psychological Association and DHHS. The Health Systems Expansion team worked with Nebraska DHHS to connect people with the resources that are available through state-funded programs for psychological support and treatment.

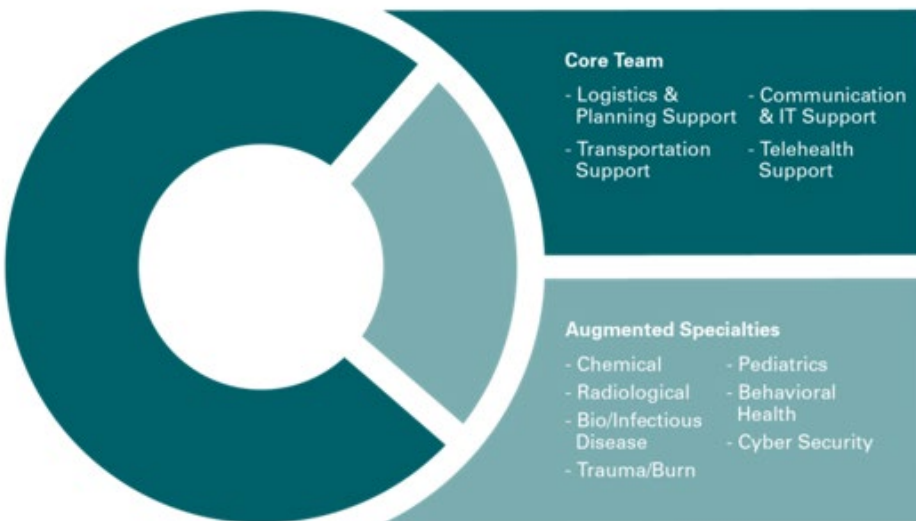
Another impactful education and training focus from Year 3 was just-in-time infusion training by R7DHRE staff to long-term care facility staff on monoclonal antibodies, which increased staff confidence of the infusion process leading to increased numbers of infusions of monoclonal antibodies in a population that otherwise might not receive the therapy due to staffing limitations. More details on this program are noted in the section on Continued Pandemic Focus.

Year 4

In Year 4, Health System Expansion will complete the plan of instruction for the tiered community-based education and training program and vet through a test pilot group for validity. To extend reach to community members, R7DHRE will build an online version of the emergency response course. The team will continue to build relationships and identify collaboration opportunities with community response partners for meaningful and impactful programs and continue to support local community and regional COVID-19 response efforts. Lastly, R7DHRE will develop a distinct scope of work and timeline of efforts for pilot communities in Year 4, as well as identifying and communicating with appropriate contacts in the communities.

Specialty Care Penetration

The specialty care penetration team focuses on development and rostering of special medical augmentation and response teams (SMART). Each team is comprised of subject matter experts for rapid deployment to a specialty-needs incident, which could include biological/infectious disease, chemical, cybersecurity, burn/trauma, behavioral health, pediatrics, and radiation. The purpose of the specialty teams is to provide consultation during disasters that require specific subject matter expertise that is either unavailable in the region or where additional help is required in overwhelming disasters. A common element, or the Core Team, will provide support to the augmenting specialty team(s) during a real-world response. The teams will have the ability to physically deploy to the area of an incident and/or provide consultation via telehealth or other virtual platforms.



Year 3 Major Accomplishments

In Year 3, the Core Team leaders further assessed the operationalization of specialty teams through Emergency Management Assistant Compact (EMAC), ESAR-VHP, and Memorandums of Understanding (MOUs). EMAC has been ratified by U.S. Congress (PL 104-321) and is law in all 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and the Northern Mariana Islands. Through EMAC, states can share resources during emergencies from all disciplines, protect personnel who deploy, and be reimbursed for mission related costs.

The **Chemical Team** has been registered as a mission ready package (MRP) within the EMAC system with tele-support and just-in-time training (JIT) as their core capabilities. The Core Team has begun identifying and drafting the logistical and equipment requirements to add physical deployment as a capability for this team. The mission ready packages (MRP) paperwork for the **Radiological Team** has been drafted to be uploaded into EMAC. More details about the Chemical and Radiological teams are detailed in their respective sections below. Core Team leads have worked with the other specialty teams to further develop their concepts of operation (CONOPs) and register the teams as MRP within the EMAC system.

Core team progress in Year 3 also included hosting meetings with the American Red Cross and American Blood Bank to discuss the mobilization of blood products during disasters. The intent of these meetings was to understand what capabilities already exist and how they might be leveraged, as well as to discuss new and innovative concepts and opportunities for collaboration.

The Core Team participated in specialty team meetings with both Massachusetts General Hospital (Region 1) and the Mountain Plains Regional Disaster Health Response System (Region 8) to share information and align plans. These meetings have allowed the sites to:

- Discuss, compare, and contrast the specialty team concepts that have been developed. The differing geographies (urban vs. rural) of the states were identified as a key influential factor in the conceptual frameworks that have been developed.
- Share information and align plans. These meetings have allowed the sites to share several different products, exchange ideas, and improve efficiency in the development of the specialty teams.
- Discuss the legal considerations and challenges related to deploying specialty teams to expeditiously operationalize these teams with the appropriate liability coverage and credentialing considerations.

Year 4

Collaboration and coordination with RDHRS programs in Regions 1 and 8 will continue in Year 4. This will include providing consultation and sharing information on the R7DHRE's approach to the HPP burn exercises, detailed in the section on Burn/Trauma Specialty Team.

Biological Specialty Team

The Biological and Infectious Diseases Specialty Response Team (BIDSRT) is comprised of subject matter experts in infectious diseases, biocontainment patient care, special pathogens, infection prevention and control, and emergency management. The team has established relationships with the CDC, the Nebraska Department of Health and Human Services, and local public health departments across the state of Nebraska. The team also partners with subject matter experts from several regional and national programs, including the National Emerging Special Pathogens Training and Education Center (NETEC), the Region 7 Special Pathogens Treatment Center, Nebraska's Infection Control Assessment and Promotion (ICAP), and UNMC's Global Center for Health Security. Through these partnerships and the collective expertise of the team and its partners, the BIDSRT has provided boots on the ground support for industries and sectors particularly vulnerable to the impacts of the COVID-19 pandemic (e.g., meat processing facilities, correctional facilities, K-12 schools, shelters, long-term care facilities). The collaboration among teams and SMEs from multiple grants to provide technical assistance across Nebraska and Region 7 is a prime example of partners serving as a force

amplifier across multiple programs. The accomplishments and impact of this collective are also recognized and described in annual reports for NETEC² and GCHS³.

Year 3 Major Accomplishments

The BIDSRT and partners continued to provide technical assistance to industries and sectors experiencing outbreaks of COVID-19. Technical support and recommendations were tailored to the needs and constraints of each facility, informed through conversations with facility leadership and walkthroughs of the facility to assess workflows and implemented infection prevention and control measures. In addition to onsite and virtual technical assistance and in response to numerous requests, the team developed industry-specific guidelines and playbooks, available on the GCHS website: <https://www.unmc.edu/healthsecurity/covid-19/playbooks/index.html>.

In Year 3, members of the BIDSRT continued to facilitate biweekly meetings with healthcare and public health leaders and stakeholders that served as a mechanism to provide regular updates, review new COVID-19 developments and challenges, share current data and trends, and exchange best practices. These updates are recorded and shared on the Global Center for Health Security website: <https://www.unmc.edu/healthsecurity/covid-19/biweekly-updates.html>.

Year 4

As the COVID-19 pandemic continues, the BIDSRT stands ready to support organizations and businesses across Nebraska and the region to mitigate and respond to outbreaks of COVID-19. Members of the team will continue to provide updates and education during MEOC meetings for as long as the Center remains activated.

Chemical Specialty Team

The R7DHRE Chemical Specialty Response Team (CSRT) is a 24/7 asset to assist in the medical management of chemical incidents throughout Region 7. Such emergencies might include, but are not limited to, inadvertent agricultural and industrial chemical exposures, chemical terrorism, hazardous materials incidents, and other toxic exposures. The CSRT is staffed by physicians who are board-certified in medical toxicology, a clinical toxicologist, and certified specialists in poison information from the four poison centers in Region 7 (Nebraska Regional Poison Center, Iowa Poison Control Center, Kansas Poison Control Center, and Missouri Poison Center). The CSRT is led by a team leader from the Nebraska Regional Poison Center and a medical director from the Iowa Poison Control Center who oversee planning, development, and operations. All team members (licensed physicians, nurses, and pharmacists) operate under the scope, requirements and restrictions of their licenses and certifications and other applicable state and federal statutes and regulations.

During a chemical exposure incident, the team's subject matter experts are available 24/7 to:

- Help identify the hazardous materials involved, based on symptoms and history

² NETEC Annual Report can be found at https://netec.org/wp-content/uploads/2020/12/NETEC-FY20-Annual-Report_12.2020.pdf

³ GCHS Annual Report can be found at <https://www.unmc.edu/healthsecurity/documents/GCHS-2020-Annual-Report.pdf>

- Assess potential toxicity and identify immediate dangers to exposed individuals
- Provide triage and treatment recommendations
- Notify area hospitals and health departments of the incident
- Notify hospitals that are receiving victims and provide patient-specific treatment recommendations
- Provide customized information on dosing and administration of chemical antidotes
- Assist with location and transfer of antidotes
- Provide on-scene triage and treatment recommendations, depending upon scope of incident

The CSRT can be activated 24/7 throughout Region 7 by calling 800-222-1222 (which routes the call to the state's own poison center). Immediate toxicology consultations can be provided via telephone, with additional support through tele-technology as needed. If team deployment is needed, direction and support will be provided by the R7DHRE Core Team.

During Year 3, the CSRT's overall strategy was to provide education and resources to prepare and equip its team members and other healthcare professionals for the medical management of chemical exposures and other hazardous materials incidents throughout Region 7. The primary goals were to complete the Specialty Team's Concept of Operations, enroll the team into the Emergency Management Assistance Compact (EMAC), expand the team by appointing a medical director and recruiting additional team members, and provide training for CSRT members and other healthcare providers to prepare them for the clinical challenges of caring for patients following chemical exposures and other hazardous threats.

Year 3 Major Accomplishments

- Onboarded Edward Bottei, MD, FCCP, FACMT, a medical toxicologist and medical director of the Iowa Poison Control Center, to assume the role of medical director of the CSRT.
- Recruited three additional members for the CSRT (two medical toxicologists from the University of Iowa Hospital and a clinical toxicologist from the Kansas Poison Control Center).
- Completed the CSRT's Concept of Operations document to prepare for the team to be enrolled into EMAC through the Nebraska Emergency Management Agency (NEMA). See pages 2-5 in Attachments for Concept of Operations.
- Completed the CSRT's Mission Ready Package document and submitted to NEMA for enrollment into the EMAC.
- Scheduled a regional Advanced Hazmat Life Support (AHLS) Provider and Instructor course (see page 1 in Attachments for flyer).
- Recruited AHLS course instructors from poison centers in Iowa, Kansas, and Nebraska.
- Held regular AHLS course planning meetings, developed marketing materials, registration procedures, and course agenda.
- On September 15-16, 2021, hosted a regional AHLS Provider course in Omaha. Eighteen poison center clinical staff and nine additional healthcare professionals from Nebraska, Iowa, Kansas, and Missouri attended the course.

- On September 17, 2021, hosted a regional AHLS Instructor course in Omaha. Six poison center clinical staff and one additional healthcare professional (paramedic) from Iowa, Kansas, and Missouri attended the course.
- Team leaders met twice with Dr. Mark Kirk, medical toxicologist at the Department of Homeland Security, to discuss his past work and upcoming projects related to chemical defense. Strategies for developing regional risk assessments, inventory of medical countermeasures, exercises, and training resources were discussed.
- Dr. Bottei, medical director of the Iowa Poison Control Center, began reviewing and adapting his center's existing clinical guidelines for potential use by the CSRT.

The CSRT's focus for Year 4 will be to share chemical exposure clinical guidelines with poison center leaders for their feedback and finalize them as Region 7 guidelines, continue to expand by recruiting new team members and identifying statewide partners, and perform an exercise to test the team's communication plans. Additionally, the CSRT would like to develop a regional inventory of available chemical and radiological medical countermeasures. The team also plans to host a second regional AHLS Provider and Instructor course.

Pediatric Specialty Team

The Pediatric Subspecialty Team sought to improve the care of children in ASPR Region 7 during disasters or mass casualty events by:

- Strengthening collaborations between children's hospital emergency management professionals and pediatric preparedness physician leaders throughout the region and nationally.
- Identifying and addressing the physical and educational needs of community hospitals for pediatric preparedness.
- Recruiting and developing an infrastructure to deploy (either physically or virtually) medical care team members with pediatric-specific expertise (i.e., Pediatric Medical Team) during a surge or large-scale disaster in the region.
- Developing/identifying Just-in-Time training for Pediatric Medical Team (PMT) members and disaster-affected community hospital providers.

Year 3 Major Accomplishments

Pediatric Disaster Readiness Needs Assessment for Hospitals: A needs assessment focusing on pediatric disaster and surge readiness was prepared using the 2013 National Pediatric Readiness Project as an initial template. The needs assessment was further refined through discussion with key stakeholders including state healthcare coalition coordinators from Iowa and Nebraska. A pilot version of the survey was launched in Iowa. Data from the pilot survey (pages 6-14 in Attachments), along with input from emergency preparedness leaders at major children's hospitals throughout the region, was used to further refine the needs assessment survey (pages 15-26 in Attachments). At the time of this summary, the Pediatrics Team is partnering with state healthcare coalitions and state Emergency Medical Services for Children (EMS-C) coordinators to distribute the survey to hospitals.

Regional Pediatric Disaster Preparedness Needs Assessment: Semi-structured interviews were conducted with emergency managers and physician preparedness leaders from eight of ASPR Region 7’s major children’s hospitals (see pages 27-28 in Attachments) regarding readiness for pediatric disaster and surge in their catchment areas. Table 2 shows key themes identified during these interviews

Table 2. Key themes identified during interviews with emergency managers and physician leaders from eight major ASPR Region 7 children’s hospitals

<i>Regional Pediatric Disaster and Surge Preparedness Needs Themes</i>
<ul style="list-style-type: none"> • Many community hospitals would benefit from expanding their knowledge base, skills, and confidence in management pediatric patients • There are limited pediatric patient transport resources outside of major metropolitan areas, and non-pediatric transport teams have variable levels of pediatric training and comfort transporting children • Hospital systems are unable to know which other hospitals have pediatric beds and staff without calling access center for all of them individually • There is a need to be able to track children prior to transfer, during transfer, and upon arrival at other hospital while awaiting reunification with parents • Unclear logistics for reverse triage if disaster or focal surge affects a major children’s hospital or large city • Lack of financial support for emergency management activities and lack of recognition of the time/effort put in by Emergency Managers and physician leaders on this topic
<i>Opportunities for regionally coordinated pediatric disaster preparedness or emergency management activities</i>
<ul style="list-style-type: none"> • Region-wide tabletop activity • Resource mapping (bed availability, transport resources) • Patient tracking

ASPR Region 7 Pediatric COVID-19 Surge Group: As the number of delta variant SARS-CoV-2 cases continued to rise in September of 2021, the Pediatric Specialty Team formed a Region 7 Pediatric COVID-19 Surge Group with leaders from eight major children’s hospitals. This group has been meeting every other week to discuss current bed capacity and challenges related to the surge. Discussion in this group lead to formation of two additional groups, the *Region 7 Pediatric Access Group* and *Region 7 Pediatric Transport Group*. Through these groups, surveys to facilitate resource mapping of transport assets (pages 29-33 in Attachments) and pediatric hospital care (pages 34-35 in Attachments) have been distributed to children’s hospitals in the region, fulfilling one of the needs identified above. Work is also underway to allow Juvare to share pediatric bed and resource availability across state lines.

Establishment of relationship with Pediatric Disaster Centers of Excellence and Regional Pediatric Pandemic Network: under the auspices of Children’s Hospital of Omaha and the

University of Iowa Stead Family Children's Hospital, the Pediatric Specialty team explored applying for the HRSA Regional Pediatric Pandemic Network (RPPN) grant. During the exploration process, ties were established with Children's Hospital of Colorado, Eugenio Litta Children's Hospital (Mayo Medical Center). Ultimately, the Pediatric Specialty team did not apply and instead supported the successful application by UCSF Benioff Children's Hospital, University of Utah Primary Children's, UH Rainbow Babies and Children's Hospital, Saint Louis University-SSM Cardinal Glennon Children's Hospital, and University of Louisville School of Medicine-Norton Children's Hospital. Members of the Pediatric Specialty Team have been selected to serve as Subject Matter Experts on RPPN grant activities, and Dr. Rachel Charney (site PI for SSM Cardinal Glennon) is an active member of the aforementioned Region 7 COVID-19 Surge Group. Collaboration with the Pediatric Disaster Centers of Excellence and the RPPN centers offers exciting new opportunities to improve pediatric readiness throughout the region.

Collection of Pediatric COVID-19 and Readiness Resources plus Just-in-Time Training modules: The team assembled online resources in the following 8 categories, available at <https://regionviidhre.com/pediatric-response-aids>. These resources are being publicized by community hospital outreach education groups at the University of Iowa and other teams in Region 7.

- References for caring for pediatric patients with acute COVID-19 or Multisystem Inflammatory Syndrome in Children (MIS-C)
- Pediatric COVID-19 resources useful for clinicians at the bedside
- Hospital disaster preparedness planning and education
- Resources for pre-hospital and emergency department providers caring for pediatric patients during a disaster or surge
- Just-in-time training modules for pediatric surge and disaster
- Disaster exercises and tabletop drills involving pediatric considerations
- Pediatric simulation resources
- Comprehensive pediatric disaster and surge resource collection

Pediatric Medical Specialty Team (PMST): Began recruiting physician and RN providers for PMST.

Year 4

In Year 4, the Pediatric Specialty Team will use data from hospital needs assessment to coordinate pediatric and preparedness education offerings throughout the region. The team will recruit and train a deep roster for the PMST and develop infrastructure for the team to be deployed either virtually or physically. This resource will then be listed on EMAC. In addition, Year 4 plans include finishing transport and pediatric care resource mapping and making these resources available to hospitals throughout the region. Lastly, the team will continue to collaborate with RPPN and Pediatric Disaster Centers of Excellence on regional and national projects.

Behavioral Health Specialty Team

The purpose of behavioral health planning is to align individual state behavioral health training, response, and recovery operations across the region to provide an efficient process for planning for and managing the behavioral health consequences of future all-hazards disasters. Establishing collaboration and partnerships with state disaster behavioral health agencies are essential in this regard. Major accomplishments for Year 3 are listed below.

Year 3 Major Accomplishments

In Year 3, the behavioral health team collaborated with the UNL Public Policy Center as a planning committee member for the 2021 Great Plains Disaster Behavioral Health Conference and Annual Exercise, focused on post-disaster community recovery and resilience. The team arranged for attendance of key disaster behavioral health stakeholders in Iowa, Missouri, and Kansas, including Eric Evans (Disaster Mental Health Lead for Missouri) who participated in a panel discussion.

To advance education, the team collected a comprehensive listing of behavioral health and other DHHS resources available in times of disaster, specifically for individuals who live in predominantly rural areas and/or who may have constrained access to services provided in more urban areas, across the region. The team also partnered with the Nebraska Psychological Association to create a 15-minute video targeted at the general population to provide information about common reactions to trauma/disaster, how to cope individually and as a community with these events, and what resources may be available to them for assistance and facilitated the uploading of the video to the RDHRE website ([COVID Resources — Region VII DHRE](#)). Online repositories for disaster behavioral health coping resources and strategies have also been compiled to provide tailored psychoeducation to the general public.

Continued progress on a multi-state CONOPS for regional disaster behavioral health triage, care, and long-term recovery planning has yielded a concentric circle model for resource allocation across the region, which can be flexibly adapted to the severity and scope of various environmental and man-made disasters.

Year 4

A primary goal for Year 4 is to identify a comprehensive and reliable just-in-time Psychological First Aid (PFA) training mechanism for disaster behavioral health responders, not only for currently trained and identified responders throughout the region, but also for use in augmenting manpower on an as-needed basis. An additional goal is to augment available resources and services for post-disaster community recovery and resilience. Hosting the collection of behavioral health tools, trainings, public resources, and public psychoeducational information in a central online location and disseminating this information to regional heads of disaster behavioral health teams will round out Year 4 goals.

Cyber Security Specialty Team

Cyberattacks are frequently identified as the top threat in many healthcare systems' Hazard Vulnerability Analyses. It is critical that healthcare facilities be proactive in preventing such attacks and be able to effectively care for patients and maintain operations should such an event occur. The cyber security team (CyberSRT) is comprised of healthcare information technology/information security specialists and is designed to assist a site experiencing a cyberattack in analyzing the situation and containing the incident.

Year 3 Major Accomplishments

Following a cyber incident at Nebraska Medicine in September 2020, and in response to a national increase in cyberattacks, the R7DHRE team collaborated with ASPR Technical Resources, Assistant Center, and Information Exchange (TRACIE) to develop a Cyber Healthcare Resource Guide (Figure 7). The guide includes lessons learned from the September 2020 event and strategies to assist other US healthcare organizations in preparing for and responding to a cyber incident. As of August 31, 2021, the guide has been downloaded via ASPR TRACIE a total of 11,238 times. In Year 3, the team also supported two educational webinars to provide additional information on how to best utilize the guide.

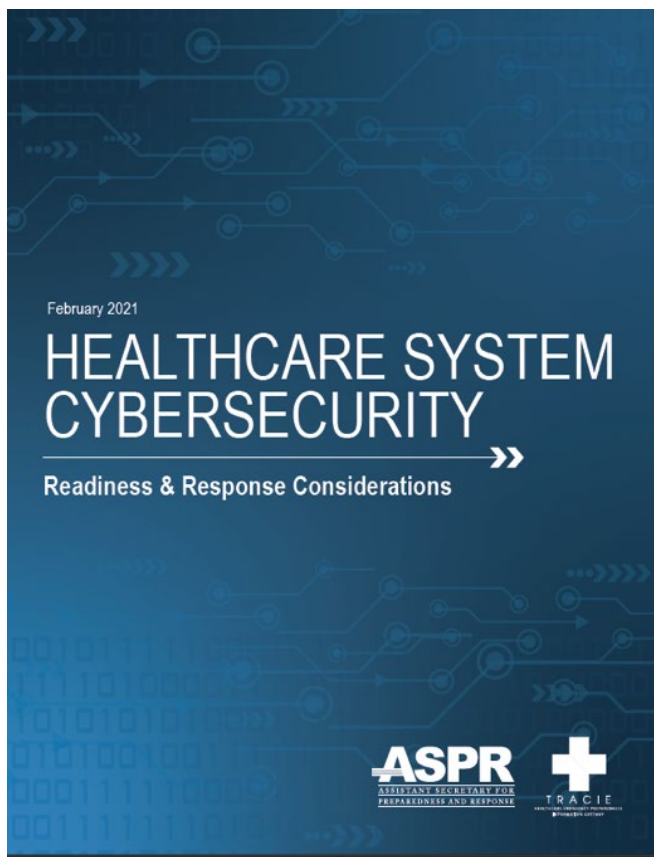


Figure 7. Cyber healthcare resource guide developed by the Region 7 RDHRE team in collaboration with ASPR TRACIE, available at: <https://files.asprtracie.hhs.gov/documents/aspr-tracie-healthcare-system-cybersecurity-readiness-response.pdf>.

In addition, during Year 3 the CyberSRT participated in monthly and quarterly panels and provided technical assistance support to the following Region 7 locations, among other national groups and health systems:

- Nebraska Hospitals ransomware Indicators of Compromise (IOC)
- Omaha/Lincoln hospitals
- Memorial Hermann, Texas
- Region 7 Healthcare CISO roundtable
- Monthly panelist participation:
 - Fortinet Security roundtables
- Quarterly panelist participation:
 - VMWare Security Council
 - Proofpoint Security Council
 - Palo Alto Security Council

Year 4

In Year 4, the CyberSRT will create some just-in-time security awareness training resources and place on the R7DHRE website for quick access and broad use by others. The team will continue to share knowledge and lessons learned from Nebraska medicine’s 2020 cyber event through education, presentations, and webinars. In addition, the team will explore the threat posed by medical device security breaches and mitigation strategies.

Radiological Specialty Response Team

The R7DHRE Radiological Specialty Response Team (RSRT) was developed to assist in risk assessment and management of radiological and nuclear emergencies where requirements might exceed the capabilities of local clinical and response personnel (e.g., industrial accidents, transportation accidents, nuclear power plant exposures, nuclear weapon strikes). The RSRT is comprised of subject matter experts in nuclear medicine, medical management of radiological casualties, emergency management, and radiation/health physics. The team is designed to assist local responders, clinicians, and public health officials either virtually through provision of guidance and training via virtual platforms or by traveling to the scene of an incident to assist in incident management and/or to provide advice and just-in-time training.

Year 3 Major Accomplishments

In Year 3, R7DHRE reached out to other medical and emergency response personnel in FEMA Region 7 regarding the use of RSRTs to assist state and federal response agencies in a radiological incident. The group determined that providing training webinars offered an early opportunity for collaboration. Five monthly training webinars were produced on radiological emergency response for FEMA Region 7 personnel focused on radiation incident response and critical components to support appropriate and timely protective actions for the public, emergency workers, and healthcare. Presenters included the Radiation Injury Treatment Network (RITN) and the Radiation Emergency Accident Center/Training Site (REAC/TS). Over 100 individuals participated in each of the webinars. Table 3 lists each of the webinar topics.

Table 3. Radiological Specialty Response Team Year 3 Webinar Topics

Session 1	February 2, 2021	Radiation Incidents Overview: Radiological Dispersion Devise (RDD)/Radiological Exposure Devise (RED)
Session 2	March 5, 2021	Radiation Protection applied to Emergency Response: Protective Actions and Zones
Session 3	April 2, 2021	Maintaining Situational Awareness through Data Collection and Sharing: Modeling Products and Field Survey and Sampling (with Rad Responder introduction)
Session 4	May 7, 2021	Overview of the Radiation Treatment Network
Session 5	June 4, 2021	Medical Preparedness and Response to Radiological Incidents

In addition, Nebraska Medicine completed all relevant tasks to maintain RITN designation for FY21. The Nebraska Medicine RSRT began to work with the Veteran’s Administration (VA) emergency response team on conducting and participating in an annual VA emergency exercise that would involve a radiological component.

Year 4

A primary goal of Year 4 is to set up comparable Radiological Specialty Response Teams in the other Region 7 states (i.e., Iowa, Kansas, Missouri) and determine the necessary logistics (MOUs) for states to rapidly utilize another state’s RSPTs. In addition, the team plans to work with national radiological emergency response agencies (e.g., REAC/TS, RITN, MERRT) so that these organizations can recognize and best use RSRTs and are exploring conducting a tabletop radiological emergency drill or hosting a RSRT workshop. The team also plans to convene the five RITN sites in Region 7 (Figure 8).

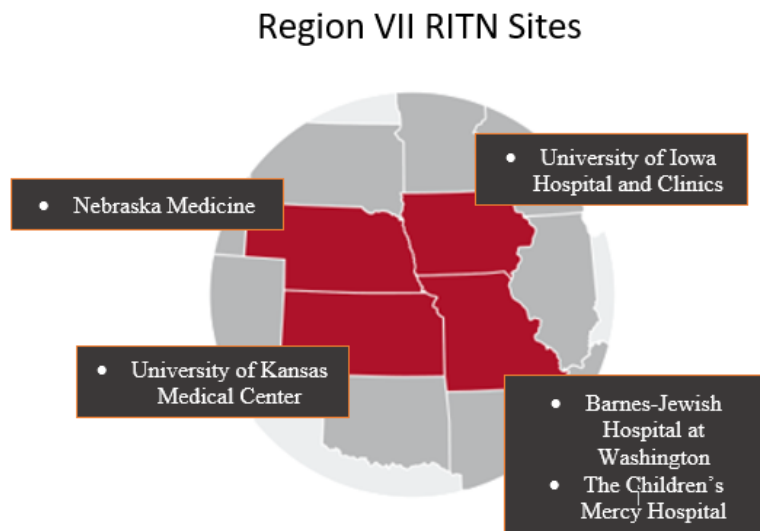


Figure 8. Region 7 RITN Site Map

Burn/Trauma Specialty Team

The primary goals of the Burn/Trauma Specialty Team are to develop an American Burn Association Planning/Preparedness Standard Operating Procedure (SOP) document and to increase diffusion of burn knowledge/content development in non-burn facilities.

Year 3 Major Accomplishments

A core goal of the Burn Specialty Team in Year 3 was focused on enhancing state and regional burn preparedness by creating and gathering burn resources to support a burn annex (see Figure 9 for a visual developed as health care coalitions (HCCs) were developing their burn annexes. The document was reviewed by several burn subject matter experts and was introduced and discussed at multiple state trauma advisory board meetings. Initial discussions with the trauma board included available education funding and areas to collaborate on education efforts. This resulted in the trauma board earmarking funds for ABLS courses as they do for ATLS courses in the state.

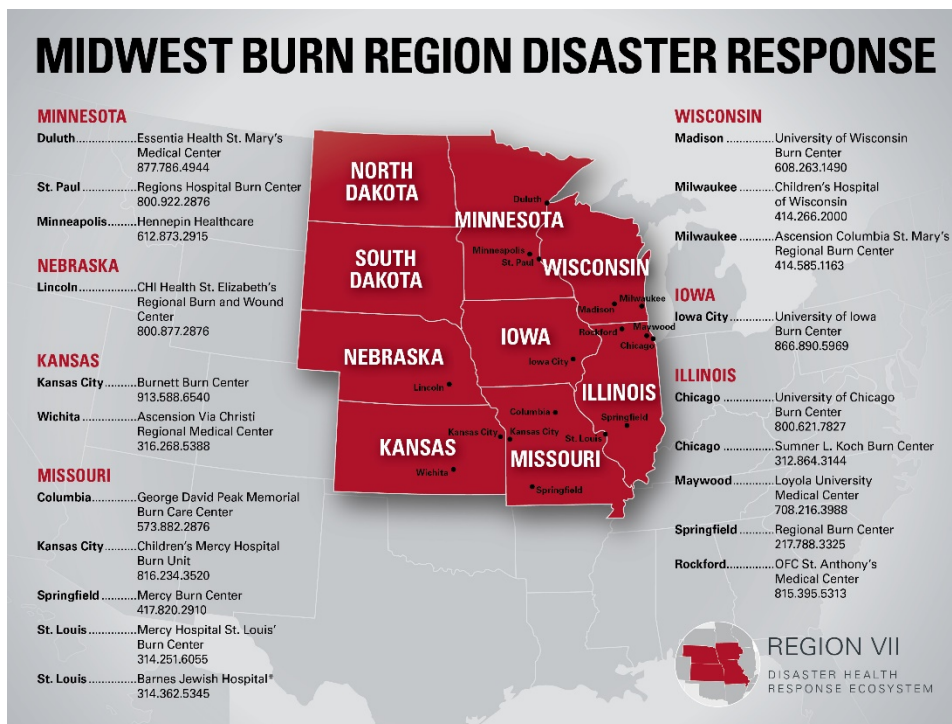


Figure 9. Visual point of contact list for the Midwest Burn Region developed by RDHRE.

Collaboration with St Elizabeth's Burn and Wound Center, the only verified burn center in Nebraska, was productive this grant year. As a result of the initial conversations, statewide funding opportunities were explored and discussions around a strategy to identify burn surge facilities across the state to increase state capacity were initiated. R7DHRE leadership continued to engage in discussion with the Nebraska Medicine trauma team to explore infrastructure and

feasibility of a deployable surgical team to augment local resources in rural areas in Nebraska during a burn or trauma mass casualty incident. Regionally, the R7DHRE team engaged with region partners in Iowa, Kansas, and Missouri and provided them with the resources used during preparation of the burn annex development and exercise planning efforts. The burn surge facility model was shared with region partners in Iowa who are exploring this as a viable option across their state to increase capacity.

The Region 7 grant team, in collaboration with UNMC’s College of Public Health and the National Strategic Research Institute, conducted 5 healthcare coalition level burn exercises across Nebraska in April 2021. The focus of the exercise was on communication and coordination between EMS/EM and hospitals with the definitive patient care destination a burn center. Over 300 participants from 139 distinct departments in federal, regional, state, county, and local healthcare as well as public service organizations participated in these exercises. Figure 10 depicts the general design of the exercise by module.

The exercise after action reports include discussions and recommendations to address gaps identified in healthcare coalition readiness and mass casualty state and regional plans for responding to large-scale incidents from thermal/burn injuries. Primary gaps existed in the development and distribution of burn-specific protocols or procedures, regional-level communication, situational awareness at the pre-hospital level, and the fundamental or specialty support that would be required in the event of large numbers of burn injuries (specifically, advanced life support skills in rural areas to support fluid loss and air-way issues specific to burn casualties). Issues unique to HCCs were also identified through the exercises. These included involving HCCs with the closest definitive burn-care centers in other states and the challenges of transport in some frontier HCCs. The report concludes with several recommendations, notably: modifications to crisis standards of care for rural emergency services in support of burn incidents and support to national organizations developing critical burn-specific training opportunities. Known communication issues for rapid regional situational awareness are discussed in the context of on-going efforts with the grant team and national partners.

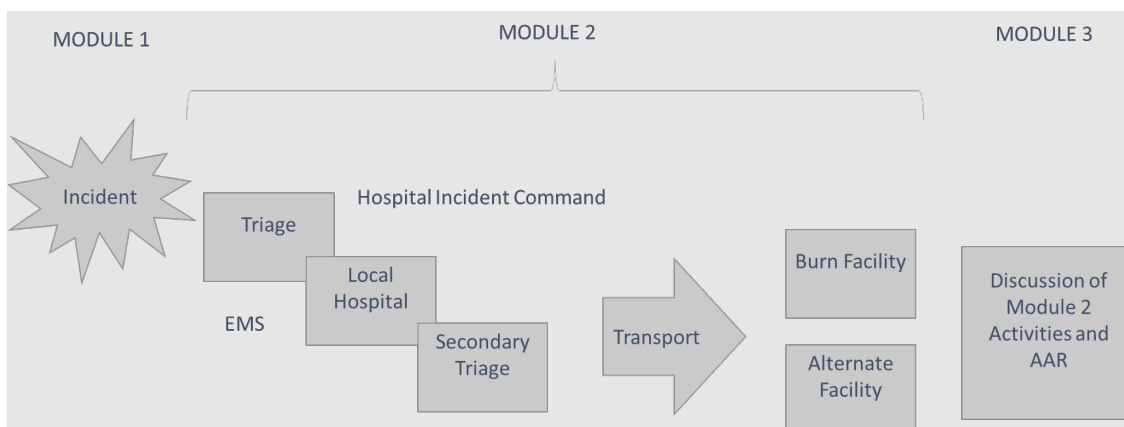


Figure 10. General scope of activities by module.

Monthly calls between Region 7 and Region 1 specialty team members were expanded to include Region 8 this year as we continue to strategize development of SME rosters and regional telemedicine capability and discuss plans to conduct a regional functional burn exercise.

Year 4

Primary goals in Year 4 are to conduct a functional burn exercise across Region 7 and to continue regularly scheduled meetings with the American Burn Association and Region 1 and Region 8 RDHRE partners to increase capability and burn resources through the development of a burn telehealth technology. Nesting all sites burn-specific work efforts with the aims and grant deliverables of the American Burn Association will be the most efficient and impactful method toward creation of a single, comprehensive burn compendium for ASPR.

Metrics and Assessment

The R7DHRE team partnered with the Region 1 RDHRS at Massachusetts General Hospital (MGH) and the Harvard School of Public Health (HSPH) to address metrics and assessment. This integrated team's approach to metrics is as a roadmap to guide healthcare coalition maturity. The metrics begin at the foundational level, tied to current Healthcare Preparedness and Response Capability 1, assessing the structure and relationships of the HCC, and will continue through a series of domains assessing the functionality of the HCC. The HSPH team first prepared a logic model to outline the key concepts that should be covered by the metrics. The logic model was then distilled to eight key domains. Within each domain there are core elements, activities, tasks, and measures for coalitions to achieve readiness. Measures are written as steps, so that coalitions can move towards readiness as they engage in additional collaborative activities.

Year 3 Major Accomplishments

The R7DHRE partnered with the MGH/HSPH team to align metric efforts across Region 1 and Region 7. The team partnered with MGH/HSPH to adopt a measurement framework theory of change and a logic model to align measurement domains and purpose across regions and to develop the Healthcare Coalition Measurement Scorecard: Building a Roadmap to Readiness. The scorecard consists of seven domains, sixteen core elements, and numerous activities and tasks for HCCs and RDHRSs to rate their progress towards the creation of a disaster ready partnership. In Year 3, a near-final version of metrics Domain 1 was produced and initial drafts of Domains 3, 4, and 5 have been developed.

The R7DHRE team also partnered with other stakeholders in national healthcare to advance HCCs to a more mature, functional, and sustainable level. While metrics efforts assess HCC's fiscal strength (beyond federal and state funding), financial sustainability is a significant challenge to many HCCs. As such, the HSPH team collaborated with the economic incentives group – comprised of healthcare preparedness, economic, and strategy experts – in visioning sessions for and review/revisions of an economic incentives white paper. The team also conceptualized how the RDHRS, and NETEC form a broader system and function to fill gaps within the nation's healthcare preparedness, including the development of a National Special Pathogens System of Care.

Year 4

In Year 4, the R7DHRE will gather feedback on the Scorecard by working with HCCs within Region 7 to refine the pool of measures most relevant to the region's specific geographic context and to inform the implementation process. The data collected during the feedback process will be analyzed and used to refine the final version of the Scorecard. At the conclusion of the process, the R7DHRE and the HSPH/MGH team will coordinate with ASPR to build implementation guidance for the Scorecard and to identify approaches to facilitate its dissemination. Further, in addition to the Scorecard, in an effort to think about novel approaches to developing preparedness metrics, the RDHRE intends to work with partners that have experience establishing and implementing a standards-setting process to develop healthcare readiness standards (see pages 36-138 in Attachments for final draft of the Score Card).

Economic Incentives

The goal of the Economic Incentives theme is to stimulate changes to the nation's strategy for funding preparedness, creating indigenous and sustainable funding within communities. It explores mechanisms for reimbursement, funding, or discounts as an incentive for an efficient and prepared community disaster response, in addition to hospital reimbursement schemes that support health system preparedness. In Year 3, the multidisciplinary Economic Incentives team continued to focus on the idea of broader community engagement, including businesses, in planning and preparing for disasters.

The team continued to expand in expertise and increased cadence of the large group meeting (from monthly to weekly). During the first quarter of the year, the group formed a multidisciplinary team of specialty physicians, nurses, economists, and industry experts from UNMC, Massachusetts General Hospital, Massachusetts Institute of Technology, US Department of Health and Human Services, Department of Homeland Security, among others. The team continued to expand throughout Year 3. Most recently, the group added a private insurance expert, data scientists, and a healthcare economist. Activities were divided into lines of effort with leads to help drive the work. A summary of the lines of effort and accomplishments are below.

Year 3 Major Accomplishments

- Overall Vision – A white paper was drafted on the overall vision for this team. The paper has also been shortened into an op-ed for a broader reach and will be submitted for publication.
- Metrics and Preparedness – The team works closely with the R7DHRE metrics workgroup including the team at Massachusetts General Hospital. A white paper is being drafted that discusses the framework of utilizing metrics to enhance preparedness. The metrics can then be used to continuously improve the preparedness framework for a community.
- Public/Private Partnerships – The group is poised to create a white paper about the value of investment from both the private and public sector and viable models and structures that have been used to address analogous challenges. Such models include the North American Energy Reliability Corporation (NERC).
- Financial Tools – The financial tools team consists of economists considering various tools, instruments, and markets that might be deployed to help communities finance pandemic preparedness. To date, discussions have primarily centered around bonds and bond ratings.
- Linking preparedness and healthcare quality – This team continues to work on linking outcomes related to quality and efficiency with health emergency preparedness and response. Creating a clear nexus between these two areas would create additional opportunity to closely tie CMS reimbursement to hospital preparedness. Initial meetings have been held with The Joint Commission to discuss incorporating standards related to healthcare quality and preparedness.
- Predictive Analytics- The most recently added line of effort is utilizing publicly available data sets to look at various characteristics of communities (based on US postal codes). This data will identify factors that might inform how and why communities manage disasters differently and have different outcomes.

Year 4

During the next year, the economic incentives group plans to submit or publish the discussion papers currently being drafted and add statisticians to assist with the complex analysis being driven the data analytics. Additionally, the group will push towards a suggestion of financial tools or instruments that might help communities better prepare for disasters or pandemics. These tools will take into account various aspects of the public/private partnerships as well as hospital reimbursement models.

Local/Regional Adaptive Planning

The purpose of this enabler is to address the planning gaps and inconsistencies that could hinder or complicate a coordinated regional response. During the COVID-19 outbreak, these efforts have been especially important as considerations had to be made for how to coordinate interstate volunteers, as well as determining how to allocate care in a crisis standards of care scenario. Over the course of Year 3, crisis standards of care planning was the highest priority, with the focus on pediatric crisis standards of care planning gaining emphasis as the Delta variant began to affect children. Unique guidance documents on crisis standards (eg. EMS, Pediatrics, Critical Access Hospitals) were made available to regional partners to assist them in their COVID response.

Year 3 Major Accomplishments

Crisis Standards of Care Plan: As the state did not have a crisis standards of care plan, the R7DHRE team created a Nebraska crisis standards of care planning guidance document in November 2020, which was endorsed and distributed by the Nebraska Medical Association and Nebraska Hospital association.

Link: https://www.unmc.edu/healthsecurity/_documents/NE-Crisis-Protocol.pdf

EMS-specific Crisis Standards of Care Plan: The team developed an EMS-specific crisis standards of care plan, with the assistance of key EMS stakeholders across Nebraska. The guidance document was reviewed by over 25 EMS stakeholders representing different EMS agencies and localities to ensure the guidance met the diverse needs of EMS workers across the state. The team provided education to the healthcare coalition regions and at the Nebraska Medical Emergency Operations Center. This plan has been disseminated and adopted widely and is published on the UNMC Global Center for Health Security website.

Link: https://www.unmc.edu/healthsecurity/_documents/EMS-CSC-Final.pdf

Small/Critical Access Hospitals Crisis Standards of Care Planning Guidance: To address the triaging concerns specific to smaller, rural hospitals, the team brought together small and critical access hospital leaders from each healthcare coalition region (administrators, clinicians, and the healthcare coalition leaders) to develop a crisis standards of care planning guidance document for small and critical access hospitals. The team provided related education and consulting to healthcare coalitions and critical access hospitals across the state to support the adaptation of the guidance for individual regions and facilities.

Link: https://www.unmc.edu/healthsecurity/_documents/Neb-CSC-CAH.pdf

Pediatric Crisis Standards of Care: The team brought together pediatric stakeholders from across Nebraska (representing clinical and educational organizations) to create a pediatric crisis standards of care workgroup. This group developed a pediatric crisis standards of care plan and was reconvened during the rise of the Delta variant to discuss practical needs of pediatric populations.

Link: https://www.unmc.edu/healthsecurity/_documents/Neb-Peds-CSC-Final-07-02.pdf

Legislative Bill 139: Legislative Bill 139 was passed by the Nebraska legislature and signed into law by the Governor on May 25, 2021. LB139 formally adopts the team-created crisis standards of care planning guidance document as the “Health Care Crisis Protocol” for the state.

Link: <https://nebraskalegislature.gov/FloorDocs/107/PDF/Slip/LB139.pdf>

Year 4

As we move into Year 4 of the grant, the focus needs to shift to developing more sustainable solutions to healthcare surge events. Changing from reactive planning to proactive planning will give area hospitals and healthcare stakeholders a better sense of preparedness for facing emergencies. As the crisis standards of care work conducted in Year 3 was focused entirely on Nebraska, Year 4 should include broader regional expansion to the other Region 7 states. Each of those states has faced their own challenges in implementing and activating crisis standards of care, so it would be beneficial to do a thorough review of the issues, gaps, and obstacles faced by each state. By documenting and analyzing these obstacles, regional plans could be developed to strengthen interstate capacity to avoid the need to activate crisis standards in future emergencies.

Education, Training Standards, and Exercises

The Education, Training Standards, and Exercises team offers trainings to healthcare professionals and community stakeholders to build capacity and resiliency through training, education, and exercise demonstration.

Year 3 Major Accomplishments

Year 3 began with the R7DHRE team defining training initiatives in collaboration with partners, including state emergency management, public health stakeholders, and healthcare facilities and agencies. The team developed a training and education section of the R7DHRE website that includes training links from FEMA’s Emergency Management Institute and the Center for Domestic Preparedness and expanded the site throughout the year.

A key focus of Year 3 training and education efforts was the continuation of monthly webinars that were well attended by the regional audience. While primarily focused on the pandemic response and providing relevant education to the evolving COVID-19 developments and challenges, additional topics also included cybersecurity, research during public health emergencies, and healthcare system readiness for other emergencies (see Table 4 for topics).

Table 4. Topics of the R7DHRE Monthly Webinar Series

Month	Topic	Participants
January	Using Creative online Tools for COVID Response	87
February	Exploring Implications of the New COVID Strain	229
March	Understanding Behavioral Health Issues in a Pandemic	170
April	Exploring a Monoclonal Antibody Allocation Framework	48
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October	Together We Stand; A Story of Resilience and Lessons-Learned from the Las Vegas Shooting	167

Year 4

The COVID-19 webinars have been well-received and will continue in Year 4. The scope of the series’ topics will expand to include distributed network operations, community preparedness, and regional priorities.

Telehealth

During Year 3, members of the telehealth team supported providers by navigating COVID-19 Public Health Emergency (PHE) waivers, as many had expired across states. The team provided education to providers on the need to adhere to licensure requirements; most notably, the need for licensure in the state in which the patient is physically present. In collaboration with Region 1, templated documents for communication were reviewed that would help facilitate the use of telehealth related to licensure and liability concerns in the event of a disaster and state of emergency proclamations.

In addition, the team documented best practices and lessons learned from responding to the beginning of the pandemic in 2020. These best practices include organizing telehealth activities onto a central and common platform, providing support to patients, and facilitating education to providers. These telehealth best practices were also reported in the pandemic literature.

An ongoing collaboration with Region 1 and Region 8 was initiated to assess the feasibility of a common platform for telehealth so that clinicians only have to have familiarity with one platform and to achieve technology best practices. The two platforms being evaluated are Bluestream and NETCCN Omnicure platforms.

Year 4

In Year 4, the R7DRHE team will finalize the recommendation on a common platform and will continue to collaborate with other regions to ensure that technology and process best practices can be achieved. In addition, the templated documents that were reviewed in Year 3 will be rebranded, socialized, and formally submitted as part of telehealth knowledge.

Information Sharing Platform

During Year 3, the information sharing team continued to be a central point in the collection and dissemination of COVID-based bed availability, cases, therapeutics, and hospitalization data statewide. Five dashboards were produced that provided over 60 different combinational views of interactive data (see Figure 11). The R7DHRE team used the platform established in Year 1 to support the data needs of state, coalitions, local public health districts, and the Medical Emergency Operations Center during Year 2 and most of Year 3. After having engaged over 30,000 discrete viewers, the daily dashboards were discontinued on July 1st when Nebraska rescinded its emergency declaration and prohibited sharing of data.

The final quarter of Year 3 brought changes to R7DHRE information-sharing due to the statewide cessation of data-sharing in July. The team fielded many requests for reports and data as cases and hospitalizations surged during the late summer delta wave. The team engaged with NeDHHS and CyncHealth (the regional health information exchange for Nebraska and Iowa) to identify the data that were available and to whom, and formally requested access to HHS Protect to produce a regionwide bed availability report. The Region 7 team met weekly to discuss the regionwide bed availability dashboard, with topics ranging from data use agreements between states to bed definitions to dashboard formats. While progress has been slow due to a wariness by state leadership to share data, clinical leadership recognizes its value and continues to push forward in hopes of creating a permanently available dashboard that is shared among all 4 states.

Region 7 members have also collaborated with border states outside the ASPR region to learn from state dashboard implementation experiences and discuss the data elements that will be shared on an ongoing basis. The team is working with Juvare to create a shared border beds dashboard if a common spirit of data sharing can be identified.

Year 4

In Year 4, the R7DHRE team will support the transition of the Knowledge Center platform to Juvare for Nebraska data. The team will continue to partner with others in the region to pursue coordination and regional data sharing agreements and investigate opportunities for collaboration and shared dashboards in Region 7 via Juvare. In addition, the team will partner with Cynchealth on a “real-time” data dashboard for Nebraska.

Pandemic Recovery Acceleration Model

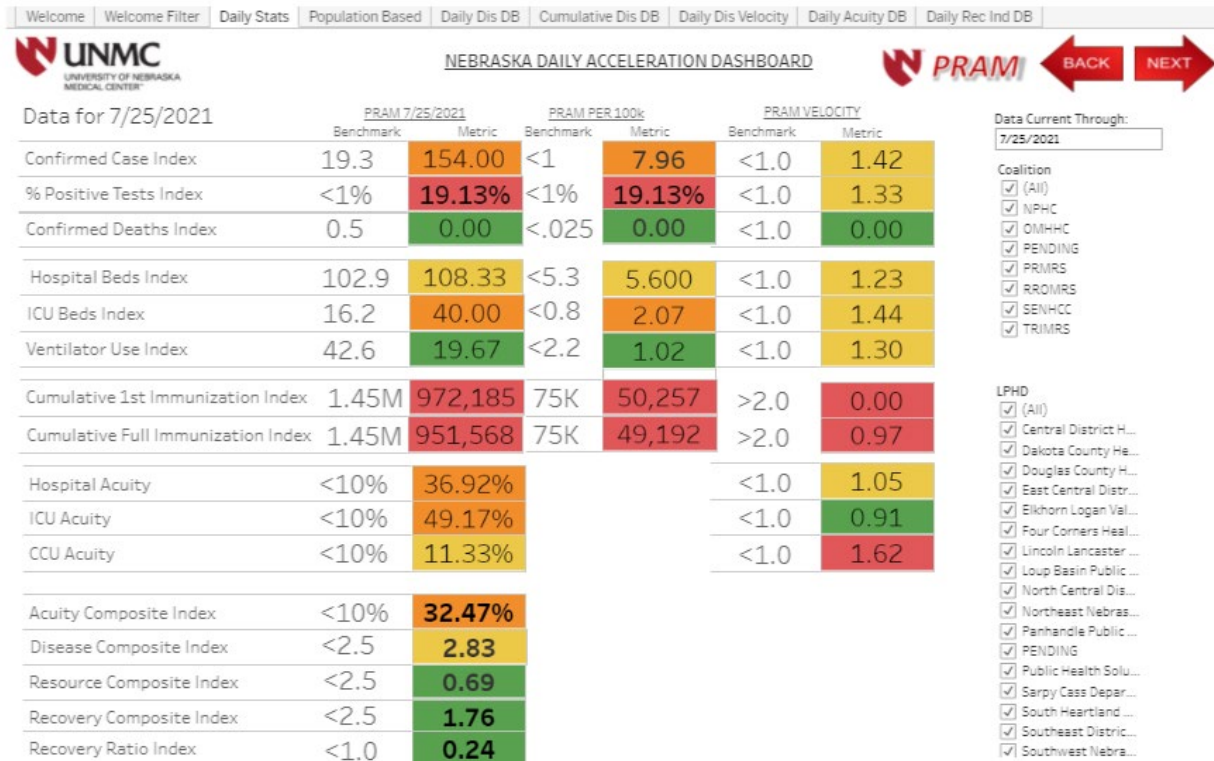


Figure 11. Pandemic Recovery Acceleration Model (PRAM) and its expanded dashboard set ceased production on August 1st, after over 15 months of uninterrupted daily reporting and garnering over 30,000 discrete viewers <https://www.unmc.edu/healthsecurity/covid-19/PRAM.html>

Region 7 COVID-19 Lessons Learned Assessment Progress

The Missouri Hospital Association (MHA) conducted a state level mid-action assessment by utilizing an established statewide hospital assessment tool. This assessment captured how hospitals handled COVID-19 response activation, implemented clinical strategies (such as testing, care coordination with long-term care facilities, treatment protocols, and vaccine administration), and addressed shortages and sourcing of personal protective equipment, or PPE. MHA established focus groups with clinical executives to collect lessons learned and created materials to help hospital staff conduct internal topic specific discussions to be incorporated into the analysis. The combined initiatives resulting in the publication of the Mid-Response Assessment: Missouri Hospitals' Response to the COVID-19 Pandemic and Missouri's COVID-19 Response: A Clinical and Operational Reflection for Missouri Hospitals. These lessons learned have provided valuable and timely insight into the reality of the COVID-19 response and how the state can better prepare in the future.

Mid-Response Assessment: Missouri Hospitals' Response to the COVID-19 Pandemic and Missouri's COVID-19 Response

Link: https://www.mhanet.com/mhaimages/COVID-19/LessonsLearned_MoHospitalsResponseToCOVID-19.pdf

Missouri's COVID-19 Response: A Clinical and Operational Reflection for Missouri Hospitals

Link: https://www.mhanet.com/mhaimages/COVID-19/Reports/Missouri_COVID-19_Response_0821.pdf

Nebraska Department of Health and Human Services conducted a mid-action assessment with compiled results currently pending distribution. The anticipated release timeline is mid-January 2022. Other states within the region are in various stages of compiling state level assessments. The continued burden of the pandemic has forced modification to timelines and delays in assessments in much of the region.

Cross Site Collaboration

The three pilot programs led by Massachusetts General Hospital (Region 1), Nebraska Medicine (Region 7), and Denver Health & Hospital Authority (Region 8) continue to collaborate on targeted initiatives to move the RDHRS program forward. Cross-site work groups have made progress in the areas of Metrics, Telehealth, Specialty Teams, and Economic Incentives. Together, the three programs are working to shape the future of national health security by addressing regional healthcare preparedness challenges, establishing best practices for improving disaster readiness across the healthcare delivery system, and demonstrating the viability of a national RDHRS network where disaster preparedness is woven into the fabric of every community.

ASPR Guidelines for Regional Health Care Emergency Preparedness and Response Systems

The Guidelines for Regional Health Care Emergency Preparedness and Response Systems (referred hereafter as ‘the Guidelines’) provide high-level recommendations for regional health care partners. To provide a framework for a regional health care approach to all-hazards planning, practices are organized by four objectives: 1) Actively Engage Public Private Partnerships; 2) Align Plans, Policies, and Processes; 3) Enhance Statewide and Regional Medical Surge Capacity; and 4) Bolster Statewide and Regional Situational Awareness and Information Sharing.

The RDHRS demonstration sites were asked to provide feedback for the initial drafts of this document. RDHRS input, in combination with input from a variety of other stakeholders, was incorporated into the document that is to be published later this year. The guidelines are meant to be used as building blocks for further expansion of regional systems. Guidelines are intended to build upon, not supplant, preexisting health care preparedness and response infrastructure.

RDHRS All Sites Manual

The RDHRS All Sites Manual, written in collaboration with Region 1 and Region 8 RDHRS programs, serves as a foundational guide to facilitate the development of a robust, coordinated network of RDHRS sites capable of responding to a multitude of specialty clinical disaster scenarios through its extensive network of subject matter experts, best practice toolkits and materials, and integrated healthcare response capabilities.

The RDHRS Handbook provides an overview of the vital role the RDHRS plays in building a more robust regional disaster healthcare response and preparedness framework. The first section outlines critical gaps that exist within the broader healthcare infrastructure and provides justification for how the RDHRS program can effectively address these gaps. In the second section, ASPR’s vision for a 21st Century National Disaster Medical System (NDMS)

Framework demonstrates how the RDHRS program supplements rather than duplicates existing local and regional healthcare response infrastructure through supporting clinical care delivery and healthcare operations when catastrophic events require significant alternations to normal operations affecting patient movement and availability of critical resources.

In the third and fourth sections of the handbook, based on firsthand experience, the three pilot programs provide guidance on the development of an RDHRS within an HHS Region as well as suggestions for how a network of RDHRS' across the United States could lay the foundation for a comprehensive healthcare disaster preparedness and response infrastructure consistent with ASPR's vision. The final section of the handbook details critical development and sustainment activities required of the RDHRS and the larger network for them to be successful. These recommendations form the pathway to a more robust, well-integrated RDHRS program.

The RDHRS Handbook describes a framework for a coordinated network of RDHRS sites based on lessons learned from each of the three pilot programs to date. The handbook provides information and guidance that can be leveraged by other HHS Regions to establish additional RDHRS partnerships in the future, with the identified core functions of an RDHRS site and the overarching RDHRS network as one suggested approach.

Year 3 In the Rear-View Mirror

The continued grind of the COVID-19 pandemic made Fiscal Year 2021 one of the most challenging of our lifetime for health system emergency response. While staying closely engaged in the day-to-day fight against the pandemic, the Region 7 Disaster Health Response Ecosystem project was able to capture acute lessons learned and implement improved response that dramatically improved Nebraska's and Region 7's ability to mitigate pandemic impact. At the same time, our team continued to provide focus on long-term solutions for all-hazards threats that can build toward a more robust, flexible, and sustainable response capability for a myriad of health security threats. As the ongoing struggle of an Omicron wave highlights, the US health system has urgent need to continue improving its posture to meet future health security challenges. The four collaborating RDHRS centers will continue to build a strong foundation for a more resilient and capable health system to protect the health and well-being of all Americans during this current health crisis as well as the next.



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Chemical Specialty Medical Augmentation Response Teams (SMART) Concept of Operations

Draft 2.17.21

1. PURPOSE

The Region VII Disaster Health Response Ecosystem (RDHRE) Chemical Specialty Medical Augmentation Response Team (SMART) is an asset, which is available 24/7 to assist in the medical management of chemical and toxicological incidents throughout Region VII. Such emergencies might include (but are not limited to):

- Inadvertent agricultural and industrial chemical exposures
- Chemical terrorism
- Poisonings

2. TEAM OVERVIEW

Composition: Team Leader (1), Medical Director (1), Team Members (4, one from each state is preferred)

Roles & Responsibilities:

Team Leader

- Works with RDHRE leaders to develop team goals and assure that they are met
- Regularly updates the team's concept of operations, policies, and procedures
- Identifies and recruits team members and other partnering agencies
- Keeps the team roster updated
- Oversees the development of training courses
- Participates in required training courses
- Assists with preparation for chemical exposure exercises by working with partners to develop objectives, clinical scenarios, team resources and training
- Participates in virtual and in-person exercises
- Contributes to After Action Reports and Corrective Action Plans following exercises and actual events
- **Responsibilities during team deployment:**
 - Travels to the scene of a chemical exposure incident as needed
 - Works with CORE team to provide support to team members
 - Coordinates communications with team members and stakeholders
 - Assists with the development of operational policies, procedures, and training materials for the team
 - Conducts quality assurance auditing for the team as needed

Medical Director

- Works with the Team Leader to achieve the team's goals
- Develops and reviews clinical guidelines, policies and procedures
- Assists with identifying and recruiting team members and other partnering agencies
- Assists with identifying and developing JIT training materials for the Chemical Team
- Participates in required training courses
- Assists with preparation for chemical exposure exercises by working with partners to develop objectives, clinical scenarios, team resources and training
- Participates in virtual and in-person exercises
- Contributes to After Action Reports and Corrective Action Plans following exercises and actual events
- **Responsibilities during team deployment:**
 - Travels to the scene of a chemical exposure incident
 - Supports incident by providing healthcare providers and first responders with consultations on patient and incident management
 - Provides on-site medical direction for team members
 - Provides just-in-time training for providers, public health, and others as needed
 - Approves medical protocols and training materials for the team
 - Conducts quality assurance auditing for the team as needed

Team Members

- Participates in required training courses
- Participates in virtual and in-person exercises (as feasible)
- **Responsibilities during team deployment:**
 - Travels to the scene of a chemical exposure incident as requested
 - Supports incident by providing healthcare providers and first responders with consultations on patient and incident management using medical-director-approved clinical guidelines
 - Assists medical director with developing just-in-time medical protocols and training materials as requested
 - Provides training for providers, public health, and others as needed

3. CAPABILITIES

a. Core Missions

The core capabilities of the Chemical SMART team lie with a group of subject matter experts (SMEs) from the four poison control centers in Region VII (Iowa Poison Control Center, Kansas Poison Control Center, Missouri Poison Center, and Nebraska Regional Poison Center). These SMEs are available 24/7 to:

- Help identify the hazardous materials involved, based on symptoms and history
- Assess potential toxicity and identify immediate dangers to exposed individuals
- Provide triage and treatment recommendations
- Notify area hospitals and health departments of the incident
- Notify hospitals that are receiving victims and provide patient-specific treatment recommendations
- Provide customized information on dosing and administration of chemical antidotes
- Assist with location and transfer of antidotes
- Provide on-scene triage and treatment recommendations, depending upon scope of incident

Civil Support Teams (CSTs) are National Guard assets and deployment is controlled by each state's governor through its emergency management agency. Team members have subject matter expertise in the detection, modeling, analysis, and mitigation of chemical, biological, radiological, and nuclear hazards. The Chemical SMART team would work with states' CSTs when appropriate.

Specific 72nd CST (Nebraska) assets include:

- NIMS Type 1 HAZMAT Entry Team
- NIMS Type 2 Communications Vehicle
- Mobile ISO 17025 accredited Analytical Laboratory
- Medical & Analytical Section integrated into LRN

b. Activation

The Chemical SMART team can be activated 24/7 by calling the state's own poison center: 800-222-1222. Immediate information can be provided via telephone, with additional support through tele-technology as needed. If team deployment is needed, direction and support will be provided by the RDHRE Core Team.

c. Operations

The Chemical SMART team consists of board-certified medical toxicologists, clinical toxicologists, and certified specialists in poison information (nurses and pharmacists).

The team can assist local responders, clinicians, and public health authorities by:

1. Providing immediate telephone advice
2. Providing advice and training via tele-technology
3. Traveling to the scene of a disaster or event in order to assist with patient/event management and provide just-in-time training as needed

d. Equipment & Supplies

PPE for Team Members (unlikely needed for consultants)

- Level C with chemical-resistant suits, gloves, boots, face shields
- PAPRs with chemical cartridges

Pharmaceuticals (for team member protection; however, unlikely needed for consultants or responders with adequate PPE)

- Hydroxocobalamin (for cyanide)
- Pyridoxine (for hydrazine)
- Albuterol (for chlorine, ammonia, and other irritant gases)
- Prussian blue (for radioactive cesium, thallium)

e. Scope of Practice

All team members (licensed physicians, nurses, and pharmacists) operate under the scope, requirements and restrictions of their licenses and certifications and other applicable state and federal statutes and regulations.

4. COMPETENCIES

- a. Recommended Training for Team Members:
 - FEMA NIMS IS-700 and IS-100 courses (minimum)
 - Advanced Hazmat Life Support (AHLS) Provider course
- b. Training Plan

Pre-Event Training

A regional Advanced Hazmat Life Support (AHLS) Provider and Instructor course is planned for September 2021 in Omaha for team members, including the region's Civil Support Teams. The course will also be open to nurses, paramedics, physicians, and pharmacists to help prepare them for the clinical challenges of caring for patients following chemical exposures and other hazardous threats.

Just-In-Time Training (JITT)

Chemical Clinical Management Guidelines

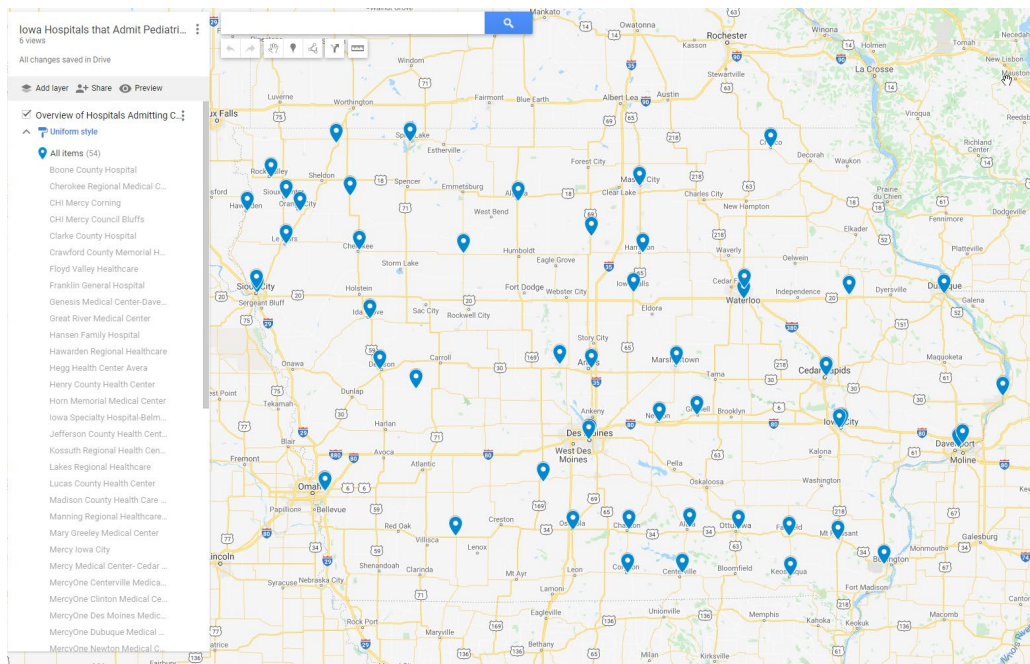
- Poison centers' existing clinical patient-management guidelines will be reviewed; new guidelines will be developed for selected chemical exposures as needed.
- If a guideline is not available, the team will develop triage and treatment guidelines, customized for the specific incident.

Appendix A

Results of Pediatric Disaster and Surge Readiness Pilot Survey of Iowa Hospitals

Background: Overview of Pediatric Hospitalization Beds in Iowa

According to the 2019 Iowa State Hospital Association survey, 45.3% of Iowa's 119 hospitals admit pediatric patients (**Map 1**). Out of 82 critical access hospitals, 30 admit pediatric patients. Only 6 hospitals in the state have general pediatric medical/surgical, PICU, and NICU beds; unsurprisingly, these are located in major population or academic centers such as Des Moines and Iowa City.

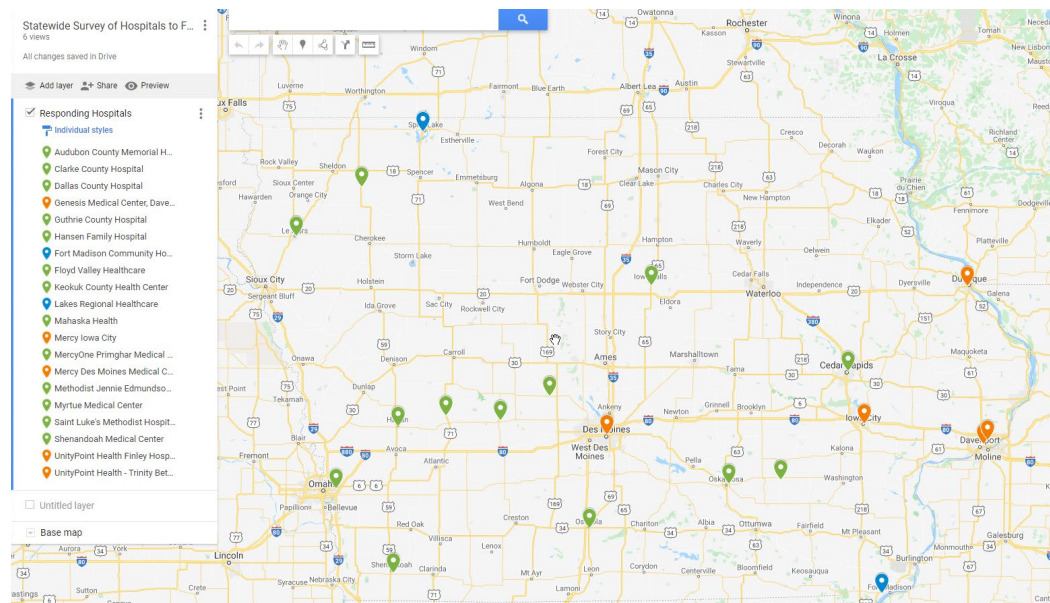


Map 1: Iowa Hospitals that Admit Pediatric Patients

Results of Pilot Survey

Hospital Characteristics and Pediatric Assessment, Admissions, and Transfers

The electronic survey was sent to all 119 hospitals in Iowa using the Iowa Trauma Coordinators listserv, and 20 hospitals (16.8%) responded (**see Map 2 below**).



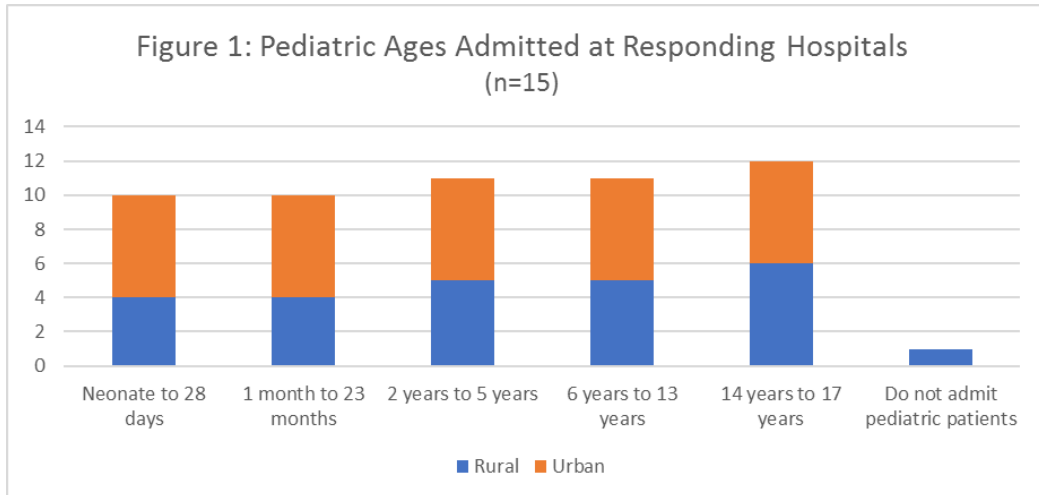
Map 2: Statewide Survey Hospitals

Of these, 12 were critical access hospitals and 2 were rural. (For remainder of this report, critical access and rural hospitals will be grouped together and referred to as rural hospitals).

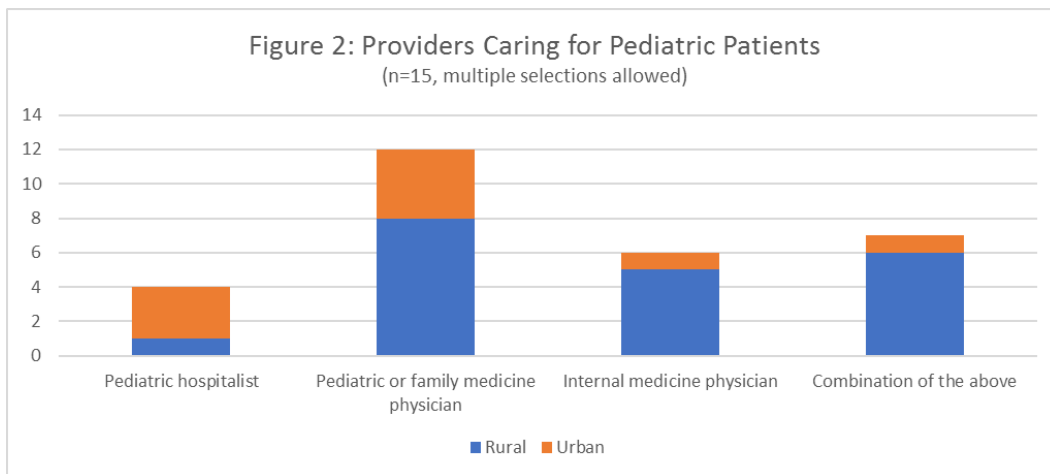
The job titles of people completing the survey were: trauma nurse coordinator (n=5), emergency services director or manager (n=7), CNO (n=2), RN title not otherwise specified (4), hospital vice president (n=1), and director of patient care (n=1).

For the critical access and rural referral hospitals responding the median number of ED beds was 5 and median number of general adult med/surg beds was 19. Only 4 of these rural hospitals had adult ICU beds. The median number of patients seen per year in the ED at rural hospitals was 4,200, and the median percentage of pediatric ED visits was 15.5%. The median number of patients seen in the ED per year at the responding urban hospitals was 33,247 and 12.5% was the median percentage of pediatric ED visits. Only 3 rural hospitals reported having 24 hour coverage by a board-certified emergency medicine physicians (all urban hospitals did). None of the hospitals had 24 hour access to a board-certified pediatric emergency physician. Only 10 hospitals (3 rural) responded that they had 24 access (in person or on call) to a board-certified pediatrician. Approximately 17% of rural hospitals and 83% of urban hospitals had policies specifying when a pediatrician should be called into the ED. Nine of the 11 rural hospitals admitted pediatric patients (**Figure 1**). Two admitted only well newborns, and the ages admitted to the other 9 hospitals varied. One hospital commented “we do not routinely admit pediatric patients. Occasionally will admit patients from age 12-18 but have not for some time now. We can manage care depending on diagnosis and comfort of the Family Medicine

provider/hospitalist”. Of the urban hospitals answering the survey (n=6), all admitted pediatric patients.



Rural hospitals reported that a mix of community-based pediatricians, family medicine physicians, and internal medicine physicians cared for pediatric patients. Unsurprisingly, urban hospitals were more likely to have a dedicated pediatric hospitalist service caring for patients (Figure 2).



Urban hospitals were also more likely to report that they had access to respiratory therapists, pharmacists, and nutritionists for at least 12 hrs a day that were experienced or competent in caring for pediatric patients (100%, 100%, and 83% of hospitals respectively). Of the rural

hospitals, 33% reported having an RT, 55.5% a pharmacist, and 11.1% a nutritionist experienced in caring for pediatric patients present 12 hours/day.

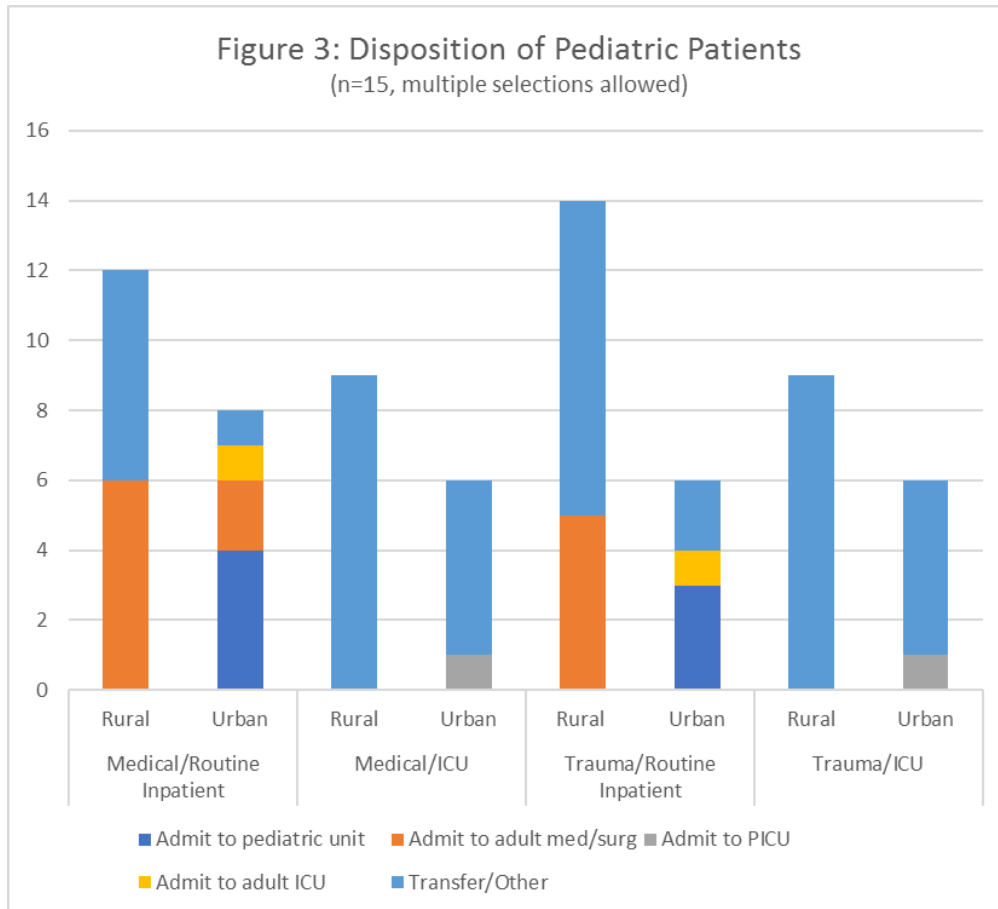
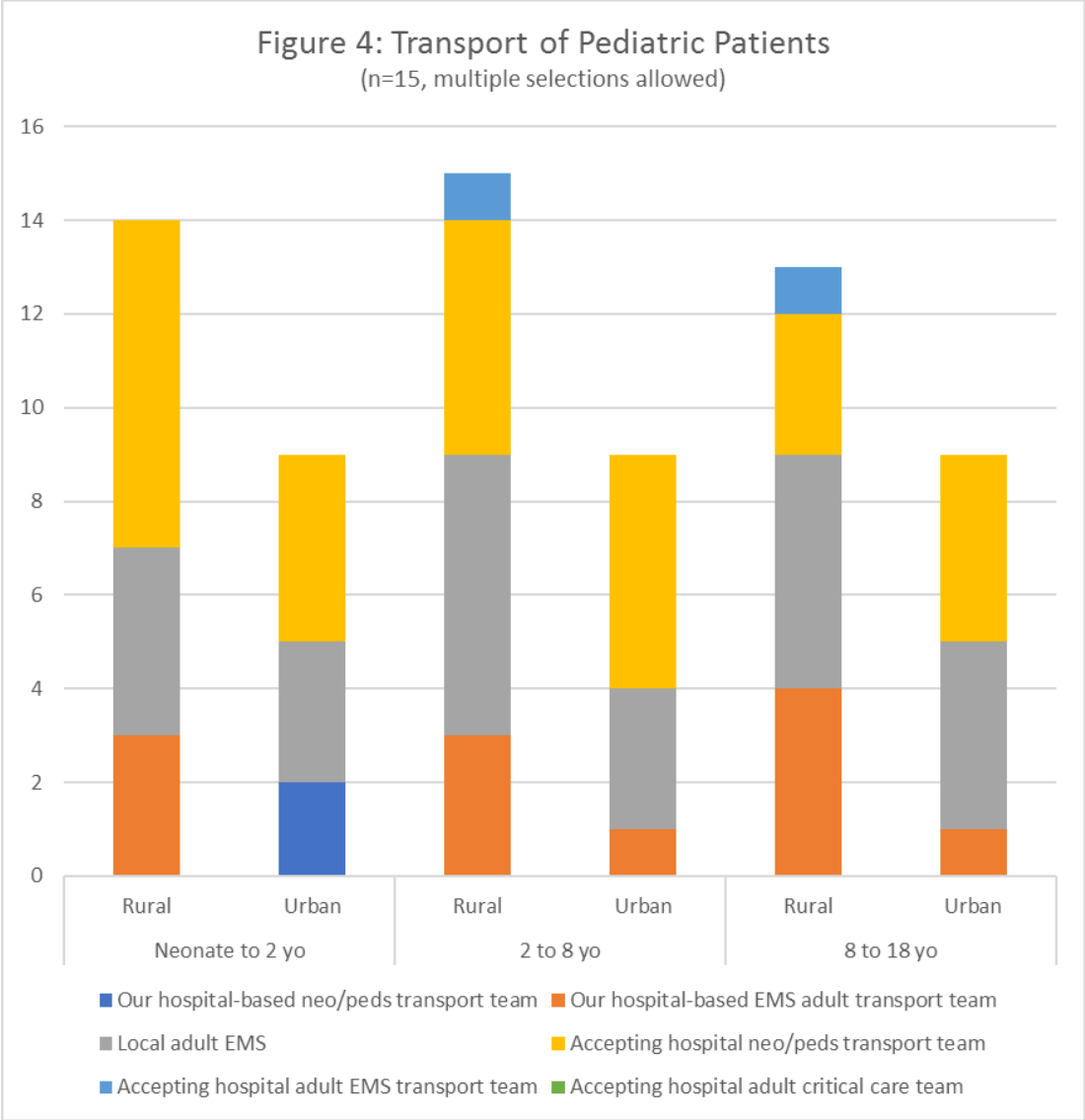


Figure 3 shows how hospitals would manage of different types of pediatric patients (n=15 hospitals, 9 rural and 6 urban). (Of note, survey responders could choose multiple answers for each type of patient.) Unless the hospital had a pediatric ICU (which only 1 urban hospital did), all survey responders answered that critical pediatric medical and trauma patients would be transferred to another institution. **Figure 4** summarizes responses of hospitals regarding who would transport their pediatric patients. Again, multiple selections were allowed for each type of patient. If the accepting hospital had a neo-peds transport team



Provider Comfort for Caring for Pediatric Patients

Fourteen hospitals (9 rural, 5 urban) responded to survey questions regarding provider comfort caring for different types of pediatric patients. All fourteen hospitals said that nurses and physicians in their ED would be comfortable caring for a non-critical pediatric medical patient or pediatric patient with minor trauma (example provided: an otherwise healthy 7 year old with broken distal radius after falling from bike (no other injuries); 6 month old with bronchiolitis needing 1liter nasal cannula). All urban hospitals also stated that RNs and physicians in their ED would be comfortable caring for a critical pediatric medical or trauma patient (example provided 9 mo old with altered mental status (GCS 8) and traumatic subdural hemorrhage after

falling off of high counter onto concrete floor; 8 year old with status asthmaticus with worsening respiratory status despite being on continuous albuterol and receiving steroids.) In contrast, only 33% and 66% percent of rural hospitals reported that their ED RNs and physicians respectively would be comfortable caring for those patients. When asked if RNs and physicians would feel comfortable temporarily caring for a pediatric patient in an adult inpatient unit (Med/Surg, Adult ICU, Adult Specialty Unit) assuming pediatric specialists were available by phone or video consultation, all urban hospitals responded “yes” or “depends upon circumstances” and all rural hospitals replied “depends upon circumstances”.

Pediatric-Specific Training Requirements

A variety of different training courses were required for providers caring for pediatric patients depending on hospital (**Table 1**). Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS) were the two most common required courses for all providers (MD/NP, RN, and RT). Trauma Nursing Core Course (TNCC) was often required for RNs (11 hospitals). Neonatal Resuscitation Program (NRP) was required for RTs at four hospitals.

Table 1: Required Training for Role (n=14, multiple selections allowed)	<i>Required for MD/NP</i>	<i>Required for RN</i>	<i>Required for RT</i>
<i>Neonatal Resuscitation Program (NRP)</i>	6	7	4
<i>Pediatric Advanced Life Support (PALS)</i>	11	13	7
<i>Advanced Trauma Life Support (ATLS)</i>	9	0	0
<i>Pediatric Emergency Assessment, Recognition and Stabilization (PEARS)</i>	0	0	1
<i>Pediatric Basic Trauma Life Support (PBTLS)</i>	1	0	0
<i>Advanced Cardiac Life Support (ACLS)</i>	12	12	6
<i>Trauma Nursing Core Course (TNCC)</i>	3	11	0
<i>Emergency Nurse Pediatric Course (ENPC)</i>	1	1	0
<i>STABLE Neonatal Education Program</i>	0	1	1

Unfortunately, courses that were required for pediatric care team members were often not offered within 60 miles of the institution (**Table 2**). This was most common in critical access hospitals.

Table 2: Distance Traveled to Required Training for Courses (n=14)	<i>Offered on site</i>	<i>Offered within 60 miles</i>	<i>Required but not offered within 60 miles</i>
<i>Neonatal Resuscitation Program (NRP)</i>	6	1	1
<i>Pediatric Advanced Life Support (PALS)</i>	10	1	3
<i>Advanced Trauma Life Support (ATLS)</i>	13	0	6
<i>Pediatric Emergency Assessment, Recognition and Stabilization (PEARS)</i>	1	3	0
<i>Pediatric Basic Trauma Life Support (PBTLS)</i>	0	3	0
<i>Pediatric Education for Prehospital Professionals (PEPP)</i>	0	3	0
<i>Advanced Cardiac Life Support (ACLS)</i>	9	1	2
<i>Trauma Nursing Core Course (TNCC)</i>	5	2	4
<i>Emergency Nurse Pediatric Course (ENPC)</i>	0	2	1
<i>STABLE Neonatal Education Program</i>	1	3	0

Physical Resources for a Surge or Mass Casualty Event

Fourteen hospitals (9 rural, 5 urban) responded to this survey section. All hospitals were aware of their surge capabilities in terms of ED beds and inpatient beds. Rural hospitals were more likely to have adult-only ventilators and to lack pediatric-specific care items such as baby food or cribs with toppers (**Table 3**). All urban hospitals were aware of morgue capabilities in their counties after mass casualty disaster while only four of the nine rural hospitals were.

Table 3: Resources for Surge or Mass Casualty Event (n=14)	Rural (n=9)	Urban (n=5)
<i>Pediatric capable ventilators</i>	2	5
<i>Infant isolettes</i>	2	5
<i>Cribs with toppers</i>	6	5
<i>Pediatric intraosseous (IO) equipment</i>	9	5
<i>Infant intraosseous (IO) equipment</i>	7	5
<i>Infant formula</i>	7	5
<i>Baby food</i>	3	5
<i>Snack options for a variety of ages (with long shelf life)</i>	8	5
<i>Diapers and baby wipes</i>	8	5

<i>Color-coded pediatric emergency cart with access, airway, and other supplies for each color on the tape with weight-based dosing</i>	8	5
<i>Physical space and support for one family member to stay with a child 24/7</i>	9	5
<i>Infant and pediatric gowns/clothing</i>	7	5
<i>Infant blankets</i>	5	5
<i>Self-soothing or self-distraction devices for children (pacifiers, teething ring, stuffed animals, TV, books, crayons etc)</i>	7	5

Mental Health Resources Following Disaster

Twelve hospitals (8 rural, 4 urban) responded to this section. Results are summarized in **Table 4** below.

Table 4: Mental Health Resources Following Disaster	Rural (n=8)	Urban (n=4)
<i>Does your hospital offer mental health/behavioral health services for pediatric patients?</i>	4	3
<i>Does your community or nearby area (defined as within 50 miles of hospital) have mental health/behavioral health clinics or practitioners for pediatric patients?</i>	6	4
<i>Does your hospital offer mental health services for staff coping with traumatic on-the-job events, such as an Employee Assistance Program or peer counselor?</i>	7	4
<i>Hospital chaplain</i>	2	4
<i>Contacts with local community pastors or religious leaders</i>	7	4
<i>Contacts with local funeral home counselors</i>	4	3
<i>Social worker or care coordinator to provide family support</i>	7	4

Desire for Additional Education Opportunities

Responding hospitals were asked if they would be interested in nursing and physician education sessions on topics such as Child-Friendly and Family Centered Care; general pediatric refresher (milestones, weight based dosing); courses such as SALT or JUMPSTART covering initial pediatric assessment, triage, and stabilization during disasters; simulations with high-fidelity pediatric and neonatal mannequins; and standardized courses such as PALS or NRP.

Rural hospitals were interested in all of those educational opportunities for their RNs. All hospitals reported that their RNs and physicians would potentially be interested in simulations with high-fidelity pediatric and neonatal mannequins.

Reflections on the Survey and Suggestions Moving Forward

- Some questions on the survey are captured in existing surveys (AHA, etc) and gathering this data from other sources may be helpful in reducing the length of the survey
- While this survey asks for comprehensive data about hospitals' pediatric capabilities and disaster response, its length may have presented a barrier to completion by more hospitals.
- It may be helpful to refine the survey to focus on one specific aspect of pediatric disaster preparedness (education vs physical resources for example) and link it to specific deliverables/offerings that survey respondents will benefit from (educational program during a certain time frame, an interactive resource map for disaster management teams at hospitals, etc)- this could increase response rate and having a desired end-product would help us further tailor questions



Pediatric Disaster Readiness Needs Assessment

Information for Survey Participants: Time to Complete

The survey should take approximately 20 to 30 minutes to complete. You may want to print a copy of the survey and gather answers from your healthcare team members prior to completing the survey online. Click the link below to get a printable copy of the survey.

Saving and Returning to a Started Survey

If you are unable to complete the survey in one sitting, scroll to the bottom of the survey page and click on "Save & Return Later". You will then be given a return code. Please write it down—without it you won't be able to return to your previous answers. Then, enter your email address to get the link you will need to return to the survey.

Your survey responses were saved!

You have chosen to stop the survey for now and return at a later time to complete it. To return to this survey, you will need both the *survey link* and your *return code*. See the instructions below.

1.) Return Code

A return code is **required** in order to continue the survey where you left off. Please write down the value listed below.

Return Code

* The return code will NOT be included in the email below.

2.) Survey link for returning

You may bookmark this page to return to the survey, OR you can have the survey link emailed to you by providing your email address below. For security purposes, the return code will NOT be included in the email. If you do not receive the email soon afterward, please check your Junk Email folder.

* Your email address will not be stored

Or if you wish, you may continue with this survey again now.

Permission for Sharing Information about Your Hospital's Physical Resources and Interests

At the end of the survey, we will ask you if we can share information from certain questions about physical resources, educational interests, and pediatric disaster planning interests with other hospitals in your state subregion, identifying your hospital by name. This will only happen if you select "yes" and submit the survey.

If possible, please complete the survey by November 30, 2021

Pediatric Disaster Readiness Needs Assessment

SECTION I: HOSPITAL INFORMATION

Title of person completing survey:

Name of person completing survey:

Email address of person completing survey:

Hospital Name

Hospital Location: County

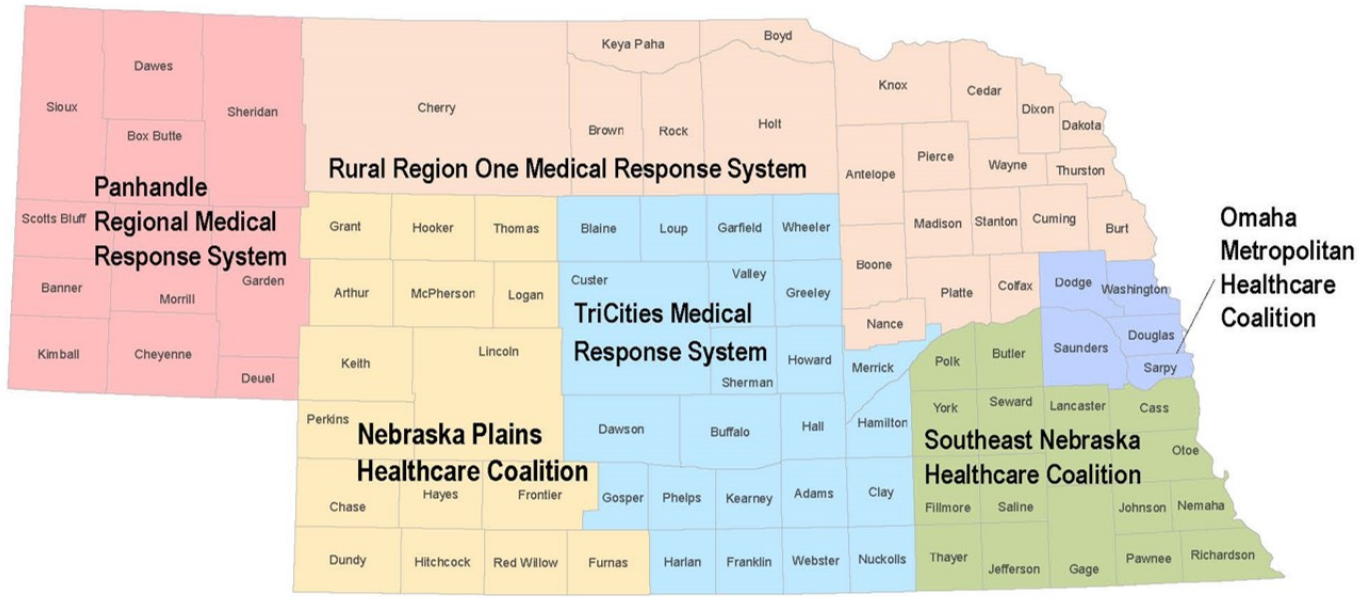
Hospital Location: State

- Iowa
- Kansas
- Missouri
- Nebraska

Hospital Location: ZIP Code

Please refer to the map of your state below and determine which regional healthcare coalition your hospital is in.

Nebraska Healthcare Coalitions



Which Nebraska Healthcare Coalition is your hospital located in?

- Panhandle Regional Medical Response System
- Rural Region One Medical Response System
- Nebraska Plains Healthcare Coalition
- TriCities Medical Response System
- Omaha Metropolitan Healthcare Coalition
- Southeast Nebraska Healthcare Coalition

1 Which of the following best describes your hospital?

- Critical access hospital (25 or fewer acute care inpatient beds; more than 35 miles from another hospital)
- General hospital that admits both adult and children (a non-specialized facility treating adults and children for all medical and trauma conditions)
- General hospital that admits only adults (a non-specialized facility treating adults for all medical and trauma conditions)
- Children's hospital (may be located within an adult hospital or free standing)

2 Is your hospital a Level I, II, or III Trauma Center?

- Yes
- No

3 How many licensed beds does your hospital have?

4 How many emergency department visits does your hospital have in a typical year?

5 Of emergency department visits, what percentage of these are pediatric visits (best estimate)?

- 0 to 10%
- 10 to 20%
- 20 to 30%
- >30%

6 How many admissions (BOTH adult and pediatric) does your hospital have in a typical year?

7 How many PEDIATRIC admissions does your hospital have in a typical year? _____

Does your hospital have the following units?

	Yes	No
8a Emergency Department	<input type="radio"/>	<input type="radio"/>
8b Adult Inpatient Ward	<input type="radio"/>	<input type="radio"/>
8c Adult Intensive Care Unit (ICU)	<input type="radio"/>	<input type="radio"/>
8d Newborn/Well Baby Nursery	<input type="radio"/>	<input type="radio"/>
8e Neonatal Intensive Care Unit (NICU)	<input type="radio"/>	<input type="radio"/>
8f Pediatric Inpatient Ward	<input type="radio"/>	<input type="radio"/>
8g Pediatric Intensive Care Unit (PICU)	<input type="radio"/>	<input type="radio"/>

9 Is your emergency room staffed 24 hrs/day? Yes
 No

SECTION II: PEDIATRIC EVALUATION IN THE ED, ADMISSIONS, AND TRANSFERS

Does your emergency department have 24-hour access (either in-house or on-call) to the following physicians?

	Yes	No
10a Board certified emergency medicine physician	<input type="radio"/>	<input type="radio"/>
10b Board certified pediatric emergency medicine physician	<input type="radio"/>	<input type="radio"/>
10c Board certified pediatrician	<input type="radio"/>	<input type="radio"/>

11 Does your emergency department have a physician, advanced practice provider, or nurse who serves as a pediatric emergency care coordinator (PECC) or pediatric champion? This person's responsibilities may include ensuring pediatric skills of staff, developing policies regarding pediatric patients, and collaborating with nursing.

Yes, a MD or DO serves in this role
 Yes, an advanced practice provider (PA or NP) serves in this role
 Yes, a nurse serves in this role
 Not at this time

12 Do you have written protocols specifying the conditions under which a pediatrician would be called to your emergency department? Yes
 No

13 Does your hospital admit pediatric patients (patients under 18 years old)? Yes
 No

14a Which pediatric age groups are admitted to your hospital? Select all that apply.

Neonate (0 to 28 days)
 1 month to 23 months
 2 years to 5 years
 6 years to 12 years
 12 years to 17 years

- 14b Who cares for pediatric patients admitted to your hospital? Select all that apply.
- An organized, inpatient-based pediatric service that follows patients from admission to discharge
 - Community pediatric or family medicine provider with hospital privileges
 - Adult medicine provider (not family medicine or pediatrics)
- 14c Does your hospital admit pediatric patients (< 18 years old) to adult medical-surgical beds (beds that are designated for ADULTS)?
- Yes
 No
- 14d Does your hospital admit pediatric patients to a COMBINED pediatric-adult medical/surgical ward?
- Yes
 No
- 15 For PEDIATRIC patients that need to be transferred to another facility, who transports:
- 15a Infants (children aged 0 to age 2 years, select all that apply)
- Our hospital-based EMS service neonate or pediatric transport team
 - Our hospital-based EMS service adult transport team
 - Local EMS service not based at our hospital
 - Accepting hospital's neonate or pediatric EMS/transport team
 - Accepting hospital's EMS/adult transport team
 - Accepting hospital's adult critical care EMS/transport team
- 15b Children ages 2 to 8 years (select all that apply)
- Our hospital-based EMS service neonate or pediatric transport team
 - Our hospital-based EMS service adult transport team
 - Local EMS service not based at our hospital
 - Accepting hospital's neonate or pediatric EMS/transport team
 - Accepting hospital's EMS/adult transport team
 - Accepting hospital's adult critical care EMS/transport team
- 15c Children ages 8 to 18 years (select all that apply)
- Our hospital-based EMS service neonate or pediatric transport team
 - Our hospital-based EMS service adult transport team
 - Local EMS service not based at our hospital
 - Accepting hospital's neonate or pediatric EMS/transport team
 - Accepting hospital's EMS/adult transport team
 - Accepting hospital's adult critical care EMS/transport team
- 16 For PEDIATRIC patients that need to be transferred to another facility, how far away in miles is the facility that you usually transfer these patients to:
- 16a Infants (children aged 0 to age 2)
- Less than 50 miles
 - 50 to 100 miles
 - 100 to 150 miles
 - 150-200 miles
 - Greater than 200 miles

- 16b Children ages 2 to 8 years
- Less than 50 miles
 - 50 to 100 miles
 - 100 to 150 miles
 - 150-200 miles
 - Greater than 200 miles
- 16c Children ages 8 to 18 years
- Less than 50 miles
 - 50 to 100 miles
 - 100 to 150 miles
 - 150-200 miles
 - Greater than 200 miles

SECTION III: PREPARING FOR AND RESPONDING TO A SURGE OR MASS CASUALTY EVENT INVOLVING CHILDREN

- 17 A SURGE is defined as a large influx of patients resulting from a disaster that exceeds the ability of the healthcare system to provide care as usual. This does NOT include temporary seasonal or weekend fluctuations in census that are not the result of a disaster. What is the estimated number of INPATIENT beds your hospital could surge to beyond your licensed capacity during a disaster if needed? For purposes of this question, include only additional beds (or emergency cots, etc.) that are already on hospital property and that can be immediately put into service.

For example, if you are licensed for 20 and could add 2 beds, please answer 2.

You can put in your best estimate.

- 18 What is the estimated number of EMERGENCY DEPARTMENT beds your hospital could add beyond your licensed capacity if needed? For purposes of this question, include only additional beds (or emergency cots, etc.) that are already on hospital property and that can be immediately put into service

For example, if you are licensed for 10 and could add 2 beds, please answer 2.

You can put in your best estimate.

- 19 Does your hospital conduct yearly or every-other-year disaster drills including pediatric patients (can be a tabletop/paper drill)?
- Yes, annually
 - Yes, every other year
 - No
- 18 Does your hospital's disaster plan address issues specific to caring for children (such as patient tracking and family re-unification, number of surge beds for children, equipment needed for pediatric care, staffing)?
- Yes
 - No

19 Does your hospital currently use telemedicine to help provide patient care? Yes No

Examples: real-time telephone or audio-visual interaction between a provider and a patient over a smartphone, tablet, or computer; remote patient monitoring

20a Does your hospital have reliable high-speed (broadband) internet? Yes No Unsure

20b Is your hospital in an area with reliable cell phone coverage? Yes No Unsure

21 Is your hospital's emergency department director or emergency manager familiar with your state healthcare coalition's pediatric surge annex? Yes No

A "pediatric surge annex" is an document created by your state healthcare coalition (HCC) that applies to mass casualty or disaster event involving a large number of children. It is an appendix to the HCC's Response Plan that addresses specific needs of children and supports providing appropriate pediatric medical care during a disaster.

Are the following items readily available at your hospital (either in the ED or on the inpatient units):

	Yes	No
22a Pediatric emergency cart with access, airway, and other supplies for each color on the Broselow tape with weight-based dosing	<input type="radio"/>	<input type="radio"/>
22b Pediatric defibrillator pads	<input type="radio"/>	<input type="radio"/>
22c Infant and pediatric intraosseous (IO) equipment	<input type="radio"/>	<input type="radio"/>
22d 22 or 24 gauge IVs	<input type="radio"/>	<input type="radio"/>
22e Neonatal or infant pulse oximeter	<input type="radio"/>	<input type="radio"/>
22f Infant and pediatric nasal cannulas	<input type="radio"/>	<input type="radio"/>
22g Neonatal, infant, and pediatric mask for bag-mask device	<input type="radio"/>	<input type="radio"/>
22h Endotracheal tubes in sizes from 2.5 to 6.0 (cuffed or uncuffed)	<input type="radio"/>	<input type="radio"/>

- 22i Laryngoscope blades (curved or straight) sizes 0,1, and 2
- 22j Neonatal, infant, and pediatric blood pressure cuffs
- 22k Diapers in a range of sizes
- 22l Soothing items (pacifiers, toys, distraction items for infants/children)
- 22m Infant formula

23 How many of the following items does your hospital have?

Pediatric ventilators (including dual adult-pediatric ventilators) _____
 Infant isolettes _____
 Infant/toddler cribs _____

In the event of a disaster, would the care team (physicians, nurses) on your ADULT INPATIENT units be able to TEMPORARILY (< 72 hrs) provide SAFE, EFFECTIVE care to PEDIATRIC patients if:

- | | Yes | No |
|--|---|-----------------------|
| 24a Short, Just-in-Time pediatric care modules were available? | <input type="radio"/> | <input type="radio"/> |
| 24b Pediatricians, pediatric critical care physician, and/or pediatric nurses were available by phone or video 24/7? | <input type="radio"/> | <input type="radio"/> |
| 24c A pediatrician, pediatric critical care physician, and/or pediatric nurse were deployed to the unit to be in-person resources? | <input type="radio"/> | <input type="radio"/> |
| 25 Does your hospital offer mental health/behavioral health services for pediatric patients? | <input type="radio"/> Yes
<input type="radio"/> No
<input type="radio"/> Unsure | |
| 26 Does your community or nearby area (defined as within 50 miles of hospital) have mental health/behavioral health clinics or practitioners for pediatric patients? | <input type="radio"/> Yes
<input type="radio"/> No
<input type="radio"/> Unsure | |

SECTION IV: INTEREST IN PEDIATRIC EDUCATION OR DISASTER EXERCISES

- 27 Does your hospital have educational/training programs or expertise in pediatric disaster planning and preparedness that you would be interested in sharing with other hospitals?
- Yes
 No
 Maybe

27a If yes or maybe, please describe.

Would your hospital's staff (physicians, APPs, and/or nurses) be interested in receiving educational opportunities related to or involving:

- | | Yes | No | Maybe |
|--|-----------------------|-----------------------|-----------------------|
| 28a Child-Friendly and Family-Centered Care | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 28b General pediatric refresher course (weight based dosing, milestones, common conditions by age) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 28c Initial pediatric assessment, triage, and stabilization during disasters such as JumpSTART | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 28d Simulations with neonatal and pediatric mannequins | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 28e Standardized courses like PALS, NRP, etc. (Please put desired courses in comments box below) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 28f Other (please describe in comments box below) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

28g Comments:

- 28h What are the barriers to obtaining desired education? Check all that apply
- Staff time constraints/availability
 Funding
 Distance to available training
 Other

Pediatric Disaster Preparedness and Planning: would your hospital be interested in:

- | | Yes | No | Maybe |
|---|-----------------------|-----------------------|-----------------------|
| 29a Assistance in planning and/or conducting a disaster drill involving pediatric patients? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 29b Participating in a regional tabletop disaster exercise involving pediatric patients? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

29c Other (please describe below)

29d Other (please describe):

SECTION V: YOUR THOUGHTS AND COMMENTS

30 What thoughts, comments, or suggestions do you have regarding how to prepare hospitals in your area to respond to a pediatric disaster or surge?

31 Are there any pediatric disaster preparedness resources that you would like to see created on the regional (IA, KS, MO, and NE) level?

SECTION VI: PERMISSION FOR LIMITED DATA SHARING

May we share your answers to the following questions, identifying your hospital by name, to facilitate collaboration?

	Yes	No
Physical resources (questions 22 and 23)	<input type="radio"/>	<input type="radio"/>
Educational interests/resources (question 28)	<input type="radio"/>	<input type="radio"/>
Pediatric disaster preparedness interests (question 29)	<input type="radio"/>	<input type="radio"/>

TO FINISH SURVEY, PLEASE CLICK BUTTON MARKED "SUBMIT" BELOW. A report summarizing data from this survey will be sent out to survey participants by Jan 15, 2022. Thank you for participating!

Appendix C

Regional Pediatric Disaster Needs Assessment: Semi-Structured Interviews with Major Children's Hospital Emergency Managers and Physician Preparedness Leaders

Semi-structured interviews of emergency managers and physician preparedness leaders of eight major children's hospitals* in ASPR Region VII (Table 1) were conducted April 2021 to June 2021. The definition of a major children's hospital for this study was a children's hospital (either embedded within an adult hospital or freestanding) that had a 20 bed or larger NICU, a 10 bed or larger PICU, a pediatric emergency department, and a Level I or Level II trauma center.

The aims of the study were to understand:

- (1) Hospital and local area strengths in pediatric disaster and surge preparedness (PDSP)
- (2) Perceived needs to optimize PDSP in ASPR Region VII
- (3) Potentially beneficial pediatric disaster preparedness or emergency management activities that could be coordinated at the regional level

The specific questions asked were:

- What are some things you feel are being done well in your local area or hospital that could be a model for other hospitals or areas?
- What do you see as needs in your region or area (for example, education, physical resources, communication with other groups) to improve?
- What are some areas of pediatric disaster preparedness/emergency management that you think people would be interested in having coordinated at a regional level?

Table 1:

Hospital	City	State
Blank Children's Hospital	Des Moines	IA
Children's Mercy	Kansas City	MO
Children's Omaha	Omaha	NE
Mercy-Springfield	Springfield	MO
MU Healthcare-Women and Children's	Columbia	MO
SSM Cardinal Glennon Children's Hospital	St. Louis	MO
St. Louis Children's Hospital	St. Louis	MO
University of Iowa Stead Family Children's Hospital	Iowa City	IA

Notes from these meetings were analyzed and key themes in response to each question were identified.

Strengths of Local and Regional Preparedness Systems

- Coordination between leadership at city, county, healthcare coalition, and state level in Missouri
- Experience planning and conducting robust disaster drills involving pediatric patients

Regional Pediatric Disaster and Surge Preparedness Needs:

- Many community hospitals would benefit from expanding their knowledge base, skills, and confidence in management pediatric patients
 - Crucial for keeping less-sick pediatric patients in place during disaster while sicker ones are transported
 - If reverse triage needed to occur, these hospitals might be called upon to take children
- There are limited pediatric patient transport resources outside of major metropolitan areas, and non-pediatric transport teams have variable levels of pediatric training and comfort transporting children
 - Potential negative impact on timely, safe patient transport if specialized neonatal transport teams are unavailable due to weather or being used for other transports
- Hospital systems are unable to know which other hospitals have pediatric beds and staff without calling access center for all of them individually
 - Takes up valuable time in a disaster
- There is a need to be able to track children prior to transfer, during transfer, and upon arrival at other hospital while awaiting reunification with parents
 - Especially important if multiple hospitals and EMS services are involved and children could be moving across state lines
- Unclear logistics for reverse triage if disaster or focal surge affects a major children's hospital or large city
- Lack of financial support for emergency management activities and lack of recognition of the time/effort put in by Emergency Managers and physician leaders on this topic

Opportunities for regionally coordinated pediatric disaster preparedness or emergency management activities

- Region-wide tabletop activity
- Resource mapping (bed availability, transport resources)
- Patient tracking

*Note: There are 9 major children's hospitals in ASPR Region VII using the above definition; repeated attempts to reach personnel from Wesley Children's Hospital (Wichita, KS) to participate in the semi-structured interview were unsuccessful.



REGION VII DISASTER HEALTH RESPONSE ECOSYSTEM

Neonatal/Pediatric Transport Team Survey

Name:

Role:

Organization or Affiliated Hospital:

Location (City/State):

Locations from which transport team has a base/deploys (for example, X Hospital and YZ Regional Airport)

Neonatal/Pediatric Transport Team Composition and Logistics:

What ages of patients does your transport team transport (example 0 to 2 years)?

Who makes up your standard (everyday) transport team? Check all that apply

- Paramedic
- RN
- Respiratory Therapist
- Nurse Practitioner
- Medical Resident
- Physician (fellow or attending)
- Other (please describe)

Are there additional team members that you may deploy for certain transports? Check all that apply.

- Paramedic
- RN
- Respiratory Therapist
- Nurse Practitioner
- Medical Resident
- Physician (fellow or attending)
- ECMO specialist/perfusionist
- Other (please describe)

Are there specific or specialized transport teams? For example, separate neonatal and pediatric transport teams.

How many staffed, ready to be deployed transport teams does your hospital or organization have on a 24 hr basis?

How long are transport team member shifts? What are typical shift start and end times?

Modes of Neonatal/Pediatric Transporting Patients

Which modes of transporting patients does your team use?

- Ground ambulance
- Helicopter
- Fixed wing

How many of the following resources does your transport team have access to/is part of your organizations transport fleet? (For example, your hospital system may own two helicopters to be used by both adult and pedi teams)

- # Ground ambulance

- # Helicopter

- # Fixed wing

- Resources not owned by organization but have contract to use (fixed wing)

What service providers do you use for resources outside of your organization (for example, MedFlight, Life Net, LifeSave Transport, etc)?

Neonatal/Pediatric Patient Population and Transport Range/Catchment Area:

What is your typical transport region (area within state/state/region)?

Does your facility have offsite crew locations (describe below)?

Are there any geographic deployment limits (for example, only within state)?

Neonatal/Pediatric Transport Special Capabilities

Which of the following special capabilities does your transport team have?

- High flow nasal cannula
- Conventional mechanical ventilation
- High frequency oscillator mechanical ventilation (HFOV)
- High Frequency Percussive Ventilation (HFPV) (ex Bronchotron)
- Inhaled nitric oxide
- ECMO
- Other (please describe)

Are there any capabilities that one of your teams has that the other does not? (For example, Neonatal team can provide inhaled nitric oxide but the Pediatric team cannot).

Please describe.

Barriers and Challenges

When thinking about a collaborative regional approach to transport during pediatric surges, what barriers or challenges do you see?

Would it be helpful to have a regional transport coordinating/facilitating center during times of pediatric surge or disaster (one phone number to call to locate a transport team outside of your institution to help with a transport)? Example: evacuation of a NICU, reverse triage.

If yes, do you think there would be institutional “buy-in” to this idea? What issues/problems do you see

Other Thoughts

What do you think is important for others to know about your transport team that we have not asked?

What other thoughts or suggestions do you have?

Pediatric Hospital Characteristics Survey:

Name of person completing survey:

Role of person completing survey:

Email of person completing survey:

Hospital Name:

Hospital Location (City, State)

Pediatric ED and Hospital Beds

Do you have a pediatric emergency room?

If so, how many beds?

How many of each type of bed does your hospital have? Enter 0 if you do not have this bed type

- Well-baby nursery
- NICU
- Pediatric ward
- Pediatric step-down unit
- Pediatric ICU (if combined PICU/PCICU, enter those beds here)
- Pediatric Cardiac/Cardiac Surgery ICU

On a typical day, how many STAFFED beds of each type does your hospital have?

- Well-baby nursery
- NICU
- Pediatric ward
- Pediatric step-down unit
- Pediatric ICU (if combined PICU/PCICU, enter those beds here)
- Pediatric Cardiac/Cardiac Surgery ICU

Advanced Support Modalities

Does your pediatric hospital offer:

- High flow nasal cannula or Vapotherm?
- CPAP/BIPAP

- Conventional mechanical ventilation
- High frequency oscillatory ventilation (HFOV)
- Inhaled nitric oxide
- Continuous renal replacement therapy
- Peritoneal dialysis
- Hemodialysis
- Venovenous ECMO
- Venovenous ECMO
- Organ transplant services (please list which ones if applicable)

Pediatric Specialty Services

Which pediatric subspecialties does your hospital have? Check all that apply. (If these consulting services are offered for children at your hospital but provided by adult subspecialists, that counts, and check the box.)

- Pediatric Allergy and Immunology
- Pediatric Cardiology
- Pediatric Critical Care
- Pediatric Dermatology
- Pediatric Emergency Medicine
- Pediatric Endocrinology
- Pediatric Gastroenterology
- Pediatric Hematology-Oncology
- Pediatric Infectious Diseases
- Neonatology
- Pediatric Nephrology
- Pediatric Neurology
- Pediatric Pulmonary Medicine
- Pediatric Rheumatology

Which types of pediatric surgeons does your hospital have? Check all that apply. (If these consulting services are offered for children at your hospital but provided by adult subspecialists, that counts, and check the box.) If they only operate on certain ages (for example, 12 and up, please specify in comment box)

- Pediatric General Surgery
- Pediatric Cardiothoracic Surgery
- Pediatric Neurosurgery
- Pediatric Orthopedic Surgery
- Pediatric ENT



**HEALTHCARE COALITION
(HCC) MEASUREMENT
SCORECARD**

Building a Roadmap to Readiness

DRAFT by the Emergency Preparedness, Research, Evaluation, and
Practice (EPREP) Program, Harvard T.H. Chan School of Public Health
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DRAFT

Domain Overview

Domain 1: Governance of a Healthcare Coalition

The goal of Domain 1 is to identify and engage current and potential coalition members and build the relationships and organizational structures necessary to facilitate coordination of health and medical assets throughout the disaster lifecycle.

A healthcare coalition is defined as a group of individual healthcare and response organizations (e.g., hospitals, emergency medical services [EMS], emergency management organizations, and public health agencies) in a defined geographic location that play a critical role in developing healthcare system preparedness and response capabilities. 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, including but not limited to the facilitation of strategic planning, identification of gaps and mitigation strategies, operational planning and response, information sharing for improved situational awareness, and resource coordination and management.

An HCC member is defined by the Office of the Assistant Secretary for Preparedness and Response (ASPR) 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.

Supplemental Guidance

[ASPR TRACIE HCC Description](#)

[Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies](#)

[ASPR TRACIE Developed Tools and Templates](#)

[ASPR TRACIE HCC Fiscal Models](#)

[CDC Community Planning Framework for Healthcare Preparedness](#)

Domain 2: Legal and Regulatory Considerations

The goal of Domain 2 is to ensure that the HCC and its key response partners have a functional understanding of the salient legal or policy issues that affect disaster medical planning, response, and recovery for the HCC. Examples of key issues that must be identified include knowledge of norms and protocols related to emergency declarations, laws and regulations related to scope of care and standards of practice, clinician licensing, credentialing, privileging, and liability, use of crisis standards of care, emergency resource procurement, and other issues. Recognizing that each state may have different legal provisions affecting various aspects of disaster medical response, the HCC must be aware of the legal environment in which it operates

Domain Overview

so it can best support response and recovery activities and can also encourage implementation of any measures in advance of a disaster that can streamline HCC activities in an emergency. HCCs may also identify legal experts within their partnerships that can help interpret the law.

Supplemental Guidance

N.B. These resources can help jurisdictions understand the legal parameters within which coalitions operate. Coalitions and states may draft their own legal guides.

[CDC - Selected Federal Legal Authorities Pertinent to Public Health Emergencies](#)

[Mutual Aid Agreements: Essential Legal Tools for Public Health Preparedness and Response](#)

[Disclosures for Emergency Preparedness - A Decision Tool](#)

[The Network for Public Health Law – Emergency Legal Preparedness and Response Resources](#)

[ASPR TRACIE Technical Assistance Request – Guidance on Quarantine and Isolation Legal Authorities - Including HIPPA](#)

[NACCHO Administrative Preparedness Legal Guidebook](#)

Domain 3: Planning

The goal of Domain 3 is to ensure that the HCC and its key response partners have preparedness and response plans in place to coordinate response and recovery activities across the coalition that are consistent with HPP and PHEP requirements as well as the operational capability and capacity of the HCC as defined in their charter. These activities include but are not limited to:

- *Mitigation and countermeasures*
- *Response / surge*
- *Quarantine/isolation*
- *Decontamination*
- *Crisis standards of care*
- *Continuity of operations*
- *Mitigation and countermeasures*
- *Supporting supply chain operations*
- *Health facility evacuation*
- *Patient tracking and reunification*
- *External affairs/communications*
- *Fatality management*
- *Recovery*

Domain Overview

Supplemental Guidance

[ASPR TRACIE Template for Preparedness Plans](#)

[ASPR TRACIE Template for Response Plans](#)

[ASPR TRACIE Template for Recovery Plans](#)

[ASPR TRACIE HCC Resource and Gap Analysis Tool](#)

[ASPR TRACIE HCC Resource and Gap Analysis Aggregator](#)

[ASPR TRACIE HCC Burn Surge Annex Template](#)

[ASPR TRACIE HCC Pediatric Surge Annex Template](#)

[ASPR TRACIE HCC Infectious Disease Surge Annex Template](#)

Domain 4: Information Sharing

The goal of Domain 4 is to establish procedures for information sharing for HCCs. This includes both what information will be shared and how it will be shared. Information sharing processes may differ in normal times and emergency times. HCCs should define the essential elements of information (EIs), indicators, and triggers that will guide information sharing. To define these terms:

- *EIs are datapoints that inform decision-making at all levels of disaster response and recovery.*
- *Indicators are datapoints that predict, "...change in demand for health care service delivery or availability of resources."*
- *Triggers are decision points for implementing response strategies and actions.*

The guidance for identifying and defining indicators and triggers outlined in [Crisis Standards of Care: A Toolkit for Indicators and Triggers](#) can be generalized beyond crisis standards of care and is a resource that can help to inform information sharing operations for some HCCs during times of emergency and medical surge.

Domain 5: Response

The goal of Domain 5 is to establish effective HCC communication, information sharing and response support through HCC-wide coordination. During response to major incidents, HCC response coordination serves as the core of support for HCC activities. HCC response activities should be in coordination with ESF-8 lead agencies. HCC wide coordination can occur through existing EOCs, MOCs, or independently as an HCC emergency operation center. Regardless of the physical structure of the HCC, what is critical is that HCCs have a coordination mechanism

Domain Overview

during response and recovery efforts. HCC-wide coordination may be activated physically in a command center type facility or virtually in support of local, state, or regional response, assisting in the coordination of situational support for disaster clinical and clinical-support operations. The Coalition response plan integrates the actions of the coalition for all hazards situations. In both no-notice and longitudinal disasters, depending on the capabilities and capacities of a particular HCC, HCC coordination may provide support for medical surge in both large-scale and highly specialized scenarios by sharing healthcare situational awareness, supporting the mobilization of appropriate resources, supplies, and medical experts, identifying EEIs regarding the number of victims and their types of injuries, and identifying the availability of medical care resources.

Domain 6: Training

The goal of Domain 6 is to determine the specialized training needs for HCC partners, identify existing trainings, and develop new trainings when applicable to address these needs. Trained HCC members are key to ensuring the effectiveness of the coalition and the preparedness and response of each member. Coalitions should consider both permanent and just-in-time (JIT) educational offerings as well as crisis leadership and health/safety trainings. The HCC should primarily serve as a coordinating hub to synthesize the training needs of coalition members.

Domain 7: Evaluation

The goal of Domain 7 is to give the HCC the opportunity to work with one another collaboratively to examine and enhance response capabilities to emergencies. A coalition wide surge exercise is also an expectation of ASPR. The exercises also serve to test key HCC concepts and protocols related to the domains presented here in a controlled environment. By exercising (or responding to a real-world incident) with other HCC members, the coalition will have a better understanding of jurisdictional issues, agency roles, and institutional limitations. Clarification of roles and responsibilities surrounding the role of the HCC in response may improve cross-disciplinary communication and pre-incident relationships. Following the exercise or real-world response, the coalition should engage in after action reviews and improvement planning.

Domain 1: Governance of a Healthcare Coalition

The goal of Domain 1 is to identify and engage current and potential coalition members and build the relationships and organizational structures necessary to facilitate coordination of health and medical assets throughout the disaster lifecycle.

A healthcare coalition is defined as a group of individual healthcare and response organizations (e.g., hospitals, emergency medical services [EMS], emergency management organizations, and public health agencies) in a defined geographic location that play a critical role in developing healthcare system preparedness and response capabilities. 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, including but not limited to the facilitation of strategic planning, identification of gaps and mitigation strategies, operational planning and response, information sharing for improved situational awareness, and resource coordination and management.

An HCC member is defined by the Office of the Assistant Secretary for Preparedness and Response (ASPR) 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.

Supplemental Guidance:

[ASPR TRACIE HCC Description](#)

[Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies](#)

[ASPR TRACIE Developed Tools and Templates](#)

[ASPR TRACIE HCC Fiscal Models](#)

[CDC Community Planning Framework for Healthcare Preparedness](#)

Domain 1: Governance of a Healthcare Coalition

Core Element 1 (WHAT): Establish an HCC partnership that includes a pre-determined geographical area that would respond to disasters in a coordinated manner

Activity 1. (ASK). Identify and recruit membership from the entities necessary for effective and collaborative disaster health planning and response, and as defined in Domain 1

HCC partnerships may involve a broad range of entities. The entities listed in Task 1A -1D are essential partnership members for a coalition to be considered “response ready” based on HCC HPP Program guidance. Coalitions may expand well beyond the entities listed as a coalition sees fit. In some areas, these stakeholders will be represented by professional associations or single representatives that coordinate with a multitude of facilities, and that may be sufficient representation for a given coalition.

Within each geographic area, coalitions may be comprised differently. This document is to guide coalitions to recommended participants, but those participants may be represented by different individuals in different areas. For example, in larger geographic areas where there are several nursing homes or LTCs, a single association may represent single or multiple facilities.

Task 1A. (HOW). Identify and recruit tertiary care (referral) hospitals within the HCC boundaries with specialty expertise or identify a referral strategy for specialty care and emergency department (ED) recognized through a statewide, territorial, or regional standardized system able to stabilize and/or manage individuals impacted by different incident types

Task 1B. (HOW). Identify and recruit other health care and emergency response entities within HCC partnership boundaries

Task 1C. (HOW). Identify emergency management and public health agencies to collaborate with

Task 1D. (HOW). Identify acute and long-term care entities that have emergency operations plans and guidelines for implementing crisis standards of care

Task 1E. (HOW). Identify and recruit community healthcare agencies, health and medical associations, Durable Medical Equipment (DME), homecare, and visiting nurse entities

Domain 1: Governance of a Healthcare Coalition

Measure 1. Status of identification and recruitment of health care and response entities within HCC boundaries

Directions:

- For each type of organization listed below, circle the value that corresponds with the current status of that organization type’s identification and recruitment into the HCC. Only one value should be selected per row. If not all organizations of the same type are in the same phase of the identification and recruitment process, circle the value that corresponds with the identification and recruitment stage achieved by all of the organizations within that organization type (in other words, “the lowest common denominator”).
 - For example, if there are four state-level emergency management agencies and one has gone through the entire recruitment process and signed a memorandum of understanding (MOU) or an analogous formal document (i.e. Letter or Support, etc.) to join the partnership, two have discussed the terms of joining the partnership, and one has only just been contacted about joining the partnership, circle the value 4.
- Once the recruitment and identification status for all of the listed organization types has been indicated, sum the values for each column. If no value has been selected in a given column, indicate a sum of 0.
- Once a sum has been calculated for each column, add the column sums together for a final composite score.
- In some areas, these stakeholders will be represented by professional associations or single representatives that coordinate with a multitude of facilities, and that may be sufficient representation for a given coalition.
- If any additional context is necessary, including if this is not applicable to your HCC, or if any organizations have declined to join the coalition, use the “Notes” column to provide additional insight into the score selected.

Emergency Management

Examples of relevant emergency management include: State Emergency Management Agency, Regional Emergency Management structures, Local Emergency Management Directors, Federal Emergency Management Partners, Non-Profit Emergency Managers, Healthcare Emergency Managers, Private Sector Emergency Managers, Emergency Management Associations

Not Started	Census of organizations within HCC boundaries		Organizations identified in census contacted about joining the HCC		Organizations have discussed terms of joining the HCC		Organizations have signed MOU or Letter of Support to join HCC		
	Started	Completed	Started	Some organizations	Started	Some organizations	Started	Some organizations	Most organizations
0	1	2	3	4	5	6	7	8	9

Domain Score:

Domain 1: Governance of a Healthcare Coalition

Notes:									
Medical Transportation									
<i>Examples of relevant Emergency Medical Service entities include: EMS services with specialized patient transport capabilities including Wheelchair, Non-ambulatory, and Bariatric; Critical Care Transport; Air Ambulance; Pediatric Ambulance; Neonatal Critical Care</i>									
Not Started	Census of organizations within HCC boundaries		Organizations identified in census contacted about joining the HCC		Organizations have discussed terms of joining the HCC		Organizations have signed MOU or Letter of Support to join HCC		
	Started	Completed	Started	Some organizations	Started	Some organizations	Started	Some organizations	Most organizations
0	1	2	3	4	5	6	7	8	9
Domain Score:									
Notes:									
Public Health									
<i>Examples of relevant public health entities include: State DPH, Regional / County DPH, Local DPH, ESF-8 Planning Partners, Public Health Associations</i>									
Not Started	Census of organizations within HCC boundaries		Organizations identified in census contacted about joining the HCC		Organizations have discussed terms of joining the HCC		Organizations have signed MOU or Letter of Support to join HCC		
	Started	Completed	Started	Some organizations	Started	Some organizations	Started	Some organizations	Most organizations
0	1	2	3	4	5	6	7	8	9
Domain Score:									
Notes:									
Nursing Home Providers									
<i>Examples of relevant nursing home providers include: Long-term Care, Skilled Nursing Facility, Rehabilitation Services, Assisted Living, Home Health Agencies / VNA, Adult Care facilities, Home Hospital</i>									
Not Started	Census of organizations within HCC boundaries		Organizations identified in census contacted about joining the HCC		Organizations have discussed terms of joining the HCC		Organizations have signed MOU or Letter of Support to join HCC		
	Started	Completed	Started	Some organizations	Started	Some organizations	Started	Some organizations	Most organizations
0	1	2	3	4	5	6	7	8	9
Domain Score:									

Domain 1: Governance of a Healthcare Coalition

<i>Notes:</i>									
Composite Domain Score:									
Other									
<i>Examples of other relevant entities include: pharmacy organizations, laboratory organizations, mortuary service organizations, long-term care networks, local businesses, Supply Chain Organizations, Medical Gas Distributors, Durable Medical Equipment Providers</i>									
<i>Not Started</i>	<i>Census of organizations within HCC boundaries</i>		<i>Organizations identified in census contacted about joining the HCC</i>		<i>Organizations have discussed terms of joining the HCC</i>		<i>Organizations have signed MOU or Letter of Support to join HCC</i>		
	<i>Started</i>	<i>Completed</i>	<i>Started</i>	<i>Some organizations</i>	<i>Started</i>	<i>Some organizations</i>	<i>Started</i>	<i>Some organizations</i>	<i>Most organizations</i>
0	1	2	3	4	5	6	7	8	9
Domain Score:									
<i>Notes:</i>									

DRAFT

Domain 1: Governance of a Healthcare Coalition

Activity 2. (ASK). Ensure a governance and organizational structure includes: A governance and organizational structure that clearly defines members’ roles, responsibilities, and resource obligations is critical to ensuring that partners will be ready to respond to disasters, equipped with the right resources in the right place at the right time

Task 2A. (HOW). Create or review a written charter that is agreed upon by the governing body of the HCC and ratified by all entities participating in the coalition

<i>Measure 2. Status of charter development</i>					
Directions:					
<ul style="list-style-type: none"> ● Circle the value that corresponds with the current status of the partnership’s charter. ● Charter should include guidelines on community engagement. ● If any additional context is necessary, including if this is not applicable to your HCC, use the “Notes” column to provide additional insight into the score selected. 					
Task Status					Notes
Not Started	<i>HCC charter draft circulated with members</i>	<i>HCC member feedback on charter draft integrated</i>	<i>Executive committee has ratified the charter</i>	<i>Updated charter shared with partners</i>	
0	1	2	3	4	
0	1	2	3	4	

Task 2B. (HOW). Establish and solidify a decision-making process

The process could be in the form of an executive committee or include all HCC members. If developing an executive committee, consider the following:

Just as the membership of each HCC is unique, the membership of each coalition Executive Committee should reflect each coalition’s unique array of disaster health organizations. The purpose of the Executive Committee is to help with strategic decision-making, governance issues, mission, and overall HCC vision. *These executive committee members may be comprised of varying levels of seniority but should be in decision-making positions. This could include emergency managers, or executive-level individuals. The primary goal of the HCC is supporting hospitals and healthcare organizations during emergencies requiring increased surge capacity, and as such, these roles may not be distributed equally.*

Recommended Executive Committee members include but are not limited to¹:

- Healthcare Facility Representative(s)
- Hospital Representative(s)
- Health Department(s) Representative

¹ Note to review the appropriate leadership group

Domain 1: Governance of a Healthcare Coalition

- Health Care Coalition(s) Representative
- One community health center representative (rotating membership)
- One long-term care facility representative (rotating membership)
- Local chapters of national specialty care organizations
- Local partners focused on specialty care such as poison centers, blood banks, veterans' associations, etc.

Measure 3. Status of identification and recruitment of representatives involved in decision-making process

Directions:

- *Circle the value that corresponds with the current status of the identification and recruitment of decision-making representatives. Only one value should be selected per row. If not all potential representative organizations are in the same phase of the identification and recruitment process, circle the value that corresponds with the identification and recruitment stage achieved by all potential representative organizations (in other words, "the lowest common denominator").*
 - *For example, if there are nine potential organizations of decision-making representatives and six have gone through the entire recruitment process and signed on as representatives, two have discussed the terms of joining the committee, and one has only just been contacted about joining the committee, circle the value 4.*
 - *If any additional context is necessary, including if this is not applicable to your HCC, use the "Notes" section to provide additional insight into the score selected.*

Task Status

<i>Not Started</i>	<i>Representatives to be involved in the decision-making process have been identified</i>		<i>Representatives to be involved in the decision-making process have been contacted about joining</i>		<i>Representatives to be involved in the decision-making process have discussed terms of joining</i>		<i>Representatives to be involved in the decision-making process have signed HCC partnership charter agreeing to their role</i>		
	<i>Started</i>	<i>Completed</i>	<i>Started</i>	<i>Some organizations</i>	<i>Started</i>	<i>Some organizations</i>	<i>Started</i>	<i>Some organizations</i>	<i>Most organizations</i>
0	1	2	3	4	5	6	7	8	9

Notes:

Domain 1: Governance of a Healthcare Coalition

Task 2C. (HOW). Create or review a mechanism for all HCC members to receive and share routine (non-emergency) communications from the HCC about its priorities and activities

Measure 4. Status of communication mechanism development					
Directions:					
<ul style="list-style-type: none"> ● Circle the value that corresponds with the current status of the HCC’s communication mechanism. ● If any additional context is necessary, including if this is not applicable to your HCC, use the “Notes” column to provide additional insight into the score selected. 					
Task Status					Notes
Not Started	<i>Proposed communication mechanism circulated with members</i>	<i>HCC member feedback on mechanism integrated</i>	<i>Executive committee has approved the proposed mechanism</i>	<i>Selected mechanism used by all members</i>	
0	1	2	3	4	

Task 2D. (HOW). Adopt participation and engagement guidelines

Measure 5. Status of HCC participation and engagement guidelines				
Directions:				
<ul style="list-style-type: none"> ● Circle the value that corresponds with the current status of the HCC’s policies and procedures. ● If any additional context is necessary, including if this is not applicable to your HCC, use the “Notes” column to provide additional insight into the score selected. 				
Task Status				Notes
Not Started	<i>Proposed participation and engagement guidelines circulated with members</i>	<i>HCC member feedback on guidelines integrated</i>	<i>Executive committee has approved the participation and engagement guidelines</i>	
0	1	2	3	

Domain 1: Governance of a Healthcare Coalition

Task 2E. (HOW). Adopt a routine review process of HCC policies and procedures

Measure 6. Status of routine review process of HCC plans and procedures					
Directions:					
<ul style="list-style-type: none"> ● Circle the value that corresponds with the current status of the HCC’s routine review process of HCC policies and procedures ● If any additional context is necessary, including if this is not applicable to your HCC, use the “Notes” column to provide additional insight into the score selected. 					
Task Status					Notes
Not Started	<i>Response plan has been drafted</i>	<i>Response plan has been adopted</i>	<i>Response plan has been reviewed annually</i>	<i>Response plan has been updated</i>	
0	1	2	3	4	

Task 2F. (HOW). Engage in community-based outreach

The Centers for Disease Control and Prevention’s (CDC) Principles of Community Engagement defines community engagement as the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices. For more information, including examples of community partners, please refer to the [CDC Community Planning Framework for Healthcare Preparedness](#) or the [CTSA Principles of Community Engagement](#).

Measure 7. Status of HCC community engagement					
Directions:					
<ul style="list-style-type: none"> ● Circle the value that corresponds with the current status of the HCC’s community engagement efforts ● If any additional context is necessary, including if this is not applicable to your HCC, use the “Notes” column to provide additional insight into the score selected. 					
Task Status					Notes
Not Started	<i>A community-based partner has been identified</i>	<i>Multiple community-based partners have been identified</i>	<i>Community-based partners have been engaged in response planning</i>	<i>Community outreach is ongoing part of response planning</i>	

Domain 1: Governance of a Healthcare Coalition

0	1	2	3	4	
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Measure 8. Status of identifying population access and functional needs

Directions:

- Circle the value that corresponds with the current status of the HCC’s efforts to identify populations with a higher likelihood of having access and function needs using the Social Vulnerability Index (SVI) or US Census.
- If any additional context is necessary, including if this is not applicable to your HCC, use the “Notes” column to provide additional insight into the score selected.

Task Status				Notes
Not Started	<i>Data obtained from SVI/ Census</i>	<i>Population access and functional needs documented</i>	<i>Population access and functional needs updated yearly using SVI/census</i>	
0	1	2	3	

Activity 3. (ASK). Establish a defined funding mechanism and structure

For more information, please refer to the [ASPR TRACIE HCC Fiscal Model document](#).

Task 3A. (HOW). Document the financing models that support HCC activities including federal funding and any other applicable mechanisms

Measure 9. Status of a sustainable HCC financing model

Directions:

- Circle the value that corresponds with the current status of the HCC’s efforts to establish a joint sustainable funding model
- If any additional context is necessary, including if this is not applicable to your HCC, use the “Notes” column to provide additional insight into the score selected.

Task Status					Notes
Not Started	<i>A sustainable financing model has been discussed by HCC members</i>	<i>A sustainable financing model has been developed into a written document</i>	<i>A sustainable financing model has been approved</i>	<i>A sustainable financing model has been implemented and reviewed</i>	
0	1	2	3	4	

Domain 1: Governance of a Healthcare Coalition

Task 3B. (HOW). Determine ways to share resources and equipment within the coalition’s geographic area and where applicable, across coalitions

Measure 10. Identify resources and equipment that allow for sharing or emergency allocation of equipment					
Task Status					
Not Started	<i>Resources and equipment for sharing/allocation have been discussed by HCC members</i>	<i>A model for equipment sharing/allocation has been developed into a written document</i>	<i>A model for equipment sharing/allocation has been approved by the HCC decision-making body</i>	<i>A model for equipment sharing/allocation has been used by the HCC in an exercise or real-world scenario</i>	<i>Notes</i>
0	1	2	3	4	

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Domain 2: Legal and Regulatory Considerations

The goal of Domain 2 is to ensure that the HCC and its key response partners have a functional understanding of the salient legal or policy issues that affect disaster medical planning, response, and recovery for the HCC. Examples of key issues include knowledge of norms and protocols related to emergency declarations, laws and regulations related to scope of care and standards of practice, clinician licensing, credentialing, privileging, and liability, use of crisis standards of care and emergency resource procurement. . Recognizing that each state may have different legal provisions affecting various aspects of disaster medical response, the HCC must be aware of the legal environment in which it operates so it can best support response and recovery activities and can also encourage implementation of any measures in advance of a disaster that can streamline HCC activities in an emergency.

Supplemental Guidance:

N.B. These resources can help jurisdictions understand the legal parameters within which coalitions operate. Coalitions and states may draft their own legal guides.

[CDC - Selected Federal Legal Authorities Pertinent to Public Health Emergencies](#)

[Mutual Aid Agreements: Essential Legal Tools for Public Health Preparedness and Response](#)

[Disclosures for Emergency Preparedness - A Decision Tool](#)

[The Network for Public Health Law – Emergency Legal Preparedness and Response Resources](#)

[ASPR TRACIE Technical Assistance Request – Guidance on Quarantine and Isolation Legal Authorities - Including HIPPA](#)

[NACCHO Administrative Preparedness Legal Guidebook](#)

Domain 2: Legal and Regulatory Considerations

Core Element 1. (WHAT): Assess regulatory and legal barriers to disaster health response

Activity 1. (ASK). Understand federal or state statutory, regulatory, or national accreditation requirements that impact emergency medical care

Task 1A. (HOW). Review each of the documents to determine federal or state statutory, regulatory, or national accreditation requirements that impact emergency medical care

Activity 2. (ASK). Identify state and federal laws and regulations relevant to acquisition of additional resources for healthcare coalition response and escalation strategies in an emergency

Task 2A. (HOW). Document the statutory and regulatory provisions in emergencies that may impact HCC response and recovery efforts

Different regulatory provisions may exist depending on the type of emergency a state or federal government declares. HCC organizations and their key response partners should identify and compare the types of provisions that exist and the distinctions regarding what they mean for public health and the delivery of healthcare services. HCCs may also identify legal experts within their partnerships that can help them interpret the law.

Measure 1. Status of documenting emergency declarations and their variation for public health among HCC members

Directions:

- Circle the value that corresponds with the current status of the review of regulatory definitions.
- If any additional context is necessary, including if this is not applicable to your HCC, use the “Notes” column to provide additional insight into the score selected.

<i>Regulatory Document</i>	<i>Task Status</i>			<i>Notes</i>
	<i>Not Started</i>	<i>The HCC has reviewed the regulatory provisions</i>	<i>HCC plans have been adapted to the regulatory provisions</i>	
<i>Centers for Medicare & Medicaid Services (CMS) conditions of participation²³</i>	0	1	2	
<i>Clinical Laboratory Improvement Amendments (CLIA)²⁴</i>	0	1	2	
<i>Health Insurance Portability and Accountability Act (HIPAA) and other Privacy Rule requirements^{25 26}</i>	0	1	2	
<i>Emergency Medical Treatment & Labor Act (EMTALA) requirements²⁷</i>	0	1	2	
<i>Licensing and accrediting requirements^{28 29}</i>	0	1	2	

Domain 2: Legal and Regulatory Considerations

<i>Federal disaster declaration processes^{30,31} and public health authorities</i>	0	1	2	
<i>Available federal liability protections Act³²</i>	0	1	2	
<i>Environmental Protection Agency (EPA) requirements³³</i>	0	1	2	
<i>Occupational Safety and Health Administration (OSHA) requirements³⁴</i>	0	1	2	

Task 2B. (HOW). Incorporate references to state and federal laws and regulations applicable to acquiring additional response resources when escalation strategies are activated

Measure 2. Status of incorporating references to state and federal laws and regulatory provisions into coalition response plans

Directions:

- Circle the value that corresponds with the current status of the review of regulatory provisions.
- If any additional context is necessary, including if this is not applicable to your HCC, use the “Notes” column to provide additional insight into the score selected.

Task Status					Notes
Not Started	<i>The HCC has reviewed state and federal regulatory provisions</i>	<i>The HCC has referenced state and federal regulatory provisions in their regional/statewide preparedness and response plans, as appropriate</i>	<i>The HCC has incorporated state and federal regulatory provisions in a coalition wide drill or exercise</i>	<i>The HCC has incorporated an annual review of state and federal regulatory provisions in their coalition preparedness and response plans, as appropriate</i>	
0	1	2	3	4	

Activity 3. (ASK). Assess and address challenges related to coordinating the use of affiliated and non-affiliated healthcare volunteers and licensed healthcare professionals in accordance with state and federal regulations

Task 3A. (HOW). Describe the processes in place to request licensed health professionals to support healthcare response and recovery operations, including those occurring at alternate care sites

Streamlined processes that are preplanned with specific healthcare organizations who are likely to contribute assets to a regional disaster event can often facilitate a more rapid response, and ultimately recovery efforts.

Domain 2: Legal and Regulatory Considerations

<i>Measure 3. Status of describing process for implementing EMAC</i>				
Directions:				
<ul style="list-style-type: none"> • Circle the value that corresponds with the current status of the process for implementing EMAC for each member. • If any additional context is necessary, including if this is not applicable to your HCC - especially as EMAC is a state-to-state initiative - use the “Notes” column to provide additional insight into the score selected. 				
<i>Task Status</i>				Notes
<i>Not Started</i>	<i>The HCC has identified pre-planned solutions for sharing assets across healthcare organizations involved in disaster medical response and recovery</i>	<i>The HCC members have signed an MOU for sharing assets across healthcare organizations involved in disaster medical response and recovery</i>	<i>The HCC has incorporated an annual review of pre-planned solutions/ strategies for sharing assets across healthcare organizations involved in disaster medical response and recovery efforts in their coalition preparedness and response plans, as appropriate</i>	
0	1	2	3	

Task 3B. (HOW). Determine the process for requesting and deploying Medical Reserve Corps (MRC) and Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) to augment individual coalition member plans

Each member should document the provisions covered in their plans related to Medical Reserve Corps (MRC) and Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)

<i>Measure 4. Status of identifying provisions for Medical Reserve Corps (MRC) and Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)</i>				
Directions:				
<ul style="list-style-type: none"> • Circle the value that corresponds with the current status of the review of provisions for MRC and ESAR-VHP. • If any additional context is necessary, including if this is not applicable to your HCC, use the “Notes” column to provide additional insight into the score selected. 				
<i>Task Status</i>				Notes
<i>Not Started</i>	<i>The HCC has identified barriers that may exist</i>	<i>The HCC has adopted common provisions for</i>	<i>The HCC has incorporated an annual review of common</i>	

Domain 2: Legal and Regulatory Considerations

	<i>relevant to use of MRC and ESAR-VHP</i>	<i>use of MRC and ESAR-VHP</i>	<i>provisions for use of MRC and ESAR-VHP in their coalition preparedness and response plans, as appropriate</i>	
0	1	2	3	

Activity 4. (ASK). Assess and address challenges related to state amended standards of practice for medical personnel and facilities in an emergency

Task 4A. (HOW). Determine how state scope of practice for medical personnel may be amended during emergencies

“Scope of practice” refers to the services HCWs may provide with a specific license or certification. Variations in the scope of practice between states can limit HCWs working or volunteering across state lines in times of medical surge. States may authorize shifts in scope of practice during declared emergencies such as a pivot to telemedicine or online consultations. HCC members should standardize scope of practice across members. *Please note that this measure may only be applicable to HCCs that have received waivers in the event of a Public Health Emergency Declaration.*

Measure 5. Status of provisions for amending scope of practice

Directions:

- Circle the value that corresponds with the current status of the provisions for amending scope of practice.
- If any additional context is necessary, including if this is not applicable to your HCC, use the “Notes” column to provide additional insight into the score selected.

<i>Task Status</i>					Notes
<i>Not Started</i>	<i>The HCC has reviewed the provisions for amending scope of practice in the state</i>	<i>The HCC has included provisions for amending scope of practice in their HCC preparedness and response plans</i>	<i>The HCC has exercised an amended scope of practice in a drill or real-life event</i>	<i>The HCC has incorporated an annual review of provisions for amending scope of practice in their coalition preparedness and response plans, as appropriate</i>	

Domain 2: Legal and Regulatory Considerations

0	1	2	3	4	
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Task 4B. (HOW). Determine how state requirements for healthcare facilities may be amended in emergencies

In an emergency, there are legal expectations of healthcare facilities. These provisions could include things like requiring hospitals to establish medical staff bylaws including provisions for credentialing/privileging in declared emergencies or legal requirements for hospitals to have an emergency management plan governing hospital response to a declared emergency. Members should be aware of the provisions that apply to healthcare facilities in their state. Different provisions may apply to different types of healthcare facilities such as alternate care sites.

Measure 6. Status of provisions for state requirements for healthcare facilities

Directions:

- Circle the value that corresponds with the current status of the provisions for amending scope of expectations for healthcare facilities.
- If any additional context is necessary, including if this is not applicable to your HCC, use the “Notes” column to provide additional insight into the score selected.

Task Status				Notes
Not Started	<i>The HCC has reviewed the provisions for amending expectations for healthcare facilities</i>	<i>The HCC has included provisions for amending expectations for healthcare facilities in their HCC preparedness and response plans</i>	<i>The HCC has incorporated an annual review of provisions for amending expectations for healthcare facilities in their HCC preparedness and response plans, as appropriate</i>	
0	1	2	3	

Activity 5. (ASK). Identify liability, immunity, and volunteer protections for healthcare workers at coalition member organizations

Liability risk for HCWs in an emergency situation may increase due to changes to the routine practice environment. Several federal and state laws protect against liability during emergency, however, there is no universal protection against all possible sources of liability, and there is likely to be variation among states within an HCC.

Domain 2: Legal and Regulatory Considerations

Task 5A. (HOW). Characterize federal and state civil liability and malpractice policies in the context of an emergency

Civil liability most often arises through legal malpractice claims. States may vary in their liability protection for “discretionary acts” by state/local actors in declared emergencies. Some state laws provide HCWs or volunteer health professionals (VHPs) with immunity or other protection from civil liability when responding to an emergency, either as individuals or as a part of designated disaster medical response teams. States laws may limit civil liability protections for acts that involve gross negligence, recklessness, or willful or wanton misconduct. Members must be aware of their state provisions in preparing for working with HCWs and VHPs that may cross state bounds in an emergency.

Measure 7. Status of identifying state civil liability policies for HCWs in an emergency						
Directions:						
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of the characterization of civil liability policies in an emergency. If any additional context is necessary, including if this is not applicable to your HCC, use the “Notes” column to provide additional insight into the score selected. 						
Task Status						Notes
Not Started	<i>The HCC has reviewed civil liability policies available at the federal level relevant to disaster medical response and recovery</i>	<i>The HCC has reviewed civil liability policies available at the federal and state level relevant to disaster medical response and recovery</i>	<i>The HCC has determined HCC wide standards for civil liability for HCC partners</i>	<i>All HCC partner organizations have adopted collectively agreed upon standards for protection of HCWs</i>	<i>The HCC has incorporated an annual review of standards for civil liability and malpractice for HCC partners in their coalition preparedness and response plans, as appropriate</i>	
0	1	2	3	4	5	

Task 5B. (HOW). Assess protections available to out of state healthcare personnel responding in a disaster such as workers compensation policies for injuries or infections contracted while volunteering

Protections for HCWs and VHPs will vary in an emergency. Some things to keep in mind that may be in place in states include how state/local laws support rights to reemployment for those assigned to emergency response efforts outside their normal employment settings, if state laws provide HCWs or VHPs with immunity from civil liability when responding to an emergency or if

Domain 2: Legal and Regulatory Considerations

state/local laws include paid sick & safe time protections for HCWs & VHPs temporarily disabled by infection or other injuries in emergencies.

Measure 8. Status of incorporating protections in place for HCWs						
Directions:						
<ul style="list-style-type: none"> • Circle the value that corresponds with the current status of the review of protections for HCWs. • If any additional context is necessary, including if this is not applicable to your HCC, use the “Notes” column to provide additional insight into the score selected. 						
Task Status						Notes
Not Started	<i>The HCC has reviewed the general protections in place for HCWs available at the federal level relevant to disaster medical response and recovery</i>	<i>The HCC has reviewed the general protections in place for HCWs available at the federal and state level relevant to disaster medical response and recovery</i>	<i>The HCC has adopted HCC wide standards for protections in place for HCWs</i>	<i>All HCC partner organizations have adopted uniform standards for protections of HCWs</i>	<i>The HCC has incorporated an annual review of standards for protections in place for HCWs in their coalition preparedness and response plans, as appropriate</i>	
0	1	2	3	4	5	

Activity 6. (ASK). Evaluate and address response challenges related to medical privacy laws and regulations – including HIPAA and EMTALA

HCC response and recovery efforts requires extensive coordination and information sharing among multiple members and stakeholders. Sometimes this means identifiable data must be exchanged between HCWs, hospitals, and public health officials.

Task 6A. (HOW). Assess how state and local laws related to medical privacy protections may affect disaster response and recovery

HIPAA typically governs the exchange of identifiable information but there are additional state and local provisions that may apply. Members should consider if health information privacy laws allow exchanges of public health information to protect public health & maximize patient care or if they allow for waivers of health information privacy laws that may limit the flow of essential public health data during an emergency. *Please note that this measure may only be applicable to HCCs that have received waivers in the event of a Public Health Emergency Declaration.*

Domain 2: Legal and Regulatory Considerations

Measure 9. Status of incorporating laws related to medical privacy protections in a disaster

Directions:

- Circle the value that corresponds with the current status of the review of medical privacy protections in a disaster.
- If any additional context is necessary, including if this is not applicable to your HCC – this may only be applicable to HCCs that have received waivers in the event of a public health emergency declaration – use the “Notes” column to provide additional insight into the score selected.

Task Status						Notes
Privacy Protection	Not Started	<i>The HCC has reviewed how state laws related to medical privacy protections may affect disaster response and recovery</i>	<i>The HCC has reviewed how state and local laws related to medical privacy protections may affect disaster response and recovery</i>	<i>The HCC has incorporated a reference to state and local laws related to medical privacy protections into their preparedness and response plans, as appropriate</i>	<i>The HCC has incorporated an annual review of state and local laws related to medical privacy protections in their preparedness and response plans, as appropriate</i>	
Health Insurance Portability and Accountability Act (HIPAA)	0	1	2	3	4	
Emergency Medical Treatment & Labor Act (EMTALA)	0	1	2	3	4	

Domain 2: Legal and Regulatory Considerations

Core Element 2. (WHAT): Develop, review, or refine plans related to alternate care systems – including crisis standards of care (CSC), alternate care sites, and isolation and quarantine

Activity 1. (ASK). Establish processes for implementing coordinated Alternate Care System guidelines in the clinical setting for all clinical care partners

Task 1A. (HOW). Create crisis standard of care (CSC) guidance that can be shared across all partners, if one does not already exist

CSC refers to the substantial changes in typical healthcare operations and level of care that can occur during emergencies. When an emergency is declared, there is often a shift to CSC which means a shift from focusing on individual to population needs. Under CSC, persons with the greatest needs tend to receive available care first until everyone requiring services can be assessed and initially treated. Most medical care delivery partners may have existing norms for CSC. If so, please indicate as such in the notes.

Task 1B. (HOW). Create Alternate Care Sites (ACS) guidance that can be shared across all partners, if one does not already exist

Task 1C. (HOW). Adopt Isolation and Quarantine (IQ) guidance that can be shared across all partners

Measure 10. Status of Alternate Care Systems Guidelines

Directions:

- Circle the value that corresponds with the current status of Alternate Care Systems guidelines.
- If any additional context is necessary, including if this is not applicable to your HCC – especially as CSC guidance can occur at the state level or vary by partner – use the “Notes” column to provide additional insight into the score selected.

Task Status						Notes
Alternate Care System	Not Started	The HCC has created or adopted shared guidelines on the Alternate Care System	All partners have approved of shared Alternate Care System guidelines	Acute and long-term care partners have adopted HCC approved Alternate Care System guidelines in their individual plans	The HCC has incorporated an annual review of shared Alternate Care System guidelines in their preparedness and response plans, as appropriate	

Domain 2: Legal and Regulatory Considerations

CSC	0	1	2	3	4	
ACS	0	1	2	3	4	
IQ	0	1	2	3	4	

Activity 2. (ASK). Identify existing plans and procedures supporting Alternate Care Systems

Task 2A. (HOW). Describe crisis standard of care (CSC) norms for the coalition and identify differences in relevant partners guidance documents (in particular, patient care partners)

Acknowledging CSC plans and norms can help mitigate potential controversial issues inherent in implementation. Members may vary in regard to their CSC decision-making protocols and allocation of scarce resources.

Task 2B. (HOW). Describe Alternate Care Sites (ACS) guidance for each partner and identify differences among guidance documents

Task 2C. (HOW). Describe Isolation and Quarantine (IQ) guidance for each partner and identify differences among guidance documents

Measure 11. Status of Alternate Care System guidance identification and review

Directions:

- Circle the value that corresponds with the current status of the review of Alternate Care System guidance.
- If any additional context is necessary, including if this is not applicable to your HCC, use the “Notes” column to provide additional insight into the score selected.

Task Status						Notes
Alternate Care System	Not Started	<i>The HCC has reviewed the Alternate Care System guidance available at the federal and state level relevant to disaster medical</i>	<i>The HCC has reviewed the specific Alternate Care System guidance at each partnering facility</i>	<i>The HCC has adopted a standard of practice related to Alternate Care System guidance in their preparedness and response</i>	<i>The HCC has incorporated an annual review of practice related to Alternate Care System guidance in their preparedness and response</i>	

Domain 2: Legal and Regulatory Considerations

		<i>response and recovery</i>		<i>plans, as appropriate</i>	<i>plans, as appropriate</i>	
CSC	0	1	2	3	4	
ACS	0	1	2	3	4	
IQ	0	1	2	3	4	

Activity 3. (ASK). Establish early warning signs that Alternate Care Systems may need to be activated

Task 3A. (HOW). Identify the mechanism by which HCC members will signal that capacity is about to be, or has been, fully exceeded by a particular partner

Measure 12. Status of identification of relevant data elements that indicate capacity has been exceeded

Directions:

- Circle the value that corresponds with the current status of the identification of relevant data elements that indicate capacity has been exceeded.
- If any additional context is necessary, including if this is not applicable to your HCC, use the “Notes” column to provide additional insight into the score selected.

Task Status						Notes
<i>Alternate Care System</i>	<i>Not Started</i>	<i>The HCC has discussed data elements that would indicate capacity has been exceeded</i>	<i>The HCC has developed an annex for notifying partners when capacity may about to be exceeded</i>	<i>The HCC has incorporated early warning signs of exceeded capacity into their preparedness and response plans</i>	<i>The HCC has incorporated an annual review of early warning signs related to activation of Alternate Care Systems in their preparedness and response plans</i>	
CSC	0	1	2	3	4	

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<i>ACS</i>	0	1	2	3	4	
<i>IQ</i>	0	1	2	3	4	

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Domain 3: Planning

The goal of Domain 3 is to ensure that the HCC and its key response partners have preparedness and response plans in place to coordinate response and recovery activities across the coalition that are consistent with HPP and PHEP requirements as well as the operational capability and capacity of the HCC as defined in their charter. These activities include but are not limited to:

- *Mitigation and countermeasures*
- *Response / surge*
- *Quarantine/isolation*
- *Decontamination*
- *Crisis standards of care*
- *Continuity of operations*
- *Mitigation and countermeasures*
- *Supporting supply chain operations*
- *Health facility evacuation*
- *Patient tracking and reunification*
- *External affairs/communications*
- *Fatality management*
- *Recovery*

Supplemental Guidance

[ASPR TRACIE Template for Preparedness Plans](#)

[ASPR TRACIE Template for Response Plans](#)

[ASPR TRACIE Template for Recovery Plans](#)

[ASPR TRACIE HCC Resource and Gap Analysis Tool](#)

[ASPR TRACIE HCC Resource and Gap Analysis Aggregator](#)

[ASPR TRACIE HCC Burn Surge Annex Template](#)

[ASPR TRACIE HCC Pediatric Surge Annex Template](#)

[ASPR TRACIE HCC Infectious Disease Surge Annex Template](#)

Domain 3: Planning

Core Element 1. (WHAT): Ensure the HCC has preparedness and response plans

For more information, please see the following templates:

[ASPR TRACIE Template for Preparedness Plans](#)

[ASPR TRACIE Template for Response Plans](#)

[ASPR TRACIE Template for Recovery Plans](#)

Activity 1. (ASK). Establish coalition preparedness and response planning

Task 1A. (HOW). Create virtual process for multi-agency coordination

Measure 1. Status of plans for virtual processes of coordination					
Task Status					Notes
Not Started	<i>Plans for virtual support of multi-agency coordination has been drafted</i>	<i>Plans for virtual support of multi-agency coordination have been finalized</i>	<i>HCC members have been trained on plans for virtual support of multi-agency coordination</i>	<i>Plans for virtual support of multi-agency coordination have been exercised or operationally tested annually</i>	
0	1	2	3	4	

Task 1B. (HOW). Create coalition member job action sheets for responsibilities during response and recovery efforts

Measure 2. Status of coalition member job action sheets for responsibilities during response and recovery efforts	
Task Status	Notes
<p>Directions:</p> <ul style="list-style-type: none"> Circle the value that corresponds with the current status of coalition member job action sheets for responsibilities during response and recovery efforts. If any additional context is necessary, including if this does not apply to your coalition, use the "Notes" column to provide additional insight into the score selected. 	

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Not Started	<i>Drafts of job sheets are under development</i>	<i>Some positions have approved job sheets</i>	<i>All positions have approved job sheets</i>	<i>All positions have approved job sheets that have been exercised or operationally tested annually</i>	
0	1	2	3	4	

Task 1C. (HOW). Integrate preparedness and response planning with appropriate ESF-8 agencies

Measure 3. Status of preparedness and response planning integration with ESF-8 agencies

Directions:

- Circle the value that corresponds with the current status of the integration of preparedness and response planning with ESF-8 agencies.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status				Notes
Not Started	<i>Some ESF-8 agency representatives have reviewed and signed the HCC response plan</i>	<i>Most ESF-8 agency representatives have reviewed and signed the HCC response plan</i>	<i>All ESF-8 agency representatives have reviewed and signed the HCC response plan</i>	
0	1	2	3	

Activity 2. (ASK). Conduct review of existing HCC partner organization hazards vulnerability assessment (HVA) that integrates information from all partners and incorporates results into planning

Please note that in some states a JRA is an analogous assessment. If that is the case, responses to this metric should reflect progress towards the HCC’s JRA.

Task 2A. (HOW). Include relevant partners including emergency management, public health, health care stakeholders, emergency medical services, acute, long-term, outpatient, and ambulatory care in HVA

Measure 4. Status of Hazards Vulnerability Assessment (HVA)

Directions:

- Circle the value that corresponds with the current status of the review of the HCC’s HVA.

Domain 3: Planning

- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Partner	Task Status					Notes
	Not Started	HVA review initiated	HVA review fully completed	Results from HVA review incorporated into planning efforts	Results from HVA review used to identify clinical capacity and capabilities required to respond to various risks	
Emergency Management	0	1	2	3	4	
Public Health	0	1	2	3	4	
Acute care centers	0	1	2	3	4	
Long-term care centers	0	1	2	3	4	
Outpatient care centers	0	1	2	3	4	
Ambulatory care centers	0	1	2	3	4	
Emergency Medical Services	0	1	2	3	4	

Activity 3. (ASK). Review, and as needed, update coalition response plans every year, and as appropriate after drills and exercises, real-world events, or updates are made to coalition HVA risks

Domain 3: Planning

For more information, please refer to the following tools:

[ASPR TRACIE HCC Resource and Gap Analysis Tool](#)

[ASPR TRACIE HCC Resource and Gap Analysis Aggregator](#)

Task 3A. (HOW). Revise preparedness and response plans to address gaps in healthcare system capability and capacity based on exercise and real-world outcomes

Measure 5. Status of addressing gaps in HCC preparedness and response plans					
Task Status					Notes
Not Started	Gaps in healthcare capability or capacity identified from exercises	Gaps in healthcare capability and capacity identified from exercises	HCC preparedness and response plans revised to address some identified gaps	Preparedness and response plans further updated following exercise or real-world event	
0	1	2	3	4	

Task 3B. (HOW). Revise coalition preparedness and response plans to address identified gaps based on exercise or real-world incident outcomes

Measure 6. Status of addressing gaps in HCC preparedness and response plans					
Task Status					Notes
Not Started	Gaps in healthcare capability or capacity identified from exercises	Gaps in healthcare capability and capacity identified from exercises	HCC preparedness and response plans revised to address some identified gaps	Revised preparedness and response plans implemented during disaster	
0	1	2	3	4	

Domain 3: Planning

Task 3C. (HOW). The healthcare coalition preparedness and response plans are reviewed by key stakeholders in the coalition

Measure 7. Status of stakeholder review of the HCC preparedness and response plans				
Directions:				
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of the review of the HCC response plan. If any additional context is necessary, including if this does not apply to your coalition, use the "Notes" column to provide additional insight into the score selected. 				
Task Status				Notes
Not Started	HCC preparedness and response plans circulated with members	HCC member feedback on preparedness and response plans integrated	Executive committee has approved the HCC preparedness and response plans	
0	1	2	3	

Core Element 2. (WHAT): Create and maintain preparedness and response plans for support of patient care management consistent with state and federal requirements

Activity 1. (ASK). Establish guidance for acquiring resources related to the 4-S Resource Planning Model (Staff, Space, Supplies [Stuff], Systems) needed for clinical support during medical surge

Task 1A. (HOW). Identify resources available to expand clinical support capabilities during a medical surge

Measure 8. Status of inventoried resources to expand clinical capabilities during a medical surge					
Directions:					
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of available resources to expand clinical capabilities during a medical surge. If any additional context is necessary, including if this does not apply to your coalition, use the "Notes" column to provide additional insight into the score selected. 					
Task Status					Notes
Model Component	Not Started	Lists of resources to expand CC identified	Resources to expand CC within the coalition inventoried	Inventoried resources to expand CC within the coalition used during exercise	
				All inventories of resources to expand CC within coalition updated annually	

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				or real-time event		
Staffing	0	1	2	3	4	
Space	0	1	2	3	4	
Supplies	0	1	2	3	4	
Systems	0	1	2	3	4	

Task 1B. (HOW). Create a written protocol to acquire resources during a medical surge

Measure 9. Status of protocols to acquire resources during a medical surge

Directions:

- Circle the value that corresponds with the current status of the protocols to acquire resources during a medical surge.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status						Notes
Model Component	Not Started	<i>Protocols to support the acquisition of resources during a disaster surge have been drafted</i>	<i>Protocols to support the acquisition of resources during a disaster surge have been finalized</i>	<i>HCC members have been trained on the protocols to support the acquisition of resources during a disaster surge</i>	<i>Protocols to support the acquisition of resources have been exercised or operationally tested annually</i>	
Staffing	0	1	2	3	4	
Space	0	1	2	3	4	

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Supplies	0	1	2	3	4	
Systems	0	1	2	3	4	

Task 1C. (HOW). Describe the process for requesting and deploying Medical Reserve Corps (MRC) and Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) to augment individual coalition member plans

Measure 10. Status of the processes for requesting and deploying MRC and ESAR-VHP

Directions:

- Circle the value that corresponds with the current status of the processes to request and deploy MRC and ESAR-VHP.
- If any additional context is necessary, including **if this does not apply to your coalition – processes may already exist for activation of the MRC or ESAR-VHP** – use the “Notes” column to provide additional insight into the score selected.

Task Status						Notes
Partner	Not Started	<i>Processes for requesting and deploying are being drafted</i>	<i>Processes for requesting and deploying have been finalized</i>	<i>HCC members have been trained on the processes for requesting and deploying</i>	<i>Processes for requesting and deploying have been exercised or operationally tested annually</i>	
Medical Reserves Corps (MRC)	0	1	2	3	4	
Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)	0	1	2	3	4	

Activity 2. (ASK). Establish prehospital protocols for communication and information sharing (note: for more information see Domain 4: Information Sharing)

Domain 3: Planning

Task 2A. (HOW). Develop communication and information sharing protocols for prehospital communication with healthcare (e.g. 911 on standby for large scale events, telecommunications, radio, online communication)

Measure 11. Status of prehospital communication protocols					
Directions:					
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of the prehospital communication and information sharing protocols. If any additional context is necessary, including if this does not apply to your coalition, use the "Notes" column to provide additional insight into the score selected. 					
Task Status					Notes
Not Started	Prehospital communication and information sharing protocols have been drafted	Prehospital communication and information sharing protocols have been finalized	HCC members have been trained on prehospital communication and information sharing protocols	Prehospital communication and information sharing protocols have been exercised or operationally tested annually	
0	1	2	3	4	

Activity 3. (ASK). Review existing CSC plans for alignment with HCC preparedness and response plans

Task 3A. (HOW). Ensure that the HCC crisis standards of care annex includes references to each of the following elements that exist within statewide CSC plans or those found in healthcare facilities:

- a. Personnel resources
- b. Triage method(s)
- c. Treatment algorithm(s)

Measure 12. Status of Crisis Standards of Care plan						
Directions:						
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of the process to review existing CSC plans for alignment with of HCC preparedness and response. If any additional context is necessary, including if this does not apply to your coalition, use the "Notes" column to provide additional insight into the score selected. 						
Task Status						Notes
Element	Not Started	CSC plan including this element has been reviewed	CSC plan including this element has been revised	HCC members have been trained on the CSC plan that	CSC plan including this element has been exercised	

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				includes this element	or operationally tested annually	
Personnel resources	0	1	2	3	4	
Triage methods	0	1	2	3	4	
Treatment algorithm	0	1	2	3	4	

Activity 4. (ASK). Support the development of an alternate care system (ACS) to provide health care to patients during response to, and recovery from a large-scale emergency

Task 4A. (HOW). Work with HCC partner organizations and government officials to ensure that mechanisms exist to deliver care in outpatient settings and other out-of-hospital services when ACS is needed

Measure 13. Status of ACS services implementation plan

Directions:

- Circle the value that corresponds with the current status of the process to create a plan for supporting the implementing ACS services.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

		Task Status				Notes
Setting	Not Started	Identify partner organization ACS plans that currently exist	Develop an inventory of current ACS plans by partner organizations	Aggregate ACS plans across coalition to identify consistencies	Create shared coalition ACS standards that are annually approved	

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Outpatient services	0	1	2	3	4	
Elective hospital services	0	1	2	3	4	
Mobile field hospitals	0	1	2	3	4	
Special medical needs shelters	0	1	2	3	4	
Other services, please specify: _____	0	1	2	3	4	

Task 4B. (HOW). Work with HCC partner organizations and government officials to ensure that procedures for transport of patients when implementing ACS care system delivery are established and tested

Measure 14. Status of patient transport procedures

Directions:

- Circle the value that corresponds with the current status of the procedures for transport of patients when implementing ACS care delivery.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the "Notes" column to provide additional insight into the score selected.

Task Status					Notes
<i>Not Started</i>	<i>Existing patient transport procedures have been identified</i>	<i>Develop an inventory of current patient transport procedures by region or statewide</i>	<i>HCC members have been trained on patient transport procedures</i>	<i>Patient transport procedures have been exercised or operationally tested annually</i>	
0	1	2	3	4	

Domain 3: Planning

Activity 5. (ASK). Plan for behavioral health needs of patients and responders in coalition Response Plan

Task 5A. (HOW). Identify behavioral health resources that are available to provide support to individuals impacted by an event and the responding personnel

Measure 15. Status of behavioral health resources available for support inside the coalition					
Directions:					
<ul style="list-style-type: none"> • Circle the value that corresponds with the current status of the availability of behavioral health resources within the coalition. • If any additional context is necessary, including if this does not apply to your coalition, use the “Notes” column to provide additional insight into the score selected. 					
Task Status					Notes
Not Started	<i>Lists of behavioral health resources identified</i>	<i>Sources of behavioral health resources within the coalition inventoried</i>	<i>Available behavioral health resources used during exercise or real-time event</i>	<i>All inventories of behavioral health resources within the coalition updated after 3 years</i>	
0	1	2	3	4	

Measure 16. Status of behavioral health resources available for support outside the coalition					
Directions:					
<ul style="list-style-type: none"> • Circle the value that corresponds with the current status of the plan to identify behavioral health resources outside the coalition. • If any additional context is necessary, including if this does not apply to your coalition, use the “Notes” column to provide additional insight into the score selected. 					
Task Status					Notes
Not Started	<i>Plan to identify available behavioral health resources outside the coalition has been drafted</i>	<i>Plan to identify available behavioral health resources outside the coalition has been finalized</i>	<i>HCC members have been trained on the plan to identify available behavioral health resources outside the coalition</i>	<i>Plan to identify available behavioral health resources outside the coalition has been exercised or operationally tested annually</i>	
0	1	2	3	4	

Domain 3: Planning

Task 5B. (HOW). Identify pediatric and adult behavioral health providers accessible to the coalition partner organizations

Measure 17. Status of available pediatric and adult behavioral health providers						
Directions:						
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of the availability of pediatric and adult behavioral health providers. If any additional context is necessary, including if this does not apply to your coalition, use the "Notes" column to provide additional insight into the score selected. 						
Type of behavioral health provider	Task Status					Notes
	Not Started	List of behavioral health providers identified	Available behavioral health providers identified	Behavioral health providers participated in exercise or operational test annually	Available behavioral health providers used during real-time emergency	
Adult behavioral health providers	0	1	2	3	4	
Pediatric behavioral health providers	0	1	2	3	4	
Senior behavioral health providers	0	1	2	3	4	

Task 5C. (HOW). Work with HCC partner organizations and government officials to ensure that a plan for triaging behavioral health needs exists and is tested

Measure 18. Status of behavioral health triage plan					
Directions:					
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of the process to create a plan for triaging behavioral health needs. If any additional context is necessary, including if this does not apply to your coalition, use the "Notes" column to provide additional insight into the score selected. 					
Not Started	Task Status				Notes
	Identify existing plans for triaging behavioral health needs	Prepare an inventory of HCC member organizations and	HCC members have been trained on plan for	Plan for triaging behavioral health needs has been exercised or	

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		<i>non-member organizations that can provide triaging services in support of behavioral health needs</i>	<i>triaging behavioral health needs</i>	<i>operationally tested annually</i>	
0	1	2	3	4	

Measure 19. Status of plan for requesting behavioral health providers during an incident

Directions:

- Circle the value that corresponds with the current status of the process to request behavioral health providers.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status					Notes
Not Started	<i>Plan for requesting behavioral health providers has been drafted</i>	<i>Plan for requesting behavioral health providers has been finalized</i>	<i>HCC members have been trained on plan for requesting behavioral health providers</i>	<i>Plan for requesting behavioral health providers has been exercised or operationally tested annually</i>	
0	1	2	3	4	

Measure 20. Status of plan for deploying behavioral health providers during an incident

Directions:

- Circle the value that corresponds with the current status of the process to deploy behavioral health providers.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status					Notes
Not Started	<i>Plan for deploying behavioral health providers has been drafted</i>	<i>Plan for deploying behavioral health providers has been finalized</i>	<i>HCC members have been trained on plan for deploying behavioral health providers</i>	<i>Plan for deploying behavioral health providers has been exercised or operationally tested annually</i>	

Domain 3: Planning

0	1	2	3	4	
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Activity 6. (ASK). Ensure that coalition Response Plan contains an Annex for specialty patient needs and events (burn, chemical incident, infectious disease, etc.)

For annex templates, please refer to the following:

[ASPR TRACIE HCC Burn Surge Annex Template](#)

[ASPR TRACIE HCC Pediatric Surge Annex Template](#)

[ASPR TRACIE HCC Infectious Disease Surge Annex Template](#)

Task 6A. (HOW). Identify available specialty care resources for individuals impacted by an emergency including burn, chemical incident, infectious disease, etc.:

- a. Burn care
- b. Chemical incident
- c. Highly hazardous communicable disease
- d. Pediatric specialty care
- e. Radiation
- f. Trauma
- g. Mass fatality

Measure 21. Status of available specialty care resources

Directions:

- Circle the value that corresponds with the current status of available specialty care resources for individuals impacted by various emergencies.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status					Notes
Specialty type	Resources not identified	List of needed resources created	Available resources identified	Available resources used during real-time emergency	
Burn care	0	1	2	3	
Chemical incident	0	1	2	3	

Domain 3: Planning

Highly hazardous communicable disease	0	1	2	3	
Pediatric specialty care	0	1	2	3	
Radiation	0	1	2	3	
Trauma	0	1	2	3	
Mass Fatality	0	1	2	3	

Task 6B. (HOW). Create an inventory of resources (including resource owner and point-of-contact) available for specialty patient care in the event of an emergency in the form of an Annex to the existing HCC Preparedness and Response Plans

Measure 22. Status of Plan annex containing inventory of patient care resources

Directions:

- Circle the value that corresponds with the current status of the plan annex containing inventory of patient care resources.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Annex	Task Status					Notes
	Not Started	Plan annex has been drafted	Plan annex has been finalized	HCC members have been trained using Plan annex	Plan annex has been exercised or operationally tested annually	
Burn care	0	1	2	3	4	

Domain 3: Planning

Chemical incident	0	1	2	3	4	
Highly hazardous communicable disease	0	1	2	3	4	
Pediatric specialty care	0	1	2	3	4	
Radiation	0	1	2	3	4	
Trauma	0	1	2	3	4	
Mass Fatality	0	1	2	3	4	

Core Element 3. (WHAT): Support the development and maintenance of HCC preparedness and response plan annexes that address mitigation and countermeasures in the event of an emergency or medical surge

Activity 1. (ASK). Work with HCC partner organizations to identify existing strategies and plans in support of acquiring and distributing medical countermeasures (MCMs) to healthcare settings and other points of dispensing

Task 1A. (HOW). Inventory sources of medical countermeasures (MCMs) available within the coalition and other coalitions across the state at least every three years

Measure 23. Status of MCM sources in coalition

Directions:

- Circle the value that corresponds with the current status of the inventory of sources of MCM available within the HCC.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Domain 3: Planning

Task Status					Notes
Not Started	<i>Lists of MCMs identified</i>	<i>Sources of MCMs within coalition inventoried</i>	<i>Inventoried MCMs used during exercise or real-time event</i>	<i>All inventories of MCMs within coalition updated after 3 years</i>	
0	1	2	3	4	

Measure 24. Status of MCM sources in other coalitions

Directions:

- Circle the value that corresponds with the current status of the inventory of sources of MCM available within other state HCCs.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status					Notes
Not Started	<i>Plan to identify available sources of MCM outside the coalition has been drafted</i>	<i>Plan to identify available sources of MCM outside the coalition has been finalized</i>	<i>HCC members have been trained on the plan to identify available sources of MCM outside the coalition</i>	<i>Plan to identify available sources of MCM outside the coalition has been exercised or operationally tested annually</i>	
0	1	2	3	4	

Task 1B. (HOW). Document processes for acquisition and distribution of MCM

Measure 25. Status of the MCM acquisition process

Directions:

- Circle the value that corresponds with the current status of the MCM acquisition process.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status					Notes
Not Started	<i>MCM acquisition process is being drafted</i>	<i>MCM acquisition process has been finalized</i>	<i>HCC members have been trained on the MCM acquisition process</i>	<i>MCM acquisition process has been exercised or operationally tested annually</i>	

Domain 3: Planning

0	1	2	3	4	
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Measure 26. Status of the MCM distribution process

Directions:

- Circle the value that corresponds with the current status of the MCM distribution process.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status					Notes
Not Started	MCM distribution process is being drafted	MCM distribution process has been finalized	HCC members have been trained on the MCM distribution process	MCM distribution process has been exercised or operationally tested annually	
0	1	2	3	4	

Task 1C. (HOW). Healthcare coalition response plan annexes includes an inventory of open and closed PODs within the coalition

Measure 27. Status of the HCC plan to inventory open and closed PODs within the coalition

Directions:

- Circle the value that corresponds with the current status of the HCC plan to inventory open and closed PODs within the coalition.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status					Notes
Not Started	Lists of open and closed PODs within the coalition identified	PODs within coalition inventoried	Inventoried PODs used during exercise or real-time event	All inventories of open and closed PODs within coalition updated after 3 years	
0	1	2	4	5	

Domain 3: Planning

Activity 2. (ASK). Identify supply chain vulnerabilities and continuity plans

Task 2A. (HOW). Describe the current supply chain process and potential points of disruption

Measure 28. Status of the HCC supply chain process					
Directions:					
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of the HCC supply chain process. If any additional context is necessary, including if this does not apply to your coalition, use the "Notes" column to provide additional insight into the score selected. 					
Task Status					Notes
Not Started	Supply chain process drafted	Supply chain process finalized	HCC members have been trained on the supply chain process	Supply chain process has been exercised or operationally tested annually	
0	1	2	3	4	

Task 2B. (HOW). Work with HCC partner organizations to identify potential partners outside of the coalition in the event of supply chain disruption

Measure 29. Status of the external partnership plan to address supply chain disruptions					
Directions:					
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of the external partnership plan to address supply chain disruptions. If any additional context is necessary, including if this does not apply to your coalition, use the "Notes" column to provide additional insight into the score selected. 					
Task Status					Notes
Not Started	External partnership plan to address supply chain disruptions drafted	External partnership plan to address supply chain disruptions has been finalized and MOUs have been signed	HCC members have been trained on the external partnership plan to address supply chain disruptions	External partnership plan to address supply chain disruptions has been exercised or operationally tested annually	
0	1	2	3	4	

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Domain 4: Information Sharing

The goal of Domain 4 is to establish procedures for information sharing for HCCs. This includes both what information will be shared and how it will be shared. Information sharing processes may differ in normal times and emergency times. HCCs should define the essential elements of information (EIs), indicators, and triggers that will guide information sharing. To define these terms:

- *EIs are datapoints that inform decision-making at all levels of disaster response and recovery.*
- *Indicators are datapoints that predict, "...change in demand for health care service delivery or availability of resources."*
- *Triggers are decision points for implementing response strategies and actions.*

The guidance for identifying and defining indicators and triggers outlined in [Crisis Standards of Care: A Toolkit for Indicators and Triggers](#) can be generalized beyond crisis standards of care and is a resource that can help to inform information sharing operations for some HCCs during times of emergency and medical surge.

DRAFT

Domain 4: Information Sharing

Core Element 1. (WHAT): Establish regular communication mechanisms among HCC members, including a catalog of EEs that will inform situational awareness and operational decision-making

Activity 1. (ASK). Establish a process for data sharing (i.e., inpatient bed census, ED census, etc.) for non-emergency days

Task 1A. (HOW). Define data usage terms and conditions

<i>Measure 1. Status of data usage terms and conditions</i>				
Directions:				
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of the data usage terms and conditions. If any additional context is necessary, including if this does not apply to your coalition, use the "Notes" column to provide additional insight into the score selected. 				
Task Status				Notes
<i>Not Started</i>	<i>Data usage terms and conditions circulated with HCC members</i>	<i>HCC member feedback on data usage terms and conditions integrated</i>	<i>Executive committee has approved the data usage terms and conditions</i>	
0	1	2	3	

Activity 2. (ASK). Maintain a list of key organizations, personnel, and mechanisms for communication prior to an emergency

Task 2A. (HOW). Create a mechanism for HCC members to receive routine communications from the HCC about its priorities and activities

Examples include: Unified command call, EOC that meets routinely, state-wide information system, email triage, or regular HCC member meetings

<i>Measure 2. Status of routine communication mechanism</i>						
Directions:						
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of the routine communication mechanism. If any additional context is necessary, including if this does not apply to your coalition, use the "Notes" column to provide additional insight into the score selected. 						
Task Status						Notes
<i>Mechanism</i>	<i>Not started</i>	<i>Plan for routine communication mechanism drafted</i>	<i>Plan for routine communication mechanism finalized</i>	<i>HCC members have been trained on how to use routine communication mechanism</i>	<i>Routine communication mechanism exercised or operationally tested annually</i>	

Domain 4: Information Sharing

Unified Command Call	0	1	2	3	4	
EOC Routine Meetings	0	1	2	3	4	
State-wide Information System	0	1	2	3	4	
Email Triage	0	1	2	3	4	
Regular statewide HCC meetings	0	1	2	3	4	
Statewide HCC Steering Committee meetings	0	1	2	3	4	
Standing Member HCC meetings	0	1	2	3	4	
Other – please specify _____	0	1	2	3	4	

Task 2B. (HOW). Establish an agreement within the HCC regarding which partner organizations will routinely share information

Measure 3. Status of agreement on what information is shared routinely

Directions:

- Circle the value that corresponds with the current status of agreement on what information is shared routinely.
- If any additional context is necessary, including **if this does not apply to your coalition – this may be in the Governance Document for HCC Response Plans** – use the “Notes” column to provide additional insight into the score selected.

Domain 4: Information Sharing

Task Status				Notes
Not Started	Routine information sharing agreement circulated with HCC members	HCC member feedback on routine information sharing agreement integrated	Executive committee has approved the routine information sharing agreement	
0	1	2	3	

Activity 3. (ASK). Establish an EEI catalog of shared nomenclature and terminology to describe medical supply and demand across the region during a disaster

Shared nomenclature and terminology in the form of EEIs enables incident leaders and organizations to effectively communicate and make decisions about health system capacity and needs.

Task 3A. (HOW). Develop a catalogue of EEIs that will inform operational decision making

For HCC that operate within states, consider the state-wide catalogue resource assessment.

Measure 4. Status of EEI catalogue development

Directions:

- Circle the value that corresponds with the current status of the EEI catalogue development.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status						Notes
Model Component	Not Started	Aggregation of HCC and state EEI catalogues underway	EEI catalogue circulated with HCC members	HCC member feedback on EEI catalogue integrated	Executive committee has approved the EEI catalogue	
Staffing	0	1	2	3	4	
Space	0	1	2	3	4	
Supplies	0	1	2	3	4	

Domain 4: Information Sharing

Systems	0	1	2	3	4	
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Task 3B. (HOW). Establish an agreement to safeguard information in EEI catalogue

<i>Measure 5. Status of agreement to safeguard information in EEI catalogue</i>						
Directions:						
<ul style="list-style-type: none"> <i>Circle the value that corresponds with the current status of agreement to safeguard information in EEI catalogue.</i> <i>If any additional context is necessary, including if this does not apply to your coalition, use the “Notes” column to provide additional insight into the score selected.</i> 						
Task Status						Notes
Model Component	Not Started	<i>Agreement to safeguard information in EEI circulated with HCC members</i>	<i>HCC member feedback on agreement to safeguard information in EEI catalogue integrated</i>	<i>Executive committee has approved the agreement to safeguard information in EEI catalogue</i>	<i>Safeguarding of EEI implemented</i>	
Staffing	0	1	2	3	4	
Space	0	1	2	3	4	
Supplies	0	1	2	3	4	
Systems	0	1	2	3	4	

Task 3C. (HOW). Establish an agreement to ensure transparency in data sharing of information in EEI catalogue – including with the state, federal, local, or county government agencies

<i>Measure 6. Status of agreement to ensure transparency in data sharing of information in EEI catalogue</i>
Directions:

Domain 4: Information Sharing

- Circle the value that corresponds with the current status of the agreement to ensure transparency in data sharing of information in EEI catalogue.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected. **In some cases, this may include legal review - please indicate if so in the notes.**

Task Status						Notes
Model Component	Not Started	Transparent data sharing agreement circulated with HCC members	HCC member feedback on transparent data sharing agreement integrated	HCC executive council has approved the transparent data sharing agreement	Relevant state, federal, county, or local government entity has agreed to HCC transparent data sharing agreement	
Staffing	0	1	2	3	4	
Space	0	1	2	3	4	
Supplies	0	1	2	3	4	
Systems	0	1	2	3	4	

Core Element 2. (WHAT): Support the activation and operation of a joint information center (JIC) in an emergency

Activity 1. (ASK). Establish a process for data sharing with JIC for non-emergency days

Task 1A. (HOW). Define data usage terms and conditions for JIC

Measure 7. Status of JIC data usage terms and conditions

Directions:

- Circle the value that corresponds with the current status of the JIC data usage terms and conditions.

Domain 4: Information Sharing

- *If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.*

Task Status				Notes
Not Started	JIC data usage terms and conditions circulated with HCC members	HCC member feedback on JIC data usage terms and conditions integrated	Executive committee has approved the JIC data usage terms and conditions	
0	1	2	3	

Activity 2. (ASK). Identify existing JIC procedures including indicators that trigger a shift from normal to emergency communication processes and align these procedures with procedures developed for the HCC

Task 2A. (HOW). Identify and define potential indicators that define a shift from normal to emergency standards of information sharing for the HCC

Measure 8. Status of indicators that define a shift from normal to emergency standards of information sharing

Directions:

- *Circle the value that corresponds with the current status of indicators that define a shift from normal to emergency standards of information sharing.*
- *If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.*

Task Status						Notes
Not Started	List of indicators that identify and define a shift from normal to emergency standards of information sharing for the HCC has been drafted	List of indicators that identify and define a shift from normal to emergency standards of information sharing for the HCC has been finalized	List of indicators that identify and define a shift from normal to emergency standards of information sharing for the HCC has been incorporated into planning/ response efforts	HCC members have been trained on updated planning/ response efforts including list of indicators	Updated planning/ response efforts including list of indicators have been exercised or operationally tested annually	
0	1	2	3	4	5	

Domain 4: Information Sharing

Task 2B. (HOW). Define which HCC information, based on the EEIs will be shared through the JIC during an incident to facilitate healthcare situational awareness, medical surge response, and critical decision-making

<i>Measure 9. Status of list of EEIs relevant to facilitating healthcare situational awareness and medical surge response</i>							
Directions:							
<ul style="list-style-type: none"> • Circle the value that corresponds with the current status of EEIs relevant to facilitating healthcare situational awareness. • If any additional context is necessary, including if this does not apply to your coalition, use the “Notes” column to provide additional insight into the score selected. 							
Task Status							Notes
Incident type	Not Started	List of relevant EEIs has been drafted	List of relevant EEIs has been finalized	List of relevant EEIs has been incorporated into planning/response efforts	HCC members have been trained on updated planning/response efforts including list of relevant EEIs	Updated planning/response efforts including list of relevant EEIs have been exercised or operationally tested annually	
Burn care	0	1	2	3	4	5	
Chemical incident	0	1	2	3	4	5	
Highly hazardous communicable disease	0	1	2	3	4	5	
Pediatric specialty care	0	1	2	3	4	5	
Radiation	0	1	2	3	4	5	

Domain 4: Information Sharing

Trauma	0	1	2	3	4	5	
Mass Fatality	0	1	2	3	4	5	

Task 2C. (HOW). Define how HCC information will be shared through the JIC during an incident to facilitate healthcare situational awareness, medical surge response and critical decision-making

Measure 10. Status of information sharing plan					
Directions:					
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of the plan to share information, through the JIC, during an incident to facilitate healthcare situational awareness and medical surge response. If any additional context is necessary, including if this does not apply to your coalition - some of this information may be documented in a specific information sharing annex or HCC response plan – use the “Notes” column to provide additional insight into the score selected. 					
Task Status					Notes
Not Started	<i>Plan for information sharing during an incident drafted</i>	<i>Plan for information sharing during an incident finalized</i>	<i>HCC members have been trained on the plan for information sharing during an incident</i>	<i>Plan for information sharing during an incident has been exercised or operationally tested annually</i>	
0	1	2	3	4	

Task 2D. (HOW). Identify and define indicators for activation and deactivation of HCC information sharing and support to the JIC

Measure 11. Status of HCC information-sharing activation indicators	
Directions:	
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of indicators that define activation of HCC information sharing and support to the JIC If any additional context is necessary, including if this does not apply to your coalition, use the “Notes” column to provide additional insight into the score selected. 	
Task Status	Notes

Domain 4: Information Sharing

<i>Incident type</i>	<i>Not Started</i>	<i>List of activation indicators has been drafted</i>	<i>List of activation indicators has been finalized</i>	<i>List of activation indicators has been incorporated into planning/response efforts</i>	<i>HCC members have been trained on updated planning/response efforts including list of activation indicators</i>	<i>Updated planning/response efforts including list of activation indicators have been exercised or operationally tested annually</i>	
Burn care	0	1	2	3	4	5	
Chemical incident	0	1	2	3	4	5	
Highly hazardous communicable disease	0	1	2	3	4	5	
Pediatric specialty care	0	1	2	3	4	5	
Radiation	0	1	2	3	4	5	
Trauma	0	1	2	3	4	5	
Mass Fatality	0	1	2	3	4	5	

Measure 12. Status of HCC information-sharing deactivation indicators

Directions:

- Circle the value that corresponds with the current status of indicators that define deactivation of HCC information sharing and support to the JIC

Domain 4: Information Sharing

- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status							Notes
Incident type	Not Started	List of deactivation indicators has been drafted	List of deactivation indicators has been finalized	List of deactivation indicators has been incorporated into planning/response efforts	HCC members have been trained on updated planning/response efforts including list of deactivation indicators	Updated planning/response efforts including list of deactivation indicators have been exercised or operationally tested annually	
Burn care	0	1	2	3	4	5	
Chemical incident	0	1	2	3	4	5	
Highly hazardous communicable disease	0	1	2	3	4	5	
Pediatric specialty care	0	1	2	3	4	5	
Radiation	0	1	2	3	4	5	
Trauma	0	1	2	3	4	5	
Mass Fatality	0	1	2	3	4	5	

Domain 4: Information Sharing

Core Element 3. (WHAT): Develop and maintain an interoperable communication system that includes secure mechanisms and alternate technologies for information sharing

Activity 1. (ASK). Identify if available, or create and test an interoperable communication system to disseminate information to address situational awareness, medical surge and critical decision-making

Task 1A. (HOW). Ensure that redundant communication technologies exist and are maintained (e.g. telecommunications, radio, online communications)

<i>Measure 13. Status of redundant communication and information sharing technologies</i>					
Directions:					
<ul style="list-style-type: none"> • Circle the value that corresponds with the current status of redundant communication and information sharing technologies. • If any additional context is necessary, including if this does not apply to your coalition, use the “Notes” column to provide additional insight into the score selected. 					
Task Status					Notes
<i>Not Started</i>	<i>Redundant communication and information sharing technologies identified</i>	<i>Redundant communication and information sharing technologies reviewed</i>	<i>HCC members have been trained on how to utilize redundant communication and information sharing technologies</i>	<i>Redundant communication and information sharing technologies have been exercised or operationally tested</i>	
0	1	2	3	4	

Task 1B. (HOW). Identify alternate technologies to maintain situational awareness in the event the primary interoperable communications system fails (e.g., radio channels, dedicated phone lines)

<i>Measure 14. Status of alternate communication and information sharing technologies</i>					
Directions:					
<ul style="list-style-type: none"> • Circle the value that corresponds with the current status of alternate communication and information sharing technologies. • If any additional context is necessary, including if this does not apply to your coalition, use the “Notes” column to provide additional insight into the score selected. 					
Task Status					Notes
<i>Not Started</i>	<i>Alternate communication and information</i>	<i>Alternate communication and information</i>	<i>HCC members have been trained on how to utilize</i>	<i>Alternate communication and information</i>	

Domain 4: Information Sharing

	<i>sharing technologies identified</i>	<i>sharing technologies reviewed</i>	<i>alternate communication and information sharing technologies</i>	<i>sharing technologies have been exercised or operationally tested annually</i>	
0	1	2	3	4	

Task 1C. (HOW). Select communication and information-sharing technologies with which the interoperable communication will expect to receive incident information from, and share incident information with HCC partner organizations

Measure 15. Status of the list of system(s) the interoperable communication center will receive incident information from and share that information with

Directions:

- Circle the value that corresponds with the current status of the list of communication and information sharing system(s) that will receive incident information from and share with HCC partner organizations.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status						Notes
Not Started	<i>List of system(s) to receive and share information from/with has been drafted</i>	<i>List of system(s) to receive and share information from/with has been finalized</i>	<i>List of system(s) to receive and share information from/with has been incorporated into the HCC preparedness and response planning</i>	<i>HCC members have trained on updated planning/ response efforts including list of system(s) to receive and share information from/with HCC partner organizations</i>	<i>Updated planning/ response efforts including list of system(s) to receive and share information from/with have been exercised or operationally tested annually</i>	
0	1	2	3	4	5	

Task 1D. (HOW). Regularly test communication and information-sharing system connectivity among HCC partner organizations that information to support situational awareness and critical decision-making

Domain 4: Information Sharing

Measure 16. Status of the plan to test communication system connectivity

Directions:

- Circle the value that corresponds with the current status of the plan to test communication system connectivity.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status					Notes
Not Started	Plan to test communication system connectivity drafted	Plan to test communication system connectivity finalized	HCC members trained on the plan to test communication system connectivity	Plan to test communication system connectivity has been exercised or operationally tested annually	
0	1	2	3	4	

Activity 2. (ASK). Work with HCC member organizations to ensure that protocols exist to prevent, or address and repair disruptions to the secure transfer of health information and networks used in the exchange of protected patient healthcare-related data

Task 2A. (HOW). Work with HCC member organizations to ensure that an alternate mechanism to securely share protected patient healthcare-related data in response to incidents that disrupt the security of health information systems and networks are in place (e.g., paper/pen, telephone, fax)

Measure 17. Status of the plan to utilize alternate mechanism to securely share information during an incident

Directions:

- Circle the value that corresponds with the current status of alternate mechanism to securely share information during an incident.
- If any additional context is necessary, including **if this does not apply to your coalition – this may be in the Governance Document for HCC Response Plans** – use the “Notes” column to provide additional insight into the score selected.

Task Status					Notes
Not Started	Identify existing plans that ensure alternate mechanisms to securely share protected patient	As appropriate, incorporate the review of the alternate mechanisms for ensuring PHI into the HCC	HCC members have been trained on how to utilize alternate mechanism to securely share	Alternate mechanism to securely share patient data during an incident has been exercised	

Domain 4: Information Sharing

	<i>healthcare-related data</i>	<i>preparedness and response plans</i>	<i>patient data during an incident</i>	<i>or operationally tested annually</i>	
0	1	2	3	4	

Task 2B. (HOW). Work with HCC member organizations to ensure that protocols exist for repairing disruptions in the secure transfer of health information and networks used in the exchange of protected patient healthcare-related data

Measure 18. Status of plan to ensure that disruptions in security of health information systems have existing plans in place to minimize any disruption

Directions:

- Circle the value that corresponds with the current status of identifying plans that exist to repair disruptions in security of health information systems.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status					Notes
Not Started	<i>Identify existing plans that ensure that plans exist for repairing disruptions in security of health information systems</i>	<i>As appropriate, incorporate the review of the plans for repairing disruptions in security of health information systems into the HCC preparedness and response plans</i>	<i>HCC members have been trained on the plan to repair disruptions in security of health information systems</i>	<i>Plan to repair disruptions in security of health information systems has been exercised or operationally tested annually</i>	
0	1	2	3	4	

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Domain 5: Response

The goal of Domain 5 is to establish effective HCC communication, information sharing and response support through HCC-wide coordination. During response to major incidents, HCC response coordination serves as the core of support for HCC activities. HCC response activities should be in coordination with ESF-8 lead agencies. HCC wide coordination can occur through existing EOCs, MOCs, or independently as an HCC emergency operation center. Regardless of the physical structure of the HCC, what is critical is that HCCs have a coordination mechanism during a response. HCC-wide coordination may be activated physically in a command center type facility or virtually in support of local, state, or regional response, assisting in the coordination of situational support for disaster clinical care. The HCC response plan integrates the actions of the coalition for varied all hazards situations. In both no-notice and longitudinal disasters, depending on the capabilities and capacities of a particular HCC, HCC coordination may provide support for medical surge in both large-scale and highly specialized scenarios by sharing healthcare situational awareness, supporting the mobilization of appropriate resources, supplies, and medical experts, identifying EEs regarding the number of victims and their types of injuries, and identifying the availability of medical care resources.

DRAFT

Domain 5: Response

Core Element 1. (WHAT): Establishment of HCC coordination

Activity 1. (ASK). Describe HCC Coordination Operations and Logistics

Task 1A. (HOW). Integrate guidelines for coordination into the existing HCC Preparedness and Response Plans that includes initial emergency notification and an ongoing cadence for communication, information sharing, situational awareness, and critical decision-making.

Measure 1. Status of HCC Coordination Response Plan Annex					
Directions:					
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of HCC Coordination System Annex to the HCC Response Plan. If any additional context is necessary, including if this does not apply to your coalition – this may occur at the state-level – use the “Notes” column to provide additional insight into the score selected. 					
Task Status					Notes
Not Started	HCC Coordination Annex to the HCC Response Plan has been drafted	HCC Coordination Annex to the HCC Response Plan has been finalized	HCC members have been trained on the HCC Coordination Annex to the HCC Response Plan	HCC Coordination Annex to the HCC Response Plan has been exercised or operationally tested annually	
0	1	2	3	4	

Task 1B. (HOW). Develop guidance for staff who will lead HCC coordination

Staff positions may include:

- HCC Response Coordinator
- HCC Medical Advisor
- HCC Executive Team
- HCC Information /Communications Officer
- RDHRS Liaison

If applicable - JAS should be developed for each position listed above - example JAS can be found in the **Appendix**. Job aids could include materials such as checklists, and user guides might be made for the technology tools used by staff leading HCC Coordination.

Domain 5: Response

Measure 2. Status of materials for staff leading HCC coordination

Directions:

- Circle the value that corresponds with the current status of materials for staff leading HCC coordination.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status					Notes
Not Started	Drafts of job sheets, job aids, and technology user guides are under development	Some positions have approved materials	All positions have approved materials	All positions have approved material that have been exercised or operationally tested annually	
0	1	2	3	4	

DRAFT

Task 1C. (HOW). Define Staffing Plan for Core HCC Coordination roles

HCC response plans should target having two coalition-wide members that can fulfil each role at a minimum. The depth of staffing for core HCC Coordination roles is listed in Task 1B.

Measure 3. Status of staffing plan for core HCC Coordination roles

Directions:

- Circle the value that corresponds with the current status of the staffing plan for core HCC Coordination roles.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status				Notes
Not Started	Some core positions have staffing plans	All core positions have staffing plans	Staffing plans are spread across more than one personnel	
0	1	2	3	

Domain 5: Response

Core Element 2. (WHAT): Enhancing response through coordination among Coalition partners and where appropriate utilizing the multi-agency coordination (MAC) group approach

Activity 1. (ASK). Agree on a shared HCC incident action plan (IAP) template that utilizes incident action cycles and is aligned with HCC partner organization members and MAC Group member IAPs

Task 1A. (HOW). Plan for IAP alignment during response

While IAPs are typically only developed during an event, the HCC should have a template in place that is aligned with existing partner organizations and MAC Group member IAPs

Measure 4. Status of the coalition-wide Incident Action Plan template					
Directions:					
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of the coalition-wide Incident Action Plan template. If any additional context is necessary, including if this does not apply to your coalition, use the “Notes” column to provide additional insight into the score selected. 					
Task Status					Notes
Not Started	IAP template circulated with members	HCC member feedback on IAP template integrated	Executive committee has approved the IAP template	IAP template has been exercised or operationally tested annually	
0	1	2	3	4	

Activity 2. (ASK). Establish HCC Coordination System information sharing capability to coordinate communication across coalition members and the community. [see Domain 4-Information Sharing] – indicators related to JIC would apply

Task 2A. (HOW). Identify and select the system(s) with which HCC-wide coordination will occur

Examples of coordination systems include: Unified command call, EOC that meets routinely, state-wide information system, email triage, or regular HCC member meetings

Measure 5. Status of HCC - wide coordination system(s)
Directions: <ul style="list-style-type: none"> Circle the value that corresponds with the current status of the HCC-wide coordination system(s).

Domain 5: Response

• *If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.*

Task Status					Notes
Not Started	List of potential coordination system(s) shared with members	HCC member feedback on potential coordination system(s) integrated	Executive committee has approved the coordination system(s)	HCC-wide coordination system(s) has/have been exercised or operationally tested annually	
0	1	2	3	4	

Task 2B. (HOW). Coordinate relevant health care disaster response and recovery information with the lead response agency (ESF-8 lead agency, for example) to ensure information is accurate, consistent, linguistically, and culturally appropriate, and disseminated to the community using one voice

Measure 6. Status of coordinated information sharing plan with JIS

Directions:

- Circle the value that corresponds with the current status of the plan to coordinate information sharing to the community with their Joint Information Center.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status					Notes
Not Started	Plan for coordinated information sharing drafted	Plan for coordinated information sharing finalized	HCC and JIC members have been trained on the plan for coordinated information sharing	Plan for coordinated information sharing has been exercised or operationally tested annually	
0	1	2	3	4	

Activity 3. (ASK). Establish coalition wide expectations for patient load balancing when facilities are overwhelmed

Task 3A. (HOW). Establish coalition ground rules for requesting assistance from the medical operations center

Domain 5: Response

Measure 7. Status of coalition rules for requesting assistance from medical operations center

Directions:

- Circle the value that corresponds with the current status of the coalition rules for requesting assistance from medical operations center.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status				Notes
Not Started	<i>List of coalition rules for requesting assistance circulated with members</i>	<i>HCC member feedback on coalition rules for requesting assistance integrated</i>	<i>Executive committee has approved the coalition rules for requesting assistance</i>	
0	1	2	3	

DRAFT

Task 3B. (HOW). Work with HCC partner organizations and MAC Group members to Identify transport resources that may be available to the coalition for evacuation and relocation

Measure 8. Status of identified transport resources for patient evacuation and relocation

Directions:

- Circle the value that corresponds with the current status of available transport resources for patient evacuation and relocation.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status						Notes
Not Started	<i>Lists of transport resources for patient evac/ relocation identified</i>	<i>Transport resources for patient evac/ relocation inventoried</i>	<i>HCC has signed MOU with transport resources</i>	<i>Inventoried transport resources for patient evac/ relocation used during exercise or real-time event annually</i>	<i>All inventories of transport resources for patient evac/ relocation within coalition updated annually</i>	
0	1	2	3	4	5	

Task 3C. (HOW). Identify mechanisms for maintaining information sharing, situational awareness, and critical decision-making across facilities

Domain 5: Response

Measure 9. Status of mechanism(s) for maintaining situational awareness					
Directions:					
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of mechanism(s) for maintaining situational awareness. If any additional context is necessary, including if this does not apply to your coalition, use the “Notes” column to provide additional insight into the score selected. 					
Task Status					Notes
Not Started	<i>List of mechanism(s) for maintaining information sharing, situational awareness, and critical decision-making circulated with members</i>	<i>HCC member feedback on mechanism(s) for maintaining information sharing, situational awareness, and critical decision-making</i>	<i>Executive committee has approved the mechanism(s) for maintaining information sharing, situational awareness, and critical decision-making</i>	<i>Mechanism(s) for maintaining information sharing, situational awareness, and critical decision-making has/ have been exercised or operationally tested annually</i>	
0	1	2	3	4	

Core Element 3. (WHAT): Provision of support and services to responders

Activity 1. (ASK). Work with HCC partner organizations and MAC Group members to plan and promote a behavioral health response

Task 1A. (HOW). Work with HCC partner organizations and MAC Group members to plan for unique behavioral health considerations of specialty populations especially children

Measure 10. Status of the psychological support plan annex for specialty populations					
Directions:					
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of the psychological support plan for specialty populations. If any additional context is necessary, including if this does not apply to your coalition, use the “Notes” column to provide additional insight into the score selected. 					
Task Status					Notes
Not Started	<i>Specialty population psychological support plans have been identified for</i>	<i>Specialty population psychological support plan</i>	<i>HCC members have been trained on the specialty population psychological</i>	<i>Specialty population psychological support plan annex has been</i>	

Domain 5: Response

	<i>HCC partner organizations</i>	<i>annex has been finalized</i>	<i>support plan annex</i>	<i>exercised or operationally tested annually</i>	
0	1	2	3	4	

Task 1B. (HOW). Work with HCC partner organizations and MAC Group members to provide for ongoing support for inpatient and outpatient psychiatric patients

<i>Measure 11. Status of the psychological support plan annex for psychiatric patients</i>					
Directions:					
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of the psychological support plan annex for psychiatric patients. If any additional context is necessary, including if this does not apply to your coalition, use the "Notes" column to provide additional insight into the score selected. 					
Task Status					Notes
<i>Not Started</i>	<i>Psychiatric patient psychological support plans have been identified for HCC partner organizations</i>	<i>Psychiatric patient psychological support plan annex has been finalized</i>	<i>HCC members have been trained on the psychiatric patient psychological support plan annex</i>	<i>Psychiatric patient psychological support plan annex has been exercised or operationally tested annually</i>	
0	1	2	3	4	

Task 1C. (HOW). Work with HCC partner organizations and MAC Group members on the dissemination of information to help providers, patients, and family identify signs of acute stress response

<i>Measure 12. Status of the acute stress response informational materials for providers, patients, and families</i>	
Directions:	
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of the acute stress response informational materials for providers, patients, and families. If any additional context is necessary, including if this does not apply to your coalition, use the "Notes" column to provide additional insight into the score selected. 	
Task Status	Notes

Domain 5: Response

Not Started	<i>Acute stress informational materials have been identified for HCC partner organizations</i>	<i>Acute stress informational materials have been finalized for the HCC</i>	<i>HCC leadership has adopted acute stress informational materials</i>	<i>HCC members have used or been trained on the acute stress informational materials</i>	
0	1	2	3	4	

Task 1D. (HOW). Work with HCC partner organizations and MAC Group members to ensure the delivery of psychological first aid

Measure 13. Status of the effort to support delivery of psychological first aid

Directions:

- Circle the value that corresponds with the current status of the effort to support delivery of psychological first aid.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status					Notes
Not Started	<i>Psychological first aid plans have been identified for HCC partner</i>	<i>Psychological first aid plan annex has been finalized</i>	<i>HCC members have been trained on the psychological first aid plan annex</i>	<i>Psychological first aid plan annex has been exercised or operationally tested annually</i>	
0	1	2	3	4	

Core Element 4. (WHAT): Support coordination with experts outside the coalition

Activity 1. (ASK). Develop a process that the HCC will use to rapidly acquire and evaluate specialized clinical knowledge needed during a disaster response

Task 1A. (HOW). Create a roster of specialized expertise available to support coalition members

Measure 14. Status of roster of specialized expertise

Directions:

Domain 5: Response

- Circle the value that corresponds with the current status of the roster of specialized expertise available to support coalition members.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status				Notes
Not Started	Roster of specialized expertise circulated with members	HCC member feedback on roster of specialized expertise integrated	Executive committee has approved the roster of specialized expertise	
0	1	2	3	

Task 1B. (HOW). Identify and define triggers for when the HCC will seek additional technical assistance during a disaster

Measure 15. Status of triggers for seeking additional technical assistance during a disaster

Directions:

- Circle the value that corresponds with the current status of triggers for seeking additional technical assistance during a disaster.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status						Notes
Not Started	List of additional assistance triggers has been drafted	List of additional assistance triggers has been finalized	List of additional assistance triggers has been incorporated into planning/ response efforts	HCC members have been trained on updated planning/ response efforts including list of additional assistance triggers	Updated planning/ response efforts including list of additional assistance triggers have been exercised or operationally tested annually	
0	1	2	3	4	5	

Task 1C. (HOW). Develop a process that the HCC will use to develop and disseminate just-in-time clinical training during a disaster

Domain 5: Response

Measure 16. Status of the process to disseminate Just-in-Time clinical training during a disaster

Directions:

- Circle the value that corresponds with the current status of the process to disseminate Just-In-Time clinical training during a disaster.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status						Notes
Not Started	Just in Time training dissemination process has been drafted	Just in Time training dissemination process has been finalized	Just in Time training dissemination process has been incorporated into planning/ response efforts	HCC members have been trained on the Just in Time training dissemination process	Just in Time training dissemination process has been exercised or operationally tested annually	
0	1	2	3 <small>DRAFT</small>	4	5	

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Domain 6: Training

The goal of Domain 6 is to determine the specialized training needs for HCC partners, identify existing trainings, and develop new trainings when applicable to address these needs. Trained HCC members are key to ensuring the effectiveness of the coalition and the preparedness and response of each member. Coalitions should consider both permanent and just-in-time (JIT) educational offerings as well as crisis leadership and health/safety trainings. The HCC should primarily serve as a coordinating hub to synthesize the training needs of coalition members.

DRAFT

Domain 6: Training

Core Element 1. (WHAT): Identify training needs

Activity 1. (ASK). Conduct a training needs assessment/gap analysis

Task 1A. (HOW). Identify the HCC training priorities for specialty care needs (i.e. CBRNE)

Measure 1. Status of identification of HCC training priorities for specialty care needs				
Directions:				
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of the identification of HCC training priorities for specialty care needs. If any additional context is necessary, including if this does not apply to your coalition, use the "Notes" column to provide additional insight into the score selected. 				
Task Status				Notes
Not Started	HCC training priorities circulated with members	HCC member feedback on training priorities integrated	Executive committee has approved the list of HCC training priorities	
0	1	2	3	

Task 1B. (HOW). Identify logistical implications for training requirements, including staff/member time factors, as well as cost and funding

Measure 2. Status of logistical training requirements					
Directions:					
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of the logistical training requirements. If any additional context is necessary, including if this does not apply to your coalition, use the "Notes" column to provide additional insight into the score selected. 					
Task Status				Notes	
Requirement	Not Started	List of logistical training requirements circulated with HCC members	HCC member feedback on logistical training requirements integrated		Executive committee has approved the list of logistical training requirements
Personnel logistics	0	1	2	3	
Cost and funding logistics	0	1	2	3	

Domain 6: Training

Task 1C. (HOW). Create a needs assessment/gap analysis tool for coalition-wide training needs

<i>Measure 3. Status of a needs assessment/gap analysis tool</i>					
Directions:					
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of the needs assessment tool. If any additional context is necessary, including if this does not apply to your coalition – this may be created at the state level – use the “Notes” column to provide additional insight into the score selected. 					
Task Status					Notes
Not Started	<i>Needs assessment/gap analysis tool has been drafted</i>	<i>Needs assessment/gap analysis tool has been finalized</i>	<i>HCC members have been trained on how to use the needs assessment/gap analysis tool</i>	<i>Needs assessment/gap analysis tool has been operationally tested annually</i>	
0	1	2	3	4	

Activity 2. (ASK). Define the desired skills that are necessary for various HCC positions/roles in support of the 4-S Resource Planning Model (Staff, Space, Supplies [Stuff], Systems)

Task 2A. (HOW). Define skills for Staffing in support of member organizations during disaster response and recovery efforts

<i>Measure 4. Status of identification of skills for Staffing in support of member organizations during disaster response and recovery efforts</i>					
Directions:					
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of the identification of skills for Staffing in support of member organizations during disaster response and recovery efforts. If any additional context is necessary, including if this does not apply to your coalition, use the “Notes” column to provide additional insight into the score selected. 					
Task Status					Notes
Not Started	<i>List of skills for Staffing support of member organizations during disaster response and recovery efforts circulated with HCC members</i>	<i>HCC member feedback members on skills for Staffing support of member organizations during disaster response and recovery efforts integrated</i>	<i>Executive committee has approved the list of skills for Staffing support of member organizations during disaster response and recovery efforts</i>		

Domain 6: Training

0	1	2	3	
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Task 2B. (HOW). Define Space needs (i.e. surge space; alternate care facilities; points-of-distribution, etc.) in support of member organizations during disaster response and recovery efforts

Measure 5. Status of identification of Space needs in support of member organizations during disaster response and recovery efforts

Directions:

- Circle the value that corresponds with the current status of the identification of Space needs in support of member organizations during disaster response and recovery efforts.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status				Notes
Not Started	List of Space needs in support of member organizations during disaster response and recovery efforts circulated with HCC members	HCC member feedback on Space needs in support of member organizations during disaster response and recovery efforts integrated	Executive committee has approved the list of Space needs in support of member organizations during disaster response and recovery efforts	
0	1	2	3	

Task 2C. (HOW). Define Supply needs (i.e. medical/surgical supplies, PPE, equipment, etc.) in support of member organizations during disaster response and recovery efforts

Measure 6. Status of identification of Supply needs in support of member organizations during disaster response and recovery efforts

Directions:

- Circle the value that corresponds with the current status of the identification of Supply needs in support of member organizations during disaster response and recovery efforts.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status				Notes
Not Started	List of Supply needs in support of member organizations during	HCC member feedback on Supply needs in support of member	Executive committee has approved the list of Supply needs in support	

Domain 6: Training

	<i>disaster response and recovery efforts circulated with HCC members</i>	<i>organizations during disaster response and recovery efforts integrated</i>	<i>of member organizations during disaster response and recovery efforts</i>	
0	1	2	3	

Task 2D. (HOW). Define Systems needs (i.e. data management; surveillance: electronic health records; emergency notification; telehealth; incident management, etc.) in support for member organizations during disaster response and recovery efforts

Measure 7. Status of identification of Systems needs in support for member organizations during disaster response and recovery efforts

Directions:

- Circle the value that corresponds with the current status of the identification of System needs in support for member organizations during disaster response and recovery efforts
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status				Notes
Not Started	<i>List of Systems needs in support of member organizations during disaster response and recovery efforts circulated with HCC members</i>	<i>HCC member feedback on Systems needs in support of member organizations during disaster response and recovery efforts integrated</i>	<i>Executive committee has approved the list of Systems needs in support of member organizations during disaster response and recovery efforts</i>	
0	1	2	3	

Activity 3. (ASK). Identify existing trainings to address skills/needs defined in **Activity 2** in support of the 4-S Resource Planning Model

Task 3A. (HOW). Identify existing trainings that address skills/needs defined in the 4-S Resource Planning Model

Measure 8. Status of identification of existing trainings

Directions:

- Circle the value that corresponds with the current status of the identification of existing trainings to satisfy the skills/needs defined in Activity 2 in support of the 4-S Resource Planning Model.

Domain 6: Training

- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status				Notes
Not Started	List of existing training offerings to address 4-S Resource Planning Model skills/needs circulated with HCC members	HCC member feedback on the existing training offerings to address 4-S Resource Planning Model skills/needs integrated	Executive committee has approved the list of existing training offerings to address 4-S Resource Planning Model skills/needs	
0	1	2	3	

Task 3B. (HOW). Document training gaps regarding skills/needs defined in the 4-S Resource Planning Model

Measure 9. Status of identification of training gaps regarding skills/needs defined in the 4-S Resource Planning Model

Directions:

- Circle the value that corresponds with the current status of the identification of gaps in available training offerings in Task 3A regarding skills/needs defined in the 4-S Resource Planning Model.
- If any additional context is necessary, including **if this does not apply to your coalition – training gaps could be based on ASPR HPP guidance or specialty annex information** – use the “Notes” column to provide additional insight into the score selected.

Task Status				Notes
Not Started	List of training gaps regarding skills/needs defined in the 4-S Resource Planning Model circulated with HCC members	HCC member feedback on the training gaps regarding skills/needs defined in the 4-S Resource Planning Model integrated	Executive committee has approved the list of training gaps regarding skills/needs defined in the 4-S Resource Planning Model	
0	1	2	3	

Activity 4. (ASK). Create training hub process for HCC member organizations

Task 4A. (HOW). Develop mechanism to share training information within HCC member organizations

Measure 10. Status of training distribution list for HCC member organizations

Directions:

Domain 6: Training

- Circle the value that corresponds with the current status of the training distribution list for HCC member organizations
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status					Notes
Not Started	Training distribution list has been drafted	Training distribution list has been finalized	HCC members have been trained on how to use the training distribution list	Training distribution list has been operationally tested annually	
0	1	2	3	4	

Task 4B. (HOW). Create a training schedule or cadence for HCC member organizations

Measure 11. Status of a training schedule/cadence for HCC member organizations

Directions:

- Circle the value that corresponds with the current status of a training schedule/cadence for HCC member organizations
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status				Notes
Not Started	Training schedule/cadence circulated with HCC members	HCC member feedback on the training schedule/cadence integrated	Executive committee has approved the training schedule/cadence	
0	1	2	3	

Task 4C. (HOW). Align training expectations across HCC member organizations

Measure 12. Status of training expectations for HCC member organizations

Directions:

- Circle the value that corresponds with the current status of training expectations for HCC member organizations.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status	Notes
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Domain 6: Training

Not Started	<i>HCC member training expectations circulated with HCC members</i>	<i>HCC member feedback on the training expectations integrated</i>	<i>Executive committee has approved the training expectations</i>	
0	1	2	3	

Activity 5. (ASK). Assist with Just in Time (JIT) Training Needs During a Disaster

Task 5A. (HOW). Identify potential Just in Time Training needs

Measure 13. Status of identification of Just in Time Training needs

Directions:

- Circle the value that corresponds with the current status of the identification of Just in Time Training needs.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status				Notes
Not Started	<i>List of JIT training needs circulated with HCC members</i>	<i>HCC member feedback on JIT training needs integrated</i>	<i>Executive committee has approved the list of JIT training needs</i>	
0	1	2	3	

Task 5B. (HOW). Create a needs assessment tool/gap analysis for coalition wide Just in Time Training needs

Measure 14. Status of a needs assessment/gap analysis tool for Just in Time Training needs

Directions:

- Circle the value that corresponds with the current status of the needs assessment/gap analysis tool for Just in Time Training needs.
- If any additional context is necessary, including **if this does not apply to your coalition**, use the “Notes” column to provide additional insight into the score selected.

Task Status					Notes
Not Started	<i>The JIT needs assessment/gap analysis tool has been drafted</i>	<i>The JIT needs assessment/gap analysis tool has been finalized</i>	<i>HCC members have been trained on how to use the JIT needs assessment/gap analysis tool</i>	<i>The JIT needs assessment/gap analysis tool has been operationally tested annually</i>	

Domain 6: Training

0	1	2	3	4	
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Task 5C. (HOW). Assist partners in delivering and evaluating Just in Time Training

Measure 15. Status of HCC Just in Time Training evaluation process					
Directions:					
<ul style="list-style-type: none"> • Circle the value that corresponds with the current status of HCC Just in Time Training evaluation process. • If any additional context is necessary, including if this does not apply to your coalition, use the “Notes” column to provide additional insight into the score selected. 					
Task Status					Notes
Not Started	<i>JIT training evaluation templates developed</i>	<i>JIT training evaluation templates shared with external partners</i>	<i>Results of the JIT training evaluation formalized</i>	<i>Feedback on a final JIT training evaluation tool shared with HCC members</i>	
0	1	2	3	4	

Measure 16. Status of HCC Just in Time Training deliveries					
Directions:					
<ul style="list-style-type: none"> • Circle the value that corresponds with the current status of HCC Just in Time Training deliveries. • If any additional context is necessary, including if this does not apply to your coalition, use the “Notes” column to provide additional insight into the score selected. 					
Task Status					Notes
Not Started	<i>JIT training deliveries identified</i>	<i>JIT training deliveries scheduled</i>	<i>JIT training deliveries conducted</i>	<i>Feedback on training deliveries shared with HCC members</i>	
0	1	2	3	4	

Task 5D. (HOW). Work with HCC partner organizations to develop a request process for Just in Time Training

Measure 17. Status of JIT request mechanism					
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Domain 6: Training

Directions:					
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of JIT request mechanism If any additional context is necessary, including if this does not apply to your coalition – HCC may use extant mechanisms or develop their own – use the “Notes” column to provide additional insight into the score selected. 					
Task Status					Notes
Not Started	JIT request mechanism has been drafted	JIT request mechanism has been finalized	HCC members have been trained on how to use the JIT request mechanism	JIT request mechanism has been operationally tested annually	
0	1	2	3	4	

Core Element 2. (WHAT): Coordinate activities requiring specialized training identified in the training needs assessment/gap analysis with HCC partner organizations

Activity 1. (ASK). Identify requisite materials, spaces, and partners to assist in supporting activities requiring specialized training identified in the training needs assessment/gap analysis

Task 1A. (HOW). Assist in procuring training materials for activities requiring specialized training that were identified in the training needs assessment/gap analysis

Measure 18. Status of training materials for activities requiring specialized training identified in the training needs assessment/gap analysis

Directions:					
<ul style="list-style-type: none"> Circle the value that corresponds with the current status of requisite HCC training for activities requiring specialized training identified in the training needs assessment/gap analysis If any additional context is necessary, including if this does not apply to your coalition, use the “Notes” column to provide additional insight into the score selected. 					
Task Status					Notes
Not Started	List of requisite training materials identified in the training needs assessment/gap analysis circulated with HCC members	HCC member feedback on requisite training materials identified in the training needs assessment/gap analysis integrated	Executive committee has approved the requisite training materials identified in the training needs assessment/gap analysis	All requisite training materials identified in the training needs assessment/ gap analysis acquired	

Domain 6: Training

0	1	2	3	4	
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Task 1B. (HOW). Identify venue – virtual or in-person – for trainings identified in the training needs assessment/gap analysis to take place

Measure 19. Status of training venue				
Directions:				
<ul style="list-style-type: none"> • Circle the value that corresponds with the current status of the venue for HCC trainings identified in the training needs assessment/gap analysis. • If any additional context is necessary, including if this does not apply to your coalition, use the “Notes” column to provide additional insight into the score selected. 				
Task Status				Notes
Not Started	Mode of delivery (in person vs. virtual) decided	Potential venues for HCC trainings identified in the training needs assessment/gap analysis identified	All necessary venues for HCC trainings identified in the training needs assessment/gap analysis secured	
0	1	2	3	

Task 1C. (HOW). Identify partners to assist in addressing training identified in the training needs assessment/gap analysis

Measure 20. Status of partners to assist in addressing training needs				
Directions:				
<ul style="list-style-type: none"> • Circle the value that corresponds with the current status of the partners to assist in addressing training identified in the training needs assessment/gap analysis. • If any additional context is necessary, including if this does not apply to your coalition, use the “Notes” column to provide additional insight into the score selected. 				
Task Status				Notes
Not Started	Mode of delivery (in person vs. virtual) decided	Potential partners to assist in addressing training identified in the training needs assessment/gap analysis	All necessary partners identified to assist in addressing training identified in the training needs assessment/gap analysis	

Domain 6: Training

0	1	2	3	
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Activity 2. (ASK). Facilitate training delivery with HCC partners to coalition members in need of specialized training

Task 2A. (HOW). Assist partners in delivering and evaluating trainings

Measure 21. Status of HCC training evaluation process					
Task Status					Notes
Not Started	HCC training evaluation templates developed	Evaluation templates shared with external partners	Results of the evaluation formalized	Feedback on a final training evaluation tool shared with HCC members	
0	1	2	3	4	

Measure 22. Status of HCC training deliveries					
Task Status					Notes
Not Started	HCC trainings identified	HCC trainings scheduled	HCC trainings conducted	HCC training evaluations documented	
0	1	2	3	4	

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Domain 7: Evaluation

The goal of Domain 7 is to give the HCC the opportunity to work with one another collaboratively to examine and enhance response capabilities to emergencies. A coalition wide surge exercise is also an expectation of ASPR. The exercises also serve to test key HCC concepts and protocols related to the domains presented here in a controlled environment. By exercising (or responding to a real-world incident) with other HCC members, the coalition will have a better understanding of jurisdictional issues, agency roles, and institutional limitations. Clarification of roles and responsibilities surrounding the role of the HCC in response may improve cross-disciplinary communication and pre-incident relationships. Following the exercise or real-world response, the coalition should engage in after action reviews and improvement planning.

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Domain 7: Evaluation

Core Element 1. (WHAT): Exercise and evaluate performance and readiness of HCC to respond to a coalition wide disaster and assist in the coordination of health care service delivery

Activity 1. (ASK). Conduct exercises with HCC partner organizations and other emergency response agencies, or participate in a real-world response/recovery incident

Task 1A. (HOW). Conduct at least one exercise, or participate in a real-world response/recovery incident biannually, that tests the HCCs abilities to assist in the coordination of health care service delivery as defined by the particular HCC charter and HCC response plan.

<i>Measure 1. Status of biannual test of HCC response and coordination</i>					
Directions:					
<ul style="list-style-type: none"> • Circle the value that corresponds with the current status of the bi-annual test of HCC response and coordination through exercises or real-world incident. • If any additional context is necessary, including if this does not apply to your coalition – this may occur at the state level – use the “Notes” column to provide additional insight into the score selected. 					
Task Status					Notes
Not Started	<i>Bi-annual exercise planned</i>	<i>Bi-annual exercise conducted, or real-world incidents have occurred</i>	<i>Results and/or feedback formalized with a peer evaluator</i>	<i>Results from peer evaluator integrated into planning and/or response efforts (i.e. Needs Assessment)</i>	
0	1	2	3	4	

Activity 2. (ASK). Develop after-action reports (AARs) and improvement plans (IPs) based on response and recovery actions identified in the HCC response plan

Task 2A. (HOW). Develop AARs for each exercise and participation in a real-world response/recovery incident based on response and recovery actions identified in the HCC response plan

<i>Measure 2. Status of AARs from previous incidents and responses</i>
Directions:
<ul style="list-style-type: none"> • Circle the value that corresponds with the current status of the development of after-action reports for previous real-world incidents or exercises.

Domain 7: Evaluation

- *If any additional context is necessary, including **if this does not apply to your coalition – this may occur at the state level** – use the “Notes” column to provide additional insight into the score selected.*

Task Status					Notes
Not Started	Draft AAR - with relevant information from extant AARs and IPs - under development	AAR for real world incident or exercise finalized based on response and recovery actions identified in the HCC response plan	Results from AARs integrated into planning and/ or response efforts	Revised plans and/ or response efforts are tested in an exercise or in response to a real-world event	
0	1	2	3	4	

Task 2B. (HOW). Define ownership of actions identified in the IP specific to the HCC or any partner organizations

Measure 3. Status of defining improvement plan (IP) ownership

Directions:

- *Circle the value that corresponds with the current status of defining improvement plan ownership.*
- *If any additional context is necessary, including **if this does not apply to your coalition – this may occur at the state level** – use the “Notes” column to provide additional insight into the score selected.*

Task Status				Notes
Not Started	Proposed IP action item ownership circulated with HCC members	HCC member feedback on proposed IP action item ownership integrated	Executive committee has approved the IP action item ownership proposal	
0	1	2	3	

Task 2C. (HOW). Use AARs to develop IPs for relevant HCC partner organizations

Measure 4. Status of IP development from AAR results and prior IPs

Directions:

- *Circle the value that corresponds with the current status of the development of improvement plans for relevant HCC partner organizations based on AAR results and prior IPs.*
- *If any additional context is necessary, including **if this does not apply to your coalition – this may occur at the state level** – use the “Notes” column to provide additional insight into the score selected.*

Task Status	Notes
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Domain 7: Evaluation

Not Started	<i>Draft IP – including follow up from previous IPs and AARs – under development</i>	<i>IP – including follow up from previous IPs and AARs – finalized</i>	<i>Results from IPs integrated into planning and/ or response efforts for relevant HCC partner organizations</i>	<i>Revised IPs tested in an exercise or in response to a real-world event for relevant HCC partner organizations</i>	
0	1	2	3	4	

Task 2D. (HOW). Use AARs to develop IPs based on relevant HCC participation in an exercise or as a participant in a real-world response/recovery incident

Measure 5. Status of IP development from AAR results and prior IPs based on relevant HCC participation in an exercise or as a participant in a real-world response/recovery incident

Directions:

- Circle the value that corresponds with the current status of the development of improvement plans based on relevant HCC participation in an exercise or as a participant in a real-world response/recovery incident based on AAR results and prior IPs.
- If any additional context is necessary, including **if this does not apply to your coalition – this may occur at the state level** – use the “Notes” column to provide additional insight into the score selected.

Task Status					Notes
Not Started	<i>Draft IP – including follow up from previous IPs and AARs – under development</i>	<i>IP – including follow up from previous IPs and AARs – finalized</i>	<i>Results from IPs integrated into planning and/ or response efforts for relevant HCC partner organizations</i>	<i>IPs tested in an exercise or in response to a real-world event for relevant HCC partner organizations</i>	
0	1	2	3	4	

Activity 3. (ASK). Evaluate partnership performance and response readiness as it pertains to the HCC response and recovery activities defined in the HCC response plan

Task 3A. (HOW). Monitor and document the execution of the IPs developed after both real-world incidents and exercises

Measure 6. Status of developed IPs

Directions:

Domain 7: Evaluation

- Circle the value that corresponds with the current status of the execution of recently developed IPs.
- If any additional context is necessary, including **if this does not apply to your coalition – this may occur at the state level** – use the “Notes” column to provide additional insight into the score selected.

Task Status					Notes
Not Started	IP has been monitored	IP has been executed	IP results have been integrated into HCC planning and/ or response efforts	IPs tested in an exercise or in response to a real-world even	
0	1	2	3	4	

Task 3B. (HOW). Develop coalition-wide evaluation plan for real-world incidents and exercises

Measure 7. Status of a coalition-wide evaluation plan

Directions:

- Circle the value that corresponds with the current status of a coalition-wide evaluation plan for real-world incidents and exercises .
- If any additional context is necessary, including **if this does not apply to your coalition – this may occur at the state level** – use the “Notes” column to provide additional insight into the score selected.

Task Status				Notes
Not Started	Proposed coalition-wide evaluation plan circulated with HCC members	HCC member feedback on coalition-wide evaluation plan integrated	Executive committee has approved the coalition-wide evaluation plan	
0	1	2	3	

Task 3C. (HOW). Engage neighboring coalitions in peer evaluation

Measure 8. Status of peer coalition evaluation

Directions:

- Circle the value that corresponds with the current status of HCC’s attempts at coalition peer evaluation.
- If any additional context is necessary, including **if this does not apply to your coalition** use the “Notes” column to provide additional insight into the score selected.

Task Status	Notes
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Domain 7: Evaluation

<i>Not Started</i>	<i>HCC has identified a peer coalition partner</i>	<i>HCC has secured a peer coalition partner</i>	<i>HCC and peer coalition have evaluated each other's exercises</i>	<i>HCC has reviewed feedback of peer HCC evaluation</i>	
0	1	2	3	4	

Activity 4. (ASK). Conduct an annual review and gap analysis of HCC to assess how well the HCC is meeting its operational responsibilities, performance goals, and metrics

Task 4A. (HOW). Identify HCC goals, key operational responsibilities, and performance metrics to be assessed

Performance goals may be developed in line with existing HPP, PHEP, or State requirements.

Measure 9. Status of document that identifies HCC goals, key operational responsibilities, and performance metrics to be assessed

Directions:

- Circle the value that corresponds with the current status of identifying HCC goals, key operational responsibilities, and performance metrics to be assessed
- If any additional context is necessary, including **if this does not apply to your coalition – this may occur at the state level** – use the “Notes” column to provide additional insight into the score selected.

Task Status				Notes
<i>Not Started</i>	<i>List of goals, key operational responsibilities, and performance metrics to be assessed circulated with HCC members</i>	<i>HCC member feedback on the list of goals, key operational responsibilities, and performance metrics to be assessed integrated</i>	<i>Executive committee has approved the list of goals, key operational responsibilities, and performance metrics to be assessed</i>	
0	1	2	3	

Task 4B. (HOW). Initiate annual review to assess how well the HCC is meeting its operational responsibilities, performance goals, and metrics

Measure 10. Status of HCC annual review

Directions:

Domain 7: Evaluation

- Circle the value that corresponds with the current status of the annual review to assess how well the HCC is meeting its operational responsibilities, performance goals, and metrics utilizing this scorecard.
- If any additional context is necessary, including **if this does not apply to your coalition – this may occur at the state level** – use the “Notes” column to provide additional insight into the score selected.

Task Status					Notes
Not Started	Relevant data to assess how well the HCC is meeting its operational responsibilities, performance goals, and metrics collected using Scorecard	Relevant data to assess how well the HCC is meeting its operational responsibilities, performance goals, and metrics analyzed	Relevant findings to assess how well the HCC is meeting its operational responsibilities, performance goals, and metrics reported and reviewed	Findings to assess how well the HCC is meeting its operational responsibilities, performance goals, and metrics have been integrated into planning and/ or response efforts	
0	1	2	3	4	

Task 4C. (HOW). Establish a process for sharing results of the annual review and gap analysis of the HCC

Measure 11. Status of a process for sharing results of the annual review and gap analysis of the HCC

Directions:

- Circle the value that corresponds with the current status of a process for sharing results of the annual review and gap analysis of the HCC
- If any additional context is necessary, including **if this does not apply to your coalition – this may occur at the state level** – use the “Notes” column to provide additional insight into the score selected.

Task Status					Notes
Not Started	Process for sharing results of the annual review and gap analysis of the HCC circulated with HCC members	HCC member feedback on process for sharing results of the annual review and gap analysis of the HCC integrated	Executive committee has approved the process for sharing results of the annual review and gap analysis of the HCC	Results of the annual review and gap analysis of the HCC have been shared using the approved process amongst HCC members	
0	1	2	3	4	

Appendix

Appendix A: HCC Logic Model

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Health Care Coalition (HCC) Logic Model

